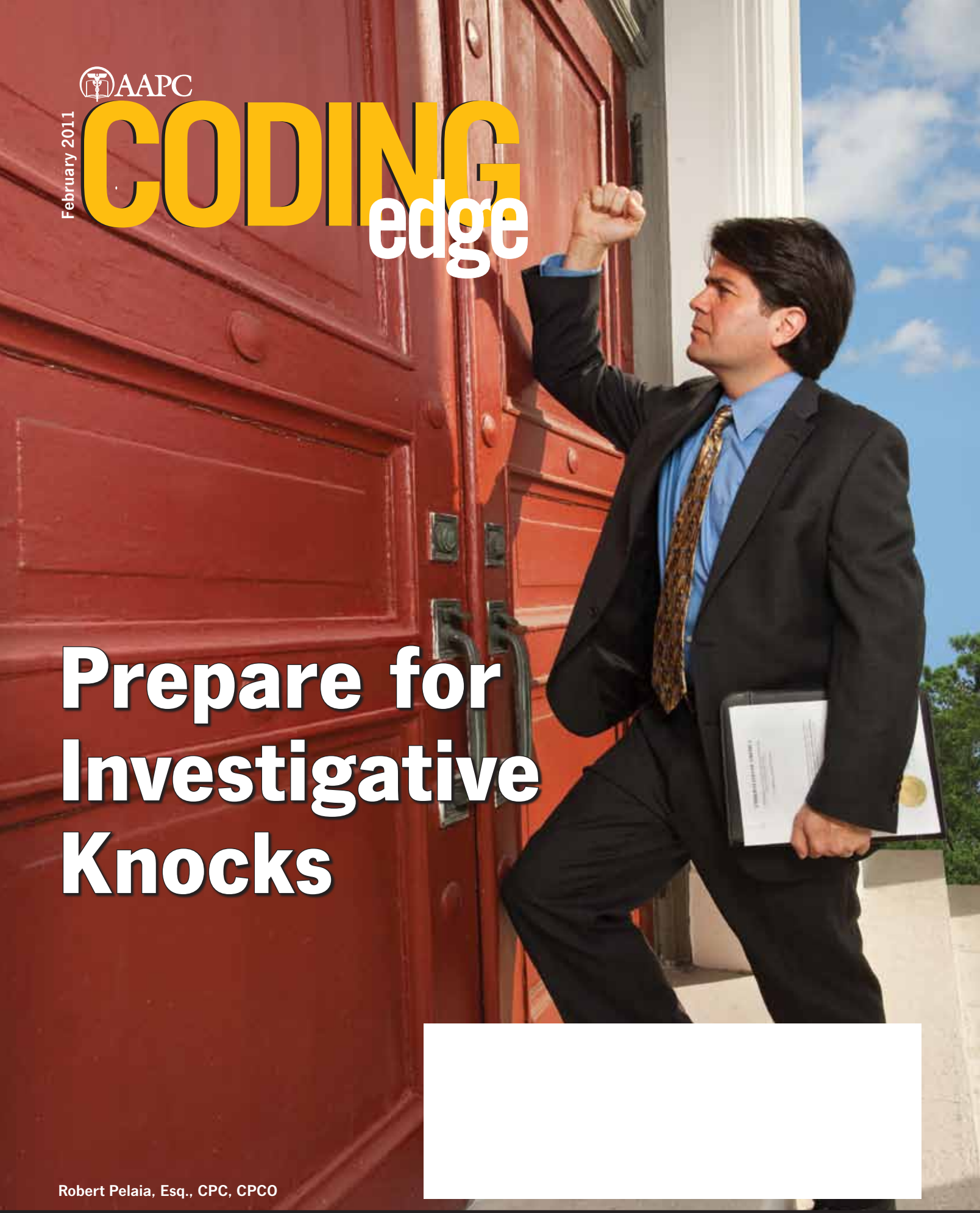
AAPC
February 2011

CODING edge



Prepare for Investigative Knocks

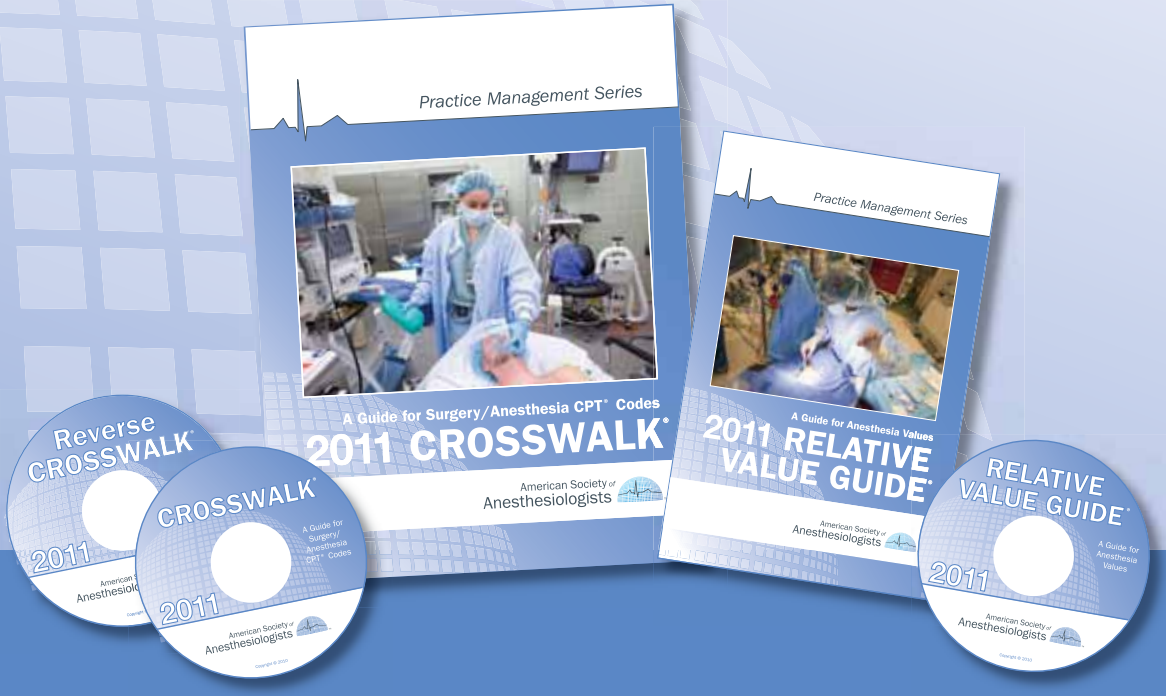
Robert Pelaia, Esq., CPC, CPCO

Plus: Vascular Codes • CPC-A Dilemmas • Up-to-date Anesthesia • ICD-10 Productivity • PQRS

ANESTHESIA CODING RESOURCES

2011 Relative Value Guide® and CROSSWALK®

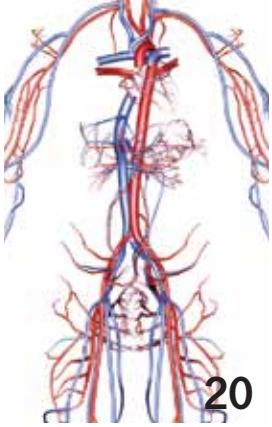
Accurately report, decrease audit liability and optimize reimbursement with 2011 coding resources developed by the authorities in anesthesia – the American Society of Anesthesiologists (ASA).



For more information and to order, contact ASA at 847-825-5586 or visit www.asahq.org/Shop-ASA.

Download a QR Reader on any smartphone with QR Reading capabilities, such as the iPhone or Droid. Then simply use the phone's camera to scan the QR code (at left) and connect quickly to the ASA website for information or to order.

American Society of Anesthesiologists™



[contents]

AAPC CODING edge
February 2011

Features

12 **Revitalize Integumentary Coding in 2011**
G.J. Verhovshek, MA, CPC, and Terri Brame, MBA, CHC, CPC, CGSC, CPC-H, CPC-I

16 **Observation Overhaul: New CPT® Codes for Subsequent Services**
Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC, and G.J. Verhovshek, MA, CPC

20 **Keep Vascular Coding in the Family**
Kimberly Engel, CPC

22 **PQRS Solidifies PQRI for Years to Come**
Penny Osmon, BA, CPC, CPCI, CHC, PCS

26 **Set Up an Offense for Investigators Who Are at Your Door**
Robert A. Pelaia, Esq., CPC, CPCO

30 **Understand Payer Guidelines to Keep Up-to-date with Anesthesia**
Kelly Dennis, MBA, CPC, CPC-I, CANPC, CHCA, ACS-AN

33 **Build Revenue with Surgical Chart Auditing**
Charla Prillaman, CPC, CPMC, CPC-I, CCC, CEMC, CHCO

34 **Master Significant Revisions to 2011 Vascular Codes**
David Zielske, MD, CPC-H, CIRCC, CCC, CCS, RCC

44 **Avoid the Dark Side of EHR Documentation**
Holly J. Cassano, CPC

On the Cover: *As Robert Pelaia, Esq., CPC, CPCO, knocks on the doors of the Karpeles Manuscript Library, Jacksonville Museum, he knows that the best response to subpoenas and search warrants is building a good offense.*
Cover photo by Jon M. Fletcher (www.jonmfletcher.com).

In Every Issue

7 **Letter from the President and CEO**

8 **Coding News**

11 **Letter from Member Leadership**

Special Features

Online **Test Yourself – Earn 1 CEU**
go to www.aapc.com/resources/publications/coding-edge/archive.aspx

14 **AAPCCA—Tackle the CPC-A Dilemma with Confidence**
Brenda Edwards, CPC, CPMA, CPC-I, CEMC

42 **ICD-10-CM Road Map—Analyze Productivity, Build Speed and Confidence**
Corrie Alvarez, CPC, CPC-I, CEDC

Education

38 **Newly Credentialed Members**

48 **Job Hunting Confessions of a CPC-A**
Brianne Rivera, BA, CPC

Coming Up

Bed Bugs

Cardiac Cath

General Surgery

Opthalmology

Fudicial Markers

Serving 100,000 Members – Including You

Serving AAPC Members

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

APPRENTICE	Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
PROFESSIONAL	More sophisticated issues including code sequencing, modifier use, and new technologies.
EXPERT	Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

advertising index

American Medical Association ..... p. 10
www.amabookstore.com

American Society of Health Informatics Managers ..... p. 6
http://ashim.org

American Society of Anesthesiologists p. 2
www.asahq.org

CodingCert.com ..... p. 50
CodingCert.com

The Coding Institute, LLC ..... p. 19
www.Audioeducator.com

The Coding Institute, LLC ..... p. 50
www.SuperCoder.com

CodingWebU ..... p. 51
www.CodingWebU.com

Contexo Media ..... p. 9
www.contexomedia.com

HeathcareBusinessOffice LLC ..... p. 25
www.HealthcareBusinessOffice.com

Ingenix ..... p. 5
www.shopingenix.com

Medicare Learning Network® (MLN) ..... p. 47
Official CMS Information for Medicare Fee-For-Service Providers
www.cms.gov/MLNGenInfo

NAMAS/DoctorsManagement ..... p. 52
www.NAMAS-auditing.com

ZHealth Publishing ..... p. 29
www.zhealthpublishing.com

AAPC CODING edge
February 2011

Address all inquires, contributions and change of address notices to:

Coding Edge
PO Box 704004
Salt Lake City, UT 84170
(800) 626-CODE (2633)

Volume 22 Number 2 **February 1, 2011**

Coding Edge (ISSN: 1941-5036) is published monthly by AAPC, 2480 South 3850 West, Suite B. Salt Lake City, Utah, 84120, for its paid members. Periodical postage paid at the Salt Lake City mailing office and others. POSTMASTER: Send address changes to:

Coding Edge c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City, UT, 84120.

Ready to expect the unexpected?

In the new world of Electronic Medical Records demand for trained health IT professionals is exceeding the supply. The United States Bureau of Labor Statistics, Department of Education has indicated a national shortage of 50,000 qualified health IT workers. Health IT training and national certification can give you a first-on-scene advantage in tomorrow's job market.

As the leading association for technical professionals who specialize in health IT, ASHIM's online course is one of the fastest ways for a medical coder to improve their career outlook and job performance. Most students complete within 12-16 weeks.

