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Win the Coders' Clock Game

Billing time-based services won't be an endurance race if you have a plan of action and follow the rules.

Michael Strong, MSHCA, MBA, CPC, CEMC

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COMING UP:

- '95 vs. '97 E/M
- Annual Wellness Visits
- Lab Follow Ups
- Multi-credentialed Staff
- Coding Knee Procedures

On the Cover: Michael Strong, MSHCA, MBA, CPC, CEMC, explains how to bill time-based services without it becoming a coder's endurance race. Cover design by Kamal Sarkar.

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Las Vegas is our largest conference of the year and a must for those wanting to gain knowledge on the newly released 2016 CPT code changes. It also gives you a chance to sharpen your skills on those CPT codes already in play. Hope to see you there. -Dr. Z

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vendor index

Ask the Legal Advisory Board

From HIPAA's Privacy Rule and anti-kickback statute, to compliant coding, to fraud and abuse, there are a lot of legal ramifications to working in healthcare. You almost need a lawyer on call 24/7 just to help you make sense of all the new guidelines. As luck would have it, you do! AAPC's Legal Advisory Board (LAB) is ready, willing, and able to answer your legal questions. Simply send your health law questions to **LAB@aapc.com** and let the legal professionals hash out the answers. Select Q&As will be published in *Healthcare Business Monthly*.

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Embrace Seasonal Change

In medical reimbursement, October means changes. This year's changes are significant with the implementation of ICD-10 after years of planning, training, and testing. I've met many of you, most recently at our regional conferences in Dallas and Chicago, and I'm impressed by how much attention and effort has been focused on successful ICD-10 implementation. It's satisfying to hear AAPC members say, "We're ready," when ICD-10 comes up in conversation.

Providers are looking to AAPC members to shepherd them through the transition, and they tell me our preparation and confidence has calmed their fears about this new code set. We'll continue to be consulted about the changes, reimbursement, and problem solving surrounding ICD-10 for many years to come. Ongoing education will be vital to our success. AAPC will continue to supply members, colleagues, and providers with fundamental and advanced ICD-10 coding and documentation training — online, onsite, and through our publications and local chapters. Watch for new ICD-10-related education, solutions, and services over the next few months.

Staying Focused On You and Our Mission

AAPC is also making changes this month – changes that ensure our focus on members doesn't change. In addition to serving you, we continue to forge ahead with our mission to elevate the business of healthcare by servicing organizations and simplifying their administration and documentation of care. Doing so involves developing innovative solutions in coding, billing, auditing, compliance, and practice management for the employers of AAPC members.

To continue fulfilling members' needs, we're launching an enterprise-centric new company, brand, and website this month. As a sister company to AAPC, Healthicity (healthicity.com) will focus on creating healthcare business applications and solutions specifically designed to drive operational simplicity and elevate performance in your organization. This allows AAPC to remain focused on training, certification, resources, and a professional community for our members. You may already have experienced Healthicity's solutions if you have tried Audicy (www.healthicity.com/audicy), 7Atlis (www.healthicity.com/7atlis), or other products created to enhance accuracy and compliance. Additional new and exciting Healthicity products and services are being developed for commercial release in the near future.

Looking Ahead

Our membership continues to grow, and I'm excited to welcome **Elena V. Kuklina, MD, PhD**, as our 150,000th member! She is representative of the future of AAPC. Like AAPC, she proactively seeks to uphold a higher standard. The new Code of Ethics (see page 11), recently developed by AAPC's National Advisory Board, reflects this. Please take a few moments to read it. We'll expand on its meaning in future issues.

As we embrace change, we continue to focus on those we serve and on advancing healthcare — not only making coding, reimbursement, auditing, compliance, and healthcare administration more effective and efficient for you, but also for your employers. Documentation improvements, value-based reimbursement, quality reporting, risk adjustment, interoperability, and other initiatives will draw our focus in the coming years. When that happens, AAPC will be there to help you learn and adapt.

Thanks for all you do as members. I'm grateful to be a part of AAPC and to journey with you through the seasons of change in pursuit of the future we envision!

Sincerely,

Jason J. VandenAkker
CEO

AAPC is also making changes this month – changes that ensure our focus on members doesn't change.

NEWS

Reporting Claims that Span the ICD-10 Implementation Date

Are you wondering how to report ICD-10 diagnosis codes on claims when the dates of service span from prior to October 1, 2015, to on or after October 1, 2015?

Many payers are requiring claims with dates of service that span the October 1, 2015, implementation date of ICD-10 to be split: Services prior to October 1, 2015, are billed separately and use ICD-9 codes; services on and after October 1, 2015, are billed separately and use ICD-10 codes.

Your best bet is to check specific payer guidelines when processing claims for services that span the October 1, 2015, transition date.

Palmetto GBA, Medicare carrier for jurisdiction M, says, "Submit ICD-10 codes for all services performed on/after October 1, 2015. Submit ICD-9 codes for all services performed on/before September 30, 2015. Separate claims must be filed for ICD-9 and ICD-10 codes. Services with ICD-9 and ICD-10 codes cannot be combined on the same claim submission."

Noridian Healthcare Solutions, Medicare carrier for jurisdictions F and E says, "A claim cannot contain both ICD-9-CM and ICD-10-CM/PCS codes. Medicare will return as unprocessable all claims billed with both ICD-9-CM and ICD-10-CM/PCS diagnosis and procedure codes on the same claim."

Although all carriers seem to require split claims, there are exceptions to the rule. As *MLN Matters*® article SE1408 explains, "There may be times when a claim spans the ICD-10 implementation date for institutional, professional, and supplier claims."

For example, if the hospital claim has a discharge and/or through date on or after October 1, 2015, the entire claim is billed using ICD-10. But if an anesthesia procedure beings on September 30, 2015, and ends on October 1, 2015, you would use September 30, 2015, as both the "from" and "through" dates.

Table A in SE1408 provides more examples of situations when you should use either the from or through date to determine which diagnosis code set to use. (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1408.pdf)

CMS Says ACOs Proving Mettle

The Centers for Medicare & Medicaid Services (CMS) is proud of how the majority of 420 Medicare accountable care organizations (ACOs) are doing, and the agency wants you to know about it. Results of 2014 quality and financial data show that ACOs improve the quality of care while trimming costs.

"These results show that accountable care organizations as a group are on the path towards transforming how care is provided," said CMS Acting Administrator Andy Slavitt in an agency press release. "Many of these ACOs are demonstrating that they can deliver a higher level of coordinated care that leads to healthier people and smarter spending."

CMS said the August 25 results demonstrate significant improvements in the quality of care ACOs are offering to Medicare beneficiaries. ACOs are judged on their performance on an array of meaningful metrics that assess the care they provide – including how highly patients rated their doctor, how well clinicians communicated, whether they screened for high blood pressure and tobacco use and cessation, and their use of electronic health records. In the third performance year, Pioneer ACOs showed improvements in 28 of 33 quality measures and experienced average improvements of 3.6 percent across all quality measures. Shared Savings Program ACOs that reported quality measures in 2013 and 2014 improved on 27 of 33 quality measures.

CMS continued to explain that when an ACO demonstrates it has achieved high-quality care and effectively reduces spending of healthcare dollars above specified thresholds, it is able to share in the savings generated for Medicare. In 2014, 20 Pioneer and 333 Shared Savings Program ACOs generated more than $411 million in savings, which includes all ACOs savings and losses. The results show that ACOs with more experience in the program tend to perform better, over time. Of the 333 Shared Savings Program ACOs, 119 are in their first performance year in Track 1, which involves starting up the program without the financial risk associated with later tracks.

HELEN MILONOPOULOS, CPC, COC

I enjoyed coding, so when my classes ended, I became an AAPC member and earned my CPC®.

I was the victim of a drunk driving accident on December 3, 2003. The driver merged from an on-ramp to the highway at 50 mph and never stayed in his lane. My driver's side car door was hit head-on. Lucky for me, it was the coldest night of the season: My blood instantly coagulated and I went into shock, which saved my life.

I spent a year and a half in and out of the hospital for reconstructive surgeries and rehabilitation. Giving up was not an option; I had two young daughters — Stephanie and Melissa — to support and nurture. I am a much stronger person because of the accident, but the experience caused them to grow up sooner than necessary.

I found support through Wentworth-Douglass Hospital (WDH), where I worked, and our school system. My ex-husband and I both have strong community ties, so when my accident became known, WDH, fire fighters/EMT, and school personnel stepped up to help with the care and support of our daughters. A local car dealership even found a car with adjustable gas/brake pedals so I could drive comfortably when recovered. My family and close friends played a major role in my recovery, keeping my spirits up and taking me out as often as possible.

I couldn't return to my jobs as diet office representative and food service for WDH because of my injuries. I contacted human resources to discuss employment options. They suggested Seacoast Career Schools' Coding/Billing/Transcription course — an accelerated two-year course completed in nine months with a six-week internship. I completed the course and interned at WDH. This was an opportunity for me to still support myself and my daughters. Determined, I excelled with high honors and perfect attendance. I enjoyed coding, so when my classes ended, I became an AAPC member and earned my CPC®.

When a charge entry position became available at WDH, I applied and interviewed with Coding Supervisor **Pam Brooks, MHA, CPC, COC, PCS**. I was so happy to get back to work. I took an evaluation and management (E/M) coding position in January 2007. Three years later, I transferred to emergency room facility coding and have held that position ever since.

Last year, I passed the Certified Outpatient Coding (COC™) exam and the ICD-10-CM proficiency exam. What's next? Mastering the former E codes, now V-Y codes in ICD-10; they have been a challenge for emergency department coding on dual coding days. I continue to support my daughters in their healthcare careers, working for a payer and as a coder.

The accident taught me to keep moving forward. You don't get anywhere standing still!

#IamAAPC

#IamAAPC

Healthcare Business Monthly wants to know why you chose to be a healthcare business professional. Explain in less than 400 words why you chose your healthcare career, how you got to where you are, and your future career plans. Send your stories and a digital photo of yourself to Michelle Dick (michelle.dick@aapc.com) or Brad Ericson (brad.ericson@aapc.com).

By Faith C.M. McNicholas, RHIT, CPC, CPCD, CDC, PCS

ICD-10 Is Here

Your local chapter is a jackpot of ICD-10 education and resources.

ICD-10 has arrived. As a credentialed AAPC member, you'll be expected to use the new diagnosis code set at your usual level of excellence. I hope you're ready for it, but if you aren't, AAPC and your local chapter are great places to look for ICD-10 coding education and resources.

Help Is Within Your Reach

For a successful transition to ICD-10, the entire office or facility needs to be on board. In collaboration with local chapters, AAPC offers a variety of low-cost ICD-10 training for all of the key players in your organization to:

- Ensure every person who sees, reviews, or assigns a diagnostic code understands the importance of appropriate ICD-10-CM code use. AAPC offers coders and auditors ICD-10 training via online, boot camps, proficiency assessments held by local chapters, on-site training for groups of 10 or more, and national and regional conferences. To learn more about available training and services, visit: www.aapc.com/icd-10/coder-icd-10-training.aspx.
- Ensure your organization's system is capable of sending and receiving ICD-10-CM code. AAPC's ICD-10 training for practice managers and administrators will help prepare your organization in every way. To learn more about available training and services, visit: www.aapc.com/icd-10/practice-managers-icd-10-training.aspx.
- Be certain clinical documentation meets rigorous ICD-10 requirements. AAPC's ICD-10 training for physicians will ensure clinicians' medical record documentation leads coders to ICD-10-CM codes of the highest specificity. To learn more about available training and services, visit: www.aapc.com/icd-10/physician-icd-10-training.aspx.

As we transition to ICD-10, visit your local chapter frequently for affordable coding education and resources, and network with your peers to find what they are doing to ensure a smooth transition. Your local chapter officers are here to help and encourage you along the way.

Good luck and happy ICD-10 coding!

Faith C.M. McNicholas, RHIT, CPC, CPCD, PCS, CDC, specializes in dermatology coding. A national speaker on coding and regulatory issues, she presents at American Academy of Dermatology annual and summer meetings, AAPC regional conferences, and several other venues. McNicholas has a wide range of experience in various medical specialties and practice settings. She is also a certified and approved ICD-10-CM/PCS expert and trainer, a member of the AAPC Chapter Association, and has served office for the Des Plaines, Ill., local chapter.

As we transition to ICD-10, visit your local chapter frequently for more coding education and resources.

By Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA

Ethics Update Strengthens AAPC Integrity and Professionalism

Part 1: Know your ethical responsibilities and the impact of negative conduct.

The following revision to AAPC's Code of Ethics has been reviewed and approved by the Ethics Committee with input from the National Advisory Board and AAPC Chapter Association board of directors.

Ethics Policy

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- *Integrity*
- *Respect*
- *Commitment*
- *Competence*
- *Fairness*
- *Responsibility*

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

The focus of the revised Code of Ethics is on professional conduct; however, it's possible that activities unrelated to work could implicate the Code of Ethics when conduct negatively affects AAPC or another member.

Compliance with the Code of Ethics is a "condition of continued membership." This is consistent with the membership application as well as the Ethics Committee's sanction authority, which is limited to determining whether an individual found to be in violation of the Code of Ethics will be permitted to remain a member of AAPC. If membership is revoked, the individual's credentials will also be revoked, as only AAPC members can hold AAPC credentials.

AAPC's Code of Ethics is what places us above all other credentialing organizations. Compliance with the Code of Ethics lifts us all to a higher standard, which makes our credentials that much more valuable to our employers.

A series of educational articles on ethics are available on the AAPC website and will be published in *Healthcare Business Monthly*. Any questions about the revised Code of Ethics, or complaints regarding potential misconduct by a member, can be directed to the Ethics Committee by email at ethics@aapc.com.

Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, is the president-elect of AAPC's National Advisory Board, serves on AAPC's Legal Advisory Board, and is AAPC Ethics Committee chair. He has over 20 years' experience in healthcare coding and over 16 years' experience as a compliance expert, forensic coding expert, and consultant. Miscoe has provided expert analysis and testimony on coding and compliance issues in civil and criminal cases and his law practice concentrates on representing healthcare providers in post-payment audits and with responding to HIPAA OCR issues. He speaks on a national level, and is published nationally on a variety of coding, compliance, and health law topics. Miscoe is a member and past president of the Johnstown, Pa., local chapter.

Compliance with the Code of Ethics lifts us all to a higher standard and makes our credentials that much more valuable to our employers.

By Michelle A. Dick

image by iStockphoto © EMmos

Coding Builds Family Bonds

When coding runs through your blood, you are bound for success.

One thing is for certain: AAPC is filled with families who code together. You may even say it has made them closer. They support, mentor, and discuss coding to help each other succeed in their chosen profession.

Although we can't feature all of our family coders, we can give you a glimpse into a few coding families that you may recognize as AAPC coding powerhouses, who have served office for our organization, won awards, and/or have been on the cover of our member magazine.

Chandra and Cindy Stephenson

You may know **Chandra Stephenson, CPC, COC, CPB, CPCO, CPMA, CPC-I, CIC, CCS, CANPC, CEMC, CFPC, CGSC, CIMC, COSC**, an AAPC National Advisory Board member, frequent speaker, and *Healthcare Business Monthly* contributor. What you may not know is that her mother **Cindy Stephenson, CPC**, codes, too. They have served together as officers of the Indianapolis, Indiana, local chapter and frequently attend conferences together.

"I've even convinced my mom to sit for another credential," Chandra said. "We are studying together for our CRC™ exams."

Let's Talk Coding

Although Chandra and Cindy are the only coders in their immediate family, gatherings sometimes become educational opportunities for non-coding family members to better understand physician billing.

"It's funny because my mother and I are the only two in the family who work in healthcare, but our conversations often turn into education sessions for other family members on why things are done a certain way at the physician's office or hospital, or why they received a bill for this or that, etc.," Chandra said.

Surprise! There's One More

Chandra and Cindy's family coding story doesn't end there. To their surprise, they found out they have another family coder, **Annie Boynton, COC, CPC, CPCO, CPC-P, CPC-I**, which they discovered through networking. Chandra recalls the story:

> Most of my close friends are in the coding industry. A few years back, after the Vegas conference in 2012, I had several friends telling me I really needed to meet Annie Boynton, who was on the National Advisory Board at the time. They all thought we had a similar sense of humor and would get along great. At the Chicago Regional Conference the following year, Annie and I finally met at a dinner with some of our shared friends. We did, indeed, hit it off. We then became friends on Facebook and kept in touch. One day, Annie posted a congratulatory message to one of her cousins on the birth of their new child and included the baby's full name. I saw the baby's name and thought the last name listed was unusual — as it was my grandmother's maiden name. I sent a message to Annie telling her just that. She replied, "How interesting!" and explained that it was also her mother's maiden name. Annie, who is very savvy with genealogy, was working on her family tree when I had traced us back to the same family in the same little town in Tennessee six or seven generations back. We are, in fact, related!

Chandra and Boynton's mutual friends found it hilarious that they are related and said it explains so much. It's also impressive that two relatives have honored AAPC with National Advisory Board service. Some things have to be genetic.

"I've even convinced my mom to sit for another credential," Chandra said. "We are studying together for our CRC™ exams."

Reuniting at Conference

Chandra says one of the perks of having coding relatives is attending and meeting at conferences. "We have a great time at conferences together and have been known to claim our end of the table as the family-only end of the table," Chandra said.

▲ Mother and daughter coders Linda Martien, Heather Allen, and Chandra and Cindy Stephenson pose together at HEALTHCON.

◀ Annie Boynton on the October 2010 issue of *Coding Edge* is a coding sensation and long lost relative of Chandra and Cindy Stephenson.

Linda Martien and Heather Allen

Linda Martien, COC, CPC, CPMA, who sits on the 2015-2016 AAPC Chapter Association board of directors and was on the 2005-2009 NAB, is a role model for AAPC members, including her daughter, **Heather Allen, LPN, COC, CPMA**. Martien is thought of so highly that she was asked to don the cover of the December 2008 issue of *Coding Edge*. Who knew she wasn't the only coding superstar in her family?

◀ Linda Martien not only spreads coding cheer to AAPC members, but also to family.

