

American Academy of Professional Coders

CODING edge

November 2009

Support Foot, Ankle, and Leg Claims

David J. Freedman, DPM, FASPS, CWS, CPC
Maryland

Plus: CEU Tracker • OB Ultrasound • Undercover Coder • Chiropractic ABN • ICD-9 Changes

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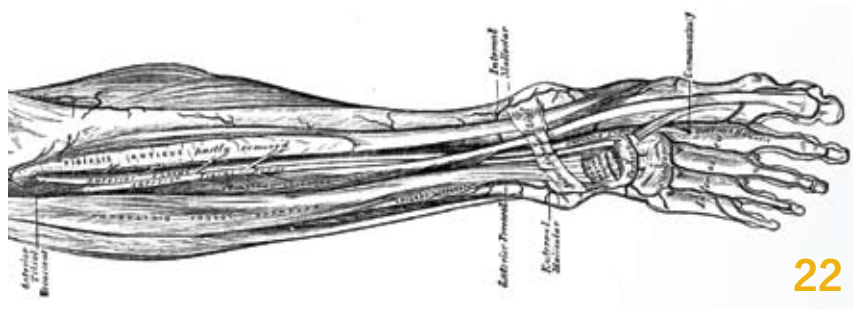


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On the Cover: David J. Freedman, DPM, FASPS, CWS, CPC, a member of the American Podiatric Medical Association (APMA) Coding Committee, has a firm foot on coding as he examines a patient's foot at the Ambulatory Foot & Ankle Center, Inc., in Silver Spring, Md. (www.foot-fixer.com). Cover photo by Mark Molesky (www.moleskyphoto.com).

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American Academy of Professional Coders

CODING

edge

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Targeting the AAPC Audience

The membership of AAPC, and subsequently the readership of *Coding Edge*, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

APPRENTICE

Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.

PROFESSIONAL

More sophisticated issues including code sequencing, modifier use, and new technologies.

EXPERT

Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

AAPC Code of Ethics

Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.



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Fulfill Your Coding Needs Online

For the past two years, we have recorded AAPC members' comments, e-mails, and other suggestions to improve our Web site. Those comments were the genesis of our new Web site. The new site went through extensive beta testing by over 100 members during the last half of October and on Oct. 31, we launched our site that allows members to access content more easily and start on your members' page, if you choose. This is just Phase I. Phase II will come over the next few months.

Quick Access Navigation

If you have not yet seen the new Web site, go to www.aapc.com and check it out. We have combined the main homepage with the Member Area, allowing a single, consistent navigation to content that previously had a different look and feel from each other. The benefit is less jumping back and forth to find specific content. It also means fewer clicks to get to the content accessed most. The primary navigation menu has you less than two clicks away from almost any page on the site.

Personalized Links

Our content is now more personalized for members and non-members. This means members can skip the pages about AAPC, enrollment to become a member, Certified Professional Coder (CPC®) certification, and other information already known to members. Your member page is also personal in terms of membership type: certified, student, or corporate. For example, if you are certified, continuing education unit (CEU) opportunities and the CEU Tracker are on the forefront of the Web site. If you are a student, course listings, instructor contact information, and quick login to online classes are linked right from your member page.

We have also improved the resources and content organization with a new single resources section displaying all available tools, articles, and other information in one place. Events are organized by topic rather



than just by format—"cardiology events" vs. "cardiology workshops"—for example. Past events are now available for download and easier to locate. We have a new bookstore with select third party vendor books available on the AAPC site for purchase at member discounts.

The site is also designed to be efficient. As a result, you should see faster page loading, navigation, and downloads.

Phase II Highlights

Moving forward, Phase II improvements will include the ability to search for CEUs by vendor or type. The member page will provide alerts and notifications and a more efficient online store. Phase II will also include a comprehensive job center for those

seeking jobs or looking to hire coders and for those who need help with resumes and other career information. Members will find better communication tools for networking with other members: officers with their chapters, students with instructors, and specialty coders with those in their specialty. All this can be found from the member page without difficult searches.

We hope you find the new site better fulfills your coding needs. As always, we welcome your feedback! 

Sincerely,

Reed E. Pew
CEO and President

American Academy of Professional Coders



Externs Gain Experience, Mentors Gain New Perspective

By Michelle A. Dick

For newly minted CPC-As, experience is the best test of what's been learned and practiced in the classroom. But, for some, taking that first step into the real world is difficult. Project Xtern is an AAPC program encouraging employers to give beginning coders experience. It is truly a win-win situation: Extra hands help lighten host sites' workloads while externs learn and gain the experience necessary to launch careers.

To get a true understanding of why Project Xtern sites and externs sign up for the program and what exactly they get out of it, however, you have to go straight to the source. We first spoke with **Cora Schrader, PCA, CPC**, billing/financial manager at Wellesley Family Care Associates, PC, and a Project Xtern mentor.

"As professional coders, we all understand what it takes to be a true successful professional in our industry: Coding demands attention to detail and the ability to research, analyze, and evaluate. It requires us to be patient and hone communication skills. It is a journey that requires a sense of curiosity and a perpetual spark of passion for the craft that is transferred to the task at hand," Schrader said. These are real-world skills acquired through experience.

"We have a new generation of coders coming on board that need opportunity and need our assistance. There is no teacher like experience and no better way to pass the torch along than to participate in the AAPC Xtern program for beginner coders," Schrader said. "Externs give back to the mentor just as much as we give to them."

Schrader has found that when the "passion for coding is shared, it becomes contagious; oftentimes unleashing within them (externs) a driving thirst for coding knowledge."

Tricia Petitpas, CPC-A, West Roxbury, Mass., is one of Schrader's externs. She said, "I had such a positive learning experience with Project Xtern. Before my internship, my only experience with health care was as a consumer. It was interesting to see the other side of a physician's office and be able to put what I have read and studied to real world use. One of the most memorable points I learned was that it is one thing to do medical coding and quite another to be reimbursed by the insurance companies."

Sabrina Furstenberg, CPC, CCP, CCS, CIC, revenue and specialty coding manager, Cardiac Cath/Electrophysiology Lab, St. Joseph Mercy Oakland, is also involved in Project Xtern. "We use Project Xtern to give new coders the opportunity to gain the skills and experience they need to apply for positions requiring background experience," she said. "We have had a wonderful set of externs who work hard to obtain the experience they need to apply for a job and successfully gain employment. Most coders have indicated that they really didn't know what was involved until they starting working as an extern and that experience has been invaluable."

Furstenburg's Project Xtern mentoring experience is a testimonial to how sharing coding passion leads to success. "We find that the externs are dedicated and willing to learn whatever it takes to become successful," said Furstenburg.

Externs Do the Compliance Legwork

Staying current with guidelines is another benefit mentors experience through the Xtern program. According to Schrader, "Externs provide much needed coding research, thereby enhancing the content and value of any practice coding library, which is critical to staying within compliance guidelines."

Summing up the wealth she has gained as a mentor, Schrader said, "Perhaps the most important asset externs bring is the ability to make their mentor a stronger coder and/or auditor by listening, conceptual discussion, and addressing dilemmas through the open eyes of a novice."

Externs Sites Set the Standard

Project Xtern sites set their own rules for the Xterns who are there to gain real-world experience for at least three months. While the extern gains valuable experience, the site can monitor the extern's preparation, work habits, and dedication. More than 220 sites are available to externs, with more being added.

For more information about Project Xtern and how to either be an extern or serve as a site, contact Daniel DeWitt at (800) 626-CODE or check out the AAPC Web site at www.aapc.com/education/medical-coding-jobs.aspx. ■

[Michelle A. Dick is senior editor at AAPC]

The Key to ICD-10-CM Success

“Physicians, don’t change how you practice medicine—but how well do you document?”

This quotation repeatedly ran through my head after ICD-10-CM guru, Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, CEMC, COBGC, CPCD, CCS-P, vice president, strategic development of AAPC, said it during her presentation, “ICD-10-CM, The Time to Begin Preparation is NOW,” at the Hawaiian Regional Medical Coding Conference. Her presentation outlined a very detailed plan she and her staff created for how they will prepare us for ICD-10 implementation.

Oct. 1, 2013 sounds far away, but there is much to do to prepare. Now is the time to create your ICD-10 team and formulate a plan.

Physicians: Coders are an important part of your office team. They know coding compliance rules and can be integral players on your ICD-10 implementation team.

Plan on Improved Documentation

The simple phrase: “Physicians, don’t change how you practice medicine—but how well do you document?” is the basis for coding success. Improved documentation should be a major component of your plan.

Most coders are not comfortable talking about documentation and ICD-10 with their physicians and staff members. Without an open dialogue, however, there is potential for catastrophic financial impacts with ICD-10. Physician training should start now—don’t wait until 2013 to find out if your physician(s) documents well enough.

I believe most physicians will say they document “enough,” but physicians shouldn’t document just “enough” to get the bill paid.

Documentation will need to be even more detailed to code with ICD-10.

To ensure proper documentation, prompt a dialogue with your physician(s) and review the basics of ICD-10-CM. You would also be wise to perform an internal audit on your practice, not only to review documentation but to get comfortable reporting your findings to the physicians.

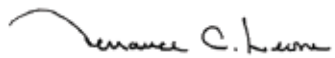
Remember: If your physicians’ documentation is thorough and compliant, the rest can be handled by the office and coding staff.

Plan on Budgeting Your Time

Look at any ICD-10 implementation budget and you will see both time and money are necessary to make the transition—time to train physicians and staff and money for necessary system software changes. A plan is necessary for positive implementation.

My recommendation is to get started. Talk to your physicians and co-workers about making an ICD-10 transition plan. Ask to form a group in your office and use the timeline located in the Member Area page on the AAPC Web site (www.aapc.com) to document your success as you move forward. The timeline tool is free to all AAPC members, and is a perfect way to prepare your office for the inevitable. 

Sincerely,



Terrance C. Leone,
CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board



Letters to the Editor

Further New Patient Coding Guidance is Established

The final portion of “Establish Patient Status at a New Location” (September 2009, pages 44-45) dealt with a question of a new physician joining a group practice with his or her own tax ID number, and whether the new physician could charge a “new” patient code for patients he or she saw. The answer as quoted from *CPT® Assistant* stated, “... if a physician is new to this group practice and had never seen or billed a patient previously though [should this be “through”?] his tax ID number, this should be considered a new patient...”

I am not sure I understand this answer. Is the patient new to this physician because the patient was never seen under either tax ID number, or is the patient “new” because the physician has never seen the patient under the new tax ID?

Pat Valenza, CPC

Practice Administrator, Lake Health Physician Group

If no member of a group practice has provided a professional service to a patient within the past three years, the patient is new, according to American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) definitions. For example, a new physician in a group practice, Dr. Jones, sees a patient, Mr. Smith. Neither Dr. Jones nor any member of the same specialty in the group practice has seen Mr. Smith for a professional service in the previous 36 months. In this case, Mr. Smith is a new patient.

CPT® Assistant (November 2008) reasons further that if a physician billing under his or her own tax ID has not provided a professional service to a patient within the past 36 months, the patient may be considered new to that physician even if the patient is established to the group practice.

For instance, Dr. Jones joins a group practice and sees Mr. Smith for the first time. Mr. Smith has received a professional service from another physician in the group practice within the past 36 months, but Dr. Jones is seeing Mr. Smith for the first time in the group practice and has not billed a professional service for Mr. Smith under any tax ID within the previous 36 months. In such a case, *CPT® Assistant* guidelines would allow Dr. Jones to bill Mr. Smith as a new patient.

As warned in the final paragraph of the article, however, CMS does not agree with *CPT® Assistant*'s interpretation. Nor may all private payers agree.

For most payers, if the patient has been seen in group practice within the previous 36 months, he or she is established to all physicians of the same specialty within that group practice, regardless of whether the individual physician has previously seen the patient personally. In the scenario immediately above, Mr. Smith would be an established patient under Medicare guidelines, even though Dr. Jones is seeing Mr. Smith for the first time in the group practice.

As usual, when in doubt as to the applicable coding rules, check with your individual payer for guidance.

Coding Edge

Wrong Year for the Long Beach Conference

In October's *Coding Edge*, we provided for you the wrong conference information in the article, “Immigrate to ICD-10: AAPC Prepares for the New Land.” Page 27 indicates next year's annual national conference is in Long Beach, Calif. when, in fact, the 2010 conference will be hosted in Nashville, Tenn. The article also indicates the 2011 conference will be back in Las Vegas, Nev. This is also inaccurate. The 2011 national conference is the conference scheduled in Long Beach, Calif.

Coding Edge

Correction: Family Physician Reports a Modifier for Assistance at Delivery

“A Tricky Case of Assistant at Surgery Coding” (*Coding Edge* Oct. 2009, p. 52) provided some misleading advice, stating:

“... if a consultant is called to perform a cesarean delivery and the family physician assists with the delivery, the consultant would bill 59514 *Cesarean delivery only* and append the appropriate modifier (80, 81, 82, or AS). The primary surgeon bills with 59510 *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care.*”

In fact, according to the American Academy of Family Physicians Web site (www.aafp.org/online/en/home/practicemgt/codingresources/codingob/globalserv.html), “If a family physician calls in a consultant to perform a cesarean delivery and the family physician assists at surgery, the consultant will usually use code 59514 (cesarean delivery only). To report his or her services, the family physician should use code 59514 with modifier -80. This indicates the family physician provided surgical assistant services.”

The AMA supports this coding, as evidenced by a Question and Answer, “Maternity Care and Delivery,” in the October 1996 *CPT® Assistant* (page 10):

AMA Comment: “If the physician assists in the delivery but does not provide any of the antepartum or postpartum services, it would be inappropriate to use the 59510 code. Instead, use 59514, *Cesarean delivery only*, to identify the assistant services. In addition, include the -80 modifier to denote the assistant services provided.”

The AAFP goes further to recommend:

“The family physician would then describe all intrapartum services taking place before the consultation by using the appropriate evaluation and management codes. For example, the family physician might bill the admission history and physical as ‘initial hospital care’ (99221-99223), as well as charging for his or her time by using, if appropriate, the ‘critical care’ (99291, 99292) codes or the ‘prolonged services’ (99356-99359) codes as appropriate.”

Coding Edge offers apologies to the AAFP, to whom the original (mistaken) recommendations were attributed.



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KUDOS!

