Get a Look at CPT® 2023

MEMBER OF THE MONTH
Bridget Toomey, CPC, CPCO, CPB, CPPM
When Accuracy is Everything

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December is traditionally a time of celebration and reflection, and I’ve been doing that a lot lately. It’s hard to believe the first year of the 2022-2025 National Advisory Board (NAB) is coming to an end. Our time is going too quickly, but we have much to celebrate!

**Coming Together**

We came together as a board for the first time in January and we hit the ground running thanks to the leadership of our NAB officers Rhonda Buckholtz, CPC, CDEO, CPMA, CRC, CENTC, CGSC, COBGC, COPC, CPEDC, AAPP Approved Instructor, Stephanie Thebarge, CPC, CPB, CPMA, CPPM, CEMC, CHONC, Stephanie Sjogren, CPC, COC, CDEO, CPMA, CPC-I, CCS, HCAF, and Astara Crews, MJ, CPC, CPEDC, CHC, CHPC, CHIAP. These ladies took the lead on our committee work and enabled a seamless transition from the previous NAB.

Over the course of the year, chairperson duties were assigned to newer NAB members, and I am so impressed with the leadership and momentum they created in all our efforts to serve AAPC membership. Mentoring is a project we remain committed to and passionate about. It has been great to see the number of mentor partnerships grow. The Career Advancement Committee continues to track and improve the AAPC Mentorship Program. If you have not already done so, please consider becoming a mentor.

**Doing the Work**

Another area we focused on was ensuring our newest members were prepared for a successful entry into the business of healthcare. In October, we held our first virtual career fair. NAB members worked tirelessly with AAPC to ensure this event was a success. NAB member Jessica Halliday, CPC, starred in an inspirational video to share her experience as someone who successfully transitioned into the healthcare field and what it took to land her first position. Resources for job search tips and soft skills that are needed in the industry were created and shared.

We also rolled out New Member Orientation meetings, which are the result of a partnership between the NAB Member Committee and the AAPC Chapter Association Board of Directors (BOD). These meetings are meant to help AAPC members understand the value of membership.

Our Exam and Certification Committee is always hard at work to ensure members have the most up-to-date education available. This year the committee was able to offer all certification exams online to give members more flexibility when scheduling an exam. This has also helped to alleviate test anxiety for some members.

**Remembering Good Times**

One of my favorite memories of 2022 was HEALTHCON Regional in Denver, Colo., this past August. It was my first time attending NAB’s annual retreat, which is when the board meets with AAPC leadership to share ways we can improve the member experience. We took the ideas generated during the retreat and assigned them to our various committees to make them happen. While our monthly Zoom meetings are always fun and productive, it was amazing to meet everyone in person, and it felt like we had known each other for years!

After the retreat ended, we headed right to conference. Many NAB members presented educational sessions, while others helped by managing the breakout session rooms. One of the highlights was the NAB Instagram takeover. This was our time to share the camaraderie of being on the NAB and the excitement of being at an AAPC conference. It was such a success that we created a Social Media Committee to continue to work on ways to reach our members through the various social media platforms.

**Looking Forward**

This has been such a wonderful year of progress, and we look forward to continuing to serve you in the coming year. If you have not already done so, I encourage you to reach out to the NAB to share your ideas and questions. And on behalf of the NAB, I wish all of you a happy, healthy, and prosperous holiday season and new year!

Sincerely,

Colleen Gianatasio, MHS, CPC, CPO, CPC-P, CPMA, CRC, CPC-I, CCS, CCD-5-O
2022-2025 NAB President
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On the cover: Turn to page 14 to learn about Member of the Month Bridget Toomey, CPC, CPCO, CPB, CPPM. Cover photography by Ivy Towler Photography. Cover design by Mahfooz Alam.
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I chose to become a medical coder because of my sister Diana. She was preparing for the Certified Professional Coder (CPC®) exam and shared with me her excitement about the many opportunities on the business side of healthcare. The industry seemed challenging and rewarding and full of ways to make a difference in people’s lives.

Preparing for My Exam
Preparation for the exam took a lot of effort, but it was worth it. I was working full time and raising a small child then, and the only time I had available to study was at night and on the weekends. I knew early on that the amount of time allotted to answer all the questions on the exam would be an obstacle, so I timed every practice quiz and test I took from the beginning of my preparations. The best advice I can give to anyone sitting for an exam is to strategize. Know your strengths and weaknesses as a test taker and practice your test-taking strategies.

Breaking In
Becoming a certified medical coder allowed me to break into the industry, though it was challenging as a newly credentialed coder without work experience. I did some research on companies that hired new coders and stalked their job boards for about six months. I applied for the entry-level position I was eventually hired for three times in those six months before securing an interview, but my persistence paid off and I got the job. Once I had my foot in the door, I got some coding experience and risk adjustment coding training. I then transitioned to a quality business analyst role followed by my current position as a coding consultant manager for Optum.

A Family Affair
While my sister Diana ultimately inspired me to take the leap into the field of healthcare, my cousins Melissa and Amanda (both of whom enjoy successful medical coding careers) encouraged me along the way, as well. Another sister, Sarah, who has an amazing career in the dental field, also cheered me on during my journey.

In addition to my wonderful family, I had an incredibly supportive boss at the beginning of my career (she’s now a colleague) who always told me that one day she would be working for me. She taught me how strong leaders support and develop their teams. I now find myself saying and doing the exact same things with my own team as she did with hers.

The Future Awaits
I plan to sit for my Registered Health Information Administrator (RHIA®) credential this winter and hope to obtain my Certified Professional Compliance Officer (CPCO™) certification in 2023. There’s so much more to learn and accomplish in my career.

#iamaapc

We want to feature you in Healthcare Business Monthly! Tell us in 350 to 500 words why you became a member of AAPC, how your AAPC credentials have helped you in your career, and the best part of being an AAPC member. Send your story and a digital photo of yourself to iamaapc@aapc.com.
Is It Really Major Depressive Disorder?

Provider groups are assigning thousands of elderly patients diagnoses they don’t have such as major depressive disorder (MDD) and a few others. I’ve worked in the business of revenue cycle management, coding, clinical documentation improvement, and education for over 25 years, and I presently work as an auditor and educator. I see many records, on a daily basis, with a code assignment of MDD without clear documentation to support the DSM-5 criteria for MDD.

What often happens is the physician group will create clinical protocols for depression, and based on how many boxes are answered with a yes and what the provider checks off, the electronic medical record auto-suggests the MDD diagnosis and the nurse practitioner accepts it. The diagnosis then gets dropped on the progress note in the Problem List and never goes away.

However, the provider more often writes the story that the elderly patient is sad and lonely due to the loss of a spouse (F43.21) or the patient has severe anxiety, a depressed mood, and doesn’t want to leave the house (F41.8). Most primary care physicians are not educated in mental health but will prescribe antidepressant medications or give refills to such medications previously prescribed by a psychiatrist. Rarely does the documentation support the clinical criteria for MDD, characterized by extreme persistent depressed mood or loss of interest causing impairment in daily life.

— Anonymous
Online Poll

Your Vote Matters

If you frequent AAPC’s Knowledge Center blog, you may have noticed the polls on our website. If you’ve already participated in one or more polls, thank you! New questions go up on the second and fourth Tuesdays of each month. View the latest poll at www.aapc.com/blog. Here are the results for polls posted in September 2022.

Poll Results - September 13, 2022
Which soft skill do you feel is most relevant to your role?

<table>
<thead>
<tr>
<th>Skill</th>
<th>Percentage</th>
<th>Votes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem solving</td>
<td>51.26%</td>
<td>428</td>
</tr>
<tr>
<td>Adaptability</td>
<td>22.99%</td>
<td>192</td>
</tr>
<tr>
<td>Active listening</td>
<td>16.17%</td>
<td>135</td>
</tr>
<tr>
<td>Emotional intelligence</td>
<td>9.58%</td>
<td>80</td>
</tr>
</tbody>
</table>

Poll Results - September 27, 2022
If you could wave a magic wand, which of these would you wish to stop doing?

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
<th>Votes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letting fear hold you back</td>
<td>37.88%</td>
<td>231</td>
</tr>
<tr>
<td>Procrastinating</td>
<td>31.88%</td>
<td>197</td>
</tr>
<tr>
<td>Sweating the small stuff</td>
<td>16.18%</td>
<td>100</td>
</tr>
<tr>
<td>Saying yes to too many things</td>
<td>14.56%</td>
<td>90</td>
</tr>
</tbody>
</table>

CMS Releases 2023 Medicare Handbook

The official U.S. government Medicare handbook Medicare & You is now available for 2023. Patients can help Medicare save money and go green by signing up to receive an electronic copy and requesting electronic Medicare summary notices. The handbook includes everything patients and caregivers need to know about Medicare, including information on types of Medicare plans, payment options, and patient rights and protections. Medicare recipients can also use the handbook to find out if Medicare covers a test, item, or service. Information about signing up for Medicare and enrollment periods can also be found.

Read the rest of this article at www.aapc.com/blog/86346-cms-releases-2023-medicare-handbook to find out what new and important information is included in the updated handbook.

Billing for Tetanus Vaccine?
Check the Diagnosis

Did you know that tetanus vaccines are only covered under Medicare Part B when given for treatment? Preventative tetanus vaccinations are not covered. I found this hard to believe, so I looked it up. Sure enough, the Centers for Medicare & Medicaid Services Internet-Only Manuals Pub. 100-02, Chapter 15, Section 50.4.4.2 states, “Vaccinations or inoculations are excluded as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition ….”

I must not be the only one who didn’t know this because Medicare Administrative Contractor (MAC) First Coast Services Option, Inc. recently posted a reminder on its website. The MAC for Florida, Puerto Rico, and the U.S. Virgin Islands says it has “identified that many providers are submitting claims for tetanus vaccinations without the proper diagnosis codes to support the medical necessity of the service.”

Read the rest of this article at www.aapc.com/blog/86567-billing-for-tetanus-vaccine-check-the-diagnosis to learn how to avoid documentation requests, claim processing delays, and possible denials.
We all need a little help from time to time. Usually, this means chipping in at work, lending an ear, or offering advice. But what do you do when times get really tough? If you’re struggling financially due to an unexpected hardship, such as an illness or a natural disaster, you may qualify for assistance from the AAPC Chapter Association’s Hardship Fund.

**How to Get Help**

The Hardship Fund offers two types of assistance: (1) help with maintaining AAPC membership and certification (excluding exam purchases), membership renewal, books, study guides, etc., and (2) help with the personal needs of members who have experienced a catastrophic disaster.

All awards are based on the availability of funds and your ability to demonstrate reasonable hardship. The AAPCCA Hardship Committee reserves the right to inquire with local chapter officers of your affiliated chapter, the AAPCCA Board of Directors representative for your region, and/or AAPC staff.

You can find more information about the AAPCCA Hardship Fund and apply for assistance on AAPC’s website.

**How Can You Help?**

This program also enables local chapters and leadership to be involved in the process. Many AAPC local chapters hold fundraisers and raffles to help raise money for the Hardship Fund.

Other ways local chapters can help:
- When possible, consider reducing registration fees for local chapter events for members experiencing a proven hardship.
- Ask for donations of code books and resource materials from previous years for members to use for exam preparation.
- Provide members with resources for low- or no-cost continuing education units (CEUs) and educational resources.
- You may also nominate a fellow AAPC member in need of financial assistance.

It’s imperative that we take care of our fellow AAPC members. Please consider supporting this wonderful cause.

Check donations should be made payable to the AAPCCA Hardship Fund and sent to:

AAPCCA Hardship Fund Program  
2233 S Presidents Dr., Suite F  
Salt Lake City, UT 84120

All donations go directly to the fund to benefit members in need.

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.
3 Ways to Access eNewsletters on Codify

See which option helps the most when you’re ready to earn CEUs.

If your Codify package includes access to one or more AAPC’s eNewsletters, there are a few different ways you can access the articles and issues. The variety of options means you can research codes without interrupting your workflow.

1. **Publications tab:** On the top menu, hover over Publications and then select Coding and Healthcare Newsletters. When the new page opens, you can select an article, read a full issue, search by code or keyword, or click “Take Quiz” if continuing education units (CEUs) are available to you for that newsletter. (Figure 1)

2. **Search bar:** In the main search bar, select Publications from the dropdown list. (Figure 2) Enter your search term and click the magnifying glass to execute the search. You can further narrow and sort the results on the results page.

3. **Code details page:** Find the Related Articles box on the code details page and select the Coding Alert(s)/Survival Guides tab. (Figure 3) You’ll find links to articles related to your code.

Deborah Marsh, JD, MA, CPC, CHONC, is a senior development editor at AAPC. She has explored the ins and outs of coding for multiple specialties, particularly radiology, cardiology, and oncology.
Fundraising Ideas for Local Chapters

These great ideas can help you keep your chapter afloat year-round.

AAPC pays local chapters for holding meetings and hosting exams, but there are lots of other ways to increase chapter funds. If you need extra cash flow in your chapter bank account to pay for things like member appreciation gifts or room rentals, here are some great ideas you can use.

Get Local Businesses Involved
Reach out to local businesses for donations in the form of gift cards or store merchandise. You can use these items to hold raffles during chapter meetings with the proceeds going to the chapter’s fund. You can also sell tickets for a 50/50 drawing, where half of the proceeds go to one lucky winner and the other half goes to the chapter’s bank account.

Host Seminars
Hosting seminars is a great way to provide education while also raising funds, and they can be conducted online or in person. When planning a seminar, consider the cost per person. If you’re hosting an in-person seminar, the amount should include the cost of food, speaker appreciation gifts, door prizes, decorations, and other associated expenses. Divide the total cost by the expected number of attendees to determine the per-person cost and then determine how much you would like to make for the chapter. For example, if the cost per person is $30, and you want to make an additional $20 per person for the chapter, you should charge $50 for registration for the seminar. Online seminars have the advantage of a lower cost and a larger pool of speakers to select from. They are also likely to bring in more attendees from outside of your immediate area.

Hold Review Classes
Offering review classes can also be a great way to earn additional income for a chapter. AAPC provides a presentation for the Certified Professional Coder (CPC®) certification exam. Also, check with your members and local instructors to see if they can assist with providing review classes. Chapters are allowed to charge a reasonable fee to hold review classes for any AAPC certification. Consider using alternate instructors if you are planning an all-day review class.

Get Creative
I hope these ideas have inspired you to think of other ways to increase your chapter’s funds. With some creativity and support, you can keep your chapter fiscally sound and fully operational for its members.