ASHIM's online courses jump start students into high-demand jobs with the skills and knowledge employers need now.

Health IT Training

Register today. Start tomorrow.

ashim.org

ASHIM®

The American Society of Health Informatics Managers. Inc. is a nonprofit, non-governmental organization that sponsors the Certified Health Informatics Systems Professional (CHISP®) credentialing exam to certify the healthcare industry knowledge of technical professionals.

877-263-1261 ashim.org

Help Your Fellow Coders

It is an enormous blessing to have people to look up to and emulate; for example, a beloved teacher, an inspiring football coach, a supportive employer, an active father, or a mother who takes time to listen, for example. These role models are referred to as *mentors*.

In the coding industry, inexperienced Certified Professional Coders (CPCs®) and Certified Professional Coders-Apprentice (CPC-As®) are in need of supportive coding mentors to emulate. In the past several months, as the new president and CEO at AAPC, this need has become quite obvious to me. Some coders lack the hands-on work experience necessary to be successful in our industry. I am looking to you, as experienced coders, to mentor and support CPC-As and CPCs who are struggling to gain experience as coding professionals. For all you seasoned coders out there: CPC-As and new CPCs need your help.

Coders are an essential piece of the claim submission puzzle; without you, services provided by a medical practice or hospital won't get paid correctly. Seasoned coders must teach new coding professionals the importance of this by example. We cannot give new coders experience, but we can become a mentor to new members. They need our experience, expertise, and guidance. The young faces we see today are the faces of the workforce and members of tomorrow.

There are two articles in this month's *Coding Edge* that I encourage you to read carefully: "Tackle the CPC-A Dilemma with Confidence," and "Job Hunting Confessions of a CPC-A." These articles show the real dilemma new coders face when they lack the experience to get a job. This is a frustrating situation for both the new coding professional and employers because there are job openings for coders but the only coders who apply are inexperienced. We need to bridge this gap. How can we help our coders gain experience?

Become a Mentor

If you ever went to summer camp as a child, you may remember having a "buddy" there to help you. Most camp attendees are assigned a buddy to help them adjust because it's scary being away from home for a long period of time. The buddy is there to help with the transition. That is the same idea of what a mentor does. Many coders have been in the industry for a long time. Someone coming into the industry either from college or a coding training program is sometimes overwhelmed at the many types of jobs, experience required, skill level required, etc.

A mentor can help the protégé through this transition and help him or her achieve full potential. The role of a mentor involves listening, advising, supporting, coaching, encouraging, constructively criticizing, and guiding.

To be a mentor, start by getting personally involved with the person. Invite a member to a chapter meeting or another professional meeting. You can be a mentor either in person or even through e-mail, if that is your only possible method of communication. Meet with the protégé at least once a week to listen and guide him or her into meeting career goals. If you mentor someone who is seeking employment, provide guidance as to what to expect, how to prepare for the interview, how to present oneself, etc.

AAPC takes mentoring very seriously. AAPC has created a program to help our new CPC-As gain experience through the Project Xtern program. We also launched a new program in 2010 called the "Virtual Experience: Apprentice Removal." This program enables a new coder to code 800 medical records and gain valuable real-world coding experience and skills.

But even with these two very important programs, it is essential that new members in the industry have a mentor—someone to look up to for advice and guidance. We have all had a mentor that changed or enriched our lives. Reach out to another coder and make a difference in his or her life.

Until next month, my friends,

Sincerely,

Deborah J. Grider

Deborah Grider,
CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P
AAPC President and CEO

coding news

2011 Corrections: CPT® and HCPCS Level II

There are additional updates to 2011 CPT® and HCPCS Level II codes. You'll want to update your codebooks with the latest revisions *Coding Edge* had on hand at press time.

CPT® 2011

The American Medical Association (AMA) added to its original CPT® 2011 corrections document, which we reported on in the last issue.

In the Surgery section, under Digestive System/Abdomen, Peritoneum, and Omentum/Introduction, Revision, Removal, revise the parenthetical note following 49419 to read:

"(49420 has been deleted. To report open placement of a tunneled peritoneal ~~tunneled~~ catheter for dialysis, use 49421. To report open or percutaneous peritoneal drainage or lavage, see 49020, 49021, 49040, 49041, ~~49060, 49061, 49062~~, 49080, 49081, as appropriate. To report percutaneous insertion of a tunneled peritoneal ~~tunneled~~ catheter without subcutaneous port, use 49418)."

The AMA also corrected the Cardiovascular Monitoring Services introductory guidelines in the Medicine section to say that event monitors do, in fact, require attended surveillance. The last sentence of the introductory guidelines should read:

"Event monitors (93268-93272) record segments of ECGs with recording initiation triggered either by patient activation or by an internal automatic, preprogrammed detection algorithm (or both) and transmit the recorded electrocardiographic data when requested (but cannot transmit immediately based upon the patient or algorithmic activation rhythm) and ~~do not~~ require attended surveillance."

Another update you should make is to delete the parenthetical note following the Neurology and Neuromuscular Procedures guidelines referencing deleted codes 0160T, 0161T.

Lastly, in Medicine Neurology and Neuromuscular Procedures, Sleep Testing, revise the third parenthetical note following 95806 *Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)* to add the term "a minimum." This note should now read: "(For unattended sleep study that measures a minimum heart rate, oxygen saturation, and respiratory analysis, use 95801)."

For the previously released changes and updated errata, download the Corrections Document - CPT® 2011 on the AMA website (www.ama-assn.org/ama1/pub/upload/mm/362/cpt-2011-corrections.pdf).

HCPCS Level II

The Centers for Medicare & Medicaid Services (CMS) released a modification to the HCPCS Level II code set.

CMS has reinstated codes L3660 *Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment*; L3670 *Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment*; and L3675 *Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment* with the original language. The termination date for these codes is no longer Dec. 10, 2010.

These corrections have been incorporated into version 3 of the Alpha-Numeric web file.

The 2011 HCPCS Level II corrections document is on the CMS website (www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage).

To keep abreast of all coding changes as they occur, read *EdgeBlast*.

2011 HCPCS Level II Corrections

Code	Action	Effective Date	Short Description	Long Description	Price
C8931	Change long description	10/1/10		Magnetic resonance angiography with contrast, spinal canal and contents	
D0486	Change long description	1/1/11		Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report	
D5992	Change long description	1/1/11		Adjust maxillofacial prosthetic appliance, by report	
E0575	Change pricing indicator	1/1/11			36
G0306	Change pricing indicator	1/1/09			21
G0307	Change pricing indicator	1/1/09			21
G0339	Change pricing indicator	1/1/11			13
G0340	Change pricing indicator	1/1/11			13
J3095	Change short and long description	1/1/11	Telavancin injection	Injection, telavancin, 10 mg	
L3660	Do not terminate				
L3670	Do not terminate				
L3675	Do not terminate				

INTRODUCING THE

Correct Coding ANALYZER

The Correct Coding Analyzer will help you keep updated on the latest NCCI edits and learn how to use them to steer clear of trouble AND get the reimbursement you deserve.

The Correct Coding Analyzer is a robust, Windows-based free standing software program that gives you the following:

- All published NCCI code pairs – including Column1, Column 2 and Mutually Exclusive codes
- CCI look-up capability
- Type in a Column 1 code and get all associated Column 2 codes (and vice versa)
- Look up any two codes or create (by import or entry) your own custom list of codes

To sign up for a Free 10-Day Demo, please call us at 1-800-334-5724 or order online at www.codingbooks.com

CONTEXO MEDIA
P.O. Box 25128
Salt Lake City, UT 84125-0128

PHONE
800.334.5724

FAX
801.365.0710

ONLINE
www.codingbooks.com

American Medical Association

Critical resources for today's demanding practice environment

With more than 40 years of experience, there's no better resource to learn from than the source of Current Procedural Terminology (CPT®), the American Medical Association (AMA). As the world's foremost scientific publisher, the AMA offers a broad range of authoritative resources that can help physicians and their staff run a more efficient practice. Improve quality and accuracy using the AMA's official coding and reimbursement resources, including the new CPT Network, a Web-based solution providing reliable answers to your most challenging CPT questions "straight from the source" of CPT codes and guidelines. **To learn more visit www.amabookstore.com or call (800) 621-8335.**

AMA
AMERICAN MEDICAL ASSOCIATION

Talk to Your Medical Billers

When I speak to coders at chapter meetings and conferences, I ask attendees to raise their hands if they have ever had a conversation with the medical billers at their company or hospital. I'm always amazed when I see only one or two hands raised among a large group of coders. I have worked in many parts of the billing and coding puzzle and I've always been part of a larger team.

Get to Know Your Biller

As you know, coding should always be done by a certified coder because the certification means the coding professional knows the rules and how to read medical records and review documentation. Billers also know the rules for billing claims and how to process UB-04 or 1500 forms. They know payer rules and how many modifiers a payer can see. They are familiar with Explanation of Benefits (EOB), filing appeals, line item billing, speaking to insurance adjustors, filing authorizations, arguing claims filed over the file limit, etc. Medical billers also are an integral part of the billing puzzle.

What I'm wondering is … where there is a lack of communication between coders and billers, who is looking at claims denied for 'not medically necessary,' missing fifth digits, missing modifiers, multiple procedure modifiers, reduced services, and other billing denials that need review and work to get claims paid?

Coders and Billers Have a Common Goal

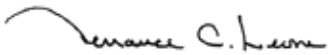
Coders and billers should meet on a regular basis, discussing denials and learning from each other to improve cash flow and account accuracy for their organization. I have been a member of billing audit committees that meet regularly to review denials. These teams meet with physicians to review their denials based on documentation deficiencies and to discuss how they can improve cash flow. The billers and coders discuss coding errors, modifier issues, and payer rule denials. The billing/coding team doesn't meet to point fingers at each other. They meet to learn from each other for the good of their organization.

Improve Collaborative Efforts for ICD-10

With the inception of ICD-10, it will become even more important for physician, coder, and biller collaboration. I strongly believe coders and billers should work side by side to educate each other as the billing and coding world evolves almost daily. If both teams work with their physicians toward accurate documentation, physicians will see firsthand the value of coders and billers to their hospitals or office organizations.

If your hospital or office has or is starting an ICD-10 committee, ask to be a member because both coders and billers have knowledge of the rules and are imperative for clean claims. Stand up, take the initiative, and be a leader in your organization—you and your superiors will be glad you did.

Best wishes,



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

Revitalize Integumentary Coding in 2011

By G.J. Verhovshek, MA, CPC, and Terri Brame, MBA, CHC, CPC, CGSC, CPC-H, CPC-I

New debridement codes and revised descriptors will help to capture services accurately.

Revisions to CPT® 2011 for integumentary-related services involve three families of debridement codes. Debridement is the removal of dead or infected tissue to improve healing of remaining, healthy tissue. Various methods—including surgical (sharp debridement), mechanical (e.g., hydrotherapy), and chemical—may be used.

Codes 11010-11012 Are Refined, Not Redefined

The first family of debridement codes to undergo revision is 11010-11012. New, standardized descriptor language clarifies the intent of these codes, but does not alter their use from previous years (new text for 2011 is underlined, deleted text is struck-through).

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

11011 Debridement including removal of foreign material ~~associated with~~ at the site of an open fracture~~(s)~~ and/or an open dislocation~~(s)~~ (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, and muscle

11012 Debridement including removal of foreign material ~~associated with~~ at the site of an open fracture~~(s)~~ and/or an open dislocation~~(s)~~ (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone

Note the specific circumstances under which you may report these codes:

- The debridement must occur at the sight of an open fracture or dislocation. An open fracture occurs when bone pierces the skin; an open dislocation (compound dislocation) is dislocation complicated by a wound opening from the surface to the affected joint. Code debridement for other reasons/sites differently (e.g., 16020-16030 for debridement of burn wounds).
- Debridement must reach to *at least* the level of skin and subcutaneous tissue (11010), but may reach as deep as muscle (11011) or bone (11012). Documentation must specify precisely the depth of debridement. Report debridement of skin only (as well as active wound care management) with 97597 or 97598.

For example, a motorcyclist loses control on a wet road and suffers a compound fracture of the ulna, with extensive "road rash" directly over the fracture that requires debridement down to muscle. The debridement portion of this procedure is reported with 11011 (open fracture repair is reported separately, per the documentation).