Southern Teamwork Makes for Joint Seminar Success

Macon and Savannah, Ga. chapters joined forces Aug. 7-8 presenting the first ever Summer Coding Blast—Southern Style seminar in Savannah. With the help of Macon's brainchild, president **Cindy Rodgers, CPC**, the Coding Blast offered a weekend of events. Albany, Atlanta, Americus, and Augusta, Ga. local chapter members as well as Orlando and Gainesville, Fla. chapter members joined the Macon and Savannah local chapters Friday evening for a sunset dinner cruise on the beautiful waters of the Savannah River. Attendees participated in CEU-awarded coding games, networking opportunities, buffet style dining (complete with Savannah shrimp), and dancing. Saturday found attendees networking and learning from four speakers in a relaxed, beach theme atmosphere. The room came alive with beach balls, door prizes (too numerous to count), and topics of E/M coding, ICD-10, health care fraud and abuse, and pain management. Macon and Savannah sincerely appreciate the 84 local chapter members and guests attending to support this event. Planning is already underway for the second annual Summer Coding Blast—Southern Style—so, keep your calendars open in August 2010!

Kudos to the Summer Coding Blast—Southern Style committee: Macon members **Belinda Copeland, CPC**; **Janice Fiveash, CPC**; **Ramona Mastrangelo, CPC**; **Cindy Rodgers, CPC**; **Teresa Tolleson, CPC**; and Savannah members **Freda Brinson, CPC, CPC-H**; and **Tamara Gentry, CPC, RHIT, CPAR**.

If you or a colleague deserve kudos, please email kudos@aapc.com.

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Medicare, Chiropractic Maintenance Care, and the New ABN

Know if discontinuing maintenance care claim submission is an option.

By Marty Kotlar, DC, CHCC, CBCS

Question: *Does the new Medicare Advanced Beneficiary Notice (ABN) form allow me to discontinue submitting claims to Medicare for patients who are getting chiropractic spinal maintenance care?*

Answer: Yes, and no.

Let's begin by going over some of the ground-rules of the ABN form. The purpose of an ABN is to inform a Medicare patient that a certain medical item or service may not be covered under his policy on the basis of medical reasonableness and necessity. This allows the patient to make an informed consumer decision about whether to receive the item or service for which he may have to pay out of pocket, or through other insurance.

As of March 1, all providers (including chiropractors) and suppliers must use the new ABN Form CMS-R-131 (03/08) for all situations where Medicare payment is expected to be denied. Also called the Advanced Beneficiary Notice of Non-Coverage, the new form replaces ABN Form CMS-R-131-G (June 2002), ABN-L Form CMS-R-131-L, and Notice of Exclusions from Medicare Benefits (NEMB) Form CMS-20007 (January 2003).

Here are recommendations for using the ABN form:

- Do *not* give an ABN to a Medicare patient unless you have a genuine doubt that Medicare will pay.
- Do *not* obtain a Medicare patient's signature in advance on a blank ABN, and then complete the ABN later.
- Give the ABN to the patient *prior* to providing the service prompting the notice.
- Review the ABN with the patient or his representative and address all related questions.
- Retain the original ABN in the patient's medical record and give a copy to the patient.
- Keep the ABN form to one letter or legal size page.

Know Your Options

The new ABN form has 10 customizable areas labeled A-J. Area G, known as the "options box," **MUST** be completed by the patient or his representative. This options box has three choices:

☐ **OPTION 1:** I want the "Chiropractic Maintenance Care" listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any

payments I made to you, less co-pays or deductibles.

☐ **OPTION 2:** I want the "Chiropractic Maintenance Care" listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3:** I don't want the "Chiropractic Maintenance Care" listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

To answer the original question, whether you continue to submit maintenance care claims to Medicare depends, in part, on which options box your patients choose. For patients who choose option one, you may continue to submit your maintenance care claims.

Caution: If a patient challenges a coverage denial, the carrier may find the ABN provided insufficient notice. The provider would then have to refund the patient's money—essentially providing the service for free.

Note, however, that Medicare statute 42 USC §1395w-4 does not require chiropractors to report maintenance care services when the patient chooses option one. Providers may refuse to render a non-covered maintenance care service when the patient requests it to be billed.

Likewise, chiropractors do not have to submit a maintenance care claim when a patient chooses options two or three.

The Modifier Matters

If the patient chooses option one, and the chiropractor agrees to provide and bill the service, do not report the procedure code with modifier AT *Active treatment*. Instead, append modifier GA *Waiver of liability statement on file*. Modifier GA is appropriate when an item or service is expected to be denied as not reasonable and necessary, and an ABN is on file (www.cms.hhs.gov/Transmittals/downloads/B02020.pdf).

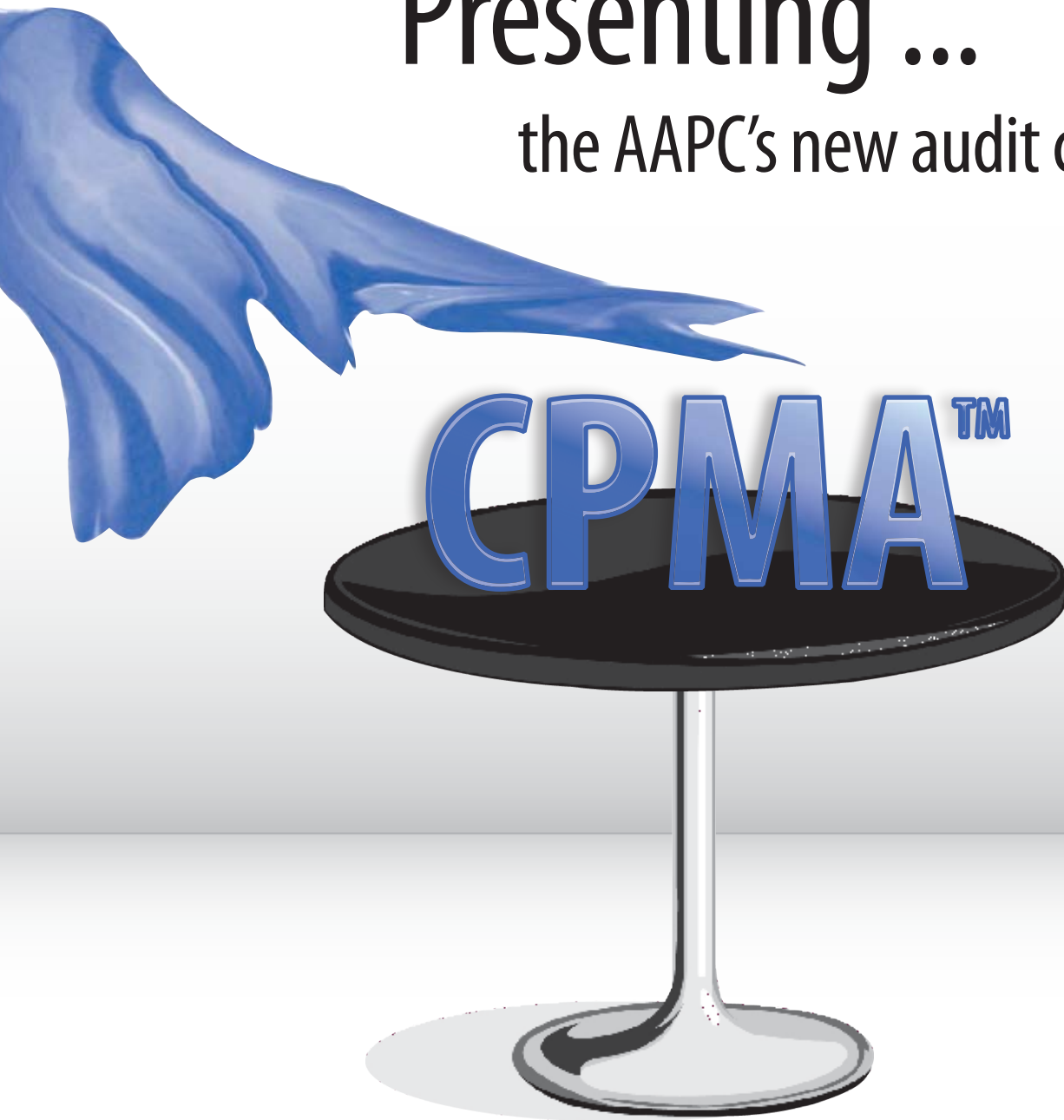
A sample ABN form, with instructions for completion, is on the CMS Web site at www.cms.hhs.gov/bni/02_ABNGABNL.asp. Contact your local Medicare carrier for additional ABN form rules and regulations specific to your region. ■



Marty Kotlar, DC, CHCC, CBCS, is the president of Target Coding. Dr. Kotlar has been helping chiropractors nationwide with coding, documentation, and compliance for over 10 years.

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Coming January 2010

coding news

Insurance Companies Work Towards Instant Billing

Eight of Ohio's major health insurance companies have created a Web site to give doctors one place to find patients' benefit information. The plan is to reduce paperwork between physician's offices and health plans and to minimize billing errors.

The Web site will allow doctors' offices to type in a patient's health plan and member identification number to see the treatments and procedures covered by their insurance carrier, check claim status, and possibly file claims. This will enable physicians and their staff more time with patients and less time on the phone with insurance companies and perusing Web sites to track claims.

Consumers will be able to check with their doctors about cost prior to a procedure to eliminate billing surprises. The Web site also should cut down on the times an insurance company rejects a patient's coverage due to double-billing.

"This [system] is analogous to the ATM technology that banks took on," said Karen Ignagni, president and chief executive officer of America's Health Insurance Plans (AHIP) (www.ahip.org). Ignagni stressed how easy the technology is to use and said, "It's a step that will ultimately transform our health system."

America's Health Insurance Plan intends to launch the coordinated site in November to nearly 30,000 doctors and hospitals in Ohio and New Jersey, before launching a nationwide campaign.

\$40 Million for CHIP

Health and Human Services (HHS) awarded \$40 million in grants to 69 grantees in 41 states and the District of Columbia to find and enroll uninsured children eligible for either Medicaid or the Children's Health Insurance Program (CHIP).

"Awards will help fulfill President Obama's pledge to assure the health and well-being of our nation's children," said Department of Health and Human Services (HHS) Secretary Kathleen Sebelius. "With millions of Americans either out of work or otherwise struggling to make ends meet during this recession, there is an even greater urgency to bring steady, reliable health care to children in these families who may have lost their coverage."

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) set aside \$100 million for years 2009-2013 to help find and enroll children who are eligible for Medicaid or CHIP but uninsured. Of the total outreach amount:

- \$80 million will be given to states and other organizations;
- \$10 million will be for Tribal organizations; and
- \$10 million will be for a national outreach effort.

These awards are for a two year period ending Dec. 31, 2011 that will be followed by another round of \$40 million in new grants.

The grant awards require recipients to show increases in enrollment and retention of children already in the programs by reporting to the Centers for Medicare & Medicare Services (CMS) the number of new enrollees and retained beneficiaries that can be directly attributed to the grant.

"No child in America should go without decent health care," said Cindy Mann, director of the Center for Medicaid and State Operations—the group within CMS administering the grants. "With the funds we are awarding ... we hope to reduce the number of children who do." ■

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Ride the Coding Wave

Surf, sand, and coding excellence: A coders' paradise

Ko Olina on the island of Oahu was the blissful backdrop for the AAPC's three-day regional Hawaii conference in September. While soaking in the ocean-side tranquility, attendees enjoyed learning a wealth of coding information on a wide range of educational topics. Networking with colleagues, friends, and doctors; earning 11.5 CEUs; and eating an array of meals and hors d'oeuvres were also included on the coder-in-paradises' "to do" list.

Tee Time Starts at 12:40 pm

Early conference participants could have registered for a "Golf Scramble with Reed Pew" or the pre-conference workshop, "Surefire Methods for Defensible Coding: Know What Makes it Correct," presented by **Glade Curtis, MD, MPH, FACOG, CPC, COBGC**, and written by **Michael Miscoe, JD, CPC, CASC, CUC, CHCC**. Golf scramblers enjoyed a game of golf and met AAPC CEO and President Reed Pew in a relaxed setting while mingling with colleagues at the Ko Olina Golf Club. Those who came early to attend the workshop experienced three hours of building coding confidence. The workshop explored how to differentiate between controlling and persuasive payer criteria, and created an analysis hierarchy to identify the relevant rules for compliant and defensible coding.

On to the Kick-off

The conference kicked off with local chapter and specialty networking, giving participants the opportunity to see what's happening in area local chapters while expanding their network of coders and friends, and enjoying refreshments.

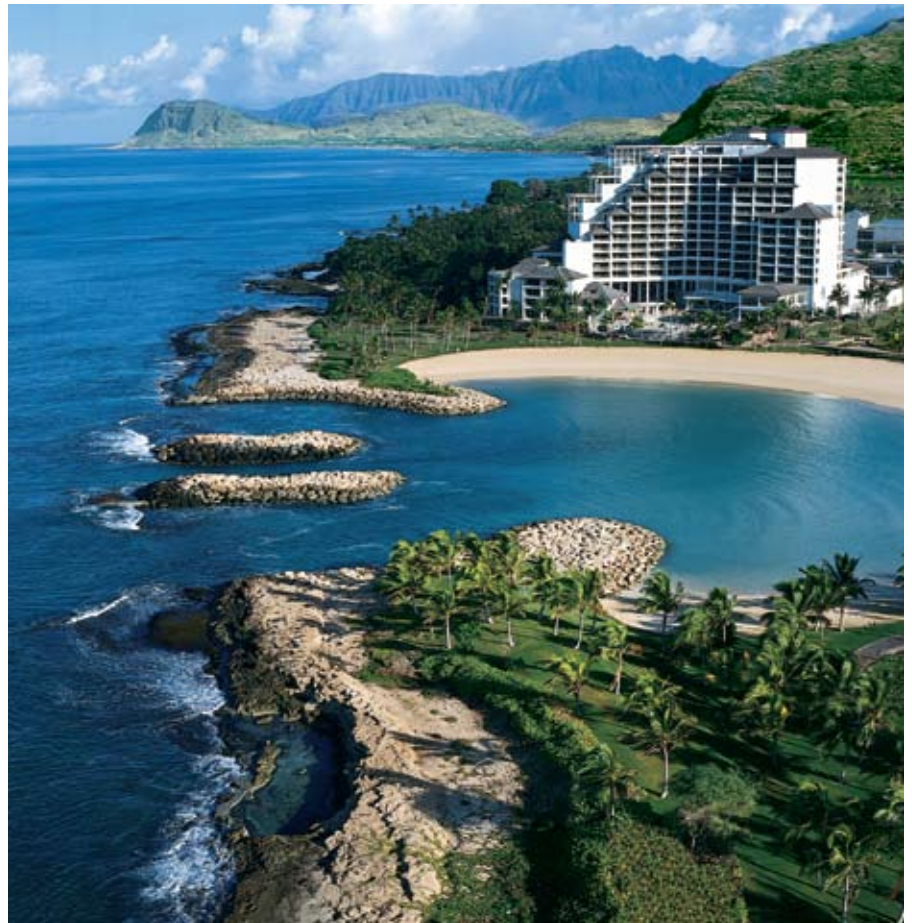
Pew, as keynote speaker, greeted attendees with, "Health Care Reform: What Is Good, What Is Bad and What Will be Very Tough to Do." Pew's speech gave an honest perspective on what is in store for health care's future.