Victoria Moll, CPC, COC, CPMA, CRC, CPRC, AAPC Approved Instructor, AAPC Fellow, has more than 10 years of multispecialty experience in coding, auditing, and healthcare management, with expertise in plastic and reconstructive surgery. She has spoken at HEALTHCON, as well as many local chapter seminars and meetings, and is known for her infectious enthusiasm. Moll is a contributor to Healthcare Business Monthly, as well as various coding blogs and podcasts. She is a member of the Allentown, Pa., local chapter, for which she has been president, vice president, and education officer. Moll sits on the 2022 AAPC Chapter Association Board of Directors.
This Social Butterfly Is Spreading Her Wings

Meet the president of the Broomfield, Colorado local chapter.

This month’s spotlight shines on Lori Jaramillo, CPC. Medical coders who spend any amount of time on social media have likely encountered Jaramillo. She is a customer support ambassador and social media manager for CCO, a coding education company. Jaramillo has been active online since 2012 and has a contagious passion for sharing her knowledge and insight with coders across the globe. She created the Facebook groups “Create a Coder” and “Medical Coding for Newbies” and is an active participant on the AAPC, AAPC Certified Members, and AAPC Officers Facebook groups. Jaramillo also posts coding content on Instagram and is active on the Medical Coding subreddit. It came as no surprise to those who know her that Jaramillo was awarded the “Social Butterfly” award at AAPC’s HEALTHCON Regional 2022 in Denver.

Cherishing Connections

Jaramillo has proudly taken on the role of president of the Broomfield, Colorado local chapter. She particularly loves the networking aspect of local chapters and how they enable AAPC members to stay connected, learn from one another, and share resources. Being involved in her local chapter has given Jaramillo a greater opportunity to give back to the coding community and help members find their voice within the group.

With all of her connections, Jaramillo easily stays up to date on the most recent coding changes. And now, as chapter president, she is excited to have even more opportunities to share her knowledge with others and offer guidance. Jaramillo aspires to be the go-to person on social media for students who need guidance about AAPC and its credentials, as well. Don’t be surprised if you see her speaking at other chapters or getting her instructor certification in the future!

Sage Advice

Jaramillo’s advice to anyone who has not yet attended a chapter meeting is to not be afraid or hesitant to go. “I suggest letting the chapter president know this is your first time,” she said, “so we have an opportunity to include you, get to know you and your goals in coding, and perhaps buddy you up with someone depending on those goals. Don’t forget to participate and ask questions, as well, as you never know who is watching; your participation can get you remembered, especially come job search time.”

Living Life to the Fullest

When she’s not inspiring others, Jaramillo enjoys spending time with her family. They enjoy going to festivals, concerts, and movies, as well as camping, biking, hiking, traveling, and just having fun. Jaramillo married Bary Jaramillo in 2021, and they have a big dog, CJ, who is their baby. Jaramillo has two beautiful daughters who have blessed her with a grandson and a granddaughter, and her husband’s son and daughter have added four more grandchildren to her life. Jaramillo is a big kid at heart, and says, “I firmly believe you are only as old as you feel, and inside I feel young!” We can’t wait to see what’s next for this community leader.

Victoria Moll, CPC, COC, CPMA, CRC, CPRC, AAPC Approved Instructor, AAPC Fellow, has more than 10 years of multispecialty experience in coding, auditing, and healthcare management, with expertise in plastic and reconstructive surgery. She has spoken at HEALTHCON, as well as many local chapter seminars and meetings, and is known for her infectious enthusiasm. Moll is a contributor to Healthcare Business Monthly, as well as various coding blogs and podcasts. She is a member of the Allentown, Pa., local chapter, for which she has served as president, vice president, and education officer. Moll sits on the 2022 AAPC Chapter Association Board of Directors.
AAPC Recognizes Bridget Toomey

Meet a member who is on a mission.

“I’m motivated to give patients the best experience possible from the time they schedule an appointment to the time they receive their bill and to also make the lives of other employees better.”
Each month, AAPC selects a member who demonstrates exemplary leadership qualities. This month, we’ve chosen Bridget Toomey, MS, CPC, CPCO, CPB, CPPM, for her positivity and drive. We think her professional journey will inspire you.

How did you get your start in healthcare?
I did a college internship in Hyderabad, India, where I worked with an organization that conducted field research and provided resources for government-run schools and hospitals. The experience piqued my interest in healthcare systems. Fast-forward a few years when I took my first job as a revenue cycle representative at the University of Iowa Hospitals and Clinics (UIHC). I fell in love with the denial management part of the job. Over the next decade, I held many different revenue cycle positions at UIHC, including denial management/billing, new-hire education coordinator, supervisor for the Medicaid denial management team, and supervisor for a coding denial follow-up team (CDFT). Then I stepped into a project management role for a large revenue cycle project involving outside consultants.

What is your current occupation?
In 2014 my mom was diagnosed with advanced ovarian cancer, which took her life in 2016. During this journey, I took her to appointments within the Obstetrics and Gynecology (ob-gyn) department at UIHC. I was awestruck by everyone on her care team. I had already been working with the ob-gyn department as one of their revenue cycle contacts, but my experience working with them from the caregiver/patient side really changed things for me. It was at this point that I knew I wanted to switch my focus to the clinical space. In July 2020, I started my current position as assistant department administrator for ob-gyn. I’m now able to work on clinical operational improvements but also have an impact on billing and coding.

What motivates you?
I’m motivated to give patients the best experience possible from the time they schedule an appointment to the time they receive their bill and to also make the lives of other employees better. Burnout was a problem before the pandemic, but the pandemic has really brought it to the forefront in healthcare. When I stepped into my current role, the first thing I did was meet with different people to ask them what was working for them and what wasn’t. From there, I kicked off several process improvement projects to help make their work lives better. I love finding opportunities to make improvements because of the positive outcomes, but also because I love being able to give my team opportunities to take the lead and own their work. I love mentoring and building up leaders.

What or who has helped you the most to be successful in this profession?
My team. Without my smart, hard-working team I would be lost. I came into my current role having never worked in a clinical setting before. I always defer to my team as the experts and bring them to the table to share in their knowledge every chance I get. I believe that surrounding yourself with a strong team and building trust is the key to being successful.

What are you most proud of accomplishing in your work?
I’m extremely proud of my CDFT. It was an idea I had played around with for some time and was honored when my leadership team trusted me enough to let me bring it into existence. And even though I’m not involved in the team anymore, it is still going strong.

I’m also extremely proud of how I have been able to bring together my personal and professional lives. In addition to my job, I’m very involved in cancer advocacy. I’m an advocate leader with the Ovarian Cancer Research Alliance and the District 2 Lead for the American Cancer Society Cancer Action Network. This past September, I obtained proclamations by the governor of Iowa and the Johnson County Board of Supervisors declaring September Ovarian Cancer Awareness Month in Iowa and in Johnson County. I also sit on the Community Advisory Board for the Holden Comprehensive Cancer Center at UIHC.

And most importantly, I’m proud to be on the AAPC National Advisory Board (NAB). When I first became an AAPC member I wasn’t very involved. But then I remembered reading an article in Healthcare Business Monthly (HBM) about the NAB and the work they do, and I knew that I wanted to be on the board someday. To work toward the goal, I started volunteering at my local chapter as the member development officer and then eventually took roles as president, vice president, and education officer. I also began writing articles for HBM. Then, last year, I applied for a place on the board and was accepted! This had been a goal of mine for years, and it has finally come true.

Is there anything you want other coders to know? Any sage advice?
Your coding and billing knowledge is powerful. The skills and knowledge you have and the connections you make with AAPC are extremely valuable and will take you places if you want them to. If there is a job out there that you are interested in but don’t think you are qualified to apply, try anyway! Ask around, make connections, and seek advice. I may not have the job I have now if I hadn’t approached my boss and told him to think of me for future opportunities. Be your own advocate!

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.
Staying Home? Stay Healthy

Don’t forget to add exercise and movement to your list of workday tasks when working remotely.

The COVID-19 pandemic has changed our lives in many ways over the last few years. While many of these changes have been challenging, there have also been some good changes — including the flexibility of remote work. In 2020, many billing and coding staff were temporarily sent offsite to enforce social distancing and to control the spread of COVID-19. More than two years after this exodus, many employers have seen the value in remote work and have elected to keep many of these workers at home.

In the 2022 AAPC Salary Survey, 70 percent of respondents reported that they remain working remotely. This number is a drastic increase from the several years of pre-pandemic data that found remote work held at 30-33 percent. Remote work offers many benefits to employees, but it can also have negative health and wellness consequences. Employees who work from home no longer have the built-in walking that comes from navigating within an office setting, which significantly decreases the movement we need each day. But there are many ways to increase health and wellness at your in-home office. Here are some great examples.

Exercise at Home

The beauty of exercising and working in your home is that you can cut out travel time. You can go from working at your desk to doing a full cardio or yoga session in just minutes! Take advantage of this extra time. Don’t have any fitness videos to use? Don’t worry. Check out some of these YouTube channels and see what works for your schedule and fitness style.

- **BeFiT**
  - BeFiT has a wide variety of exercise videos. Do a 10-minute extreme cardio workout or check out a fat-burning Latin dance workout with the one and only Jane Fonda!

- **Zumba Class**
  - Love to dance? This channel has classes for all fitness levels and experience.

- **Walk at Home**
  - The Walk at Home channel is all about getting those steps you are missing when you aren’t going to the office. If walking is your style but it’s cold outside, or you don’t have a good place to walk near you, this channel gives you a variety of instructor-led “walks” to get you moving.

Improve Your Workspace

Research shows that sitting for long periods of time can increase the risk of chronic health problems. Working in the same place you live and sleep by nature decreases movement from one location to another and increases the amount of time you spend in a chair. Consider purchasing one of the following to help combat the reduced movement of sitting in one place all day:

- **Sit-to-stand desk**
  - If it’s within your budget and you have the space for it, you may want to invest in a full sit-to-stand desk,
which moves your entire workspace up and down. Once hard to find, these desks are now readily available from multiple retailers at different price points. If a full workstation doesn’t suit you, a sit-to-stand desk converter or riser may do the trick. Once you have the setup you like, alternate every hour between sitting and standing.

• **Under-desk treadmill**
  - If you want to take your standing desk configuration up a notch, consider purchasing an under-desk treadmill. These handy machines can be set at a pace so you can walk and work at the same time. Plus, you can use the same machine on breaks or after work to get in your daily workout just by turning up the speed.

• **Under-desk elliptical or cycle**
  - If your mobility limits your ability to stand while working, consider investing in an under-desk elliptical or cycle. These mini cycles fit under your desk and allow you to pedal in place while seated. They help to keep your blood flowing, while also helping you burn calories as you work.

### Try an App

If you already have your exercise covered, maybe you just need a reminder to get up and move. Check out these apps that can help you break up your day.

- **Stand Up! The Work Break Timer**
  - Free for iOS
  - Set timers at intervals between 5 minutes and 2 hours that conform to your workday. The app won’t send you reminders before or after work (unless you want it to). Schedule reminders to stand, drink water, exercise, and more.

- **Randomly RemindMe**
  - Free for Android
  - Similar to Stand Up!, this app allows you to set reminders throughout the day to get up, stretch, and drink more water.

- **Workrave**
  - Free for Windows OS
  - Workrave monitors keyboard and mouse usage and alerts you to take microbreaks or rest breaks. It can also restrict your computer usage. Set limits based on your needs and this handy program will help keep you accountable for the goals you have set for yourself.

### Get Moving!

Working remotely is here to stay, so it’s important for everyone to take workplace wellness home with them. Try one, or all, of these ideas, and get moving! 

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“**The beauty of exercising and working in your home is that you can cut out travel time. You can go from working at your desk to doing a full cardio or yoga session in just minutes!”**
There has been a recent focus on diversity, equity, and inclusion (DEI) throughout a variety of industries; and understanding their impact on healthcare organizations is important in improving health outcomes and quality of life for patients. Medical coders have a unique behind-the-scenes view of patient care. They may not have personal interactions with patients, but they are indirectly involved in the patient environment. You can help to ensure your healthcare organization offers a welcoming, diverse office environment that extends to the patient level through DEI.

L Renee Bradley, Ed.D, MBA, CPC, CPC-P, professor of medical coding and special assistant to the president for DEI at Rhodes State College in Lima, Ohio, presented “Diversity, Equity, and Inclusion Awareness in the Medical Field” at AAPC’s HEALTHCON Regional 2022 in Denver, Aug. 3-5. Bradley emphasized that she wanted the audience to “listen, learn, and take back” what she was teaching in her presentation because DEI awareness has shifted to the forefront in this country. Here are the takeaways from Bradley’s presentation. Share them with your healthcare organization to ensure a culture of diversity, equity, and inclusion.

Understand Diversity, Equity, and Inclusion

Diversity is a word you’ve heard since the ’70s, but more recently two other words have helped to broaden its scope: equity and inclusion. Diversity has not gone away, it’s just been enhanced, according to Bradley. She defines these key terms as follows:

Diversity — The presence of differences in people that may include race, gender, religion, sexual orientation, ethnicity, nationality, socioeconomic status, language, (dis)abilities, age, or political perspective.
Bradley recommends looking at your healthcare organization and noting what diverse populations exist. Focus on which ones are underrepresented among practitioners in your work environment and those who are marginalized in society.

**Equity**—Promoting justice, impartiality, and fairness within procedures, processes, and distribution of resources by institutions or systems.

It is important to understand the difference between equality and equity. Bradley says that equality was a catchword in the ’70s, ’80s, and ’90s, and it means giving everyone the same thing to help them achieve their goals. That concept doesn’t work for everyone, however, as you can see in Figure A, which shows that not everyone can achieve their goal (seeing over the fence) using the same thing (a box to stand on).

How do you remedy the shortcomings of equality via equity? The tallest person in Figure A doesn’t need a box to achieve the goal of seeing over the fence to watch the game, so their box is taken away and given to the smallest person in purple who needs two boxes to achieve the goal of seeing over the fence. The mid-sized person can see over the fence with just the one box they were given. Everyone now achieves the goal of seeing the game.

Equity, Bradley says, is being able to say, “I’m giving everyone something they can actually utilize in their particular space, time, and situation.” Explore what unique aspects fulfill what the individuals in your work environment need daily to achieve their desired outcomes. “Tackling equity issues requires an understanding of the root causes of outcome disparities (especially in healthcare) within our society,” said Bradley.