Report 11042-11047 by Square Centimeters

Codes 11042-11044 have been revised and their family has grown with the addition of 11045-11047. These codes describe debridement at various depths, and now are reported by the total square area treated.

To the depth of subcutaneous tissue:

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

+**11045** Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

To the depth of muscle and/or fascia:

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

+**11046** Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

PROFESSIONAL

To the depth of bone:

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

11047 Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Once again, debridement of skin (epidermis and/or dermis) only should be reported using wound care codes 97597-97598. These codes previously were reported only by nonphysician providers, but may now be reported by any billing provider. In addition to depth, the total area treated must be documented. The standard unit of measurement for these codes is 20 sq cm.

The AMA's *CPT® Changes 2011: An Insider's View* offers the following example:

> A 74-yr-old diabetic female with limited mobility presents with a 4.0 cm x 3.5 cm posterior heel ulceration involving the skin and subcutaneous tissues and Achilles tendon/muscle. She requires debridement of the wound, including debridement of the tendon/muscle.

Because debridement occurs to the level of muscle, our code choices are 11043-+11046. The total area treated is 4.0 cm x 3.5 cm, or 14 sq cm. This is reported using a single unit of 11043.

In a second example, the surgeon performs debridement to the depth of bone. The total area is 48 sq cm. This is reported with 11044, 11047 x 2.

11044	**first**	**20 sq cm**
11047	**additional**	**20 sq cm**
11047	**additional**	**08 sq cm**
	Total	**48 sq cm**

You may report the add-on codes if even 1 sq cm beyond the first 20 sq cm is debrided. For instance, if the area in the above example had been 7 cm x 3 cm (21 sq cm), you would then report 11044 for the first 20 sq cm and 11047 for the remaining 1 sq cm.

Skin Only Debridement Now Coded 97597-97598

Deleted are codes 11040 and 11041, which in previous editions of CPT® described debridement of skin, partial or full thickness. As a result, active wound care codes 97597 and 97598 are revised to include these procedures:

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

+97598 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

These codes describe active wound care of the skin, dermis, or epidermis. For debridement below the level of skin, refer to integumentary codes (e.g., 11042-11047). Consider also 16020-16030 for certain (but not all) burn debridements, and pressure ulcer excision codes when a pressure ulcer is debrided and closed (if the ulcer is not closed, 1104x codes apply).

Codes 97597-97598 also are revised to include sharp, selective debridement. Previously, the codes only included nonselective debridement. Because any type of debridement now applies, the level of debridement (skin) determines when 97597-95978 are appropriate.

When reporting 97597 or 97598, consider several points:

- Per CPT®, "Provider is required to have direct (one-on-one) patient contact." This hands-on contact should be documented.
- Total area treated must be documented to code appropriately.
- Codes 97597-97598 should not be reported with 11042-11047 for the same wound.
- Add-on codes apply if even 1 sq cm beyond the first 20 sq cm is treated.

For example, a diabetic patient has a chronic open wound on the lower right leg, measuring 6 cm x 5 cm (30 sq cm). The physician determines that selective active wound care management is appropriate to threat the wound. The treatment is reported 97597, 97598.

G. John Verhovshek, MA, CPC, is director of editorial development/managing editor at AAPC.

Terri Brame, MBA, CHC, CPC, CGSC, CPC-H, CPC-I, is the director of coding and charge capture for University of Washington Physicians, a practice group of over 1,500 physicians and health care providers associated with UW Medicine. She is a past AAPC local chapter president, and has had the opportunity to speak at two AAPC national conferences.

Tackle the CPC-A Dilemma with Confidence

Look for ways to use your coding skills and gain experience in an evolving industry.

By Brenda Edwards, CPC, CPMA, CPC-I, CEMC

Thinking back on the past 25 years, it is amazing to see the changes coders have gone through in the medical coding industry. The role of a coder was once thought of as incidental, unnecessary, and something that anyone could do. Times sure have changed.

Coding in the Early Years

In the early 1980s there were no coding credentials, curricula, or examinations specific to professional fee services. In those days, coders learned by experience. Many started in a different role in the practice and progressed through the medical office by working as the receptionist, filing in medical records, posting charges, posting payments, submitting insurance forms, etc.. And then, one day, the "coding lady" was out for an extended time and somebody (whoever was the bravest) stepped up and filled in—and a coder was born.

As new coding certifications were created, some seasoned coders were no longer "qualified" due to lack of certification. A difficult test had to be passed to continue performing the job the coder had done for years. Experienced coders, who passed the test, proudly became Certified Professional Coders (CPC®)—and all of their previous experience was relevant again.

The New Coding Challenge

Currently, there are many new faces joining the coding profession. Some are people who have experience in another area of the medical field (e.g., clerical, transcription, medical records, nursing, radiology or laboratory technician, and even service provider). Others who come into the field by happenstance—possibly as a displaced worker—have a much more difficult journey towards becoming a CPC.

Today, with increasing government rules and regulations, payer guidelines and significant yearly coding changes, this field has evolved into a profession where many employers require both credentials and experience. These requirements prompt a vicious "employment vs. experience" dilemma for the apprentice. Apprentices with certification that lack experience sometimes feel stuck between a rock and a hard place.

For those entering this line of work without experience, the million dollar question is: How does one gain experience?

Peruse Available Resources

AAPC has many resources available to assist CPC-As that are in need of coding experience including:

- **Project Xtern** matches newly certified coders with employers willing to provide field experience. The business benefits from a non-paid, educated professional medical coder extern and the extern earns much needed experience.
- **Local chapter meetings** are the perfect place to network with seasoned coders and other apprentices. You never know who you'll meet, who needs a coding resource, or who can provide a coding resource.
- **Coding conferences** are "think tanks" for coders. AAPC hosts both regional and national coding conferences where you will meet coders from across the nation. This could be another opportunity to find a resource to gain experience. The networking possibilities are endless at coding conferences.
- **Vendors** are resources found at coding conferences as well; they may know of or have coding opportunities to share with a less experienced extern.
- **AAPC's website** is full of information. Start at the Resources tab. AAPC recently launched Virtual Experience: Apprentice Removal—where 800 chart notes can be coded at your own pace. Once coded at 90 percent accuracy, the apprentice designation is removed from your credential. Be sure to check out the many other resources on the AAPC website designed to help you succeed.
- **Coding forums** on AAPC's website provides 24/7 networking opportunities with people across the country. There are forums for apprentices, local chapters, specialties, education, employment, and general discussions. Scan the forums on a daily basis, not only for employment opportunities, but also for the wealth of information that is available, free-of-charge.

Think Outside the Box

Becoming a full-fledged CPC and landing a job in the coding field may require thinking outside of traditional coding occupations. There are numerous options for those with coding skills who lack experience—for example, coding positions with insurance companies, durable medical equipment (DME) vendors, or medical software companies.

Volunteering is also an effective method for gaining experience. Volunteer options include a teacher's aide for a coding curriculum instructor, or as a file clerk in a billing office or medical practice. Paid or not, the experience counts!

Solidify Your Medical Coding Career

As the CPC-A in search of a career, you may need to start by getting your foot inside an employer's door. To do so, present yourself as the candidate for the job. Some tips to consider:

- **Appearance**—Are you dressed for success? Consider how colleagues might view you. Remember: Dress for the job you want, not the job you have.
- **Adaptability**—Are you willing to take a position within a company with the possibility of less pay to get your foot in the door? Sometimes it takes a step backward to take 10 steps forward.
- **Commitment**—Do you have the commitment to make this your career path? This is a profession worth working for, but it requires commitment and dedication.

There is immense growth potential for apprentices in this profession. Before long, your "A" will be gone and you'll look back at your early coding years with appreciation, and find yourself a seasoned veteran helping the next generation of coders.

Brenda Edwards, CPC, CPMA, CPC-I, CEMC, serves on the AAPCCA board of directors and is coding and compliance specialist at Kansas Medical Mutual Insurance Company. After starting at an entry level position nearly 25 years ago, she progressed through chart auditing, compliance education, coding, accounts receivable, billing and insurance, coding education, and medical records. Brenda has spoken to coding chapters throughout Kansas and presented at AAPC regional conferences. She is co-founder and past-president of the Northeast Kansas Chapter.

Observation Overhaul:

New CPT® Codes for Subsequent Services

Three new codes help resolve opposing guidance.

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

EXPERT

CPT® 2011 includes three new codes to report hospital observation services spanning more than two dates of service. The codes are a welcome addition; prior to 2011, CPT® and the Centers for Medicare & Medicaid Services (CMS) offered conflicting guidelines on how to report these services.

Subsequent Observation Care Codes

The three new subsequent observation care codes (99224-99226) are "resequenced" codes that appear out of numerical order in the CPT® manual:

99224 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99225 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99226 Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Note: Subsequent care codes are to be used in addition to initial observation care codes 99218-99220 and observation care discharge 99217 *Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]).*

Observation Is a Status, Not a Place

Observation, much like critical care, defines a patient status rather than a location. That is, a hospital may have a designated observation area, but a patient needn't necessarily be placed there to receive observation care. Likewise, observation is not an inpatient service. Patients under observation care may be in the hospital, but unless and until they are admitted formally, they remain outpatients (in the same way that hospital emergency department (ED) patients are outpatient status).

Physicians may provide observation care for patients whose condition warrants additional monitoring, but who do not require immediate inpatient care. For example, a patient arrives in the ED after falling from a ladder. He has no broken bones and only minor bruises, but has struck his head. He was disoriented momentarily after the fall, and is experiencing minor dizziness. The physician may order a computed tomography (CT) scan or other diagnostic test to rule out

immediate intracranial damage, and may place the patient under observation for several hours to be sure a serious problem doesn't develop.

Coding for observation services depends on how long the observation lasts. The codes you choose will differ, for instance, if the patient is sent home the same day, the next day, or on day three or later. If the patient is admitted as an inpatient, coding will change again, and will depend on how long the patient was in observation before being admitted.

Observation Length Determines Coding for Same-day Discharge

Commonly, patients placed under observation are discharged the same day. Coding for this scenario depends on the length of the observation provided.

Under Medicare rules, if a patient receives fewer than eight hours of observation care on the same calendar date, you should report the service using an appropriate level Initial Observation Care code (99218-99220) only. All related evaluation and management (E/M) service provided on the same day are rolled into the observation/discharge code. CPT® instructs, "When 'observation status' is initiated in the course of an encounter in another site of service (eg, hospital emergency department, physician's office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating 'observation status' are considered part of the initial observation care when performed on the same date."

Returning to our earlier example, the patient arrives at the ED at 2 p.m. and, following examination, is placed under observation status. At 9 p.m. on the same day, he is discharged, for a total observation time of seven hours. In this case, the ED visit, admission to observation, and discharge all are billed together using a single code from 99218-99220.

Per Medicare, if the patient remains in observation for at least eight hours, but fewer than 24 hours, and is discharged the same day, report an appropriate service level from the Observation or Inpatient Care Services (Including Admission and Discharge Services) codes, 99234-99236 (*Medicare Claims Processing Manual*, chapter 12, section 30.6.8.B).

For example, the patient arrives at the ED at 2 p.m. and, following examination, is placed under observation status. At 11 p.m. the same day, he is discharged, for a total observation time of nine hours. The ED visit, admission to observation, and discharge is bundled together and reported using a single code from 99234-99236.

Two Dates of Service Call for Separate Initial Care, Discharge Codes

When a patient remains under observation for multiple dates of service, you may report the initial observation care (99218-99220) and observation discharge (99217) separately (*Medicare Claims Processing Manual*, chapter 12, section 30.6.8.B).

For example: The patient arrives at the ED at 2 p.m. on Wednesday. He is examined and admitted to observation status, where he remains until 9 a.m. the next morning. The supervising physician reports an appropriate service level from the initial observation care codes, 99218-99220. This service includes any related E/M services provided in the ED by the same physician. Again, CPT® stresses, "Evaluation and management services on the same date provided in sites that are related to initiating 'observation status' should not be reported separately."

For the discharge on day two, the physician reports 99217. As specified in the code descriptor, 99217 reports "all services provide to a patient on discharge from 'observation status' if the discharge is on other than the initial date of 'observation status.'"