Sit Back, Relax, and Bask in the Coding Experience

With ICD-10 on the forefront of coders' minds, the conference addressed their concerns with an action plan for implementation. To help put coder's fears at ease, the conference featured the general session, "ICD-10-CM: The Time to Begin Preparation Is Now," presented by **Deborah Grider, CPC, CPC-H, CPC-P, CPC-I, CDERC, CEMC, COBGC**. She discussed why having good physician documentation is key to ICD-10 success and she explained how you can start preparing now to lessen the stress when October 2013 is here.

Breakout session topics included telemedicine, emergency room (ER), gastroenterology, evaluation and management (E/M) chart auditing, ambulatory surgery centers (ASCs), anatomy, Medicare risk adjustment, cardiology, obesity, recover audit contractors (RAC), hormone replacement, facility infusions, and hand anatomy and finger importance.

The conference featured many physician presenters, including **Gary Katz, MD; Douglas T. Hutchinson, MD; Cedric Lorenzo, MD; and William Dang, MD**. The physicians' perspective provided coders with a better understanding of



anatomy, diseases and injuries, the latest procedures for treatment, and real-case coding scenarios.

Leave with a Smile

The last day featured the popular break-out session, “Give ‘em the Finger,” by hand surgeon Dr. Douglas T. Hutchinson. His light-hearted presentation discussed the importance of your hand, how to use digits for hand gestures, anatomy, what surgeons do to complete a hand that is missing a digit, and how to code the reconstructive surgeries.

Using an irreverent, wry approach, he presented each digit starting with the evolution of the thumb and ending with the pinky finger:

Thumb—Needed for thumb sucking, having a green thumb, thumb wrestling, brewing beer, measuring, and giving the thumbs-up, hang loose, and OK signs. Without it, you’d have 40 percent hand,

36 percent upper extremity, and 22 percent whole body impairment.

Index finger—Needed for picking the nose, sporting the No. 1 sign, giving the peace sign, and silencing someone with a “Shhhh!” Without it, you’d have 20 percent hand, 18 percent upper extremity, and 11 percent whole body impairment.

Middle finger (a.k.a. long finger, third finger, phallic finger, and birdie finger)—Needed for crossing your fingers for good luck, making donkey ears behind someone’s head, and giving the bird. In China the middle finger salute in sign language denotes the first son. Without it, you’d have 20 percent hand, 18 percent upper extremity, and 11 percent whole body impairment.

Ring finger—Needed for wearing wedding rings. It is the largest digit in flexion and prone to flexor digitorum profundus (FDP) avulsion and is common

to syndactyly (webbed or conjoined). Without it, you’d have 10 percent hand, 9 percent upper extremity, and 5 percent whole body impairment.

Pinky finger (a.k.a. little finger, fifth finger, and small finger)—Needed for drinking tea delicately, playing octave piano, gripping golf clubs, and making pinky promises. It is most common to be affected by Dupuytren’s disease. Without it, you’d have 10 percent hand, 9 percent upper extremity, and 5 percent whole body impairment.

Mahalo to AAPC staff, presenters, National Advisory Board (NAB), members, and vendors who worked hard to make the Hawaii Regional Conference such a success.

Read more about the conference at www.aapc.com/conferences/hawaii-regional-conference/. 

[Michelle A. Dick is senior editor at AAPC]

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Give Outpatient Therapy Documentation the Support It Needs

Part three of our physical and occupational therapy series.

By Shannon Sullivan, CPC; William Pena, PT, DPT; and Carl Petitto, OTR/L

In the April *Coding Edge* article, “PT and OT: Extend Coding Know-how to Full Capacity,” we discussed what constitutes reasonable and necessary physical therapy (PT) and occupational therapy (OT) services according to Medicare guidelines. We also explained how to determine whether a service is skilled; and we elaborated on untimed codes, timed codes, and individual treatment. In July, we explained the coding differences for group therapy and individual therapy in the article, “Time Adds Up When Billing Group and Individual Therapy.” We’ll complete this three-part series with a discussion on documentation guidelines and what constitutes as unauthorized personnel providing outpatient therapy services.

Support Timed and Untimed Claims

Maintaining records demonstrates billing for individual therapy or group therapy is proper. The Centers for Medicare & Medicaid Services (CMS) provides guidance on reporting service units that includes documentation instructions.

A therapist or therapy assistant should record the total treatment time (the beginning and ending time) for services described by timed codes, untimed codes, and untended (billed and unbilled) activities. The total number of timed 15 minute units that can be billed for each patient by the therapist or therapy assistant is constrained by the therapist or therapy assistant’s total time of skilled therapeutic one-on-one intervention.

For the untimed codes, including “supervised” modalities, group therapy, and the evaluation codes, documenting the session’s time can justify the appropriateness of provided services. In cases where recording the total treatment time doesn’t describe sufficiently the therapeutic procedures’ extent or where practice policies require it, the time spent delivering each service described by either a timed or untimed CPT® code can be recorded. In these





Documentation must establish that the patient needs the unique skills of a therapist to improve functioning. This is accomplished through a description of the patient's condition, and any complexities affecting that condition.

cases, the therapist can document the total time (beginning and ending) for each session defined by a timed code and/or the total time (segments of time) the patient is involved in services defined by untimed codes and unattended codes.

Support Medical Necessity

Documentation should support fully the medical necessity for services included within the local coverage determination (LCD). The documentation includes relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Assessment time is included and billed within the appropriate treatment intervention CPT® code.

Therapy services are payable when the medical record's documentation and claim information consistently and accurately reports covered therapy services. To justify medical necessity for billed services, documentation must be legible, relevant, and sufficient, according to CMS Pub. 100-02, section 220.3.

Identify Skilled Service Provider

Medicare requires a legible identifier of the person(s) who provided the service. Handwritten or an electronic signature can be used to sign an order or other medical documentation for medical review purposes. Electronic or handwritten signatures communicated through fax are also accepted. Stamped signatures are no longer acceptable as of April 28, 2008.

Forms 700 and 701 are not required for submitting documentation as documentation may be submitted in any format containing the necessary information. Documentation must establish that the patient needs the unique skills of a therapist to improve functioning. This is accomplished through a description of the patient's condition, and any complexities affecting that condition. Documentation should also describe the provided services requiring the expertise, knowledge, clinical judgment,

decision making, and abilities of a clinician that assistants, qualified auxiliary personnel, caretakers or the patient cannot provide independently.

Specific Examples Identify Good Documentation

A therapist's skills may be documented, for example, by describing the skilled treatment, treatment changes due to an assessment of the patient's needs on a particular treatment day, or progress sufficient enough to modify the treatment toward the next more complex or difficult task. For example, a therapist who works to help his or her patient regain wrist joint stability may document:

"Secondary to significantly decreased pain and edema and increased range of motion as outlined on the attached flow sheet, dynamic, oscillatory exercises have been initiated to increase wrist joint stability in order to further increase functional use of his right upper extremity while further decreasing discomfort."

Note: On the flow sheet, specific exercises need to be listed with duration. Remember the therapist or clinician should document (and charge for) patient education when modifying a home exercise program.

Documentation should establish the variables influencing the patient's condition, especially those factors influencing the therapist or clinician's decision to provide services beyond those typical for the individual's condition. Documentation should also establish through objective measurements that the patient is making progress toward goals. When regression or plateaus occur, the reasons for the lack of progress should be noted to justify continued treatment. An example of documentation such as this could say, "Mr. Smith came to the office not until three weeks post-op; therefore, he arrived with stiffness and edema atypical for his condition. Despite the initial setback, aggressive treatment, education, and close follow-up allowed Mr. Smith to progress toward goal attainment outlined on attached flow sheets. The plateau

in Mr. Smith's progress seen over the last 10-day period is due to the recent secondary illness, which resulted in a compromise of ability to perform his home exercise program in its entirety. With reeducation to a modified home exercise program (performed 8/15/09) and continued progressive treatment techniques, he will resume a significant rate of progress."

Only a clinician may perform an initial examination, evaluation, reevaluation, and assessment, or establish a diagnosis or care plan. The clinician may include as part of the evaluation or reevaluation, objective measurements, or observations made by a physical therapy assistant (PTA) or occupational therapy assistant (OTA) within their scope of practice, but the clinician must actively and personally participate in the evaluation or reevaluation. The clinician may not merely summarize the objective findings of others, or make judgments drawn from the measurements and/or observations of others. **BS**



Shannon Sullivan, CPC, holds a bachelor's in business management. She is managing owner of Atlantic Billing & Coding, LLC and president of her local coding chapter, which she founded last year. Shannon can be reached at smsullivan@atlanticabc.com.



William Pena, PT, DPT, holds a doctorate in physical therapy. He is an owner of a private practice, continuing patient treatment in a variety of settings, and part owner and manager of Atlantic Billing & Coding, LLC. He also performs audits for private physical therapy practices. William can be reached at wpena@atlanticabc.com.



Carl Petitto, OTR/L, holds a bachelor's degree in occupational therapy, health and human services and earned a commission in the U.S. Army Reserve as an occupational therapist. He is also part owner and manager of Atlantic Billing & Coding, LLC. Mr. Petitto can be reached at cpetitto@atlanticabc.com.

Personnel NOT Authorized to Provide Outpatient Therapy Services

Medicare pays only for skilled, medically necessary services delivered by qualified individuals, including therapists or appropriately supervised therapy assistants. Supervising patients who exercise independently is not a skilled service.

Students, aides, athletic trainers, exercise physiologists, massage therapists, recreation therapists, kinesiotherapists, low vision specialists, lymphedema specialists, Pilates instructors, rehabilitation technicians, and life skills trainers are not considered qualified therapy professionals and may not bill their services under the Medicare therapy benefit, even if performed under the supervision of a qualified therapist.

Qualified professionals may serve as clinical instructors for therapy students within their scope of practice. Physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) may only serve as clinical instructors for PTA and OTA students, respectively, when performed under the direction and supervision of the licensed physical therapist (PT) or occupational therapist (OT) (in states where licensure applies). Services performed by a student (therapy student or therapy assistant student) are not reimbursed, even if provided under "line of sight" supervision of the therapist. The services of a qualified professional are covered, however, even when a student is participating in the care.

To be covered when the student is participating, the qualified professional must be present in the room and *must*:

- Direct the service, making the skilled judgment and assessment, and assume responsibility for the treatment;
- Not be treating another patient or doing other tasks at the same time (such as documentation); and
- Sign all documentation appropriately.

A student may also sign the documentation, but it is not necessary as the Part B payment is for the qualified professional's service, not for the student's services.

It is an ethical choice and a legal obligation to ensure education according to guidelines. Know the guidelines set forth by the Centers for Medicare & Medicaid services (CMS) and the Office of Inspector General (OIG). The safety of the public must be protected and payers must ensure they are paying for skilled treatment only. The guidelines that differentiate skilled professionals from unskilled personnel not only are in place to ensure public safety and maximize positive treatment outcomes, but also serve to safeguard the scope of our professions.

The Medicare contractor who pays your claims is the best source for answers to specific Medicare questions. Contractors are carriers, intermediaries or program safeguard contractors who interpret Medicare laws, develop local policies and educate providers. Contractor Web sites list local policies. You may also contact your Medicare Regional Office for assistance.

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The Thermal Chondroplasty Challenge

By G. John Verhovshek, MA, CPC

Consider coverage, not just coding, when payers deny reimbursement.

Deborah Robinson, CPC, with HCA Healthcare in Florida writes to *Coding Edge*:

We have a serious problem with a major private payer not wanting to pay for the thermal chondroplasty of the patella as an unlisted code (29999 *Unlisted procedure, arthroscopy*). The payer initially issued a denial letter instructing us to use 29879 *Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture* or 29877 *Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)* because those codes are “more specific.”

The American Academy of Orthopedics’ *AAOS Bulletin*, April 2005, and the *CPT® Assistant*, October 1998, both support that thermal chondroplasty of the patella is an unlisted procedure. I cited these facts in a return letter to the payer, and noted that reporting 29879 or 29877 in this case would be considered upcoding. I further noted that CPT® guidelines state “it is incorrect to select a code that ‘merely approximates’ the service being rendered,” and that the “anatomically specific unlisted code” should be used instead. Finally, I cited information from Ingenix’ *Coders’ Desk Reference* for procedures describing 29877 and 29879, which do not match the description of thermal chondroplasty of the patella.

The payer still denied all the payments, and issued a new reply stating, “This was an integral part of the other procedures because the services were performed at the same time as a primary procedure, and required little additional resources.”

In fact, the doctor entered a different knee compartment, using low-power thermal energy to smooth the cartilage. This was the only procedure done in that compartment. The doctor also may use this procedure to tighten the joint, either in the shoulder or the knee.

Confirm Code Selection

As we consider this letter, we must first ask, “Is 29999 the correct code to describe thermal chondroplasty?”

Unlike “mechanical” chondroplasty, as described by 29877 and included in 29879, thermal chondroplasty uses either radiofrequency or laser energy to shape cartilage or tighten a stretched anterior cruciate ligament (ACL).

Robinson has done her homework: As she notes, *CPT® Assistant*, October 1998, advises, “There is no specific CPT® code that accurately describes the use of heat to shrink the capsule in the shoulder performed through an arthroscope. Therefore, the unlisted arthroscopic code 29999 [*Unlisted procedure, arthroscopy*] would be reported.” The *AAOS Bulletin*, April 2005, confirms, “The unlisted code 29999 should be used” for the procedure.

Tip: If a payer instructs you in writing to report a particular procedure using a specific code that works to your advantage, you should follow those instructions (even if you do not agree with the code selection). If the payer later objects, you can rely on the payer’s own documentation to justify your coding.

Same vs. Different Compartment Matters

With code selection confirmed, the next step in this case is to determine whether chondroplasty may be reported separately.