Becoming a "Clone" Is the Answer

Allen was working as a nurse when her mom recruited her to switch from the clinical side of healthcare to the business side. This was after Allen told Martien that she was finding it difficult to work as a nurse and pay for child care for her adopted 5-year-old and newborn twins.

"It was hard to do her job, and the cost of child care was prohibitive," Martien said. She thought her daughter would like coding, so she set her up with a self-study program. Allen completed the program in about nine months and passed the Certified Outpatient Coding (COC™) exam. Allen has been remotely coding and auditing ever since, and is presently employed by T-Systems as client account manager and auditor.

Now that Allen is entrenched in coding, Martien jokingly said about her daughter, "She calls herself my clone. We are very much alike in the way we think, our attitudes and personality."

Coding talk is normal occurrence at family functions; however, some family members wish the gory details were left out.

Grossing Out the Family

Coding talk is normal occurrence at family functions; however, some family members wish the gory details were left out. Those who are interested in anything medical may join in on the conversation, "but those with weaker stomachs have a fit when we talk about gruesome ER procedures, which we love to do, of course!" Martien said.

Bonding at Conference

As with the Stephensons and Boynton, AAPC conferences are also a time to bond for Martien and Allen. They attend conferences together, which allows for a less costly experience by sharing a hotel room and other expenses. "We also get some special mom and daughter time doing something we love," Martien said.

Coding has brought Martien and Allen closer. "It's given us another commonality to share," Martien said. Together they code and network as members of the Jefferson City, Missouri, local chapter.

Lynn and Nickolas Nobes

Albany, New York, local chapter President **Lynn M. Nobes, RHIA, CPC, CPC-I, CEMC, CCS, CCS-P, CMBS**, was the catalyst for the chapter being awarded AAPC's Local Chapter of the Year in 2014. Her enthusiasm for coding is so infectious that her son, **Nickolas M. Nobes, CPC-A**, has begun a career path on the business side of medicine.

Lynn Nobes (striped shirt) and Nickolas Nobes (blue shirt) are holding a congratulatory sign as Albany, N. Y., wins AAPC's 2014 Local Chapter of the Year award.

"We are very passionate about coding and discuss challenging scenarios all the time," Lynn said. For coding fun, they attend monthly chapter meetings and May MAYnia together.

Doing What Comes Naturally: Coding

Lynn never forced her son into a coding career; his enthusiasm came naturally. "I never encouraged Nick to join the coding profession because I didn't think he would be interested," Lynn said. Nickolas surprised her when he was the one who decided it was a good career. "He is very happy with his choice," according to Lynn.

Having coding careers in common can be beneficial in more ways than one. For example, when a family member was recently admitted to a local hospital, Lynn and Nickolas found comfort by discussing coding. "Nick and I discussed which codes would be utilized for the visit," Lynn said.

Coding Is Contagious for Families

Besides Lynn and Nickolas Nobes, the Albany, New York, local chapter has two more family coding teams:

Kathy L. Racette, CPC, and Nicole E. Racette, CPC-A

C. Sheila VanVorst, CPC, COC, and Kyle T. VanVorst, CPC

According to Chandra Stephenson, the Indianapolis, Indiana, local chapter also has a family coding pair: Patricia Hollingsworth, CPC, and Shelby Driscoll, CPC.

For more AAPC family coding stories, read "Families Who Code Together Stay Together," June 2008, pages 24-28, located in *Healthcare Business Monthly* Archives at www.aapc.com/resources/publications/healthcare-business-monthly/archive.aspx.

For more family coder stories, see June 2008 *Coding Edge*.

If You Can't Beat 'Em, Join 'Em

Is there a chance for more Nobes coders? Most likely not, but there may be hope. Nickolas said:

> When I am visiting my parents' house and my mother and I are talking about coding scenarios and medical terminology, Dad overhears our conversations and will ask questions, showing a slight interest in what we are talking about. Due to these conversations, I believe my father has a broader knowledge of medical terms.

Another perk in overhearing the conversations is that senior Mr. Nobes is starting to better understand what his wife and son do as coders.

When Mom Is Your Mentor

Nickolas has been in the medical coding field for a short time, and Lynn has been alongside him to help, encourage, and teach.

"Mom is always there as a great resource for me, with her vast history in the medical coding — and she is only a phone call away," Nickolas said. Since Nickolas is new to the field, he taps into his mom's knowledge and expertise often. "These questions of mine keep us talking and ultimately bring us closer together," he said.

Lynn said she feels the same way about the coding relationship with her son. "I was Nick's teacher, so we have a special bond, in addition to our mother/son relationship," said Lynn. "He wants to learn as much as he can from my knowledgebase, since I have been in the HIM profession for the past 36 years and he's only been for a couple."

Lynn couldn't be happier about her son's chosen career path. "I am so proud that he is a coder!" she said.

Michelle A. Dick is executive editor at AAPC.

By Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC, and G.J. Verhovshek, MA, CPC

Quick Coding for Women's Preventive Services

Women's screening codes and coverage may vary depending on risk factors.

Coding for women's preventive services requires a firm understanding of not only the procedures, but also of the related codes and coverage requirments.

Cervical Cancer Screening

Several CPT® code families describe Pap tests, depending on how tissue samples are prepared for examination.

During a conventional Pap smear (CPT® 88150-88154 *Cytopathology, slides, cervical or vaginal*), the collected sample is smeared directly onto a microscope slide for examination. Final code selection depends on how the results are screened (i.e., manually with physician supervision, manually with computer-assisted rescreening under physician supervision, or manual screening and rescreening under physician supervision).

The Bethesda method (CPT® 88164-88167 *Cytopathology, slides, cervical or vaginal (the Bethesda System)*) evaluates specimen adequacy and provides specific categories for abnormal findings. It has been updated twice since its introduction in 1988. As with a conventional Pap smear, final code selection depends on the method of screening and, when applicable, the method of rescreening.

For the liquid preservative method, such as ThinPrep® (CPT® 88174-88175 *Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation*), the collected sample is preserved in liquid rather than smeared directly onto a slide. This helps to prevent drying and clumping of cells and improves diagnosis accuracy. Final code selection depends on whether the screening is fully automated, or automated with manual rescreening under physician supervision.

The most common tests combine liquid preservation with Bethesda methodology (CPT® 88142-88143 *Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation*). The sample is manually screened under physician supervision. Final code selection depends on whether there is also rescreening under physician supervision.

Breast Cancer Screening

There is no separate code to report a clinical breast exam; instead, the service would count as part of any preventive or E/M service provided.

Code 77057 *Screening mammography, bilateral (2-view film study of each breast)* describes a bilateral screening mammogram. Apply +77052 *Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)* if a computer is used to review the mammography results.

There is no separate code to report a clinical breast exam; instead, the service would count as part of any preventive or E/M service provided.

Ovarian Cancer Screening

Report a limited ultrasound assessment for ovarian screening using 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles).*

Per the American Urological Society, elements of a complete pelvic ultrasound (76856 *Ultrasound, pelvic (nonobstetric), real time with image documentation; complete*) go beyond examination of the ovaries to include medically necessary examination with a description and measurement of the uterus and adnexal structures, endometrium, bladder, and of pelvic pathology (e.g., ovarian cysts, uterine leiomyomata, free pelvic fluid). Do not apply 76856 for a limited ovarian screening.

You may report the blood test CA 125 using 86304 *Immunoassay for tumor antigen, quantitative; CA 125.*

Osteoporosis Screening

There are several screening tests for osteoporosis. The most common is dual energy X-ray absorptiometry (DEXA or DXA), reported with 77080 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)* or 77081 *Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel).*

Tip: For more information on DEXA scans and other bone density testing methods, see "Strengthen Your Bone Density Test Coding," November 2013 *Cutting Edge* (http://news.aapc.com/strengthen-your-bone-density-test-coding/).

Medicare and CPT® Requirements Differ

Medicare coverage for women's screening exams may vary, depending on whether the Medicare beneficiary qualifies as high risk. For example, Medicare Part B covers a screening Pap test for all asymptomatic female beneficiaries every 24 months. Medicare will cover Pap screening annually for beneficiaries of childbearing age who have had an abnormal Pap test within the past three years, or beneficiaries at high risk for cervical or vaginal cancer. High-risk categories include:

- Early onset of sexual activity (under 16 years of age);
- Multiple sexual partners (five or more in a lifetime);
- History of a sexually transmitted infection, including human immunodeficiency virus (HIV) infection;
- Fewer than three negative Pap tests or no Pap tests within the previous seven years; and
- Diethylstilbestrol (DES)-exposed daughters of women who took DES.

CMS designates nearly a dozen HCPCS Level II codes to describe various screening Pap tests, including physician supervision and laboratory specimens.

Medicare covers a screening pelvic examination (G0101 *Cervical or vaginal cancer screening; pelvic and clinical breast examination*) every two years for most female beneficiaries. If the patient meets Medicare's criteria for high risk (similar to those for Pap smear), the examination is reimbursed every year.

Medicare Part B covers screening mammogram annually for beneficiaries aged 40 and older. CMS accepts the standard CPT® codes for screening mammography, but also designates HCPCS Level II code G0202 *Screening mammography, producing direct digital image, bilateral, all views* for bilateral screenings producing direct 2-D digital images.

For bone density screening, Medicare accepts CPT® DXA codes, as well as G0130 *Single energy x-ray absorptiometry (sexa) bone density study, one or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)*, when applicable. Screenings are covered every 24 months for beneficiaries who meet program requirements.

Resources:

Access the Medicare Learning Network booklet on Screening Pap Smears at: **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-Pap-Tests-Booklet-ICN907791.pdf**.

To learn more about screening pelvic exams, see: **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-Pelvic-Examinations.pdf**.

Complete guidance on mammogram screening may be found in the Medicare Claims Processing Manual, chapter 18, section 20: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf**.

For more information on bone density screening, visit: **www.medicare.gov/coverage/bone-density.html**.

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By Sharon Thompson, MD, MPH, FACOG

Women's Preventive Health Update

Image by iStockphoto ©cnythzhang

Screening recommendations continue to change for cancers and osteoporosis in women.

Preventive care has been a moving target in the past few years. The number of possible screening tests, who should be screened, how often, and with which test seem to change every few months. Here are the latest recommendations for women's health screening tests for cervical, breast, and ovarian cancers, and osteoporosis.

Cervical Cancer Screening

The Papanicolaou test (Pap smear) is a common screening for cervical cancer. The U.S. Preventive Services Task Force (USPSTF), the American Congress of Obstetrics and Gynecology (ACOG), and the American Cancer Society (ACS) agree screening should start at age 21 and occur every three years for women aged 21 years and over, and every three to five years for women over 30 who do not have a recent history of an abnormal test.

The appropriate test for the under 30 group is the Pap smear (slide or thin prep), with testing for human papillomavirus (HPV) only in certain cases of abnormal results (reflex to HPV). Women over 30 can be screened the same as younger women with the Pap with reflex to HPV every three years, or with Pap and HPV testing at the same time (co-testing). If the later screening test is done, and the results of both tests are negative, tests should be repeated no more than every five years. Cervical cancer screening stops at age 65 or with a hysterectomy for any cause not related to abnormal cells.

Breast Cancer Screening

Breast cancer screening for low-risk women (no breast cancer gene mutations) has traditionally been done using three modalities:

1. Breast self exam (BSE)
2. Clinical breast exam (CBE)
3. Mammogram

BSE means a woman is taught to examine her own breasts regularly to detect changes, which she reports to her doctor or provider. BSE is widely taught and is still recommended by many organizations working to educate about breast cancer; however, this method of detection has been found in studies to result in many false positives, to create anxiety, and to result in invasive procedures while failing to detect more cancers than other screening tools. The ACS continues to recommend BSE as an option. The USPSTF and ACOG no longer recommend it. ACOG describes "breast awareness," whereby a woman is familiar with the contours of her own breasts so she can report changes to her provider.

In 2011, the USPSTF updated its guidelines to recommend bone density screening for women over age 65 only …

A CBE is performed by a qualified healthcare professional. Studies show a small increase in cancer detection over no screening or mammogram alone. ACOG and the ACS recommend CBE every one to three years for women aged 20-39, and annually for women over 40. The USPSTF finds insufficient evidence to recommend for or against CBE.

Mammography uses X-ray with low-dose radiation to detect patterns of calcifications that can indicate cancer cells. In the United States, it's recommended annually for women over age 40. This recommendation has come under fire recently because research data does not strongly show a mortality benefit for women screened in their 40s. In addition, normal breast physiology causes many false results (negative and positive), leading to many invasive procedures (not to mention anxiety) for benign findings. Finally, there is a small but non-trivial issue of over-diagnosis and treatment.

Mammography is great at finding very small cancers. Studies show many of these cancers would do no harm for years (if at all); yet women are treated with surgery, radiation, and/or chemotherapy. USPSTF 2009 recommendations (which, you may recall, created great controversy when they were released) are still listed as "update in progress." They recommend biennial screening for women 50-75 and individualization of screening for women 40-50 (e.g., based on the patient's personal risk factors). ACOG and the ACS continue to recommend annual screening with mammogram for women over 40. Newer modalities such as magnetic resonance imaging, 3D mammography, and thermography are not included in recommendations due to insufficient data.

Ovarian Cancer Screening

A sensitive and specific screening test for ovarian cancer remains elusive. Combinations of blood tests and blood tests with pelvic ultrasound have been studied, but none have been able to detect early ovarian cancer with sufficient accuracy to be useful as a screening test for asymptomatic women. ACOG recommends pelvic ultrasound and CA-125 only to evaluate women who have persistent or progressive symptoms such as bloating, feeling full quickly, or pelvic pain, or for women at high risk due to genetic mutation or family history. The USPSTF recommends against screening for ovarian cancer.

Osteoporosis Screening

Because women lose bone rapidly after menopause, screening for osteoporosis typically starts after menopause and is conducted every two years using a bone density test. With the average age of menopause beginning at 51, this has resulted in many diagnoses of thin bones (osteopenia or osteoporosis) in fairly young women, with subsequent long-term pharmacologic treatment for many of these women. In 2011, the USPSTF updated its guidelines to recommend bone density screening for women over age 65 only, with women under 65 to be screened only if they have factors that increase their risk of fracture to that of a 65-year-old woman. ACOG mirrored these guidelines in its updated recommendations in 2012.

As scientific data accumulates and new modalities develop, the landscape of screening recommendations continues to change. Stay tuned. HBM

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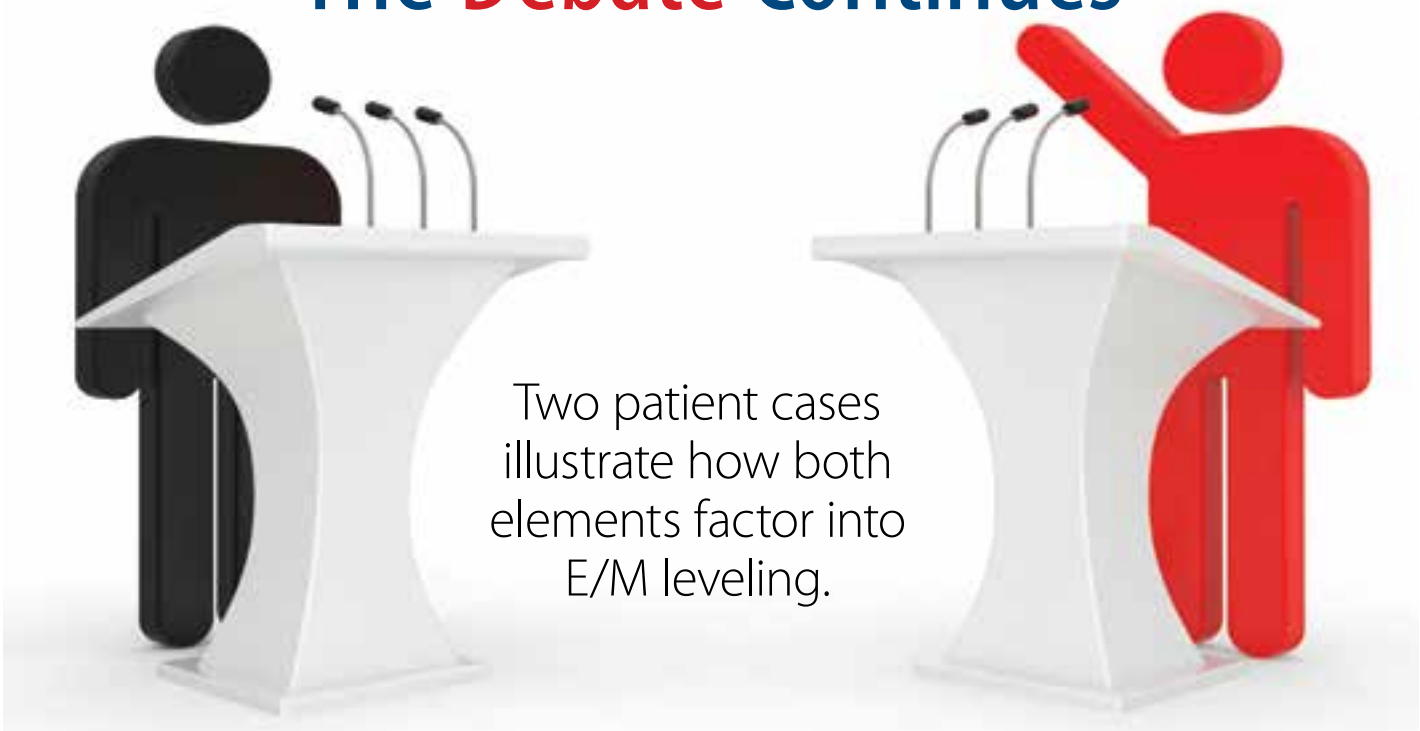
By Suzan Berman (Hauptman), MPM, CPC, CEMC, CEDC

MDM vs. Medical Necessity: The Debate Continues



Two patient cases illustrate how both elements factor into E/M leveling.

As coders, we read many, many notes supporting the services we code. We know the documentation guidelines related to evaluation and management (E/M) services. We know the physicians for whom we work are knowledgeable and skilled in assessing their patients and determining the proper course of treatment. The documentation of such planning is also important — but may not always be the provider's highest priority.