Note: The above coding guidelines are per strict Medicare direction as given in the *Medicare Claims Processing Manual*. Individual payers may specify different requirements. Check with your individual payer, and request its guidelines in writing.

If the observation care spans three or more dates of service, you may call on the new subsequent care codes, 99224-99226.

For instance, the patient arrives at the ED and is placed under observation at 2 p.m. on Wednesday. She remains in observation until 4 p.m. on Friday (such

Only Supervising Physician's Services Are Bundled into Observation Care

Under CPT® and CMS rules, Initial Observation Care includes all related E/M services provided on the same date of service. For instance, if a patient is seen in the ED and then placed under observation in the hospital, only the observation service is billable; the ED service is included in the observation.

This rule only applies to the supervising physician who places the patient under observation, however. Other physicians who provide services to the patient while the patient is under observation may report their services separately. For example, if the supervising physician requests a consult from a neurosurgeon for a patient in observation, the neurosurgeon may report his or her service separately. The consult by a different physician isn't bundled to the observation care.

Patients under observation care may be in the hospital, but unless and until they are admitted formally, they remain outpatients (in the same way that hospital emergency department (ED) patients are outpatient status).

Observation Coding at a Glance

CMS rules for observation care coding can be confusing. To make it easier, use this quick coding chart.

Admit, Discharge on...	Observation Time	Report Codes	Billable Services	Discharge
Same date	< 8 hours	99218-99220	Initial Observation	Not Separate
Same date	> 8 hours	99234-99236	Observation incl./ discharge	Included in 99234-99236
Different dates	Any length	99218-99220 99224-99226* 99217	Initial Observation Subsequent care* Observation discharge	Separate w/ 99217

** You may report 99224-99226, as appropriate to the documented level of service, for subsequent days of service (not including the day of discharge).*

extended observation stays are infrequent). For the initial observation care (which included related E/M services in the ED), the supervising physician reports 99218-99220. To report care on the second day, the supervising physician reports subsequent observation care (99224-99226, as appropriate to the level of care provided and documented). For the final day (Friday), on which discharge occurs, the supervising physician reports 99217.

Note: Prior to 2011, the American Medical Association (AMA) recommended reporting subsequent observation care days using 99499 *Unlisted evaluation and management service* (*CPT® Assistant*, September 2006). CMS, by contrast, required an Office or Other Outpatient Services code (99211-99215) to report subsequent observation care (*Medicare Claims Processing Manual*, chapter 12, section 30.6.8.C). With the addition of 99224-99226, these guidelines are no longer effective.

CPT® guidelines specify that subsequent observation care includes "reviewing the medical record and reviewing the result so diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician."

Note also that the subsequent hospital care codes include a reference time (e.g., 99224: "Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit"), so services may be based on time if counseling and/or coordination of care dominates (more than 50 percent) the provider/patient encounter. Although observation is an outpatient ser-

To discuss this article or topic, go to www.aapc.com

vice, "time" is based on unit/floor time (as is typical of inpatient services) rather than face-to-face time (as is typical of outpatient services).

Inpatient Admission Takes Priority Over Observation

Occasionally, a patient placed under observation will be admitted to inpatient status by the same physician. If the patient is admitted on the same day he or she is placed under observation, only the initial hospital care code (99221-99223) may be reported for that day. The *Medicare Claims Processing Manual*, chapter 12, section 30.6.8.D states, "Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial observation care code for services on the date that he or she admits the patient to inpatient status."

If the patient is admitted as an inpatient on a day other than the day he or she was placed under observation, the observation service would be billed as normal, with the initial hospital care code (99221-99223) reported for the day the patient was admitted to inpatient service. Note, however, that a discharge from observation and an initial hospital care code may not be reported on the same day.

For example, the patient arrives at the ED and is placed under observation. Later that same day, the patient is admitted as an inpatient. All services by the supervising physician are reported using an Initial Hospital Care code (99221-99223, as appropriate to the level of service provided and documented).

In a second example, the patient arrives at the ED on Tuesday at noon and, following examination, is placed under observation. The next morning, the patient is admitted as an inpatient. For day one, the supervising physician reports initial observation care. For day two, he reports initial hospital care. The discharge from observation is bundled into the hospital admission service.

G. John Verhovshek, MA, CPC, is director of editorial development/managing editor at AAPC.

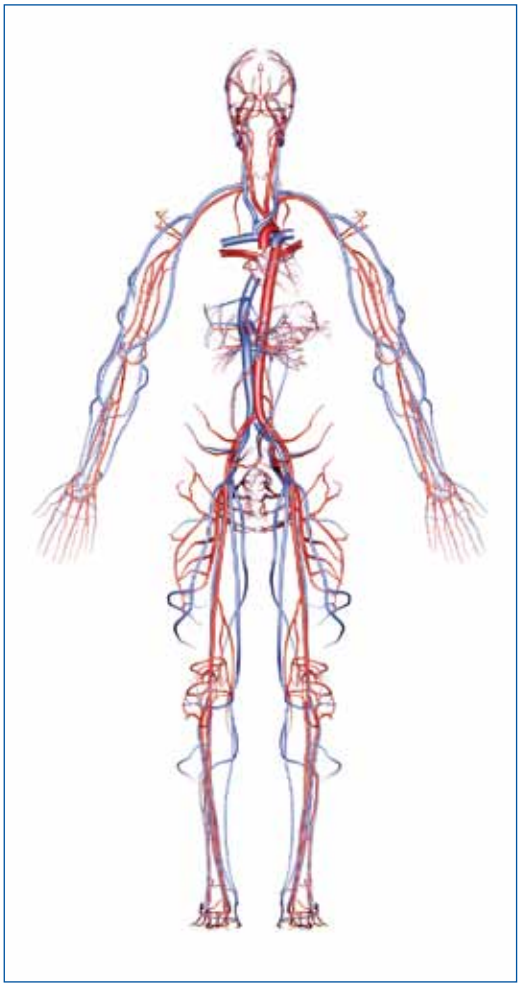
Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC, has been in the health care field for nearly 19 years. She has over 11 years of clinical experience in women's health, and had been the coding educator for a 220+ multispecialty clinic since 2004. She is the president for her local AAPC chapter, and a member of the AAPC National Advisory Board (NAB).

Keep Vascular Coding in the Family

Each branch of the "family tree" can help you determine additional vessel orders.

By Kimberly Engel, CPC

Previously, we looked at how best to determine the order of vessels ("In the Journey Through Vessels, Code Destinations, Not Waypoints," November 2010) and reviewed the basics of catheter placement ("Catheter Location, Not Wire, Decides Proper Interventional Coding," December 2010). Now, let's expand on those topics to explain more advanced concepts, such as coding for additional second- and third-order vessels and the dreaded "bypass configurations."



Coding Second- and Third-order Vessels

A vascular family is just that: a family, with vessels branching from a common origin to form a "family tree." As an example, the brachiocephalic is a first-order vessel, or a "child" of the aorta (in this example, the aorta is our Eve). The brachiocephalic has two children, the right axillary and right common carotid, which are second-order vessels. From this point, each branch of the family stems out again, with third-order vessels (grandchildren/cousins), such as the right mammary, right costo trunk, right vertebral, right internal and external carotid, etc.

In a case scenario, documentation may look something like: "The right common femoral artery was accessed. Guidewire was manipulated through the vessels up to the thoracic arch. Catheter was selectively placed in the arch and angiography was performed. The guidewire was then moved into the right internal carotid and catheter followed. Angiography was performed and the vessel was widely patent. I then selectively engaged the right external carotid performing angiography also showing a widely patent vessel."

In this example, the catheter was placed in the right internal carotid (a third-order vessel), and also a "sister" third order vessel, the right external carotid. Code 36217 *Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family* and 36218 *Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate).*

Now, let's use the same scenario, but change one placement:

"The right common femoral artery was accessed. Guidewire was manipulated through the vessels up to the thoracic arch. The catheter was selectively placed in the arch and angiography was performed. The guidewire was then moved into the right internal carotid and catheter followed. Angiography was performed and the vessel was widely patent. I then moved the catheter back and selectively engaged the right vertebral performing angiography, also showing a widely patent vessel."

In this case, we have "cousin" vessels: Code 36217

... we have "cousin" vessels: Code 36217 for the right internal carotid and 36218 for the right vertebral. These vessels share a common "grandparent" so they are still in the same family, but they arise from different "parents," or branches, off of the right common femoral artery.

for the right internal carotid and 36218 for the right vertebral. These vessels share a common "grandparent" so they are still in the same family, but they arise from different "parents," or branches, off of the right common femoral artery.

Beware of the Bovine Arch

In cases where there is a bovine arch, you need clear documentation of where the arch branches from. Often, it will branch from the right brachiocephalic, making it part of this family. In such a case, the left common carotid becomes a child (second order), and the left internal and external carotids are the grandchildren/cousins (third order) of the right branch. Remember that not all anatomy is the same—if the provider states "bovine arch," ask from where the arch originates to ensure proper coding.

Count Your Way to Bypass Codes

Bypass vessels are like man-made paths, and can be confusing to report. There are two types of bypasses:

The first is to bypass an injured or diseased portion of a vessel. Common types are aortofemoral, femoral-popliteal, and popliteal-tibial, but these are not the only kinds that bypass a diseased portion of a vessel. Remember to use basic concepts of counting the order by how many bifurcations (road name changes) you pass in these types of bypasses (see, "In the Journey Through Vessels, Code Destinations, Not Waypoints," November 2010).

For example, a previously-placed left aortofemoral bypass is present. The provider enters at the right common femoral artery, then moves the catheter up the aorta (zero order) and into the bypass. This is a first-order placement (36245 *Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family*) from this route because only one bifurcation was passed. Another route into this bypass, from the place of access, through and over the aortic bifurcation (zero order), past the left iliac (first order) and into the femoral artery (second order), and then into the bypass vessel, makes this a third-order placement (36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family*). Three bifurcations were passed to get to this point.

In documentation, an example of a fem-pop bypass might be: "Access was obtained in the right common femoral artery. Catheter was moved over the aortic bifurcation, down to the left common femoral and into the fem-pop bypass. Angiography of the bypass was obtained, showing diffuse stenosis."

How many bifurcations or roads did we pass? We know the aorta and aortic bifurcation is a zero order. After that is the iliac (first order). Next is the femoral (second order), to which the graft was anastomosed. Lastly, we turn to enter the bypass (third order).

The second type of bypass is when a vessel is passed completely, with the bypass as a replacement road. In this case, the catheter placement would be just as if this was the original vessel. For example, the patient has a femoral-axillary bypass, completely passing the aorta. The provider places the catheter from the left femoral artery into the bypass at any point; this is zero order (the aorta always is zero order, as reported by 36200 *Introduction of catheter, aorta*).

To make coding such difficult cases much more manageable and less confusing, ask and answer these questions:

- Did I take a detour (bypass)?
- What was the detour rerouting me from?
- Was the entire road or just a portion of a road under construction?
- How many bifurcations did I pass; or how many roads did I drive on?

And that completes our journey!

Kimberly J. Engel, CPC, is owner of Decision Medical Management Solutions, LLC, in Atlanta, Ga. (www.decisionmedicalmanagementsolutions.com). She has been a Certified Professional Coder (CPC®) for nearly a decade and also is former coding management for Duke University Medical Center and Aurora-Advanced. She has been an instructor for state technical colleges and does speaking engagements on various coding concepts.

PQRS *Solidifies* PQRI *for Years to Come*

Big changes to PQRI in 2011 put pay for performance in the spotlight.

By Penny Osmon, BA, CPC, CPCI, CHC, PCS

EXPERT

Updates to the Physician Quality Reporting Initiative (PQRI) signal that the shift from pay for reporting to pay-for-performance has begun. The 2011 Physician Fee Schedule final rule, issued Nov. 2, 2010 by the Centers for Medicare & Medicaid Services (CMS), incorporates key provisions of the Patient Protection and Affordable Care Act (PPACA), and gives PQRI a new name—Physician Quality Reporting System (PQRS)—to reflect its permanence. Quality reporting no longer can be ignored; the time has come for practices to embrace the process.