Chondroplasty, when performed in the same joint compartment and at the same time as another procedure, is incidental and not separately coded. For example, if the surgeon performs same-knee medial meniscectomy and medial chondroplasty, the chondroplasty is included in the more-extensive, same-compartment meniscectomy (29881 *Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)*). These bundling guidelines are supported by American Medical Association (AMA) instructions and National Correct Coding Initiative (CCI) edits.

When performed in a different joint compartment, however, chondroplasty may be reported independently of other procedures.

Coding Varies By Payer

For Medicare, report chondroplasty performed with another arthroscopic knee procedure using G0289 *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondro-*

If a payer instructs you in writing to report a particular procedure using a specific code that works to your advantage, you should follow those instructions (even if you do not agree with the code selection). If the payer later objects, you can rely on the payer's own documentation to justify your coding.

plasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee rather than 29877. For example, to report a medial meniscectomy and a lateral chondroplasty for a Medicare patient, the appropriate coding is 29881, G0289. For lateral chondroplasty alone, 29877 is appropriate.

The April 2005 *AAOS Bulletin* further advises, "Carriers should understand that the G code can be reported more than once, provided each mention is for a separate compartment." For example, "a medial meniscectomy with chondroplasties in both the lateral and patellofemoral compartments would be reported with 29881, G0289 and G0289-59." The use of modifier 59 *Distinct procedural service* alerts the payer that the second unit of G0289 occurred in an anatomically distinct location.

Some private insurers also have adopted G0289 and, like Medicare, require it (rather than 29877) to report chondroplasties performed concurrent with other arthroscopic knee procedures. Check with the individual payer before reporting these procedures to third-party insurers.

For those payers who do not require G0289, report 29877 to describe chondroplasty in a separate compartment. Unlike G0289, only a single unit of 29877 should be reported, regardless of how many separate chondroplasties the surgeon performs, according to *CPT® Assistant*, August 2001.

For example, a medial meniscectomy with chondroplasties in both the lateral and patellofemoral compartments would be reported 29881, 29877-59. *CPT® Assistant*, June 1999, explains, "When reporting meniscectomy and shaving of articular cartilage performed in separate compartments of the knee at the same session, appending the 59 modifier to the second procedure will communicate that the procedures were performed in separate compartments of the knee" (see also *CPT® Assistant*, April 2005).

Regardless of specific code or modifier selection, documentation for chondroplasty "needs to describe what you found, how you performed the chondroplasty, and whether it resolved the patient's problem," according to the *AAOS Bulletin*.

These guidelines apply specifically to mechanical chondroplasty, but the payment logic should apply equally to thermal chondroplasty. If performed in a separate knee compartment, the chondroplasty should be billable separately with unlisted procedure code 29999.

The payer's denial stating that chondroplasty "was an integral part of the other procedures because the services were performed at the same time as a primary procedure, and required little additional resources," doesn't ring true to Robinson's description.

29877, G0289 Provide Fee Guidance

The 2009 National Physician Fee Schedule Relative Value File assigns 8.15 relative value units (RVUs), or approximately \$290, to the physician work component of 29877. The assigned physician work RVUs for G0289 are significantly less—1.48 RVUs, or approximately \$50 in average Medicare payment. This makes sense under Medicare rules as 29877 describes chondroplasty alone, and should be reported only once, regardless of the number of compartments addressed; G0289 describes chondroplasty at the same time as another scope, and may be reported once for each separate compartment the surgeon addresses.

Although 29877 and G0289 do not describe thermal chondroplasty accurately, the physician's effort and resources are comparable. When assigning a fee to 29999 for thermal chondroplasty, recognize 29877 and G0289 as benchmarks.

Coverage May Be the Real Culprit

The code is correct, coding logic observes accepted practice, and we'll assume the documentation substantiates the procedure. Before pursuing further appeal or requesting a meeting with the insurer's medical review board, there's a final factor to question: Coverage.

Many insurers consider thermal chondroplasty and shrinkage procedures to be experimental or not medically necessary and will not reimburse for them. Although the payer has cited everything except lack of coverage as the reason for denying payment, non-coverage is likely to be the real culprit in this and other similar cases. Providers should review their payer contracts or seek specific direction from the payer regarding thermal chondroplasty (or shrinkage) coverage.

To avoid surprises, alert patients prior to surgery via an Advance Beneficiary Notice (ABN) that insurance may not cover the expense of thermal chondroplasty. If the patient elects to proceed, he will be aware of his financial responsibility. ■

[G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.]

Support Foot, Ankle, and Lower Leg Claims

SKIP SEVEN COMMON FOOT AND ANKLE MISTAKES AND LEAP TO BETTER CODING.

Fig. 299.—The Popliteal, Posterior Tibial, and Peroneal Arteries.

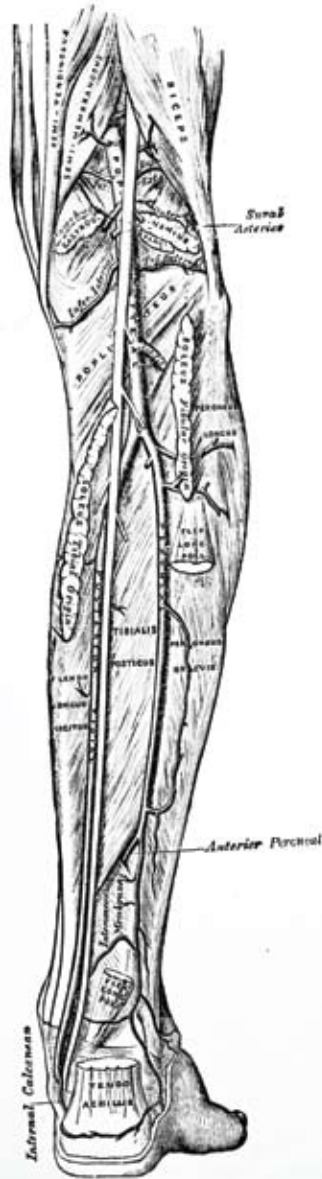


Fig. 300.—Surgical Anatomy of the Anterior Tibial and Dorsalis Pedis Arteries.



By David J. Freedman, DPM, FASPS, CWS, CPC



While reviewing records for submission, I often see coding and billing errors in foot, ankle, and lower leg claims. Bypassing the following seven common foot and ankle mistakes and using certain tips for ensuring successful coding will help you collect what your practice is entitled to.

1. E/M Visits Are Reported Separately During Procedure's Global Period

Related evaluation and management (E/M) visits during the global period are included in the original procedure, and should not be reported separately.

For E/M visits unrelated to the original procedure, append modifier 24 *Unrelated evaluation and management service by the same physician during a postoperative period* to the appropriate E/M service code. To stress the unrelated nature of the E/M service, include in Box 19 of the CMS-1500 form (for paper claims) or the "electronic notes" portion of the claim (for electronic claims) the accompanying statement, "This visit is unrelated to the surgery."

For example, within the 10-day global period for an excision of nail and nail matrix (11750 *Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal*), a patient is evaluated and treated for a new complaint of heel pain. For this you would bill 9921x-24 for the E/M visit's heel pain care.

2. Modifier 78 and 79 Use Is Confused

A frequent source of confusion is the appropriate application of modifier 79 *Unrelated procedure or service by the same physician during the postoperative period* versus modifier 78 *Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period*.

Keep in mind: Modifier 78 is for a return trip to the operating/procedure room for a related procedure during the post-operative period. The place of service (POS) must be an operating/procedure room (hospital inpatient, hospital outpatient, or ambulatory surgical center (ASC)). Modifier 79 is for when a new, unrelated procedure is performed in the post-operative period. The POS could be the aforementioned, but may include other options such as office, home, nursing home, assisted living, etc.

For instance, a patient is treated for incision and drainage (I&D) of an abscess on the right foot (10060 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single*). Within the 10-day global period of the initial I&D, the patient undergoes I&D for another abscess on the left foot. Because the second I&D is unrelated, but occurring during the global period of the initial procedure, modifier 79 is required for coverage and is reported as 10060-79.

In an alternate scenario, a patient undergoes correction of hallux valgus by metatarsal osteotomy (28296 *Correction, hallux valgus (bunion), with or without sesamoidectomy; with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)*). The osteotomy is displaced during the global period and requires a return to the operating room (OR) to recreate the osteotomy for an angular correction. In this case, you would append modifier 78 to 28306 *Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; first metatarsal* to describe the related but unplanned return to the OR during the global period.

3. Modifier Usage for New Condition Requiring Same Day Procedure Is Wrong

When a patient is seen for a new condition/diagnosis and a procedure is rendered the same day, report the E/M visit separately with modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*.

Do not report an E/M service routinely with every procedure. Most procedures include an element of E/M. The E/M service must stand by itself as a truly significant and separately-identifiable service to report it and append modifier 25 correctly.

For Medicare and other payers (check with your individual private payers for guidance), append modifier 57 *Decision for surgery* — rather than modifier 25 — if the E/M service prompts the decision to render a major procedure (defined by Medicare as a procedure with a 90-day global period). Use modifier 25 when an E/M service is provided on the same day as a minor procedure (defined by Medicare as having a 0-day, 10-day, or "xxx" global period).

For example, a patient is seen for a scheduled minor procedure, such as partial nail and nail matrix excision (11750). In such a case, it would be inappropriate to bill an E/M visit on the same date as the planned, related procedure. If the patient is scheduled for the same minor procedure but an additional E/M service is performed for an unrelated reason (i.e., the patient is diagnosed with tinea pedis, ICD-9-CM 110.4 *Dermatophytosis of foot*), report the separate E/M service at the appropriate level with modifier 25 appended (9921x-25).

In another example, a new diabetic patient is seen for consultation at the request of his endocrinologist. After a workup in the office, the patient is determined to have cellulitis (682.7 *Other cellulitis and abscess; foot, except toes*) with an ulceration (707.13-707.15 *Ulcer of lower limbs, except pressure ulcer; ankle/heel or midfoot/other part of the foot*) and acute osteomyelitis (730.07 *Acute osteomyelitis; ankle and foot*). The patient is sent to the hospital for admission, and surgery is performed that evening to incise and drain the infection, and to debride necrotic tissue and bone.

DO NOT REPORT AN E/M SERVICE ROUTINELY WITH EVERY PROCEDURE. MOST PROCEDURES INCLUDE AN ELEMENT OF E/M. THE E/M SERVICE MUST STAND BY ITSELF AS A TRULY SIGNIFICANT AND SEPARATELY-IDENTIFIABLE SERVICE TO REPORT IT AND APPEND MODIFIER 25 CORRECTLY.

Depending on the exact nature of the procedure, applicable codes for debridement may include codes from series 28120-28124 or 11040-11044. Codes 28120-28124 are major procedures, with a 90-day global period (11040-11042 have a 0-day global, 11043-11044 have a 10-day global).

Applicable codes for the I&D could include 10061 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple* (10-day global); 28002 *Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space* (10-day global); 28003 *Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas* (90-day global); or 28005 *Incision, bone cortex (eg, osteomyelitis or bone abscess), foot* (90-day global).

The E/M consultation is separately reportable. Medicare (and some other payers) requires modifier 57 to be appended to the E/M visit (codes 99241-99245) if a major procedure (for instance, any of the procedures above with a 90-day global) is performed on the same date.

4. EOB isn't Checked for Denied or Improperly Paid Claims

Always review the explanation of benefits (EOB) for claims denied or improperly paid. Identify any errors and sit down with the physician to assess whether the error can be appealed based on the medical record. Such reviews should occur immediately, and may require a call to the payer to identify specifically what went wrong. Whenever possible, submit an appeal.

When contacting the payer, verify the address or fax number where the appeal should be sent (I prefer fax because you get a confirmation of receipt from the fax machine.). The address provided on the EOB is not necessarily the address where the appeal should be sent. Include necessary identifying information about the practice, the patient, and the processing identification number of the originally-denied or improperly-paid claim in the appeal.

Correct your claims prior to resubmission. When claims are resubmitted with the same error, you won't achieve anything.

5. Radiology Reimbursement for Multiple Studies is Often Overlooked

A patient is seen with a fracture, for example, and three views of the foot are initially taken (73630 *Radiologic examination, foot; complete, minimum of 3 views*). The doctor performs a closed reduction of the fracture, however, neces-

sitating a follow-up X-ray study to assess the alignment.

Report the subsequent study using the same CPT® code and the appropriate body modifier (LT *Left side* or RT *Right side*) with the addition of modifier 76 *Repeat procedure by same physician* (for a repeat procedure).

6. Physicians Are in the Dark About CCI Determinations

Many physicians either do not know about, or do not know how to apply, the National Correct Coding Initiative (CCI). The CCI, administered by the Centers for Medicare & Medicaid Services (CMS), allows coverage determinations with regard to paired CPT®/HCPCS Level II codes. Private insurers increasingly are using similar edit systems for their payment or denial of payment of paired claims.

To be sure the chosen code combinations are separately reportable and payable under the particular circumstances for Medicare claims, coders and physicians should review the Column 1/Column 2 edits and Mutually Exclusive CCI edits prior to billing multiple codes on the same date. Rules for private payers are specified by contract. Providers should not assume the private carrier is using CCI unless that provision is in their contract.

Medically Unlikely Edits (MUEs) impose frequency limitations on certain procedures for Medicare claims. For instance, a bunionectomy cannot occur more than twice on one given date. Other MUEs prevent billing for clinically impossible situations, such as a procedure specific to females cannot be reported for a male patient.

7. Undercoding of E/M Services is Due to Lackluster Documentation

When supported by medical necessity, physicians should document the history of present illness (HPI) in four areas. The review of systems (ROS) should attempt to document at least two pertinent elements, with documentation of at least one element from the patient's past medical/surgical history, family history, and social history. These initial steps go a long way in supporting necessary E/M services preventing recoupment in an audit.

Following generally accepted guidelines helps to secure successful coding results. Be aware, be smart and be ethical. ■



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LEGAL



KNOW THE LEGAL RISKS OF PHYSICIAN AND PATIENT E-MAIL COMMUNICATION.

Welcome to a new bimonthly column in which one of the AAPC's Legal Advisory Board answers legal question from members. This month's question is answered by Robert A. Pelaia, Esq., CPC.

Question: The physician I work for constantly is responding to e-mails she receives from patients. Sometimes the e-mails contain medical and personal information about the patient or details of billing information. I don't think the physician should be doing this but she likes technology and does not seem to have a problem with using e-mail in this way. Is it a problem?

Answer: As is typical of legal advice, the answer is, "It depends."

Increasingly, patients are requesting their medical providers communicate with them via e-mail and, more often than not, such electronic communication contains protected health information. There is a significant risk, however, that electronic messages can be misdirected or intercepted by unintended parties. Accordingly, it is not possible to guarantee the confidentiality of messages sent over the Internet.



