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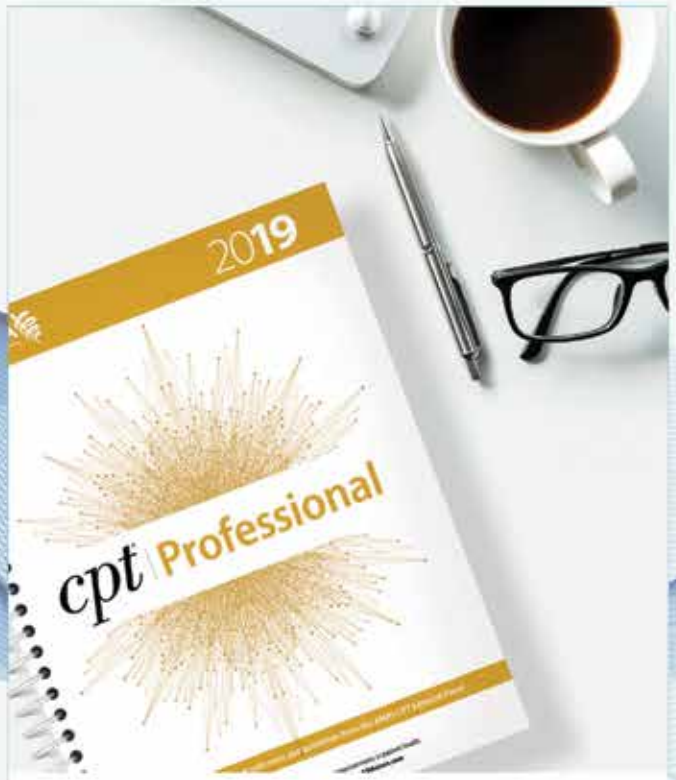

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COVER | Coding/Billing | 30

Any Way You Spin It, CPT® 2019 Will Surprise You

John Verhovshek, MA, CPC

Raemarie Jimenez, CPC, CPB, CPMA, CPPM, CPC-I, CDEO, CANPC, CRHC

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COMING UP:

- Cyberbullying
- From Nurse to Coder
- FQHC Services
- Infusions/Injections
- Ways We Make Misteaks

On the Cover: Take a spin through CPT® 2019 with **John Verhovshek, MA, CPC**, and **Raemarie Jimenez, CPC, CPB, CPMA, CPPM, CPC-I, CDEO, CANPC, CRHC**, to see what it holds for you in January. Cover design by Mahfooz Alam.

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For coding questions, please use our forums (**www.aapc.com/memberarea/forums/**) or Ask an AAPC Expert service (**www.aapc.com/resources/ask-an-expert/ask-an-expert-purchase.aspx**).

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Soft Skills: Credentials Are Just the Beginning

In an extremely complex and fast changing industry, where additional layers of learning can be a critical step in career growth, it's essential to regularly seek out and prepare for the qualifications you'll need for future success. And while stackable credentials validate the hard skills required for role candidacy, they are only part of your career success. The easily defined and measured abilities you used to get to your current job aren't always (unfortunately) the ones you'll need to advance in the healthcare marketplace.

Separate Yourself as a "Great"

A decade ago, Marshall Goldsmith, in his book *What Got You Here Won't Get You There*, argued that behavioral problems, not technical skills, separate the great from the near great. He made a compelling case for soft skills.

The World Economic Forum (WEF), an international business think tank, listed 10 professional skills considered essential in 2020. They are:

- Complex problem-solving
- Critical thinking
- Creativity
- People management
- Coordinating with others
- Emotional intelligence
- Judgment and decision-making
- Service orientation
- Negotiation
- Cognitive flexibility

Emotional intelligence and cognitive flexibility are the newest entrants to the 2020 list, having just edged out quality control and (surprisingly) active listening from the 2015 WEF top 10 list. Emotional intelligence is the ability to recognize your emotions and those of others, label them, and use them to guide behavior and decisions; and cognitive flexibility is what helps you face new and unexpected conditions in your environment.

Hone Essential Skills

A good place to hone essential skills is your AAPC local chapter, where interacting with your peers and volunteering to fulfill leadership roles will help you evolve, progress, and advance. Soliciting honest feedback and suggestions from your leaders, peers, and subordinates at work, followed by active efforts to improve, is also key to your future success.

Through online personal and career development courses, AAPC now provides training on many of these topics, and more are planned next year. Cost is minimal ($49), with trainings dropping to half price after you've completed your first course, and we're looking to bundle and make a low-cost subscription available as another member benefit. Look for "Professional Development" under the educational tab on our AAPC website or go directly to www.aapc.com/SoftSkills.aspx.

We're also regularly delivering webinars, publications, and other educational content to help you; and your employer may offer their own resources.

The bottom line? Hard skills may have got you the job, but soft skills will ensure your success.

Sincerely,

Bevan Erickson
AAPC CEO

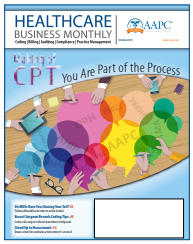
We're also regularly delivering webinars, publications, and other educational content to help you; and your employer may offer their own resources.

Letters to the Editor

Please send your letters to the editor to:
letterstotheeditor@aapc.com

Hospice Is Part A, Not Part B

In the article "Know the Essentials of Hospice Billing and Reimbursement" on page 22 of November's *Healthcare Business Monthly*, the first sentence in the article should read, "Hospice is a Medicare Part A covered benefit most often provided to terminally-ill patients who wish to remain in their homes," not Medicare Part B.



Correction: Global Period Begins One Day Prior to Major Surgery

The article "Know the Right Time to Append E/M Modifiers" (October, pages 24-25) states, "Modifier 57 is used when an E/M service is rendered within the three days preceding, or on the same day as, a procedure with a 90-day global period." I have never heard of the three-day rule. I researched the resources that were included with the article and do not find where a three-day rule is referenced. Would you please let me know where this information is found? Thank you.

Kelly J. Traver, CPC

The "three-day" statement was an error. In fact, Modifier 57 *Decision for surgery* may be appended when an E/M service resulting in a decision for surgery is rendered one day prior, or on the same day as a procedure with a 90-day global period.

This guideline is found in the Centers for Medicare & Medicaid Services (CMS) Global Surgery Booklet (**cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalSurgery-ICN907166.pdf**), which states:

90-day Post-operative Period (major procedures).

- One day pre-operative included
- Day of the procedure is generally not payable as a separate service.
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

If the decision for surgery is made two or more days prior to the procedure, it falls outside the global time frame and a modifier is not required to secure reimbursement for the E/M service.

Modifier 57 does not increase reimbursement. It allows for separate payment within the global period, however, the E/M will reimburse according to the level billed. Typically, a decision for surgery warrants a higher-level E/M service.

Elizabeth Redman, CPC, COSC

Kudos

Kudos to the Lahey Health Coding Team

The coding team at Lahey Health deserve kudos from their management team because they are a unique group of professionals who are driven to constantly adapt to the changes in healthcare. The diverse skills enable them to thrive in this fast-paced environment.

As we end 2018, the team has started working towards a vibrant 2019 with a clear strategy to tackle any coding challenges. One of the strategies is to review current infrastructure to be sure it will align with 2019 coding changes.

They continue to build relationships with other stakeholders within the organization's revenue cycle. These relationships increase the level of open, transparent dialogue among the key players within the revenue cycle.

As the team faces challenging healthcare decisions in 2019, my mantra from my native language Igbo, a tribe in Nigeria, is "igwebuike," which means "united we stand."

Oby Egbunike, CPC, COC, CPC-I, CCS-P

Kim Oepen and the Code Book Carousel

Code book carousel raises money for the Hardship Scholarship Fund.

Member **Kim Oepen, CPC-A**, donated a code book carousel to the Charlotte, North Carolina, local chapter. This carousel can hold both ICD-10 and CPT® code books and it turns for easy access. The Charlotte chapter is taking raffles until the end of the year. All proceeds will go towards the AAPC Chapter Association's Hardship Scholarship Fund.

For decades the Charlotte, North Carolina, Carolina Coders have been fortunate to have members who have volunteered their time to the chapter and we are thankful for them all.

Elizabeth Martin, RHIT, CDIP, CPC, CPC-I, CRC

NEHA BHARGAVA, CPC-A

I came to America in 2006 and, shortly after, enrolled in Purdue University in the Biomedical Engineering program. After graduation, I worked as a research associate at the Veterans Affairs hospital in Memphis, Tennessee, and San Francisco, California. I contributed to a research publication while working in Memphis.

With a deep interest and knowledge in anatomy, physiology, and medical devices, I researched career options in the healthcare industry aligned with those interests. After moving to Charlotte, North Carolina in 2016, I came to know about the Certified Professional Coder (CPC®) credential and associated job prospects.

I purchased AAPC's CPC® Study Guide and practice material, which gave me the necessary tools and flexibility for online study at my own pace. With self-motivation and determination, I completed the practice material and was certified in my first attempt, in only eight months.

My Chapter Helped Me Find My First Coding Job

After a few months of applying for work, I reached out to the Charlotte, North Carolina local chapter President **Elizabeth Martin, RHIT, CDIP, CPC, CPC-I, CRC**, via email, introducing myself and my background. She welcomed me to the chapter and said she looked forward to meeting me in person at the next meeting. When I met her, I mentioned my interest in getting a full-time job. Martin told me the chapter provides job leads via newsletter and social media. I asked her if she would look over my resume, and she did. After attending several meetings, I learned of a job at a local pathology billing company. I applied, interviewed, and landed my first job as a professional coder. I love every aspect of my job.

I'm Grateful for the Carolina Coders

Alongside my determination and hard work was a chapter with volunteers who shared my passion and who were willing to support me as I embarked upon my new career path. I'm proud to be a member of the Charlotte, North Carolina, local chapter, and I'm very grateful for how they support members. Attending local chapter meetings provided a platform for networking with other professionals, keeping up with the trends, and learn about news in the coding arena. We exchange ideas and learn from each other. #IAMAAPC

AAPC's CPC® Study Guide and practice material, which gave me the necessary tools and flexibility for online study at my own pace.

#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).

#IamAAPC

By Susan O'Loughlin, CPC, CPMA, AAPC Fellow

Bored with the Same Old Chapter Humdrum? Liven It Up!

Implement eight unique ways to make your chapter fun.

When my fellow officers and I started the Plattsburg, New York, local chapter back in 2002, the four of us were quite green. We were excited, ready to share our ideas, earn continuing education units (CEUs), network, and meet fellow coders. As of today, we have over 90 members and very proud of it.

Over the years, we've learned that there are times when members need just a bit more excitement. Sure, the education is fantastic, but who doesn't like to have fun and receive education at the same time?

Here are eight tried-and-true ideas that are sure to liven up your local chapter meetings:

1. **Have a picnic.** Most towns and cities have parks, beaches, or some open area where you can meet and have a picnic. Everyone bring a dish to share. Don't forget the dessert and blankets.
2. **Hold a seminar or a one-day workshop.** There are many speakers who will come and speak for an hour or two for little or no cost. Depending on your education content, you may be able to offer six CEUs for a six-hour workshop. Offer food and time to network to make it feel more like more of a social event.
3. **Take a tour.** Arrange a tour of one of the departments at your local hospital. For example, our chapter took a tour of radiology. We split into groups and rotated through the various imaging areas led by a department manager. It was fascinating to learn about MRIs, CT scans, and unusual films. We met with a few interventional radiologists who were more than pleased to show us their reading rooms and what they were looking at — so interesting!
4. **Be philanthropic.** Every chapter has at least one very crafty person. Ask them to make a special craft for the chapter to raffle off and donate the proceeds to AAPCCA's Hardship Scholarship Fund to help a fellow coder in need. Another idea: Collect socks, toothpaste, combs, brushes, blankets, and find-a-word puzzles, and donate these items to a local nursing home or shelter.

iStockphoto/Wavebreakmedia

5. **Make local chapter T-shirts.** Get creative and colorful, and make sure to use the AAPC-approved logo. Wear your T-shirts to meetings and other coding events with pride.
6. **Ask community organizations to speak at a meeting.** Ask your local American Red Cross, American Diabetes Association, Alzheimer's Association, etc., to speak at your chapter. Other good sources include your local police department, physicians' office, nursing home, etc.
7. **Get festive with fall fun!** October can be a tedious month during elections, but next year look at it as an opportunity to enjoy seasonal festivities. Have a costume contest, host a pot luck dinner — just make sure someone brings the "ghoulash!"
8. **Have a December holiday party.** Wear your ugly sweaters and do a cookie exchange. Play fun coding games and celebrate a successful year!

These are just some ideas that are fun, interactive, and won't interfere with your education time. Best of all, you can enjoy your chapter and truly get to know one another. You never know what opportunity may knock at your door when you think outside of the box and have fun while learning.

Susan O'Loughlin, CPC, CPMA, AAPC Fellow, has been in the medical field for over 30 years and is director of revenue cycle at University of Vermont Health Network, Champlain Valley Physicians Hospital Medical Center. She is a 2017-2020 AAPCCA board of directors Region 2 representative and a member of the Plattsburgh, N.Y., local chapter.

Have a costume contest, host a pot luck dinner — just make sure someone brings the "ghoulash!"

Chapter News

By Gina Piccirilli, CPC, CPMA

PREPARE YOUR INCOMING OFFICER BOARD

Elections are over! Now is the time to prepare your incoming officer board for the new year and ensure you're handing off an organized local chapter. Don't forget to update AAPC's website with your new officers by Nov. 30.

It's common practice to hold a "kick-off" meeting for the new board, which can be in person or via a conference call. Here's how to hold a kick-off meeting with success:

- Discuss each position in detail.
- Have a copy of the Local Chapter Handbook for this meeting. This is your guide for running the perfect local chapter. Each officer should have access to it. If you have a question, the answer is in the handbook. If it's not there, send an email to your AAPC Chapter Association (AAPCCA) representative, so it can be added.
- Tie up loose ends regarding finances. Treasurers: This is a good time to report earnings and walk the new treasurer through the uploading of financial documents.
- Thank the exiting board and introduce the incoming board to your members.
- Be enthusiastic! This is an exciting time, as the new officers will bring fresh ideas.
- Tell the new board about all the resources they have, like their AAPCCA regional representative and social media pages.
- Have officers sign up for the 2019 Officer Facebook page, if they have a Facebook account. Otherwise, they can sign up for the AAPC Group Facebook page.

As always, thank you for your volunteerism. We appreciate everything you do. Have an incredible year!

Gina Piccirilli, CPC, CPMA, is director of HIM at Ellenville Regional Hospital. She also consults in documentation improvement and E/M auditing. She is a Region 2 – Atlantic AAPCCA representative and can be reached at gina.piccirilli@aapcca.org.

By Gina Piccirilli, CPC, CPMA

Monica Jordan, CPC
Covington, Georgia, Local Chapter

The December spotlight belongs to **Monica Jordan, CPC**, who has been in the medical field since 2008. She obtained her Certified Professional Coder (CPC®) credential in December 2007. Jordan has held various positions from payment posting to accounts follow-up to appeals, and today works in coding denials. She enjoys learning, helping, and sharing with other members.

During the October 2017 elections Jordan was nominated to be the 2018 member development officer for the Covington, Georgia, local chapter, which boasts more than 400 members. She felt compelled to reach out, try something new, and gain experience.

Being a member development officer has been a confidence-boosting experience for Jordan. "This position has helped my normally shy self, build confidence with meeting new people," she said.

This is the first officer position Jordan has held, and she loves welcoming new members into the chapter. During her term, the Covington chapter started a back-to-school drive, where they collected school supplies and donated them to an elementary school in the community.

"I have a deep desire to learn," Jordan said. "Even though I may not absorb it at first, I just keep on until I have." She is not afraid of failure because she sees it as a lesson learned, and these lessons have shaped her to be the person she is today.

Jordan takes pleasure in learning all that this medical field has to offer and is studying for her Certified Risk Adjustment Coder (CRC) certification. **HBM**

During her term, the Covington chapter started a back-to-school drive, where they collected school supplies and donated them to an elementary school in the community.

If you are interested in becoming a Certified Professional Coder (CPC®) or a Certified Risk Adjustment Coder (CRC™), like **Monica Jordan, CPC**, go to **www.aapc.com/certification/cpc/ and www.aapc.com/certification/crc/** to find out more.

Gina Piccirilli, CPC, CPMA, is director of HIM at Ellenville Regional Hospital. She also consults in documentation improvement and E/M auditing. She is a Region 2 – Atlantic AAPCCA representative and can be reached at **gina.piccirilli@aapcca.org**.

By Vanessa L. Moldovan, CPC, CPMA, CPPM

AAPC Resources and Support Are at Your Fingertips

Find what you're looking for at aapc.com.

A goal of the National Advisory Board (NAB) is to bring to light the extensive resources and support AAPC offers to ensure its members achieve career success in the business of healthcare. Let's discuss two topics that many of you have discussed with me: how to use AAPC's website to serve your individual needs and using AAPC's support network.

Go to AAPC's Website for Resources

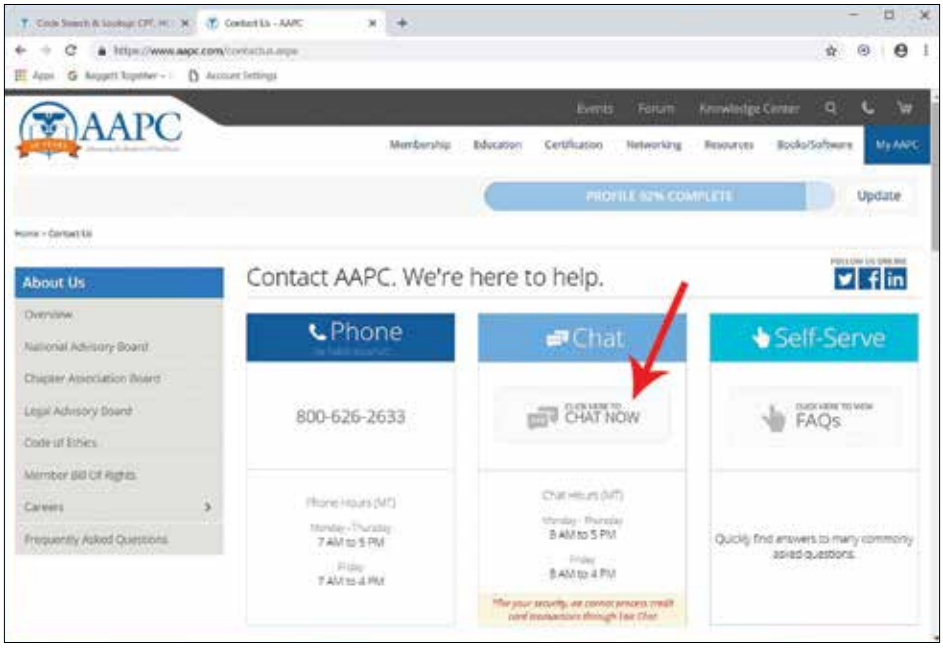
AAPC's website is overflowing with information regarding education, networking, membership, certifications, and resources. There isn't a question that isn't answered on www.aapc.com. Some of my personal favorites are:

- AAPC Coder (check out a free trial at: www.aapc.com/code/);
- Knowledge Center (www.aapc.com/blog/); and
- Ask an Expert (www.aapc.com/resources/ask-an-expert/ask-an-expert-purchase.aspx).

I encourage you to explore the website. You can also reach out to your regional NAB representative(s) and request they come to your chapter and give a demo.

Get the Support You Need

In my nine years as an AAPC member, I have experienced AAPC as a heartfelt, supportive, resourceful, and innovative organization, but I understand that everyone's journey with AAPC is different. It's the gaps in any member's experience that the NAB would like to close. If you are experiencing a lack of support, need assistance with exams or job searches, or just need encouragement, please consider the following:



- Contact AAPC directly through the website (the Contact Us page has a "Chat Now" button, as shown in figure above)
- Talk to your local chapter officers
- Reach out to your regional NAB representative

You can also get help with coding questions through the Knowledge Center, Ask an Expert, and Forums. Contact information and details are on the AAPC website.

Reap the Rewards

I sincerely hope you take advantage of the resources and support that AAPC offers online. I am 100 percent certain you'll find what you are looking for. You may even find something like discounted movie tickets that you didn't know you needed.

Let us know how it goes! HBM

Vanessa L. Moldovan, CPC, CPMA, CPPM, is a revenue cycle expert at Medic Management, LLC. Her focus for more than 17 years has been on education and the physician revenue cycle. Moldovan holds a Bachelor of Arts degree in Healthcare Administration from Ashford University. She has worked as a revenue cycle assessor, a revenue cycle manager, an executive account manager, and a consultant. Moldovan is the NAB's Region 5 representative. She has been serving as a Des Plaines, Illinois, local chapter officer since 2013; she served as president from 2014-2017, and is 2018 educational officer.

Know Who to Contact at AAPC

Not sure who at AAPC is the best person to contact for help with your situation or need? Read the article "Know Who Represents You and Who to Contact at AAPC," on page 66.

By Brenda Edwards, CPC, CDEO, CPB, CPMA, CRC, CPC-I, CEMC, CMRS

TAB YOUR CODE BOOKS FOR EFFICIENCY

Make learning fun and tab up your books for easy code look-up.

I am a visual learner and a "tabber." Tabbing CPT®, HCPCS Level II, and ICD-10 code books enables me to use them with the utmost efficiency. Each year, I look forward to receiving my new code books, so I can start tabbing. Tabbing is a good way to familiarize yourself with the new year's code and guideline changes, as well as layout changes to the books. This tabbing system is especially helpful for locating codes while taking an exam for a new AAPC medical coding credential, where you can't use an electronic code lookup tool such as AAPC Coder.

Are you sold? Then read on to learn how to tab your code books.

Become Familiar with the Layout

All AAPC code books come with labeled sticky tabs. Use these color coordinated tabs to mark sections and make your code searches more efficient.

ICD-10-CM

To find a code in ICD-10-CM, begin by looking for the main term in the Alphabetic Index. Then, verify the accuracy of the code in the Tabular List. Your code search is not complete until you've checked the ICD-10-CM Official Guidelines for Coding and Reporting for any further guidance. These guidelines are in the front of your book.

As an AAPC ICD-10-CM trainer during the big transition from ICD-9-CM to ICD-10-CM, we had some catchy ways to remember chapters. My brain is still programmed to consider each chapter with a catchy term instead of the medical language it is assigned. The chart we used was originally created by **Donna Stewart, CPC, COC, CPCO, CPC-P, CPMA, CPC-I**, and, over the years, I've morphed it into what you see in **Chart A**. You can use the "ICD-10-CM Catchy Term" column to label tabs for the corresponding "ICD-10-CM Tabular Section" column.

Chart A: Tab your ICD-10 code book with terms you'll remember.