For 2011, CMS has made the reporting process less cumbersome by reducing the threshold of claims reporting to 50 percent (down from 80 percent in 2010), offering a new group reporting option for entities of fewer than 200 eligible professionals (EPs), and adding a new measure group for asthma. The list of eligible professionals remains the same, and there still is no solution that allows participation of rural health clinics (RHCs), federally qualified health centers (FQHCs), or critical access hospitals (CAHs) to be reimbursed via method II (for additional information on CAH billing standards, see: www.cms.gov/transmittals/downloads/R231CP.PDF).

Participation Incentives

PPACA provisions not only extended the incentive payments for successful participation through 2014, but added payment adjustments for unsuccessful reporters beginning in 2015. A 1 percent incentive payment is available in 2011, and a 0.05 percent incentive payment is available for successful reporters from 2012 to 2014. A *negative* payment adjustment of 1.5 percent will apply for noncompliance in 2015, increasing to 2 percent in 2016.

PQRS incentive payments are based on total allowed, reimbursed charges for services covered under the Medicare Part B Physician Fee Schedule (PFS) during the reporting period. Although the money may provide incentive to participate, don't forget the future alignment of PQRS with quality improvement programs. This is illustrated in the final rule:

"As the program matures and we phase out the incentives for satisfactory reporting and phase in payment adjustments for failing to satisfactorily report, we envision continuing further refinements aligning PQRS with a more robust role in quality improvement."

An *additional* 0.05 percent incentive payment is available from 2011 through 2014 for EPs who provide data on quality measures through a Maintenance of Certification® (MOC) program operated by a specialty body of the American Board of Medical Specialties (ABMS). In addition to reporting PQRS data successfully for one year, submitted through an MOC program, the physician must participate in and successfully complete an MOC program. Board certification status may require more frequent reporting. For physicians to wade through the confusion, CMS must issue further clarification and guidance on the interaction between CMS contractors and the medical boards. This optional incentive may prove too confusing and require duplicate work triggering physicians to ask: "Is it worth the effort?"

Quality Reporting Methods

The four reporting methods from which to choose in 2011 are: (1) claims; (2) CMS qualified registry; (3) CMS qualified electronic health record (EHR); and (4) group reporting, which is divided into sub groups a) GPRO I (>200 EPs) and b) GPRO II (2199–EPs).

In addition to the four reporting methods, EPs can choose to report on either individual quality measures or measure groups. If an EP chooses to report individual quality measures and submit by claims, three measures must be reported on at least 50 percent of all eligible Medicare patients.

If submitting through a registry, there is a threshold of 80 percent of all eligible Medicare patients. If less than two individual quality measures apply to a particular

In addition to reporting PQRS data successfully for one year, submitted through an MOC program, the physician must participate in and successfully complete an MOC program.

EP, one or two measures may be reported through claims reporting; however, the EP is subject to a measure applicability validation process to verify that additional measures did not apply.

The reporting periods for both registry and claims continue to provide flexibility, with both a six month and 12 month option—with the exception of the 30 patient measure group reporting method, which is a 12 month reporting period for claims and registry. EHR reporting is available only as a 12 month option and requires submission of 20 predetermined quality measures. Quality data recorded through this method will be submitted to CMS in early 2012. A list of certified EHR products for 2011 is online at: www.cms.gov.

To participate in either GPRO option, organizations must make a decision and self-nominate between Jan. 3 and Jan. 31, 2011. The GPRO I option requires the entire group to participate on 26 predetermined measures focused on preventive and chronic conditions. Groups selecting this method will receive a pre-populated collection tool from CMS. Reporting GPRO II is based on group size and requires reporting a combination of individual and group measures. CMS plans to accept approximately 500 groups for GPRO II participation in 2011.

Claims Based vs. Registry Based Reporting

Claims and registry based reporting continue to be the primary methods of choice. In the 2010 PFS final rule, CMS hinted at potential elimination of the claims reporting option. In the 2011 rule, this position is clarified:

"CMS believes it would be premature to eliminate the claims based reporting mechanism for 2011 and by doing so would create a barrier to participation. When there is an adequate number and variety of registries available, a transition may occur."

CMS recently announced, through an open door forum, the success rate of claims reporting in 2008 and 2009 was 50 percent, while the success rate for registry reporting was 90 percent. Although the statistics might initially guide EPs directly to the registry option, most registries have costs associated with them. Another important aspect is workflow within the clinic. The claims process is built on collection of real time data, while a registry allows EPs to collect the data along the way and report on it later.

Reporting a measure group on 30 Medicare Part B fee-for-service (FFS) patients using the claims method must be initiated by reporting a measure group specific intent G code to indicate the selected reporting method. Claims reporting of measure groups also allow EPs to submit one measure group specific composite G code when all applicable measures within the measure group are completed successfully on a patient. When deciding which option best meets the needs of an EP, there are many components to consider.

Tip: To learn more about PQRS related G codes, go to www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, select the link labeled "Additional 2011 Physician Quality Reporting System Measure Documents," and open the *2011 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications Manual* (2011_PhysQualRptg_MeasuresGroups_SpecificationsManual_121510.pdf) file.

The practical first step is to determine which of the 194 measures for 2011 best apply to the EP's clinic, noting the 44 measures that can be submitted only through a registry. If there are less than two measures that apply, EPs must report via claims.

If EPs identify three or more applicable measures, the next step is to determine whether to use individual or measure group reporting. The 2011 measure groups are:

- Diabetes Mellitus
- Chronic Kidney Disease (CKD)
- Preventive Care
- Rheumatoid Arthritis

PQRS Reporting Requirements at a Glance

Measure Group Comparison		
Reporting Method	**Claims**	**Registry**
Reporting Period	6 or 12 months	6 or 12 months
Target Sample	30 Part B FFS Medicare patients (12 months) or 50 percent of all Medicare patients for whom the measures apply (minimum of 8 patients for 6 months or 15 for one year)	30 Part B FFS Medicare patients (12 months) or 50 percent of all Medicare patients for whom the measures apply (minimum of 8 patients for 6 months or 15 for one year)
Submission Cost	Free	Yes, varies by registry
Average Success Rate	50 percent	90 percent
Workflow Considerations	Real time data submission on a claim	Data submission can occur after the date of service.
Other Notables	Must indicate intent to submit a group measure with a G code. Can use a composite G code.	Zero performance measures will not be counted.

Individual Measure Comparison		
Reporting Method	**Claims**	**Registry**
Reporting Period	6 or 12 months	6 or 12 months
Target Sample	50 percent of all Medicare Part B FFS patients for whom the measures apply	80 percent of all Medicare Part B FFS patients for whom the measures apply
Submission Cost	Free	Yes, varies by registry
Average Success Rate	50 percent	90 percent
Workflow Considerations	Real time data submission on a claim could impact chart prep.	Data submission can occur after the date of service.
Other Notables	Submission should begin early in 2011 for the best chance of success.	Collection of clinical data should begin early.

- Coronary Artery Bypass Graft (CABG)
- Rheumatoid Arthritis
- Perioperative Care
- Back Pain
- Hepatitis C
- Heart Failure
- Coronary Artery Disease (CAD)
- Ischemic Vascular Disease (IVD)
- HIV/AIDS
- Community Acquired Pneumonia
- Asthma

Note that measure group specifications may vary from the individual measure specifications that comprise the group. The specifications for both are online at www.cms.gov.

After determining quality measures for reporting, the EP can identify which method (claims or registry) is most appropriate. Two important changes to registry reporting in 2011 are:

- If an EP chooses to report a measure group on 30 patients through a registry, all 30 patients must be Medicare Part B FFS patients. In 2010, only two Medicare Part B FFS patients were required.
- A zero-measure performance rate will not be accepted for registry submission. If reporting on a measure group, this means all individual measures within the measure group must be reported at least once for the 30 Medicare patients. When submitting individual measures through a registry, all three measures must be reported as performed at least once.

A list of CMS approved registries for 2011 will be available in spring 2011 at www.cms.gov/pqri. If an EP chooses the registry option, clinical data collection begins in January 2011, and the data will be entered into the registry tool at a later date. If you select this reporting method, consider how you will capture and track the data for submission at a later date. This could include a spreadsheet, printed summary report, or another alternative that meets the needs of organizations.

When deciding between claims and registry, consider other initiatives or projects occurring in the clinic. Important considerations include: current workload, potential workflow changes, and potential return on investment recognized by staff time gained; less room for errors on claims, and; the ability to submit quality data at your convenience.

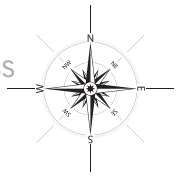
Pay for Performance Is Coming

Ultimately, the focus of clinical quality measure data collection will shift to performance improvement. PPACA requires CMS to develop a plan by 2012 outlining how to integrate the PQRS measures with the EHR meaningful use incentive program. The 2011 PFS proposed rule specifically sought comments on how best to align the two incentive programs, and stated:

"In an effort to align PQRI with the EHR incentive program, we propose to include many American Recover and Reinvestment Act (ARRA) core clinical quality measures in the PQRI program to demonstrate meaningful use of EHR and quality of care furnished to individuals. We propose the selection of these measures to meet the requirements of planning the integration of PQRI and EHR reporting."

Clearly, we are slowly migrating to a pay-for-performance reimbursement system where clinical data will help drive quality improvement in health care.

Penny Osmon, BA, CPC, CPCI, CHC, PCS, is the director of educational strategies for the Wisconsin Medical Society. She has over 15 years of experience in Medicare compliance, coding, and practice management. She presents educational programs on revenue cycle, risk management, and health information management for physician practices throughout Wisconsin and the Midwest region with an emphasis on reducing waste, mitigating risk, and improving quality. She serves on the Wisconsin Medical Group Management Association Third Party Payer and Medicare and Medicaid Workgroups.



Set up an Offense for Investigators Who are at Your Door

Know best practices for responding.

By Robert A. Pelaia, Esq., CPC, CPCO

Disclaimer: Information published in this article is not intended to be, nor should it be considered, legal advice. Readers should consult with an attorney to discuss specific situations in further detail.

"The best defense is a good offense."

This cliché is used most in the military or sports world, meaning the best way to defend yourself is to go on the offensive. In other words, you should defeat your opponent before your opponent defeats you. The theory behind the quote can be attributed to many individuals, including German military theorist Carl von Clausewitz, football coaching legend Vince Lombardi, and the Roman poet Ovid, who asked in 8 A.D., "Isn't the best defense always a good attack?" Regardless of the origins of this phrase, it is good advice in the health care compliance arena, as well.

For a practice to survive in this day and age, providers need to offer high-quality medical care on the front line and work as top notch business managers behind the scenes. Unfortunately, the business side of medicine contains many complex fraud and abuse laws on both the federal and state level. Billing errors and omissions may result in violations of these laws and prompt government investigations.

The complexities surrounding government subpoenas, interviews, and search warrants are immense, but it's the lesser-thought-about nuances that potentially can cause compliance problems for health care providers. In this article, we'll focus on ways you can affectively respond to various government-initiated investigations.

Search Warrants

A search warrant is a document issued by the court or a magistrate. It permits government agents to search and seize tangible property described in the search warrant or located in an area specifically identified as covered by the search warrant. A search warrant is to obtain documents only—both hard copies and electronic copies. It is not for testimonial evidence.

The best defense:

- Obtain the card or name and agency of the officer presenting the warrant.
- If a search warrant is being served, contact legal counsel or your compliance officer immediately.
- Preventing an agent from removing medical records or documents subject to the search warrant is difficult: You need to respond appropriately because intentional obstruction could result in other charges.
- In today's electronic world, search warrants usually contain a provision allowing retrieval of computer records. Have an internal computer expert work with the agents to download the information in a correct manner. If you refuse to cooperate, the agents may decide simply to take your computer equipment out the door with them. We all have seen the news video footage of federal agents removing desktop and laptop computers from a business under investigation. You do not want that to happen to you.

Subpoenas

There are two subpoena types: a basic subpoena and a subpoena *duces tecum*. With either kind, the organization is required to respond only within the scope of the request noted in the subpoena.

A subpoena is a court or administrative order issued by a government agency requiring a person to appear and testify in court or to an agency. Depending on state or federal law, it may be delivered (i.e., served) either in person, by mail, or by leaving the subpoena at a home or place of business.