When educating providers (physicians, physician assistants, certified registered nurse practitioners, etc.), we advise them to "show your work." In other words: Illustrate what went through your mind when you ordered tests, asked questions, and added examination elements to the patient visit. Showing the "why and what" demonstrates the medical need for the tests, the visit, and the recommended treatment. But should this be the driving force for the visit?

Should the medical decision-making (MDM) components drive the code selection?

We know that with the continued adoption of electronic health records (EHRs), information can be loaded into the notes for visits very easily. A lot of this is good information for the attending physician to review and, perhaps, to include in the documentation to substantiate why things were ordered, performed, or recommended. In justifying each of these areas, we can show medical necessity.

The prevailing question is: If we justify the many history questions and the extensive examination, shouldn't that be enough?

Before you answer that question, remember: Medical necessity is the "why" of the E/M service's MDM component; but even if the MDM is low in nature, the level of service could still be high if the necessity of the history and examination is evident in the documentation.

Let's look at the two examples (on the next page) to illustrate this point further:

For **Patient A**, report 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity* based on the history and examination. Medical necessity, not MDM, drives the coding.

For **Patient B**, report 99215 based on the documentation of the history and the examination documentation.

By looking at these two examples, you can clearly see how medical necessity can be the overarching criterion, even though the MDM does not rise to a higher level.

There are many things to consider when faced with this dilemma. First, we need to know how the documentation got into the note.

But even if the MDM is low in nature, the level of service could still be high if the necessity of the history and examination is evident in the documentation.

Example 1: Patient A

Ms. Snow is here today for her six-month DM check. She has been doing well. She exercises four times a week and watches what she eats. Her left foot numbness has resolved. She tries to curb pasta and bread. She feels well and only occasionally has BG spikes over 180 (most recently, last week at her niece's birthday party after she had some cake). Past medical history includes her controlled DM. She also takes a multi-vitamin, biotin, and coQ10. Her family history shows that only her grandmother had insulin-treated diabetes from the age of 14. She has been married for 11 years, refrains from all tobacco products, and has an occasional glass of red wine.

ROS as per HPI with the addition of: No fever; No blurred vision; No sensor issues; Slight indigestion with the consumption of white flour; Able to walk up several flights of stairs without SOB; The rest of the comprehensive ROS is negative.

Exam:

Vital signs are stable. Patient appears younger than stated age.

PERRLA

RRR, no edema.

CTAB, no wheezing, rales, or cracks.

Abdominal aorta palpable.

No hernias, no organomegaly, abdomen shows a faint scar from her appendectomy.

AAO x 3

Mood is appropriate.

Neck is supple with oropharynx mid-line.

Able to move all extremities without limits; normal range of motion; pedal pulses active, normal sensation on bottom of feet.

Assessment/Plan:

Patient seen for her six-month IDDM check.

She is doing very well. Will recheck her A1C, fasting glucose. Suggested a BDS. Refill given for insulin, test strips, and lancets. RTC in six months, unless acute issue presents.

Review results of this note:

History: Comprehensive - 99215

Examination: Comprehensive - 99215

MDM: 99213

1. Diagnoses/Management options: Straightforward

2. Data: Low

3. Risk: Moderate

Example 2: Patient B

A well-known patient comes in today complaining of a runny nose and cough for two days. She has taken Tylenol without relief. She is a daycare worker exposed to many children each day. She has had no fever.

Smoker: No.
Occupation: Daycare worker.
Married: No.
Education: High school.
Medications: None.
Past illnesses: None.
Immunizations: Current.
Dietary status: None.
Operations: None.
Allergies: None.
Family history: Not on file.

Review of systems:

Constitutional: Negative.
Eyes: Negative.
ENT: Negative.
GI: Negative.
GU: Negative.
CV: Negative.
Resp: Negative.
Neuro: Negative.
Hem: Negative.
Endo: Negative.
Skin: Negative .
Psych: Negative.

Exam:

Constitutional	VSS
Eyes	Normal
ENT	Nares very moist
GI	Soft, non-tendered
GU	Normal genitalia
Cardiovascular	RRR
Respiratory	CTAB

Constitutional	VSS
Neuro	AAOx3
Hem/Lymph	Normal
Endo	Normal
Skin	Warm and dry
Psych	Normal affect
Musculoskeletal	Normal range of motion

Assessment/Plan:

Patient has a cold. She should drink plenty of liquids and take Tylenol for any aches. This will run its course and should be gone within three days.

She should stay home from work if she discovers she has a fever. She is no longer contagious.

Review results of this note:

History: Comprehensive - 99215

Examination: Comprehensive - 99215

MDM: 99213

1. Diagnoses/Management options: Moderate

2. Data: N/A

3. Risk: Low

The outlined notes had far more information in them than the well-organized paragraphs, proving quality, not quantity, is needed to show medical necessity.

Did the physician pull it in because she needed it for decision-making, or was it automatically populated through the EHR? EHRs can be very useful, but can also pull in documentation that might be historical and not add to the current situation. "Canned" notes by the EHR don't substantiate a service. It's up to the physician to make certain the notes are specific to the patient and the current problem. The uniqueness of the documentation will clearly illustrate if the information was brought in and reviewed.

Second, it's important to remember that the quality of the documentation is far more important than the quantity.

I knew a physician who wrote in full sentences and paragraphs when he documented his services. Another physician in the same practice wrote in outline form. In comparing their documentation against the documentation guidelines, the outlined notes had far more information in them than the well-organized paragraphs, proving quality, not quantity, is needed to show medical necessity.

Look to Payers for Guidance

When it comes to the importance of MDM versus medical necessity, learn from your top payers. For example:

Novitas Solutions (the Medicare carrier for jurisdictions H and L) advises on its website:

- **When scoring medical records, how is medical necessity considered?**
  - All services under Medicare must be **reasonable and necessary** as defined in Title XVIII of the Social Security Act, Section 1862(a)(1)(A). This section states, in so many words, that no payment may be made for any expenses incurred for items or services, which are not reasonable and necessary for the diagnosis or treatment of injury or to improve the functioning of a malformed body member. **Therefore, medical necessity is the first consideration in reviewing all services.** [emphasis added]

Wisconsin Physicians Service Insurance Corp. (the Medicare carrier for jurisdictions 5 and 8) provides another example:

> **Documentation Requirements:**
>
> Providers can ensure accurate Medicare payments with correct documentation of MDM for E/M services. Either the 1995 or the 1997 E/M Documentation Guidelines may be utilized, but the elements from each set of guidelines may not be mixed. Documentation requirements include:
>
> - Complete, clear and legible medical records, supporting the **medical necessity** for the service performed.
> - Two of the three elements must be met or exceeded to qualify for a given type of decision-making …
> - All problems directly addressed in the encounter should be used to determine the level of decision-making …
> - MDM level billed depends on the status of the patient and/or the services performed by the provider. [emphasis added]

Understanding the payers' requirements is very important. In the examples above, it's evident that Patient A needed the history and examination elements for the physician to plan for the future. Was the history and examination necessary in Patient B? Perhaps: had there been co-morbid conditions that required the additional information, it may have lent itself to the comprehensiveness of the service.

Finally, and not to be overlooked, be aware that some payers may have specific rules regarding MDM as a "must" for one of the two components for established patients.

Resources:

Novitas Solutions, Evaluation and Management Services: **www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00005056**

WPS, Medical Decision Making In the E/M Visit: **http://wpsmedicare.com/j5macpartb/resources/provider_types/emvisitdecision.shtml**

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By Michelle Hafford, CPC

Dig Deep into Debridement

Shed damaging coding habits and promote healthy reporting of wound debridement procedures.

Wound debridement is a medical procedure that removes infected, damaged, or dead tissue to promote healing. Debridement is generally associated with injuries, infections, wounds, and ulcers. To better understand how to code properly for wound debridement, let's first look at why debridement is performed, and how it's accomplished.

Wound Debridement

CPT® codes 11042-11047 describe the work performed during wound excisional debridement. An excisional debridement can be performed at a patient's bedside or in the emergency room, operating room (OR), or physician's office. Some key elements to look for in the documentation are:

- The technique used (e.g., scrubbing, brushing, washing, trimming, or excisional)
- The instruments used (e.g., scissors, scalpel, curette, brushes, pulse lavage, etc.)
- The nature of the tissue removed (slough, necrosis, devitalized tissue, non-viable tissue, etc.)
- The appearance and size of the wound (e.g., fresh bleeding tissue, viable tissue, etc.)
- The depth of the debridement (e.g., skin, fascia, subcutaneous tissue, soft tissue, muscle, bone)

To determine the proper code choice, first consider the depth of the debridement. This is determined by the deepest depth of removed tissue. Keep in mind the wound may extend to the bone, but if only subcutaneous tissue is removed, the depth of debridement is to the subcutaneous tissue only.

Wound Surface Biofilm, Epidermis, Dermis

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

+97598 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Subcutaneous Tissue

11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

+11045 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Muscle or Fascia

11043 Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

+11046 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Bone

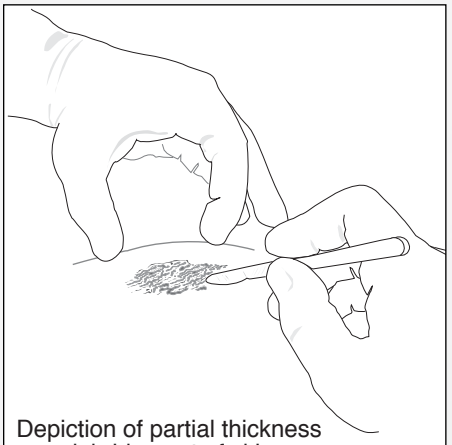
11044 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

+11047 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

When debridement is performed to the same depth on more than one wound, the surface area of the wounds is combined. When the depth is different for two or more wounds, each wound is coded separately.

The second aspect of picking the proper wound debridement code is determining the surface area of the wound. If the entire wound surface has been debrided, the surface area is determined by the square centimeters (sq cm) of the wound after the debridement has been completed. If only a portion of the wound is debrided, report only the measurement of the area actually debrided.

Example 1: A patient with a 4 cm x 4 cm ulcer on his calf requires debridement of necrotic subcutaneous tissue. After the debridement is complete, the area measured 5 cm x 5 cm. Because the whole area was debrided, we code based on the final measurement of 5 cm x 5 cm (25 sq cm).



Anatomical Illustrations 2014, Optum Insight, Inc.

Depiction of partial thickness debridement of skin

Skin is debrided of dead tissues and/or other material. Report code 11040 for removal of a partial thickness of skin. Report 11041 when a full thickness of skin is removed. Report 11042 when subcutaneous tissues must also be removed

When debridement is carried down to muscle, report 11043. And report code 11044 when debridement is carried down to include bone

The codes for this case are 11042 and 11045.

Example 2: The same patient has a 4 cm x 4 cm ulcer on his calf, but over half of the ulcer was healing. The surgeon states that she debrided necrotic tissue on a 1 cm x 1 cm section. Code selection is based on the 1 cm x 1 cm section (1 sq cm).

The code for this case is 11042.

Example 3: The patient was in a motorcycle accident and has several abrasions on both arms, but no broken bones. The wounds are: left forearm 3 cm x 3 cm (9 sq cm); right shoulder 2 cm x 2 cm (4 sq cm); and right forearm 6 cm x 5 cm (30 sq cm). The patient is taken to the operating room and the surgeon performs a debridement of skin, subcutaneous tissue, and muscle in all three wounds. Because all three wounds are debrided to the same depth, we add the size together to determine the correct CPT® code(s).

The codes for this case are 11043 and 11046 x 2.

Wound Care Management

The CPT® codebook directs us to use the Active Wound Care Management codes 97597-97598 for debridement of the skin (i.e., epidermis and dermis only):

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

+97598 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Notice the description states "selective debridement," verses "non-selective," as captured by 97602 *Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session*.

Selective debridement is the removal of non-viable tissue, with no increase to wound size and typically no bleeding because the tissue removed is non-viable. Non-selective wound debridement is usually done by brushing, irrigation, scrubbing, or washing of devitalized tissue, necrosis, or slough. In non-selective wound debridement, the focus goes beyond the non-viable tissue.

Example 1: The patient has a pressure ulcer. The physician examines the ulcer and uses a pressure waterjet to debride the skin and eschar from the wound. The wound is left open to continue healing. This is an example of selective wound care, 97597-97598.

Example 2: The patient comes into the wound clinic for treatment of an open wound on the left thigh. It's noted the deeper layers of the wound are healing very well. The provider uses a brush to scrub and wash the wound, removing all nonviable skin. The provider then dresses the wound with non-adherent gauze. This is an example of non-selective wound care, 97602.

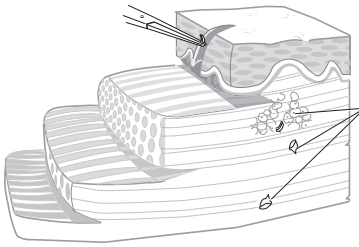
Fracture Debridement

Fracture and Dislocation Debridement codes 11010-11012 are based on the depth of the tissue removed, and whether any foreign material was removed at the same time.

11010 Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin and subcutaneous tissues

11011 skin, subcutaneous tissue, muscle fascia, and muscle

11012 skin, subcutaneous tissue, muscle fascia, muscle, and bone



These codes address debridement stemming from fractures and dislocations. Code 11010 for fracture related debridement confined to the skin and subcutaneous regions; code 11011 when the matter extends down to muscle fascia and muscle tissue; and code 11012 when debridement is carried down to the bone

Repeat debridement may be necessary in certain circumstances. When coding for a "staged" or "planned" debridement during the usual postoperative follow-up period of the original procedure, it's important to use the appropriate modifiers.

Use modifier 58 *Staged or related procedure or service by the same physician or qualified health care professional during the postoperative period* in the following instances:

- When the debridement procedure(s) are staged prospectively at the time of the original procedure, or during the usual postoperative follow-up period of the fracture treatment.
- When the staged procedure is more extensive than the original procedure. For example, when an initial debridement procedure(s) is performed and a larger procedure (e.g., definitive open fracture treatment) is a staged surgical intervention.
- When other reconstructive procedure(s) (e.g., skin graft, myocutaneous flap, vessel graft) are planned or staged prospectively at the time of either the original procedure or during the usual postoperative follow-up period of other reparative procedure(s) and/or fracture treatment.

Example: The patient was in an automobile accident and sustained an open fracture of the left femur. On the day of the accident, the patient was brought to the OR and the open fracture was debrided of all necrotic tissue and debris. Under fluoroscopic guidance, the

> … the wound may extend to the bone, but if only subcutaneous tissue is removed, the depth of debridement is to the subcutaneous tissue only.

surgeon was able to manipulate the bone to create an ample reduction. An external fixator device was used and a dressing was applied to the open area.

Two days later, the patient was returned to OR and the dressing is removed. The surgeon examined the open fracture and irrigated the wound with saline. An area of 3 cm x 4 cm was dark and dusky looking. The subcutaneous tissue and skin was excised with a #15 blade to bleeding tissue. Some nonviable muscle tissue was also debrided. The area was then copiously irrigated and a dressing was placed.

Coding for the second debridement is 11011-58.

Resources:

CPT® Assistant, October 2012; volume 22, issue 10, "Debridement of Open Fracture/Dislocations"

CPT® Assistant, May 2011; volume 21, issue 5

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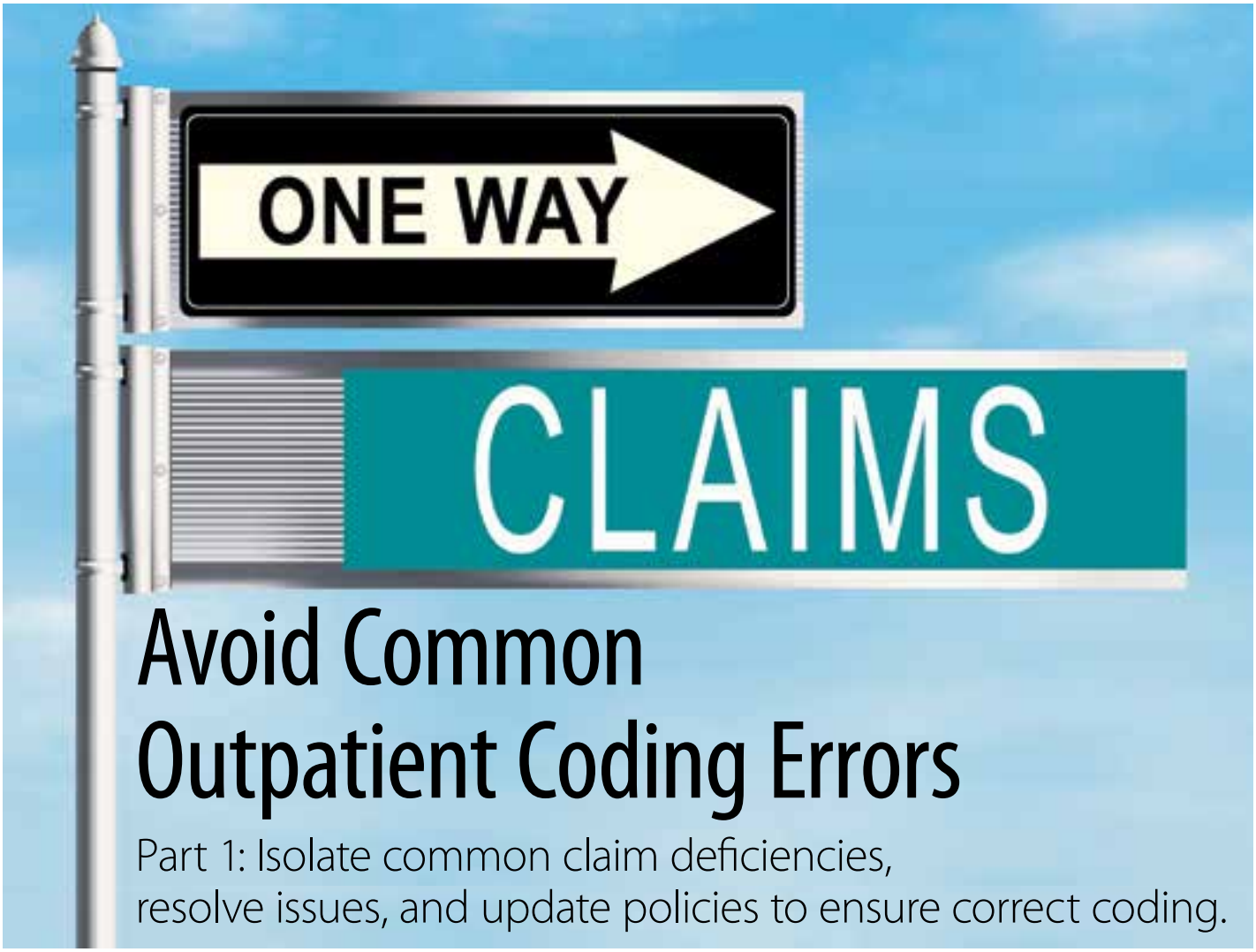
By Marianne Durling, MHA, RHIA, CDIP, CPC, CIC



Avoid Common Outpatient Coding Errors

Part 1: Isolate common claim deficiencies, resolve issues, and update policies to ensure correct coding.