ICD-10-CM Tab	ICD-10-CM Tabular Section	ICD-10-CM Catchy Term
A00-B99 Infectious	Certain Infectious and Parasitic Diseases	Aids, Bacteria
C00-D49 Neoplasm	Neoplasms	Cancer
D50-D89 Blood	Diseases of Blood and Blood-forming Organs	Dracula Deficient (immune)
E00-E89 Endo	Endocrine, Nutritional and Metabolic Diseases	Endocrine
F01-F99 Mental	Mental and Behavioral Disorders	Flashback
G00-G99 Nervous	Diseases of Nervous System	"Gittery" Gravis (Myasthenia)
H00-H59 Eye/Adnexa	Diseases of Eye and Adnexa	Hordeolum
H60-H95 Ear	Diseases of Ear and Mastoid Process	Hearing
I00-I99 Circulatory	Diseases of Circulatory System	Infarction Ischemia
J00-J99 Respiratory	Diseases of Respiratory System	Junk in the Lungs
K00-K94 GI	Diseases of Digestive System	Kaopectate
L00-L99 Skin	Diseases of Skin and Subcutaneous Tissue	Lesion
M00-M99 Musculoskeletal	Diseases of Musculoskeletal System and Connective Tissue	Muscles
N00-N99 GU	Diseases of Genitourinary System	Nephrology

ICD-10-CM Tab	ICD-10-CM Tabular Section	ICD-10-CM Catchy Term
O00-O9a OB/GYN	Pregnancy, Childbirth and the Puerperium	OB
P05-P96 Newborn	Certain Conditions Originating in the Perinatal Period	Perinatal
Q00-Q99 Congenital	Congenital Malformations, Deformations and Chromosomal Abnormalities	Quirky
R00-R99 Signs & Symptoms	Symptoms, Signs and Abnormal Clinical and Laboratory Findings	Rash

ICD-10-CM Tab	ICD-10-CM Tabular Section	ICD-10-CM Catchy Term
S00-T88 Injuries	Injury, Poisoning and Other Consequences of External Causes	Sprain Trauma
V00-V99	Accidents	Vehicles
W00-W99	Falls, Exposure, Drowning	Whoops
X00-Y90	Explosive, Assault	Exit Wounds
Y92-Y99 Activity	Place and Activity	Why Where
Z00-Z99	V Codes	Z is the New V

CPT®

When the coding world began, there were no classes or certification exams. Like many others, I taught myself how to maneuver code books. It's much easier to find codes by going directly to the organ system within each code book. It's beneficial because you become extremely familiar with your books.

As shown in **Chart B**, you can tab your CPT® code book by sections, and then break it down even further to include the code range, organ system, and the most common corresponding ICD-10-CM chapters. (Please keep in mind that the ICD-10-CM column is not all-inclusive and is just a place to start.)

Chart B: Use tabs to identify more than just sections.

CPT® Code Range	Organ System	Corresponds to ICD-10-CM
99211 – 99499	E/M Services	All chapters
00100 – 01999	Anesthesia	All chapters
10021 – 19499	Skin	L, M, R, S-T, Z
20005 – 29999	Musculoskeletal	M, S-T, Z
30000 – 32999	Respiratory	J, P, Q, R, Z
33010 – 37799	Cardiovascular	I, O, P, Q, R, Z
40490 – 49999	GI	K
50010 – 58399	GU	N, O, P, Q
54000 – 55899	Male GU	N, P, Q
56405 – 58999	Female GU	N, O, P, Q
61000 – 64999	Nervous	G, H, M, O, P, Q, R, Z
65091 – 68899	Eyes	H, L, R, Z
69000 – 69979	Ears	H, L, R, Z
70010 – 79999	Radiology	All chapters
80047 – 89398	Path and Lab	All chapters

CPT® Code Range	Organ System	Corresponds to ICD-10-CM
90281 – 90756	Vaccinations/Immunizations	Z
90785 – 90899	Psychiatry	F, Z
90935 – 90999	Dialysis	N
91010 – 91299	GI	K
92002 – 92499	Eyes	H
92502 – 92700	Ears	H
92920 – 93998	Cardiovascular	I
94002 – 95199	Respiratory/Allergy	J
95249 – 95251	Endocrine	E
95782 – 96020	Neurology	G
96360 – 96549	Injection/Admins	All chapters
96567 – 96999	Skin	A-B, C-D, H, L, M, P, Q, R, S-T, Z
97161 – 98962	PT/OT/Wound/Chiro	E, L, M, Q, R, S-T, Z
98960 – 99199	Misc. (may not be paid)	All chapters
99500 – 99607	Home Services/Med Mgmt.	All chapters

Enter Other REALMS

Another tidbit for customizing your CPT® code book is to use "REALMS" on the inside cover and in the modifier appendix. The information is already in your book, but we all know how "test day" can make us forget the simplest things! **Chart C** is just another quick reference: My descriptions are abbreviated compared to what you will find inside the cover.

Chart C: Use REALMS to remember which modifiers are applicable to which sections.

KEY: R – Radiology, E – E/M, A-Anesthesia, L – Lab, M – Medicine, S - Surgery

Modifier	Description	R	E	A	L	M	S
22	Increased procedure						S
23	Unusual anesthesia						S
24	Unrelated E/M service same provider during post-op		E				
25	Significant, separately identifiable E/M same provider, same day of procedure/service		E				

Modifier	Description	R	E	A	L	M	S
26	Professional component	R				M	
32	Mandate service		E				
33	Preventive service		E				
47	Anesthesia by surgeon						S
50	Bilateral procedure	R				M	S
51	Multiple procedures						S
52	Reduced services	R				M	S
53	Discontinued services	R				M	S
54	Surgical care only						S
55	Postop management only						S
56	Preop management only						S
57	Decision for surgery		E				
58	Stage/related procedure by same provider in post-op						S
59	Distinct procedural service	R				M	S
62	Two surgeons						S
63	Procedure on infant less than 4 kg						S

Modifier	Description	R	E	A	L	M	S
66	Surgical team						S
76	Repeat procedure/service by same provider	R			L	M	
77	Repeat procedure/service by another provider	R			L	M	
78	Unplanned return to OR by same provider in post-op						S
79	Unrelated procedure						S
80	Assistant surgeon						S
81	Minimum assistant surgeon						S
82	Assistant surgeon (qualified resident not available)						S
90	Reference (outside) lab				L		
91	Repeat clinical diagnostic lab test				L		
92	Alternative lab platform testing				L		
95	Synchronous telemedicine service via real-time		E			M	
96	Habilitative services		E			M	
97	Rehabilitative services		E			M	
99	Multiple modifiers	R	E	A	L	M	S

HCPCS Level II

Consider HCPCS Level II the catchall of what you don't find in CPT®. HCPCS Level II codes are usually used with the main procedure code set, but also may be used independently. If you don't spend much time in your HCPCS Level II code book, that's all the more reason to become familiar with the layout of each chapter. Use **Chart D** to help you tab your book.

Chart D: Use tabs to help you remember what is included in each section.

Alpha Code	Included
A	Ambulance Supplies Administrative
B	Enteral/Parenteral therapy
C	OPPS
E	DME (have to be reusable)

Alpha Code	Included
G	Procedures/Professional services
H	Alcohol/Drug abuse treatment
J	Drugs (not admin codes)
K	DME (MAC discretion)
L	Orthotics/Prosthetics
M	Medical services
P	Path and lab
Q	Temporary
R	Diagnostic radiology
S	Temporary (non-Medicare)
T	Medicaid
V	Vision and hearing

Customize Your Learning

There is not a one-size-fits-all approach to learning the layout of your code books. Evaluate your learning style and do what makes the most sense to you. HBM

Need Code Books?

For all your 2019 medical code book needs, go to AAPC's online bookstore, where you can buy them individually or in bundled package deals (**www.aapc.com/medical-coding-books/**).

Brenda Edwards, CPC, CDEO, CPB, CPMA, CRC, CPC-I, CEMC, CMRS, has more than 30 years' experience in chart auditing, coding and billing, education, consulting, practice management, and compliance. She has worked closely with practices, providers, and residency programs to ensure documentation is compliant and accurate. Edwards is an avid writer with a humorous and engaging presentation style at AAPC conferences and local chapter meetings. She is also a webinar presenter. Edwards served on the AAPC Chapter Association (AAPCCA) board of directors from 2010-2014 and held office as chair. She continues to advocate for the AAPCCA Hardship Scholarship Program. Edwards is passionate about mentoring, is co-founder of the Northeast Kansas (NEKAAPC) chapter, and has served many officer positions

Wrong Year, Wrong Ad

The wrong advertisement for ZHealth Publishing (www.ZHealthPublishing.com) was inadvertently placed in the November issue of *Healthcare Business Monthly* on page 49. Our apologies for the error.

Advertisement that was supposed to run in November on page 49.

By John Verhovshek, MA, CPC

CMS Revises E/M Policy, PROMISES MORE CHANGES

CMS stirs the pot with a final rule to follow through on E/M changes.

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Earlier this year, the Centers for Medicare & Medicaid Services (CMS) caused a stir by proposing radical changes to the documentation requirements, coding conventions, and payment of new and established outpatient evaluation and management (E/M) services. With the Nov. 1 release of the Medicare Physician Fee Schedule (MPFS) final rule for calendar year 2019, CMS has shown it will follow through with many of its proposed changes — albeit over a three-year period.

Proposed Changes

CMS' 2019 MPFS proposed rule, published in the July 27 *Federal Register*, outlined three primary, proposed changes relative to office/outpatient visit CPT® codes 99201-99215.

Proposal 1: Simplify the history and exam documentation requirements for established patients, "such that, for both of these key components, practitioners would only be required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed." For both new and established patients, "practitioners would no longer be required to re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary. The practitioner could simply indicate in the medical record that they reviewed and verified this information."

Proposal 2: Eliminate the history and exam from consideration when choosing an E/M service level. Medical decision-making (MDM) would stand as the sole determinant of E/M service level (except when counseling or coordination of care dominated the visit, in which case time could be used as the primary component to select an E/M service level).

Proposal 3: Providers would receive a flat fee of $135 for all level 2-5 new patient visits, and a flat fee of $93 for all level 2-5 established patient visits.

The proposed rule contains additional suggested changes to include reduced documentation requirements for home visits, reduced reimbursement for E/M services provided on the same day as a procedure, and the creation of add-on G codes to be reported by primary care physicians and certain specialists to compensate for the inherent complexities of specified E/M visits.

In total, CMS argued that reduced administrative burden associated with less stringent documentation requirements would offset

any potential loss in reimbursement from the rate changes.

Finalized Changes

As outlined in the 2019 MPFS final rule, for 2019 and 2020 CMS will follow existing coding guidelines and payment structures for all E/M services. That means you should continue to use either the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services when assigning E/M service levels. There will be no change in how the history and MDM components will be treated when selecting an E/M service level. And Medicare will continue to pay varying amounts for different E/M service levels (i.e., there will be no "single" E/M payment, as previously proposed).

CMS will follow through with a number of important E/M changes in 2019, per the *CMS Newsroom* fact sheet "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019:"

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- For new and established patients, E/M office/outpatient visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the patient. The practitioner may simply indicate in the medical record that they reviewed and verified this information; and
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

Looking Ahead

The 2019 MPFS final rule lays out further changes to E/M policies that CMS will finalize beginning in 2021. These include:

- A single payment rate for E/M office/outpatient visit levels 2-4 for established and new patients. Level 5 visits will continue to be paid at a higher rate.
- Elimination of the history and exam as required components when selecting a service level for E/M office/outpatient visits, levels 2-5. Physicians who wish to do so could continue to use the current 1995 or 1997 E/M documentation guidelines.
- More flexibility in how E/M office/outpatient levels 2-5 visits are documented. Per CMS, "… when using MDM or current framework to document the visit, we will … apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making."
- If time is the controlling component when selecting an E/M service level, providers will be required to document the medical necessity of the visit and that the billing provider personally spent the required time face-to-face with the patient.
- Implementation of add-on codes for use with level 2-4 E/M office/outpatient visits to describe additional resources inherent to primary care and certain specialized medical care visits.
- Adoption of a new "extended visit" add-on code to use with level 2-4 E/M office/outpatient visits to account for additional resources when practitioners spend extended time with a patient.

Although implementation of these steps is assumed, CMS "intends to engage in further discussions with the public to potentially further refine the policies for CY 2021."

Off the Table

The final rule lays to rest several proposals that CMS says it will not adopt. These include reduced payment when an E/M office/outpatient visit is furnished on the same day as a procedure and separate codes and payment for podiatric E/M visits.

AAPC Will Bring You More

The 2019 MPFS final rule was released as this issue of *Healthcare Business Monthly* was going to press. Keep an eye on future issues, as well as AAPC's Knowledge Center (www.aapc.com/blog/) for more information about the final rule, including further details about new policies regarding new and established patient office/outpatient visit codes 99201-99215. HBM

John Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Hendersonville-Asheville, N.C., local chapter.

Resources

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019 at: **https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf**

CMS Newsroom, Fact Sheet, "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019" at: **www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year**

1995 or 1997 Documentation Guidelines for Evaluation and Management Services:

- **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf**
- **www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf**

By Amy C. Pritchett, BSHA, CPC, CPMA, CPC-I, CEDO, CANPC, CASCC, CEDC, CRC, ICDCT-CM/PCS, CCS

CHANGE IS HERE
Review the 2019 ICD-10-CM Code Changes

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In addition to updated guidelines summarized in November's *Healthcare Business Monthly* ("Change Is Here: Review the 2019 ICD-10-CM Guideline Updates," pages 32-36) the 2019 ICD-10-CM code book gains 279 new codes, revises 143 codes, and deletes 51 codes. To help you prepare for the year ahead, here's a quick, chapter-by-chapter rundown of the notable changes.

Chapters with No Changes

There are no changes in Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), Chapter 3: Diseases of the Blood and Blood-forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89), and Chapter 8 Diseases of the Ear and Mastoid Process (H60-H95). Chapter 10: Diseases of the Respiratory System (J00-J99) has one minor revision to correct formatting.

Chapter 2: Neoplasms (C00-D49)

There are 45 codes added to describe neoplasm sites of the right or left, upper or lower eyelids. As a result, 19 less-specific codes are deleted.

Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E89)

Six codes are added:

E72.81	Disorders of gamma aminobutyric acid metabolism
E72.89	Other specified disorders of amino-acid metabolism
E75.26	Sulfatase deficiency
E78.41	Elevated Lipoprotein (a)
E78.49	Other hyperlipidemia
E88.02	Plasminogen deficiency

Two codes are deleted: E72.8 and E78.4.

Code E67.1 was revised to correct the spelling of "hypercarotenemia" and E72.53 (hyperoxaluria) now specifies "primary."

There are 45 codes added to describe neoplasm sites including right and left, upper and lower eyelids.

Chapter 5: Mental, Behavioral and Neurodevelopment Disorders (F01-F99)

Five codes are added:

F12.23	Cannabis dependence with withdrawal
F12.93	Cannabis use, unspecified with withdrawal
F53.0	Postpartum depression
F53.1	Puerperal psychosis
F68.A	Factitious disorder imposed on another

Code F53 is deleted and F68.10-F68.13 are revised to indicate *factitious disorder imposed on self…* (new text is underlined).

Chapter 6: Diseases of the Nervous System (G00-G99)

Four codes are added in the G51.31-G51.39 range for *right, left, bilateral, and unspecified clonic hemifacial spasm* and four codes added in the G71.00- G71.09 range describe *the types of muscular dystrophy.*

The less-specific codes are deleted: G51.3 and G71.0.

Chapter 7: Diseases of the Eye and Adnexa (H00-H59)

A total of 42 new codes are added to include the addition of upper and lower eyelids.

Chapter 9: Diseases of the Circulatory System (I00-I99)

Four codes are added:

I63.81 Other cerebral infarction due to occlusion or stenosis of small artery

I63.89 Other cerebral infarction

I67.850 Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy

I67.858 Other hereditary cerebrovascular disease

Code I63.8 is deleted, and four cerebral infarction codes are revised: I63.219 and I63.239 change "arteries" to "artery" and the word "due" is added to I63.333 and I63.343.

Chapter 11: Diseases of the Digestive System (K00-K95)

There are 15 new codes:

K35.20 Acute appendicitis with generalized peritonitis, without abscess

K35.21 Acute appendicitis with generalized peritonitis, with abscess

K35.30 Acute appendicitis with localized peritonitis, without perforation or gangrene

K35.31 Acute appendicitis with localized peritonitis and gangrene, without perforation

K35.32 Acute appendicitis with perforation and localized peritonitis, without abscess

K35.33 Acute appendicitis with perforation and localized peritonitis, with abscess

K35.890 Other acute appendicitis without perforation or gangrene

K35.891 Other acute appendicitis without perforation, with gangrene

K61.31 Horseshoe abscess

K61.39 Other ischiorectal abscess

K61.5 Supralevator abscess

K82.A1 Gangrene of gallbladder in cholecystitis

K82.A2 Perforation of gallbladder in cholecystitis

K83.01 Primary sclerosing cholangitis

K83.09 Other cholangitis

Five less-specific codes are deleted as a result of these new codes, which offer improved specificity of acute appendicitis, ischiorectal abscess, and cholangitis.

Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)

There are three revised codes (new text is underlined):

L98.495 Non-pressure chronic ulcer of skin or other sites with muscle involvement without evidence of necrosis

L98.496 Non-pressure chronic ulcer of skin of other sites with bone involvement without evidence of necrosis

L98.498 Non-pressure chronic ulcer of skin of other sites with other specified severity

Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

Four codes are added:

M79.10 Myalgia, unspecified site

M79.11 Myalgia of mastication muscle

M79.12 Myalgia of auxiliary muscles, head and neck

M79.18 Myalgia, other site

Less specific code M79.1 Myalgia is deleted.

Chapter 14: Diseases of the Genitourinary System (N00-N99)

Seventeen codes are added:

N35.016 Post-traumatic urethral stricture, male, overlapping sites

N35.116 Post infective urethral stricture, not elsewhere classified, male, overlapping sites

N35.811 Other urethral stricture, male, meatal

N35.812 Other urethral bulbous stricture, male

N35.813 Other membranous urethral stricture, male

N35.814 Other anterior urethral stricture, male, anterior

Five less-specific codes are deleted as a result of these new codes, which offer improved specificity of acute appendicitis, ischiorectal abscess, and cholangitis.

N35.816 Other urethral stricture, male, overlapping sites

N35.819 Other urethral stricture, male, unspecified site

N35.82 Other urethral stricture, female

N35.911 Unspecified urethral stricture, male, meatal

N35.912 Unspecified bulbous urethral stricture, male

N35.913 Unspecified membranous urethral stricture, male

N35.914 Unspecified anterior urethral stricture, male

N35.916 Unspecified urethral stricture, male, overlapping sites

N35.919 Unspecified urethral stricture, male, unspecified site

N35.92 Unspecified urethral stricture, female

N99.116 Postprocedural urethral stricture, male, overlapping sites

With the addition of these more specific codes, N35.8 and N35.9 are deleted.

Chapter 15: Pregnancy, Childbirth and the Puerperium 000-094)

Codes are added in the ranges O30.131-O30.139 *Triplet pregnancy, trichorionic/triamniotic, (first, second, third and unspecified trimester)* and O30.231-O30.239 *Quadruplet pregnancy (first, second, third and unspecified trimester).*

Other new codes include:

086.00 Infection of obstetric surgical wound, unspecified

086.01 Infection of obstetric surgical wound, superficial incisional site

086.02 Infection of obstetric surgical wound, deep incisional site

086.03 Infection of obstetric surgical wound, organ or space site

086.04 Sepsis following an obstetrical procedure

086.09 Infection of obstetric wound, other surgical site

The less-specific code O86.0 is deleted.

Chapter 16: Certain Conditions Originating in the Perinatal Period (P00-P96)

There are 25 new codes involving newborn complications related to maternal drug use, metabolic disorders in the newborn, and newborns affected by the Zika virus:

P02.70 Newborn affected by fetal inflammatory response syndrome

P02.78 Newborn affected by other conditions from chorioamnionitis

P04.11 Newborn affected by maternal antineoplastic chemotherapy

P04.12 Newborn affected by maternal cytotoxic drugs

P04.13 Newborn affected by maternal use of anticonvulsants

P04.14 Newborn affected by maternal use of opiates

P04.15 Newborn affected by maternal use of antidepressants

P04.16 Newborn affected by maternal use of amphetamines

P04.17 Newborn affected by maternal use of sedative-hypnotics

P04.18 Newborn affected by maternal other maternal medication

P04.19 Newborn affected by maternal use of unspecified medication

P04.40 Newborn affected by maternal use of unspecified drugs of addiction

P04.42 Newborn affected by maternal use of hallucinogens

P04.81 Newborn affected by maternal use of cannabis

P04.89 Newborn affected by other maternal noxious substances

P35.4 Congenital Zika virus disease

P74.21 Hypernatremia of newborn

P74.22 Hyponatremia of newborn

P74.31 Hyperkalemia of newborn

P74.41 Alkalosis of newborn

P74.421 Hyperchloremia of newborn

P74.422 Hypochloremia of newborn

P74.49 Other transitory electrolyte disturbance of newborn

The less-specific codes for these conditions are deleted: P02.7, P04.1, P04.8, P74.2, P74.3, and P74.4.

Chapter 17: Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00-Q99)

Seven codes are added:

Q51.20 Other doubling of uterus, unspecified

Q51.21 Other complete doubling of uterus

Q51.22 Other partial doubling of uterus

Q51.28 Other doubling of uterus, other specified

Q93.51 Angelman syndrome

Q93.59 Other deletions of part of a chromosome

Q93.82 Williams syndrome

Two less-specific codes are deleted: Q51.2 and Q93.5.

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)

There are 10 codes are added:

R82.991 Hypocitraturia

R82.992 Hyperoxaluria

R82.993 Hyperuricosuria

R82.994 Hypercalciuria

R82.998 Other abnormal findings in urine

R93.811 Abnormal radiologic findings on diagnostic imaging right testicle

R93.812 Abnormal radiologic findings on diagnostic imaging of left testicle

R93.813 Abnormal radiologic findings on diagnostic imaging of testicles, bilateral

R93.819 Abnormal radiologic findings on diagnostic imaging of unspecified testicle

R93.89 Abnormal findings on diagnostic imaging of other specified body structures

The two less-specific codes for these conditions are deleted: R82.99 and R93.8.

Five codes in the range of R40.2330-R40.2334 (coma scale) are revised to correct the omission of the word "flexion" in the descriptors.

Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)

A total of 54 codes are added, to include:

- T43.641-T43.644 - Poisoning by ecstasy (accidental, intentional, assault, undetermined) (initial, subsequent, sequela)
- T74.51X-T766.2X - Adult, child forced sexual exploitation/labor exploitation (confirmed) (suspected) (initial, subsequent, sequela)
- T81.40X-T81.43X - Infections following a procedure (initial, subsequent, sequela)
- T81.44X-T81.49X - Sepsis following a procedure (initial, subsequent, sequela)

Three codes representing infection following a procedure (initial, subsequent, sequela) are deleted: T81.4XXA-S.