Get Consent in Writing

I do not recommend health care providers communicate protected health information with patients via e-mail unless the patient has agreed in writing to such communication, after being advised fully of the risks and agreeing to assume responsibility for such risks. Some items that might be included in the patient authorization to use e-mail could include the following:

1. A warning that e-mail transmissions can be forwarded, intercepted, printed, and stored by others.
2. A warning that e-mail should never be used for emergencies or time-sensitive issues.
3. A statement that patients cannot be guaranteed they will receive a response within any given time period.
4. A warning that the health care provider is not liable for intercepted, lost, or misdirected information.

A copy of the patient's written authorization to use e-mail should be included in the patient's medical record before the first e-mail is sent.

Patients often request that e-mails containing protected health information be sent to the patient's work e-mail account. Patients should be cautioned that work e-mail accounts might be viewed or monitored by the patient's employer; employers generally have the right to access e-mails received or sent using their equipment or networks.

I recommend health care providers establish clear e-mail communication guidelines with the patient, which might include things like how often e-mail will be checked and the types of information exchanges appropriate for e-mail. Information that might have special protections, such as HIV/AIDS information, substance abuse treatment information, and mental health information, should not be communicated via e-mail.

Once the authorization has been signed, each individual e-mail sent between patients and physicians should contain a confidentiality statement.

Be Aware of State Laws

Before engaging in e-mail communication with patients, health care providers should review any applicable state laws that may affect the use of e-mail for transmitting confidential patient health information. For example, on Oct. 1, 2008, Nevada became the first state to require encryption for all electronic transmissions of personal information outside of secure networks (see Nev. Rev. Stat. § 597.970).

If a Nevada health care provider transmits certain types of sensitive patient data electronically (including social security information, credit card numbers, drivers license numbers, etc.), Nevada law requires the electronic transmission

Patients should be cautioned that work e-mail accounts might be viewed or monitored by the patient's employer; employers generally have the right to access e-mails received or sent using their equipment or networks.

be encrypted. In the physician/patient context, the Nevada law would not require encryption for e-mails discussing medical information by itself—unless the e-mails contain the social security number of the patient (which easily could happen if copies of medical records were sent via e-mail). Most states have already enacted data breach notification laws, and other states probably will soon follow Nevada and establish data encryption laws.

State laws may also prohibit providers from communicating to patients whose residence is outside of the state where the physician is located, unless the provider is licensed to practice medicine in that state.

No Easy Answer

E-mail is inherently risky. Nevertheless, it is easy to see why providers and patients alike might prefer this quick and efficient mode of communication. As a general rule, I recommend that you suggest to the physician you work for to use an abundance of caution, and to only use encrypted e-mail to communicate protected health information with patients, and only after the patients have signed a comprehensive authorization permitting such electronic communication.

Information published in this article are the personal views of the author and not that of the University of Florida. Information published in this article is not intended to be, nor should it be considered, legal advice. Readers should consult with an attorney to discuss specific situations in further detail. ■



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POS Codes Can Determine If a Claim is Accepted

Apply the correct place of service (POS) code to avoid potential denials.

Coders often ask, “What are place of service codes?” or “Why do I need to list one?” Let’s examine both questions.

By Trina Cuppett,
CPC, CPC-H

A coder initially may believe a facility is a nursing home, when it actually is categorized as a skilled nursing facility (SNF) or an intermediate care facility.

Place of service (POS) codes are maintained by the Centers for Medicare & Medicaid Services (CMS). Medicare states POS codes are two-digit codes on health care professional claims indicating the setting in which a service is provided. In other words, POS codes describe *where* services are rendered. POS information often is necessary to determine whether a provider’s services will be accepted when directly billed to Medicare, Medicaid, or private insurance.

Keep Abreast on POS Updates

POS codes are listed in the front of the CPT® manual with a brief description for each code. The POS database was updated by CMS on Aug. 4 and is available for viewing on the CMS Web site: www.cms.hhs.gov/PlaceofServiceCodes/. Keep the codes and descriptions readily accessible to all coders and billing personnel.

Identify all rendered professional services on the CMS-1500 form in Block B under the date(s) of service. Have a POS code listed to identify where the service was rendered for each billable line.

Improper application of POS codes can have serious consequences, and “Place of Service Errors” are an area of special investigation in the Office of Inspector General’s (OIG) 2010 Work Plan.

For example, payments made to physicians in an office setting include a “practice expense” value not factored into payments for other places of service. As the 2010 Work Plan explains, “Federal regulations... provide for different levels of to physicians depending on where the services are performed. Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician’s

office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC.” Using a POS code 11 *Office* when an inpatient POS is appropriate can result in unwarranted reimbursement dollars. Be warned: The OIG specifically is looking for such errors.

Additionally, if the POS code does not match the service location of a billed E/M service, the claim likely will be denied. For instance, a POS 11 isn’t appropriate when billing an inpatient E/M service, such as 99222 *Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.*

Know SNF and Nursing Facility Differences

Note: Sometimes more information needs to be obtained by a facility before applying a POS code for an encounter. For example, a coder initially may believe a facility is a nursing home, when it actually is categorized as a skilled nursing facility (SNF) or an intermediate care facility.

The difference between a nursing facility and an SNF can be confused easily. The American College of Nurse Practitioners (www.acnpweb.org/i4a/pages/Index.cfm?pageID=3433) defines each as follows:

A **SNF** is an institution or a distinct part of an institution (see §201.1) such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals (see §201.2 for transfer agreements and §205 for definition of a participating hospital) and which:



- Is engaged primarily in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and
- Meets the requirements for participation in §1819 of the Social Security Act and regulations in 42 CFR part 483, subpart B. A qualified SNF meets all the requirements in the above definition. For Medicare purposes, the term SNF does not include any institution which is primarily for the care and treatment of mental diseases or tuberculosis.

A **nursing facility** or **nursing home** is a residence facility providing a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems keeping them from living on their own. They usually require daily assistance. The distinction is based primarily on whether skilled medical or nursing care or rehabilitation is required.

If the provider renders services to residents at either facility types, you must apply the correct POS code to avoid claim errors and potential denials.

For example, if a physician provided initial nursing facility care (99305 *Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Physicians typically spend 35 minutes with the patient and/or family or caregiver.*), we would indicate the POS code (32) on the CMS-1500. **RE**



Trina Cuppett, CPC, CPC-H, is president of the Hickory Coding Specialists chapter in Hickory, N.C., and the founder of the Mooresville Coding Chapter in Mooresville, N.C. She teaches medical terminology and medical billing and reimbursement issues at a local community college, and is a member of the AAPC National Advisory Board (NAB).



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THE "DISEASE OF THE KINGS" IS MAKING
A COMEBACK IN THE UNITED STATES.

By Sheri Poe Bernard, CPC, CPC-H, CPC-P



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It's gout, and it's called the "disease of kings" because attacks can be triggered by rich foods and liquor, historically available to royalty. A propensity toward gout also can be hereditary, and heirs to the crown would often be heirs to this malady, as well. Among the kingly gout sufferers are Charlemagne, Henry VIII, Charles IV, and Charles V. Notable democratic leaders have suffered the disease, as well, including John Hancock, Benjamin Franklin, Thomas Jefferson, and Martin Luther King, Jr.

The incidence of gout in the United States doubled in the last decade. It's thought lifestyle issues precipitated this increase. Obesity, alcohol use, hypertension treated with diuretics, and a diet rich in meat and seafood increases a patient's risk for gout, which is now considered the most common form of inflammatory arthritis in the United States. Aging population contributes to the incidence of gout, as well.

A Word About Gout

Gout occurs when uric acid build-up in the blood leads to the deposit of monosodium uric crystals in the soft tissue of joints. Uric acid forms when purines break down in the blood. Meats, fish, shellfish, and beer are rich in purines. Nearly 75 percent of the cases of gout are first diagnosed in the big toe, and men outnumber female sufferers at least three-to-one. An acute attack may last a few days or weeks, and some patients may not have a repeat attack for years. Typically, gout has four stages:

- ▶ Asymptomatic accumulation of crystals in the tissue, with some tissue damage occurring;
- ▶ Acute flares with hot painful swelling. Uric acid levels may be within normal range;
- ▶ Intercritical segments in which the symptoms abate, but the damage continues to occur within the joint tissue; and
- ▶ Chronic gout, which is characterized by arthritis, soreness, joint aches, and in some cases, tophi (lumpy deposits of uric crystals in the soft tissue). The presence of tophi heralds the most severe form of the disease.

Diagnosis Coding

Criteria for diagnosing gout require uric crystals in synovial fluid, tophus pathology of uric crystals, or a preponderance of clinical and X-ray evidence. Diagnostic coding for gout changed last month with the addition of several new codes to ICD-9-CM. The codes allow for reporting of the acute or chronic nature of the gout.

Until the change, coders had only one code to report gouty arthritis (274.0 *Gouty arthropathy*). The new codes increase to five digits allowing for more specific reporting of the disease's progression:

274.00 Gouty arthropathy, unspecified

274.01 Acute gouty arthropathy

274.02 Chronic gouty arthropathy without mention of tophus (tophi)

274.03 Chronic gouty arthropathy with tophus (tophi)

The hallmark of acute gouty arthropathy is searing pain. Many patients report they cannot tolerate even the weight of a sheet upon their afflicted joint, which is typically swollen, red, and hot. Podagra, the tell-tale painful inflammation of the big toe in acute gout attacks, has been reindexed for 2010 from 274.9 *Gout, unspecified* to 274.01 *Acute gouty arthropathy*. Chronic conditions also may be painful, but can be accompanied by arthritic deposits that produce disfigurement and impede joints.

Gout cannot occur without uric acid buildup. However, this buildup, called hyperuricemia, may be resolved at the time of the diagnosis. In fact, only 50 percent of new cases of gout occur with hyperuricemia. Hyperuricemia is classified to 790.6 *Other abnormal blood chemistry*. Hyperuricemia can be a benign condition, but in some people can lead to the development of gout. Medications, including chemotherapy, immunosuppressants, aspirin, diuretics, and niacin can cause formation of gout crystals. Chronic conditions including kidney disease, multiple myeloma, hypothyroid, Kelley-Seegmiller or Lesch Nyhan syndrome, hemolytic anemia, and psoriasis may also predispose an individual to gout. If an underlying cause is documented, it should be coded in addition to the gout.



Benjamin Franklin's Battle with Gout

Benjamin Franklin suffered from gout during an era when sloth and gluttony were its understood cause. It was believed that exercise and moderation in food and drink could prevent gout attacks. He wrote of it in his "Dialogue Between Franklin and the Gout," in 1780, excerpted here:

Franklin: Eh! Oh! Eh! What have I done to merit these cruel sufferings?

Gout: Many things; you have ate and drank too freely, and too much indulged those legs of yours in their indolence.

Franklin: Who is it that accuses me?

Gout: It is I, even I, the Gout...

Franklin: Oh! oh!—for Heaven's sake leave me! And I promise faithfully never more to play at chess, but to take exercise daily, and live temperately.

Gout: I know you too well. You promise fair; but, after a few months of good health, you will return to your old habits; your fine promises will be forgotten like the forms of the last year's clouds. Let us then finish the account and I will go. But I leave you with an assurance of visiting you again at a proper time and place ...

Gout can lead to the formation of kidney stones. If the stones are from uric acid, the correct code is 274.11 *Uric acid nephrolithiasis* rather than 592.0 *Calculus of kidney*. ■

[Sheri Poe Bernard, CPC, CPC-H, CPC-P, is AAPC's vice president of clinical content.]

Get Coding Results You Want with OB Ultrasound

Five criteria help narrow down obstetric ultrasound code choice.

By Gayathri Natarajan, BPT, CPC, CPC-H

Obstetric (OB) pelvic ultrasounds emit sound waves that enable clinicians to view pelvis organs and structures, such as the bladder, ovaries, uterus, cervix, and fallopian tubes in women. A pelvic ultrasound may be used in pregnancy to check fetal age, or to find a tubal pregnancy (ectopic pregnancy) or multiple pregnancies.



Identify an OB Ultrasound

To select a CPT® code describing pelvic ultrasound, first determine if the service is OB-related or non OB-related.

AMA's *CPT® Assistant* states that OB codes are appropriate anytime the patient is established as pregnant, by any method or means, and the indications for the ultrasound could be pregnancy-related, regardless of whether the outcome confirms a pregnancy or not, or might produce a non pregnancy-related diagnosis.

Fetus findings categorize the service as OB related. During early weeks of pregnancy, fetal organs usually can't be visualized and probably only a small gestational sac can be seen. In such a case, the clinical indication prompting the exam, such as a positive pregnancy test, guides code selection.

For a patient who is not diagnosed as pregnant, and the indications for the ultrasound study are not pregnancy-related, non-OB ultrasound codes are appropriate, regardless of whether the study's outcome shows a pregnancy or pregnancy-related complication.

For instance, the physician orders a transabdominal OB ultrasound for a 25-year-old female with a clinical indication of positive human chorionic gonadotropin (hCG). The report bears no evidence of an intrauterine gestational sac. The rest of the organs look normal, as per the physician's interpretation. This is an OB-related service because the physician's order states "OB US." A positive hCG verifies this is an OB service.

Narrow Code Choice with Five Criteria

To select an appropriate OB ultrasound code, you must determine:

1. The approach (transabdominal or transvaginal).
2. If using a transabdominal approach, is the gestation age greater or less than 14 weeks?
3. Single or multiple gestations?
4. If the study was performed for specific reasons, such as fetal nuchal translucency measurement, follow-up, fetal biophysical profile (BPP), Doppler velocimetry, echocardiography, etc.
5. If the study was complete or limited.

Base Code Selection by Age, Purpose

With these criteria in mind, let's review the available OB ultrasound codes one by one.

Codes 76801 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation* and +76802 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* describe transabdominal ultrasound during the first trimester. In twin pregnancy cases, add on code +76802 is reported in addition to primary code 76801.

These codes require the interpretation support findings of both the fetus and the mother. The maternal findings are readings of the adnexa, uterus, ovary, etc. The evaluation also includes survey of the fetal and placental amniotic structure, amniotic fluid volume, etc.

For the transabdominal ultrasounds done at more than 14 weeks, codes 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation* and +76810 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* are appropriate. In twin pregnancy cases, add-on code +76810 is reported in addition to primary code 76805.