**Inclusion**—An outcome to ensure those who are diverse are welcomed and/or feel welcomed. Inclusion outcomes are met when you, your organizations, and your programs are truly inviting to all.

Figure B illustrates equality, equity, liberation, and inclusion. In the third picture (liberation) the fence has come down and the three individuals no longer need boxes because the fence is not obstructing anyone’s view. All feel as if they are part of the game. The fourth picture (inclusion) is the game changer; the three individuals are given a team uniform and are no longer spectators. They can participate fully. In a healthcare organization, this inclusion would allow all three individuals to participate in decision-making processes and development opportunities, according to Bradley.

**Bonus:** Listen to Dr. L Renee Bradley explain in detail the nuances of inclusion and how diversity, equity, and inclusion can be incorporated into your healthcare organization through awareness, which starts by asking these three questions:

- Diversity asks: Who is in the room?
- Equity asks: Who is trying to get in the room but can’t?
- Inclusion asks: Has everyone’s ideas been heard?

You can find the 5-minute clip of Bradley’s HEALTHCON Regional 2022 presentation “Diversity, Equity, and Inclusion Awareness in the Medical Field” in the electronic version of Healthcare Business Monthly, available in your My AAPC app.
Be a DEI Champion in the Coding Industry

Bradley encourages everyone to become a DEI champion. She says DEI champions are individuals within a team, organizational culture, or medical field who are:

• Committed to DEI,
• Leaders in moving the DEI needle forward,
• Thoughtful listeners who exhibit empathy, and
• Engaged in professional development and training to help enhance DEI in their workplace.

Bradley became a DEI champion in the medical coding industry when she joined AAPC. She said, “There is something that stirs within you that says, ‘You know what? I want the same for everyone.’” Bradley realized once she got active in AAPC that there weren’t many coders in her area who were certified. To change this, Bradley said, “Let’s start a chapter. Let’s make that happen, so we’re providing the education. We’re providing motivation … to get individuals engaged.” Now all certified coders have the means to earn low-cost and free continuing education units (CEUs).

Bradley warns: Don’t go back to your employer and say, “Guess what? I’m a DEI champion. I’ve declared myself as such and you need to add this. You talk to HR and make it happen.” Instead, be a champion for yourself first, so the champions are within your team.

The people who watched Bradley’s presentation are already DEI champions, she said, because they showed up and are aware of DEI by choosing her session. It shows that they are dedicated to professional development and training to enhance their knowledge of DEI environments and take it back to the workplace. Other educational opportunities that you can seek to become a DEI champion include joining diversity councils, attending diversity retreats, connecting with community resources and organizations about diversity awareness and celebrations, and supporting and recognizing important dates and events throughout the year.

According to Bradley, the responsibilities of DEI champions are REAL:

Reveal relevant opportunities: Identify specific actions with curiosity and appreciative inquiry. Focus on a few areas that you are already engaged in and areas that you need to be stronger in for the future.

Elevate equity: Prioritize fair and contextually appropriate access to resources and opportunities. Switch from talking about equality to bringing awareness to equity.

Activate diversity: Acknowledge, celebrate, and catalyze different characteristics, values, beliefs, experiences, backgrounds, and behaviors.

Lead inclusively: Intentionally create and sustain an environment that supports direction, alignment, and commitment from everyone in your organization.

DEI champions are intentional and purposeful. They intentionally form committees, make time for professional development, and purposefully acknowledge diversity.

Implement DEI Initiatives

According to Bradley, “Organizations that implement DEI initiatives have a workforce of individuals whose decision-making, creativity, and innovation skills are enhanced, as there is a more central focus on the overall benefits of the organization as a whole — not just individual parts.”

Bradley encourages implementing DEI initiatives throughout multiple areas of the healthcare field to help improve the patient and family experience in outpatient and inpatient settings. When you start looking at your own healthcare system and implementing initiatives to develop DEI statements, you’ll discover “there’s already a base there that either got developed before you came or was developed years ago,” Bradley said. Some may have been developed decades ago. That’s too long, according to Bradley. Diversity is something that is in constant flux; it’s not static. Your diversity statements should be reviewed, developed, and updated on a yearly basis.

While reviewing your DEI statements, focus on policies and procedures, hiring practices, professional development and training, and implementing DEI initiatives for patients and communities served by your healthcare organization. Make sure your DEI statement says what your healthcare organization wants to represent from a diverse aspect. Consider tying it to your mission statement, so they are cohesive.

After you review your DEI statement, Bradley recommends following these revision guidelines. The DEI statement should:

• Demonstrate your organization’s commitment to building an inclusive, varied workplace, welcoming people of all backgrounds
DEI

• Complement your organization’s mission and vision statements
• Be engrained throughout all areas of your organization
• Guide your hiring, employee benefits, customer service, and workplace culture
• Use positive language that is solution-focused (e.g., exclusive, celebrate, grow, freedom, commitment, experience, equality, equity)
• Cite specifics and point out tangible ways to bring awareness and DEI initiatives into your workplace (e.g., programs, policies, training, partnerships)
• Take action and use data to support your progress
• Push beyond normal expectations: Review the progress and DEI statement for alignment with your organization’s mission and vision, including targets.

Make It Personal

Bradley stressed in her presentation the importance of making DEI personal. Creating your own diversity statement can help you become more focused on change in your workplace and demonstrate your commitment to DEI with prospective employers. Four steps that Bradley recommends you take to develop your personal DEI statement are:

1. Think about your past DEI experiences and select one that influenced you most.
2. Explain how the experience contributed to your current personal and professional growth.
3. Identify aspirations for continued DEI growth, such as certification, professional development, and being a member of a DEI organization.
4. Discuss how you want to and will inspire others to embrace DEI.

“Creating your own diversity statement can help you become more focused on change in your workplace and demonstrate your commitment to DEI with prospective employers.”

Bradley says it’s the “fire in your belly” that will prompt you to bring awareness to DEI and make it personal. She shared a story from college that started the fire in her belly and influenced her to become a DEI advocate. Bradley’s college professor treated her, as well as the other students, like a number. She realized that she could do a better job and make people feel welcome. The experience led Bradley “to wanting a career change and a specific career just to be able to treat people equally.” When she became a teacher, she remember not to make people feel like a number. Bradley pushed herself to recognize her students as individuals, so they felt welcomed and like they mattered.

Bradley provided an example of a personal DEI statement for medical coders:

I am committed to promoting diversity, equity, and inclusion in the medical coding field, first by my certification(s), which show(s) my commitment to a field that welcomes and embraces diversity, and by serving on teams and/or committees that are dedicated to enhancing diversity within my community (field or work environment).

I’ve participated in Title IX, Safe Zone, and other training and/or professional development with DEI focus.

“Your DEI statement should show what you have done and also encourage others, and show someone what you would like to do,” said Bradley. She encouraged attendees to share stories that helped them get to the point where DEI was personal and to write their own DEI statements and share them with the others at the session.

The session ended with attendees asking questions, sharing stories, and reciting personal DEI statements. The DEI stories were heartfelt and inspiring — real eye-openers that showed we all can do better to include others and promote DEI. The participants were brave for standing up and sharing the diversity “Ah ha!” moments that have impacted their careers and lives.

It was a dynamic and interactive session, and everyone left with a sense of purpose for the future.
Capture Chronic Conditions in the Outpatient Setting With Confidence

Know when to assign diagnosis codes for chronic conditions.

While assigning diagnosis codes for chronic conditions may seem straightforward, some confusion remains regarding which conditions should be coded in the outpatient setting.

Medical coders are responsible for assigning ICD-10-CM codes for all diagnoses made by a healthcare professional that affect the patient’s care. These codes tell a detailed story about the patient’s condition, provide a comprehensive summary for the payer, and help to create continuity of care between healthcare providers and settings. The first-listed diagnosis explains the primary reason for the patient’s visit, but often it is the secondary codes that help to provide medical necessity for the services performed. Luckily, there are resources available to point coders in the right direction.

Know the Rules

The ICD-10-CM guidelines provide guidance on which codes are to be included on medical claims. There are two important guidelines which can be used when determining whether a code for a chronic condition should be assigned:

- Guideline IV.I. states, “Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).”
- Guideline IV.J. states, “Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.”

Use MEAT to Decide

When thinking about what might affect patient care or management, coders can use the acronym MEAT (monitoring, evaluating, assessing, and treatment) to help them decide which codes to assign. The MEAT acronym is often used in risk adjustment coding but can be used in any coding setting to help determine whether a condition has been addressed. Questions to consider are:

- Did the provider monitor signs and symptoms or disease progression or regression?
- Did they evaluate test results or the patient’s response to treatment?
- Did they assess the patient?
- Did they review tests or records or provide counseling?
- Did they treat the patient using medication or some other modality?
Chronic conditions

“Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).”

It’s important to note that not all the components of MEAT need to be satisfied; even just one component met can demonstrate medical necessity.

Consider Patient History

If a condition has been previously treated and resolved, it should not be coded as a current condition. However, the guidelines state that history codes may be used as secondary codes if the historical condition or a family history has an impact on the patient’s current care or if it influences treatment.

Personal history codes show that a patient no longer has a condition that requires treatment but may have the potential for recurrence and therefore should be monitored. Documenting and coding for personal history is valuable because having a history of an illness could alter the treatment ordered. Often times facilities will develop guidelines regarding the capture of history and other status codes. Coders should always check with their facility for any internal policies regarding patient history.

The American Hospital Association’s AHA Coding Clinic® recently published advice regarding the coding of chronic conditions in the outpatient setting. Its 2021 3rd quarter issue advises not to assign codes based solely on diagnoses noted in the history, problem list, and/or medication list, and that it is the provider’s responsibility to document that the chronic condition affected care and management of the patient for that encounter.

Simply stating in the past medical history that a patient has hypertension is not enough documentation to assign a diagnosis code for that condition. When reviewing the medical record, coders need to look for evidence that the condition, or its treatment, had an impact on the encounter. Was the patient’s hypertension monitored, evaluated, assessed, or treated? Did the provider state its significance to the encounter or show how it affected their medical decision making? The condition must be relevant to assign a code. Consider the following example.

Case Example

A patient presents for outpatient surgery for a musculoskeletal problem. There is a documented history of anxiety in the past medical history, and the medication list shows that the patient is taking a prescription drug for the condition. With just that information alone, the coder should not assign a code for anxiety according to Coding Clinic® advice. However, if the provider had documented that the patient was anxious during the stay and that it was affecting their treatment, or that medications were adjusted or managed due to the patient’s anxiety, then the anxiety would be coded because the provider documented that the condition was relevant to the present encounter.

This Coding Clinic® advice is in keeping with the official coding guidelines, which instruct the coder to assign codes for all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management, and that chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

Code With Confidence

While current guidelines and advice clearly instruct how and when to code for chronic conditions, it can still be difficult at times to determine whether a condition should be coded. But by following all available guidelines and applying MEAT criteria, coders can more confidently capture chronic conditions in the outpatient setting.

Anne Nolan, CCS, CPC, CIC, COE, CDEO, CRC, CPMA, CAH-CBS, AAPC Approved Instructor, has over 25 years of experience in the healthcare industry, including coding, auditing, and educating. She currently works as an internal auditor and has developed Lighthouse Coding, an educational resource for coders offering CPC® preparation as well as other healthcare-related education. Nolan is a member of the Spokane, Wash., local chapter and may be reached via email at anne.nolan@lighthousecoding.com.

Resources

2022 ICD-10-CM Official Guidelines for Coding and Reporting
AHA Coding Clinic®: 3rd qtr 2021: Clarification: Reporting Additional Diagnoses in the Outpatient Setting
The ICD-10-CM codes for endometriosis are expanded in the fiscal year (FY) 2023 update, which went into effect Oct. 1, 2022. After multiple requests, the American College of Obstetricians and Gynecologists (ACOG) and the American Association of Gynecologic Laparoscopists (AAGL), succeeded in getting the N80 Endometriosis code family expanded to allow providers to paint a clearer picture of what’s going on in the patient. “This will enable better tracking, measurement, and ultimately treatment for endometriosis,” the associations stated at the ICD-10 Coordination and Maintenance Committee Meeting, Sept. 14-15, 2021.

What Is Endometriosis?

Endometriosis occurs when the uterine lining, or endometrium, grows outside of the uterus, causing excessive menstrual cramps, heavy periods, and painful sexual intercourse. An estimated 2 to 10 percent of women in America between 25 and 40 years of age suffer from endometriosis.

This abnormal tissue growth typically occurs on the surface of the uterus and may extend to the fallopian tubes, uterosacral ligaments, pelvic cavity lining, and ovaries. Less often, the endometrial tissue may grow on or around the vagina, cervix, bladder, intestines, rectum, or stomach.

Endometrium tissue in the uterus sheds with each menstrual cycle, but when it grows outside of the uterus, it builds instead. Left untreated, this buildup can lead to inflammation, scarring, cysts, and other complications, including infertility.

Endometriosis is classified from stages 1 to 4 and measured in terms of tissue depth:

- **Superficial endometriosis**: Ectopic growth of endometrial tissue extending 5 mm or less below the peritoneal surface.
- **Deeply infiltrating endometriosis**: Ectopic growth of endometrial tissue that extends greater than 5 mm below the peritoneal surface.

Lesions can occur in either case, but the deeper the tissue growth, the worse they become.

Why Were More Codes Needed?

The existing N80 codes, located in Chapter 14: Diseases of the Genitourinary System (N00-N99) of ICD-10-CM, only describe the location of the endometriosis, such as the uterus, ovary, fallopian tube, etc. The new codes provide details for laterality, depth of invasion, volume of disease, and whether specific organs are involved.

New five- and six-character codes greatly expand the existing code category. For example (new codes are green):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N80.0</td>
<td>Endometriosis of uterus</td>
</tr>
<tr>
<td>N80.00</td>
<td>Endometriosis of the uterus, unspecified</td>
</tr>
<tr>
<td>N80.01</td>
<td>Superficial endometriosis of the uterus</td>
</tr>
<tr>
<td>N80.02</td>
<td>Deep endometriosis of the uterus</td>
</tr>
<tr>
<td>N80.03</td>
<td>Adenomyosis of the uterus</td>
</tr>
<tr>
<td>N80.1</td>
<td>Endometriosis of ovary</td>
</tr>
<tr>
<td>N80.10</td>
<td>Endometriosis of ovary, unspecified depth</td>
</tr>
</tbody>
</table>

New ICD-10-CM codes allow healthcare providers to be clearer about the patient’s condition.
“The new codes provide details for laterality, depth of invasion, volume of disease, and whether specific organs were involved.”