There are 87 revised codes: Many of the revisions result from the replacement of "medial" with "middle" in the fractures of the phalanx in subcategory codes S62.626A-S62.659S.

Chapter 20: External Causes of Morbidity (V00-Y99)

A single code is added:

Y07.6 Multiple perpetrators of maltreatment and neglect

Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

Seventeen new codes are added:

Z04.81 Encounter for examination and observation of victim following forced sexual exploitation

Z04.82 Encounter for examination and observation of victim following forced labor exploitation

Z04.89 Encounter for examination and observation for other specified reasons

Z13.30 Encounter for screening examination for mental health and behavioral disorders, unspecified

Z13.31 Encounter for screening for depression

Z13.32 Encounter for screening for maternal depression

Z13.39 Encounter for screening for other mental health and behavioral disorders

Z13.40	Encounter for unspecified developmental delay
Z13.41	Encounter for autism screening
Z13.42	Encounter for screening for global developmental delays (milestones)
Z13.49	Encounter for screening for other developmental delays
Z20.821	Contact with and (suspected) exposure to Zika virus
Z28.83	Immunization not carried out due to unavailability of vaccine
Z62.813	Personal history of forced labor or sexual exploitation in childhood
Z83.430	Family history of elevated lipoprotein(a)
Z83.438	Family history of other disorder of lipoprotein metabolism and other lipidemia
Z91.42	Personal history of forced labor or sexual exploitation

Two less-specific codes are deleted: Z04.8 and Z13.4.

Stay up to date on the newest code set changes for 2019 by monitoring the AAPC Knowledge Center at www.aapc.com, the Centers for Medicare & Medicaid Services (CMS), and American Hospital Association for any addendums or errata to the new codes that may follow.

If you haven't purchased an ICD-10-CM code book or updated your encoder subscription, do so now. Not only were these codes changed, but there were changed to guidelines, coding instructions, indexes, and other elements of the code set. **HBM**

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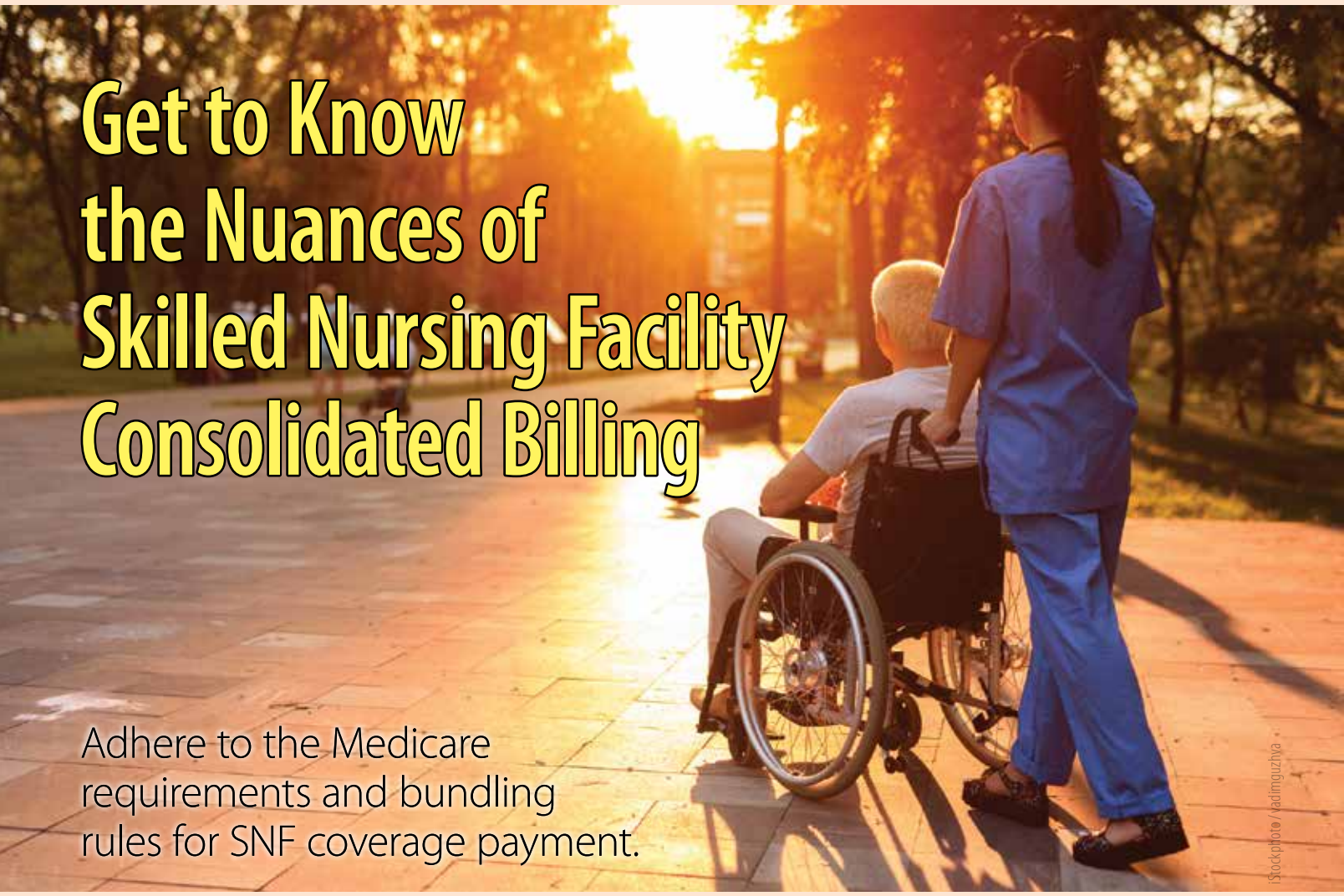
Five codes in the range of R40.2330-R40.2334 (coma scale) are revised to correct the omission of the word "flexion" in the descriptors.

By Stephanie A. Thebarge, CPC, CEMC, CHONC, CPPM

Get to Know the Nuances of Skilled Nursing Facility Consolidated Billing



Adhere to the Medicare requirements and bundling rules for SNF coverage payment.

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If you don't work in a skilled nursing facility (SNF), you may not understand how SNF consolidated billing (CB) affects you. The way you answer the following two questions may help you to see the connection:

- Have you ever had a Medicare patient come to your office from a nursing facility?
- Have you ever had Medicare recoup their payment due to patient residing in a SNF?

If you answered yes to either question, you need to know about SNF consolidated billing.

Recognize Skilled Care

Before delving into Medicare billing rules and jargon, let's consider what a SNF is and how it differs from a nursing home. For example:

- Skilled care is provided by nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, and audiologists; and
- SNF residents are patients admitted to a Medicare-participating SNF.

There are strict requirements for SNF coverage. The patient must:

- Be eligible for Medicare Part A;
- Require daily skilled services;
- Have had at least three consecutive days of inpatient hospital care for a related illness or injury; and
- Be admitted to the SNF within 30 days of hospital discharge.

Nursing homes can have skilled care within their establishment; and patients can be residents of a nursing home, but not require skilled care.

Years ago, SNFs had the option to furnish the services or transport the patient to a physician for care. This "outsourcing" method created several billing and liability issues, including duplicate billing.

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare-covered SNF be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor

Years ago, SNFs had the option to furnish the services or transport the patient to a physician for care. This "outsourcing" method created several billing and liability issues, including duplicate billing.

(MAC). A Part A-covered SNF stay covers a patient's medical services and room and board; a Part B non-covered SNF stay (when Part A benefits are exhausted) does not cover a patient's room and board, but does cover certain medical services, if provided and medically necessary.

Payment for the majority of services to patients in a Medicare-covered Part A SNF stay, including most services provided by entities other than the SNF, are included in a bundled prospective payment through a MAC to the SNF. The SNF must bill these bundled services to the MAC in a consolidated bill. For services subject to CB and provided by entities other than the SNF, the entity looks to the SNF for payment, and cannot (legally) bill Medicare separately for those services.

Know How SNF Patients Affect Your Billing

SNFs bill Part A. You bill Part B. Are your services bundled with theirs?

The answer is: Yes.

Example: Medicare patient Peggy is admitted to the hospital for a hip fracture. She is unable to go home and perform daily functions after her inpatient stay at the hospital, so she needs to be admitted to a SNF for rehabilitation. Peggy is being treated for her breast cancer by her primary oncologist. The SNF transports Peggy to the oncologist for treatment. The oncologist reviews labs and decides to proceed with the recommended treatment.

In this scenario, Peggy needs to be seen by her oncologist, but she is also covered under a Part A SNF stay. If her oncologist were to bill Medicare, any charges that are subject to SNF CB rules would be denied.

Know What to Bill and What Not to Bill

Here's the good news: There is a list of services that are billable through Medicare Part B even for patients covered under a Part A SNF stay. There are four files located on the Annual Part B MAC Update webpage:

- File 1 - Part A Stay - Physician Services
- File 2 - Part A Stay - Professional Components of Services to be Submitted with a 26 Modifier
- File 3 - Part A Stay - Ambulance
- File 4 - Part B Stay Only - Therapy Services

Each file provides a listing of CPT® and HCPCS Level II codes updated annually (make sure to verify the year against the date of service). The services represented by these codes are not subject to SNF CB for Medicare beneficiaries in a SNF Part A-covered stay and should instead be submitted to the Part B MAC for payment consideration. If a code is not on the list, it's not billable.

In our example, best practice would be to coordinate the care with the SNF prior to the patient coming into the office. Usually, the SNF arranges the appointment with the nurse; if the nurse communicates this to your billing department, you may be able to save time and money.

If your front desk staff notifies the billing department when a patient is transported from a SNF, then someone could call to verify SNF coverage. If you are aware the patient is in a Part A-covered SNF, then alert the SNF about the charges the patient (like Peggy) will incur. The SNF appreciates the right to refuse to have the oncologist treat the patient, and instead may wish that labs and smaller injectables be performed at their facility. If the SNF verbally agrees to the expense, you may bill the charges to the SNF.

When billing a SNF, use a form letter (see the link to a sample form letter in the Resources section) stating that your practice has been advised that "Peggy" was a patient at the facility at the time services were rendered by your practice, and that you wish to bill the facility for the services on the enclosed claim(s), in accordance with the SNF CB Prospective Payment System. Adjust all the codes to the Medicare allowable rate, so the facility is aware of the amount it needs to render to your practice.

Bill the Part B-covered services as usual and bill the SNF Part A services on a CMS-1450 (UB-04).

To provide further understanding, let's recap Peggy's scenario:

1. Peggy checks in with Mary at the front desk. Peggy was transported by the SNF and has paperwork from them, indicating she is in a Medicare Part A SNF stay. Mary alerts billing of Peggy's arrival and skilled care status.

2. Peggy is due for labs, chemotherapy, and hydration today. Billing calls the SNF to address the plan of care of the patient and to notify the administration of services provided under the CB rules.
3. The SNF agrees Peggy must have her chemotherapy and accepts the terms of the treatment and payment for services included in CB.

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4. You bill the SNF for the services included under CB rules and receive payment in a timely fashion.

Consider Every Option

What if you didn't know the patient was in a SNF? Perhaps Peggy was transported by her daughter and no one at the SNF was alerted.

Unfortunately, this is a common scenario, and one of two things could happen:

1. Medicare could deny the charges. On your remittance advice, you will see Remittance Advice Remark Code (RARC) CO-109: *Claim not covered by this payer/contractor.* You must send the claim to the correct payer/contractor with Claim Adjustment Reason Code (CARC) N538: *The facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.* You will have to bill the SNF for the services rendered, and hope they pay without a verbal agreement.
2. Medicare could recoup the money from the physician's office once they have received a bill from the SNF and it's posted to the Common Working File (CWF). This would

trigger a review by your account receivables (A/R) staff to find out why Medicare is recouping payments and possibly bill those services included in CB to the SNF.

Remember when billing Part B services provided to a Part A SNF patient to:

- Verify whether the Medicare beneficiary's residence is a home, nursing home, or an SNF.
- Work with the staff of the SNF to verify patient information (Part A stay?) and establish an agreement that outlines payment.
- Make billing staff aware of the excluded and included services for the SNF CB.
- Watch your remittance advice for denials or recoupments.

Hopefully, you can avoid delays in payment, costly recoupments, and unpaid claims related to CB. The No. 1 thing you need to remember is to communicate — within your practice, with your patient, and most importantly with the SNF. HBM

Stephanie Thebarge, CPC, CEMC, CHONC, CPPM, is the compliance manager for New England Cancer Specialists in Southern Maine. She has more than 18 years of experience in healthcare, working in oncology coding, evaluation and management auditing, and revenue cycle management. She manages the Accounts Receivable team at NECS. Thebarge is the owner of Seacoast Health Compliance Consultation, LLC, auditing and educating physician practices. She serves on AAPC's National Advisory Board, representing Northeast Region 1 and 2018 education officer for Portland, Maine, local chapter.

Resources

Consolidated Billing Claims Processing Instructions: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/flowchart.pdf

Medicare Learning Network, SNF Billing Reference booklet: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-LN/MLNProducts/MLN-Publications-Items/CMS1244978.html?DLPage=1&DLEntries=10&DLFilter=snf&DLSort=0&DLSortDir=descending

SNF Consolidated Billing at CMS.gov: www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html

Annual Part B MAC Update: www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/2018-Part-B-MAC-Update.html

Refer to the CMS web page "Best Practices Guidelines," for sample forms: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/BestPractices.html

MLN Booklet, SNF Billing Reference: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SNFSpellIllnesschrt.pdf

Chapter News

By Marti Johnson

"MY AAPC" APP MAKES IT EASY TO GET CEUS AT CHAPTER MEETINGS

Membership QR Code

Your chapter officers hope you'll be joining them at the next chapter meeting and are excited to see you for several reasons. They are beginning a new process of tracking attendance at their meetings. Chapter officers now have the capability to use one of the latest features in the **My AAPC** app to make the check-in process more efficient. They can scan your membership card, which is found in the form of a QR code (barcode) in the app on your mobile device, to mark your attendance for the meeting. This will automatically insert applicable continuing education units (CEUs) into your CEU Tracker, which is now also available in the app.

To use it at your next meeting:

1. Download and install My AAPC from the App store on your Apple or Android smartphone or tablet prior to the chapter meeting (if it's already installed, you will need to update it).
2. Log into the app with the same username and password you use to log into your member account on www.aapc.com.
3. Check your email address in the My Account section on your device to make sure it's up to date. If it is invalid or incomplete, the feature won't work.
4. Click on your Member ID from the home page (or go to Membership in the menu) and you should see your membership QR Code to the right of your membership card. Just slide or click on it to view it.
5. Show your Membership QR Code at the meeting to have your attendance scanned straight to your CEU Tracker.

Getting CEUs couldn't be easier!

We hope you'll come out to your meeting and experience this new procedure. When you do, if for some reason your chapter officers don't scan your mobile device, let them know they can contact AAPC for help in understanding the process.

Marti Johnson is director of local chapters at AAPC.

By Morgan Jones, CPC, COBGC, CPRC

To Fee or Not to Fee OB?

Know when and how to report fee-for-service obstetric visits.

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Many obstetric offices charge for obstetric (OB) visits using a global care code. In some cases, however, you may need to report OB visits individually as fee-for-service visits. Let's review the steps to ensure your providers are hitting all documentation requirements for these services.

STEP 1: Recognize when Fee-for-Service Is Appropriate

As part of the "typical" global obstetrical package, the provider will see the patient:

- Once a month until the patient reaches 28 weeks; then once every two weeks until the patient reaches 36 weeks; and then weekly until the patient delivers.

Usually, these services are billed using a single global CPT® code at the end of the pregnancy. The appropriate code depends on the patient's delivery type. For example:

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery

But what happens if the patient moves out of state and needs to resume prenatal care via a different provider? Or the patient's employer changes insurance carriers during the pregnancy? These instances require fee-for-service billing.

STEP 2: Be Sure Documentation Supports the Services

Documentation requirements for fee-for-service routine OB charges are no different than the requirements for any other fee-for-service charge. Evaluation and management (E/M) guidelines indicate an addressed abnormality or complaint establishes a problem-oriented E/M service reported with a CPT® code from range 99201-99215.

A **chief compliant (CC)** is required for all levels. The degree of information gathered for the remaining elements related to a patient's history depends on the clinician's judgement and the nature of the presenting problem. The CC for this type of patient can be as simple as routine obstetrics (ROB) or as complex as:

A 25-year-old Gravida I Para 0-0-0-0 female complains of nausea in the morning for the past 2 weeks. She has been able to tolerate the nausea because it usually subsides by 10 a.m. She is very active with a full-time legal aid position, but has noted more fatigue at the end of the day. She has not had any vaginal bleeding. She has not felt fetal movement as of this time.

The **history of present illness (HPI)** is a sequential description of the development of the patient's present illness from the first sign/symptom or from the previous encounter to the present. This is also a required

element when reporting fee-for-service OB visits. The HPI elements are:

- Location (e.g., labia)
- Quality (e.g., aching, burning, radiating pain)
- Severity (e.g., 10 on a scale of 1 to 10)
- Duration (e.g., started 3 days ago)
- Timing (e.g., constant or comes and goes)
- Context (e.g., coitus)
- Modifying factors (e.g., better when heat is applied)
- Associated signs and symptoms (e.g., numbness in toes)

There are two different types of HPI: brief and extended. The HPI for this type of patient can be as simple as "doing well," or it can go on to list the problems the patient may have had in the interim.

The **review of systems (ROS)** is a list of body systems attained by asking the patient different questions. This is another required E/M element for any problem-focused visit. There are three different types of ROS: problem pertinent, extended, and complete. For an OB patient, the provider may document something as simple as "GYN ROS negative;" or they may document a more extended or complete ROS, depending on the severity of what the patient's complaint. In all cases, the extent of the ROS should be supported by medical necessity.

A **physical exam** (required) may involve several organ systems or a single organ system. The type and degree of the completed exam is based on the clinician's judgement, the patient's history, and the nature of the presenting problem. This information can be pulled from the patient's prenatal summary, kept and reviewed at each patient visit, which includes height, weight, fundal height, fetal movement, fetal heart rate, and urinalysis results obtained at the beginning of the visit.

Medical decision-making (MDM) refers to the complexity of establishing a diagnosis and selecting management options. This is determined by the number of possible diagnoses and management options, as well as the amount and complexity of medical records, diagnostic tests, and other information that must be acquired, reviewed, and evaluated. This is where the provider documents prenatal labs the patient needs completed, as well as radiology testing, medication, etc. The provider also reviews the testing results with the patient and makes recommendations and directions that the patient needs to follow until her next visit.

STEP 3: Don't Overdo It

Although including all the required elements (detailed above) may seem like a lot of information, these can be simple notes that don't require a lot of extra information.

Here's a great example of a problem-oriented OB visit:

S- 25-year-old Gravida I Para 0-0-0-0 female complains of nausea in the morning for the past 2 weeks. She has been able to tolerate the nausea because it usually subsides by 10 a.m. She is very active with a full-time legal aid position, but has noted more fatigue at the end of the day. She has not had any vaginal bleeding. She has not felt fetal movement as of this time.

O- B.P. 120/80, P 72, Weight 130

Uterine Size about 2 cm below the umbilicus FHT 120

Urinalysis – negative

Here's an example of a patient at 12-weeks gestation with nausea:

P- 1. Continue taking prenatal vitamins.

2. Supportive care for nausea – to notify me if increased problems.

3. Offer childbirth classes in the future.

4. Appointment in 4 weeks with UA.

Finally, here's a great example of a routine OB visit:

CC: ROB - doing well

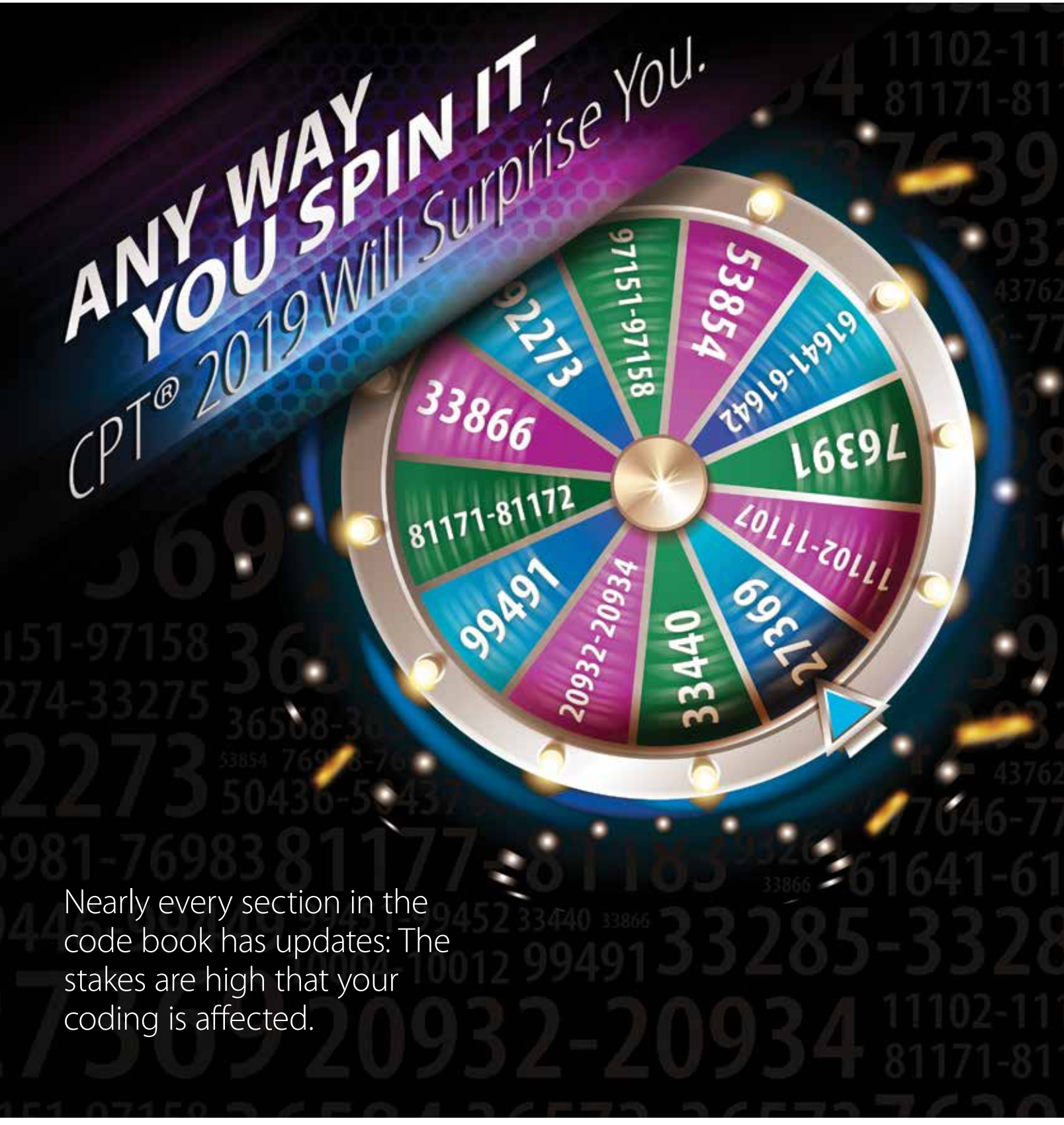
GYN ROS - neg

Reviewed prenatal lab results, discussed nutrition, fetal screening options. RTC in 4 weeks.