Maternal organs usually are easier to visualize during early stages of pregnancy because of the smaller size of the fetus. As the gestational age progresses, the fetal size grows and maternal organs are hardly visible on the ultrasound. The documentation of the maternal component is minimal on ultrasounds done at later stages of pregnancy and hence the guideline for codes 76805 and 76810 demands examination of maternal adnexa only when visible.

Codes 76811 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation* and +76812 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)* require a detailed fetal anatomic examination in addition to the routine fetal and maternal evaluation. In twin pregnancy cases, add-on code +76812 is reported in addition to primary code 76811.

These procedures evaluate the fetal brain and ventricles, face, heart and outflow tracts, chest, abdominal anatomy, number, length and architecture of limbs and a detailed evaluation of the umbilical cord, placenta, and other fetal anatomy that may be clinically indicated. When any of the elements are not visualized, the reason for non visualization needs to be reported in the document to qualify for the code.

Code 76815 *Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position, and/or qualitative amniotic fluid volume), one or more*

fetuses describes a quick look at the fetus, which is a limited exam. This code is reported only once even in case of evaluation of more than one fetus (e.g., twin pregnancy). The procedure is usually done using a transabdominal approach.

Code 76816 *Ultrasound, pregnant uterus, real time with image documentation, follow up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), trans abdominal approach per fetus* is a reassessment or a follow-up of the interval growth of the fetus compared to a previous ultrasound. This code is reported once per fetus. For each additional fetus, 76816 is reported again with modifier 59 *Distinct procedural service*.

Code 76817 *Ultrasound, pregnant uterus, real time with image documentation, transvaginal* is the only transvaginal code available in the OB category. If transvaginal examination is done in addition to a transabdominal obstetrical ultrasound exam, use 76817 in addition to the appropriate transabdominal exam code—listing the higher-paying transabdominal code first.

For all OB ultrasounds, images are stored as a hardcopy or in electronic format. Documentation for all services needs to support determination of all components of chosen CPT® codes' descriptors like the number of fetuses and amniotic/chorionic sacs, measurements appropriate for gestational age, survey of intracranial, spinal, and abdominal anatomy, four-chambered heart, umbilical cord insertion site, placenta location, amniotic fluid assessment, and maternal adnexa as applicable. The study's documentation must be available to the insurer on request, and a written interpretation of the study should be maintained as part of the patient's record.

Interpretation Determines Diagnosis

ICD-9-CM code selection is based on the study's interpretation. In normal interpretation cases, the pre-service signs, symptoms, and conditions prompting the study would be the ICD-9-CM code of choice.

Consider Coverage Guidelines

The conventional 2-D ultrasound is covered by most payers. Medicare usually reimburses all OB ultrasounds with relevant medical necessity documented and that are within the scope of the physician's license. When the OB ultrasound is done only to determine fetal gender or to provide a keepsake image of the fetus, the procedure is considered as not medically necessary and is not covered.

Typically, OB ultrasound is not included in the obstetrical package and billed separately. Some insurers bundle the payment of OB ultrasounds into the global maternity package, so be aware of your payers' specific policies. ■



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2010 ICD-9-CM Changes Provide a Glimpse of History

Yearly changes reflect American health and social issues at the time.

By Sheri Poe Bernard, CPC, CPC-H, CPC-P

When we crack open our new edition of ICD-9-CM codes each year, we not only open a big to-do list for education and implementation associated with changes, we also get a snapshot of our nation's social, scientific, and medical history. If we take the time to consider the code changes in that perspective, we can understand where we've been, where we are, and even where we are headed with American health care and social issues.

Each year, advancements are chronicled with the addition of new codes reflecting new technologies for treating diseases. For example, Savient Pharmaceuticals received Food and Drug Administration (FDA) approval for a drug to treat chronic gouty arthropathies, and so we have codes specific to arthritic gout with tophus (274.03 *Chronic gouty arthropathy with tophus (tophi)*).

Military Codes

Similarly, social issues are catalogued and new codes are created to report these conditions. Clearly, the effects of combat in Iraq and Afghanistan upon the U.S. population weighed heavily in code creation this year. Several codes were created to report traumatic brain injury (TBI). TBI is the hallmark injury in Mideast conflicts due to the use of improvised explosive devices (IEDs) against U.S. troops. The force of the explosive device can create damage without visible wounds (or with devastating wounds). Some soldiers see changes in cognition, behavior, or personality that later are linked to TBI. The U.S. military reports that 43,779 patients were diagnosed with TBI due to the Iraq War in 2003 - 2007.

New codes for 2010 report a history of TBI, screening for TBI, psychological symptoms associated with TBI, and codes specific to suicide bombers and other

IED attacks. In addition to war-related injuries, TBI is linked to car accidents, sports injuries, and falls. One million Americans are treated in U.S. emergency departments (EDs) for TBI each year, and an estimated 5.3 million are living today with a disability related to TBI.

Baby Codes

Sometimes, too, epidemiologists and other medical scientists request codes in hopes that reporting might provide more data and lead to better understanding of disease. Such was the case last year with the new vulvodynia code, and such is the case this year with a new code for an apparent life-threatening event (ATLE) in an infant. Code 799.82 *Apparent life-threatening event in an infant (ALTE)* was created to report a clinical syndrome that puts patients at greater risk for sudden infant death syndrome (SIDS). The syndrome includes apnea, color change, muscle tone change, choking, or gagging. The current rate of ATLE is reported to be as high as 6 percent in the infant population, and the American Academy of Pediatrics wants more information on its incidence and its outcomes.

Aging Codes

At the other end of the age spectrum are new codes for disorders that typically are associated with our aging population. New codes for a particularly nasty form of skin cancer, Merkel cell carcinoma, were created. Merkel cell carcinoma typically attacks the skin of elderly people. Several codes also target speech deficits that may result from strokes or other insults to the brain, typically seen in the older population. This year's expansion of thrombosis codes into chronic and acute disorders specified by vessel also will see heavy play among older patients. And, there is the new E code to report an injury occurring while knitting and crocheting—one of more than

100 new E codes identifying recreational activities that might lead to injury.

Codes Pertinent to You

For a complete look at the ICD-9-CM changes for 2010, go to the AAPC Web site www.aapc.com/Member-Area/resources/documents/ADDENDUMicdtab10add.pdf. Remember that significant changes to how we use codes appear as index or instruction changes, so read the addendum thoroughly. Be sure to download the new guidelines from the AAPC Web site www.aapc.com/2010icd9updates/icdguide09.pdf. The guidelines are published by the government too late in the year to be included in the code books, so it is the responsibility of every coder to download and review the new guidelines to ensure compliance. The government kindly boldfaces all year-over-year changes, so a quick scan is all that's required to see what's different for 2010.

Be certain to go through the addenda and your code book, highlighting those changes pertinent to your practice. Create a documentation cheat sheet of 2010 updates that must be documented differently to be coded, and share this with your clinicians. Be sure all software, paperwork, and personal lists are updated with the new codes, and contact payers with any questions you have regarding new codes and medical necessity edits. Don't forget to check for ICD-9-CM errata issued from the government. The AAPC Web site will post these in the *Members Area* under "Resources."

Which codes will go down in history as the pivotal codes for 2010? It's probably too early to tell. The inclusion of TBI codes will certainly be noted, as well as the thrombosis codes and the E codes identifying activities such as hang-gliding, mopping, animal milking, and horseplay. And while ICD-10 may seem like it is just over the horizon, the folks at the Centers for Medicare & Medicaid Services (CMS) are busy considering requests for new codes for 2011, including codes for multiple gestation placenta status, do not resuscitate order status, high cardiac output heart failure, and homicidal ideation. ■

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There is the new E code to report an injury occurring while knitting and crocheting—one of more than 100 new E codes identifying recreational activities that might lead to injury.

Stroll Down Memory Lane with Historical ICD-9 Codes

Oct. 1, 1994 AIDS/HIV is assigned a unique code of 042 *Human immunodeficiency virus [HIV] disease* in the United States. The first case of U.S. AIDS dates back to 1981. Until 1994, AIDS was reported with 279.19 *Other deficiency of cell-mediated immunity*; and more than 40,000 patients died and 70,000 were infected with AIDS. Today, the Centers for Disease Control and Prevention (CDC) says more than 1.1 million Americans are living with HIV infection.

Oct. 1, 2002 Terrorism E codes are created to allow for the identification of injuries and illnesses in the wake of 9/11. The use of these codes is reserved exclusively for injuries sustained in events the Federal Bureau of Investigation (FBI) designates as acts of terrorism. E979.1 *Terrorism involving destruction of aircraft* describes terrorism in which an aircraft is used as a weapon or is burned, exploded, or shot out of the sky.

Oct. 1, 2005 Body mass index (BMI) is assigned a series of V codes so the nature of a patient's weight problem can be coded. Obesity is defined as a BMI of 30 or greater, and morbid obesity as 40 or greater. Obesity among adults in the United States is 34 percent. The CDC says this is due to American society becoming "obesogenic, characterized by environments that promote increased food intake, unhealthful foods, and physical inactivity."

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Analyze ICD-10's Impact on Your Practice

Get an in-depth look at the systems and processes impacted most.

By Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, COBGC, CEMC, CDERC, CCS-P

The goal of an impact analysis is twofold. The first objective is to gather relevant information from each department to obtain an understanding of the current environment. The second is to map out what needs to be addressed for successful ICD-10-CM implementation. The ICD-10-CM project team for each department is responsible for ensuring the impact analysis is conducted in their department. Once the analysis is complete in all departments, the project team can analyze each department's needs and develop a budget for ICD-10-CM implementation.

The preliminary impact analysis is a good tool for assessing which areas may be affected most in the early stages of ICD-10-CM implementation. Vulnerable areas may include:

- Information systems
- Documentation
- Staff education needs
- Clinical and administrative

Analyze Information Systems

Conducting a system audit for ICD-10-CM compatibility is part of the impact assessment. Start by performing a comprehensive audit of all data systems currently using ICD-9-CM; and then analyze the systems that will use ICD-10-CM.

Your analysis should answer the following questions:

- How are ICD-9-CM codes used in each information system?
- Which vendor software applications—versus internally developed system interfaces, customizations and other affected software (like Charge Description Masters, practice management software, financial software, etc.)—are being used?
- How are codes entered? Are they manually entered or imported from another system or software?
- What is the current character length specification in the system? The 5010 conversion should resolve this problem.
- Can the system handle alphanumeric structure? It must.

- Can the codes, code descriptions, and supported documentation be obtained in a machine-readable format?
- Does the code format include a decimal?
- Can the current system house both ICD-9-CM and ICD-10-CM codes simultaneously?
- Will the vendor or internal information technology (IT) personnel be able to map forward from ICD-9-CM to ICD-10-CM and backward from ICD-10-CM to ICD-9-CM.
- How is the quality of data checked?
- How do the systems interface? (if applicable)

Once you perform a comprehensive audit of the IT systems, map the electronic data flow to inventory and all reports containing ICD-9-CM codes. Then perform a detailed analysis of necessary changes to be implemented for the transition to ICD-10-CM. You may need to contact software and hardware vendors during the analysis phase to identify potential costs that will affect your budget. Typical expenses may include the following:

- Hardware
- Software
- Upgrading systems
- Customization
- Staffing and overtime

Software modifications may include the following:

- Change to alphanumeric structure
- Longer code descriptors
- Field size expansion
- Edit and logic changes
- Use of decimals
- Table structure modification
- System interfaces
- Expansion of flat files containing diagnosis codes
- Redefinition of code values and their interpretation

Identify which forms and reports will need to be reformatted or revised. IT also needs to evaluate whether each system's storage capacity is sufficient to support both ICD-9-CM and ICD-10-CM during the transition or if the capacity will need to be increased. Also consider how long ICD-9-CM will be accessible, what staff will need to access ICD-9-CM, and how long the legacy data will need to be available.

Contact Vendors

Contact system vendors during this phase to determine whether they can support legacy and new coding systems and for how long. This is an ideal time to identify costs for upgrading software and storage capacity as well as contract issues with the vendor. This will help with the system conversion budget over the next several years.

Determine if upgrades are included in the current contract or if there are any additional costs. If upgrades are not included, inquire as to what costs will be incurred. Coordinate with the vendor the timeline for testing and installation of the new or upgraded software or system. Other IT system considerations might include a conversion to electronic health records (EHRs) or electronic medical records (EMRs) during this transition if the organization hasn't previously converted.

Assess Documentation

In the clinical area, the largest impact to ICD-10-CM implementation is documentation. Since ICD-10-CM is more robust and has up to seven digits of specificity, assess whether documentation currently in the medical record will support ICD-10-CM on the "go-live" date. Analyzing the documentation and conducting medical record documentation audits will enable you to assess the impact. The organization should have an experienced auditor(s) conduct audits either internally or externally. Random samples should be evaluated and various types of medical records should be reviewed. A clinical documentation assessment tool should be used to conduct this audit to be sure current documentation adequately supports ICD-10.

Take an in-depth look at the medical record's current

level of documentation. Review the lack of specificity in the documentation and analyze how to begin the process of improvement. Based on the practice's specialty, review the most common diagnosis codes used and their frequency.

Once an audit is conducted and analyzed, the organization will have a good assessment of documentation deficiencies, and can develop a priority list of diagnoses requiring more detail. The audit also helps identify practitioners who will benefit from focused training using ICD-10-CM.

Implement a documentation improvement program within the organization and monitor the documentation on an on-going basis. This will ensure improvement and identify areas where practitioners are deficient and who needs more assistance. These audits should be conducted periodically to validate ICD-10-CM compliance. As with any audit, submit a report summary to senior management.

Coding and Billing Education

The key issue when assessing coding and billing in the impact analysis is education and training on the new ICD-10-CM code set. The organization must first identify who needs training, how many hours of training will be required, and the most beneficial training method. Questions to ask when determining training needs are below:

- How much training on ICD-10-CM will be necessary?
- How many training days will be required?
- Will there be lost revenue if the physicians and non-physician practitioners need to be out of the office for training?
- How will productivity be affected?
- How much training does each department need?
- What extent of training does each staff person need?

These are all valid concerns that need to be part of the impact analysis. Everyone in the medical practice will need some form of training. Physicians, non-physician practitioners (NPPs), coders, and billing staff will need



Since reimbursement is tied to procedural and diagnosis coding, the finance area will be impacted greatly ... after the implementation date, if an insurance carrier cannot yet accept ICD-10-CM codes, the medical practice probably will not be paid.

more extensive training than ancillary staff (nurses, MAs, managers, etc.).