The remaining existing codes in this category are expanded similarly. For example, code N80.3 *Endometriosis of pelvic peritoneum* is expanded to include four- and five-character codes for the anterior and posterior cul-de-sac, pelvic sidewall, pelvic brim, and uterosacral ligament(s). And code N80.5 *Endometriosis of intestine* is expanded to include four- and five-character codes for the various sections of the intestines. This category is also expanded to include new codes for endometriosis of the bladder and ureters (N80.A-), cardiothoracic space (N80.B-), abdomen (N80.C-), and pelvic nerves (N80.D-).

These codes support the medical necessity of such diagnostic procedures as computed tomography (CT) of the abdomen and pelvis, ultrasound, and magnetic resonance imaging (MRI). Laparoscopy and biopsy also may be used to diagnose endometriosis. These codes would also support the medical necessity of common treatments for endometriosis such as laparoscopy or laparotomy, hormone treatments (e.g., luteinizing hormone-releasing hormone analogs), and hysterectomy.

**Call to Action**

Healthcare practitioners should be educated about these code changes for endometriosis, and clinical documentation improvement is necessary to ensure the medical record contains the necessary information to capture these new codes for FY 2023. Additionally, make sure your electronic health record system is updated with the new codes and that practitioners are making the most of the available specificity to improve data measurement and patient care.

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**Resources**

- Johns Hopkins Medicine: [www.hopkinsmedicine.org/health/conditions-and-diseases/endometriosis](http://www.hopkinsmedicine.org/health/conditions-and-diseases/endometriosis)
- Centers for Disease Control and Prevention, National Center for Health Statistics. ICD-10-CM Coordination and Maintenance Committee: [www.cdc.gov/nchs/icd/icd10cm_maintenance.htm](http://www.cdc.gov/nchs/icd/icd10cm_maintenance.htm)
A comprehensive literature review of telehealth (telemedicine) interventions for diabetic patients was conducted to investigate how telehealth can potentially impact healthcare quality and lower the rate of health disparities in patients with type 2 diabetes. This review was necessary to understand whether telehealth is more effective in the management of chronic diseases such as type 2 diabetes.

**The Effects of Telehealth on Mental Health Disorders**

Using a randomized control trial, Alessi et al. (2021) sought to understand the impact of telehealth intervention on diabetes-related emotional distress among patients with type 2 diabetes during the COVID-19 pandemic. During the trial:
- The participants were 18 years of age and older with a previous clinical diagnosis of type 2 diabetes.
- Telehealth intervention included a set of strategies aimed at helping patients remain healthy during the COVID-19 pandemic. The interventions were provided through phone calls.
- Healthcare professionals discussed topics with the patients during the phone calls, which included diabetes care, healthy eating habits, physical exercise, and mental health and coping strategies.
- Researchers encouraged patients to adhere to the treatment on every call.

At the baseline, the rates of psychological disorders were similar between the control and intervention groups. After 16 weeks, however, 37 percent of patients who received telehealth intervention experienced mental health disorders compared to 57.8 percent of patients in the control group.

These results suggest that telehealth intervention effectively improves mental health disorders associated with type 2 diabetes.

Alessi et al.’s findings also showed that telehealth intervention effectively reduces diabetes-related emotional distress. Specifically, patients in the telehealth intervention group had lower emotional distress (21.7 percent) than the control group (42.2 percent). Compared to patients in the telehealth intervention group, those in the control group had a 2.63-fold higher likelihood of being diagnosed with diabetes-related emotional distress.

A third finding was that, even though telehealth intervention effectively reduced the prevalence of mental health disorders and diabetes-related emotional distress, it had no significant impact on treatment adherence, sleep disorders, and eating disorders in the study group.

**The Effects of Telehealth on Glycemic Control**

Several research articles have been published on the effects in patients with type 2 diabetes who receive telehealth services to manage their A1C levels.
Egede et al. (2018) conducted a randomized control trial to investigate the effect of telehealth-delivered behavior activation treatment on A1C levels in older adults with type 2 diabetes. At the baseline, the patients in the control and telehealth intervention groups had comparable A1C levels (telehealth 6.9 vs. control 7.3). After 12 months, however, the telehealth group’s A1C levels still averaged 6.9, while the control group’s average increased to 7.7. (A normal A1C level is below 5.7 percent.) These findings suggest that telehealth-delivered behavior activation treatment effectively lowers A1C values in older adults with type 2 diabetes.

Akinci et al. (2018) conducted a similar single-blind, randomized controlled study to compare the effects of telehealth-delivered exercise and supervised group exercise in patients with type 2 diabetes. The results revealed that telehealth-delivered exercise was more effective in A1C control than supervised group exercise.

Greenwood et al.’s (2017) systematic article review evaluated the impact of technology-based diabetes self-management education and support. Messaging and mobile phones were mostly used to deliver education and support to diabetes patients. The primary outcomes included metabolic monitoring, physical activity, and healthy eating. Out of the 25 article reviews, 18 found a significant decline in A1C as a primary outcome. Additionally, the researchers revealed that the critical elements of telehealth that lead to the improvement of A1C include education, communication, feedback, and patient-generated health data. Interventions that led to the most significant reductions in A1C included a technology-enabled self-management feedback loop that linked the patients and the healthcare professional through two-way communication, personalized feedback, customized education, and analyzed patient-generated health data.

Kooiman et al. (2018) conducted a randomized control trial to assess if an online self-tracking program effectively reduces A1C levels and other health outcomes in patients with type 2 diabetes. The patients were randomly assigned to receive a web-based self-tracking program (e.g., Fitbit Zip). The study revealed no statistically significant difference in A1C levels between the participants in the intervention and control groups. However, participants who registered an increase in the number of walking steps per day had a significant decrease in A1C levels compared to those in the control group.

Lee et al.’s (2020) cluster-randomized controlled trial evaluated the impact of remote telemonitoring in individuals with type 2 diabetes. The participants consisted of adults with type 2 diabetes who had A1C levels between 7.5 and 11 percent. The intervention group was given home devices that allowed participants to monitor their blood glucose levels remotely and transmit the data to the healthcare team, who would adjust participants’ therapy accordingly. The team encouraged the patients to adhere to the treatment and live a healthier lifestyle. The primary outcome was a reduction in A1C levels at the 24th and 52nd weeks for those who received telehealth intervention.

Kim et al. (2019) conducted a systematic review and meta-analysis to compare the efficacy of telemonitoring versus standard care
in patients with type 2 diabetes. In a review consisting of 38 studies, telemonitoring resulted in a significant decrease in A1C compared to usual care. Specifically, telemonitoring led to a significant decline in A1C levels when biological data was shared through online devices weekly, when audio feedback was given daily, and when patients were counseled. Additionally, this telehealth technique decreased A1C in studies that monitored participants’ compliance with medication. Lastly, compared to the standard care group, patients in the telehealth group had a 1.8-fold higher likelihood of achieving A1C levels of less than 7 percent.

Sun et al. (2019) conducted a randomized control trial to investigate the utilization of mobile phone-based telemedicine apps to manage type 2 diabetes in patients 65 years and older. Patients in the intervention group were given glucometers that transmitted personal health data and received healthcare advice about physical exercise, diet, and medication. The control group received standard care with no extra intervention. After six months, patients who received telehealth intervention showed a decrease in A1C levels greater than that of the control group.

**The Effects of Telehealth on Medication Adherence**

Adherence to diabetes medications is crucial in controlling the disease and preventing morbidity and premature mortality.

Bingham et al.’s (2021) systematic review revealed that telehealth interventions effectively improve medication adherence. In this review, telehealth intervention involved telephonic outreach, and specialized tools focused on improving health literacy.

Cohen et al. (2020) conducted a similar randomized control study to determine if pharmacist-led telehealth intervention is more effective than nurse-led standard care in enhancing medication adherence, among other outcomes. This study concluded that pharmacist-led telehealth intervention is more effective than nurse-led routine care in improving medication adherence.

Jeong et al. (2018) evaluated the effectiveness of telemedicine and telemonitoring compared to standard care in people with type 2 diabetes. Participants in the telemonitoring group were required to visit the outpatient clinic regularly along with a telemonitoring service that included remote glucose monitoring with computerized patient decision support via messaging. The telemedicine group received remote glucose monitoring, but video conferencing replaced outpatient visits. Medication adherence was better in both telehealth groups (telemedicine and telemonitoring) compared to that in the standard care group.

Zhang et al.’s (2021) systematic review and meta-analysis also showed evidence that telemedicine effectively enhances medication adherence.

**The Effects of Telehealth on Physical Activity**

There have been many studies on the effect telehealth has on improving physical activity levels in patients with diabetes.

Poppe et al. (2019) examined the short-term impact of mobile health intervention in changing physical activity levels and sedentary behavior in adults with type 2 diabetes. In this study, mobile health intervention reduced sitting time and increased participants’ engagement in physical exercise (both moderate and vigorous).

Kongstad et al.’s (2019) systematic review investigated the effectiveness of technology-based feedback intervention versus usual treatment on physical activity levels in people with type 2 diabetes. This review showed that remote feedback intervention led to a small to moderate increase in physical exercise levels.

In a related study, Kooiman et al. (2018) conducted a randomized control trial to evaluate whether a web-based self-tracking program effectively improves physical exercise, A1C levels, and other health outcomes in individuals with type 2 diabetes. The patients were randomized to receive web-based self-tracking intervention or usual care. Physical exercise was measured using the number of steps a participant made per day for 12 weeks. The results showed that the web-based self-tracking program intervention effectively increased physical activity more than usual care. Specifically, participants in the intervention group increased the number of days of physical exercise per week by between one and a half to three days. On these days, participants engaged in 30 minutes of moderate-to-vigorous activity. In the control group, there was no increase in the duration of physical activity. Additionally, participants in the intervention group registered an increase in the number of walking steps per day from 1,255 to 1,500.

**The Results Are In**

Given the collective research, a solid conclusion can be made that telehealth is a useful technology for healthcare professionals to use to manage patients with type 2 diabetes. Telehealth has improved the ability to provide quality healthcare and lower the rate of health disparities in patients with type 2 diabetes. These results can be used in healthcare organizations and practices across the world.

While telehealth is not a substitute for in-person medical care, it provides a solid option for those who have circumstances which limit their mobility and/or travel. Although this research was
“Adherence to diabetes medications is crucial in controlling the disease and preventing morbidity and premature mortality.”

Focused on targeting telehealth as a care option for patients with type 2 diabetes, there is substantial evidence that telehealth could be beneficial for managing other chronic conditions and serving patients in underserved and rural areas, potentially helping to lower rates of health disparities across the country. 

LaTonya Atkinson, MSHI, RHIA, COC, CDEO, AAPC Fellow, has worked in the field of HIM for over 20 years and has specialized in many areas of coding working for the Department of Veterans Affairs. Passionate about educating and mentoring, Atkinson is currently working on her Ph.D. in Health Sciences and has served her AAPC local chapter as an officer since 2020.

Resources


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Change Your Post-op Pain Management Reporting in 2023

Imaging guidance update may bring lower pay for 64415-64417 and 64445-64448.

If you report somatic nerve injections for postoperative pain management, you won’t want to miss important CPT® updates for 2023. The changes to these codes will affect how you report these injections when the provider uses imaging guidance.

Here’s what you need to know about these changes from CPT®, effective Jan. 1, 2023, along with news of some potential payment changes for these codes announced in the 2023 Medicare Physician Fee Schedule (MPFS) proposed rule.

Editor’s Note: This article was published prior to the release of the MPFS final rule by the Centers for Medicare & Medicaid Services. Any mention of 2023 Medicare policy is subject to change.

Understand How ‘Imaging Guidance’ Addition Affects Coding

The codes that will change in 2023 are 64415-64417 and 64445-64448, which all share this common start to their descriptors: Injection(s), anesthetic agent(s) and/or steroid ....

“Anesthesia practices have used these codes for many years to report postoperative pain management. They bill ultrasound separately for imaging guidance, and this will be a major change,” says Kelly D. Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I, owner of Perfect Office Solutions in Leesburg, Fla. “Ultrasound is popular to use as it reduces the chance of patients having adverse effects,” she adds.

In fact, “the specialty societies stated that CPT® codes 64415, 64416, 64417, 64446, 66447, and 64448 were reported with the imaging code CPT® code 76942 Ultrasound guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) more than 50 percent of the time,” the 2023 MPFS proposed rule states (www.federalregister.gov/d/2022-14562/p-506).

What’s changing: CPT® 2023 will add “including imaging guidance, when performed” to the descriptors for these codes. That means you will no longer report ultrasound (such as 76942) or other types of imaging guidance separately when the provider uses that guidance to perform services you report using 64415-64417 and 64445-64448. The examples below help demonstrate how these descriptor revisions will affect coding.

Old way: For a 2022 date of service (DOS), an anesthesiologist at a facility uses ultrasound guidance to perform a brachial plexus anesthetic injection for post-op pain management on the same date as performing anesthesia for the operation. You report the injection and guidance using these codes:

- Injection: Report 64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus

New way: Consider the same example as above, but for a 2023 DOS. You will report only one procedure code:
Post-op Pain Management

• **Injection and guidance:** Report 64415 ..., including imaging guidance, when performed with modifier 59 or XU appended.

You should append modifier 59 or XU based on Medicare’s National Correct Coding Initiative Policy Manual, Chapter II.B.4. It states that if you report a peripheral nerve block injection (64400-64530) for post-op pain management on the same DOS as an anesthesia 0XXXX code, you may append modifier 59 or XU to the peripheral nerve block code to show it was for post-op pain management.

**Bonus tip:** The 2023 descriptors state the codes include “imaging guidance, when performed,” so you will report the code regardless of whether the provider uses imaging guidance. You should not append a modifier such as 52 Reduced services to indicate the provider did not use imaging guidance.