By having your provider add a bit more documentation in the front end, you can ensure they are being reimbursed appropriately for their time spent on the back end. HBM

Morgan Jones CPC, COBGC, CPRC, is senior clinic coder for a large healthcare system in the Midwest and a member of the St. Louis West, Mo., local chapter.

By John Verhovshek, MA, CPC, and Raemarie Jimenez, CPC, CPB, CPMA, CPPM, CPC-I, CDEO, CANPC, CRHC



Nearly every section in the code book has updates: The stakes are high that your coding is affected.

CPT® 2019 includes 212 new Category I and III codes, 50 revised code descriptors, and 71 deleted codes — plus revised introductory guidelines, and new and revised parenthetical references. Nearly every section of the code book (except anesthesia and Category II codes) receives significant updates. You'll find major changes in the reporting of remote patient monitoring, fine needle aspiration, skin biopsy, peripherally inserted central venous catheters, molecular pathology, medicine services, and emerging technologies. Here's a review of what CPT® 2019 holds.

Guideline Change for Modifier 63

New guidelines allow you to append modifier 63 *Procedure performed on infants less than 4 kgs* with Medicine/Cardiovascular (90000-series) codes to describe increased complexity of procedures performed on patients of less than 4 kg (approx. 8.8 lbs.). Per *CPT® Changes 2003: An Insider's Guide*.

> In this population of patients, there is a significant increase in work intensity, specifically related to temperature control, obtaining IV access (which may require upwards of 45 minutes) and the operation itself, which is technically more difficult, especially with regard to maintenance of homeostasis.

CPT® disallows modifier 63 with many codes that describe procedures involving congenital anomalies, and those valued to reflect heightened complexity associated with prematurity. You can find a complete list of modifier 63 exempt codes in Appendix F of CPT®.

Evaluation and Management (E/M) Services

CPT® 2019 introduces two new codes to report remote physiologic monitoring services (e.g., weight, blood pressure, pulse oximetry) during a 30-day period: one for device setup and patient education (99453), and a second for supply of the device with daily recording or programmed alert transmissions (99454).

Also added is 99457 to report remote physiologic monitoring treatment management services. Per CPT®, these services "are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan." The code describes "time spent managing care when patients or the practice do not meet the requirements to report more specific services."

A new, time-based chronic care management code (99491) describes the work of a qualified provider to establish, implement, revise, or monitor the care plan for a patient with two or more chronic continuous or episodic health conditions that are expected to last at least 12 months (or until the death of the patient) and put the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Integumentary System

CPT® 2019 will include a single code to report fine needle aspiration (FNA) of an initial lesion without imaging guidance (10021, which has been revised) and four new codes (10004-10007) to report FNA of an initial lesion using specified imaging modalities including ultrasound, fluoroscopy, computed tomography (CT), and magnetic resonance imaging (MRI). Add-on codes (10008-10012) will report FNA for each additional lesion targeted beyond the first, depending on whether (and what type of) imaging guidance is used. You can "mix and match" the primary and add-on codes in any combination necessary to report medically-necessary services, as provided. You may not separately report imaging with any of the new FNA codes.

Six new codes are added to describe biopsy by various techniques:

- 11102, +11103 describe tangential biopsy. CPT® 11102 is for a biopsy of a single lesion and add-on code 11103 is for each additional lesion biopsied, beyond the first. A tangential biopsy is performed with a sharp blade to remove a sample of epidermal tissue (which may include some underlying dermis).
- 11104, +11105 describe punch biopsy. Punch biopsy requires a punch tool to remove a full-thickness cylindrical sample of skin and includes simple closure of the defect. CPT® 11104 describes biopsy of a single lesion, and add-on code 11105 describes each additional lesion biopsied.
- 11106, +11107 describe incisional biopsy. Incisional biopsy is performed using a sharp blade to remove a full-thickness sample of tissue via a vertical incision or wedge, penetrating deep to the dermis, into the subcutaneous space. CPT® 11106 describes biopsy of an initial lesion by this method, and add-on code 11107 describes additional lesions targeted by incisional biopsy.

You may combine the new codes to report biopsy by various methods.

Musculoskeletal System

New add-on codes will allow clinicians to report osteoarticular (20932), hemicortical (partial) intercalary (20933), and complete intercalary (20934) allografts in addition to tumor removal procedures.

Code 27369 is added to describe contrast knee arthrography or contrast enhanced CT/MRI knee arthrography.

Cardiovascular System

New codes are added to describe implantation (33274) and removal (33275) of permanent leadless pacemakers, as well as the implantation (33285) and removal (33286) of subcutaneous cardiac rhythm monitor, and implantation of a wireless pulmonary artery pressure sensor (33289).

Code 33440 is added to describe the Ross-Konno procedure (a method of aortic valve replacement).

New add-on code 33866 reports aortic hemiarch graft when performed in addition to an ascending aortic graft (33860, 33863, or 33864), when ascending aortic disease involves the aortic arch.

Codes for peripherally inserted central venous catheter (PICC) lines will experience a refresh for 2019. Existing codes 36568 (younger than age 5) and 36569 (age 5 and older) are revised to report PICC placement *without* subcutaneous port or pump, and *without* imaging guidance. Two new codes —one for a patient younger than age 5 (36572) and the second for age 5 and older (36573) — are added to describe PICC line procedures that bundle imaging guidance, image documentation, and all associated radiological supervision and interpretation. The codes include documentation of evaluation of the potential puncture sites, patency of the entry vein, real-time ultrasound visualization of needle entry into the vein, and confirmation of catheter tip location. If confirmation of the catheter tip location is not performed, CPT® tells us to report a reduced service.

Hemic and Lymphatic System

Code 38531 is added to report open biopsy or excision of inguinofemoral lymph node(s), which are located near the groin.

Digestive System

Code 43760 is deleted and replaced by two new codes that define simple versus complex replacement of a percutaneous gastrostomy tube: 43762 for percutaneous replacement of gastrostomy tube

without imaging or endoscopy and 43763 for percutaneous replacement of gastrostomy tube with removal when performed without imaging or endoscopy.

Urinary System

Code 50395 is deleted and replaced by two new codes: 50436 describes enlargement of an existing percutaneous tract to the renal collecting system to allow the use of instruments used during an endourologic procedure; 50437 reports the same service with the addition of new access into the renal collecting system during the same session, if there is no pre-existing tract.

New code 53854 describes the use of radiofrequency energy to transform sterile water into vapor (steam). The resulting thermal energy is used to destroy obstructive prostate tissue cells.

Nervous System

Codes +61641 and +61642, which describe dilatation of intracranial vasospasm, have revised descriptors, but the application of these codes is not affected.

Several codes within the nervous system are deleted due to low utilization. In the rare case you need to report a deleted service, revert to an unlisted procedure code.

Radiology

Added codes 76978-76979 report ultrasound procedures that use dynamic microbubble-sonographic contrast with targeted ultrasound to evaluation lesions. Report 76978 for the initial lesion targeted and +76979 (with 76978) to report additional lesion(s) targeted, beyond the first.

Three new codes report ultrasound elastography (USE), which works on the principle that abnormal tissue (e.g., a neoplasm) is "stiffer" than normal tissue, and may be identified by ultrasound elastography:

- 76981, parenchyma (i.e., the functional parts of a body organ)
- 76982, first target lesion
- +76983, for each additional target lesion (reported a maximum of two units per session)

Existing breast MRI codes 77058 and 77059 are deleted. In their place, CPT® 2019 introduces four new codes for breast MRI:

- 77046: Unilateral (MRI imaging of one breast) without contrast
- 77048: Unilateral (MRI imaging of one breast) with contrast
- 77047: Bilateral (MRI imaging of both breasts) without contrast
- 77049: Bilateral (MRI imaging of both breasts) with contrast

Pathology and Laboratory

Due to frequent use, many services previously classified within "Tier 2" molecular pathology codes are now described using standalone "Tier 1" codes (examples include 81171-81172 and 81173-81183).

BRCA1 and BRCA2 testing codes (e.g., hereditary breast cancer) are revised due to changes in clinical practice and to standardize molecular pathology code structure.

Medicine

A new vaccine product for influenza virus gains a code, 90689.

Code 92275 is deleted and replaced by three new codes for electroretinography (ERG). Per CPT®, ERG:

> is used to evaluate function of the retina and optic nerve of the eye, including photoreceptors and ganglion cells. A number of techniques are used which target different areas of the eye, including full field (flash and flicker) (92273) for a global response of photoreceptors of the retina, multifocal (92274) for photoreceptors in multiple separate locations in the retina including the macula, and pattern (0509T) for retinal ganglion cells.

New code 95836 describes recording of electrocorticogram (ECoG) from electrodes chronically implanted on or in the brain, and includes unattended recording with storage for later review and interpretation during a 30-day period.

A group of new codes (95976-95984) describe services related to implanted neurostimulator pulse generator/transmitter.

A new subsection for Adaptive Behavior Services is added, with the conversion of Category III codes 0359T, 0360T, 0361T,

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If a Category III code is available, you must use it in place of a Category I unlisted procedure code.

0363T, 0364T-0372T, and 3747T to time-based Category I codes. These services include:

- Behavior identification assessment (97151 and 97152);
- Adaptive behavior treatment by protocol (97153 and 97154);
- Adaptive behavior treatment with protocol modification (97155);
- Family adaptive behavior treatment guidance (97156 and 97157); and
- Group adaptive behavior treatment with protocol modification (97158).

Two new, time-based codes describe developmental test administration (96112, first hour and +96113, each additional 30 minutes). These services must include an interpretation and report when performed by a qualified provider.

Codes 96130, +96131, 96136, +96137, 96138, +96139, 96146 are added to report time-based, psychological testing evaluation and administration and scoring services.

Category III Codes

Category III codes report emerging technologies and allow for data tracking. If a Category III code is available, you must use it in place of a Category I unlisted procedure code.

New Category III codes 0512T and +0513T report extracorporeal shock wave therapy (ESWT), a non-surgical treatment that involves the delivery of shock waves to musculoskeletal areas to reduce pain and promote healing of the affected soft tissue (existing codes 0101T and 28890 are used to report ESWT to the musculoskeletal system and plantar fascia, respectively).

Revised code 0335T describes extra-osseous (lateral aspect) implantation of a subtalar implant to stabilize a talotarsal displacement (partial dislocation of the ankle bone on the heel bone). Two new codes describe removal (0510T) and removal and reinsertion (0511T) of sinus tarsi implant.

Codes 0515T-0523T are added to report services related to wireless cardiac stimulator system (e.g., insertion of various components, device programming, etc.), which provides biventricular pacing of the heart using a previously implanted pacemaker or defibrillator and a wireless electrode implanted on the endocardium of the left ventricle.

Similarly, new codes 0525T-0532T describe services related to intracardiac ischemia monitoring system, an implantable electrogram device that records cardiac data and detects ischemic events by way of an intracardiac lead in the right ventricular apex. The system provides a warning if it detects an impending acute ischemic event to help reduce the time from ischemic event onset to the onset of care.

Parkinson's KinetiGraph™ (PKG™) gains several codes, 0533T-0536T, for patient setup and training, data analysis, etc. The PKG is a passive, wearable device that continuously measures and tracks the movements of patients with Parkinson's disease. The resulting data is used to manage patient care and treat symptoms such as bradykinesia, dyskinesia, and tremor.

Two codes now report magnetocardiography (MCG), a non-invasive technique to measure and map magnetic fields produced by electrical activity in the heart. MCG is more sensitive to weak cardiac signals than is ECG, which is beneficial when diagnosing ischemic heart disease (IHD).

Code 0541T describes the technical portion of an MCG study (e.g., performance of the test using equipment as specified in the code descriptor), while 0542T describes the related interpretation and report (i.e., the professional portion of the service).

There's More to Learn!

This is only a summary of changes to CPT® 2019. For a complete rundown of the new, revised, and deleted codes and guidelines, sign up for AAPC's comprehensive 2019 CPT® Coding Updates Virtual Workshop, which airs "live" on Dec. 6 and is available on demand starting Dec. 7. Go to: www.aapc.com/workshops/2019-cpt-coding-updates.aspx.

And if you haven't already, be sure to get your 2019 CPT® code book, renew AAPC Coder, or view this year's 2019 CPT Changes webinar at www.aapc.com/medical-coding-books.

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By Michelle A. Dick, BS

Get the Most Out of HEALTHCON 2019

You'll feel like a winner after three days with AAPC in Las Vegas.

If you're interested in, or work on, the business of healthcare, the place to be on April 28 through May 1, 2019, is Caesars Palace in Las Vegas, Nevada. That's where thousands of medical coders, billers, compliance officers, practice managers, auditors, and clinicians will gather from all around the world to hone their skills in outpatient and inpatient revenue cycle management. AAPC brings exhibitors and healthcare business professionals together to share their expertise and network.

Here's what you can look forward to at HEALTHCON 2019.

Great Location: The Best Food and Entertainment

It's easy to get around at HEALTHCON with Caesars Palace ideally located right on the Las Vegas Strip, which gives you central walking access to some of the best entertainment and food in the city. Past AAPC National Advisory Board President **Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC,** said, "I think it's great to have access to so many shows all at one location. And if you like to people watch, it's a great location for that."

HEALTHCON offers a delicious variety of food during educational breaks, with healthy options at every meal. When it comes to finding excellent food outside of the conference, Vegas delivers big time. "There are so many great places to eat. Each time I go to Vegas, there are more new restaurants," Kipreos said. Some restaurant favorites are Bobby Flay's Mesa Grill, which is in Ceasars Palace, Hexx in the Paris Hotel and Casino, and Giada's restaurant at The Cromwell.

Unprecedented Education

Nowhere else can you earn 18 continuing education units (CEUs) in one shot. HEALTHCON offers over 90 educational sessions with a wide variety of topics to choose from. There are General Sessions and Breakout Sessions that cater education to your individual needs:

General Sessions

The first General Session will be the "Conference Welcome" presented by AAPC's CEO **Bevan Erickson**, where he delivers his State of AAPC address.

This year's keynote speaker is former Acting Assistant Secretary for Health at the U.S. Department of Health and Human Services **Karen B. DeSalvo, MD, MPH, MSc**. She will share her unique perspective and expertise on healthcare.

A General Session favorite at HEALTHCON will be featured again this year: "Legal Trends and Issues." This discussion, led by AAPC's Legal Advisory Committee, offers insight, and answers your pressing legal questions regarding healthcare organizations facing increased financial scrutiny and regulation.

Breakout Sessions

A hot topic at conference will undoubtedly be the finalized evaluation and management (E/M) services coding changes, which have caused quite a stir among the healthcare community. HEALTHCON 2019 will offer the latest information on the latest regulations. Presentations include:

- "The Future of E/M Coding" – **Suzan Berman Hauptman, CPC, CEDC, CEMC**
- "Advanced E/M - Dissection of a Clinical Note" – **Lewanda Dawn Teehee, CPC, CPC-I, CEMC**
- "The Complexities of Inpatient E/M Services" – **Shannon O'Tyson DeConda, CPC, CPMA, CPC-I, CEMC**

Risk adjustment is another hot topic among the medical coding community. HEALTHCON 2019 offers the breakout educational session "Tackling Risk Adjustment in the Emergency Department." This is presenter **Rik Salomon's, CPC, CRC, CEDC**, first time speaking at HEALTHCON. "I am beyond excited!" he said. "Having an opportunity to share my passion for coding and offer information to others is rare." In his presentation, he will discuss HCC coding in the emergency department arena (pro-fee versus facility). "It's a timely topic, which deserves attention," Salomon said. This is an area of the coding world where coding professionals can directly help patients, he said. "It's a win-win!" Salomon said.

Other topics include HEDIS, Medically Unlikely Edits, clinical documentation improvement programs, becoming a subject matter expert, infusion and injection services, gender identity and electronic health records and insurance barriers, opioid crisis, mental health, oncology, non-physician practitioner services, endovascular aneurysm repair, radiology, forensic auditing, telemedicine, MOHS surgery, inpatient coding, fraud, wound care, hypertension, critical care, colon and rectal surgery, MACRA, hierarchical condition categories (HCCs), and more!

There will also be extra events offered that you may be interested in attending, such as "CPC® Exam Review Course," "MGMA Lean Six Sigma White Belt Program," and "Teach the Teacher," as well as AAPC exams, leadership training, and an Anatomy Expo.

Networking and AAPC Members Supporting Members

HEALTHCON is a great place to meet new friends and reunite with old ones from across the country who do the same thing you do every day. There is a Networking Expo where you can enjoy coffee while mingling with AAPC employees, National Advisory Board members, subject matter experts, and other like-minded colleagues.

If this will be your first time, "HEALTHCON Rookies - Learn the Ropes" is for you. It teaches you how to get the most out of your HEALTHCON experience.

This year's charity walk is "Walk the Block," where AAPC promotes better health, education, and wellness. It is a quick walk between sessions to give you a chance to network, meet AAPC leadership, and donate to the AAPC Chapter Association's Hardship Scholarship Fund, which helps AAPC members affected by a natural disaster or financial crisis maintain their membership and credentials.

Wares to Improve Your Productivity

Top-notch vendors are there to offer career options, resources, tools, and products to make your coding life easier. You'll see familiar companies represented, such as the American Medical Association (AMA), Optum 360, The Coding Network, Healthicity, National Healthcareer Association, ReadyMed, and Find-A-Code. HEALTHCON 2019 dedicates time each day in the schedule for attendees to browse products and services at the vending booths.

Fond Memories

Salomon went last year for the first time and he was hooked. "This will be my second consecutive HEALTHCON," he said. "It's going to be a fantastic time!"

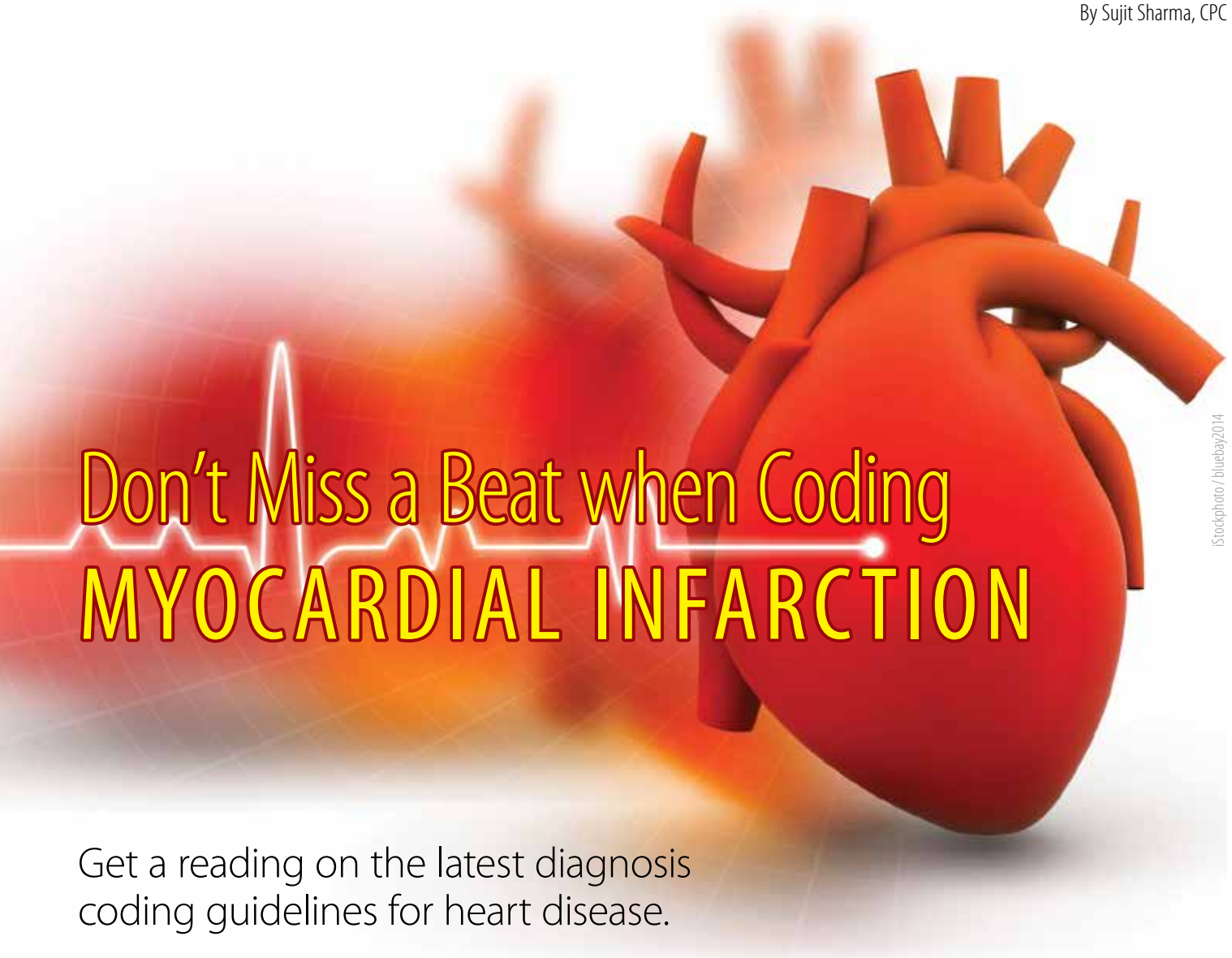
Looking back on last year, Salomon said, "My most memorable experiences involve meeting and networking with fellow coders and auditors. Having wonderful conversations, and attending seminars geared towards those topics I enjoy the most, always makes it worth the trip."

"The wealth of information is immeasurable!" he said.

For more information and to register, go to www.healthcon.com.

Michelle A. Dick, BS, is executive editor at AAPC and a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

By Sujit Sharma, CPC



iStockphoto/blueday2014

Don't Miss a Beat when Coding MYOCARDIAL INFARCTION

Get a reading on the latest diagnosis coding guidelines for heart disease.