Outpatient services account for the majority of medical services coded and billed. In 2012, U.S. hospitals billed 675 million outpatient visits. Doctor's offices billed another 956 million visits. Complex, occasionally subjective coding guidelines, inadequate staff training, and lackluster physician documentation are a few reasons not all of those claims were correct. To help you isolate deficiencies in your claims, this two-part series reviews some of the most common outpatient coding errors.

Here are just a few of the effects that claims errors can have, from an operational viewpoint:

- Most practices lose money every year due to incorrect coding.
  - For example, one practice had a 71 percent error rate on its most commonly billed service, which caused it to lose $185,000 in one year.
- Incorrect coding can subject your office to audits from:
  - Claim analytics – zone program integrity contractors (ZPICs), recovery audit contractors (RACs), Medicare administrative contractors (MACs), and Comprehensive Error Rate Testing (CERT) contractors.
- Your practice can be penalized for negative audit results, such as:
  - Possible loss of payer contracts; and
  - Medicare and Medicaid fines.

Most Common Causes of Coding Errors

Most outpatient coding errors result from carelessness and lack of preparation, including:

- Outdated software/codebooks
- Outdated forms
- Untrained/Unqualified staff
- Poor quality documentation
- Inadequate office policies and procedures

Before You Do Anything Else, Update Everything

Best practice is to review your coding and billing related policies and procedures annually to reflect changes in industry standards, gov-

Although these forms and systems are getting a major overhaul with the implementation of ICD-10, it's imperative for someone to oversee regular reviews and updates of this information.

ernmental regulations, and payer contract requirements. As policies and procedures are updated, ensure all staff and providers are updated, as well. This is an area where many practices fall short. Yearly educational updates should include a review of all policies. This is especially important if staff have changed job duties during the year.

The same annual review and update should take place for any coding and billing related forms and software (e.g., paper or electronic superbills). Although these forms and systems are getting a major overhaul with the implementation of ICD-10, it's imperative for someone to oversee regular reviews and updates of this information. If you rely on an outside vendor for updates, you need to ensure they are updating the information correctly. This is especially important with ICD-10 mapping. Because ICD-9-CM to ICD-10-CM conversion isn't a one-to-one mapping for most codes, the data will only be as accurate as the knowledge of the person inputting that data into the system. Errors could result in improper payments, or worse. Make sure you are confident that the person who is doing your mapping is qualified.

Don't forget about your coding and billing software. Encoders, billing programs, batching or grouping software, and clearinghouse software should be updated and checked quarterly.

Other tasks that should be done quarterly:

- Update codes and ambulatory payment classifications.
- Update reimbursement amounts.
- Update local coverage determinations and national coverage determinations.
- Review consistent use of either 1995 or 1997 Documentation Guidelines for Evaluation and Management Services.
- Update codebooks for all staff.

Now, let's focus on the less obvious and more difficult areas of error prevention.

Check Provider Billing Against Peers

Many practices don't use analytics to assess providers' billings against their peers. This is a missed opportunity because that is what payers do to determine whether they should audit you.

Examine your practice case mix by provider, and compare each provider in your practice to assess how he or she documents, and the evaluation and management (E/M) levels each provider charges for his or her case mix. This will enable you, for instance, to identify a provider who is playing it safe by always coding a mid-level visit (e.g., 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity*) in an attempt to avoid red flags (even though this strategy is a red flag).

"Playing it safe" by always selecting mid-level codes can also have a financial impact. For example, if we assume a $41 reimbursement difference between 99213 and 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity*, times five patients per day, we lose nearly $50,000 a year!

The first step is to compare your providers to one another. Look at how they code for the same, most common patient types. For example, in a family practice group, compare how each provider codes for similar, chronic disease patients, such as patients with an upper respiratory infection or chronic pain. These statistics are your practice case-mix analytics. Do you have providers who routinely under-code to save their patients copays or coinsurance? What about a new doctor who over-codes or over-orders to make sure he or she doesn't miss anything?

Next, look at how your practice compares to the Centers for Medicare & Medicaid Services' (CMS) benchmarks for your type of practice, in your area.

In comparing your data to your local peers, there shouldn't be a noticeable difference in coding patterns. If you fall outside of the benchmark, either higher or lower, you are an "outlier." This can raise suspicion and can be grounds for an audit. You can do this analysis yourself by gathering data and creating a bar chart for each physician's services charged over a set time. You can also outsource the job to an audit firm.

The old adage is, "If it isn't documented, it didn't happen." But if something is documented, does that mean it definitely happened? Not necessarily …

image by iStockphoto © AlexRaths

Keep in mind that as healthcare becomes more focused on quality, cost savings, and patient involvement, analytics such as these will be used to score your providers against each other and against other local providers. This information will be given to patients to help them make better-informed healthcare choices. You want to know where you stand and how you stack up to the competition well before your patients do, so you can correct and improve what could negatively affect your practice.

Be Sure What's Documented Is Done

The old adage is, "If it isn't documented, it didn't happen." But if something is documented, does that mean it definitely happened? Not necessarily — and that is our next area of concern.

Documentation cloning has become a problem with the advent of the electronic health record (EHR). EHR templates can save time, but also may have a negative impact on documentation habits and revenue. Auditors and payers look for cloned documentation. When they find it, they also usually find things like documentation failing to who medical necessity, over-coding levels of service, and outright fraud.

What constitutes medical record cloning?

- Cloning refers to documentation that is worded exactly like previous entries. This may also be referred to as "cut and paste" or "carried forward."
- Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an EHR.
- Cloned documentation does not meet medical necessity requirements for coverage of services. This type of documentation will lead to denials for lack of medical necessity and recoupment of all overpayments made.

Each provided service to a patient should be independent of any previously provided service. This means you should not have patients with the same history of present illness, exam, review of symptoms (ROS), or treatment plan elements from visit to visit. Each of these elements must reflect the specific reason for a service provided to a patient on a given date. If a patient has the exact same vital signs, exam, and ROS from visit to visit, for instance, that is a red flag for possible cloning.

Every entry must be relevant for that date of service, as well. Providers should not include past, family, and social history items from previous visits if they were not reviewed at that visit. A payer or auditor will question anything that could resemble cloned or copied text. If your provider copies entries, such as medical history or medications, but makes no changes based on the chief complaint, these elements cannot be considered when assigning the E/M level of work. Each element must be reviewed with the patient during the encounter for it to count towards the E/M code for the visit.

Next Month: A review of common modifier errors in outpatient coding.

Resources:

CMS benchmarks: **www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier2013.html**

Outsource auditing services at AAPC Client Services. You can find a demo of this tool on the AAPC practice services website at **www.aapcps.com/resources/em_utilization.aspx**.

See what your patients can see about your physicians at the Medicare's Physician Compare website: **https://data.medicare.gov/data/physician-compare**.

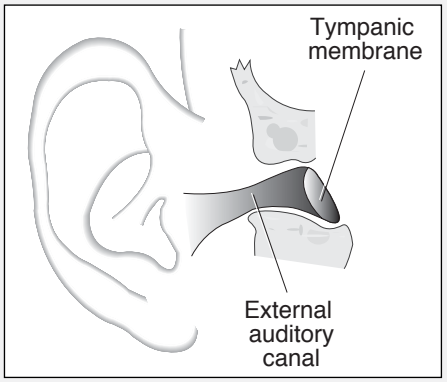
Marianne Durling, MHA, RHIA, CDIP, CPC, CIC, has 33 years of healthcare experience. She is the health information management director for Granville Health System. She developed and taught a successful medical coding program for 11 years, which helped her to win Instructor of the Year in 2012. She has a master's degree in Healthcare Administration and a post-baccalaureate certificate in Health Information Administration. She served on the 2011-2013 AAPC National Advisory Board, and has served multiple terms as president of the Oxford Tri-County, N.C., local chapter.

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Otitis Externa

Otitis externa (OE) is an acute or chronic infectious process of the external auditory canal (EAC). The EAC contains varying amounts of cerumen and desquamated skin. Acute OE, also called swimmer's ear, is most common after water exposure, but can also happen after trauma to the external ear canal. Retained moisture will alkalize the canal, making it prone to bacterial infections. Sometimes the infection can extend outside the canal and become periauricular cellulitis. Infection can spread outside of the canal when the patient is immunocompromised or a poorly controlled diabetic. Treatment includes cleaning and topical preparations.

Signs of OE include discharge, conductive hearing loss, and swelling of the external ear canal. Pressing on the ear may lead to significant pain. Symptoms usually present with a 48-72 hour history of progressive pain, itching, discharge, and aural fullness. The patient may also complain of jaw pain.



Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.

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By Michael Strong, MSHCA, MBA, CPC, CEMC

WIN THE CODERS' CLOCK GAME

Billing time-based services won't be an endurance race if you have a plan of action and follow the rules.

Over the course of two decades, various medical specialties have had to adapt to the "clock game." Those specialties and their codes now include:

- Anesthesiology
- Physical therapy, rehabilitation, chiropractic, occupational therapy
- Evaluation and management (E/M) services
- Infusion therapy
- Mental health

Let's explore time more closely, from a reporting and reimbursement perspective.

Anesthesiology

Other than a brief paragraph in the Anesthesia Guidelines within the CPT® codebook, there are no official guidelines published by the American Medical Association (AMA) regarding anesthesia time. Medicare historically required anesthesia time to be reported in minutes; and some private payers may have requested services to be reported in units.

Since the HIPAA 5010 transaction set became effective, however, the standard anesthesia reporting method is in minutes. Time begins when the anesthesiologist or certified registered nurse anesthetist (CRNA) prepares the patient for the induction of anesthesia, and concludes when the anesthesiologist or CRNA transfers the patient for postoperative supervision.

Although the reporting has become standardized, reimbursement for anesthesia continues to be controversial. Historically, units were determined by dividing the total number of minutes by 15 to determine the time units. Total units were determined according to the following formula:

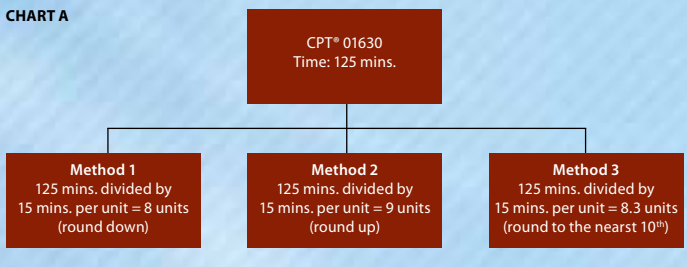
Time Units
\+ Base Units for Code
\+ Physical Status Modifier Units
= Total Units

Converting time to units is open to three reimbursement methodologies, as shown in **Chart A**.

For example, depending on the method used, a patient undergoing an arthroscopic rotator cuff repair (29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair*) with general anesthesia for 125 minutes may "count" as eight time units, nine time units, or 8.3 time

Medicare historically required anesthesia time to be reported in minutes; and some private payers may have requested services to be reported in units.

CHART A



units (excluding modifiers for physical status, or CRNAs with or without supervision by an anesthesiologist). In each case, report as 01630 *Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified.*

Method 3 is becoming more popular because it reimburses providers most accurately for time, with limited overpayments and underpayments associated with rounding.

Calculating anesthesia time becomes further complicated when modifiers are added to reflect shared services by an anesthesiologist and CRNA. Depending on the payer, reimbursement may be split by as much as 50 percent between the two providers.

Reimbursement tips:

- Verify with payers the method used to determine time units. Share this information with the appeals team and management to determine efficiency for appeals and payment contracts.
- Ensure all anesthesia services are reported in total minutes only. This will help to prevent denials or reduced reimbursement due to incorrect time unit conversions.
- Verify the reimbursement split for shared services performed by a CRNA and an anesthesiologist.

PT, Rehab, Chiro, and OT

When coding physical therapy services for a physical therapist, occupational therapist, rehabilitation medicine doctor, and/or chiropractor, use the AMA time rule in the CPT® codebook's Introduction section and/or the Medicare time rule.

According to the AMA time rule, "A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and 60 minutes). A second hour is attained when a total of 91 minutes have elapsed." Under this requirement, time-based physical therapy codes (97032-97542, 97750-97762) require a minimum of eight minutes to report the first unit. A second unit would require 23 minutes (15 minutes for the first full unit, and eight minutes for the midway point for the second unit).

Medicare has interpreted this rule to mean that the time spent performing all time-based physical therapy services is combined to determine the total number of units, and divided by 15 minutes. **Chart B** and **Chart C** show two examples of how services would be reported using the Medicare and the non-Medicare methods.

Providers must make a decision either to incorporate two different reporting standards, or to adopt a single reporting method. This inconsistency creates many challenges for providers, coders, billers, and accounts receivable.

Many insurance carriers have adopted the Medicare method, and some payers have placed limits on the number of units or amount of daily physical therapy services eligible for reimbursement. In some cases, certain services have received classification as complementary and alternative medicine (CAM), such as massage therapy (97124 *Therapeutic procedure, 1 or more areas, each 15 minutes; massage, in-*

CHART B

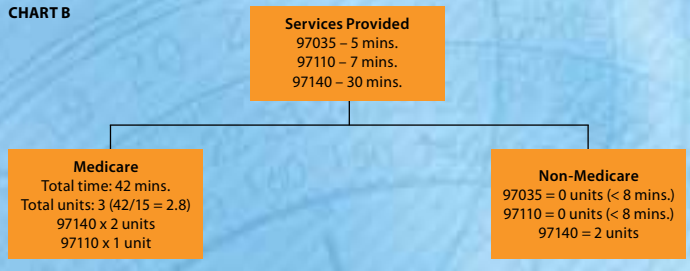
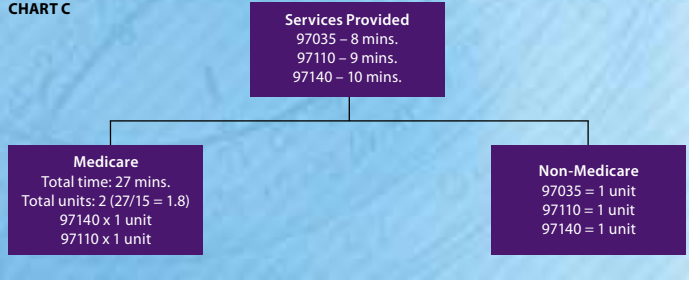


CHART C



Unlike other time-based services codes, time-based coding for E/M services is meant to be the exception and not the rule.

cluding effleurage, petrissage and/or tapotement (stroking, compression, percussion)). Some services, such as the application of hot and cold packs under 97010 *Application of a modality to 1 or more areas; hot or cold packs* have received universal denial as a status B code because the service requires no advanced training or skill to perform. To complicate matters, there are numerous codes for electrical stimulation, with no consistency amongst payers for reporting.

Tips for reporting physical therapy services:

- Ensure the specific region or treated area (for all physical therapy codes) is documented.
- Ensure the total treatment times for all time-based services are documented.
- Ensure the treatment time for each individual time-based service is documented.
- Identify in the records or company policy if you're using Medicare, non-Medicare, or both reporting methods.
- Verify with payers the reporting policy for reimbursement.
- Communicate payer information and company policy with your billing, appeals, and accounts receivable departments.

E/M Services

Unlike other time-based services codes, time-based coding for E/M services is meant to be the exception and not the rule. Generally, E/M services are coded based on the level of history, exam, and medical decision-making (MDM) after determining the type of patient and place of service. A few exceptions exist within E/M services, such as critical care. When choosing time as the controlling factor, the documentation must indicate total time, a statement that at least 50 percent of the time was spent performing counseling and/or coordination of care, and a description of the counseling and/or coordination of care.

Example 1: A new patient presents to the office for counseling of type II diabetes. The visit took 50 minutes, with more than 50 percent of that time spent counseling the patient on her medication, wound care treatment for diabetes, recognizing signs and symptoms of low and high blood sugar, and monitoring blood sugar levels at home. The service is reported with 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which*

requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, 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. Typically, 45 minutes are spent face-to-face with the patient and/or family, with time as the controlling factor.

Example 2: A patient reports for pre-op clearance for knee surgery. The visit lasts 30 minutes and includes counseling and coordination of care. This is not reported based on time because the documen-

When mental health codes were changed in 2013, coders and providers were able to report services based on time ranges.

Image by iStockphoto © Stasis82

tation does not indicate how much of those 30 minutes were spent performing counseling and coordination of care. The documentation also does not describe the extent of the counseling and coordination of care. The service would be coded based on two out of three key components for history, exam, and/or MDM.

For critical care services, documentation must indicate at least 30 minutes to report 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes*, with a minimum of 75 minutes to report +99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)*. The documentation must also demonstrate that critical care services are provided to a critically ill or injured patient.

Prolonged physician services (99354-99359) follow a similar reporting requirement, with a minimum of 30 minutes to report the first unit and 75 minutes required to report the second unit.

Hospital discharge management requires documentation of more than 30 minutes to qualify for 99239 *Hospital discharge day management; more than 30 minutes*.

Note that not all E/M services have an associated time. Emergency room services (99281-99285) have no time component. Some hospital observation codes (99218-99220 and 99234-99236) also have no associated time. Preventive medicine codes are based on the age of the patient, rather than the time.