<table>
<thead>
<tr>
<th>Injection Code</th>
<th>Nerve</th>
<th>2022 Work RVUs</th>
<th>2023 Proposed Work RVUs</th>
<th>Difference in Work RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Injection</td>
<td>76942</td>
<td>Total</td>
</tr>
<tr>
<td>64415</td>
<td>Brachial plexus</td>
<td>1.35</td>
<td>0.67</td>
<td>2.02</td>
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<tr>
<td>64416</td>
<td>Brachial plexus, continuous infusion by catheter (including catheter placement)</td>
<td>1.48</td>
<td>0.67</td>
<td>2.15</td>
</tr>
<tr>
<td>64417</td>
<td>Axillary nerve</td>
<td>1.27</td>
<td>0.67</td>
<td>1.94</td>
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<tr>
<td>64445</td>
<td>Sciatic nerve</td>
<td>1.00</td>
<td>0.67</td>
<td>1.67</td>
</tr>
<tr>
<td>64446</td>
<td>Sciatic nerve, continuous infusion by catheter (including catheter placement)</td>
<td>1.36</td>
<td>0.67</td>
<td>2.03</td>
</tr>
<tr>
<td>64447</td>
<td>Femoral nerve</td>
<td>1.10</td>
<td>0.67</td>
<td>1.77</td>
</tr>
<tr>
<td>64448</td>
<td>Femoral nerve, continuous infusion by catheter (including catheter placement)</td>
<td>1.41</td>
<td>0.67</td>
<td>2.08</td>
</tr>
</tbody>
</table>

**Look Ahead to Payment Changes**

Because the injection codes will include imaging guidance time and services, the proposed 2023 MPFS includes potential updates to the work relative value units (RVUs) for these codes (Table 1). “This is a huge change that will affect payments,” says Dennis.

You can expect all the injection services with imaging guidance to have a reduction in work RVUs in 2023. See the accompanying table for a comparison of the proposed 2023 injection code work RVUs to the 2022 work RVUs for the injection code plus ultrasound guidance (76942). Remember that work RVUs are part of the basic formula to determine the MPFS payment amount:

\[(\text{Work RVUs} + \text{practice expense RVUs} + \text{malpractice RVUs}) \times \text{MPFS conversion factor}\]

Geographic location also will affect final payment. The final work RVUs for these codes may differ, so be sure to check the MPFS final rule.

Deborah Marsh, JD, MA, CPC, CHONC, is a senior development editor at AAPC. She has explored the ins and outs of coding for multiple specialties, particularly radiology, cardiology, and oncology.

This article is reprinted from Anesthesia Coding Alert. For more articles like this, as well as other specialty-specific articles, check out AAPC’s full line of newsletters at www.aapc.com/newsletter.
Every year, there are always a lot of code changes to learn about, and this year is no exception: CPT® 2023 includes 225 new codes, 93 revised codes, and 75 deleted codes. There are coding and guideline changes in every section of the CPT® 2023 code set, except anesthesia. The most significant changes are to the evaluation and management (E/M), percutaneous pulmonary artery revascularization, hernia repairs, lab and pathology, and COVID-19 vaccination codes. Also added are two new appendices for artificial intelligence (AI) taxonomy (Appendix S) and synchronous real-time interactive audio-only telemedicine services (Appendix T). Here is an overview of the changes by section, all of which are effective Jan. 1, 2023.

**Evaluation and Management**

The E/M section is overhauled to bring all the E/M categories in line with the guidelines that were released in CPT® 2021. There are a lot of changes to unpack in this section, and a thorough review is necessary. These changes render the Centers for Medicare & Medicaid Services’ (CMS’) 1995 or 1997 Documentation Guidelines for E/M Services outdated. In the 2023 Medicare Physician Fee Schedule (PFS) proposed rule, CMS said it planned to accept the CPT® 2023 E/M guidelines with some modifications. (The final rule had not been published at the time of this writing, so stay tuned for those modifications.) This is a monumental change to have one set of guidelines for E/M services and should alleviate some of the administrative burdens on providers, coders, and auditors.

The medical decision making (MDM) table is revised to be used with all other E/M categories where MDM is a coding option. Definitions added throughout the guidelines include examples and clarification for when to use MDM for code selection in the other categories. There is also a difference for total time in the descriptors: Instead of a time range (for example, 99202 Office or other outpatient visit for the evaluation and management of a new patient … 15-29 minutes of total time), the other category codes include the amount of time that must be met. For example, the code descriptor for 99221 includes “40 minutes must be met or exceeded.”

The Hospital Observation Services and Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Oversight Services sub-category is deleted. For 2023, observation care services are reported with hospital inpatient services codes, which are revised to include hospital inpatient and observation care services. Also in CPT® 2023, Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services codes were deleted and merged with Home Services codes 99341-99350 (except for deleted code 99343).

Many coders were expecting consultation services to be deleted altogether, but that is not the case. Only level one consultation codes 99241 and 99251 are deleted. Although Medicare does not reimburse consultation codes, other payers do; and the medical specialties feel that the services performed in a consultation are distinct from other E/M services and that the consultation code descriptors better describe the work performed.

Emergency department visits (99281-99285) are reported based on MDM only — the total time concept doesn’t apply in the ED setting. Another coding concept introduced is that 99281 may not require the presence of a physician or other qualified healthcare professional. In this section, 99281 is compared to 99211 in the office and outpatient setting.

The annual nursing facility assessment code 99318 was deleted; you will instead use the subsequent nursing facility care codes (99307-99310) or Medicare G codes. The nursing facility care codes are also revised and new guidelines exist.
“Many coders were expecting consultation services to be deleted altogether, but that is not the case.”

Lastly, in this section, there is a new prolonged services add-on code (99418) for use only after the highest level of E/M is reached, based on total time in the inpatient and observation care or nursing facility. This add-on code is reported in 15-minute increments. Code 99417 is revised and may be reported with home and residence services and outpatient consultation codes.

Surgery: Integumentary System

Removal of sutures under anesthesia code 15850 was deleted, and 15851 is revised to “sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation).” “Other surgeon” was removed from the code descriptor. Two new add-on codes allow you to capture the practice expense when sutures or staples are removed in the office at the time of an E/M service: Code 15855 for the removal of sutures or staples not requiring anesthesia and 15854 for the removal of sutures and staples not requiring anesthesia.

Surgery: Musculoskeletal System

The code for total disc arthroplasty (22857) is revised to make “single interspace, lumbar” a suffix. Use new add-on code 22860 when total disc arthroplasty is performed on the second interspace of the lumbar spine.

Surgery: Respiratory System

A new code for the repair of a nasal valve collapse, 30469, is added to report the use of low-energy, temperature-controlled subcutaneous/submucosal remodeling.

Surgery: Cardiovascular System

CPT® 2023 includes five new codes for percutaneous pulmonary artery revascularization by stent placement. Introductory guidelines and parentheticals are also added.

• Code 33900 is for an initial procedure performed unilaterally in normal native connections.
• Code 33901 is for an initial procedure performed bilaterally in normal native connections.
• Code 33902 is for an initial procedure performed unilaterally in abnormal connections.
• Code 33903 is for an initial procedure performed bilaterally in abnormal connections.
• Code +33904 reports each additional vessel or separate lesion in normal or abnormal connections. This add-on code can be reported with 33900, 33901, 33902, or 33903.

Two new codes are added for percutaneous arteriovenous fistula creation: Code 36836 describes stent placement across major side
branches (existing code 33895 describes single access of both the peripheral artery and peripheral vein including fistula maturation procedures), and code 36837 describes separate access sites of the peripheral artery and peripheral vein including fistula maturation procedures. Both procedures include vascular access, imaging guidance, and radiologic supervision and interpretation.

**Surgery: Digestive System**

A new code, 43290, describes esophagogastroduodenoscopy (EGD) with the deployment of an intragastric bariatric balloon. For the removal of the intragastric bariatric balloon(s) by EGD, use new code 43291.

There are extensive changes to the hernia repair codes for abdominal hernias which include epigastric, incisional, ventral, umbilical, and spigelian hernias. Eighteen codes were deleted and replaced with 15 new codes. Introductory guidelines and parentheticals are also added. The new code family includes any approach because these procedures can be performed using a combination of approaches in a hybrid model. Select these codes based on whether the procedure is initial or recurrent, reducible, incarcerated, or strangulated, and the total defect size:

- Codes 49591-49596 are for the initial procedure.
- Codes 49614-49618 are for recurrent abdominal hernia repairs.
- Codes 49621 and 49622 describe the repair of a parastomal hernia.

All the new procedures include mesh implantation. If during the procedure noninfected mesh is removed, report add-on code 49623 in addition to the code for the hernia repair. This new add-on code can only be reported with codes 49591-49622.

**Surgery: Urinary System**

Codes for percutaneous nephrolithotomy or pyelolithotomy (50080 and 50081) are revised to clarify which services are included when performing the procedure, so they can be properly valued. Code 50080 is reported for a simple procedure that involves stones up to 2.0 cm. Stones greater than 2.0 cm, branching stones, stones in multiple locations, ureter stones, and anatomical complications are considered complex and reported with 50081.

**Surgery: Male Genital System**

Laparoscopic simple subtotal prostatectomy is described by new code 55867. This procedure includes robotic assistance when performed.

**Surgery: Nervous System**

Codes in the nerve injection family (64415-64417 and 64445-64448) are revised to include imaging guidance when performed.
You’ll laugh. You’ll cry. You’ll code accurately.

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There are extensive changes to the hernia repair codes for abdominal hernias which include epigastric, incisional, ventral, umbilical, and spigelian hernias.

Surgery: Eye and Ocular Adnexa

Transluminal dilation of aqueous outflow canal codes 66174 and 66175 are revised to include canaloplasty, as an example.

Surgery: Auditory System

The osseointegrated implant procedure codes 69717, 69719, 69726, and 69727 are revised and three new codes are added:

- Code 69728 describes the removal of the osseointegrated implant with magnetic transcutaneous attachment to an external speech processor outside of the mastoid that results in the removal of greater than or equal to 100 sq mm surface area of bone.
- Code 69729 describes the implantation of the osseointegrated implant with magnetic transcutaneous attachment to an external speech processor outside of the mastoid that results in the removal of greater than or equal to 100 sq mm surface area of bone.
- Code 69730 describes the replacement including the removal of the implant with magnetic transcutaneous attachment to an external speech processor outside of the mastoid that results in the removal of greater than or equal to 100 sq mm surface area of bone.

Radiology

The descriptor for limited ultrasound code 76882 is revised to include “focal evaluation of,” and the descriptors for tomographic SPECT codes 78803, 78830, 78831, and 78832 are revised to include “or acquisition.” Also in this section, new code 76883 describes an ultrasound of the nerves and accompanying structures throughout the entire anatomic course in one extremity.

Pathology and Laboratory

New code 81418 describes a drug metabolism genomic sequence analysis panel. Inherited bone marrow failure syndromes testing is described with new code 81441.

Codes 81445, 81450, and 81455 are revised to specify that the procedure includes DNA analysis or combined DNA and RNA analysis. When the targeted genomic sequence analysis panel for a solid organ neoplasm involves only RNA analysis, use new code 81449; and when the targeted genomic sequence analysis panel for hematolymphoid neoplasms or disorder includes only RNA analysis, use new code 81451.

There are also many new proprietary laboratory analyses (PLA) codes. These codes describe PLAs provided by either a single laboratory or licensed/marketed to multiple providing...
“New proprietary laboratory analyses (PLA) codes describe PLAs provided by either a single laboratory or licensed/marketed to multiple providing laboratories.”

Medicine

Codes for COVID-19 vaccines are released for early use based on the public health emergency. The vaccine administration codes include the type of vaccine and the number of doses. To properly report COVID-19 vaccines, there is an administration code and a supply code (if your provider did not receive the supply of the vaccine for free). Appendix Q is added for coding clarification on the proper use of the COVID-19 vaccine administration and supply codes.

Four new codes are added to the cardiac catheterization subcategory for angiography procedures.

- Code 93569 describes unilateral selective pulmonary arterial angiography.
- Code 93573 describes bilateral selective pulmonary arterial angiography.
- Code 93574 describes selective pulmonary venous angiography of each distinct pulmonary vein.
- Code 93575 describes a selective pulmonary angiography of major aortopulmonary collateral arteries arising off the aorta or its systemic branches.

Category III Codes

There are many new Category III codes created for new and emerging technology. Some examples include 0751T-0763T for digital pathology digitization procedures, 0764T-0765T for assistive algorithmic EKG risk-based assessment, 0766T-0769T for transcutaneous magnetic stimulation of nerves for chronic nerve pain, and 0771T-0774T for virtual reality patient procedural dissociation.

Learn More About CPT® Updates

For training and application of the CPT® code changes for 2023, please join us for AAPC’s hands-on virtual workshop on Dec. 6 (www.aapc.com/workshops). 

Raemarie Jimenez, CPC, CIC, CPB, CPMA, CPPM, CPC-I, CDEO, CANPC, CRHC, CCS, is chief product officer at AAPC and a member of the Salt Lake City, Utah, local chapter.
The news I heard after answering the phone was unexpected. “Your life insurance application was denied.”

As my term life insurance policy was about to expire, I decided to apply for a new policy. The 40-page application was daunting, but I carefully answered every question and did so truthfully. Being in my early 50s, I knew my health was not as great as it was 20 years ago, but it was not bad. Yes, I have a few pounds to lose, but other than that, I feel like Superman!

How an inaccurate diagnosis code changed my life.

The Personal Cost of Improper Diagnosis Coding
My wife just laughed at that. Okay, maybe not Superman, but I take good care of myself by maintaining a healthy diet and level of activity. When my insurance agent shared the news, I asked why my application was denied. I should have been approved. She responded, “It was your medical history. A letter explaining the adverse decision will be mailed to you.”

A week later, I received the letter in the mail. I was denied because I have type 2 diabetes.

The Inaccurate Diagnosis

I do NOT have type 2 diabetes. I called the insurance agent requesting additional information. I wanted to know which medical record was used to come to their conclusion and where it was documented that I had this diagnosis. She sent an inquiry to the life insurance company and the response came back a couple of days later. I was diagnosed in 1996 by my primary care physician. I logged in to my healthcare provider’s patient portal and pulled up the notes from my visit. There it was. I was diagnosed with type 2 diabetes mellitus without complications.

I reached out to my physician, asking about the diagnosis from years ago. He assured me I did not have diabetes and explained that the diagnosis code was used to justify the hemoglobin A1C test he ordered at that visit. Unfortunately, he said, there were no “I’m testing for” or “suspicious of” codes, so the medical office had to use the code they did, even though there was no formal diabetes diagnosis. He said that he could not remove the diagnosis code because it was attached to the lab test order but reassured me that I did not have diabetes.

I told the doctor that this diagnosis of a condition I do not actually have resulted in my being denied life insurance. I informed him of codes he could have used to indicate he was screening for diabetes. He acknowledged that he knew of those codes but, “Unfortunately, insurances don’t frequently cover the Z codes (with some exceptions, like mammograms and colonoscopies).” He explained that diabetes screening is much more variable depending on the insurance and plan. “It just takes a few people complaining that a test wasn’t covered with the Z code for us to stop using them except where we know they are going to work,” he said.