Even after the addition of coding guidelines for acute myocardial infarction (MI) in 2017, many coders remain confused between the different types of MI and the relevant code categories. You may wonder, for example, what differentiates acute MI from subsequent MI. Proper diagnosis coding of MI requires you to know what it is and what causes it. This review will help you comprehend and remember the details of MI coding guidelines.

What Is Myocardial Infarction?

Myocardium means muscle of the heart. *Infarction* means death of a tissue or necrosis. *Acute* MI means death of the tissues of the heart muscle.

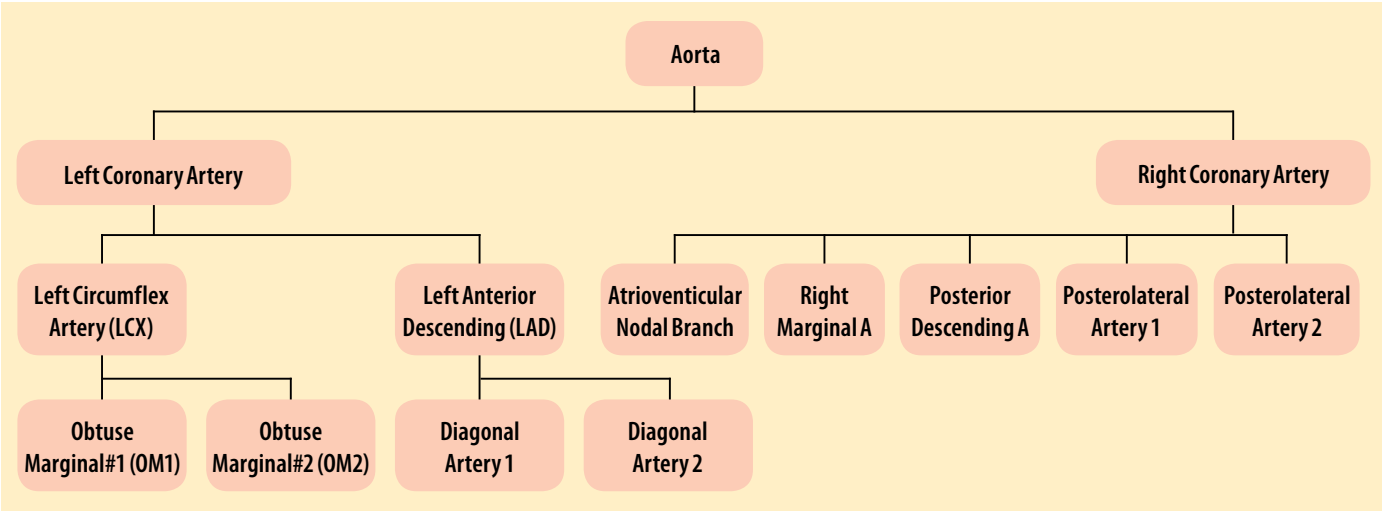
The heart pumps blood through the body in a cyclic manner by powerful contraction and relaxation of the heart muscle. The heart muscles require oxygen, glucose, and other nutrients to survive and to work. These elements are supplied through the blood that is pumped through the body by the heart muscle (myocardium). The blood vessels supplying the myocardium are known as coronary vessels. Obstruction in the flow of coronary blood vessels may cause a cut in the blood supply to the heart, which may lead to an MI, also known as a heart attack.

The coronary arteries supply the oxygenated blood to the myocardium and the cardiac veins drain the deoxygenated blood. **Figure A** is a flow chart that illustrates the way major coronary arteries originate from the aorta and then branch off.

The major cause of MI is atherosclerosis — plaque formed in the coronary artery, reducing the lumen of the artery and obstructing blood flow. Plaques can become unstable, rupture, and promote the formation of a blood clot in an artery; this can occur in minutes. Blockage of an artery can lead to tissue death of tissue being supplied by that artery.

There are other causes, as well, which may reduce the blood supply to the myocardium such as spasm of coronary artery, some infections, high fever, and complication of certain procedures (e.g., coronary artery bypass grafting (CABG)).

FIGURE A: CORONARY CIRCULATION



The major risk factors for MI are smoking, hypertension, diabetes, low high-density lipoprotein (HDL), high low-density lipoproteins (LDL) and high triglycerides, and inadequate physical activity.

Types of MI

MI classification from the Third Universal Definition of Myocardial Infarction is:

1. Type 1 - Spontaneous MI is related to plaque erosion and/or rupture, fissuring, or dissection.
2. Type 2 - MI due to ischemia results from increased oxygen demand or decreased supply (e.g., coronary artery spasm, coronary embolism, anemia, arrhythmias, high or low blood pressure).
3. Type 3 - MI due sudden cardiac death is when no biomarkers are found in the blood.
4. Type 4:
   - Type 4a - MI related to percutaneous coronary intervention (PCI).
   - Type 4b - MI related to stent thrombosis.
   - Type 4c - MI related to restenosis.
5. Type 5 - MI related to CABG

Diagnosing MI

The most common symptom of MI is chest pain, which may radiate to the left arm, neck, lower jaw, and back. Other symptoms include shortness of breath, palpitations, lightheadedness, fainting, nausea, and vomiting.

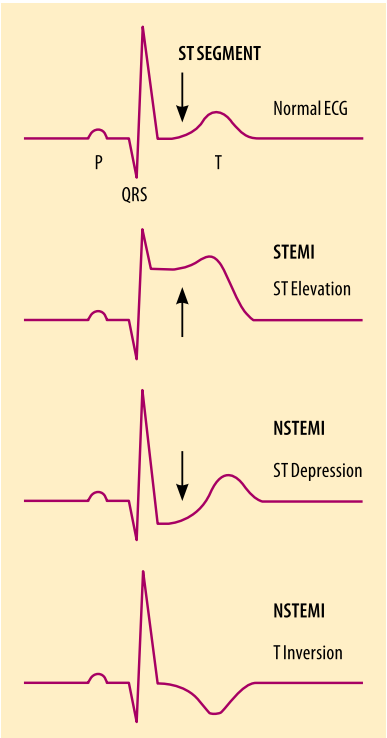
Along with the clinical signs and symptoms, diagnostic tests used to detect MI include:

- Electrocardiogram (EKG or ECG) - Changes in electrocardiography, as interpreted by a physician.
- Cardiac biomarkers - The injury caused to the heart muscle releases certain substances (biomarkers) into the blood, which may help to diagnose an episode of acute MI. There are many biomarkers released but troponins are preferred. Troponin levels rise within two to three hours of injury to heart muscles. Other biomarkers are creatine phosphokinase (CPK) and myoglobin.

MI can also be classified according to the EKG pattern. As shown in **Figure B:**

1. ST segment elevation myocardial infarction (STEMI) – Is where the ST segment of the EKG is elevated in the rhythm pattern. There

FIGURE B: EKG READINGS FOR STEMI AND NSTEMI



If a type 1 NSTEMI evolves to a STEMI, assign the STEMI code. If a type 1 STEMI converts to a NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

is 100 percent blockage of the coronary artery and immediate catheterization treatment is required.

2. Non-ST segment elevation myocardial Infarction (NSTEMI) – Is where the ST segment of the EKG is not elevated. The blockage in coronary artery is severe but not 100 percent. This can be treated by clot/blockage dissolving medicines, but catheterization and stenting may also be required.

Coding Acute MI

The guidelines for coding of acute MI are found in the ICD-10-CM Guidelines for Coding and Reporting, Chapter 9: Diseases of Circulatory System (I00-I99). The important points, as mentioned in the 2018 ICD-10-CM code book, are:

1. **Type 1 STEMI and NSTEMI:**
   - Subcategories I21.0-I21.2 and code I21.3 *ST elevation (STEMI) myocardial infarction of unspecified site* are used for STEMI.
   - Code I21.4 *Non-ST elevation (NSTEMI) myocardial infarction* is used for NSTEMI and non-transmural MIs.
   - If a type 1 NSTEMI evolves to a STEMI, assign the STEMI code. If a type 1 STEMI converts to a NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

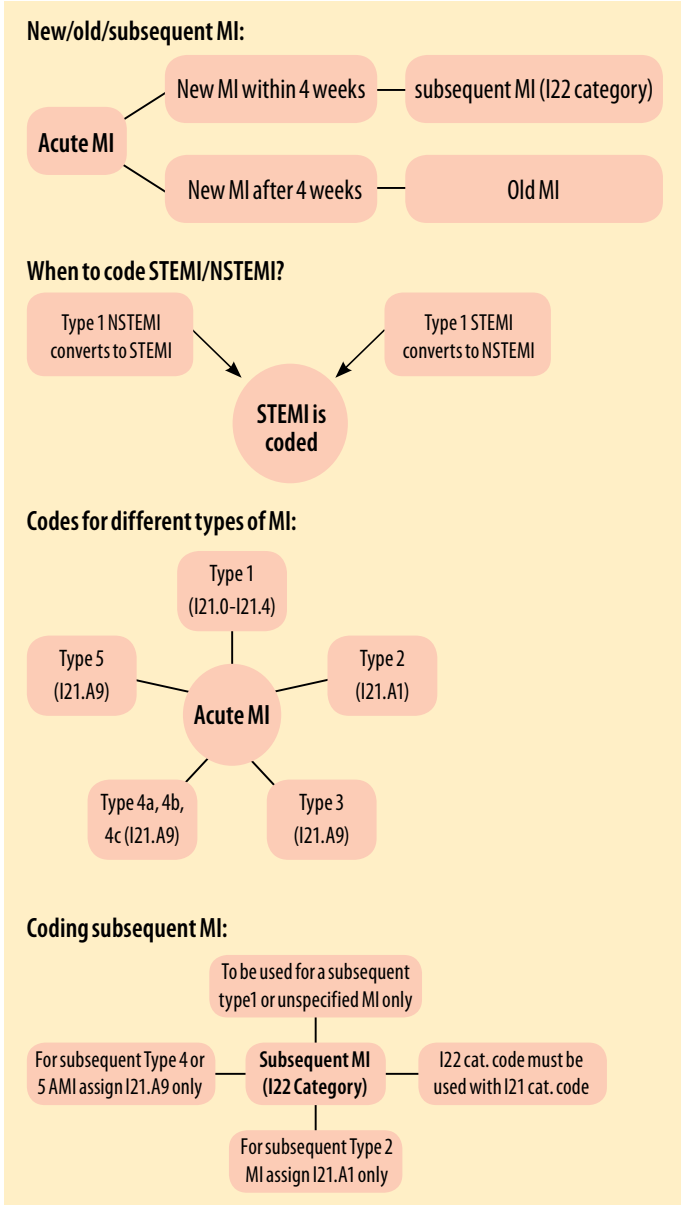
- For unspecified acute MI, code I21.9 *Acute myocardial infarction, unspecified*.

2. **Subsequent Acute MI:**
   - Use a code from category I22 *Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction* when a patient who has suffered a type 1 or unspecified acute MI has a new acute MI within the four-week time frame of the initial acute MI.
   - Use a code from category I22 in conjunction with a code from category I21 *Acute myocardial infarction*.
   - The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.
   - Do not assign code I22 for subsequent MIs other than type 1 or unspecified. For subsequent type 2 acute MI assign only code I21.A1 *Myocardial infarction type 2*. For subsequent type 4 or type 5 acute MI, assign only code I21.A9 *Other myocardial infarction type*.
3. **Other types of MI:**
   - Type 1 MI are assigned to codes I21.0-I21.4.
   - Type 2 MI, due to demand ischemia or secondary to ischemic balance, is assigned to code I21.A1 with a code for the underlying cause.
   - Sequencing of type 2 acute MI or the underlying cause is dependent on the circumstances of admission. When a type 2 acute MI code is described as NSTEMI or STEMI, only assign code I21.A1.
   - Codes I21.01-I21.4 should only be assigned for type 1 acute MIs.
   - Acute MIs type 3, 4a, 4b, 4c, and 5 are assigned to code I21.A9.

Figure C may help for better understanding.

The Code Also and Code First notes in the ICD-10-CM code book should be followed related to complications, and for coding of post-procedural MI during or following cardiac surgery.

FIGURE C: CODING ACUTE MI



Sujit Sharma, CPC, is a graduate in alternative system of medicine with a diploma in international business operations. He has more than nine years of outpatient coding, auditing, and training experience. Sharma is assistant manager for Coding Compliance and Audit with R1RCM Global Pvt. Ltd., a U.S.–based leading RCM company. Sharma is a published author of the short story (medical fiction), "Carcinosin: The Fiction" and "Theory of Systematic Randomization" on Amazon kindle. He is a member of the Hyderabad Telangana, India, local chapter.

By Barbara Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CPCO, CENTC

Requirements for Reporting Allergy Services Are Nothing to Sneeze At

Make sure your practice is billing testing and immunotherapy preparation and provision correctly.

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Allergy services are on the radar of third-party payer investigation units because they have found that many practices code and bill these services wrong. Similarly, many practices fail to follow the Part B Medicare rules for billing the preparation of the allergy immunotherapy serum. Let's review the requirements for correct reporting of allergy testing, immunotherapy serum prep, and provision of immunotherapy to patients.

Know Supervision Requirements

The first step in the allergy immunotherapy process is allergy testing. Typically, this is performed by medical assistants, nurses, nurse allergists (specialty certification in nursing), and other non-physician providers. You may think these ancillary staff and non-physician providers are working and billing under the incident-to rules, but their services actually fall under the diagnostic services supervision rules, which require the practice to provide them with either "general," "direct," or "personal" supervision. Although these levels of supervision are the same as described in incident-to services, a different set of rules apply to diagnostic services. Each diagnostic CPT® code is assigned a supervision level requirement in the Medicare Physician Fee Schedule (MPFS) database depending on the perceived risk of the procedure.

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required. Under general supervision, the training of the non-physician personnel who perform the diagnostic procedure and the maintenance of the necessary equipment and supplies is the continuing responsibility of the physician.

Direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician does not have to be present in the room where the procedure or service is performed. Direct supervision guidelines for diagnostic testing and incident-to services are the same, but not all diagnostic procedures call for direct supervision.

Personal supervision means the physician must be in the room during the performance of the procedure. This is required for diagnostic procedures that pose the highest risk to the patient.

The MPFS database carries a "1" in the Diagnostic Supervision field if the code only needs general supervision, a "2" if the code requires direct supervision, and a "3" if the code requires personal supervision. If the field carries a "9," the supervision concept does not apply.

The most common form of allergy testing, often called a "scratch test," is reflected by code 95004.

Common allergy testing codes that require direct supervision are:

95004 Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

95024 Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report by a physician, specify number of tests

95027 Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report by a physician, specify number of tests

95028 Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests

95044 Patch or application test(s) (specify number of tests)

95052 Photo patch test(s) (specify number of tests)

95056 Photo tests

High-risk codes requiring personal supervision are:

95060 Ophthalmic mucous membrane tests

95070 Inhalation bronchial challenge testing (not including necessary pulmonary function tests); with histamine, methacholine, or similar compounds

95071 with antigens or gases, specify

The concept of diagnostic testing supervision does not exist, as reflected by a "9" in this field in the MPFS, because neither the provision of the allergy serum nor the allergy shots are diagnostic. Instead, these services fall under the rules of incident-to services and, therefore, require direct supervision if performed by someone other than the physician.

Identify the Type of Skin Testing

Allergy skin testing codes are divided into environmental, venoms, and food (there are other codes for testing other substances, but the bulk of the codes fall into these three broad categories). Some codes, such as 95004, do not differentiate between the type of allergen that is tested.

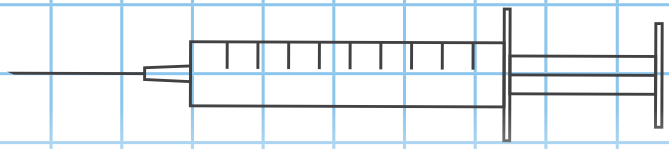
There are three types of skin testing: prick or scratch testing (most common), incutaneous testing, and sequential and incremental testing.

- *Prick or scratch testing* "pricks" or "scratches" the surface of the skin to see if there is a reaction to the allergen antigen.
- *Incutaneous testing* involves a syringe that injects a small amount of the allergen antigen into the skin.
- *Sequential and incremental* (often referred to as "SET testing" (skin endpoint titration testing)) employs syringes. The testing may involve four or five dilutions, increasing the concentration of the antigen with each dilution, challenging the patient to react to the allergen.

The most common form of allergy testing, often called a "scratch test," is reflected by CPT® code 95004. The units for this test are counted by the number of allergens tested. If five different allergens are tested, which involves pricking the patient with five different substances and reading the reactions, the code is reported with five units.

Codes 95017 *Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests* and 95018 *Allergy testing, any combination of percutaneous (scratch,*

IMMUNOTHERAPY



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puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests involve any combination of percutaneous (scratch, puncture, prick), intracutaneous (intradermal), sequential and incremental testing. Both tests look for immediate-type reactions and include the test interpretation and report.

Counting the units for 95017 and 95018 is more complicated than with 95004. For these tests, the number of scratch, puncture, or prick tests and incutaneous tests are counted per allergen, as with 95004 and 95024; but then you add the number of dilutions, or the number of patient sticks performed during the sequential and incremental testing.

Example 1: A patient is given four increments of five antigens during the sequential and incremental portion of the testing, for 20 units (4 x 5). This is added to the number of antigens that were prick tested and incutaneous tested (for example, another five antigens). The number of units billed is then 25 (five for the prick testing plus 20 for the sequential and incremental testing. The selection of 95017 versus 95018 is determined by what was tested, venoms (95017) or drugs/biologicals (95018).

Code 95024 represents the second type of skin testing described above, where the skin is injected with allergen antigen to see if a reaction can be provoked. As with prick tests (95004), the units counted for 95024 equal the number of allergen antigens tested.

Code 95027 describes sequential and incremental (SET testing) and is used for environmental allergies. As with 95017 and 95018, the sequential and incremental testing does not count just the number of allergen antigens tested, but also the number of times the patient is stuck (each allergen antigen will require the patient to be tested multiple times at increasing dilutions). If 10 allergen antigens are tested at four dilutions, the number of units billed is 40 (10 antigens x 4 dilutions).

The codes and types of testing discussed so far have been for immediate reactions. An "immediate" reaction is considered to occur within 15-20 minutes. Incutaneous testing, described by 95028, differs in that it looks for a delayed reaction 24-72 hours after administration of the antigen(s).

Account for Allergy Immunotherapy Serum Prep

After testing is completed and the provider has determined what the patient is allergic to, a regimen of immunotherapy is formulated. The immunotherapy starts out with highly diluted antigen, which is gradually increased over time. The goal is for the patient to increase their tolerance to what they are allergic to.

It takes a long time for the dilution to be brought to what is considered the "maintenance dose" for the patient. In 2000, Medicare Part B would not pay for dilutant beyond what is needed for the maintenance dose when billed for the immunotherapy serum. This created a lot of confusion and problems in the specialty. Treatment vials are created from undiluted antigen that are then drawn from and put into dilution vials. Each of the dilution vials have sequentially increasing dilutions. Traditionally, payers are billed for the total number of cubic centimeters (cc) of serum that is created from the non-diluted vial.

Example 2: 10 units of maintenance dose can be diluted down to a total of 70 units. Until Medicare published a rule in 2000, all payers would have been charged for 70 units of serum. After Medicare published this rule, for Part B Medicare only, the practice can only charge for the maintenance doses created: 10 units. All other payers may be billed 70 units, but Medicare Part B may be billed only 10 units.

The rule does not apply to Medicare Advantage plans, but applies to all patients with Medicare Part B. This is important for calculating units for 95145-95180. The most commonly used code for the provision of serum is 95165 *Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)*. Overbilling Medicare Part B for the units for this service is "on the radar," and can get the practice into trouble. Be sure your Medicare Part B units are calculated correctly!

Many insurance companies limit the number of allergy tests that may be performed at a single session and may set medical necessity requirements for sequential and incremental SET testing.

Factor in Administration of Allergy Immunotherapy

Administering allergy immunotherapy, commonly known as "allergy shots," can be performed in a variety of ways. Some allergy practices give the patients the serum vials to bring to their primary care physician (PCP) to administer the shots according to the treatment plan. Some providers let the patients self-administer the shots, while other allergists say they consider patient self-administration to be unsafe.

When the provider who makes up the serum is also the administer of the allergy shots, the provider may make up the sequentially diluted serum sets that are specific to the patient and then administer first from the most diluted vial, moving on to the next most diluted vial, and eventually up to the maintenance vial. Although each vial may have been billed based on 1 cc doses, the doses given to the patient may be 0.5 cc doses, which means a vial can last for 20 doses. The payer pays for the serum up front for 95145-95180 (and most often 95165), times the number of units billed. Then, the practice bills one of the two injection codes.

Some antigens do not mix with other antigens and must be diluted in separate vials. The number of vials determines the number of shots the patient receives. The two possible injection codes for administering immunotherapy are:

95115 Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection

95117 2 or more injections

Note that 95117 is not an add-on code: Do not report 95115 with 95117; one or the other is coded, not both.

Some doctors prepare their serum for immunotherapy "off the board." Using this technique, the technician works with the formula and has a board of all the different antigens. She draws up into the syringe a specific amount of antigen A, a specific amount of antigen B, and a specific amount of dilution per a formula for the patient, and then administers the shot. Although 95120 *Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; single injection* and 95125 *Professional services for allergen immunotherapy in the office or institution of the prescribing physician or other qualified health care professional, including provision of allergenic extract; 2 or more injections) (or 95130-95134 for venoms* are the codes that most reflect what is done when allergy immunotherapy is performed "off the board," no payers process claims using these more appropriate codes. As a result, the practice still must bill as if they make up pre-made vials and then administer the shots, using 95145-95180 (most often 95165) and 95115 or 95117.

Finally, there are providers who make up maintenance dose vial sets and then use an "off the board" process, diluting the patient's full maintenance dose with the appropriate dilutant when preparing the immunotherapy. These services also must be coded using 95145-95180 (95165, most often), plus the shot administration using 95115 or 95117.