Some studies indicate less than 16 hours of training is necessary on ICD-10-CM. Physicians will need approximately 16-20 hours of training. Coders will need between 40-60 hours of training, with the ancillary staff and nurses needing six to 10 hours of training. Training depends on the individual's understanding of anatomy, terminology, and ICD-9-CM. A person who is experienced in ICD-9-CM coding, with a good understanding of anatomy and terminology in their specialty, may take less time to train than a person with limited knowledge.

Physicians and managers are usually compensated based on revenue or salary, so overtime compensation will not be a consideration for this group. Coders and ancillary staff, on the other hand, typically are paid hourly rates. The recommended overtime budget is at a minimum of 15-20 hours pre-implementation and 20-40 hours post implementation. After implementation, work will increase due to system problems, denials, etc. Address these issues along with the daily business that occurs in a typical medical practice.

Figure Finances

Since reimbursement is tied to procedural and diagnosis coding, the finance area will be impacted greatly. For example, after the implementation date, if an insurance carrier cannot yet accept ICD-10-CM codes, the medical practice probably will not be paid. If your organization is not ready and cannot transmit claims, your practice's finances will be impacted as well. Review the current reporting for procedures and services using ICD-9-CM codes and compare them to

ICD-10-CM codes. Professional services are paid based on the procedure code, but the diagnosis code supports medical necessity, which is the driving factor in payment for all medical procedures and services.

Reports tied to diagnosis codes, such as the accounts receivable analysis, pending claims reports, analysis by provider type, collection reports, etc., also will be impacted. Conduct an assessment of the reports currently impacted by ICD-9-CM and what impact will be realized with ICD-10-CM.

After implementation, the impact of such a major coding change will be felt and may be quite burdensome for practices. Pended or denied claims are expensive for practices to deal with, and generally are dealt with through a manual process. Any increase in the number of claims not processed or paid will first decrease provider cash flow, then increase both provider workload and plan workload to process the denials. Providers need to know the change in documentation and coverage requirements ahead of time to adapt in time for implementation.

For information on ICD-10 assistance within your practice or organization or to inquire about AAPC ICD-10 Implementation training for providers or health plans, contact Deborah Grider at deb.grider@aapc.com.

Next time: Organizing cross-functional efforts. 



Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, COBGC, CEMC, CDERC, CCS-P, is the AAPC's vice president of strategic development and the former AAPC National Advisory Board president. Deborah is the author of *ICD-10-CM Implementation Guide, Make the Transition Manageable*, American Medical Association Press, 2009.

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HITECH Update:

HHS Issues Rule Governing Security Breach Notification

AVOID BREACH NOTIFICATION REQUIREMENTS BY SECURING PROTECTED HEALTH INFORMATION (PHI) IN YOUR PRACTICE.

By Michael D. Miscoe, Esq.,
CPC, CASC, CUC, CHCC

On Aug. 24, the Department of Health and Human Services (HHS) published an interim final rule regarding security breach notification rules required by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which is part of the American Recovery and Reinvestment Act of 2009 (ARRA). Security breach notification is a key measure of the HITECH Act, designed to further electronic health record (EHR) adoption by providing more stringent protections for patient information.

The interim final rule requires covered entities (health care providers, health plans, health care clearinghouses, and their business associates), effective Sept. 23, to:

- Promptly notify affected individuals whose unsecured protected health information (PHI) was the subject of a security breach;
- Report such breaches to HHS (either concurrently or annually); and
- In certain circumstances, communicate security breaches to the media.

Business associates also must notify reportable security breaches to their covered entities, so the covered entities can make reports to affected individuals and others as required by the regulations.

Note: HHS has said it will refrain from imposing sanctions on covered entities for failure to make such notifications until 180 days from publication of the interim final rule (Feb. 22, 2010) to allow time for compliance.

Unsecured PHI vs. Secured

Notification obligations under the regulations apply only to breaches involving unsecured PHI. The HITECH Act defines unsecured PHI as not secured with a technology or methodology rendering PHI unusable, unreadable, or indecipherable to unauthorized individuals. A breach of “secure” PHI is not subject to notification requirements.

For example, encryption and destruction are methods to secure PHI. Qualifying encryption must be an algorithmic process with a confidential process or encryption key. The encryption key must be kept on a separate device from the encrypted data to ensure the key is not breached. To qualify as “destroyed,” paper copies of PHI must be shredded or destroyed and electronic media copies of PHI must be cleared, purged, or destroyed.

Redaction of paper records does not satisfy destruction requirements; however, redaction is an acceptable method for PHI de-identification. Because de-identified information is not PHI, it is *not* subject to breach notification requirements.

Identify a Breach

The HITECH Act defines “breach” as the “unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of the PHI, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.”



The interim final rule clarifies that “unauthorized acquisition, access, use, or disclosure” means the acquisition, access, use, or disclosure is impermissible under the HIPAA Privacy Rule. The rule clarifies that an unauthorized activity “compromises the privacy or security of PHI” if it poses a significant risk for financial, reputational, or other harm to the individual.

As a result, not every impermissible use or disclosure of PHI constitutes a reportable breach. This limits the required number of breaches covered entities or business associates can report, and requires covered entities and business associates to perform a risk assessment to determine whether there is a significant harm risk to the individual as a result of the impermissible activity.

The interim final rule advises when performing risk assessment, the covered entity or business should assess and identify:

1. Who impermissibly used information, or to whom the information was disclosed impermissibly. When the PHI was disclosed improperly to another covered entity, for instance, the risk would be low because that entity shares an equivalent obligation to protect PHI.
2. Whether immediate steps taken to minimize the harm render the risk to the patient as less than “significant.” As an example, the party who improperly receives the information either destroys it and/or signs a confidentiality agreement providing assurances it will not use or further disclose the PHI.
3. Whether the impermissibly-disclosed PHI was recovered prior to it being accessed for an improper purpose.
4. The type and amount of PHI involved in the impermissible use or disclosure. When only limited information is disclosed (i.e., the patient’s name and that services were received by the covered entity), likely the risk is minimal that such information could cause the patient significant financial or reputational harm.

Breach Assessment

To decide if a reportable breach has occurred, covered entities and business associates should:

1. Determine if the PHI constitutes “unsecured” PHI.
2. Determine whether there has been an impermissible acquisition, access, use, or disclosure of PHI in violation of the HIPAA Privacy Rule.
3. Conduct a risk assessment to determine whether the impermissible activity compromised the PHI’s security or privacy. Document the risk assessment’s results, especially where the risk is determined to be so low that the breach needn’t be reported.
4. Evaluate whether the incident falls under one of the notification obligations’ exceptions.

Accomplish Notification

When a reportable security breach occurs, notification in compliance with the interim final rule is required.

1. Covered entities must notify affected individuals when their unsecured PHI is breached. Timely notification is within 60 calendar days from the time the covered entity discovers the breach, or should have discovered the breach using reasonable diligence. This 60-day timeframe only can be tolled where law enforcement determines notification would impede an ongoing investigation.
2. Covered entities should conduct an investigation into a potential breach, but the time necessary to complete an investigation does not extend the 60-day timeframe. The interim final rule includes a provision, however, alleviating covered entities from liability for failure to provide breach notifications where the covered entity did not know, or did not have reason to know, of the breach.
3. Covered entities must provide timely breach notification to the media where the breach involves at least 500 individuals in a given state or jurisdiction.
4. Covered entities must notify concurrently any breach involving at least 500 individuals, regardless of location, to the HHS secretary.
5. Covered entities must provide the HHS secretary with an annual log of breaches involving fewer than 500 individuals.

**ACTUAL NOTIFICATION
REQUIRES THE COVERED
ENTITY TO TRANSMIT
WRITTEN NOTICE
TO THE AFFECTED
INDIVIDUAL, BY FIRST-
CLASS MAIL AT THE
INDIVIDUAL'S LAST
KNOWN ADDRESS.**

Business associates also are required to provide timely notification of unsecured PHI breaches to the covered entity providing the PHI.

Notification Requirements

When a breach occurs, the regulations require notification to individuals be written in plain language. A proper notification must contain:

1. A brief description of how the breach occurred, including the breach date and discovery date.
2. A description of the PHI that was disclosed.
3. Recommended steps the individual should take to protect him or herself.
4. A description of the actions taken by the covered entity to investigate the breach's cause, to mitigate the harm to the individual associated with the breach, and to preclude future PHI breaches.
5. Contact information (at least one of the following: a toll-free number, e-mail, Web site, or postal address), so the affected individual can obtain additional breach information from the covered entity.
6. A description of sanctions the covered entity imposed on any workforce members involved with or responsible for the breach.

Methods for Providing Notification

The interim final rule adopts HITECH Act provisions permitting either “actual” notification or “substitute” notification. Actual notification requires the covered entity to transmit written notice to the affected individual by first-class mail at the individual's last known address. E-mail notice is permissible if the individual previously consented to being contacted in this manner. Only in emergent cases, where there is a fear of imminent misuse of an individual's PHI, the regulations authorize a covered entity to use alternative methods of contact, such as by telephone. In such a case, a covered entity is required to follow up with written notice, as well.

When the affected individual's last known contact information is out-of-date or incomplete, the covered entity can provide a substitute notice only if the substitute notice is likely to reach the affected individual.

If the substitute notice itself necessarily discloses PHI, accomplish substitute notification in any of the following manners:

1. When there are less than 10 individuals involved, an alternate written form such as an e-mail or fax, a telephone call, or other means of direct contact likely will satisfy this requirement.
2. When at least 10 individuals are involved, the covered entity can satisfy the substitute notification requirements by posting a conspicuous notice on the home page of its Web site for 90 days, or placing a conspicuous notice in a major print or broadcast media in the geographic areas where the individuals reside. The substitute notice must be drafted and published so it's likely to reach the affected individuals, and must include a toll-free number for affected individuals to contact the covered entity for additional information. The toll-free phone number must remain active for at least 90 days.

Notification Requirement Exceptions

There are exceptions to the notification requirements. When PHI is disclosed inadvertently by a person with authority to access the PHI at a covered entity or business associate to another person with authority to access the PHI from the same covered entity or business associate, the notification provisions are not triggered—as long as the recipient does not further disclose the information in violation of the HIPAA privacy rule. An unauthorized disclosure of unsecured PHI need not be reported where the person to whom PHI is disclosed would not reasonably have retained the information.

If your practice is complacent with HIPAA privacy and security compliance, the HITECH Act will require additional focus to secure PHI. Consider appropriately securing PHI to avoid the breach and notification requirements. Although, it is unlikely all PHI can be “secured” appropriately, training pertaining the interim final rule changes regarding what constitutes a breach—where one occurs and how to comply with the rule's notification provisions—will be necessary. 



Michael D. Miscoe, Esq., CPC, CASCC, CUC, CHCC, is president of Practice Masters, Inc. and the founding partner of Miscoe Health Law, LLC. He is a past member of the National Advisory Board (NAB) and current member of the Legal Advisory Board (LAB). He is admitted to the Bar in the state of California as well as to the practice of law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. Mr. Miscoe has nearly 20 years of experience in health care coding and over 13 years as a compliance expert testifying in civil and criminal cases.



Stop Playing Guessing Games with Patient Care

Good documentation starts with the chief complaint.

By Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC

Remember playing Twenty Questions on long car rides as a child? The object of the game was to guess the person or object your opponent was thinking of by asking 20 questions or less with only “yes” or “no” responses. Going into an exam room not knowing why the patient is there is like Twenty Questions, Extreme. Evaluating a patient and creating a care plan is challenging enough without playing guessing games.

The chief complaint (CC) removes the guess work. CPT® defines the CC as a “concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient’s words.” CPT® recognizes five levels of presenting problems: minimal, self-limited or minor, low severity, moderate severity, and high severity.

The CC is related to the nature of the presenting problem or “disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter,” according to the CPT® manual. The definitions for the CC and the presenting problem overlap.

Evaluation and management (E/M) documentation guidelines define the CC similarly to CPT®, and further state, “The medical record should clearly reflect the chief complaint.” This shows that not only is the CC helpful to the provider, it’s a documentation requirement.

Go to the Source for the CC

The first thing a provider’s assistant does after she directs a patient to an available examination room is ask, “So what brings you in today?” She documents the patient’s response—the CC—in the chart.

The provider is responsible for verifying the CC. As a provider, I have seen cases where the patient’s response to the assistant is quite different than that given to me. Some-

times a patient is embarrassed, or has personal reasons for not sharing the real CC with ancillary staff.

Let the CC Be Your Guide

The CC can be problem-oriented or preventative. In the case where the CC is problem-oriented, it acts like a directional arrow, pointing the provider in the vicinity of a patient’s concerns. By knowing the reason the patient is presenting to the office, the provider can narrow the scope of questioning in the history of present illness (HPI).

In other words, the CC is like the “YOU ARE HERE” arrow on the mall directory, except that it is directing the provider’s

attention to a spot in or on the human body. For instance, a patient whose CC is “low-back pain” constitutes a problem-oriented visit because the CC directs the physician to a particular problem.

If the CC is not problem-oriented, then the provider knows that the service is preventative. If the patient is “Here for my annual exam,” for instance, you would not expect to see an HPI.

Consider CC and HPI Separately

Don’t confuse the CC with the HPI—they are separate elements and not interchangeable. The CC is the reason the patient presented for the office visit. The HPI details the CC. Although the CC directs the HPI and the review of systems’ (ROS) line of questioning, the extent of history obtained is based solely on the provider’s clinical judgment. It should not be more than is medically necessary to evaluate the patient. ■

In the case where the CC is problem-oriented, it acts like a directional arrow, pointing the provider in the vicinity of a patient’s concerns.



Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC, has been in the health care field for over 18 years. She has over 11 years of clinical experience in women’s health, and is the coding educator at a multispecialty clinic. She is president of her local AAPC chapter and a member of the AAPC National Advisory Board (NAB). She was a presenter for the Wisconsin Medical Society’s 2007 and 2008 Annual Symposia, and has conducted several audio and day seminars on its behalf.

Undercover Coder Codes Off Duty

Educating others about coding shouldn't stop—even if you're the patient.



By Simone Tessitore, CPC, COBGC

We've all done it — mentally coded our doctor visit while sitting on the table, trying to hold our gowns closed, looking over our own fee ticket with a raised eyebrow. "Hmmm ... this should have been a 99213, not a 99214." Sometimes you tell the doctor or staff, sometimes you don't.

I recently went through Roux-en-Y gastric bypass surgery, which required contact with many different specialty providers to fulfill the requirements of both my health maintenance organization (HMO) and my surgeon. I've worked in billing and coding for 20 years, so I'm pretty familiar with documentation rules and how things should be done. Naturally, I thought it would be fun to code and audit my way through the entire process.