Hindsight is 20/20

So, here I am, searching for another life insurance application to complete. I now must disclose that a previous application for life insurance was denied and list the reason. My physician offered to write a letter, if needed, indicating that I don’t have diabetes. Will that be good enough? The inaccurate diagnosis remains a part of my permanent medical history.

If I knew then what I know now, I may have offered to pay for the test out of pocket. My physician may then have been more open to the use of a diagnosis code associated with screening.

Far-reaching Effects

I encourage you to consider the consequences of a diagnosis code used primarily to ensure reimbursement versus one based on actual symptoms. In my experience, the impact of a less-than-accurate diagnosis code has had lasting negative effects.

Accuracy is one of the hallmarks of the coding profession. Your coding doesn’t just affect the company’s bottom line, it also ensures a patient’s medical history is accurate, which is a profound responsibility.

Scott Burk, CPC, has more than 30 years of experience in the healthcare industry. He currently serves as a client success manager for a healthcare technology company that leverages diagnostic information to improve the quality and economics of healthcare. Burk earned his BBA and MBA from the University of Houston — Clear Lake and is a member of the Pasadena/LaPorte, Texas local chapter. He currently resides in Pasadena, Texas, with his wife and two children.
When EMRs Diagnose Our Patients

A case study on miscoding major depressive disorder.
Electronic medical records (EMRs) have changed the face of healthcare as we know it. The EMR has made it much easier to house documentation and coordinate care among healthcare providers and specialists, for one. Provider groups can also use their EMR system to create clinical guidelines for screening patients for illnesses such as depression. This allows the EMR to capture the data points for the screening, compile them into a problem or symptom list, and then suggest possible diagnoses. This all sounds great, but unfortunately, what the EMR advises does not always equate to what the provider has documented in the patient’s record at the time of the visit.

**Case In Point**

During a screening for depression, for example, a patient may indicate that they are having feelings of anxiety, sadness, or grief, and voice a loss of interest in participating in activities. The provider may even prescribe a low-dose medication.

In this case, the patient has not displayed the clinical requirement for major depressive disorder (MDD). A diagnosis of MDD requires certain additional elements such as “discrete episodes of at least 2 weeks’ duration involving clear-cut changes in affect, cognition, and neurovegetative functions and inter-episode remissions,” according to the American Psychiatric Association.

However, because the provider selected suggested items from the EMR problem/symptom list, the EMR may automatically push a diagnosis of MDD. That diagnosis is then submitted on a claim to the patient’s insurance and thus becomes part of their medical history. This medical history can affect many things such as coverage for certain procedures, illnesses, authorizations, and possibly life insurance coverage.

**Create a Policy**

The best way to avoid the EMR system from making an unsubstantiated diagnosis is to have a policy that lays out the specifics of provider review before the note is marked complete for that visit. Having providers take accountability for diagnosis review, not just check box review, allows for changes to the EMR-driven diagnosis and reduces the number of errant diagnoses that are made. Having a review policy is not only beneficial for MDD, but for all illnesses that can greatly impact a patient’s life.

Most of us love our EMR system and have grown to depend on it for the majority of day-to-day functions with our patients. Just remember that the provider, not the EMR, should make the final diagnosis. Healthcare providers have the responsibility of documenting and coding in truth to the best of the provider’s ability.

Jamie Taylor, CPB, has worked in the healthcare industry for 25 years with experience in HEDIS, Medicare/Medicaid, CMS, STARS, and commercial insurance plans. She is an expert in behavioral health and psychiatry. She served as director of provider education in her prior role and is currently a network program consultant. Taylor has developed and presented provider strategy, engagement, and education across the country.

**Resources**

The Cost of Undercoding

Is billing of critical care time (by documenting such) mandatory? What if you are in a situation where you are hoping to minimize patient cost? Documenting all the usual interventions appropriately, just not adding the critical care declaration?

The provider should be treating the patient based on what is medically necessary. If the patient is critically ill, the provider should document it as such. Critical care codes are time-based, so if the patient receives critical care and this time is missing from the documentation, the coder should query the provider.

Not reporting a service that was provided can be considered undercoding. The coder should educate the provider on the documentation requirements for critical care services (see Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners).

— Becky Strom, CPC, COC, CPCO, CPC-H, MCS-P

Not reporting at the appropriate level or type of service is a form of undercoding, but why it is problematic is two-fold:

1. It could be construed as an inducement and/or a kickback (discount to the patient is construed as an inducement to undergo the care) or could be considered remuneration for the patient to refer themselves to that facility for critical care services as opposed to some other. These concerns, however, turn on whether there are any billable services to a third party (Medicare, commercial payer) that result following this discounted service.

2. Where the practice is done only for self-pay patients and not where insurance would cover critical care, this is not only discriminatory but in effect amounts to a bifurcated fee schedule — insurance gets charged more for what is, in reality, the same service.

Providing free care pursuant to a courtesy policy is fine, presuming there is an actual policy and both the patient and the service are defined in the relevant class (patient/service). Where the patient is financially unable to pay and qualifies for a reduction on out-of-pocket expenses under an objective hardship policy, this would be another possible way to justify this (not undercoding the service but reducing the patient’s out-of-pocket expense obligation — even if uninsured). This is a better approach than arbitrarily downcoding the service. Those write-offs should be specific and traceable.

— Michael Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, CEMA, AAPC Fellow

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- Interventional Radiology Coding Reference, 20th edition
- Diagnostic & Interventional Cardiovascular Coding Reference, 17th edition
- Vascular & Endovascular Surgery Coding Reference, 17th edition
- Diagnostic Radiology Coding Reference, 13th edition
- Cardiothoracic Surgery Coding Reference, 8th edition
- ICD-10-PCS Coding Companion for Interventional Radiology, 8th edition
- Pain Management Coding Reference, 7th edition
- CIRCC Study Guide 2023
Why Coding Specificity Matters

The repercussions of using unspecified codes are far-reaching.

When squeezing in that last chart before lunch or the end of the day, your resolve to improve coding specificity may wane. You’re already thinking about that creamy Caesar salad waiting for you or the mountain of chores to be completed when you get home. When that last chart contains a series of injuries, each in a different body area and each requiring a unique code, it’s tempting to just throw an ICD-10-CM code T07 Unspecified multiple injuries at it and call it a day. After all, does specificity in diagnosis coding really matter as long as the claim gets paid?

The short answer is yes. According to the ICD-10-CM Official Guidelines for Coding and Reporting, “When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned.” So, selecting a code that doesn’t take into account all the specifics of separate injuries is in clear violation of this guideline. The need for specificity, however, goes beyond strict adherence to the guidelines.

Improve Patient Care

When ICD-10-CM was first introduced in the United States in October 2015, providers were given a one-year grace period in which to adjust to the change from ICD-9-CM. The goal was for providers to submit codes to the highest specificity, but as long as valid ICD-10-CM codes were submitted, they were accepted. Unfortunately, seven years later, many coders are reportedly still defaulting to unspecified codes rather than the detailed codes that could be abstracted from the provider’s documentation.

While there are valid situations in which an unspecified code is the correct choice, it should be selected only when no possibility of further
specificity exists. Or, as the Guidelines put it, “Diagnosis codes are to be used and reported at their highest number of characters available and to the highest level of specificity documented in the medical record.”

This is a good reminder that coding is a team effort: Medical coders need a keen eye and clear documentation from the provider to fully capture the patient encounter. If you’re not getting it, this is where provider queries and department education come in. Don’t be afraid to speak up when you need improved clinical documentation from your providers.

Diagnosis codes serve to reflect an accurate patient health status and facilitate proper patient care. Assigned diagnoses follow patients in their health records from provider to provider throughout their lives, so accurate records contribute to quality care.

Consider the Risk

Coding specificity doesn’t affect just immediate patient care, claims payment, and audit outcomes. Health data among the population is collected from submitted ICD-10-CM codes and used to formulate financial predictions for healthcare and future payment models. Financial decisions based on risk adjustment models affect both your practice’s future reimbursement and your patients’ accessibility to healthcare down the road.

In no more important place can this be seen than in hierarchical condition category (HCC) coding for chronic conditions. Using an unspecified chronic condition code instead of a chronic condition with complications code, for example, may not only skew the HCC risk adjustment factor (RAF) score, but possibly result in the patient being denied coverage for medically necessary healthcare in the future.

Be Your Own Auditor

Productivity metrics can play a part in coding specificity, too. Rushing to reach quotas can result in overlooked key areas of documentation where the specifics may be hiding. Mitigate this risk by taking time to glance at their usual hangout spots — the physical exam, radiologists’ notes, and other places you may find support for a more specific code. Once you’ve made your final code choices, look at them as a group and ask yourself, “Is there a combination code that would better capture the clinical picture represented?”

Reap the Rewards of a Job Well Done

Be proactive when it comes to what you code and why you code it that way. A medical coder’s purpose is to translate a provider’s narration of a patient encounter into codes that paint a clear picture of what was done and why. Armed with the right system of know-how and practice, you can code with specificity and then go enjoy that salad! 🥗

Erin Fitzgerald, CPC, CRC, has a passion for coding. She has worked in emergency department coding for a hospital system and risk adjustment coding and auditing. Fitzgerald is a member of the Lewiston, Me., local chapter.

Resources


Can You Bill Critical Care and Hospital Discharge Services?

Medicare policy leaves this billing conundrum open to interpretation.

Medical coders, billers, auditors, and other healthcare business professionals always come to AAPC’s HEALTHCON loaded with questions, in search of answers. This past conference, held virtually on March 27-30, was no different.

During the Evaluation and Management (E/M) Panel general session, an expert panel made up of a physician, coder, auditor, payer, and a representative from the American Medical Association (AMA) answered audience questions regarding the 2021 E/M guidelines for office/outpatient visits.

The panelists were AAPC’s Chief Product Officer Raemarie Jimenez, CPC, CDEO, CIC, CPB, CPMA, CPPM, CPC-I, CANPC, CRHC, Jaci Kipreos, COC, CPC, CDEO, CPMA, CRC, CPC-I, CEMC, Samuel Le Chase, MD, MPH, CPC, CRC, CPC-I, and CPT® Assistant Managing Editor Leslie Prellwitz, with 2022-2025 National Advisory Board President Colleen Gianatasio, CPC, CPCO, CPC-P, CPMA, CRC, CPC-I, moderating.

Here is one question posed by a member that kind of stumped everyone and required further investigation.

Q: If our provider rendered critical care services earlier in the day and the patient died later that same day, can our provider bill both 99291 and the discharge? I don’t think it is appropriate, but the provider thinks otherwise and wants to report both services.

A: According to CPT® Assistant (Nov. 2009, Vol. 19, Issue 11), “The hospital discharge services codes may be used to report discharge services to patients who die during the hospital stay.” CPT® code 99238 reports 30 minutes or less of hospital discharge services and 99239 reports any additional time spent on discharge services beyond the first 30 minutes.

If the hospital admission and discharge occur on the same day, you should instead use observation or inpatient hospital care codes 99234-99236 (if more than 8 hours but less than 24 hours passed between admission and discharge). Per Medicare, “When the patient is admitted to inpatient hospital care for less than 8 hours on the same date [as the discharge], then Initial Hospital Care, from CPT code range 99221-99223, shall be reported by the physician. The Hospital Discharge Day Management service, CPT codes 99238-99239, shall not be reported for this scenario.”

As for billing the critical care furnished prior to the patient’s death, we turned to Medicare policy (Pub. 100-04, Ch. 12, Sec. 30.6.12.6) for guidance and found this statement:

If more than one E/M visit is provided on the same date to the same patient by the same physician, or by more than one physician in the same specialty in the same group, only one E/M service may be reported, unless the E/M services are for unrelated problems.

Read a little further and the policy goes on to say (emphasis added): However, in situations where a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation) as long as the medical record documentation supports: 1) that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care, 2) that the services were medically necessary, and 3) that the services were separate and distinct, with no duplicative elements from the critical care services provided later in the day. Practitioners must use modifier -25 (same-day significant, separately identifiable evaluation and management service) on the claim when reporting these critical care services.

Nowhere does it say you can (or cannot) bill for an E/M service performed after the critical care service. But the green light on using modifier 25 on the critical care code seems the most likely way to get both the critical care code(s) and discharge code(s) paid.

In the end, the requirements for billing these codes must be met; and because the Centers for Medicare & Medicaid Services left the policy open to interpretation, a final determination will be made by the payer. HBM

Resource

Happy member wellness month!

This month, it’s ALL about YOU.

Spending all day on our computers, while often necessary, is not great for our health. We need to balance this with healthy activities that keep us ... well, healthy.

Get outside daily

Eat healthy

Exercise regularly

Get enough sleep

Work & home life balance

Getting a CFPC certification in December also helps AAPC members.

For Member Wellness Month, a portion of proceeds from all CFPC exams will be donated to the AAPCCA Hardship Fund. This fund helps our members in times of crisis. Learn more about the hardship fund: aapc.com/hardshipfund.

If you work in family practice, this is a great time to certify your expertise. Remember, more certifications can lead to higher pay:

“My income catapulted after becoming certified. And the more credentials I get, the higher it goes.”
Kim Montenegro, CPC, CPCI, CPB, CPPM, CPMA, COC, CSFAC, CRC

Learn more about CFPC certification:
aapc.com/cfpc
Get Paid for After-Hours Visits

Use miscellaneous CPT® codes to bill physician services not performed during regular business hours.

CPT® includes three codes to describe services a physician provides during nontraditional hours. Although Medicare does not recognize these codes, third-party insurers may allow additional reimbursement for after-hours services. The key is to demonstrate it is in the payer’s best interest to do so.

Office Hours Matter for 99050, 99051

Per CPT® guidelines, you may report 99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays Saturday or Sunday), in addition to basic service for services a physician provides in the office during hours when the practice would normally be closed, such as evenings or weekends.

For example, if your office keeps standard 9 to 5 hours, but a physician schedules a 6:30 p.m. appointment and provides a level 3 consultation, you would report the appropriate evaluation and management (E/M) code 99243 Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity with 99050.

In this case, what matters are the office hours, not the physician’s hours. That is, if a physician comes to the office on his day off to see a patient but the office normally operates during those hours, 99050 does not apply.

If your practice keeps regular hours on evenings, weekends, or holidays, and a physician provides an office service during those times, you should forgo 99050 in favor of 99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.