Keep Payer Limits in Mind

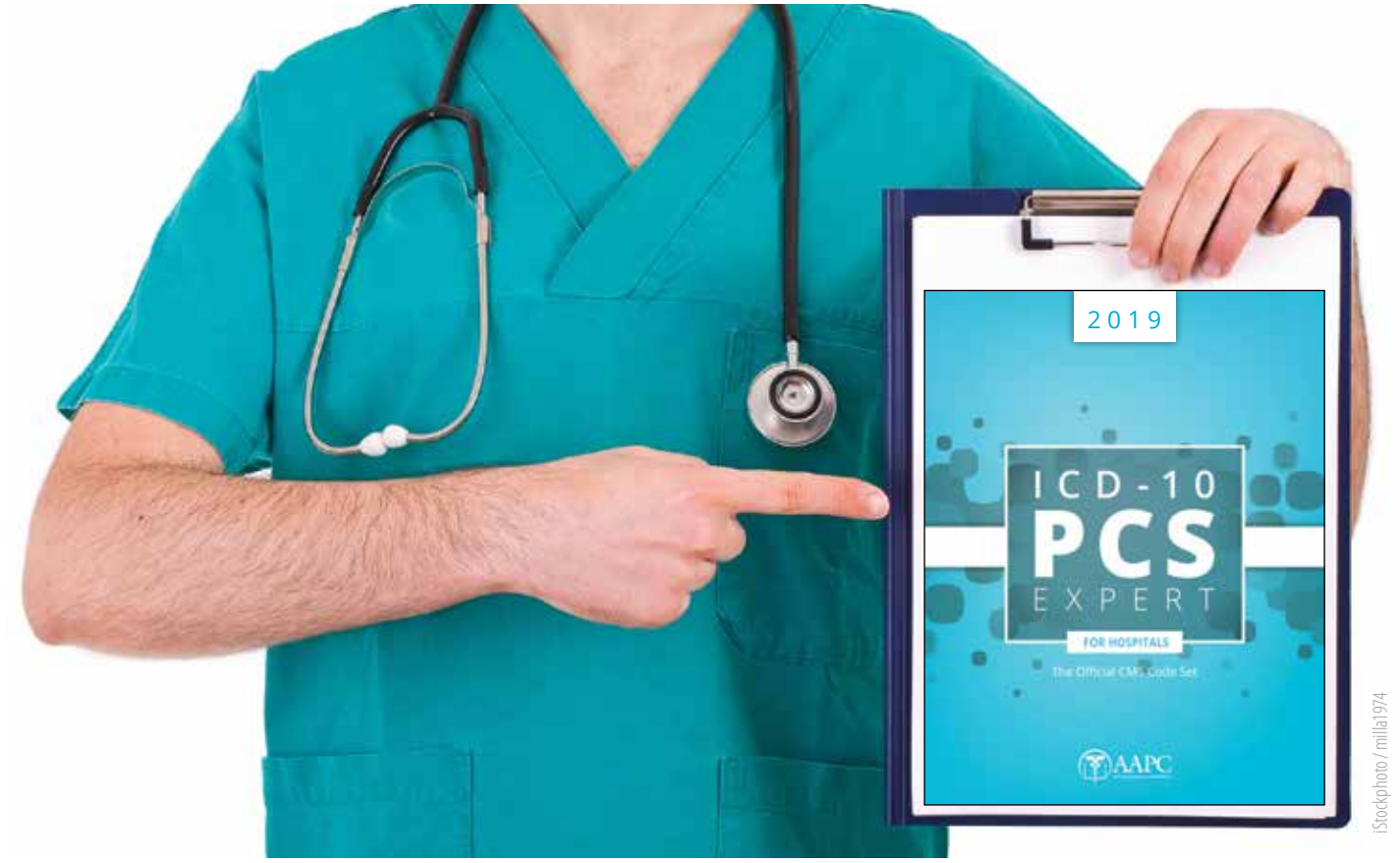
Many insurance companies limit the number of allergy tests that may be performed at a single session and may set medical necessity requirements for sequential and incremental SET testing. They also may limit the number of units of antigen they allow for 95145-95180 (most often, 95165) at one time. Be sure to review each payer's guidelines on their website, so your practice knows the limitations and medical necessity requirements. It's a good idea to log each payer's information in an Excel spreadsheet to make sure the practice doesn't perform services that will not be paid. **HBM**

Barbara Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CPCO, CENTC, is CEO of CRN Healthcare Solutions. She is an expert in otolaryngology coding and billing. She is a past member of the AAPC National Advisory Board as well as their EB. Cobuzzi owned Cash Flow Solutions, a billing company, for 13 years before she entered into full-time consulting. She is a member of the Monmouth, N.J., local chapter.

Resource

MPFS: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/

By Alicia Scott, CPC, CPC-I, CRC



iStockphoto / milla1974

An Outpatient Coder's Basic Crash Course in ICD-10-PCS

This open and expandable procedural code set is nothing to be intimidated by.

When outpatient coders talk about ICD-10, they typically mean the ICD-10-CM (diagnosis) code set. But there's another ICD-10 code set: ICD-10-PCS. If you're unfamiliar, here's an introduction.

PCS Describes Inpatient Procedures

The ICD-10-PCS code set is used to code inpatient procedures; PCS stands for Procedure Coding System. The code set was funded by the Centers for Medicare & Medicaid Services (CMS) and released for trial in the spring of 1998.

ICD-10-PCS builds on Volume 3 of ICD-9 —formerly used to report inpatient procedures, prior to adoption of ICD-10 — to enhance four major attributes. The first three of these attributes are based on code format:

- **Completeness**: Unique codes are not based on body parts or different approaches within a body system.
- **Expandability**: New codes are easily incorporated as unique codes.
- **Multiaxial**: Independent characters may be used to expand an individual axis.

But it's the forth attribute, **standardized terminology**, that really sets ICD-10-PCS apart from other code sets.

In ICD-9-CM Volume 3, the same term often had multiple meanings, depending on the context (the CPT® code set suffers a similar problem). This confusion is eliminated in ICD-10-PCS: Terminology

is consistent throughout the code set. When using ICD-10-PCS, there is no guesswork or ambiguity.

How to Build an ICD-10-PCS Code

Each character in ICD-10-PCS "builds" on the previous character. The first character describes the **section**. Think of this as the area of medicine that best describes the procedure — for example, Medical and Surgical (0) is a commonly used section. Other sections include Obstetrics (1) and Mental Health (G). Additional characters follow and expand on the code definition, as such:

- Character 1 = Section
- Character 2 = Body System
- Character 3 = Root Operation
- Character 4 = Body Part
- Character 5 = Approach
- Character 6 = Device
- Character 7 = Qualifier

Approximately 30 root operation terms are defined. When choosing PCS root operations, the relevant factor is the outcome of the procedure. For example, ICD-10-PCS defines a bypass as:

> **Bypass: Altering the route of passage of the contents of a tubular body part**

Consider also how ICD-10-PCS defines *detachment* versus *removal*:

> **Detachment: Cutting off all or part of the upper or lower extremities**

> **Removal: Taking out or off a device from a body part**

Following these definitions, a below-the-knee amputation is a detachment, not a removal. A removal must involve a device (e.g., a halo device).

Each section (character 1) lists the root operations (character 3) that apply within that specific section (not all root operations are relevant in every section). There is no need to memorize the root operations because they are always listed in your code book or encoder.

The fourth character of an ICD-10-PCS code (body part) is directly related to the second character (body system) in which the procedure was done. For example, if you are in the Medical and Surgical section (0), *Heart and Great Vessels* body system (2), and coding an *Excision* root operation (B), you will not find *Mediastinum* as a possible body part (described using the fourth character) because it is not part of the heart or great vessels. *Mitral Valve* (G) is an option because it is part of the *Heart and Great Vessels* body system. ICD-10-PCS removes the guesswork by eliminating inappropriate options.

The fifth character tells the approach. This character also relates to the previous character choices. For example, an excision on the *Mitral Valve* (G) offers *Open* (O), *Percutaneous* (3), or *Percutaneous Endoscopic* (4).

> … terminology is consistent, throughout the code set. When using ICD-10-PCS, there is no guesswork or ambiguity.

The sixth characters often describes a device. A device must remain in place after the procedure is done. If the device is removed before the completion of the procedure, or using a device is not an option with a given procedure, the correct option is *No Device* (Z). The ICD-10-PCS Official Guidelines for Coding and Reporting, section B6.1b, state, "Materials such as sutures, ligatures, radiological markers and temporary post-operative wound drains are considered integral to the performance of a procedure and are not coded as devices."

The seventh, final character of an ICD-10-PCS code is the Qualifier. This character allows room for code expansion, if necessary. Example characters are *Diagnostic* (X) or *No Qualifier* (Z). Terms often used as qualifiers in the *Medical and Surgical* (0) section are:

- Allogeneic - Taken from different individuals of the same species. Two or more individuals are said to be allogeneic to one another when the genes at one or more loci are not identical.
- Synogeneic - Genetically identical or closely related to allow tissue transplant; immunologically compatible (one identical twin to another).
- Zooplastic - The surgical transplantation of living tissue to the human body from an animal.

Is PCS the Future?

Unlike CPT®, the ICD-10-PCS code set is open and expandable; for example, there's no need for "re sequenced" codes, as in CPT®. ICD-10-PCS allows for a high degree of specificity; and with practice, it's faster to use than CPT®. There is even a possibility that ICD-10-PCS could eventually replace CPT® for outpatient procedure coding, which would give us a single code set for use in both inpatient and outpatient settings. **HBM**

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Resources

Development of the ICD-10 Procedure Coding System (ICD-10-PCS): www.cms.gov/Medicare/Coding/ICD10/downloads/pcs_final_report2012.pdf

Dictionary.com, Zooplasty definition: www.dictionary.com/browse/zooplastic

ICD-10-PCS Official Guidelines for Coding and Reporting: www.cms.gov/Medicare/Coding/ICD10/2019-ICD-10-PCS.html

By Robert Gilbert, COC, FHFMA

Charge Description Master: Use It to Optimize Revenue

Secure hospital revenue integrity by implementing best practices for compliant charge capture.

When billing hospital services, it's important to know the fundamental elements of the Charge Description Master (CDM). Here's guidance to ensure your CDM is correct and compliant to keep your hospital's financial livelihood strong.

Recognize CDM Functionality

CDM, commonly referred to as the "Charge Master" or "CDM," is the heart of a hospital's cash flow. This system master file is the catalogue of every chargeable item that a hospital offers. Every patient revenue dollar that flows through an organization is generated through this file. Hospitals that take great care to ensure their CDM is correct are able to optimize their revenue cycle for enhanced patient experience and improved financial sustainability.

An improperly set up and maintained CDM can cost an organization millions of dollars in lost revenue or compliance penalties. Medicare and the Office of Inspector General consider accepting overpayments from health insurance companies or the government to be fraud, which can result in substantial penalties.

Proper CDM setup and maintenance is especially important as the healthcare system faces declining reimbursements and rising scrutiny of charging accuracy, pricing transparency, and justification. These factors have put hospitals in difficult positions to generate revenue. Hospitals have had to take a hard look at their revenue cycle best practices and seek opportunities for improvement, starting with the CDM.

Improve Coding Accuracy

Medical coders play a critical role in a hospital's revenue cycle. By gaining an appreciation for the function of the CDM, you can improve your coding accuracy and, in turn, optimize your hospital's revenue cycle and improve patient experience by mitigating billing errors. This starts by fostering a culture of accountability and communication between CDM managers, coders, and clinical staff to ensure the CDM is properly set up and maintained.

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Break Down the CDM Components

CDMs can vary from hospital to hospital. Generally, there are several basic elements:

Description of Service: The Healthcare Financial Management Association's (HFMA) Patient Friendly Billing Project recommends that all patient financial communications be clear, concise, and correct. Many modern billing systems can have multiple description lines, the most common are a technical description and a billing description. The technical

An improperly set up and maintained CDM can cost an organization millions of dollars in lost revenue or compliance penalties.

description is typically what is used internally, and the billing description is typically what appears on a patient's itemized bill.

Most organizations have the same description on all lines, but there may be situations where different descriptions make it easier for patients to understand their bill. For example, CPT® code 95808 *Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist* is for polysomnography. Although this is an acceptable description for internal use, from a patient perspective it may make sense to use "sleep study" as the external description for the itemized claim.

CPT®/HCPCS Level II Codes: Most of the charge master is comprised of services where the code will not change. When the service is not likely to change, then the codes are directly programmed as part of the charge. If the CPT® code is variable, then generally the charge is a "shell" charge and coders assign those codes.

Modifier Codes: Modifier codes can also be programmed as part of the charge; but be careful when placing a modifier in the CDM. Modifiers should only be added when a specific situation calls for modifier use 100 percent of the time.

For example, a single-view wrist X-ray does not have a specific code, while a two-view wrist X-ray is reported using CPT® 73100 *Radiologic examination, wrist; 2 views*. As such, it's appropriate to report 73100 with modifier 52 *Reduced services* when only one view is taken, to communicate to the payer that full payment should not be received for this charge.

Revenue Codes: Designated by the National Uniform Billing Committee, revenue codes inform the payer where the service took place. For example, an infusion given in the emergency room is reported with revenue code 0450 *Emergency Room – General.* This differentiates it from an infusion given in an infusion clinic, which is reported with revenue code 0260 *IV Therapy - General*. Medicare also uses these codes to group revenue for cost reporting.

Identify Chargeable Supplies

Supplies often fall into a "gray area" in terms of what is considered chargeable. Many supplies are considered non-chargeable because they are part of a hospital's "floor stock," which means they are included in an inpatient's room and board charge or are included in the payment for the outpatient procedure/service.

Hospitals can improve their revenue capture of chargeable supplies by developing guidance based on the following questions:

- Is the item medically necessary and specifically ordered by a physician?
- Is the item used specifically for and by the patient?
- Is the item not commonly furnished as part of a medical procedure or treatment?
- Is the item not commonly available for patient use in the medical department or setting?
- Is it documented within the medical record that the item was used?

From a compliance perspective, this last question (documentation of supplies used within medical records) is very important. Auditors often cite hospitals for insufficient documentation of supplies used, especially for operating room procedures.

Hospitals should not rely on physicians to dictate all of the supplies as part of their procedure notes; rather, nurses should be trained to document all supplies used on an inventory sheet with attestation and capture revenue this way.

Check the Price

One area that varies widely from hospital to hospital (unlike any other industry) and that confuses patients the most is pricing. Pick any three hospitals within a 30-mile radius of each other and you can bet the price of the same procedure at each hospital varies — sometimes, greatly.

Medicare does not dictate how an organization should establish their pricing, but it does offer the following guidance in the Medicare Paper Based Manual (section 2202.4) to ensure a reasonable relationship between cost and price:

> Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.

For compliance best practice, hospitals should price services for reimbursement maximization only.

- **Service prices should be defendable** - for example, be sure the price can be explained to a consumer.

- **Service prices should be consistent** - for example, left and right should have the same price.
- **Service prices should be logical** - for example, a computed tomography (CT) scan without contrast should be priced less than a CT scan with and without contrast.

Consideration should be given to commercial fee schedules to assess if the organization is leaving money on the table.

Maintain the CDM for Accurate Payments

CDM maintenance, whether centralized or decentralized, needs to be consistent and often. Many hospitals centralize oversight of the charge master with a CDM analyst/manager. These positions are important but are not enough on their own. Clinical departments must be accountable for their charges because the CDM analyst/manager, although responsible for ensuring consistency within the CDM, is not a practitioner and does not know the actual practice at the patient's bedside.

An often-overlooked area of CDM maintenance is external ancillary systems, which are not directly part of the CDM but do interface with the patient accounting system (e.g., lab, radiology, and pharmacy). This extra complexity is why maintaining the CDM should be a shared responsibility between the CDM analyst/manager and the clinical department.

Although modern patient accounting systems are more integrated than 10 years ago, periodic reviews should include mapping out these external ancillary systems within the CDM. Hospitals can inadvertently charge the wrong service if said service is not mapped correctly throughout the system. Clinical departments should review their charges annually, at a minimum.

Ensure Proper Charge Entry

Charges can be processed in many ways: Typically, charges are automated or connected with clinical documentation. Clinicians may not be aware that, as they document in the record, charges are being generated. As such, it's essential for the CDM to be set up to facilitate proper billing.

Example:

A nurse in an oncology clinic administers bevacizumab to a patient. The patient needs 950 mg. Bevacizumab (HCPCS Level II code J9035 *Injection, bevacizumab, 10 mg*) needs to be billed in 10 mg increments. If this charge is not set up to report in 10 mg increments, the hospital is at risk of receiving a significantly incorrect payment.

The national reimbursement rate for Medicare is $76.66 per unit. For a 950 mg dose (excluding reporting waste), 95 units should be reported, for a Medicare payment of $7,282.70. Incorrectly reporting the bevacizumab per milligram would result in 950 units and an overpayment of $72,827. Incorrectly reporting the drug per dose, as one unit, would result in an underpayment of $76.66.

It's important for departments to have a full understanding and ownership of their charges, including reconciling charges on a consistent basis. One way to ensure that consistent and ongoing charge reconciliation is happening is to periodically complete charge audits on clinical departments.

> Organizations with a defendable pricing structure and effective revenue integrity/charge capture programs will secure their revenue now and in the future.

Maintaining the charge master is more than entering a charge in a systems' master file. Other aspects to consider include:

- Charges that are too high, too low, or inconsistent
- Improper revenue codes for where the service has been completed
- Incorrect CPT®/HCPCS Level II codes for the actual bedside service
- Inappropriate pharmacy units
- Obsolete charges
- Zero volume charges
- Inadequate or inappropriate charge descriptions
- Use of miscellaneous charge codes
- Application of markup policies for drugs and supplies

Ensure Compliance and Proper Charge Capture

Creating a culture in an organization where maintaining the charge master is a team effort is critical to ensuring proper compliance and charge capture, especially as high deductible plans force pricing transparency and billing scrutiny.

Teaming up with compliance can be an effective way to expedite a CDM accountability culture. Organizations with a defendable pricing structure and effective revenue integrity/charge capture programs will secure their revenue now and in the future. The end goal is to ensure your organization is paid every dollar due: no more, no less. **HBM**

Robert Gilbert, COC, FHFMA, is senior manager in the Healthcare Consulting Practice at Baker Newman Noyes. He specializes in operational areas including charge capture, revenue cycle, revenue integrity, charge master, claims, provider reimbursement, and business systems. Gilbert has dedicated his career to assisting healthcare organizations with revenue cycle. He is a member of the Seacoast-Dover, N.H., local chapter.

Resource

Medicare Paper-based Manual, Section 2202.4:
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html

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By Trevor Wasden, MPH, CPC

Determine Medical Necessity for 99233

Know what payers are looking for in subsequent hospital care claims and how to give it to them.

Medical necessity is the No. 1 consideration when selecting an evaluation and management (E/M) service code. Without medical necessity to support billed services, your practice is put at a serious noncompliance risk. Consider, for example, one payer's review of claims including inpatient subsequent care CPT® code 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity*. The results of this review may help you to improve coding accuracy and compliance in your healthcare office or facility.

Review Deficiencies in Documentation

Prior to the introduction of Targeted Probe and Educate reviews, the Parts A/B Medicare Administrative Contractor (MAC) for jurisdictions E and F, Noridian Healthcare Solutions, undertook a service-specific probe review for internal medicine providers reporting 99233.

Most of the published findings reflected simple process issues, such as lack of signature, failure to submit documentation, incorrect date of service, incorrect provider, and illegible documentation. But one finding was more significant: insufficient documentation/medical necessity.

Insufficient documentation reflects a failure to meet the documentation requirements based on the CPT® code description. Documentation requirements for supporting 99233 are two of the following three key components:

- Detailed interval history
- Detailed exam
- High complexity medical decision-making (MDM)

If billing 99233 based on time, 35 minutes floor/unit time in the care of the patient with the majority in counseling or coordination of care must be documented.

These documentation requirements for 99233 are seemingly straightforward, but Noridian cited deficiencies in both documentation and medical necessity.

Define Medical Necessity

To understand the medical necessity requirements for 99233, begin by reviewing the Social Security Act and the Medicare Claims Processing Manual (emphasis added).

Social Security Act, Section 1862(a)(1)(A):

> Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services — which, except for items and services described in a succeeding subparagraph, are not **reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member**.

Medicare Claims Processing Manual, Chapter 12, Section 30.6.1:

> **Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code**. It would not be medically necessary or appro-

priate to bill a higher level of evaluation and management service when a lower level of service is **warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed**. Documentation should support the level of service reported.

In other words, just because the physician documents a detailed history and detailed exam doesn't necessarily mean you can bill 99233. All billed services must be reasonable, necessary, and warranted.

Consider Patient's Condition

Neither guideline provides fully objective, quantitative criteria by which medical necessity for an E/M service may be judged. Understanding the medical necessity for ordering a lab or radiologic exam is comparatively easy: for example, a provider orders a chest X-ray for suspected pneumonia, or serial troponins are ordered for chest pain to rule out acute coronary syndrome. Connecting the dots between a 99233 and medical necessity is not as clear.

Fortunately, CPT® provides a clue in the full code descriptor for 99233: "Usually, the patient is unstable or has developed a significant complication or a significant new problem."

The full descriptions for subsequent care codes 99231 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity* and 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity* also include a "usually" statement referencing the stability of the patient:

- 99231 – "Usually, the patient is stable, recovering or improving."
- 99232 – "Usually, the patient is responding inadequately to therapy or has developed a minor complication."

Based on these statements, it is the documented stability of the patient that determines the medical necessity of these subsequent care levels (when not billing based on time).

Differentiate Between "Significant" and "Unstable"

I'm often asked, "What constitutes 'significant' or 'unstable?'" Although these terms are not specifically defined, we can use Medicare's 1995 and 1997 Documentation Guidelines for Evaluation and Management Services to point us in the right direction — specifically, the examples for a high level of risk under the Presenting Problem(s) column in the Table of Risk:

- One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment
- Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure
- An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss

For a new complication or problem to be considered "significant," it should be comparable to the table of risk examples.

"Unstable" also follows this guideline, but for ongoing conditions rather than new problems or complications. Example: A patient admitted yesterday for sepsis with respiratory failure and acute kidney injury, who today remains tachypneic and tachycardic, with worsening oxygen requirements and significantly elevated blood urea nitrogen (BUN), creatinine, and lactate levels. Accounting for the presenting problems and the "usually" statements in CPT®, and factoring in critical care, you can create a spectrum of patient stability that points to the medical necessity requirements for each subsequent care code level, as shown in **Chart A**.

Chart A: Create a spectrum of patient stability.

	99231	99232	99233	99291
New Problem:	N/A	Minor	Significant*	Critical
Ongoing Problem:	Stable Recovering Improving	Responding Inadequately	Unstable*	Critical

*High Risk Presenting Problem (MDM)

Identify Medical Necessity within a Note

Although you still need to count the history and exam elements to meet the 99233 documentation requirements, you should keep in mind the stability of the patient's conditions by asking:

- How is the patient responding to treatment (e.g., "worsening," "uncontrolled," "stable," or "improving")?
- Are there new complaints or symptoms?
- What and how severe are the abnormal findings in the exam?

You must look at the overall picture of the patient's stability, as painted by the provider's note. One condition documented as "improving" does not mean the patient's overall condition is stable.

The audit elements for MDM complexity should especially help paint a picture:

- Is there a new undiagnosed problem or complication the provider is working up?
- Is the provider ordering additional diagnostic services?
- How frequently does the provider want labs run?
- What diagnostic results is the provider pulling in to their note, and what are they saying about the results?
- Does the provider need to seek advice from another physician?
- How do comorbidities increase the risk of the presenting problem(s)?
- Is the provider changing the treatment plan because the problem is worsening or failing to change as expected?