A subpoena *duces tecum* directs a person to bring certain documents, such as medical or billing records, to court or to give these documents to a government agency. The subpoena *duces tecum* also may require the person to accompany the records and testify as a witness.

The best defense:

- Take the subpoena immediately to your legal counsel or compliance officer.
- You are not required to provide the responsive documents right away, even though the agent may ask for them.
- It's a good idea to wait until the compliance date on the subpoena so you can formulate an appropriate and accurate response.

Responding to Search Warrants and Subpoenas

Advance preparation is the most important thing a practice can do to respond to government investigations. A good offense to an external audit includes putting policies and procedures in place that provide guidance and answer the following questions:

- What might happen?
- Who needs to be contacted?
- Who's in charge?

When possible, designate one person within the facility to coordinate a response in the event of a subpoena or search warrant. Then, incorporate the following points into your plan of attack.

- Make it known throughout your internal policies and procedures that an employee is not authorized to provide confidential facility documents to anyone, including a law enforcement officer, without a valid subpoena, search warrant, or court order.
- Verify the scope of the subpoena or search warrant. The scope of an agent's search or seizure is limited to the scope declared in the subpoena or warrant.
- Bring it to the agent's attention if searched items or areas are not listed specifically in the warrant. An agent is not allowed to access any document or property other than those described in the subpoena or warrant.

> "A false statement to an agent can be a crime ... Martha Stewart did not go to jail for insider trading ... she went to jail for lying."

- Do not volunteer any document or information that is not specified in the subpoena or search warrant.
- You can and should request to make copies of the medical records (or other documents) being seized to provide continual patient care.

Know Your Rights

Individual employees have the right not to interview, to schedule it for a time when it is more convenient, to start an interview and then cease in the middle whenever they want, and to have a lawyer present.

- Most likely, you will need to assert your rights because the government agent might not do it for you. In fact, the agent might act surprised and offended if you try to assert your rights. Individuals assert these rights all the time and the agent is not surprised, although he or she may act surprised. Do not be frightened by questions like: "Why do you need a lawyer?" or "What do you have to hide?"

Do not be frightened by questions like: "Why do you need a lawyer?" or "What do you have to hide?"

- Do not be intimidated into giving an interview for which you aren't fully prepared. Law enforcement officers are trained in intimidation tactics because they know that the best chance of getting an admission or confession is at their initial encounter. Take the time to review the files to refresh your recollection of events before giving an interview. You can delay until you are prepared to be completely accurate. Unless you are under arrest, the agents cannot detain you.
- There may be someone else at the facility who is more knowledgeable on the issue being investigated. Feel free to direct the agent to someone else who might give a more accurate response.
- Employees should only communicate with agents when required to do so.
- Don't guess or speculate. A false statement to an agent can be a crime. You need to be absolutely certain that everything you say is truthful, accurate, and correct. Contrary to popular belief, Martha Stewart did not go to jail for insider trading. She was sentenced for obstruction of an agency proceeding and for making false statements to federal investigators. Basically, she went to jail for lying.
- If you are interviewed, prepare written notes of what occurred and what was discussed during the interview. Like your ICD-9-CM coding, prepare your notes with the highest degree of specificity. Agents may get things confused, particularly in the complex area of medical billing. Your notes may be the only accurate record of the conversation two years from now.

Proliferation of federal and state government-initiated investigations has made it essential for health care organizations to create a premeditated response and strategy for handling such investigations. A critical aspect of responding to any external investigation is defining the organization's expectations and managing those expectations as the investigation continues. This entire process starts when the subpoena or search warrant arrives, so practices need to be prepared. Now is the time to implement policies and procedures that will let employees know what to expect in case the unexpected takes place. Build up your offense for a good defense. CE

Robert A. Pelaia, Esq., CPC, CPCO, is senior university counsel for health affairs at the University of Florida College of Medicine in Jacksonville, Fla. Pelaia is certified as a Health Care Law Specialist by the Florida Bar Board of Legal Specialization and Education. He is a member of the AAPC National Advisory Board. Information published in this article is the personal views of the author and not that of the University of Florida.

"Outstanding! With a physician coder speaking the take away value of this seminar is very high."

Rich Carrillo
LaJolla, CA

"Dr. Z is the best speaker I have ever heard at a coding seminar."

Karen Martinez
Chicago, IL

"How wonderful to have these complex procedures concisely explained by a physician."

Sarah Mountford
Kansas City, MO

"The course is the best I've ever been to."

Shelley Kubczak
Saginaw, MI

"This was definitely the best organized and most comprehensive seminar. Can't say enough about ZHealth Publishing and Dr. Z."

Marge Helgesen
Dallas, TX

May 3-6
Omni Parker House
Boston, MA

JOIN US & LEARN

IR & CARDIOLOGY CODING SEMINARS

February 22-25

FireSky Resort & Spa

Scottsdale, AZ

ZHealth
PUBLISHING

visit ZHealthPublishing.com or call 1-877-873-9893 for Coding Reference Manuals • Illustrations
Seminar registration • Webinars • Online Services • Self-Study CEU Programs
and visit AAPC.com for CIRCC exam registration

Understand Payer Guidelines to Keep Up-to-date with *Anesthesia*

Both new and seasoned coders should know the many risk areas in anesthesia coding

By Kelly Dennis, MBA, CPC, CPC-I, CANPC, CHCA, ACS-AN

The American Medical Association's (AMA's) 2011 CPT® codebook was released without anesthesia-related code changes for this coming year. Because there are no changes to consider, it's a good time to review both anesthesia coding basics and frequent coding problem areas.

Anesthesia services represent a small portion of CPT®, but correct anesthesia coding requires complete comprehension of various anesthesia guidelines. Services reported by anesthesia providers are not limited to anesthesia codes 00100-01999; and instructions found in the CPT® Anesthesia Guidelines do not cover many of the coding nuances specific to anesthesia billing (for instance, coding for the services of a certified registered nurse anesthetist (CRNA) or anesthesia assistant (AA)). Additional coding resources are required to gain a better understanding of anesthesia coding.

CMS and NCCI Offer Anesthesia Resources

The Centers for Medicare & Medicaid Services (CMS) and the National Correct Coding Initiative (NCCI) each publish information regarding anesthesia coding regulations. Although not all insurance companies follow CMS and/or NCCI guidelines, many use interpretations of both guidelines. Both publications are available through the Anesthesiologist Center of the CMS website (www.cms.gov/center/anesth.asp).

The CMS Internet-Only Manual (IOM) (www.cms.gov/manuals/downloads/clm104c12.pdf, chapter 12) provides guidelines for both anesthesiologists (Section 50 – Payment for Anesthesiology Services) and CRNAs (Section 140 – CRNA Services). Although AAs aren't mentioned specifically in the chapter heading under CRNA, the guidelines were revised in 2002 to include these providers. CMS recognizes both CRNAs and AAs as nonphysician anesthesia providers. Commercial insurances typically do not make a distinction between the two anesthetist types with regard to payment for services provided under medical direction of an anesthesiologist.

Although many practices are familiar with a care team approach that includes anesthesiologists and CRNAs, fewer may be familiar with AAs. AAs are licensed in 18 states and also are recognized under the TRICARE system. One important distinction between CRNAs and AAs (depending on state scope of practice, delineation of privileges by the facility, and individual malpractice carrier requirements), is that CRNAs may be allowed to practice as nonmedically directed, whereas an AA must be medically directed. See American Academy of Anesthesiologists Assistants, Facts about AAs (www.anesthetist.org/factsaboutaas/) for more information.

The most up-to-date version of the NCCI (as of this writing) is 16.3 (www.cms.gov/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip), which became effective Oct. 21, 2010. Anesthesia guidelines are found in chapter two. These guidelines for anesthesia coding are much more in-depth than CPT® guidelines and include an introduction to correct coding for anesthesia and information regarding which services are bundled. For example, time spent during the usual pre- and post-operative visits, patient monitoring, and various other activities are bundled into the base value of anesthesia services.

NCCI also discusses which services are billable separately. Separate procedure services, such as insertion of an arterial line (36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous*), Swan-Ganz catheter (93503 *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes*), and a central venous pressure line (36555 *Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age* and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*) are payable separately to anesthesiologists, as well as to CRNAs/AAs if these procedures are furnished within the parameters of state licensing laws. The NCCI also provides examples of coding scenarios regarding postoperative pain management, ventilation management, and discontinuous time. The postoperative pain management example explains factors to help coders determine when postop pain is considered outside of the global surgical package.

Armed with the knowledge gleaned from these published anesthesia resources, you can gain valuable insight into information available to insurance companies. Keep in mind, however, that it is up to individual payers which guidelines to follow (for example, many payers follow guidelines set forth in the American Society of Anesthesiologists (ASA) Relative Value Guide® (RVG)).

Be Watchful of Payer-Specific Guidelines

Anesthesia coders should understand that anesthesia coding and billing guidelines will change from state to state and from payer to payer. Although CMS loosely follows the same IOM guidelines across all states, each state has its own idiosyncratic payer rules. This also is true for Medicaid, Blue Cross/Blue Shield (BCBS), and worker's compensation. Individual payer contracts often include verbiage indicating their specific billing policies will be followed, yet they may not provide a copy of their coding/billing policy.

One of the best ways to ensure your practice is following individual state- and payer-specific anesthesia guidelines is to research which guidelines are available from your practice's payers. The Internet has made it easy to access information; although, other sites may require provider login information (e.g., Blue Shield of California). If the information is not provided or accessible, it should be requested and reviewed on an annual basis, at a minimum. The onus for keeping up-to-date with changing regulations is placed solely on the anesthesia provider—who, in turn, typically relies on his or her coding and billing staff to know when changes occur.

Communicate Potential Risk Areas with Clinical Staff

Risk areas for anesthesia providers usually are understood by the coding and billing staff, but aren't always relayed to the clinical staff. Coders understand the discipline, "If it wasn't documented, it didn't happen." With anesthesia records, however, sometimes it is very difficult to determine the exact diagnosis and procedure code and/or who actually provided services.

For example, if the anesthesia record has a checkbox for placement of an arterial or central venous pressure (CVP) line, and both an anesthesiologist and CRNA or AA are involved in the case, a checkmark doesn't indicate clearly who placed the arterial line or CVP. Because many carriers require that services are filed under the name of the provider who performed the service, the service may go unbilled unless clear procedure notes are documented either in the Remarks or Comments section, or provided on a separate procedure form.

Another risk area is medical direction criteria. Many anesthesiologists fail to sign or initial their participation appropriately with a medically-directed case, and may consider their signature as sufficient documentation of involvement. CMS and other payers require documentation during the most demanding procedures in the anesthesia plan, which includes induction and emergence, when applicable. Unless a monitored anesthesia care (MAC) case converts to general, induction and emergence are not applicable. Similarly, there is not an induction or emergence period associated with regional anesthesia.

Time Really Can Be Relative

Time reporting on claims may vary, and there is no national guidance. According to the CPT® Anesthesia Guidelines, time units are reported as is "customary in the local area." Although Medicare requires exact time reporting, other payers may request either rounded time, or time in units, rather than minutes. Anesthesia providers always should provide exact start and stop times on the anesthesia record which, according to the ASA, correlate with "when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area, and ends when the anesthesiologist is no longer in personal attendance." Coders should not expect to see large or unexplained gaps of anesthesia time around either the start or stop times, or times that routinely end with a "0" or "5." Internal reviews of anesthesia times should be performed periodically.

Because there are many risk areas in anesthesia coding, it is our job as apprentice or certified coders to ensure we understand the importance of following payer guidelines and keeping up-to-date with changes. If you see risk areas in your practice, work closely with your anesthesia providers to ensure correct coding, documentation, and billing. Keep in mind that although there were no anesthesia code changes this year in the CPT® book, the RVG® may contain changes to either parenthetical notes or positions listed in the back of the guide. Make sure you check for verbiage or position statement changes when you receive your 2011 RVG®. CE

Kelly Dennis, MBA, CPC, CPC-I, CANPC, CHCA, ACS-AN, has over 27 years experience in anesthesia and speaks about anesthesia issues nationally. She serves as lead anesthesia advisor for Board of Medical Specialty Coding and has been consulting since November 2001.