For instance, if your practice posts regular office hours of 12 p.m. to 4 p.m. on Saturdays, the physician would be justified in reporting 99051 in addition to all Saturday services rendered, according to American Medical Association (AMA) in CPT® Changes 2006: An Insider’s View.

CPT® does not precisely define “evening hours,” although presumably, these would begin no earlier than 5 p.m. To keep your use of 99050 and 99051 consistent, your practice should post its office hours conspicuously. Only consider 99050 for services provided outside posted hours, and 99051 for services falling within posted office hours but outside normal business hours.

Select 99053 for 24-Hour Services

If a 24-hour facility asks your physician to provide red-eye or early-bird service, AMA guidelines allow you to claim 99053 Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service, as well as the basic service. Code 99053 can apply whether the physician is already at the facility or whether a special trip must be made to care for the patient.

The place of service, along with the time of service, drives the decision to use 99053. To report 99053, the service the physician provides must occur at a 24-hour facility such as an ambulatory surgical center (POS 24), urgent care facility (POS 20), or emergency department (POS 23). Emergency department (ED) physicians can, and often
do, report 99053 for services rendered between 10 p.m. and 8 a.m. The American College of Emergency Physicians supports this use of 99053 and states on its website, “It is appropriate to apply (99053 for late-night services), especially given the nighttime practitioner availability costs typically incurred by all medical practices, including emergency medicine.”

The AMA’s CPT® Assistant (August 2006) also offers examples of proper 99053 use both for a physician who must travel to the hospital to treat an inpatient at 2 a.m. and for an onsite emergency physician who treats a patient for severe abdominal pain in the emergency ED at 4 a.m.

Negotiate With Third-Party Payers for Reimbursement

You will not gain extra reimbursement for after-hours services from Medicare or other payers that follow Medicare guidelines. Medicare bundles 99050-99053 into payment for any other same-day services. But that doesn’t mean you should dismiss these codes as worthless.

Many coding experts suggest negotiating payment for after-hours codes with private payers as part of any contractual agreement using potential cost-savings as leverage. For example, explain to the insurer’s representative that you’re willing to send patients to the ED rather than provide in-office services, but that ED services generally cost much more (as much as 10 times more) than comparable physician services.

Another way you can demonstrate cost savings is to bill all applicable after-hours codes for your practice. Over time, you can compile a record of claimed charges to show the insurer how often you provide after-hours services, and how paying these services might save the insurer the much higher price of ED visits.

“Many coding experts suggest negotiating payment for after-hours codes with private payers as part of any contractual agreement using potential cost-savings as leverage.”

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Lead the Way to Better Provider Education

A successful auditing team starts with expert leadership.

As leaders in the healthcare industry, it’s important for us to ensure that our auditors have the proper tools, attitudes, and skills necessary to become adept at provider education. Communicating effectively and respectfully with providers while armed with the latest rules in coding, billing, and auditing is paramount to successful educational outcomes.

Recently, I sat down with CJ Wolf, MD, M.Ed., CPC, COC, and discussed the webinar “5 Tips to Enrich Provider & Rev Cycle Team Relationships,” which was held live in September. During the webinar, we received many excellent questions. We did our best to answer questions as they came in, but time always seems to run out when the audience is so engaged! Several questions pertained to how auditors can discuss coding topics or audit results with providers. This article discusses how auditors can approach providers with care and confidence to get the results they seek.

Communication is Key

In addition to coding and auditing, your auditors need to be adept at communication. A provider who receives low scores on an audit may have a bad attitude. Do your auditors know how to defuse the situation when a provider is angry or resistant? Pointing to relevant coding guidelines and showing the reasoning behind the scores can relieve the tension.

Effective communication skills will enable your auditors to elicit positive educational sessions. But communication comes in many different forms such as face-to-face conversations, emails, text messages, and online web meetings. When auditors are setting up a meeting with a provider, they should have some inkling of how that provider prefers to communicate. Oftentimes there are limited options available. Since I work remotely, for example, all of my educational calls are via Zoom. I am comfortable turning on my camera, but the provider may not be. I leave my camera on because there is much communication that happens non-verbally. Smiling, looking directly at the same computer screen as the camera, and even slight head tilts or nods all speak louder than words. (There are several good books written about non-verbal communication. I recommend Martin Lewis’s “Body Language.”)

I have had clients request an auditor to come onsite because they know their providers are going to respond better with a human in front of them. Others request a brief phone call to give the provider the principal point such as, “Stop billing all services at a level 5!” Your auditors should have as many resources as possible to cater to a provider’s preferences.

Practice Makes Perfect

Perfecting communication skills comes with practice, and the only way to practice is to do training sessions. As you build your auditing team, allow auditors to sit in with each other on sessions. Have them take turns presenting. Role-playing (as mentioned by several attendees during the webinar) is also helpful. For example, have a good cop, bad cop scenario session with your auditors, where one (respectfully) plays the doctor who doesn’t have time to listen to the auditor. This can also double as a fun team-building experience.

Another good book to check out is “Crucial Conversations,” by Joseph Grenny, et al. Dr. Wolf and I both highly recommend this one. The book teaches powerful skills that ensure every conversation — especially difficult ones — leads to the results you want. Some of the conversations your auditors are having are difficult; the more adept they are at having difficult conversations, the better off your compliance program will be.
“Effective communication skills will enable your auditors to elicit positive educational sessions.”

Show Proper Respect

Respect is not a tool that you can place in your auditors’ hands. But you can give respect to your team, and they in turn will respect you for it. Then, just like kindness, it spreads throughout the organization from the top down. Providers should be held accountable if they are disrespectful to an auditor (or anyone for that matter). There is no need for argumentative debates that are non-productive. The same goes for auditors, as well. I hear so many coders and auditors degrading doctors behind their backs. But remember: Providers went to medical school to take care of humans, not to spend hours learning coding and billing.

Auditors should take the time to prepare prior to meeting with a doctor. I usually allot 15 minutes of preparation time prior to a provider education call. If it was a large audit or a difficult specialty, I may set 30 minutes aside. I review the audit report, pull up any documentation that was marked as incorrect, and write myself notes on what to speak about. Taking that time to prep for the meeting is so important and shows the provider that the auditor respects their busy schedule by taking the time to give them only the pertinent information they need.

Encourage Education

None of this information will do any good if your auditors aren’t kept current with recent coding and billing changes. Coders and auditors must stay continuously educated to be effective in their work and provide the most effective provider education.

It’s also important that auditors are held to their own standards. When was the last time your auditors were audited? It’s a good idea to do this periodically. Hire an external audit company to perform the audits, when possible, to ensure an unbiased review of your auditors, along with education and feedback. A favorable result will show providers how proficient their auditors are.

Take the Lead

Your auditors should be viewed as a positive company asset, and that starts with leadership. Show your team that you are vested in their education and skill building. Show each auditor respect and expect others to respect them as well. Having adeptly trained auditors will improve your compliance program and your healthcare organization overall.

Lori Cox, MBA, CPC, CPMA, CPC-I, CEMC, CGSC, CHONC, has 20 years of experience working in the business side of medicine. She began her career in patient accounts and then moved into billing and coding for a multispecialty clinic. She was promoted to billing supervisor and then to compliance officer, where she trained employees and providers on fraud and abuse. In 2015, Cox received her MBA from Quincy University. She has traveled the country educating coders and physicians on complex coding topics such as hematology/oncology and E/M guidelines. Cox is the past member relations officer for AAPC’s National Advisory Board, an active member of her AAPC local chapter, and regional director for AAPC Services.

Resource

www.aapc.com/business/resources/5-tips-to-enrich-provider-and-rev-cycle-team-relationships
How to Use Comparative Billing Reports as an Educational Tool

Improve your billing practices and avoid compliance issues by utilizing this Medicare program.

The Centers for Medicare & Medicaid Services (CMS) initiated the Comparative Billing Report (CBR) program in 2010 to evaluate claims submission data, develop provider education, and raise awareness of peer-to-peer billing patterns. CBRs are unique to a specific provider and can be used as a free educational resource and tool for possible billing improvements. Even the most compliant billing process can benefit from this sort of analysis. In this article, we’ll explain the review process and look at the latest CBRs for 2022.

What Is a CBR?
CBRs are designed to protect the Medicare Trust Fund by focusing on areas that may be vulnerable to compliance, billing, and/or coding issues. To this end, a CBR team works to identify clinical areas with the potential to significantly affect the Medicare Trust Fund, analyzes claims data associated with those areas, and generates individualized CBRs for providers.

The report compares providers on a state, specialty, and/or national level and summarizes Medicare claims data statistics in areas that may be at risk for improper Medicare Part B payments. While a CBR cannot identify improper payments, it can alert providers if their billing statistics look unusual as compared to their peers.

A CBR is presented to a provider when the analysis of their billing patterns differs from their peers. The analysis of a provider’s billing patterns is completed by assessing CBR topic metrics and their potential risk to the Medicare Trust Fund.

How Are CBR Topics Selected?
Working with CMS, the CBR team identifies CBR topics by gauging the vulnerability of Medicare Part B claims billing for errors, as well as the potential educational value to providers and administrative billing staff. The selection of each topic for analysis is a detailed process involving resource research and data analytics. This process begins with an analysis of nationwide claim submissions, after which the CBR team examines the results in conjunction with relevant coding guidelines and Medicare payment policies. The CBR team uses these shared analyses to confirm that a topic will provide useful information and education. CMS oversees the creation of the CBR and supporting resources and holds final approval for all selected topics.
How Are CBRs Created?
CBRs include five detailed sections that explain all facets of the CBR topic:

- The Introduction section contains:
  - An explanation of the CBR focus
  - The CBR analysis timeline
  - An expectation of provider behavior regarding billing and coding
  - The vulnerability of the CBR topic, according to improper payment rates
  - The criteria for receipt of a CBR

- The Coverage and Documentation Overview section identifies:
  - The CPT®, ICD-10-CM and/or HCPCS Level II codes used in the report analyses
  - A summary of the provider’s utilization related to charges, units, and beneficiary count pertaining to the topic.

- The Metrics section describes:
  - The metrics included within the report
  - The peer group definitions (usually the nation and the provider’s state) used to identify outliers for CBR receipt using metric comparisons

- The Methods and Results section presents:
  - A national-level and state or specialty summary of the number of providers included in the analysis and the overall claims submission volume for the topic
  - An explanation of the calculation for each metric
  - The individual provider’s results for each metric
  - The comparison of the provider’s outcomes to each peer group for each specific metric

There is also a References and Resources section for complete transparency.

Who Receives a CBR?
The CBR team determines the criteria for receiving a CBR for each release. A CBR is presented to a provider when the analysis of their billing patterns differs from the provider’s peers.

Receiving a CBR is not an indication of, or precursor to, an audit. A CBR is not an indication of wrongdoing; the CBR is educational in nature and should be reviewed as such. Receipt of a CBR is not a prompt to make changes to your clinical care. The report is merely a comparison tool and is not a suggestion of services that should be provided to patients. Receipt of a CBR does not necessitate a response — it is meant for internal use.

Even if a provider does not receive a CBR, staying abreast of areas of vulnerabilities is an important part of an internal compliance program. For every CBR release, public resources are available, including a sample CBR, the data used in the analysis, a webinar recording, slides and transcript, a guidance and considerations document, and a Q&A document.

How Are CBRs Distributed?
A provider is issued a CBR by email or fax and through the mail. These communications are distributed to the contact information that is listed in the Medicare Provider Enrollment, Chain, and Ownership system (PECOS). Providers are encouraged to log in to PECOS each year to confirm or update their information. The alerts contain a verification code, which is used to download the CBR through a secure online portal, located at cbrfile.cbrpepper.org. Providers are encouraged to download their CBR to be saved as a PDF file for reference during future annual internal compliance reviews.

Recent CBR Releases
CBR topics for 2022 included billing for certain services in chiropractic, podiatry, allergy and immunology, ambulance, laboratory, and ophthalmology.

Chiropractic Manipulative Treatment of the Spine
Vulnerability:
Chiropractic services carry an improper payment rate of 33.7 percent, which represents $176,774,349 in possible improper payments. An 86.8 percent improper payment rate is attributed to insufficient documentation and an 8.6 percent improper payment rate is attributed to medical necessity errors.
After review of and research into the improper payment rate, this CBR was created to analyze the possible threat associated with chiropractic services to the Medicare Trust Fund. The expectation is that providers who perform chiropractic manipulative treatment (CMT) will maintain proper documentation and appropriate use of modifier AT Acute treatment (chiropractic).

**Metrics:**
1. Average allowed services per beneficiary
2. Percentage of CMT of the spine billed with CPT® code 98942
3. Percentage of claims billed with modifier AT

**Podiatry: Nail Debridement and Evaluation and Management (E/M) Services**

**Vulnerability:**
Podiatry carries an improper payment rate of 10.8 percent for podiatry providers, which represents $162,308,133 in possible improper payments for Medicare Part B claims. A 90 percent improper payment rate is attributed to insufficient documentation and a 5.3 percent improper payment rate is attributed to incorrect coding.

After review of and research into the improper payment rate, this CBR was created to analyze the possible threat associated with podiatry services to the Medicare Trust Fund. The expectation is for providers who perform nail debridement and E/M services on the same date of service to maintain proper documentation and appropriate CPT® code assignment and use of modifier 25 Significantly, separately identifiable E/M service by the same physician on the same day of the procedure or other service.

**Metrics:**
1. Percentage of nail debridement services billed with E/M services and modifier 25
2. Percentage of nail debridement services billed with CPT® code 11721
3. Average nail debridement services, per beneficiary, per calendar year
4. Average minutes, per visit, of E/M services appended with modifier 25 and billed with nail debridement services

**Lipid Panel Testing**

**Vulnerability:**
Clinical laboratories hold an improper payment rate of 23.7 percent, which represents $907,854,203 in possible improper payments for Medicare Part B claims. A 90 percent improper payment rate is attributed to insufficient documentation and an 8 percent improper payment rate is attributed to medical necessity errors.

After review of and research into the improper payment rate, this CBR was created to analyze the possible threat to the Medicare Trust Fund associated with lipid panel testing. The expectation is for providers who refer patients for a lipid panel to order testing according to patients’ medical necessity and maintain proper documentation for patient care.