You must look at the overall picture of the patient's stability, as painted by the provider's note. One condition documented as "improving" does not mean the patient's overall condition is stable.

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Time-based Coding Changes the Criteria

How is medical necessity met when reporting 99233 based on time? In this case, we find additional guidance from both the CPT® code book and the Medicare Claims Processing Manual (emphasis added).

Medicare Claims Processing Manual, Chapter 12, Section 30.6.1:

> However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. **Documentation must be in sufficient detail to support the claim**.

CPT® code book, Evaluation and Management Services Guidelines:

> This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). **The extent of counseling and/or coordination of care must be documented in the medical record**.

There must be "sufficient detail" to justify the time spent, but what constitutes this requirement?

We've discussed how all the elements of the history, exam, and complexity of MDM should paint a picture of the severity of a patient's condition. A provider does not necessarily need to document an equal amount of text detailing the counseling or coordination of care; however, there does need to be more than a list of topics covered, or more than a sentence or two detailing the content of the counseling and coordination of care. When reporting on time, a provider is essentially saying, "I needed to spend more time than expected based on the stability of the patient, and here is why." The amount of content documented should correlate with the amount of time spent (e.g., more content is expected for a 35-minute 99233 than a 15-minute 99231).

The content of the counseling and coordination of care can be documented with the provider's time statement, or the time statement can include the context of the counseling and coordination and connect back to the body of the note where the content is located.

Review these examples of good documentation from portions of a hospitalist's daily progress notes:

Example 1

I spent 45 minutes floor/unit time in the care of this patient, greater than 50 percent in counseling and coordination of care on an incredibly complex individual, with multiple barriers to care. Unfortunately, pt. has an incredibly complex medical situation, and low motivation to take good care of himself. I suggested that he might do best going to skilled nursing for at least a while after discharge, and he adamantly refused this. I asked about his reluctance, and he told me that he's got his garden and if he goes to a facility the garden will die. I countered with the fact that he nearly died yesterday from hyperkalemia, and if he hadn't been able to summon his neighbor, he would have probably died from a hyperkalemic arrest within hours. This did not seem to faze him as I would've expected. He values his independence, finds nursing home life demoralizing, and wants to go home with home health at the time of discharge. I think this is a plan for disaster as he has demonstrated on multiple occasions that he is not able and/or willing to appropriately take care of himself.

Example 2
Assessment/Plan

1. Pneumonia, Parapneumonic effusion: Pt. has pneumonia with a parapneumonic effusion. Her two-view chest X-ray yesterday, which I reviewed personally, demonstrates increasing consolidation of the left base, with a probable small associated effusion. Effusion was confirmed with chest ultrasound. We discussed the risks, benefits, and alternatives to thoracentesis. She was willing to proceed, and I talked with radiology to accomplish this. Painful effusions do have a slightly higher potential for infection. Of note, I gave her a small dose of Toradol, which markedly improved her pain. We'll see if we can get a sputum culture, in case she has a resistant organism, considering the worsening consolidation on X-ray.
2. Chest pain, pleuritic: Pleuritic chest pain likely due to parapneumonic effusion. We will use NSAIDs temporarily, recognizing increased kidney risk.
3. Acute respiratory failure with hypoxemia: She is still requiring 2 L of oxygen, but hopefully now that she is not splinting she'll use her incentive spirometry more.

I spent 40 minutes of floor/unit time caring for this patient, more than 50 percent of which was spent on counseling and coordination of care. I discussed in detail with the patient the disease process, prognosis, and treatment options, as well as the treatment plan, as noted in the assessment and plan. This included my initial visit to discuss my concerns about her chest X-ray, with a second visit to follow up on her chest ultrasound and to consent her for thoracentesis.

I also coordinated care with radiology for the procedure. I anticipate a third visit later today to discuss results of thoracentesis.

Key Takeaway

The key takeaway for providers regarding when to report a 99233 is that, in addition to the documentation requirements, their note needs to establish that the patient is unstable or has developed a significant complication or a significant new problem; or give enough content of the counseling or coordination of care to justify the documented time spent. HBM

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By Maria Rita Genovese, CPC, PCS

Improve Healthcare Through a Personalized Patient Experience

With a personal, patient-centered practice, you can provide complete, quality and efficient care for your patients.

The patient experience encompasses the entire range of interactions that patients have with a healthcare system. Understanding patient experience is key to moving toward patient-centered care and complete healthcare quality.

Factor into the Patient Experience

The patient experience encompasses several key components:

- **Effectiveness:** Your practice is effective when it allows patients to access care efficiently, and in a timely manner. For example, consider the turnaround time for return phone calls and look at ways your practice can help patients navigate the healthcare system.
- **Culture of Safety:** Create an environment that promotes a culture of safety in your organization. Safety culture is the attitude, beliefs, perceptions, and values that employees share in relation to safety in the workplace.
- **Responsiveness:** This applies to individual preferences, such as catering to patients' needs and values. For example, think about your office hours: Patients should be able to access care at times convenient to them. Consider having hours early in the day, in the evenings, or on weekends.
- **Clear Communication:** This includes creating guides to define the expectations of the patient and care team. For example, you might assign a navigator to a disease-based team to assist the patient in accessing appointments, as well as informative guides that list all the services your practice offers.
- **A Patient Committee:** Create a committee of current and former patients to discuss initiatives and process improvements. The committee discusses their experiences and what should be improved or remain the same.

Make It Personal

Making it personal is about making the patient feel valued, respected, and cared for. It's about making them feel that their well-being matters. Patients will value an experience that:

- Provides easy appointment scheduling. Access to care and an easy scheduling process matter to patients, as does a quick response to phone calls. If the provider's schedule does not have a quick turnaround time, inform the provider; they may be able to add time to see the patient.
- Clearly communicates between the physicians, clinical team, and the patient. Communication huddles should occur at the beginning of the session and should include all team members, including the front desk.
- Offers timely appointments with a quick turnaround time. It's critical to inform patients about delays. If a provider is running late, contact your patients throughout the day to inform them. The front desk should communicate to patients about delays every 15 minutes.
- Accounts for patient preferences. Consider providing multiple locations with different hours. Evening and Saturday hours add convenience for patients.

You can take some simple steps to personalize the healthcare experience for your patients:

- Personal details matter: Take the time to acknowledge birthdays, special occasions, and holidays. When staff remember specific details about a patient (such as asking them about their children, their job or hobbies, or a favorite pet), it makes them feel appreciated and special.
- Employees should seek to establish a dialogue with patients and display empathy at all times. Pay attention to patient demographics and participate in active listening.
- Using a patient's name is personal and respectful, but try to use the patient's preferred name. For instance, a patient named "Joseph" may like to be called "Joey."
- Always meet and greet: Encourage face-to-face interaction in your office, welcome the patient, and inform them of pertinent information.
- Use all possible channels for engagement. A smile and eye contact goes a long way.

Look Beyond Appointments and Procedures

The patient experience encompasses more than appointments with physicians for whatever ails them. It can also include:

- Outreach programs, including community health screenings such as breast screenings and men's health education.

- Nutritional education and seminars.
- Concierge service (e.g., having a navigator to assist with treatment).
- An integrative medicine program, which focuses on incorporating the three pillars of a healthy lifestyle — nutrition, physical activity, and emotional health — into the patient's care plan.
- Complementary medicine programs for emotional healing, ranging from healing gardens to cooking sessions. This program enhances the quality of life and wellness of individuals living with, through, and beyond a cancer diagnosis, for example. Such a program uses scientific-based therapies that focus on mind, body, and spirit, while supporting mainstream medical care.

Explore Complimentary Medicine

While traditional medicine and healthcare treat the illness, complementary medicine therapies help promote wellness in the whole person. It empowers participants by providing them with an opportunity to take a positive, active role in their care and treatment. For example, complementary therapies in our practice are designed to lessen the pain, stress, and anxiety associated with cancer. Therapies provide patients assistance with handling the side effects of traditional treatments such as radiation and chemotherapy.

Complementary medicine programs may include laughter workshops, therapeutic massage and reflexology, mindfulness, guided imagery and meditation, Qi Gong, creative arts for healing, horticultural healing, and chair yoga.

Use Data to Measure Satisfaction

The patient experience is measured through outcomes data and survey results. Institutions are part of this process and results are acquired and distributed to review and improve upon. Most institutions use Hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Press Ganey. Areas surveyed often include:

- Overall assessment
- Likelihood of recommending
- Overall rating of care
- Staff worked together to provide care
- Personal issues
- Concerns for privacy
- Sensitivity to patient needs
- Response to concerns/complaints
- Registration
- Ease of scheduling appointment
- Ease of the registration
- Helpfulness of registration person
- Informed about delays
- Waiting time in registration, and test or treatment areas
- Explanations given by staff
- Friendliness of staff
- Skill of techs/therapists/nurses
- Staff concern/questions worries

To achieve positive survey results, the question "What Do Patients Want?" factors into discussion. Generally, according to National Association of Healthcare Access Management's (NAHAM) "Customer Service to Patient Experience: The Cultural Shift" patients desire:

- **Confidence:** This is the belief that patients can trust the practice or facility's physicians and clinical team to deliver on its promises.
- **Integrity:** This reflects the belief that the hospital always treats patients fairly and satisfactorily resolves problems that occur.
- **Pride:** This is the degree to which a patient feels good about using the hospital and about how using the hospital reflects on them.
- **Passion:** The belief that the practice or facility is irreplaceable and an integral part of patients' lives.

Overcome Challenges

There are many challenges to overcome when trying to provide a personalized patient experience, such as:

- Poor quality
- Cost of healthcare
- Access
- Morale

To understand how to give the best personalized experience, every employee must experience care the way your patients do. Encourage every employee to think about their purpose, not just their functions. Teams must stop giving cues of indifference and uncaring. The way in which we deliver care is just as important as the service itself.

Teach your employees how to handle a patient or family member's complaint and create a blame-free environment. Empower staff to manage up, and not to blame other departments for issues that a patient may incur. "Sorry" may be the hardest word to say, but everyone needs to learn when to say it. Have sessions regarding empathy using role playing for staff (for example, Ted Talks).

Examine your patient flow or perform daily team meetings to isolate problem areas and to anticipate patient needs. Understand that improving patient satisfaction is about systems, just as much as smiles. HBM

Maria Rita (Rita) Genovese, CPC, PCS, is the vice-president of AAPC's Greater Philadelphia Local Chapter, and is a former chapter president and vice president. She is a former member of the AAPC's National Advisory Board, a former member of the AAPC Chapter Association (AAPCCA) board of directors and she served on its executive board. Genovese is the director of revenue cycle and business operations for MD Anderson Cancer Center at Cooper. She educates physicians and staff in medical coding and compliance regulations.

Resources

NAHAM, Customer Service to Patient Experience: The Cultural Shift: **https://cdn.ymaws.com/www.naham.org/resource/resmgr/2016_NE_Presentations/Customer_Service_to_Patient_.pdf**

TED Talks, TED Conferences, LLC: **www.ted.com/talks**

By Ann Barnaby, CPC, CRC, CASCC

Navigate Your Path to Career Satisfaction

Find your passion and follow it all the way to success.

We all deserve to work in a job we love. Preparing yourself for the journey can make all the difference in achieving career success.

Find Your Passion

Identifying your true passion in the business of healthcare is one of the first steps to realizing your career dreams. This may be a decision you make right after you earn your first coding credential, or it may be an idea that comes to you after years of working as a medical coder. No matter what the stage of your career, it's never too late or too early to think about what brings you the most satisfaction at your job.

To find your passion, ask yourself:

- What do I love most about medical coding?
- Which section of the CPT® code book interested me most as I prepared for the Certified Professional Coder (CPC®) exam?
- Thinking back to previous jobs I've held, what aspects did I like and what didn't I like?

After you've answered these questions, focus your job search and career path to drive results that will allow you to pursue your passion. Make every step count toward the goal of finding a career in your chosen field. This may require more certification, further education, or years of experience that you don't have. Don't let those obstacles cloud your vision. If you can dream it, you can do it.

Maximize Your Job Search Tools

Discovering jobs, companies, and positions that use medical coders can be fascinating. To unlock the opportunities available to you, it's important to use search tools and job listings to your advantage.

We've all used the tried-and-true search keywords "medical coder" to search for open positions in our area. This term sounds like the obvious choice — we are, after all, medical coders! But we're not JUST medical coders; we deal with so much more: the Centers for Medicare & Medicaid Services (CMS) guidelines, HIPAA policies, revenue cycle, claims submission, education, and many other aspects of healthcare. If you use those keywords in your job search, the results will increase exponentially.

The next time you're surfing the Web for job postings, try different search terms and check out the results. For example, what positions have the term "CPT" in the description? By using focused terms and specific aspects of the medical coding process, you'll expose yourself to countless jobs that may have never crossed your mind.

Don't limit your search to coding terms or job search sites. Googling "healthcare nearby" will supply an extensive list of hospitals, physician practices, even healthcare sales organizations. Take the time to explore each result: Go to each company's website and look in the "Careers" section to find jobs they may not have advertised on a large job search site. You never know what you'll find with creative job search terms and a little bit of time.

Get Organized

As the saying goes, "Finding a job is a job in itself." This may sound intimidating, but the job search process doesn't have to be. Preparing for the abundance of information that comes with a job search, and remaining organized, will drive your success through the process.

As you start your job search, stay organized by following key steps:

- Keep a list of companies that may have positions available now or in the future.
- On this list, make note of the positions you've applied for, received an email in response, or heard back from an employer.
- Keep track of dates, contact names, phone numbers, etc.

This reference list will help you to feel in control of your applications and quickly become invaluable. There's so little we can control in the job application process; organizing your progress can have a calming effect.

Sharpen and Finalize Your Resume

Your resume is your first introduction to employers, hiring managers, and recruiters. It's important to present an error-free document that describes yourself and your talents, just as you would do if you were to introduce yourself in person.

Make your resume serve as a snapshot of your certifications, skills, education, and experience. Don't go overboard or write long paragraphs of what you've accomplished and what you have to offer; there will be plenty of time for that during the interview.

Include specific information that will help employers get a sense of your strengths and capabilities. Always include your coding certifications after your name — you earned them, show them off. Include a more detailed list of your certifications and what they represent in the body of the resume.

Your education — even education that isn't coding education — is important to include, as well. Completing (or even enrolling in) education programs shows employers that you have ambition and are willing and ready to learn.

Make a succinct list of your coding-related skills. This list will help employers find you when they perform a search of candidates' resumes for specific skills needed for their listed position.

Finally, list your work experience. Don't be worried if you don't have experience specific to coding and billing. A good hiring manager will see the skills you've gained from other work experience and envision how those skills apply to coding. For instance, a customer service position requires patience, perseverance, the ability to cope under high-pressure situations, and the ability to prioritize and resolve issues. These skills are essential for coders, too. Show off the work you've accomplished and make your resume a true reflection of yourself.

Ensure a Successful Job Interview

You've made it to the next step: You've scheduled a job interview. As intimidating as that might sound, job interviews don't have to be nerve-wracking or scary. Just like it was in any other phase of the job search, preparation is key to success.


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Before you go to a job interview, research the company. This is an important step that many people neglect. Having information about the company, their values, their services, and the people who work there allows you to interview feeling prepared and not as if you're talking to a complete stranger.

Before you go to a job interview, research the company.

Confirm the location of your interview and your contact when you arrive. There's nothing more stressful than getting lost or not having a name for the receptionist who asks you who you're there to see.

Arrive at your interview 10 minutes early. There are several reasons behind the 10 minute "rule." If you arrive too early, your interviewer may feel pressed to finish a project or abandon their work to meet you. If you arrive too late, you've already created a bad first impression.

After checking in with reception, sit quietly in the waiting area. Don't check your phone: It is awkward to greet someone and not be able to shake hands until you put your phone away. Leave your phone in the car if you can't resist its lure.

During the interview, listen to your interviewer and take notes on the information they give to you. Always bring a portfolio or notepad to an interview. This minor action, along with taking notes during the interview, can be the difference between getting the job and getting a "Thanks, but no thanks" email. Use the notebook to your advantage:

- Make notes for yourself about projects you've completed or items about your background that you don't want to forget.
- Write the word "Smile!" in the margins. When you see it, you'll inevitably smile, putting yourself at ease and letting your interviewer see that you're relaxed and enjoying the conversation.
- At the end of the interview, if you're asked if you have any questions, always have two or three questions prepared (in case your mind goes blank). For example, you might ask:
  - What is a typical day like for the person in this position?
  - Who would I report to?
  - What are the production and quality expectations?

Asking questions gives you a chance to relax, and lets the interviewer do the talking for a change.

Embarking on a new career is an exciting and fulfilling endeavor. With preparation, self-reflection, confidence, and organization, you can find your dream job. Don't give up! **HBM**

Ann Barnaby, CPC, CRC, CASCC, is the managing director of Project Resume, a company providing professional development education to medical coders. She began her professional journey when she earned a Bachelor of Science degree in Health Policy and Administration as a student at Pennsylvania State University. Barnaby has enjoyed a career in medical coding and billing, recruiting, training, and management of medical coding teams. She is a member of the Richmond, Va., local chapter and can be reached at ann@projectresume.net.

By David Blackmer, MSC

What AAPC Stands For

Our name has changed over the past 30 years, but our mission is the same.

Since AAPC's inception in 1988, our official name has changed a few times. A decade into existence, we went from the *American Academy of Procedural Coders* to the *American Academy of Professional Coders*. That name lasted a little over 10 years, at which point we officially simplified it to AAPC. We had roughly 100,000 members at the time, and we were noticing a broader spectrum of careers being represented. Our growth was attracting individuals with diverse job titles – those who were still involved in the business of healthcare, but who were not necessarily medical coders.

We Represent a Diverse Group

We expanded our horizons to include and welcome billers, auditors, compliance officers, practice managers, educators, clinicians, lawyers, etc. The name change reflected this expansion, as the focus was no longer narrowed to medical coders, but open to all who cared about advancing the business of healthcare. The largest segment of our membership still handles coding for a living (42 percent), but more than half of our members are involved in different careers.

Our Commitment Is Unwavering

Offering more training, certification, and resources for these other career paths does *not* come at a cost to the core medical coding crowd we have served from the beginning. We have maintained the same level of commitment to our foundational certifications, simply adding various options and services to accommodate those who are not medical coders.

In fact, medical coders find the expanded networking, extra articles and webinars, and other educational tools available to be new and helpful perspectives to fulfill their current job duties or prepare for a career shift in the future, if desired. Since the last name change, we've seen our community of healthcare professionals grow to an impressive network.

AAPC Stands for Excellence

Unfortunately, history lessons don't make for the most interesting responses when someone is trying to figure out what AAPC stands for. Equally deflating is the factual statement that the letters in AAPC aren't even associated with words anymore!

Our name has changed over the years, but our mission remains the same: to set and uphold a higher standard. Our credentials are now known throughout the industry as a sign of excellence, and it's all thanks to our members. AAPC is you!

David Blackmer, MSC, is the director of member experience at AAPC. He is a member of the Salt Lake South Valley, Utah, local chapter.

Since the last name change, we've seen our community of healthcare professionals grow to an impressive network.

PROPS TO OUR CUSTOMER SERVICE REPRESENTATIVES

We appreciate feedback from members about their experiences with AAPC's customer service. We especially love receiving props! Here's what a few members said recently about their customer care experiences:

"I give Jenika an 11 on your scale of 10! She was super helpful. She was prompt in getting back to me by email with the proctor-to-examinee instructions she promised to send me. It was available within a couple minutes after I hung up. Now that it prompt! She knew right where to find the CPC® questions per section and helped me locate that in seconds. Keep up the good work."

It also sounds like you knew what you were looking for. You mentioned great resources to prepare for the administrative examination processes. Proctor instructions are accessible from our Exam Tips page (www.aapc.com/ExamTips), and each certification page (e.g., www.aapc.com/certification/cpc) has details on the bottom of what's covered on the exam.

"Each and every time I call 1-800-626-2633, I receive professional and accurate information regarding my questions. Not only is the AAPC representative professional, but also kind and courteous, just like Jaci was today. Each member of your team that I met at the Anaheim Conference was friendly and helpful, too. It is apparent that each of you enjoy the job you do and your employment with AAPC. Thanks so much!"

We DO love being a part of AAPC! Employees are dedicated to serving our membership, whether at a live event, on phone/chat/email, or wherever you may encounter us.

To nominate an AAPC employee for excellent service you received, send an email to thanks@aapc.com.

NEWLY CREDENTIALED MEMBERS

Can't find your name? It takes about three months after you pass the exam before your name appears in *Healthcare Business Monthly*.