Infusion Therapy

For infusion therapy services, time is more fluid for the first unit. Unlike other time-based codes that have a rigid time requirement, the first unit for infusion services (96365, 96367, 96369, 96413, 96417, and 96422) is reported up to 1 hour of service. For fewer than 15 minutes, however, report the injection or push service codes (96372-96379, 96409, 96411, and 96420) rather than the infusion codes. For each additional infusion, a minimum of 30 minutes beyond the first hour is necessary to report the additional infusion.

For example, a 60-year-old female patient recently diagnosed with limited-stage small cell lung cancer receives 1 hour of Cisplatin and Etoposide concurrently, followed by 100 minutes of Etoposide. This service is reported as 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* x 1, +96368 *Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)* x 1, and +96415 *Chemotherapy administration, intravenous infusion technique; each additional hour (List separately in addition to code for primary procedure)* x 2.

Mental Health

When mental health codes were changed in 2013, coders and providers were able to report services based on time ranges. Although psychotherapy is not reported if performed for 15 minutes or less, the available codes are based on ranges. This makes mental health

Without clear and consistent guidelines for reporting or reimbursement, multiple standards may exist and potential billing errors can occur.

codes unique when compared to physical therapy codes based on a time rule, infusions for services up to 1 hour, anesthesia with no clear AMA time rules, and E/M services with specific documentation requirements.

To choose the correct mental health code based on time, you must verify if it was performed with an E/M service by a qualified healthcare provider during the same encounter. **Chart D** and **Chart E** show two examples based on whether an E/M service was performed:

CHART D

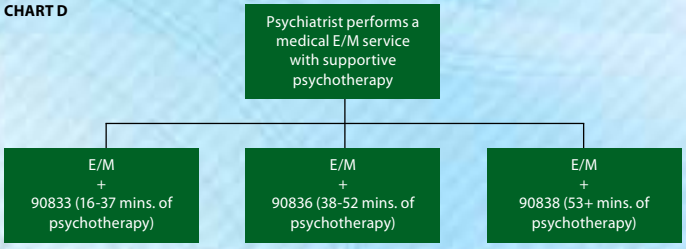
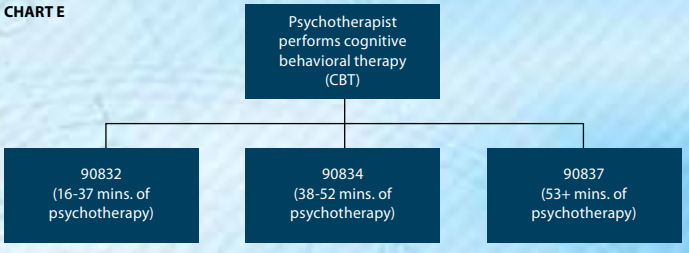


CHART E



If a patient is in psychotherapy for crisis, you can throw out the mental health rules and bring in critical care time rules. In other words, if a patient is receiving psychotherapy for crisis, the first 30 to 74 minutes are reported as 90839 *Psychotherapy for crisis; first 60 minutes*. For each additional 30 minutes, report +90840 *Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)*. For example, for 100 minutes of psychotherapy for crisis, the provider would report 90839 x 1 and 90840 x 1.

Have a Thorough Understanding of Guidelines

Looking back on these different rules for time, the clock game is an appropriate name for coding time-based services. Without clear and consistent guidelines for reporting or reimbursement, multiple standards may exist and potential billing errors can occur. Such errors may cause a provider to be charged or accused of false claims and other allegations of fraud, waste, or abuse. With such diverse rules for time-based services, providers and coders should verify with payers about reporting and reimbursement policies, develop clear internal policies, and consider specialized training for reporting these services. AAPC offers specialty coding credentials for Certified Anesthesia and Pain Management Coder (CANPC™), Certified Chiropractic Professional Coder (CCPC™), Certified Evaluation and Management Coder (CEMC™), and Certified Hematology and Oncology Coder (CHONC™) — all specialties that include many time-based services.

In the end, you must be certain of the following when reporting time-based services:

- What is the specialty?
- Does a specific time rule exist within the AMA CPT® codebook or with the payers?
- Has the practice adopted a single standard for reporting physical therapy services?
- Have the time rules and reimbursement rules been communicated to billing, appeals, and accounts receivable departments to ensure efficiency and accuracy in revenue cycle management?

Michael Strong, MSHCA, MBA, CPC, CEMC, is the bill review technical specialist at SFM Mutual Insurance Company. He is a former senior fraud investigator with years of experience performing investigations into fraud and abuse and a past EMT-B and college professor of health law and communications. Strong is a member of the St. Paul, Minnesota, local chapter. He can be contacted at michaelallenstrong@yahoo.com.

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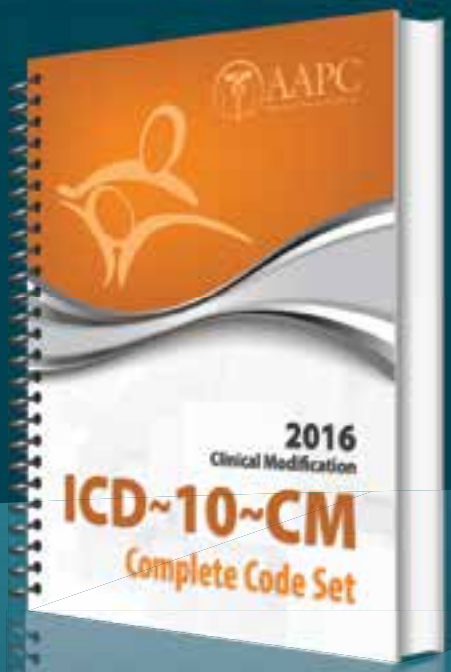

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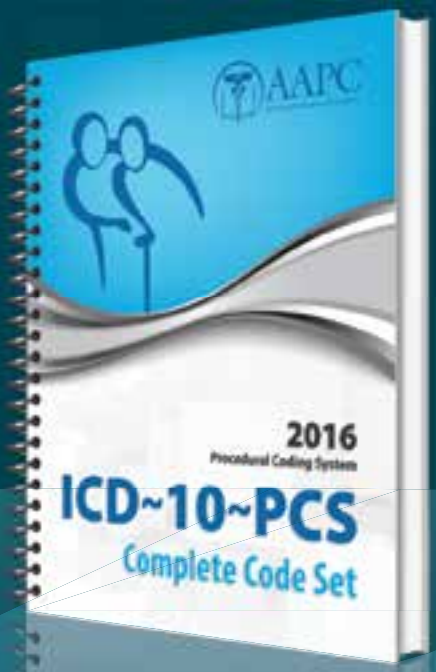

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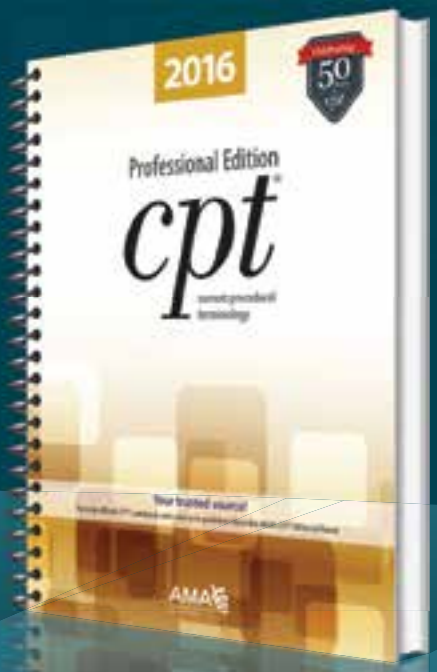

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By Nancy G. Higgins, CPC, CPC-I, CIRCC, CPMA, CEMC

Dual Dx Coding for BURNS

Look for three things in the documentation to accurately report encounters in ICD-9-CM and ICD-10-CM.

According to the American Burn Association, an estimated 486,000 hospital admissions and visits to hospital emergency departments occur annually for burn evaluation and treatment in the United States. An estimated 30,000 more individuals are hospitalized at burn centers for treatment of burn injuries every year.

When selecting diagnosis codes for burns, the guidelines in both ICD-9-CM and ICD-10-CM direct you to consider the anatomical location of the burn, the severity of the burn, and the cause of the burn.

Guidelines for Classifying Burns

Unlike the ICD-9-CM code set, ICD-10-CM differentiates between burns and corrosions. ICD-10-CM burn codes describe thermal burns caused by a heat source, such as a fire, and burns resulting from electricity or radiation. ICD-10-CM corrosion codes describe burns caused by chemicals, such as battery acid. The ICD-10-CM guidelines are the same for both burns and corrosions, and mirror the burn guidelines in ICD-9-CM.

Burn severity is classified based on the depth of the burn:

First degree = Erythema

Second degree = Blistering

Third degree = Full-thickness (epidermis and dermis)

Many patients suffer from burns in multiple anatomical locations. When coding these cases:

- Assign a separate code for each location with a burn.
- If a patient has multiple burns on the same anatomical site identified by a code, select the code that reflects the most severe burn for that location.
- Sequence the codes in order of severity, with the most severe burn listed first.

Example: A patient presents to the emergency department after being burned in a house fire. The emergency department physician's documentation indicates the patient has first-, second-, and third-degree burns on his upper back, first- and second-degree burns on his left palm, and second- and third-degree burns on his left upper arm.

In ICD-9-CM, appropriate coding is:

942.34 Full-thickness skin loss [third degree, not otherwise specified] of back [any part]

943.33 Full-thickness skin loss [third degree, not otherwise specified] of upper arm

944.25 Blisters, epidermal loss [second degree] of palm

In ICD-10-CM, appropriate coding is:

T21.33XA Burn of third degree of upper back, initial encounter

T22.332A Burn of third degree of left upper arm, initial encounter

T23.252A Burn of second degree of left palm, initial encounter

Burns Classified According to Extent

Both ICD-9-CM and ICD-10-CM guidelines address coding burns classified according to the extent of body surface involved. In ICD-9-CM, the codes under 948 *Burns classified according to extent of body surface involved* are used. In ICD-10-CM, the codes under T31 *Burns classified according to extent of body surface involved* or T32 *Corrosions classified according to extent of body surface involved* are used.

Report these codes when the provider doesn't specify the site of the patient's burns in the medical record, or when there is a need for additional data. Burn units often accumulate this data to evaluate burn mortality. The guidelines also suggest using these codes when there is mention in the documentation of a third-degree burn involving 20 percent or more of the body surface area.

These codes are based on the classic "rule of nines" (as shown in the **Rule of Nines Burn Percentages figure**) in estimating body surface involved. Body areas are measured in increments of 9 percent.

In ICD-9-CM, the fourth digit identifies the percentage of total body surface with all degrees of burns. The fifth digit identifies the percentage of the patient's body surface with third-degree burns. Although a table of fifth digit options is not provided in ICD-10-CM, the codes follow the same general pattern as ICD-9-CM.

Example: A patient has burns on 75 percent of his body surface. Approximately 1/3 (33 percent) of his body surface has third-degree burns.

In ICD-9-CM, appropriate coding is:

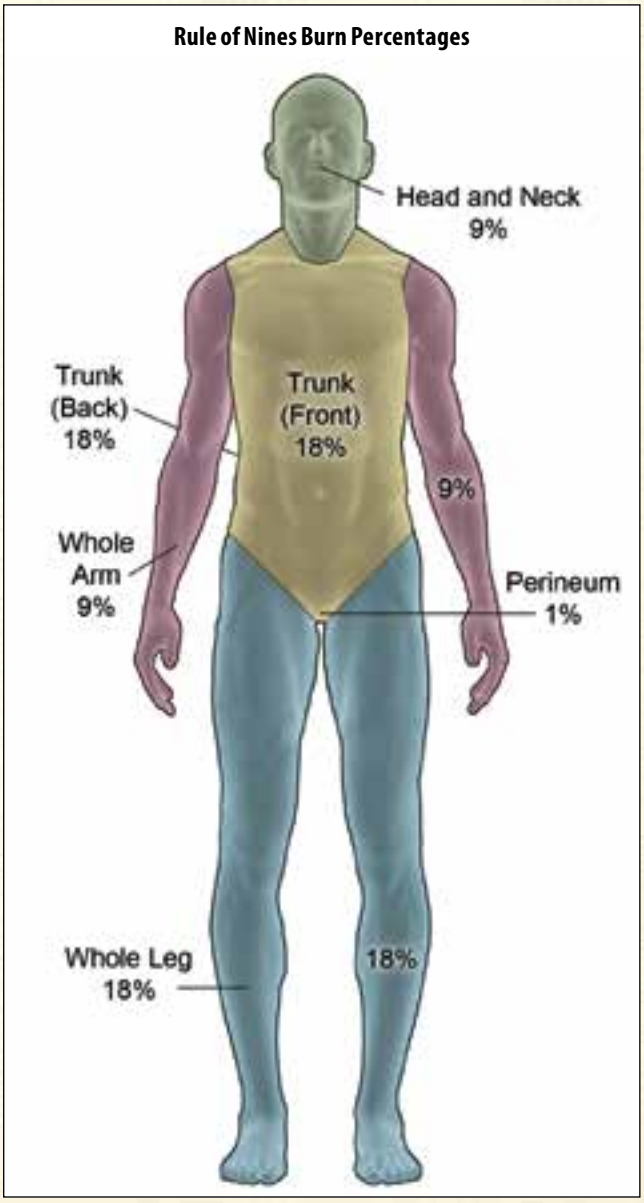
948.73 Burn [any degree] involving 70-79 percent of body surface with third degree burn, 30-39%

In ICD-10-CM, appropriate coding is:

T31.73 Burns involving 70-79% of body surface with 30-39% third degree burns

CODING/BILLING

Both ICD-9-CM and ICD-10-CM guidelines recommend reporting appropriate external cause codes for burn patients.



External Cause Codes

Both ICD-9-CM and ICD-10-CM guidelines recommend reporting appropriate external cause codes for burn patients. Not all payers accept these codes, however.

Example: A young man who was severely burned during an extensive, uncontrolled fire at the factory where he works was seen at the emergency room for evaluation. Investigators are unable to determine the cause of the fire.

Appropriate ICD-9-CM codes are:

E891.3 Burning caused by conflagration in other and unspecified building or structure

E988.1 Injury by burns or fire, undetermined whether accidentally or purposefully inflicted

E849.3 Accidents occurring in industrial places and premises

E000.0 Civilian activity done for income or pay

Appropriate ICD-10-CM codes are:

X00.0XXA Exposure to flames in uncontrolled fire in building or structure, initial encounter

Y26.XXXA Exposure to smoke, fire and flames, undetermined intent, initial encounter

Y92.63 Factory as the place of occurrence of the external cause

Y99.0 Civilian activity done for income or pay

With the high volume of burns occurring on an annual basis, it's important for you to understand the guidelines for coding these injuries. When documentation lacks the details necessary for you to code with the utmost specificity, query the provider. **HBM**

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By Frank Mesaros, MPA, MT (ASCP), CPC

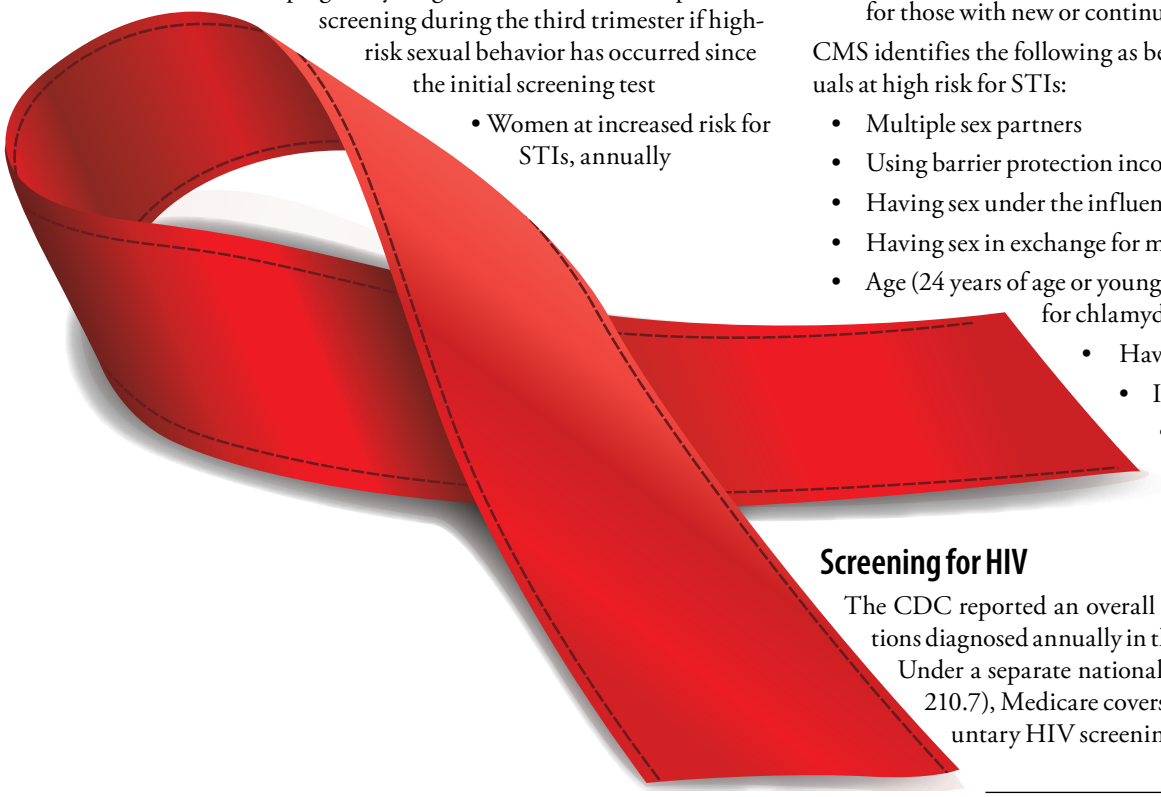
STI Screening Under Medicare

The Centers for Disease Control and Prevention (CDC) estimates nearly 20 million new, sexually transmitted infections (STI) occur every year in the United States, accounting for almost $16 billion in healthcare costs. Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and hepatitis B once every 12 months, or at certain times during pregnancy. Certain conditions must be met, however.