**Metrics:**
1. Percent of lipid panels with direct low-density lipoprotein (LDL) cholesterol test on the same day
2. Percent of beneficiaries receiving greater than one lipid panel in a rolling year
3. Percent of beneficiaries receiving greater than three LDL cholesterol tests in a rolling year
4. Percent of beneficiaries receiving greater than three total cholesterol tests in a rolling year

**Ambulance Ground Transport**

**Vulnerability:**
Ambulance services carry an improper payment rate of 7.9 percent, which represents $405,165,149 in possible improper payments for Medicare Part B claims. A 56.6 percent improper payment rate is attributed to insufficient documentation and a 31.3 percent improper payment rate is attributed to medical necessity errors. Additionally, HCPCS Level II code A0428 Ambulance service, basic life support, non-emergency transport, (BLS) holds an improper payment rate of 19.3 percent, which represents a potential $153,096,405 in improper payments.

After review of and research into the improper payment rate, this CBR was created to analyze the possible threat to the Medicare Trust Fund associated with ambulance ground transportation. The expectation is for the clinical documentation for ambulance ground transportation to validate the patient’s need for the service.

**Metrics:**
1. Percent of ambulance services that are basic life support (BLS), non-emergency transportation services
2. Average number of rides, per beneficiary, for BLS non-emergency
3. Average ground mileage reported with A0425, according to urban, rural, and super-rural locales
Allergy and Immunology

Vulnerability:
Allergy and immunology services hold an improper payment rate of 1.9 percent, which represents $13,391,179 in possible improper payments for Medicare Part B claims. A 63.5 percent improper payment rate is attributed to insufficient documentation and a 36.5 percent improper payment rate is attributed to incorrect coding.

After review of and research into the improper payment rate, this CBR was created to analyze the possible threat to the Medicare Trust Fund associated with allergy and immunology services. The expectation is for providers who provide allergy and immunology services to maintain proper documentation for patient care and confirm correct coding processes.

Metrics:
1. Percent of all claim lines that were allergen injections
2. Percent of allergy services that were antigen preparation
3. Percent of allergen injections submitted with an E/M service

Cataract Surgery

Vulnerability:
Eye procedures—cataract removal and lens insertion carries an improper payment rate of 12.7 percent, which represents $218,340,490 in possible improper payments made under Medicare Part B. Findings include an 87.2 percent improper payment rate attributed to insufficient documentation and a 12.8 percent improper payment rate attributed to incorrect coding.

After review of and research into the improper payment rate, this CBR was created to analyze the possible threat to the Medicare Trust Fund associated with cataract surgery services. The expectation is for providers who provide cataract surgery services to maintain proper documentation for patient care and confirm correct coding processes.

Metrics:
1. Percent of cataract surgeries billed as a complex procedure
2. Percent of beneficiaries with a cataract surgery who have a subsequent secondary cataract surgery on the same eye performed by the same or different provider within 547 days
3. Percent of cataract surgeries where postoperative care was rendered by a different provider

Get CBR Support

To ensure that all CBR information is received in a timely fashion, confirm your PECOS information and check the email box within PECOS regularly for CBR notifications.

Stay on top of CBR releases by:
1. Going to the CBR home page at cbr.cbrpepper.org/home for information about past and upcoming CBR releases; and
2. Clicking the link on the home page to join the email list to receive up-to-date information about all things CBR.

If you have questions or concerns, submit a ticket to the help desk at cbr.cbrpepper.org/Help-Contact-Us. The CBR team is there to support you; don’t be afraid to reach out!

Add CBRs to Your Compliance Arsenal

Compliance is constantly evolving and expanding to every area of patient care administration. More than ever, correct billing and coding play a key role in claim submission and in the protection of the Medicare Trust Fund. CBRs support compliance and education by raising awareness and offering tailored knowledge for recipients. All providers and support staff can take advantage of the wealth of education, analyses, and resources that accompany each CBR topic to ensure compliance in their organizations.

Resources


https://cbrfile.cbrpepper.org
https://cbr.cbrpepper.org

“Receiving a CBR is not an indication of, or precursor to, an audit.”
Be Prepared for What’s Coming Down the Pike With MIPS

CMS’ acknowledgment of COVID’s impact on providers may help you breathe more freely.

The Centers for Medicare & Medicaid Services (CMS) has provided an update on the Merit-Based Incentive Payment System (MIPS), acknowledging the impact COVID-19 has had on healthcare by shifting to a softer launch of its MIPS Value Pathways (MVPs) program.

CMS released more information via a Quality Payment Program (QPP) proposed rule, published in the Federal Register July 29, 2022. Here’s what you need to know.

Beware These Adjustments

Traditional MIPS: CMS aims to offer MIPS-eligible clinicians (ECs) “continuity and consistency while they gain familiarity with MVPs,” the fact sheet indicates. The agency’s proposals include the following:

• CMS wants to use 2017 performance year/2019 payment year data to determine 2023 performance year/2025 payment year thresholds and set the threshold at 75 points, reminding that the 2022 performance year was the final year for the additional exceptional performance adjustment. The agency expects this policy decision “would subject approximately one-third of MIPS eligible clinicians to negative payment adjustments for the CY 2023 performance period,” explains Suzanne Michelle Joy, senior public affairs advisor with law firm Holland & Knight LLP, in online analysis.

• CMS proposes several equity-inspired updates, including redefining what high-priority measure means; cutting quality measures from 200 to 194; updating QPP standards with equity language; and adding, revising, or deleting specific improvement activities.

• As has been the case in past rules, CMS proposes several changes to the Promoting Interoperability updates. First, the agency advises making the Query of Prescription Drug Monitoring Program (PDMP) measure a required measure. CMS also proposes offering a third option to fulfill the Health Information Exchange (HIE) objective by participating in the Trusted Exchange Framework and Common Agreement (TEFCA) and updating the clinician types on the automatic reweighting list.

MVPs: As a reminder, MVPs focus more on specialty and scope, offering ECs the option to report “a more connected, cohesive set of measures and activities and allowing for comparative feedback that will be more beneficial to patients,” the fact sheet notes. For CY 2023, CMS proposes modifying the seven MVPs it has already established, according to the rule. Those include revisions to the following MVPs:

1. Advancing Care for Heart Disease
2. Optimizing Chronic Disease Management
3. Advancing Rheumatology Patient Care
4. Improving Care for Lower Extremity Joint Repair
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Patient Safety and Support of Positive Experiences with Anesthesia
7. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
Plus, CMS intends to add five more MVPs for the 2023 performance year. The proposed rule mentions these MVP additions: Advancing Cancer Care; Optimal Care for Kidney Health; Optimal Care for Neurological Conditions; Supportive Care for Cognitive-Based Neurological Conditions; and Promoting Wellness.

CMS also offers more guidance on MVP subgroup eligibility, registration, and scoring, the rule says.

**Advanced APMs:** In its CY 2023 proposals, CMS aims to bolster participation in the higher QPP track, Advanced Alternative Payment Models (AAPMs).

Remember, AAPMs offer differentiated services to patients, but they come with a plethora of financial rewards for providers — as well as risks. Originally, the current Generally Applicable Nominal Risk standard, which is set at 8 percent, was slated to expire in performance year 2024 and increase. Instead, CMS proposes to make the 8 percent minimum permanent. “This standard determines which models have sufficient risk to qualify as an AAPM and would not impact individual AAPM Entities,” Joy explains.

**Know About 2021 Targeted Reviews**

If your MIPS data, final score, or payment adjustment for the 2021 performance year doesn’t match up with your files, now is the time to request a targeted review before the window closes.

**Then:** CMS recently updated EC accounts with 2021 performance year final scores for preview. The preview option is new this year and is part of CMS’ efforts to offer providers more transparency about payment adjustments and MIPS final scores.

**Remember:** “For MIPS-eligible clinicians, your 2021 final score determines the payment adjustment you’ll receive in 2023; a positive, negative, or neutral payment adjustment will be applied to the Medicare paid amount for covered professional services furnished in 2023,” reminds CMS in an Aug. 22 alert.

**Now:** CMS announced that the MIPS 2021 targeted review period has begun, reminding MIPS-eligible clinicians that their 2021 final scores determine their 2023 payments, the alert says. Plus, those 2023 MIPS payments reflect “a positive, negative, or neutral payment adjustment [which] will be applied to the Medicare paid amount for covered professional services furnished in 2023,” CMS explains.

CMS allows ECs to request a targeted review of their data when they discover an error in payment adjustment calculations. Past reasons for requests have included MIPS eligibility and status errors; incorrect national provider identifier or taxpayer identification number; and the reweighting of the wrong performance category, according to the agency.

ECs, groups, virtual groups, and APM entities can request targeted reviews via the Quality Payment Program portal through Oct. 21.

Kristin Webb-Hollering is a development editor for Part B Insider, Medicare Compliance & Reimbursement and Health Information Compliance Alert. With decades of experience as a writer and editor, she focuses on such hot topics as regulatory reform, MACRA, Medicare billing, federal policy, fraud and enforcement, and HIPAA.

**Resources**


https://qpp.cms.gov/login

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TOP 10

Expert Advice for Getting a Medical Coding/Billing Job

10 invaluable resources that will help you hear those words, “You’re hired!”

Experienced healthcare business professionals frequently share with us in this magazine how they got started in the industry. In their articles, they offer an array of advice for finding job openings, building a resume, writing a winning cover letter, interview do’s and don’ts, and more. Here are 10 articles we’ve published in the past that you will want to bookmark in your internet browser for easy reference.

1. A Coder’s Roadmap to Career Pathing

Everyone hopes for a career that brings personal fulfillment, and this article gives plenty of great advice on how to make it happen. Review the various roles that exist in the business of healthcare and then set a course for success!

This article is available online at www.aapc.com/blog/49527-a-coders-roadmap-to-career-pathing.

2. Find a Medical Coding Job

This article outlines the usual process for becoming a medical coder and provides links to many AAPC resources that will help you gain the experience needed to remove your apprentice designation, locate viable job postings, ascertain what you’re worth monetarily, and more.

This article is available online at www.aapc.com/blog/52182-find-a-medical-coding-job.

3. How to Get Noticed and Land Your Dream Job: Parts 1 and 2

This two-part series provides a step-by-step guide to getting the job you want. The authors discuss the importance of writing unique cover letters, offer tips for resume writing, explain what soft skills are, provide tips for the interviewing process, and much more.

These articles are available online at:
www.aapc.com/blog/50746-how-to-get-noticed-and-land-your-dream-job

4. How to Find a Coding Job in the Digital Age

Gone are the days of mailing resumes! Today’s job seekers need to create a professional presence on all social media. This article steps you through the process of creating an online presence and how to market yourself.

Look for this article online at www.aapc.com/blog/45443-how-to-find-a-coding-job-in-the-digital-age.

5. Short on Experience? Soft Skills May Get You the Job

You don’t need to be a jack of all trades, but being overly focused on one skill, such as coding, and overlooking other skills you may need, such as communication and time management, will hinder your performance. Employers know this and look for people who possess both hard and soft skills.
Top 10

6. A Successful Coding Career Starts With You

In this article, the author provides advice on how to break into the business of healthcare. You’ll learn that it takes much more than submitting resumes.

Read the article online at www.aapc.com/blog/84073-a-successful-coding-career-starts-with-you.

7. Remote Coding and Billing: Dream Job or Nightmare?

Many people try to get a job in medical coding and billing because they think they can do it at home. First, that’s the wrong reason to choose a career. Second, working from home isn’t all it’s cracked up to be.

Before you accept a remote job, read this article. It’s available online at www.aapc.com/blog/50128-remote-coding-and-billing-dream-job-or-nightmare.

8. Don’t Limit Yourself to Medical Coding Careers

Opportunities abound in the healthcare industry, so don’t limit your job search to just medical coding jobs. Find out what other opportunities exist for you.

Read this article online at www.aapc.com/blog/34598-dont-limit-yourself-coding-careers.

9. Navigate Your Path to Career Satisfaction

Career success is not necessarily about how far up the ladder you climb. This article gets you thinking about what your passion is and how to get a job that meets your expectations.

You can read this article online at www.aapc.com/blog/44925-navigate-your-path-to-career-satisfaction.

10. Justify Your Job Expenses

Before you accept a job, find out what it pays and what benefits are available. If the employer expects you to be certified, consider asking for the cost of maintaining your credential(s) to be included in your compensation package. This article walks you through the process of asking for what you’re worth.

Read the article online at www.aapc.com/blog/46066-justify-your-job-expenses.

One Last Piece of Advice

AAPC’s member forums are a great resource for job hunting, networking, and building relationships with fellow coders. Local chapter meetings, virtual meetings, educational seminars, coding conferences, a cup of coffee with friends in your industry — these additional interactions can all lead to job opportunities. Let your friends, peers, and colleagues know you are looking for employment.

Renee Dustman, BS, is the managing editor of content and editorial for AAPC’s Publishing Department. She is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

“Local chapter meetings, virtual meetings, educational seminars, coding conferences, a cup of coffee with friends in your industry — these additional interactions can all lead to job opportunities.”
Advice From a CANPC®

A PC member Jenny Lin, CPC, CANPC, began her career 17 years ago as a home healthcare biller. In 2010, she moved into anesthesia billing at Penn Medicine. Five years ago, Lin had the opportunity to become a medical coder within the same department at Penn Medicine and is currently a practice coding specialist for anesthesiology and the critical care department.

AAPC asked Lin about her experience with earning the Certified Anesthesia and Pain Management Coder (CANPC®) credential, how it has helped her career, and what sort of advice she has for anyone considering the specialty certification.

What led you to obtain the CANPC® credential?
I decided to pursue the CANPC® credential because I wanted to solidify and further my knowledge in anesthesia coding.

Do you have any tips for individuals preparing for the CANPC® exam?
I used AAPC’s CANPC® preparation course, as well as AAPC’s practice exams and study guides. The prep course included an evaluation and management section, which is important for pain management coders. I suggest anyone studying for the exam to get familiar with the CPT® anesthesia codes and anesthesia modifiers and practice calculating total anesthesia minutes and common nerve block codes.

How has the CANPC® credential helped you in your job/career?
My CANPC® credential shows my providers and others that I have invested in my career in the anesthesiology and pain management specialty.

Who do you think would most benefit from the CANPC® credential?
Anesthesia coders, pain management coders, managers, and auditors would all benefit from having the CANPC® credential.

What resources do you use most to earn your continuing education units (CEUs)?
I have an AAPC webinar subscription and attend my local chapter virtual meetings to earn CEUs. I have also signed up for a learner’s account with my Medicare Administrative Contractor.

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.

“My CANPC® credential shows my providers and others that I have invested in my career in the anesthesiology and pain management specialty.”
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