Magna Cum Laude

Abdus Shahid Sheikh, COC, **CPC**
Alissa VanHook, **CPC-A**
Angela K Alexander, CPC, **CIRCC**
Aswani Vk, **CPC-A**
Bethany Williams, **CPC-A**
Brittany Simmons, **CPC-A**
Chris Jones, **CPC-A**
Christi Barrow, **CPC**
Corrina Rottum, CPMA, CGIC, **CRC**
Dawn Osborn, **CPC-A**
Dea Lu Furgason, **CPC-A**
Debra Trexler, **CPC-A**
Donna Akins, COC, **CRC**
Elymi Peralta, **CPC**
Gouthami Chinthakindi, **CPC-A**
Heather Hunt, **CPC-A**
Hyunhee Kim, **CPC-A**
Jasusri Jayasimhan, **CPC-A**
Jeanette Aldrich, **CIRCC**
Jennifer Gallipo, CPC-A, **COPC**
Jennifer Holben, **COPC**
Jennifer Thau, **CPC-A**
Jocel Mae Lovendino Noriega, **CPC-A**
Kelli Greene, **CPC**
Kimberly Gay A Villena, **CPC-A**
Koppula Sudhakar Reddy, **CPC-A**
Kris Ann Allen, **CPC-A**
Laurie Davis, **CPC-A**
Laverne Calupaz Canlas, **CPC-A**
Maddu Dinesh Naidu, CIC, **CPC-A**
Maimoona Fatima, **CPC-A**
Mangesh Prakah Patole, **CPC-A**
Marci Kelley, **CPC-A**
Martha Pung, **CPC-A**
Mary Harmon, COC, **CIRCC**
Moirangthem Jasmine Chanu, **CPC-A**
Muralidharan P K, CPC-A, **CIRCC**
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Patricia Kennedy, CPC, CPMA, **COPC**
Peggie Rossi, **CPC-A**
Rachel Hamm, CPC, **CUC**
Rajender Narayanapuram, **CPC-A**
Rakhi Sinha, **CPC-A**
Ramya Vaidyanathan, **CPC-A**
Renji Paul, **CPC-A**
Sara Mattison, **CPC-A**
Shekkina JC Shammah Shekkina, **CPC-A**
Soleti Anusha, **CPC-A**
Stacie Meyer, **CPC-A**
Sumpi Borgohain, **CPC-A**
Swati Mohalikar, **CPC-A**
Teresa Molsbee, **CPC-A**
Veera Mekala, **CPC-A**
Virginia Mares, **CPC-A**
Vivian Liu, **COPC**

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Cynthia Herring, **CPC**
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Erin Ward, **CPC**
Estell Lam, **CPC**
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Glinner Wilson, **CPC**
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Heather D Bettis, **CPC**
Heather Ellis, **CPC**
Heather Maguire, **CPC**
Herpsima Khatchadorian, **CPC**
Ife Baptiste, **CPC**
Iris Havelka, **CPC**
Jack H Sycz, CRC, **CPC**
Jacqueline Macak, **CPC**
Janet Kunze, **CPC**
Janice Mercaldi, **CPC**
Jeanette Wright, **CPC**
Jennifer Chance, **CPC**
Jermisha Person, **CPC**
Jessi I Faso, **CPC**
Jessica Courtney, **CPC**
Jessica Gerding, **CPC**
Jessica Marie Welter, **CPC**
Joie Lane, **CPC**
Jose Pecanha, **CPC**
Julia Ann Durfee, COC,, **CPC**
Kalilou Kane, **CPC**
Karen Beery, **COC**
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Karla Martinez, CPC, CRC, **COC**
KaSheena Quinones, **CPC**
Katherine Davila, **CPC**
Katrina Guzman, **CPC**
Kaydi Gregston, **CPC**
Kayla M Smith, **CPC**
Kelly Perry, **CPC**
Kendall Moss, **CPC**
KerryAnn Martel, **CPC**
Kim Miller, **CPC**
Kimberly Matthews, **CPC**
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Krista Tjelmeland, **CPC**
Kristi Elaine Shaffer, **CPC**
Kristie McAdams, **CPC**
LaKenya Brazelton-Howard, **CPC**
Laura Curtis, **CPC**
Laura Ellor, **CPC**
Laura P Martinez, **CPC**
Lauren Marie Cassano, **CPC**
Laverne Singleton, **CPC**
Leigh Ellis, **COC**
Leodanis Rodriguez, **CPC**
Lindsay Ireland, CPC, CEMC, CGSC, **COC**
Lisa Balsam, CRC, **CPC**
Lisa Collins, **CPC**
Lisa Davis, **CPC**
Lisa Neidy, **CPC**
Lisa Zagresky, **CPC**
Loretta Wesley, **CPC**
M V Ganesamoorthy, **CPC**
Ma Amelia Tadios, **CPC**
Manuel Silva, **CPC**
Maria America Mac Kizer, **CPC**
Mary Kaye Kurvink, CPC, **COC**
Mary Ruth McCray, **CPC**
Melissa Harris, **CPC**
Melissa Wheeler, **CPC**
Melissa Yuhas, **CPC**
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Nicole Norris, **CPC**
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Odalys Dupotey Obregon, **CPC**
Pamela Mason, **CPC**
Patricia L Jones, **CPC**
Patricia Parker, **CPC**
Perlita Hernandez, **CPC**
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Princia Preethi, CRC, **CPC**
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Raji Maheshan, **CPC**
Raquel Garcia, **CPC**
Raul Hernandez, **CPC**
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Rose Dunaway, **CPC**
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Tracy Schutt, **CPC**
Tricia Olsen, **CPC**
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Twilla Squire, **CPC**
Victoria Bossard, **CPC**
Vonda Parks, **CPC**
Yamile Valdesprieto, **CPC**

AAPC NEWLY CREDENTIALED MEMBERS

Apprentice

A Sandhya, **CPC-A**
Abdul Rashid, **CPC-A**
Abdul Shukoor, **CPC-A**
Abraham Varghese, **CPC-A**
Adrea Ann Nevin, **CPC-A**
Afreen Sheik, **CPC-A**
Agnes Elizabeth Antony, **CPC-A**
Ajay Kumar, **CPC-A**
Ajeesh Lukose, **CPC-A**
Ajit Sadashiv Gawade, **CPC-A**
Akashvani Chavan, **CPC-A**
Akhil S Raj, **CPC-A**
Akhlaq Ahmad, COC-A, **CPC-A**
Alan Philip Thomas, **CPC-A**
Alecia Hanke, **CPC-A**
Alejandro - Lopez, **CPC-A**
Alethea Vest, **CPC-A**
Alexander Johnston, **CPC-A**
Alexandra Boton, **CPC-A**
Alexandra Stock, **COC-A**
Alexis Moczygemba, **CPC-A**
Alexis Skog, **CPC-A**
Alisa Jones, **CPC-A**
Alisha Rose Hebert, **CPC-A**
Alison Wingrove, **CPC-A**
Allison Bowersox, **CPC-A**
Alyssa Eller, **CPC-A**
Alyssa Hodge, **CPC-A**
Amanda Chevez, **CPC-A**
Amanda Hewitt, **CPC-A**
Amanda Kiddey, **CPC-A**
Amanda Liset Cangas, **CPC-A**
Amanda Meng, **CPC-A**
Amanda R Lowery, **CPC-A**
Amanda West, **CPC-A**
Amber Turner, **CPC-A**
Amneh Mika, **CPC-A**
Amrutha K George, **CPC-A**
Amy E Quinn, **CPC-A**
Amy Jarman, **CPC-A**
Amy Krysiak, COC-A, **CPC-A**
Amy Rochowiak, **CPC-A**
Amy Shope, **CPC-A**
Amy St Clair, **CPC-A**
Amy Watson, **CPC-A**
Amy Young, **CPC-A**
Anais Maria Jimenez, **CPC-A**
Anandhi Priyadharshini D, **CPC-A**
Anandu A, **CPC-A**
Anbarasi Ladislaus Gaspar, **CPC-A**
Ancy Sam, **CPC-A**
Andon Morgan, **CPC-A**
Andrea Sanchez, **CPC-A**
Andrew Lauer, **CPC-A**
Andrew Nichole Acosta Barro, **CPC-A**
Angela D Smith, **CPC-A**
Angela Denise Baytops, **CPC-A**
Angela LeMay, **CPC-A**
Angela Martinez, **CPC-A**
Angela Turner, **CPC-A**
Anitha S, **CPC-A**
Anjali Krishna S, **CPC-A**
Anjana Thampi, **CPC-A**
Anjumol Abraham, **CPC-A**
Ann Marie Dacion, **CPC-A**
Anna Maria Dabbicco, **CPC-A**
Anna Muri, **CPC-A**
Anna Philip, **CPC-A**
Anne Kausalik, **CPC-A**
Annette Vesey, **CPC-A**
Annie Stinson Sams, **CPC-A**
Anooja J, **CPC-A**
Anupama Manoj, **CPC-A**
Anuradha Manoharan, **CPC-A**
Anusha V, **CPC-A**
Anvin S Mathew, **CPC-A**
Anweshraju Brhamandabheri, **CPC-A**
Aracely Suri, **CPC-A**
Arathi Alexander, CRC, **CPC-A**
Arathi Pillai, **CPC-A**
Arax Nazarian, **CPC-A**
Archana PriyaS, **CPC-A**
Arianna Miller, **CPC-A**
Arijana Krajnovic, **CPC-A**
Arlena Seim, **CPC-A**
Arlene Cochran, **CPC-A**
Arlinda Abadilla Balancad, **CPC-A**
Arun Kumar, **CPC-A**
Ashley Britt, **CPC-A**
Ashley Layton, **CPC-A**
Ashley McConnell, **COC-A**
Ashton Smith, **CPC-A**
Ashwini Shetty, **CPC-A**
Asna Abdul Shukkoor, **CPC-A**
Aspen Orr, **CPC-A**
Aswathy KR, **CPC-A**
Athena Martisha Theodorides, **CPC-A**
Audra Castillo, **CPC-A**
Autumn Westbury, **CPC-A**
Autumn Willis, **CPC-A**
Avinash Nimse, **CPC-A**
B Praveen Goud, **CPC-A**
Balaji Gillela, **CPC-A**
Balaji V, **CPC-A**
Balakrishna Molleti, **CPC-A**
Balamanikandan Gunasekaran, **CPC-A**
Bandaru Swathi, **CPC-A**
Barbara Portera, **CPC-A**
Barbara Smith, **CPC-A**
Battula Lakshmi, **CPC-A**
Bavithra Boobalakrishnan, **CPC-A**
Beck Christina, **CPC-A**
Ben Auerbach, **CPC-A**
Bency Vincent, **CPC-A**
Bensil Mathew, **CPC-A**
Beth Braum, COC-A, **CPC-A**
Beth Hudson, **CPC-A**
Bethany Harris, **CPC-A**
Bethany Lykins, **COC-A**
Beula Priyadarshini B, **CPC-A**
Beulah Yolanda Brogden, **CPC-A**
Beverley Tortora, **CPC-A**
Beverly Andzelik, **CPC-A**
Bhagya Laxmi B, **CPC-A**
Bharani Chitavoiena, **CPC-A**
Bhavana LL, **CPC-A**
Bhavanaben Sureshbhai Patel, **CPC-A**
Bhoopathy Balraj, **CPC-A**
Bianca Moreno, **CPC-A**
Bill Kasse Bakayoko, **CPC-A**
Bo Zhang, CPB, **CPC-A**
Bobbie Lerma, **CPC-A**
Bolla Subba Rao, **CPC-A**
Brandi Beckman, **CPC-A**
Brandi J Kimmet, **CPC-A**
Brandy Duran, **CPC-A**
Brenda Hale, **CPC-A**
Breon Mccoll-Stork, **CPC-A**
Brian K Aken, **CPC-A**
Bridget Johnson, **CPC-A**
Bridgette Route, **CPC-A**
Brielyn Alena Aponte-Whaley, **CPC-A**
Brittany Baggett, **CPC-A**
Brittany Boyers, **CPC-A**
Brittany Rhoades, **CPC-A**
Brittany Webb, **CPC-A**
Brittney Allison Michaels, **CPC-A**
Brooke King, **CPC-A**
Brooke Riggan, **CPC-A**
Brooklynn Bullard Sheats, **CPC-A**
Bryn Shank, **CPC-A**
Budumuri Parathpara Rao, **CPC-A**
Bushra S Qasim, **CPC-A**
Caitlin Crane, **CPC-A**
Caitlyn Brennan, **CPC-A**
Camille Eloisa Asuncion Cardenas, **CPC-A**
Candice Zelasney, **CPC-A**
Carla Graham, **CPC-A**
Carrie Franklin, **CPC-A**
Casey Arnold, **CPC-A**
Casey Hawkins, **CPC-A**
Casey Petrauskas, **CPC-A**
Cassandra Bolen, **CPC-A**
Cassandra Omalley, **CPC-A**
Cathleen Cyr, CPB, **CPC-A**
Cathy Jo Symonds, **CPC-A**
Cathy Lee Butler, **CPC-A**
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Orlando Cintron, **CPC-A**
P Kalpana, **CPC-A**
Paage Beach, **CPC-A**
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Pamela Van Note, **CPC-A**
Pandaga Uma, **CPC-A**
Paranthaman K, **CPC-A**
Parris Hampton, **CPC-A**
Parthiban Selvaraj, **CPC-A**
Patricia Renner, **CPC-A**
Patrick George McSweeney, **CPC-A**
Patrina Cave, **CPC-A**
Paul Simpson, **CPC-A**
Paul Yakatan, **CPC-A**
Paula Ames, **CPC-A**
Paula Jones, **CPC-A**
Pauli George, **CPC-A**
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Pavithra Selvam, **CPC-A**
Payel Das, **CPC-A**
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Peggy Cichos, **CPC-A**
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Philo Crescencia Navis, **CPC-A**
Phoebe Rush, **CPC-A**
Ponduru Raju, **CPC-A**
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Rachel Ann Gomez Tolentino, **CPC-A**
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Rachel Glisson, **CPC-A**
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Rebecca Parker, **CPC-A**
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Rebecca Sanders, **CPC-A**
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Rehna RC, **CPC-A**
Reji Philip, **CPC-A**
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Yamilett Graybill, **CPC-A**
Yamini Priya Moorthy, **CPC-A**
Yamisleydis Leon, **CPC-A**
Yetsy Betancourt, **CPC-A**
Ying Deng, **CPC-A**
Yogaraj P, **CPC-A**
Yogesh B, **CPC-A**
Yolanda Diaz, **CPC-A**
Yuko Plambeck, **CPC-A**
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Yvonne Cisneros, **CPC-A**
Yvonne Korol, **CPC-A**
Zachary Sears, **CPC-A**
Zahiry Pena, **CPC-A**
Zeeshan M, **CPC-A**
Zhiqin Hong, **CPC-A**

Specialties

Adeola Omowunmi Kunrunmi, **CPB**
Adrian Avila Limbo, CPC, **CPMA**
Adriene Williams, CPC, **CPB**
Agena Foiles, CPC, CPMA, **CIRCC**
Alex Niederhofer, **CRC**
Alicia Berrett, **CPB**
Alicia De La Torre, **CIRCC**
Alina Uchenik, **CPMA**
Alka Suresh Jhurani, CCC, **CDEO**
Allison Wise Stewart, CPC, **CRC**
Alvin Glenn Digo Banaag, CPC, **CPMA**
Amanda E Coates, CPC, **CRC**
Amanda Gail Griffith, CPC, **CPMA**
Amanda Hartman, CPC, CPMA, **CEMC**
Amanda K Rupansingh, CPC, CFPC, **CRC**
Amanda Kim Boutte, **CHONC**
Amanda Long, **CRHC**
Amanda Rene Morgan, CPC, **CRC**
Amaya Tabraue, **CRC**
Amber Care, **CRC**
Amia Thrash, **CRC**
Amy Heath, **CRC**
Amy L Burrows, CPC, **CRC**
Anagha Jadhav, CPC, **CPMA**
Andrea E Siekierski, CPC, **CRC**
Andrea McClung, **COBGC**
Angela Dailey, CPEDC, **CRHC**
Angela Shumate, CPC, **CRC**
Angela Watts, CPC-A, **CRC**
Angelia Barrett, CPC, CRC, **CPMA**
Angina Aromin, **CPB**
Anna Kharitonov, CPC, CRC, **CPMA**
Anna M Cruz, CPC, CPC-I, **CEDC**
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Anne Jordan, **CPB**
Anne L Pedigo, **CRC**
Anne M Noel, COC, CPC, CPB, CRC, CPC-I, **CIRCC**
Anthony Neelankanil Raphael, **CPMA**
Anyei Pichel, CPC, CRC, **CPMA**
April Boyce, CPC, **CRC**
April Cooper, CPC-A, **CPB**
Aracely Figueroa, CPC, **CRC**
Arelis Batan-Martinez, CPC-A, **CRC**
Arielle Hepler, CPC-A, **CRC**
Ashley Burdsall, CPC, **CPMA**
Ashley Curry, CPC, **CRC**
Ashley Johnson, CPC, **COBGC**
Ashley McIntosh, **CPB**
Ashley Moore, CPC, **CRC**
Ashley Nicole Johnson, CPC, **CPMA**
Aura Garcia, CPC, **CRC**
Barbara A Johnston, CPC, **CRC**
Barbara Butler, CPC, CGSC, **CPMA**
Barbara Regalado, COC, CPC, CPMA, **CRC**
Beth Crabtree, CPC, **COBGC**
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Brandy Marczuk, **CPPM**
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Brenda Mier, CPC, **CRC**
Bridget C Brown, CPC, CPMA, **CGSC**
Britanous Talley, CPC, **CGSC**
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Chelsea Lynn Barry, CPC, CPMA, CEMC, **CDEO**
Cheri Lee Matthews-Wagner, CPPM, **CRHC**
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Cheryl Marie DeSarno, CPC, CPB, CANPC, **CPMA, CRC**
Cheryl Sak, CPC, **CPB**
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Christina Drennen, CPC, **COPC**
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Diane Crosthwaite, CPC, CANPC, **CDEO**
Diane Jackson, CPC, **CEMC**
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Dianne Henson, CPC, CPMA, **CUC**
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Donna Stevens, **CFPC**
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Elizabeth Moore, **CRC**
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By Michelle A. Dick, BS

Know Who Represents You and Who to Contact at AAPC

From governing bodies to staff, reach out to AAPC key contacts who help advise and support you.

With so many individuals and boards to represent and govern AAPC membership, you may be confused as to who you should reach out to with a question or for advice. Here is who you should contact and when.

Our Governing Boards

Complementary to a dedicated, compassionate staff, AAPC has three advisory boards to direct AAPC and membership:

- National Advisory Board (NAB)
- AAPC Chapter Association (AAPCCA)
- Legal Advisory Board (LAB)

These advisory boards are made up of experienced professionals who provide honest and valued input to our organization. They are your voice.

NAB

The NAB advises AAPC leadership on coding issues, trends, and member needs. Through active participation in nationally sponsored conferences, events, publications, and educational programs and activities, the NAB promotes AAPC's mission to Uphold a Higher Standard in the business of healthcare. Each NAB representative is a spokesperson for AAPC and you.

The NAB is comprised of 16 members, appointed by AAPC, who serve for a three-year period. They represent eight geographical regions of the United States with clinical, legal, consultant, coding, auditing, and compliance expertise. There are four officers elected by the NAB: president, president-elect, member relations, and secretary, as well as committees who represent AAPC in specialized areas.

For a list of current AAPC NAB members, go to: www.aapc.com/AboutUs/national-advisory-board.aspx or read the article "2018-2021 AAPC National Advisory Board" in the May edition of *Healthcare Business Monthly* (www.aapc.com/blog/41527-2018-2021-aapc-national-advisory-board).

AAPCCA Board of Directors

The AAPCCA is a non-profit governing board for nearly 500 local chapters and is comprised of 16 certified AAPC members. All have former local chapter leadership experience, and all work collaboratively with AAPC staff and current local chapter officers. They are your local chapter cheerleaders.

AAPCCA board members help create, maintain, and sustain chapter infrastructure and advise chapters when situations arise. They develop policies, bylaws, and processes, and they define the roles of officers and committees. All board members visit chapters and speak on behalf of AAPC and the AAPCCA.

Marti Johnson is the director of local chapter support at AAPC and the AAPC national office AAPCCA representative. Local chapters are divided into eight regions with two representative board members each. For a list of current members and their contact information, go the AAPC website at: www.aapc.com/aboutus/local-chapter-board-of-directors.aspx.

If you are an AAPC member who has served as a local chapter officer, you are invited to apply to serve on the AAPCCA Board of Directors.

LAB

With increased healthcare regulations, quality measures, and government audits, you may be confronted with a legal issue and have a compliance question. The LAB serves to advise the AAPC national office, the NAB, and the AAPCCA on legal issues associated with the business of healthcare. They address members' legal issues through member forums, author articles in *Healthcare Business Monthly*, and attend HEALTHCON. LAB members also sit on AAPC's Ethics Committee.

You'll find LAB member contact information at www.aapc.com/AboutUs/legal.aspx.

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Upholding a Higher Standard

AAPC's governing bodies and employees provide structured leadership and a strong foundation of support to membership. We are here to serve you; reach out to us!

Michelle A. Dick, BS, is executive editor at AAPC and a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

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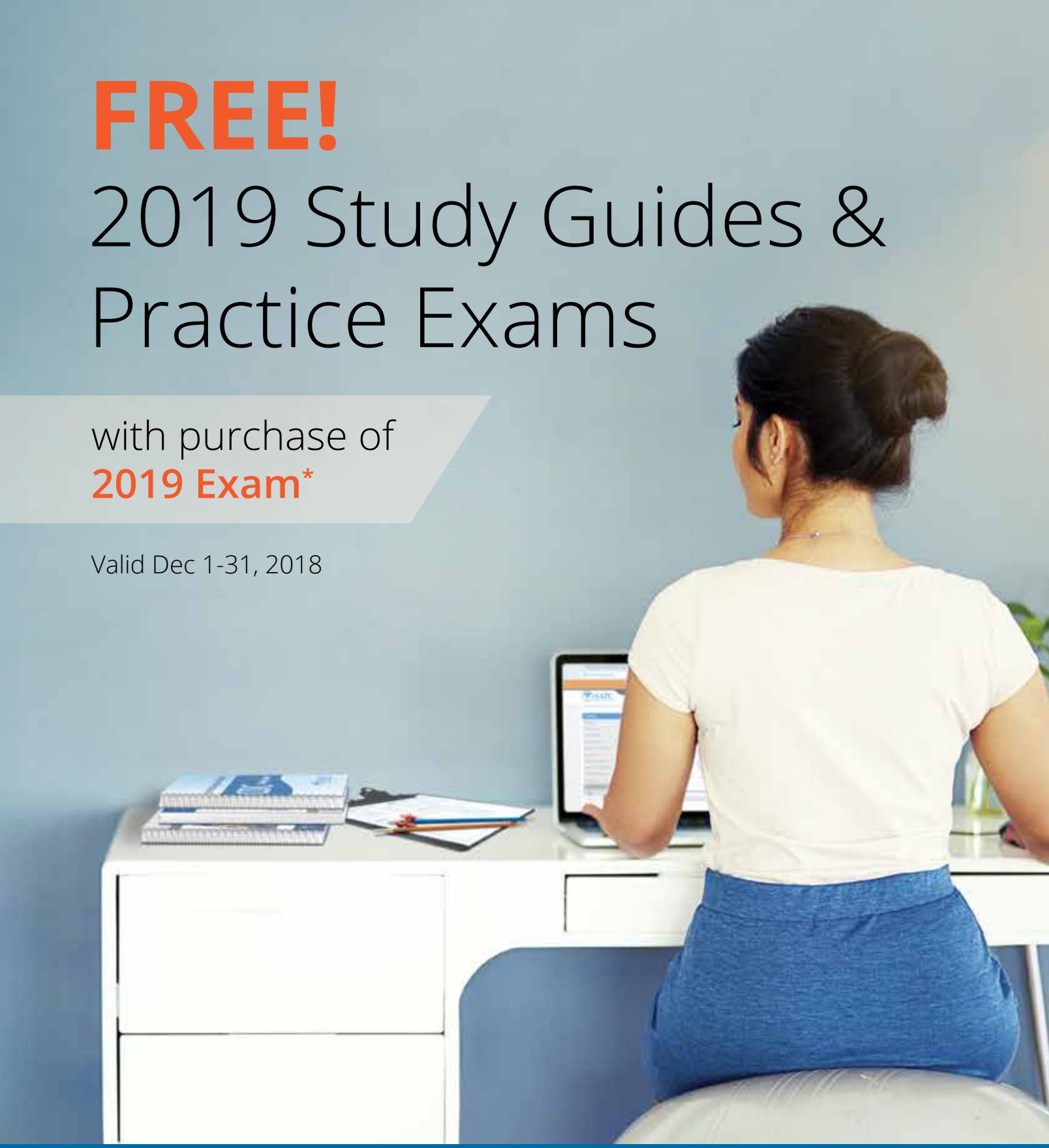

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