Screening for Chlamydia and Gonorrhea

The CDC reported a 1.5 percent increase in chlamydia cases from 2012 to 2013. Those eligible for screening include:

- Pregnant women age 24 years or younger when a pregnancy diagnosis is known, with repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test
- Pregnant women who are at increased risk for STIs when a pregnancy diagnosis is known, with repeat screening during the third trimester if high-risk sexual behavior has occurred since the initial screening test
- Women at increased risk for STIs, annually



Screening for Syphilis

The CDC reported a 10 percent increase in syphilis cases, predominantly among gay and bisexual men, and a 4 percent increase in congenital syphilis from 2012 to 2013. Beneficiaries eligible for screening include:

- Pregnant women when a pregnancy diagnosis is known, with repeat screening during the third trimester and at delivery if high-risk sexual behavior has occurred since the previous screening test
- Men and women at increased risk for STIs, annually

Screening for Hepatitis B

The CDC reported a 5.3 percent increase in acute hepatitis B cases from 2012 to 2013. Those eligible for screening include:

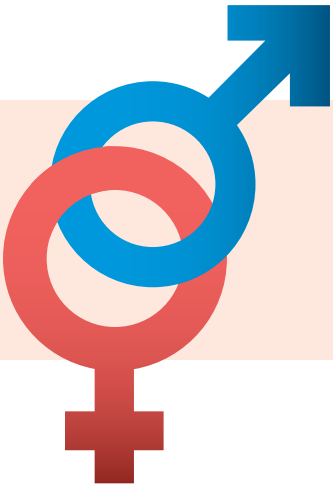
- Pregnant women at the first prenatal visit when the diagnosis of pregnancy is known, with rescreening at time of delivery for those with new or continuing risk factors.

CMS identifies the following as behaviors/factors putting individuals at high risk for STIs:

- Multiple sex partners
- Using barrier protection inconsistently
- Having sex under the influence of alcohol or drugs
- Having sex in exchange for money or drugs
- Age (24 years of age or younger, and sexually active women for chlamydia and gonorrhea)
- Having an STI within the past year
- IV drug use (for hepatitis B only)
- Men having sex with men and engaged in high-risk sexual behavior, regardless of age

Screening for HIV

The CDC reported an overall stabilization of new HIV infections diagnosed annually in the United States, at 50,000 cases. Under a separate national coverage determination (NCD 210.7), Medicare covers a maximum of one, annual voluntary HIV screening for beneficiaries:



The CDC reported a 5.3 percent increase in acute hepatitis B cases from 2012 to 2013.

- Between the ages of 15 and 65, without regard to perceived risk
- Younger than 15 or older than 65 who are at increased risk for HIV infection, as defined by USPSTF guidelines (see below)

Pregnant women have different coverage parameters. A maximum of three voluntary HIV screenings for pregnant Medicare beneficiaries is covered:

1. When the diagnosis of pregnancy is known;
2. During the third trimester; and
3. At labor, if ordered by the woman's clinician.

HIV Risk Factors

The USPSTF identifies the following individuals at high risk for HIV infection:

- Men who have had sex with men after 1975
- Men and women having unprotected sex with multiple partners
- Past or present injection drug users
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users
- Persons being treated for sexually transmitted diseases
- Persons with a history of blood transfusion between 1978 and 1985

image by iStockphoto.© dhui2001

Procedure Coding

Common CPT® codes associated with STI screening include:

Chlamydia

86631	Antibody; Chlamydia
86632	Antibody; Chlamydia, IgM
87110	Culture, chlamydia, any source
87270	Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis
87320	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique
87810	Infectious agent antigen detection by immunoassay with direct optical observation; Chlamydia trachomatis

Gonorrhea

87590	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, direct probe technique
87591	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhea, amplified probe technique
87850	Infectious agent antigen detection by immunoassay with direct optical observation; Neisseria gonorrhea
87800	Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; direct probe(s) technique

Syphilis

86592	Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART)
86593	Syphilis test, non-treponemal antibody; quantitative
86780	Antibody; Treponema pallidum

Hepatitis B

87340	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg)
87341	Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; hepatitis B surface antigen (HBsAg) neutralization

HIV (Medicare HCPCS Level II)

G0432	Infectious agent antibody detection by enzyme immunoassay (EIA) technique, HIV-1 and/or HIV-2, screening
G0433	Infectious agent antibody detection by enzyme-linked immunosorbent assay (ELISA) technique, HIV-1 and/or HIV-2, screening
G0435	Infectious agent antibody detection by rapid antibody test, HIV-1 and/or HIV-2, screening

The CDC reported an overall stabilization of new HIV infections diagnosed annually in the United States, at 50,000 cases.

- Persons who request an HIV test despite reporting no individual risk factors, as this group is likely to include individuals not willing to disclose high-risk behaviors

In addition to individual risk factors, community social factors — such as high prevalence of STIs in the community populations — are considered in determining high/increased risk for chlamydia, gonorrhea, and syphilis, and for recommending high-intensity behavioral counseling.

Diagnosis Coding

Claims for STI screening should include the appropriate screening diagnosis code, such as ICD-10-CM code Z11.3 *Encounter for screening for infections with a predominantly sexual mode of transmission* (ICD-9-CM code V74.5 *Screening examination for venereal disease*) or Z11.59 *Encounter for screening for other viral diseases* (ICD-9-CM V73.89 *Special screening examination for other specified viral diseases*) with the screening lab tests.

Diagnosis codes Z72.51 *High risk heterosexual behavior*, Z72.52 *High risk homosexual behavior* and Z72.53 *High risk bisexual behavior* (ICD-9-CM V69.8 *Other problems related to lifestyle*) indicate the beneficiary is at high or increased risk for STIs.

Diagnosis codes Z34.0x *Encounter for supervision of normal first pregnancy* (ICD-9-CM V22.0 *Supervision of normal first pregnancy*), Z34.8x *Encounter for supervision of other normal pregnancy* (ICD-9-CM V22.1 *Supervision of other normal pregnancy*), or O09.9x *Supervision of high risk pregnancy, unspecified* (ICD-9-CM V23.9 *Supervision of unspecified high-risk pregnancy*) are to be used in addition to the above coding, when appropriate.

The Medicare Claims Processing Manual (publication 100-3, chapter 18, section 130) indicates that you should list diagnosis code V73.89 as primary and V69.8 as secondary for high/increased risk beneficiaries, which crosswalk to ICD-10-CM Z11.4 *Encounter for screening for human immunodeficiency virus (HIV)* as primary, and Z72.51, Z72.52, or Z72.53 as secondary.

The following examples include only coding for laboratory services, and do not include coding for the office visit or specimen collection.

Example 1: A 66-year-old female presents to her primary care physician with sores around her mouth. Her social history indicates multiple heterosexual risk factors for STIs and HIV, categorizing her as high risk. The physician orders a rapid HIV 1/2 screen, immunoassay screens for chlamydia and gonorrhea, and a qualitative syphilis screen.

Resources:

CDC, "CDC Face Sheet - Reported STDs in the United States 2013 National Data for Chlamydia, Gonorrhea, and Syphilis," Dec. 2014: **www.cdc.gov/nchhstp/newsroom/docs/std-trends-508.pdf**

CDC, HIV Prevention in the United States, Expanding the Impact: **www.cdc.gov/nchhstp/newsroom.HIVFactSheets/Progress/Trends.htm**

CDC, Prevention of HIV/AIDS, Viral Hepatitis, STDs, and TB Through Health Care. Nov. 7, 2014: **www.cdc.gov/nchhstp/PreventionThroughHealthCare/Index.htm**

CDC, Table 3.1 Reported cases of acute hepatitis B, nationally and by state - United States, 2009-2013: **www.cdc.gov/hepatitis/statistics/2013surveillance/index.htm#tabs-801937--1**

CMS, Pub. 100-03, CR 7610, Transmittal 141, Jan. 26, 2012

CMS, Decision Memo for Screening for Sexually Transmitted Infections (STIs) and High-Intensity Behavioral Counseling (HIBC) to prevent STIs (CAG-00246N). Nov. 8, 2011: **www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=250**

CMS, NCD for Screening for HIV Infection (210.7): **www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=335&ncdver=1&bc=AAAAgAAAAAAA&**

CMS, pub. 100-03, chapter 1, section 210.7, Dec. 8, 2009

CMS, pub. 100-04, chapter 18, section 130, July 6, 2010

OIG, "OIG Compliance Program Guidance for Clinical Laboratories," 63 FR 163 45079

Palmetto GBA, Lab Guidelines, Feb. 27, 2012: **www.palmettohealth.org/bodylab.cfm?id=2181&action=list&startingrow=38**

Procedure coding is: G0435, 86592, 87810, 87850. ICD-10-CM coding is: Z11.4, Z72.51, Z11.3

Example 2: A male Medicare beneficiary presents to his primary care physician with penile warts and requests an STI screen. His physician provides counseling, prescribes medications, and orders chlamydia and gonorrhea screens by polymerase chain reaction, a rapid HIV test, and a qualitative syphilis test.

Procedure coding is: G0435, 86592, 87491, 87591. ICD-10-CM coding is: Z11.4, Z11.3.

This article is not meant as a replacement for Medicare guidance. Always refer to the respective payer guidelines for specific instructions in each case. **HBM**

Frank Mesaros, MPA, MT(ASCP), CPC, is a member of the Harrisburg, Pa., local chapter and CEO of Trusent Solutions, LLC, a management consulting firm specializing in the laboratory industry. Trusent provides revenue stream integrity services to regional laboratories, hospital based laboratories, and physician office based laboratories.

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

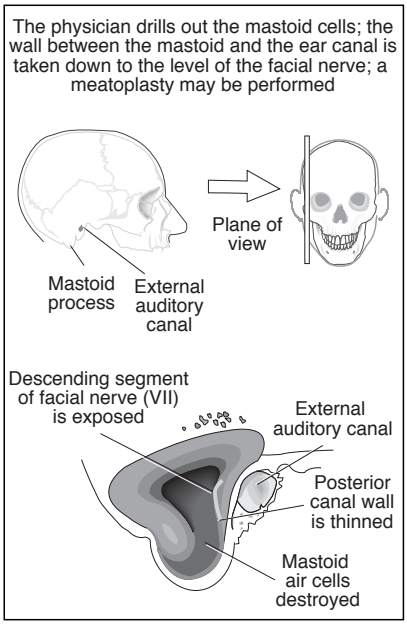
Think You Know ICD-10? Let's See . . .

A 58-year-old male patient presents after several months of antibiotics treatments for severe persistent otalgia, purulent otorrhoea, and facial palsy. Tympanic membrane and middle ear are normal in both ears. Patient has a history of diabetes mellitus. Upon exam, the patient was noted to have stage II disease, limited skull base osteomyelitis. Culture and sensitivity of the purulent discharge showed pseudomonas aeruginosa. Scrapings from the left ear (the affected ear) showed non-specific inflammatory changes with necrosis and osteomyelitis. CT scan showed soft tissue mass in the temporal bone. Surgical debridement was done and drilling of diseased and necrosed bone and a modified radical mastoidectomy were performed.

In ICD-10-CM, otitis externa (OE) is broken down by the type and laterality. What is the correct ICD-10-CM code for this case of OE?

Check your answer on page 65.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.



ICD-10 Quiz

By Deborah Neville, RHIA, CCS-P

Regulations that Affect Coding, Documentation, and Payment

Ignoring government regulations won't make them go away.

Image by iStockphoto ©Creativeye99

Federal regulations touch almost every aspect of healthcare documentation, coding, and reporting. Recently, the U.S. government has been undertaking regulatory activities to drive down healthcare costs and improve patient outcomes. It's imperative for your organization to keep a close eye on published regulations, as they often overlap and have crossover effects on the business of healthcare.

Pay It Right, the First Time

One of the Centers for Medicare & Medicaid Services' (CMS) key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers for covered, reasonable, and necessary services furnished to eligible beneficiaries. The top three reasons for inaccurate claims payment can be attributed to insufficient documentation, medically unnecessary services, and incorrect diagnosis coding.

Fraud and Abuse Prevention

Fraud and abuse prevention is a complex, time-consuming activity. Initiated by the Fraud Prevention System (FPS) on June 30, 2011, the government was given the directive to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement. In the third implementation year of the FPS, the government reported a return on investment of $2.84 for every dollar spent, and more than $453 million in unadjusted savings that the FPS identified.

Readmission Reduction Program

A more recent activity is the Readmission Reduction Program, in which healthcare claims are evaluated for patients who are admitted within 30 days of discharge. The intent is to ensure appropriate care was provided to the patient and identify extenuating circumstances requiring readmission. Documentation and associated codes for the following conditions are being reviewed:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Acute exacerbation of chronic obstructive pulmonary disease
- Elective total hip arthroplasty
- Total knee arthroplasty

In fiscal year 2017, coronary artery bypass grafts (CABG) will be added to the review list.

The top three reasons for inaccurate claims payment can be attributed to insufficient documentation, medically unnecessary services, and incorrect diagnosis coding.

Patient Safety

Patient safety is not only a clinical concern. Specific documentation supports coding and reporting of Patient Safety Indicators (PSIs) developed by the Agency for Healthcare Research and Quality (AHRQ). These conditions include healthcare-associated infections, surgical complications, falls, and other adverse effects of treatment. Results allow hospitals to identify areas of opportunity to improve patient care and patient safety.

Value-based Purchasing

The healthcare industry is moving from a volume-based payment system to a value-based payment (VBP) system that uses documented and coded patient outcomes to decide whether a patient was provided quality care. The VBP is a CMS initiative that rewards acute care hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The incentive payments are based on a hospital's performance on a predetermined set of quality measures and patient survey scores collected during a baseline period, compared to a performance period.

HAC Reduction Program

Another initiative affecting payment is CMS' Hospital-Acquired Condition (HAC) Reduction Program. Initiated in section 3008 of the 2010 Patient Protection and Affordable Care Act, this program modifies payment for a selective number of conditions if they occur during a hospitalization and were not present on admission. It's felt that these conditions are preventable if appropriate care is provided and documented. Hospitals ranked in the bottom 25 percent of all hospitals will receive only 99 percent of their Medicare Inpatient Prospective Payment System payments in 2015. Complete HAC Reduction Program information may be found on the CMS.gov website. HBM

Deborah Neville, RHIA, CCS-P, is director of revenue cycle, coding and compliance for Elsevier, Inc. She is a member of the St. Paul, Minn., local chapter.

Resources:

Department of Health and Human Services Office of Inspector General, "The Fraud Prevention System Increased Recovery and Prevention of Improper Medicare Payments, but Updated Procedures Would Improve Reported Savings," June 2015: http://oig.hhs.gov/oas/reports/region1/11400503.pdf

U.S. Department of Health and Human Services. HHS Agency Financial Report, FY 2014: www.hhs.gov/afr

www.cms.gov/Medicare/medicare-fee-for-service-payment/acuteinpatientPPS/readmissions-reduction-program.html

QualityNet.org, Hospital Inpatient Quality Reporting Program: Electronically Specified Clinical Quality Measures Programs Overview: www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228773849716

AHRQ, Patient Safety Indicators: www.qualityindicators.ahrq.gov/

CMS, VBP initiative: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/

CMS, Hospital Compare: www.medicare.gov/hospitalcompare/search.html

CMS, HAC Reduction Program: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html

By Mike Semel

THE HIPAA POLICE ARE COMING

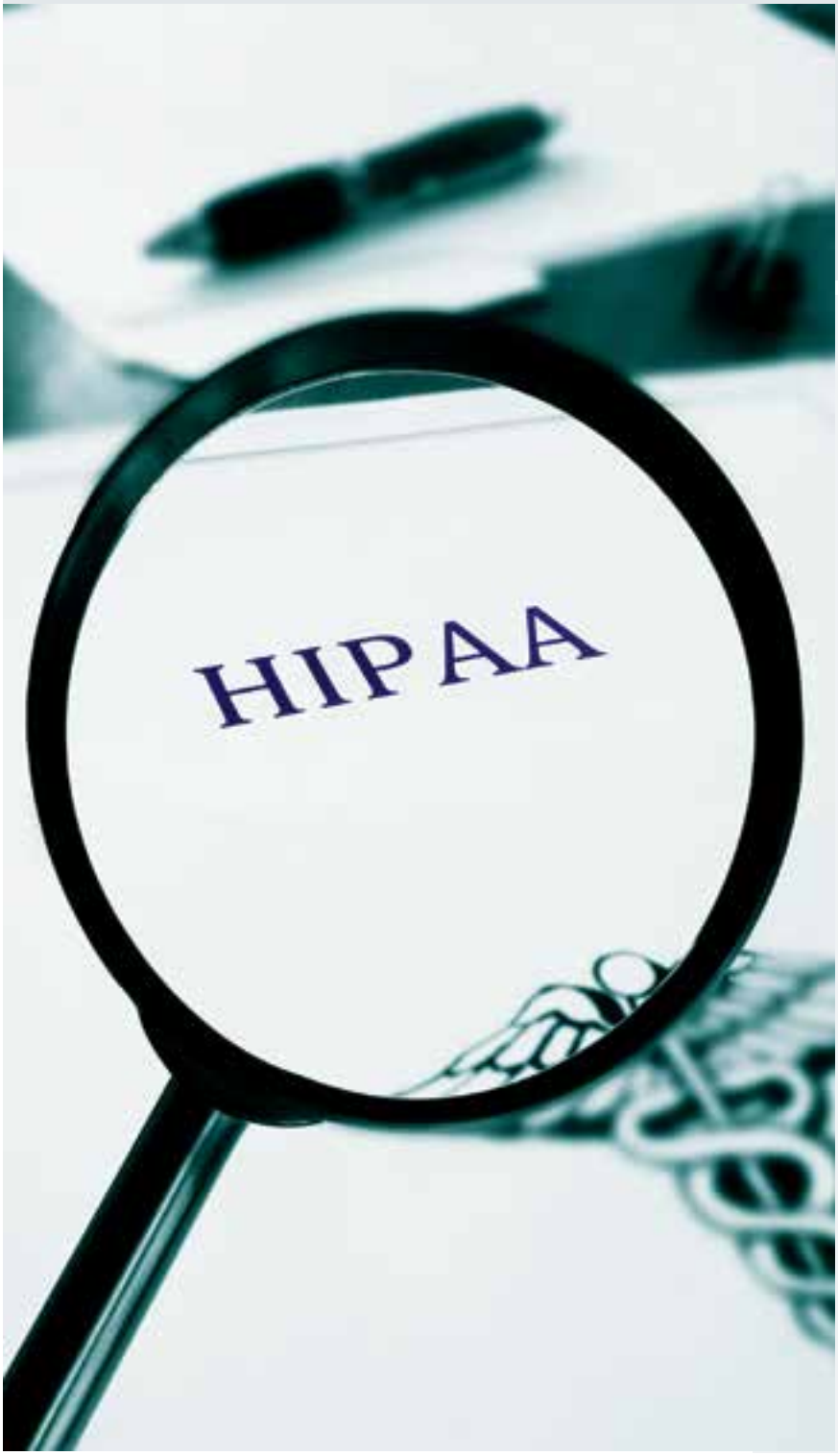


image by iStockphoto © ammyt/ws

Knowing who they are and what they want is all part of HIPAA compliance.