AAPC

MARCH WORKSHOP

ADVANCED SURGICAL CHART AUDITING

50+ Cities | 6 CEUs | $149

A regular program of internal auditing is the best way to prepare for (and pass!) an external audit. Surgical chart auditing is a skill that requires practice to perform correctly. In addition to assuring the proper coding was assigned, other legal aspects found in a surgical record must also be considered, such as informed consent and documentation requirements. This workshop will teach you how to completely and accurately review and validate surgical services from a compliance perspective.

You'll Learn To:

- Outline the process for correctly dissecting an operative note
- Evaluate the key elements of surgical procedures
- Design an auditing report and/or corrective action plan based on results
- Apply surgical chart auditing hands-on skills working with multiple surgical cases

NEW THIS YEAR

Workshops are four hours and include interactive, hands-on exercises. Please bring your core coding books (CPT®, ICD-9-CM, HCPCS Level II).

Find a workshop location near you and register today!
www.aapc.com/surgicalaudits

UPCOMING WORKSHOPS

MAY	AUGUST	NOVEMBER
Advanced E/M Chart Auditing	Modifiers – The Rest of the Story	RACs, MRACs, MICs and ZPICs What Codes Are Being Targeted Now?

www.aapc.com/surgicalaudits | 1-800-626-CODE (2633)

Build Revenue with Surgical Chart Auditing

By Charla Prillaman, CPC, CPMC, CPC-I, CCC, CEMC, CHCO

The number and scope of external auditing agencies pursuing improper payments are increasing significantly, making medical record auditing more important than ever. If you think your practice is exempt, consider this: The "Improper Medicare Fee-For-Service Payments Report: November 2009," revealed that 7.8 percent of Medicare dollars paid did not comply with one or more Medicare coverage, coding, billing, or payment rules. That is approximately one out of every 12 dollars paid was in error.

To ensure accurate surgical coding—not to mention, peace of mind in the event an outside audit occurs—your practice's quality protocol should include regularly scheduled proactive reviews of all code selections.

In a surgical practice, an essential part of your auditing efforts should include checking the accuracy of evaluation and management (E/M) levels and reviewing surgical services charts. These are critical steps to ensure CPT® codes submitted for adjudication accurately represent the services your physician provided. You also should be on the lookout for erroneously selected CPT® codes, missed charges, missing or inaccurate modifier selections, and/or inaccurate ICD-9-CM diagnosis code selections.

Catch Overlooked Surgery Details

Something else to look for during an internal audit is operative note headings that inadequately or incompletely describe rendered services. The heading might indicate, for example, "colonoscopy with polypectomy." Selecting a code from just the heading might lead to a claim submission of 45384 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery*. The detailed description in the body of the operative report, however, may reveal the surgeon removed two polyps using hot biopsy forceps, and removal of a separate polyp by snare.

A qualified auditor will recognize that an additional procedure (45385 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*) should be reported, with modifier 59 *Distinct procedural service* appended because the National Correct Coding Initiative (NCCI) indicates this code pair usually is "mutually exclusive." As a result, reimbursement may increase nearly $500 per case where this type of error has occurred.

When an audit reveals miscoding, formulate steps to improve coding and capture all appropriate revenue.

Uncover Internal Weaknesses

Routine auditing demonstrates how well you apply complex coding principles and payer policies to your specialty. You may find documentation weakness that (if uncorrected) could lead to allegations of wrongdoing or misunderstanding that is a source of lost revenue. An audit also can uncover billing area weaknesses that could result in claims denials.

Get Expertise From Surgical Auditors

Auditing in the surgical practice setting requires skills beyond the foundational ability to identify and assign correct CPT® and ICD-9 CM codes for the services provided. The surgical specialty auditor also must remain up-to-date in other areas, including:

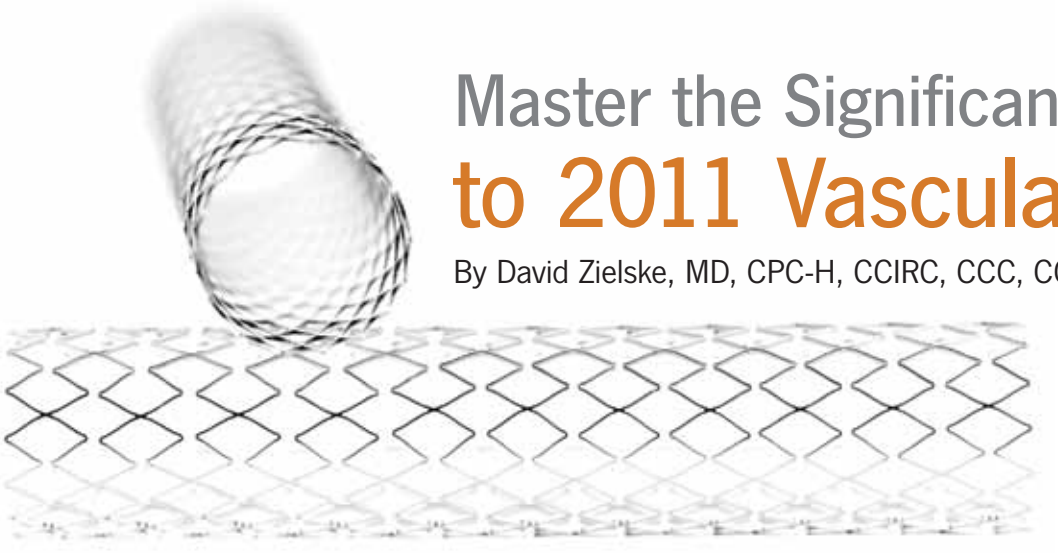
Demonstrate how well you apply complex coding principles and payer policies to your specialty

- Surgical global package concept
- Correct modifier application
- Payer policy
- Screening vs. diagnostic vs. therapeutic procedures
- Place of service (POS) reporting
- NCCI edits
- E/M services provided during the global period
- Complex rules surrounding services furnished by mid-level providers

When your audit is completed and you have analyzed the impact of any issues, you can strengthen any documentation weaknesses, mend any holes in the claims management process, and rest easy knowing your coding is accurate.

To assist you with surgical chart audits, AAPC will be offering an Advanced Surgical Chart Auditing workshop in March. For details, visit www.aapc.com/workshops/index.aspx.

Charla Prillaman, CPC, CPMC, CPC-I, CCC, CEMC, CHCO, has more than 25 years of health care experience, including seven years as a director for physician compliance for a health care system employing more than 1,500 providers. She also has worked as a consultant. She has been a CPC® since 1997. She was named AAPC Coder of the Year for 2000, and is one of the original members of the AAPCCA board of directors.



Master the Significant Revisions to 2011 Vascular Codes

By David Zielske, MD, CPC-H, CCIRC, CCC, CCS, RCC

Changes make it quicker and easier to code these complex procedures

EXPERT

Dramatic coding changes for lower extremity endovascular revascularization have been implemented for 2011:

- Sixteen new Category I CPT® codes (37220-37235) apply to combinations of angioplasty, atherectomy, and stent placement (interventions) performed in lower extremity arteries. The codes describe interventions performed for treatment of stenotic/occlusive disease, and report either open or percutaneous approaches.
- Five new Category III CPT® codes (0234T-0238T) replace the previous percutaneous and open atherectomy codes.

To report the new codes correctly, you'll need to review the guidelines and bundling issues that apply.

Three Territories Divide Lower Extremity Arteries

The arteries of the lower extremities have been divided into three "territories," each with separate guidelines and codes describing interventional procedures.

Like the coronary artery intervention codes, the lower extremity revascularization codes follow a hierarchy in which stent placement with atherectomy is considered the highest level of intervention, followed by stent placement, atherectomy, and then angioplasty. Subsequently, angioplasty is bundled to each of the new lower extremity revascularization codes.

1. Iliac Territory

The iliac territory, with three separately billable vessels (the internal iliac, external iliac, and common iliac arteries) allows separate billing of atherectomy, in addition to an angioplasty or stent placement. This is because atherectomy in the supra-inguinal vessels (iliacs, visceral, aorta, renal, and brachiocephalic) utilize Category III CPT® codes 0234T-0238T, which do not have the same bundling issues as infra-inguinal lower extremity revascularization codes.

CPT® codes 37220 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty* and 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)* describe initial and additional iliac angioplasty. Meaning, if angioplasty is the only intervention performed in the iliac arteries on one extremity, use these codes (one for the initial vessel, and up to two additional codes if two additional vessel—not lesion—angioplasties were performed).

If iliac stent placement was performed additionally in one vessel, replace 37220 (initial angioplasty) with 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed*, which bundles angioplasty in the same vessel. Code any additional iliac angioplasty procedures in additional iliac arteries with add-on code 37222.

If atherectomy is performed instead of stent placement, use 0238T *Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel* in addition to code 37220 for the initial angioplasty. If atherectomy and stent placement are performed in the common iliac artery, use codes 0238T and 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed*.

The hierarchy still applies: Stent placement supersedes atherectomy, which supersedes angioplasty.

The new supra-inguinal atherectomy codes are coded in addition to any other intervention in the same vessel at the same lesion site. You may bill angioplasty, atherectomy, and stent placement in the aorta or a renal, visceral, brachiocephalic artery, depending on documentation.

2. Femoral/Popliteal Territory

The femoral/popliteal territory is unusual compared to the other two territories because all four vessels in this territory are considered a single vessel for coding purposes. All interventions performed in the common femoral, profunda femoral, superficial femoral, and popliteal arteries are described by a single code. The hierarchy still applies: Stent placement supersedes atherectomy, which supersedes angioplasty.

There are two choices for stent placement in the femoral/popliteal territory: Code 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* describes stent placement alone (with or without angioplasty), while 37227 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* describes stent placement with atherectomy (with or without angioplasty).

For one femoral/popliteal territory, consider all treatments in all vessels as treatment in a single vessel. For all interventions performed in this territory, only one code between 37224 and 37227 should be submitted, regardless of the number of interventions performed in these four vessels. There are no initial or additional revascularization codes for the femoral/popliteal territory; so if an angioplasty is performed in the profunda femoral, an atherectomy is performed in the superficial femoral, and a stent is placed in the popliteal artery, report stent placement with atherectomy, with or without angioplasty (37227).

3. Tibial/Peroneal Territory

The tibial/peroneal codes allow for more than one vessel to be described and coded. Three separately-billable vessels are recognized: the anterior tibial, posterior tibial, and peroneal arteries. The tibial/peroneal trunk is considered part of any distal intervention performed in the posterior tibial or peroneal arteries, while the dorsalis pedis artery is considered continuation of the anterior tibial artery, and the medial malleolar artery is considered continuation of the posterior tibial artery.

Here again, the hierarchy applies: Stent placement with atherectomy supersedes stent placement without atherectomy, which supersedes atherectomy, which supersedes angioplasty alone. Remember: Angioplasty is included in all interventions, if performed.) Code the highest vessel intervention as the initial intervention in this territory, and any other vessel interventions as additional tibial/peroneal interventions. Codes 37228-37231 describe initial interventions while add-on codes 37232-37235 describe additional interventions in the other two tibial/peroneal arteries.

Remember to code each territory separately (except bridging lesions) with initial and additional revascularizations in each territory, as appropriate (the femoral/popliteal territory does not use initial/additional designations). For instance, you can have an initial iliac revascularization and an initial tibial/peroneal revascularization. If you perform a bilateral procedure in the lower extremities, start the coding all over again for the opposite leg with initial revascularization codes for both sides (e.g., 37220, 37220-59; or 37220-50 for bilateral iliac angioplasty).

Include Angioplasty and More in Lower Extremity Revascularization

As already noted, all 16 lower extremity revascularization codes (37220-37235) include angioplasty, if performed.

- Angioplasty (balloon dilation of a stenosis or occlusion) can be performed with a compliant, non-compliant, cutting, or cryoballoon.
- Atherectomy (removal of atheroma) devices include rotational, front-cutting, side-cutting, and photoablation (laser) devices.

To discuss this article or topic, go to www.aapc.com

- Stent placement utilizes self-deploying, balloon expandable, covered (stent grafts), and drug-eluting stents.