It Started With a Misguided Consult Code

The first surgeon I went to charged me \$434 at my first appointment. I was told they would later bill my insurance and I'd get this money back. As it turns out, they billed my insurance \$434 for a 99245 *Office consultation for a new or established patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.*

A consult code? Nobody sent me to this doctor for an opinion on my treatment. I called and mentioned my misgivings about this coding. Nobody called me back. I did receive a refund, however, when I switched surgeons.

The second surgeon charged me \$100 at the first visit. The staff said, "Because he doesn't examine you, we can't bill it to your insurance." Really? Perhaps they didn't read the CPT® guidelines or the contract they signed with my insurance company.



My advice for you the next time you find a coding discrepancy when you're the patient is to get off the table, clutch your gown modestly around you, and ask to speak to the lead coder.

Followed by Two Nights of Sleep and Four Co-pays

I was sent to a specialist for a sleep study which, of course, runs overnight. Because it included two dates of service, I was charged two co-pays. Then I had a second overnight study and, yes, two *more* co-pays. I called and was told this “always” happens and, unfortunately, wasn’t caught before the insurance was billed. Good thing I called. On further investigation, I found I also was charged 99244 for a consultation with a doctor I don’t recall seeing. It stipulates “*Physicians typically spend 60 minutes face-to-face with the patient and/or family.*”

On to Psychiatric Testing Without a Code

I saw a psychiatrist to confirm I was mentally stable and had good coping skills. She administered something she called “the computer test,” which isn’t covered by insurance. I was charged \$50. The test was actually the Millon™ Behavioral Medicine Diagnostic (MBMD™), and because it’s a self directed pencil and paper test there isn’t a code for it. Should I have been charged \$50? Should an unlisted code have been submitted? Perhaps 96103 *Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report* with modifier 52 *Reduced Services* would be more appropriate? I just don’t know.

Next is Pre-op Clearance Billed as a Consult

I visited pulmonology next, which included performing pulmonary function tests and drawing arterial blood gases. Then there was the visit with the doctor. He spent maybe 20 minutes with me, reviewed my results, performed a brief exam, and billed a 99245. Again, my question is: “Who asked for an opinion about my treatment?” This was a pre-operative clearance.

A similar thing happened with cardiology, except they (inappropriately) billed only a level-IV consult, 99244.

True, insurers sometimes consider preoperative consultations appropriate. Medicare guidelines for consultation services, for instance, are spelled out in the Medicare *Claims Processing Manual*, chapter 12, section 30.6.10. My question is: “Were the pre-operative consultation criteria met for the services I received?” I don’t think so.

And, Finally, an EGD Under False Pretenses

My favorite was the very kind doctor who performed my esophagogastroduodenoscopy (EGD). While I was on the table he said to me, “You’re having a lot of heartburn. That’s the only way your insurance will pay for this.” Excuse me? Yes, I have had some heartburn, but that wasn’t the reason for my EGD. It was a pre-operative clearance required by my surgeon.

Coding Doesn’t Stop When Leaving the Office

Now that my surgery is over and everything is fine, I’m going to make some phone calls and send out some letters. I’ll include this article with Medicare and CPT® guidelines and copy my insurance company.

I’m not trying to point the finger at the physicians who took such good care of me. Coding errors seem to come from every level of care—office staff to physicians. I am in a part of the country with many active chapters and thousands of good, strong coders. Opportunities for education are everywhere.

My advice for you the next time you find a coding discrepancy when you’re the patient is to get off the table, clutch your gown modestly around you, and ask to speak to the lead coder. ■



Simone Tessitore, CPC, COBGC, has worked in coding and billing for almost 20 years, in payer, private practice, and large group environments. She works as a coding and billing supervisor for the University of Oklahoma (Simone-Tessitore@ouhsc.edu).



Take the Automatic Approach to Submitting CEUs

The CEU Tracker provides a quick-and-easy way to track, submit, and view your CEUs.

By Jamie Johns

The process for submitting continuing education units (CEUs) for AAPC credentials has become more intuitive for members. In the past, we required each certified member to submit an itemized CEU form with supporting documentation for credits earned. With our continued membership growth, this process became very time consuming. An efficient and user-friendly way to submit CEUs was essential—and the online CEU Tracker was born.

With the CEU Tracker, you need only submit supporting documents when asked. CEU submissions are randomly selected to verify 25 percent of credits submitted on the CEU Tracker. Verification selection is done after CEUs are submitted. Keep your supporting documents for at least six months after submission in case the AAPC randomly selects you for CEU verification.

CEU Trackin' Made Easy

The CEU tracker is available to certified members and is located online through our new Web site (www.aapc.com). To have access to the CEU Tracker, you must log in to the Web site.

1. Once you've logged in, the CEU Tracker box will appear on the left side of the Home page. You no longer have to navigate to another page to access it.
2. If you have an index number for your CEUs, input the number in the box.
3. Click SUBMIT.
4. If you don't have an index number, you will be required to click the button that says SUBMIT CEUs. This will take you to the CEU Tracker, where you can see all of your CEUs so far and enter your CEU in manually.
5. Click Add CEUs
6. When asked if you have an index number, choose No
7. Input all the information you have for your CEUs, and then click ADD CEUS.

Track CIRCC® and Specialty CEUs

If you hold a Certified Interventional Radiology Cardiovascular Coder (CIRCC®) or specialty certi-

fication, you're required to earn a certain amount of CEUs towards the credential. In the CEU Tracker there is a separate column to enter specialty-specific CEUs. Enter the credits as indicated above and then locate the option that allows you to assign CEUs towards your specialty. The tracker totals the CEUs entered in the first column. The number of credits you've designated to count towards the specialty requirement displays in the corresponding specialty column.

Enter as You Earn

The CEU Tracker stores all credits entered until they're ready for submission. This allows you to enter CEUs as you earn them, or wait until they are due. Once you've entered the minimum CEU requirement and are within 60 days of your due date, the Submit button turns green. When you click Submit, the information entered is sent to the AAPC to update your file. At this point, you can start entering CEUs towards your next renewal. CEUs must come from within your renewal time frame. If you have entered more than the required CEUs and there are credits you can use towards the next submission, be sure to remove them from your current tracker before clicking Submit. The tracker *won't* filter out extra credits to apply towards your next submission.

Keep a Record of Past CEUs

You also can access a listing of your previous online submissions through the CEU Tracker. Click on the Previously Submitted tab at the top corner of the page to see a listing of the total number of CEUs and the dates submitted. To see submission specifics, click on Details to view everything you entered.

Because the CEU Tracker proves to be a time-saving tool for members, we now require its use for your CEU submissions. If you do not have computer access, we suggest using your local library's computer. Once you start using the CEU Tracker, you'll be amazed at the convenience and ease of CEU submission. If you have any questions or concerns, please feel free to call at (800) 626-CODE (2633). ■

[Jamie Johns is membership manager of AAPC.]



The American Society of Health Informatics Managers, Inc. is a non-profit, non-governmental, professional member association of IT professionals who specialize in Health IT (HIT). ASHIM conducts the nationally recognized credentialing exam to certify the health care industry knowledge of working level IT professionals.

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Apply the AAPC Code of Ethics in Your Workplace

Demonstrate exemplary professional and personal behavior every day.

By Michelle A. Dick

You've read it at least a dozen times, and you adhere to it, yet you wonder if there is more to it than you realize. "It" is the AAPC Code of Ethics (see page 4), and it should affect your day-to-day decisions at work. Like any written work, however, it's open to interpretation. To help you develop a true code of ethics in your workplace, let's break down the AAPC Code of Ethics one bullet at a time. For added insight, we've asked a few members for their interpretation as well.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers and all other colleagues.

Employers recognize the higher coding standards set forth by the AAPC. **Freda Brinson, CPC, CPC-H, CEMC**, compliance auditor, Corporate Compliance at St. Joseph's/Cander Health System said, "Employers recognize that as an AAPC certified coder and as an AAPC member, our professional and personal ethics are of the highest standards." Based on her experience in the health industry, Brinson says she has noticed, "Employers know the caliber of employees that come from AAPC members. The trust, confidence, and pride these opinions give our members are contagious."

As for respecting the rights of patients, clients, and employers this means obeying Health Insurance Portability and Accountability Act (HIPAA) privacy and security laws when dealing with patient's confidential records. It also means using discretion, stating the facts, and listening to the other side when confronting a client, physician, or employer about coding or billing issues.

- Members shall use only legal and ethical means in all professional dealings and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive or illegal acts.

Robert Pelaia, Esq., CPC, senior university counsel for Health Affairs, University of Florida, summed "up this statement in four quick words: 'Do the right thing.' As the tagline for the 1989 Spike Lee movie said, 'you can do nothing, you can do something, or you can ... Do

the Right Thing.'" Pelaia adds, "There is a big difference between the three options." As members, it is our duty to "pick the right one."

- Members shall respect and adhere to the laws and regulations of the land and uphold the mission statement of the AAPC.

To **Timothy P. Blanchard, JD, MHA, FHFMA**, of McDermott Will & Emory LLP, this mission statement means, "Coders are frequently under pressure as part of the revenue cycle and compliance teams to help secure all of the reimbursement to which their organization is properly entitled under applicable rules. Embracing the ethical principles set forth in the AAPC Code [of Ethics] should enable a coder to further these objectives—getting paid and staying paid—with confidence and without compromise."

When it comes to respecting and adhering to laws and regulations, "respecting the law sometimes requires doing the harder right, rather than an easier wrong," said **Michael D. Miscoe, Esq., CPC, CASC, CUC, CHCC**, president of Practice Masters, Inc. and the founding partner of Miscoe Health Law, LLC. "It is a critical character trait of any true professional person and is what generates respect for our profession among those we serve," Miscoe said. Upholding the mission statement of the AAPC fundamentally makes us the "go to" folks for coding. We can't be if we cannot be trusted to know, understand, and follow the law both in our personal and professional lives," said Miscoe.

- Members shall pursue excellence through continuing education in all areas applicable to their profession.

Because codes change yearly and regulations change frequently, "It's extremely important for members to keep up-to-date with the myriad of changes occurring every year," said **Keith Russell, CPC, CPC-H**, senior compliance analyst at Baylor College of Medicine. "Even in these difficult economic times there are many ways members can continue their ongoing education for free or at a minimal expense." Russell takes advantage of CEUs offered locally. He said, "In my area at Baylor we offer the coders

several learning opportunities including attendance at our Baylor Coder's User Group, ... we provide AAPC audio conferences, ... and we do a quarterly newsletter," to get educational information out to coders. "Beyond that the Houston area has two local chapters that the members can attend to earn CEUs," Russell added. Continuing education is easy and inexpensive; you just have to seize the opportunities out there.

- **Members shall strive to maintain and enhance the dignity, status, competence and standards of coding for professional services.**

"Often coders are looking for the 'perfect' answer to a coding dilemma. We've been trained to look for the absolute answer," said **Barbara Fontaine, CPC**, business office supervisor for Mid County Orthopaedic Surgery & Sports Medicine. "I think it's important to realize it's our job to get the most correct code for any situation, while recognizing that others may have a different opinion. She continued, "This is where the old joke about putting five coders in a room and you may get five different answers originated." To settle opposing coding opinions in the workplace or elsewhere, Fontaine maintains her dignity and status by "listening politely and responding courteously to the opinions of others when making a decision, whether it's coding or any social situation." She said that this is the "best way to maintain your own dignity and increase your competence as a coder or as a person. You need to use your education, your expertise, and your manners to be a great coder."

- **Members shall not exploit professional relationships with patients, employees, clients or employers for personal gain.**

In the workplace, this translates to not using others' weaknesses, relationships, or personal information to get a promotion, to make yourself look better, or for financial gain. You also should never accept bribes from pharmacies, vendors, or insurance carriers to promote their products or accept monetary incentives from doctors for capturing extra revenue using suggested codes.

"The CPC® certification carries with it a high level of trust which in turn demands integrity of its owner," says **Christopher A. Parrella, JD, CHC, CPC**, of the Health Law Offices of Anthony C. Vitale, P.A. Because the CPC® connotes excel-

lence, "any personal gain acquired from the exploitation of a personal or professional relationship should be avoided at all costs within the scope of employment."

- **Above all else we will commit to recognizing the intrinsic worth of each member.**

This boils down to valuing each member in our organization. Each person has a voice and opinion that can contribute to the greater good. As members, we should foster other members to help them grow. Look to strengthening each member professionally and on an individual basis, which in turn will strengthen AAPC as a whole.

Promote High Standards

"When you know you are doing your best and really 'living' the ethics of the AAPC and your employer, others see it," said Brinson. "You help set the standard of professionalism in the workplace."

Our code of ethical standards for AAPC members strives to promote and maintain the highest standard of professional service and conduct among our members. If you feel a member has acted in violation of the AAPC Code of Ethics, visit www.aapc.com/aboutus/ethics-committee-policies-and-procedures.aspx for more information. ■

[Michelle A. Dick is senior editor at AAPC]



Pamela W. Christensen, CPC

Centegra Health System, Lake Geneva, Wis.



Coding Edge (CE): Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.

Pamela: My husband is a retired hospital chief financial officer. He brought home the idea of a coding career to me when our daughter was about to enter high school and we needed to start saving for her college tuition. I took the coding course at Madison Area Technical College. I had a great instructor who helped me succeed in spite of my busy schedule. I have been in coding for almost 12 years, the first six were in the clinic setting for physicians and the last six have been in the hospital setting, which I prefer. For the last five years I have been coding for two outpatient clinics: ambulatory treatment and cancer treatment. I work three days per week and I work from home.

CE: What is your involvement level with your local AAPC chapter?

Pamela: The supervisors at my first job strongly encouraged us to join AAPC. We were compensated for our time and mileage. I now attend meetings regularly, but I have never been an officer.

CE: What has been your biggest challenge as a coder?

Pamela: My biggest challenge has been educating physicians on Medicare policies and getting them to supply complete orders/scripts.

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?

Pamela: When I worked on the physician side, my organization assigned us to perform quarterly audits followed by a feedback meeting with the physician. This made physicians and coders accustomed to meeting with each other.

CE: If you could have any other job, what would it be?

Pamela: Genetic counseling.

CE: How do you spend your spare time? Tell us about your hobbies, family, etc.

Pamela: I enjoy golf, reading, biking, and boating. I have competed in four triathlons. I have three children: a son in Boston, who is the father of my three granddaughters; a daughter in San Francisco, who is a social worker and is expecting twins in September; and a daughter who lives and works in Chicago. My husband and I really love living in the beautiful resort area of Lake Geneva, Wis. ■

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