There is only one agency that will audit your healthcare organization for HIPAA compliance, but you might be surprised how many agencies will investigate you, and pile on the penalties, if your practice fails to protect the personal health information your patients have entrusted you with.

Compliance is the law, and preventing identity theft is part of good patient care. To get a handle on what HIPAA compliance means to your practice, let's look at what the rules are, who is enforcing them, and why you should care.

Privacy Rule

HIPAA was enacted in 1996. In 2003, the Privacy Rule became effective, protecting all identifiable protected health information (PHI), whether verbal, written, or electronic.

PHI is patient information, including demographic information, relating to:

- The individual's past, present, or future physical or mental health condition;
- The provision of healthcare to the individual; or the past, present, or future payment for the provision of healthcare to the individual; *and*
- That which identifies the individual, or could be used to identify the individual (e.g., name, address, birth date, Social Security number).

Security Rule

The Security Rule provides a framework for organizations seeking to protect electronic protected health information (ePHI). The Security Rule defines three types of data security safeguards: administrative, physical, and technical.

Texting through your cell phone's service is not secure or compliant. A five-doctor cardiac practice paid $100,000 for using free email.

- *Administrative safeguards* include policies, procedures, and training.
- *Physical safeguards* relate to the locks, alarm systems, and other tools used to keep devices from being stolen, or from unauthorized people accessing patient information.
- *Technical safeguards* only make up approximately a quarter of the rules protecting data. They include passwords, network firewalls, anti-virus software, and backups.

HIPAA is a risk-based security framework. That means you first must identify the risks to your ePHI, and then determine how you will address them. This is where many practices fail to comply adequately with the regulations, possibly because fixing compliance issues can cost money and be inconvenient.

HIPAA requires:

- A comprehensive and thorough security risk analysis, and the remediation of identified security issues.

  This is also a requirement for electronic health record (EHR) meaningful use incentive awards. Many HIPAA and meaningful use penalties refer to missing or inadequate risk analysis.
- Computers and servers accepting security patches and updates, and business class firewalls with current security subscriptions are required to protect networks against hackers.

  Older equipment doesn't qualify, even if it still works. For example, a non-profit mental health clinic paid a $150,000 fine for using unsupported equipment.
- Business-class secure email and secure texting services.

  Free email from Google, Yahoo!, and your Internet service provider are not confidential and do not meet the compliance requirements. Texting through your cell phone's service is not secure or compliant. A five-doctor cardiac practice paid $100,000 for using free email.
- Unique user logins and security passwords.
- Systems that automatically lock screens and require a password to log back in.
- Encrypted data.

  Several organizations have each paid over $1.5 million for lost, unencrypted hard drives and laptops.
- Offsite data backups and the ability to recover data after a disaster.
- Prohibiting the use of consumer-grade solutions that do not offer compliant security, such as free Dropbox, Google Drive, and consumer data backup solutions.

Risk Analysis

A security risk analysis requires an understanding of information technology (IT) security. While there are do-it-yourself tools available, healthcare organizations that use them may not know what is really happening under the skin of their networks. They do things to secure data, but there is evidence that it isn't working or has never happened.

The FBI has warned healthcare organizations, "The biggest vulnerability (to the protection of health data) was the perception of IT healthcare professionals' beliefs that their current perimeter defenses and compliance strategies were working when clearly the data states otherwise."

Many healthcare providers think they just need the risk analysis document. HIPAA requires ongoing risk prevention. The Office of the National Coordinator for Health Information Technology (ONC) — the principal federal entity charged with overseeing the administration's health IT efforts — says, "To comply with HIPAA, you must continue to review, correct or modify, and update security protections."

If you are participating in EHR meaningful use, you're likely to be audited and may have to return overpayments, or face charges of Medicare fraud if you falsely attest that you have performed a security risk analysis and remediation. Do-it-yourself risk analysis checklists may fail the audit, and you could potentially risk losing your incentive payments and face reduced Medicare/Medicaid payments, moving forward. According to the ONC, "Doing a thorough and professional risk analysis that will stand up to a compliance review will require expert knowledge that could be obtained through services of an experienced outside professional."

Business Associates

Business associates are individuals and companies that provide services to healthcare organizations that may come in contact with their PHI and ePHI. Examples include shredding companies, EHR software vendors, IT companies, lawyers defending malpractice suits, accountants, billing companies, etc. Even document storage companies, data centers, and cloud vendors are business associates.

You must have IT staff or an outsourced IT provider working diligently on security — not just keeping networks up and data backed up.

Business associates must sign special confidentiality agreements and, since the 2013 HIPAA Omnibus Final Rule, implement full HIPAA compliance programs. If a business associate causes a data breach of patient records, they can be fined, and so can the healthcare organization that hired them. If a business associate causes a breach, they must notify the healthcare organization, who then must notify its patients.

Who Are the "HIPAA Police?"

The Office for Civil Rights (OCR) enforces HIPAA compliance and investigates data breach complaints. OCR has started a new round of audits to assess HIPAA compliance. Many data breach cases are settled with corrective action plans, while others incur million-dollar fines. Breaches of more than 500 records are publicized on the OCR "Breach Portal: Notice to the Secretary of HHS Breach of Unsecured Protected Health Information," also known as the HIPAA "Wall of Shame."

Mental health and substance abuse treatment information is protected by other federal laws, and is enforced by the Substance Abuse and Mental Health Services Administration.

The Federal Trade Commission (FTC) investigates healthcare breaches because patients' names, birth dates, Social Security numbers, and other personally identifiable information are covered under consumer protection laws. The FTC once placed a business on a *20-year* monitored compliance program for allowing a security breach while acting as a business associate to two Minnesota hospital systems.

Forty seven states, plus Washington, D.C. and Puerto Rico, have laws protecting data. Some provide additional protections to medical information, while others focus on protecting driver's license information, Social Security numbers, and credit card and banking info. State attorneys generally are authorized to enforce HIPAA, and many have taken action independent of federal regulators. In Puerto Rico, a health plan was fined $6.8 million for a data breach. The Massachusetts attorney general successfully penalized a Rhode Island hospital for breaching Massachusetts residents' information. In the same case where the FTC placed a business on a 20-year compliance program, the Minnesota attorney general banned the company from doing business in his state for two years.

Become Familiar with Patient Security

The HIPAA Security Rule can apply to protecting all types of data. You must have IT staff or an outsourced IT provider working diligently on security — not just keeping networks up and data backed up. You should have a security risk analysis done by a certified professional, just as you would want a diagnosis of a serious illness done by a board-certified specialist.

You need to identify all of the regulations that apply to your organization. Even with a good risk analysis and risk management plan, you should also have a comprehensive plan in the event of a data breach. Like professional coders, there are certified professionals who offer these services. While you are focusing on ICD-10 and other challenges, these professionals can lighten the load for the security and protection of your data, and your compliance with federal and state laws.

Resources:

FBI Cyber Division Private Industry Notification, (U) Health Care Systems and Medical Devices at Risk for Increased Cyber Intrusions for Financial Gain, April 8, 2014: **https://info.publicintelligence.net/FBI-HealthCareCyberIntrusions.pdf**

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By Tracy Bird, FACMPE, CPC, CPMA, CEMC, CPC-I

CUSTOMER SERVICE: THE KEY TO HAPPY PATIENTS

Promote a positive patient experience to retain loyal patients, improve finances, and reduce liability.

Successful retail and service industries know the importance of good customer service. The healthcare industry knows this, as well, but has only begun to see patients as "customers." Healthcare organizations are quickly learning that making customer service a business requirement reaps benefits that come with attracting and maintaining loyal patients.

In the wake of all the complexities built into our delivery systems, providing good customer service can be simple and uncomplicated when the right tactics are used. Delivering good customer service can provide triple benefits to your organization by:

- Enhancing patient satisfaction
- Improving financial performance
- Reducing liability exposure

Patient Satisfaction

Enhancing patient satisfaction can be achieved by adopting a "three P" methodology, according to Jason Wolf in the *Hospital Impact* article, "The Importance of Anticipating the Patient Experience:"

1. People
2. Processes
3. Place

Your **people** are the most important aspect of this strategy. They are the ones making connections with your patients and they represent the brand that is your clinic or practice. Michael Eisner, the former CEO of Disney, said, "A brand is a living entity — and it is enriched or undermined cumulatively over time, the product of a thousand small gestures."

Small gestures — such as using the patient's name in a sentence, showing compassion, engaging him or her in the treatment process, or using simple language rather than medical jargon — build closer relationships. Building a service culture promoting staff who work together as a team, like their jobs, and respect one another can translate to higher patient confidence, better clinical outcomes, and patient retention.

Efficient **processes** also play a role in improving patient satisfaction. The use of technology — whether it's a patient portal to streamline the appointment process or receiving care plans and lab results electronically in a secure environment — adds to efficient processes patients seek. Patients are also looking for efficient access to care, including evening and weekend appointments, and urgent care availability.

Patients value efficient processes, such as scheduling appointments, managing correspondence, handling refills, prior authorizations, and facilitating communication with the medical team, and they like receiving services in one location. Streamlined processes create the value patients are coming to expect.

Patients are also seeking a **place** to receive their care in a clean and safe environment, with easy access and navigation. Virginia Mason Hospital in Seattle has studied wait times, walking distances, work sequencing, and other issues affecting their ability to treat patients as a way to add value to the patient experience. The high level of attention paid to both patient care policies and facility design has contributed to placing them in the 90th percentile of national quality surveys, according to "Customer Service in Health Care Optimizing Your Patient's Experience," by Karen A. Meek. Carole Kassir-Garcia, a senior interior designer with Collins Woerman, suggests the best places for patients to receive care are those that blend hospitality with wellness.

Financial Performance

The U.S. healthcare system is transforming from volume-based reimbursement to value-based reimbursement. The Affordable Care Act ties Medicare reimbursement, in part, to patient satisfaction scores and to quality and cost data. Commercial payers are joining the shift in reimbursement away from fee-for-service to pay-for-performance models, with customer service scores factored in. Medicare data and commercial payer data are posted online to aid patients in making informed decisions about their care.

It is estimated that 87 percent of Americans use the Internet, and that one in five report accessing provider ratings online prior to seeking care. Another 40 percent report they have left comments on rating websites related to their healthcare encounters with providers, according to Pew Research Center's article, "Peer-to-Peer Health Care." When you consider the number one quality patients are seeking in a provider is good service, and that future reimbursement will be tied partly into customer satisfaction scores, you can conclude that patients' perceptions of their care do have value, and their complaints should drive change toward improving customer service.

Liability Exposure

Liability exposure is an inherent risk with the practice of medicine. Approximately one in four physicians receives a complaint every year, and 65 percent of physicians are sued sometime during their careers, according to the Press Ganey whitepaper, "Return on Investment: Reducing Malpractice Claims by Improving Patient Satisfaction."

According to a number of studies about why patients pursue litigation, specific behaviors by physicians or their staff members may precipitate a lawsuit. The top three litigation triggers — did not listen, showed little concern, rude — suggest a lack of customer service as the main reason for a lawsuit.

Press Ganey said it best in the 2012 white paper:

> Patients who are more satisfied are less likely to sue. Period. All studies of malpractice claims show the same result. Communication is the key to the vast majority of suits. Anger, not injury, is the trigger for most claims … empathy and good interpersonal skills prevent malpractice claims.

Treating patients as customers is a paradigm shift for healthcare. Patients today have a wide range of care options. This increases competition among providers and underscores the need for organizations to treat patients as customers. Taking steps to provide good customer service helps build and retain loyal patients, improves financial position, and reduces liability exposure. The premise is simple: Ask that an ordinary job be performed in an extraordinary way. HBM

Resources:

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By Marsha McGraw, CRHC

Cracking the CODING CODE at Providence

A professional development plan improved revenue, increased risk returns, and reduced denials by supporting its coders.

Post-impressionist painter Vincent Van Gogh said, "Great things are done by a series of small things brought together." If you look at Van Gogh's paintings up close, you can see a series of squiggly colorful lines and dabs of paint. But if you back up, a magnificent picture appears right before your eyes.

This "big versus small" concept resonates well with me as a finance coding manager. Within the Oregon Region of Providence Medical Group (PMG), I oversee a staff of more than 40 certified coders who handle 150 primary care and specialty clinic locations. As we keep our eye on the big picture of our medical group's coding integrity, we also are working on the small things — each code generated by our 450 providers, who see 15,000 patients each month at our clinics.

To compose a beautiful, big picture of our health system, we focused on some small changes in our staffing models. These colorful touches transformed the way we code at PMG-Oregon, as well as throughout our broader, five-state health system, Providence Health & Services.

Small Problems Add Up

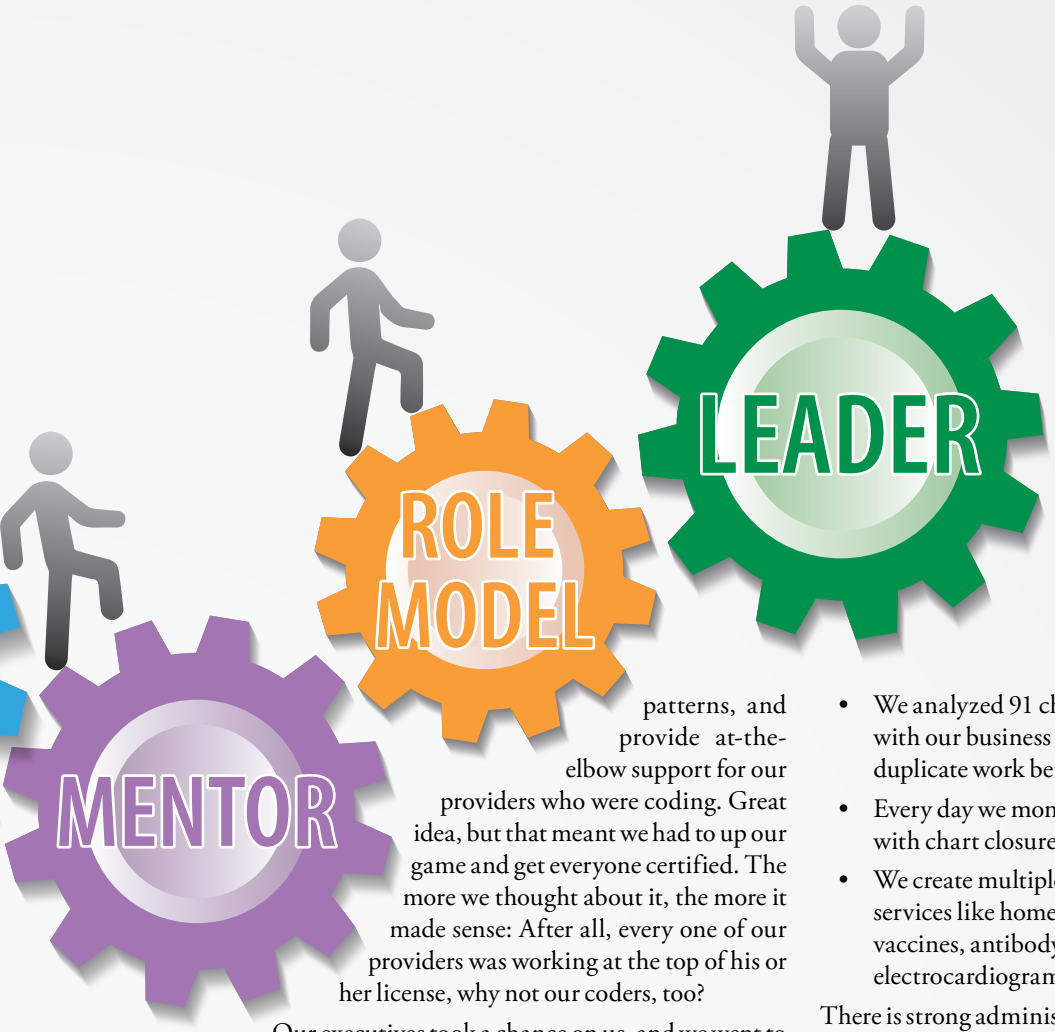
The story starts in the summer of 2013, when a small team of us in the finance department met with clinics across our specialties. We heard some pretty charged frustration from our providers. They were upset about many things that were going wrong: coding changes occurring on the back end without provider consent, complex documentation guidelines, and lack of coding training and local support. Our customers weren't happy, and we had changes to make.

Providence was in the midst of a system-wide implementation of Epic, which was challenging in its own right. With the transition to Epic, the role of the charge order reviewer suddenly was unnecessary because coding was done by the provider directly into the electronic health record (EHR). Instead, the important work of reviewing the charges was diverted to our centralized business office, which threw a major wrench in our processes. Suddenly, our providers were no longer talking to the coders in the clinics; in fact, they weren't really talking to anyone. Instead, they coded alone, and the business office reviewed those codes alone. That valuable relationship between provider and coder was interrupted. The business office was only able to review a percentage of encounters, whereas before, the charge order reviewers had looked at everything. We stopped in our tracks to come up with a smart solution.

Thinking Big

We took a hard look at our team, but it wasn't the people — we had a great team! We discovered that it was their roles that were the weak links. We noticed that because our charge order reviewers were not certified, we had a massive productivity barrier on our hands.

So we made a proposal to our executives: We wanted to put the coders back in the clinics, not as charge order reviewers but as certified coders. Only certified coders would be able to make changes, look for



The story starts in the summer of 2013, when a small team of us in the Finance department met with clinics across our specialties. We heard some pretty charged frustration from our providers.

patterns, and provide at-the-elbow support for our providers who were coding. Great idea, but that meant we had to up our game and get everyone certified. The more we thought about it, the more it made sense: After all, every one of our providers was working at the top of his or her license, why not our coders, too?

Our executives took a chance on us, and we went to work. We told all of our charge order reviewers we wanted them to get certified. We offered them training boot camps, bought them books, drilled them on practice tests, and paid for their certification exams. To our amazement, 70 percent of our team made the transition successfully! Within six months, they were promoted to certified coders. For those on our team who didn't accept the challenge, we helped them transition elsewhere within Providence.

With our new certified coders embedded in the clinic, providers now have localized support and training. Coders are there to provide immediate and direct feedback on documentation review.

Truth in Numbers

Numbers don't lie, and here is the story our system's data tells:

- We have an internal email inbox to handle coding questions and concerns, averaging 155 inquiries per month.
- We have a PMG coding denial inbox to review documentation and coding questions that resulted in a denial or patient charge questions; it averages 200 inquiries per month.
- We analyzed 91 charge review work queue rules in partnership with our business office to streamline edits and eliminate duplicate work between the two departments.
- Every day we monitor open encounters to support providers with chart closure for services that are more than 15 days old.
- We create multiple reports to capture missing charges for services like home health certifications and recertifications, vaccines, antibody and drug administrations, electrocardiograms, labs, and supplies.

There is strong administrative infrastructure for this new system, including:

- Monthly meetings with coders and business office leadership to review ongoing issues and solve problems;
- A monthly coding newsletter sent to all providers and clinic leadership with workflows, smart phrases, changes, and documentation tips; and
- Collaborative partnership with providers including training, compliant coding audit review, auditor feedback, and retrospective reviews to identify error trends and provide education to eliminate future mistakes.

Coders of the Future Unite!

What makes our business case really innovative is that this program is sustainable for the long term. Once our newly certified coders were promoted, we realized that we had a professional gap in our team. Who would be our future certified coders? We had heard that our front desk staff (a role we call a patient relations representative [PRR]) did not have room for advancement. So we created a highly coveted

We created a highly coveted Coding Apprentice Program to provide a pathway for professional development for future coders and a pipeline for exceptional talent.

Coding Apprentice Program to provide a pathway for professional development for future coders and a pipeline for exceptional talent. PRRs apply, get recommendations, write essays, undergo performance evaluations, and pledge to take the exam within six months.

After acceptance into the apprentice program, PMG pays for the AAPC Certified Professional Coder (CPC®) prep course, books, and exam. Once the apprentices obtain their certification, they are moved into a paid Coding Apprentice position. This continuous feed creates a career ladder as the junior coders gain experience, moving from a Certified Professional Coder – Apprentice (CPC-A®), to supporting primary care clinics, and finally moving to more complicated specialty clinics. This support has increased staff engagement, and apprentices feel that PMG supports their success and their career. We received 13 applications for the apprentice role the first year, and we accepted five PRRs who were our best performers across the medical group.

Small Wins Lead to a Big Victory

This entire program has developed over the course of one fast-paced, productive year, and I am proud of the accomplishments our certified coders and apprentice coders have made. The support of PMG Finance leadership has made it all possible. Thanks to their vision, our new model is held up as a model throughout Providence, and we have pilot projects underway throughout our organization that are using the infrastructure that we built. Our providers are happier, our relative value units are higher, and our reimbursement is soaring. And thanks to them, our PRRs and coders now have professional development opportunities and career paths that were not available to them before. **HBM**

Marsha McGraw, CRHC, is the PMG Finance coding manager for Providence Health & Services in Portland, Ore. She became a certified coder in 2009 and focused on rheumatology coding at PMG Arthritis Center for four years. McGraw transitioned to PMG Finance in August 2014 to lead the team of clinic coders. She is a member of the Portland Rose City, Ore., local chapter.

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By Bridget Toomey, CPC, CPB, RYT-200

Wellness Apps That Help You Regain Focus

If you need a reminder to take a break and stretch — there's an app for that!

Do you get so busy at work that hours pass before you realize you haven't taken a break? This sort of work habit is actually counterproductive. To stay focused and prevent stress-related injuries, it's important to get up and move around every so often. If you're someone who needs a reminder to take care of yourself, there are many affordable wellness and fitness apps out there that can help you. Here are a few.

Office Yoga - Fitness AT Work

The *Office Yoga - Fitness AT Work* app shows yoga poses that you can do right at your desk. These exercises are so simple, you don't need previous yoga experience. The app explains each pose with photos, text instructions, and audio and video instructions. There are two versions of this app for iOS users: Office Yoga - Fitness AT Work is $1.99.

Office Yoga

Office Yoga is an Android app featuring simple postures you can do at your desk, in the copy room, or out in the hallway, and it's free.

Relax: Stress & Anxiety Relief

Relax: Stress & Anxiety Relief encourages you to focus on the connection between your breathing and your stress and anxiety. Stress can manifest in your body, so it's important to get it under control. The app guides your breathing, so you can close your eyes and relax. This app has a free Lite version, or you can purchase the full version for $4.99 for iOS or $3.99 for Android.

StretchClock

StretchClock is a browser add-on for Firefox. This application reminds you to take breaks and walks you through various stretching exercises.

Gimme a Break!

Gimme a Break! is a browser add-on for Google Chrome. It has a timer that allows you to schedule when you want to take breaks and for how long. A pop-up reminds you to take a break from your work to do some leisurely Internet surfing or to get up and leave your desk completely. HBM

Bridget Toomey, CPC, CPB, RYT-200, teaches Kundalini yoga at Heartland Yoga in Iowa City, Iowa. She is certified by the Kundalini Research Institute as a Kundalini yoga teacher and is a member of the International Kundalini Yoga Teachers Association. Toomey works for the University of Iowa Hospitals and Clinics in Patient Financial Services as a revenue cycle coordinator, where she supervises staff on the physician Iowa Medicaid team. She is a member of the Iowa City, Iowa, local chapter.

Strike a Pose

For five, simple yoga exercises that can be done daily without leaving the office, read the article "Improve Productivity with Office Yoga" in *Healthcare Business Monthly* (August, p. 42-45).

By Dawn Moreno, PhD, CPC, CBCS, CMAA, MTC, CPL, CLT

What a Good Online Coding Program Offers

Get some pointers from an instructor who has experience on her side.

As an online medical coding and billing instructor for many years, I am frequently asked, "What should a good training program offer?"

Costs and Features

You can expect training to cost anywhere between $1,500 and $3,000. Don't let pricing be your main factor in choosing a course, however. As a new student, you should seek a training program that offers one-on-one attention, even if it's online. A qualified instructor should be available during normal business hours to answer any questions you may have on the material. Questions should be answered within 24 hours, so you are able to continue to progress without waiting for answers. Instructors should be reachable by email or telephone.

Consider your learning style, as well. While nearly everyone benefits from hands-on training, a program with both text and visual components accommodates all learning styles best. Even with a text-based curriculum, it's beneficial for pictures, charts, graphs, and other images to accompany text. A good online program also should contain strong content from recognized sources (e.g., using industry-standard texts, such as the CPT® codebook, in the course).

Curriculum

A good medical coding/billing program should offer training in medical terminology and anatomy, especially if the student has not already had such training. With the advent of ICD-10, which requires more specificity than ICD-9-CM, it's important for medical coding and billing professionals to have a more in-depth and detailed knowledge in these areas.

Along with medical terminology and anatomy, there should be content-specific courses in medical billing procedures, practice with the CMS-1500 form, UB-04 form, and training in compliance and HIPAA issues. The different health insurance carriers — such as Tricare, BlueCross BlueShield, Medicare, and Medicaid — should be discussed, as well.

The medical coding portion of the program should include plenty of practice in looking up and assigning codes to case studies or scenarios. It's advantageous if the medical coding/billing program is geared toward AAPC certifications. This way, you can graduate from the program and be prepared to sit for the Certified Professional Coder (CPC®) exam or the newer CPB Certified Professional Biller (CPB™) exams offered by AAPC.

Textbooks and Software

Many textbooks now come with simulation demo software to assist students with completing case studies or scenarios; however, I don't feel this is a crucial component to any course. Not all practices use the same software, so what you learn in school may not be what you'll use on the job. Adding a full medical billing software package to a training program can substantially increase the cost of your education.

Guidance to Help You Succeed

There should be some career guidance within the program, explaining how and where to find job and how to network. I am an advocate for programs that promote professionalism, such as having students join AAPC and pursue local chapter networking opportunities.

Medical coding and billing is a great career to pursue. With the Affordable Care Act, the aging of the baby boomer population, and older coders and billers retiring from the field, there are many new opportunities available. It all starts with a strong foundation from an excellent career training program. **HBM**

Dawn Moreno, PhD, CPC, CBCS, CMAA, CLT, CPL, is an instructor and manager of admissions with MTACC. Her passion is in teaching adults new career skills and she enjoys reading and writing. Moreno's motto is "You are never too old to learn something new." She is a member of the Albuquerque, N.M., local chapter.

A qualified instructor should be available during normal business hours to answer any questions you may have on the material.

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Allison Sinclair, **CPC-A**
Allison Zeise, **CPC-A**
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Alyssa Mintus, **CPC-A**
Amala Aluri, **CPC-A**
Amanda Bakker, **CPC-A**
Amanda Clawson, **CPC-A**
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Amanda Sell, **CPC-A**
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Amber Elizabeth Barkley, **CPC-A**
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Amberr Nunez, **CPC-A**
Ambika Tokas, **CPC-A**
Ameya Chitre, **CPC-A**
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Anandanvesh Velpula, **COC-A**
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Melissa Barnes, **CPC-A**
Melissa Black, **CPC-A**
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Michele Tricarico, **CPC-A**
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Milissa Gronholm, **CPC-A**
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Mohit Gupta, **COC-A**
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Monisha Rajendran, **CPC-A**
Mounika Cheela, **COC-A**
Mounika Reddy Theekulla, **COC-A**
Mounikareddy Modugu, **COC-A**
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Mylene Reyes Padre, **CPC-A**
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Thadakamalla Mahesh, **COC-A**
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Tiffany Marie Hatfield, **COC-A,** CPC-A
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Tracy Sciulla, **CPC-A**
Trinity Farwell Albertson, **CPC-A**
Trudy Smith, **CPC-A**
Tucker Robins, **CPC-A**
Ujwala Bhanudas Patil, **COC-A**
Umair Khalil, **CPC-A**
Umapati Mishra, **CPC-A**
Umavathi Rai, **CPC-A**
Usha Rani, **CPC-A**
Ushod Chandra Sudunagunta, **CPC-A**
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Valakatla Raju, **COC-A**
Valerie Vera, **CPC-A**
Varalakshmi Devi Chamarthi, **CPC-A**
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Vedi Raja, **COC-A**
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Vemuri Lahari, **CPC-A**
Venise Trujillo, **CPC-A**
Venkataramana Pabbisetti, **CPC-A**
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Vetha Kanagasabapathy, **CPC-A**
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Vinaykumar Joginipelly, **COC-A**
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Vinitha V, **CPC-A**
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Virginia McCoy, **CPC-A**
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Vishal Tiwary, **CPC-A**
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Vishnukumar Mandala, **COC-A**
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Vuyyuru Kavitha, **CPC-A**
Wendy Guerriero, **CPC-A**
Yamini Peta, **COC-A**
Yandrey Gonzalez Casas, **CPC-A**
Yaquelin Santos, **CPC-A**
Yareci Amaya, **CPC-A**
Yogarani Selvam, **CPC-A**
Yogesh Patil, **CPC-A**
Yulia Willoughby, **CPC-A**
Zakiyyah Wagerle, **CPC-A**
Ziyad Azeez, **CPC-A**
Zoraida Muro, **CPC-A**

Specialties

Adriana Rodriguez, CPC, **CRC**
Agatha A Prokscha, CPC, **CHONC**
Alberto Rando Sous, CPC, **CPMA**
Alex Strahan, **CPCO**
Alicia Rubalcava, CPC, **CRC**
Allyson LaFave, CPC, **COSC**
Alvin David Hamm, CPC, CPMA, **CEMC**
Amber Pendleton, **CPB**

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Amy Morrow, **CPB**
Amy Scherf, **CRC**
Amy Westerhuis, CPC, **CEDC**
Ancha Yamini, **CIC**
Andie Zurbrick, CPC, **CRC**
Andrea Arnzen, CPC, CPMA, **CEMC**
Andrea R McGuire, CPC, **CPPM,** COSC
Andrea Ryken, CPC, **CPB**
Andres Michel Gutierrez, CPC-A, **CPMA**
Angela Bridget Martin, COC, CPC, **CIRCC,** CPMA
Angela Thompson, CPC, **CRC**
Angela Weaver, **CPCO**
Anita Gue, **CEDC**
Anjanette Lobitana Abraham, **CPMA**
Ann Carroll Onaye, COC, CPC, **CPMA,** CEMC
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Annette Appenzeller, CPC, **COSC**
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Arlene Roque, CPC, **CIRCC**
Ashlee Abdelnour, CPC, **CEDC**
Ashley Carrasco, CPC, **CEDC**
Ashley Grubb, **CPPM**
Ashley Reeves, CPC, **CPPM**
Aswathy Sreedevi, **CIC**
Audrey Widner, CPC, CEMC, **CRC**
Avinash Budhani, **CPMA**
Azeena Anzal, **CIC**
Babu Dhanaraj, COC, CPC, **CPMA**
Bambi Winter, CPC, **CPMA**
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Barbara O'Neil, **CPB**
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Beth Lee, CPC, **CPB,** CPC-I
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Carla McCullough, **CPPM**
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Christine Nguyen, **CPB**
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Cindy Pannell, CPC, **COBGC**
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Heather Harrison, **CPB**
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Holly Stuart, CPC, **CPMA**
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Jane Steinkamp-Denker, CPC, **CPMA**
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Jennifer Chenoweth, **CPB**
Jennifer Wersland, CPC, **CRC**
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Karla Manuales, **CPMA**
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Zukhra Kasimova, CPC, CPB, **CSFAC**

ICD-10 Quiz Answer (from page 47)

The correct answer is: H60.22 *Malignant otitis externa, left ear.* Malignant EO (or MEO) is an infection that affects the external auditory canal and temporal bone. The causative organism usually is pseudomonas aeruginosa, and the disease commonly manifests in elderly patients with diabetes. The infection begins as OE and progresses into osteomyelitis of the temporal bone.

By Michelle A. Dick

AAPC Raises the Bar with 150K Member: ELENA KUKLINA

Doctor at the National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health, Is Welcomed to AAPC.

AAPC's 150,000th member, **Elena V. Kuklina, MD, PhD**, may not fit into our organization's typical coder mold, but she is the perfect example of how our distinguished, diverse membership is expanding into all areas of healthcare. She is a health scientist at the Centers for Disease Control and Prevention (CDC), an adjunct professor of nutrition and health sciences at Emory University, and an inspiration to our members seeking a career in the business of healthcare.

Kuklina's membership represents how our organization and its education services are valuable not only to hospitals and physician offices to capture compliant reimbursement of services, but also to CDC doctors to capture clinical data to help monitor healthcare processes.

Improving Health Through Data Capture

Kuklina plans to continue her work in the obstetric field and focus her efforts on improving maternal health in the United States.

Over the past 10 years, Kuklina has worked with colleagues from the CDC and leading teaching hospitals on the development of surveillance methodology for obstetric complications in the United States. "Our work is based on using a set of diagnosis and procedure ICD-9-CM codes to identify hospitalizations for childbirth from hospital discharge databases," Kuklina said.

As an AAPC member, Kuklina wants to further her public health work and to strengthen her research. "Given the nature of my public health work and research, I plan to obtain Certified Inpatient Coder (CIC™) and Certified Obstetrics Gynecology Coder (COBGC™)." she said. "I would like to maintain AAPC certifications and see how I can use credentials and knowledge to develop more advanced surveillance systems including registries."

Kuklina sees the certifications as a way to achieve her long-term career goals at the CDC. "In 10 years, I hope to see substantial changes in data collection and opportunities to use these data for quality improvement initiatives related to maternal care," she said. Kuklina's plan is "to get nationally recognizable certification, and stay up-to-date with the knowledge of medical coding."

AAPC Staking Claims in the Healthcare Industry

Since our founding in 1988 as the American Academy of Procedural Coders, AAPC has reached several milestones:

1990 – 2,000 members and the organization changed its name to American Academy of Professional Coders

2000 – 15,000 members

2005 – 50,000 members

March 2009 – **Andrea Malcolm, CPC,** became AAPC's 75,000th member

April 2010 – **Donna Peters, CPC-A,** became AAPC's 90,000th member

November 2010 – **Carla Peacock, CPC-A**, became AAPC's 100,000th member

December 2013 – **Lori Pimentel**, became AAPC's 125,000th member

To honor this record-breaking membership, AAPC is offering Kuklina:

- An all-expense paid trip to HEALTHCON 2016;
- $500 AAPC bucks (money to spend on AAPC products);
- One *free* year of AAPC Coder; and
- *Free* ICD-10 Assessment Training.

Please help us welcome Doctor Kuklina to AAPC!

150K Is the Tip of the Iceberg

AAPC's certified members are held to the highest industry standards by physicians and clinical professionals for their business-side of medicine expertise.

As quality initiatives, compliance, and proper claims and data capture become the forefront for healthcare business professionals, AAPC expects to expand over the next several years. Its focus remains to be the best resource for coding, billing, auditing, compliance, and practice management education.

There will be more membership milestones ahead. Stay tuned for more announcements on AAPC's website (www.aapc.com), as the nation's largest association of medical business professionals leads its members into the future of healthcare.

Michelle A. Dick is executive editor at AAPC.

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3. **Qualified coder shortage and managing the impact on performance.** We'll discuss solutions to these issues, as well as hiring, coding, productivity, transitioning outpatient coders to inpatient coders, remediation, clinical documentation improvement queries, physician education and job opportunities in a growing industry.
4. **Coding compliance.** Prepare for all the code changes and understand the reasoning behind them with our coding update sessions for CPT®, ICD-10, OPPS, IPPS and HCPCS.
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