New codes 37220-37235 also bundle:

- Conscious sedation
- Vascular access
- Catheter placement
- Traversing the lesion
- Imaging related to the intervention (previously billed as the supervision and interpretation code for the specific intervention)
- Use of an embolic protection device (EPD)
- Imaging for closure device placement
- Closure of the access site (which could be by suture for an open approach, or by placement of a closure device for percutaneous approach)

Diagnostic imaging remains separately billable. The imaging must be truly diagnostic, however, and not performed just for confirmation of a lesion or guidance for an intervention. Imaging is bundled when done to measure vessel size, localize a lesion, follow up an intervention, or guide the procedure.

Other interventions in these lower extremity vessels treated with angioplasty, atherectomy, and/or stent placement are separately billable. These include: Intravascular ultrasound (IVUS) (37250, 75945), thrombolysis (37201, 75896, 75898), thrombectomy (37184-37186), and embolization (37204, 75894).

Bill Initial Vessel at Highest Intervention Level

Always bill the initial vessel intervention as the highest intervention level performed within a single territory. If a separate intervention is performed within a different territory, start coding all over again with an initial intervention for that territory, based on hierarchy guidelines (stent placement with atherectomy, followed by stent placement, atherectomy, and then angioplasty).

These guidelines are for treatment of one extremity. If performing intervention on both legs, start coding all over again on the new leg. You may need modifier 59 *Distinct procedural service* (per CPT® instruction), or modifier 50 *Bilateral procedure* (per the Physician Fee Schedule Relative Value File), as appropriate, to alert the payer that intervention occurred in both extremities.

Bridging lesions still are considered a single vessel intervention, even if the bridging lesion extends from one territory into another. You still need to have a hemodynamically-significant vessel stenosis to meet medical necessity and code for these interventions.

Example Shows How Codes Have Been Condensed

Compare coding between 2010 and 2011 guidelines and codes, with this example.

> Patient with known left external iliac 80 percent stenosis, left SFA 90 percent proximal stenosis, 90 percent mid popliteal stenosis and posterior tibial and peroneal artery occlusions. The iliac lesion is treated with balloon angioplasty alone and the SFA is treated with an appropriately sized balloon however a flow limiting dissection occurred requiring a self-deploying stent. The popliteal artery is treated with a stent graft alone while atherectomy with a laser is performed in both the posterior tibial and peroneal arteries with 70 percent residual stenosis in both requiring 3 mm drug-eluting stents. Closure device is placed.

In 2010, the appropriate codes from a contralateral approach would have been: 36247, 36248, 35473, 75962, 35474, 75964, 37205, 75960, 37206, 75960-59, 35495, 75992, 35495-59, 75993, 37206, 75960-59, 37206, 75960-59, and G0269.

In 2011, the appropriate codes are:

- 37220
- 37226
- 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed*
- 37235 *Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)*

We've gone from 19 codes in 2010 to four codes in 2011. Once you master the new codes, you will be able to code these complex procedures with improved accuracy and decreased compliance risk.

David Zielske, MD, CPC-H, CIRCC, CCC, CCS, RCC, is an interventional radiologist and president of ZHealth and ZHealth Publishing in Brentwood, Tenn.

newly credentialed members

Amy Renee Bolam, CPC Anchorage AK
June Richardson, CPC Fairbanks AK
Allison Singer, CPC, CPMA Birmingham AL
Brenda D Berryhill, CPC Dothan AL
Patricia M Byars, CPC Dothan AL
Cassondra Michele Chadwick, CPC Dothan AL
Cindy Wall, CPC Eufaula AL
Donna K Chandler, CPC, CIRCC, CPMA, CPC-I Fultondale AL
Regina Parker, CPC Little Rock AR
Connie Anderson, CPC Casa Grande AZ
Deborah R Allen, CPC Claypool AZ
Brenda D Frisch-Stricklin, CPC Fountain Hills AZ
Christine Cisneros, CPC Marana AZ
Margaret Kathleen Gallion, CPC, CPC-H Peoria AZ
Janet M Small, CPC Peoria AZ
Cherubini Y Co, CPC Phoenix AZ
Kelly Lloyd, CPC Phoenix AZ
Jane Moraleda, CPC Phoenix AZ
Toni Wenner, CPC Scottsdale AZ
Clare Baucom, CPC Tucson AZ
Tricia H Bohnet, CPC Tucson AZ
Jamie Dyan Martinez, CPC, CPC-P Tucson AZ
Stacey Cassaday, CPC Vail AZ
Angela Mazzella, CPC Apple Valley CA
Marisela R Montiel, CPC, CPC-H Bakersfield CA
Luzviminda Carreon Pareja, CPC Chula Vista CA
Karina Cruz, CPC Escondido CA
Carol Greer, CPC Escondido CA
Nur Arleni Gutierrez, CPC Gardena CA
Ammala Wu, CPC Hacienda Heights CA
Veronica Rodriguez, CPC Highland CA
Carol J Laning, CPC Huntington Beach CA
Linda M Joy, CPC Irvine CA
Barbara Sizelove, CPC Live Oak CA
Alicia Ehle, CPC Modesto CA
Robin Noain, CPC Modesto CA
Beneranda Gumbayan, CPC Murrieta CA
Monica Jasso, CPC Patterson CA
Melinda Morris, CPC Rancho Santa Margarita CA
Annie Hansberger, CPC Riverside CA
Deana Canfield, CPC San Diego CA
Stephanie D Southwick, CPC San Diego CA
Lori A Stratinsky, CPC San Jose CA
Alicia Rubalcava, CPC San Marcos CA
Nasreen Asaria, CPC Santa Monica CA
Stacy Rogers, CPC Santee CA
Andres Espinola, CPC Sherman oaks CA
Caramie Wheeler, CPC Stockton CA
Pinnky E Chagoya, CPC Sunnyvale CA
Elmer Papa, CPC Temple City CA
Kerri B Darling, CPC Tracy CA
Violeta Arbulu-Neira, CPC Victorville CA
Jeannette Grimmer, CPC Vista CA
Leilani Lacson Reyes, CPC Walnut CA
Raquel Villarreal, CPC Watsonville CA
Carrol A Hawkins, CPC Yuba City CA
Megan Broschat, CPC Aurora CO
Codella Dickerson, CPC Colorado Springs CO
Steve Darnell, CPC Denver CO
Judith F Hale, CPC Denver CO
Deborah Marie Brundage, CPC Danbury CT
Karen Marie Lavoie, CPC Danbury CT
Surrinder Kaur Lal, CPC New Milford CT
Beth Judith Burak, CPC Ridgefield CT
Anita M Berlingo, MPH, CPC Brandon FL
Cheryl Williams, CPC Crystal River FL
Bonnielee Bruns, CPC Dunedin FL
Karen Chappell, CIRCC Fort Lauderdale FL
Pamala M Evans, CPC Fort Lauderdale FL
Annette Erickson, CPC, CPC-H Fort Myers FL
Judith N Cordonero, CPC Gainsville FL
Maria E Barro, CPC Hialeah FL
Tania G Cruz, CPC Hialeah FL
Angel Puente, CPC Hialeah FL
Diana Faye Taylor, CPC-H Inverness FL
Charlene Brown, CPC Jacksonville FL
Phoenix Jackson, CPC, CPC-P Jacksonville FL
Josefina Khirsukhani, CPC Jacksonville FL
Cindy Marrs, CPC Jacksonville FL
Dana ODell, CPC Jacksonville FL
Laura Lynne Paavola, CPC, CPMA Jacksonville FL
Diane Prevatt, CPC, CPMA Jacksonville FL
Mindy L Simmons, CPC Jacksonville FL
Okisha R Lowe, CPC Lake City FL
Nicole Lee Zwickel, CPC Lake City FL
Barbara Steele, CPC-H Lake Wales FL
Theresa Crosby, CPMA Lakeland FL
LaParsha White, CPC-H Lehigh Acres FL
Nathalie Carlo, CPC Melbourne FL
Ivonne Garcia, CPMA Miami FL
Lazaro Gonzalez, CPC Miami FL
Aysa N Lopez, CPC Miami FL
Carmen L Martinez, CPC Miami FL
Melba Monje, CPC Miami FL
Mercedes Mantilla, CPC, CPC-H, CPMA Miami Gardens FL
Kathleen Peterson, CPC-H North Port FL
Nancy Alexander, CPC, CPC-P, CEMC Ocala FL
Cheryl Marie DeMent, CPC Ocala FL
Jennifer Upchurch, CPC Palm Coast FL
Lissette Leon, CPC, CPC-H, CPMA Plantation FL
Bibi Z Chowrimootoo, CPC Sorrento FL
Cristy V Kaibigan, CPC Summerfield FL
Windette Solomon, CPC Sunrise FL
Kimberly Zeilenga, CPC Sunrise FL
Karen Stefanese, CPC Tampa FL
Glennda Gutierrez, CPC Tavares FL
Dalania L Carson, CPC, CPC-H, CPC-P Valrico FL
Michelle Rossi, CPC Vero Beach FL
Richard H Ackerman, CPC Wilton Manors FL
A Machelle Bowen, CPC Atlanta GA
Latitia C Brooks, CPC-H Atlanta GA
Brian O'Neal Taylor, CPC-H Atlanta GA
Shawn D Williams, CPC, CPC-H Atlanta GA
Michael Wright, CPC Atlanta GA
Tara Mason, CPC Augsuta GA
Trenee Summerlin, CPC College Park GA
Jennifer Gaines, CPC Cumming GA
Melba A Mejia, CPC Cumming GA
Katherine Lyle, CPC Duluth GA
Denise Garrett, CPC Eastman GA
Laurant Jolly, CPC-H Ellenwood GA
Vera Mize, CPC Gainesville GA
Amanda Smith, CPC Gainesville GA
Patricia A McDade, CPC, CPMA Hephzibah GA
Tana S Edmond, CPC Jonesboro GA
Leslie Floyd, CPC Lilburn GA
Manderley Harrell, CPC, CPC-H Marietta GA
Amy K Morgan, CPC, CPMA, CEMC Moultrie GA
Katie Leverett, CPC Norcross GA
Peggy Y Green, CPC, CPMA, CPC-I Rome GA
Crystal Gail Moore, CPC-H, CPMA Rome GA
Tracey Yvonne Hartridge, CPC-H Roswell GA
James Blevins, CPC Snellville GA
Sharon Giddens, CPC Thomasville GA
Patricia Burnley, CPC Thomson GA
Julie Hynes, CPC Kamuela HI
Catherine Coulson, CPC Davenport IA
Amy L Ronberg, CPC Coeur d'Alene ID
Janeen L Banker, CPC Aurora IL
Tina Crossley, CPC Belleville IL
Kimberlee Daesch, CPC Belleville IL
Kendra Lynn McHugh, CPC Carrier Mills IL
Farah L Castillo, CPC Chicago IL
Olga Garcia, CPC Chicago IL
Angela Jerlean Gosa, CPC Chicago IL
Sarah Han, CPC Chicago IL
Luz Maria Marquez, CPC Chicago IL
Dalilah Perez, CPC Chicago IL
Chiffon Jewel Roebuck, CPC Chicago IL
Porsha Latisa Spencer-Battle, CPC Chicago IL
Rosemary Mojica, CPC Cicero IL
Joanna Kazmierczak, CPC Elk Grove Village IL
Jennifer Stuart, CPC Jacksonville IL
Kim Guynn, CPC Metropolis IL
Wendy Wiesbrook, CPC Mineral IL
Carol Pickrum, CPC Oak Forest IL
Helen J Jones, CPC Olive Branch IL
Gregg Davis, CPC Princeton IL
Sherry J Brokering, CPC Indianapolis IN
Kathleen M Goodwin, CPC, CPMA La Porte IN
Yvonne Lowe, CPC LaPorte IN
Jennifer Karner, CPC Monroe IN
Christina Vorbroker, CPC Moores Hill IN
Shirley A Smith, CPC Muncie IN
Donna Knight, CPC Smyrna IN
Brent Back, CPC Clearfield KY
Jean R Pryor, CPC, CPMA, CPC-I, CIMC Crestview Hills KY
Leah Michelle Burton, CPC Georgetown KY
Peggy Lammers, CPC Lexington KY
Cheryl Smith, CPC-H Lexington KY
Jacilyn Mueller-Hallum, CPC, CPC-H Louisville KY
Christina Joyce Rich, CPC Louisville KY
Samantha Reid, CPC Manchester KY
Marissa Majors, CPC Paducah KY
Mia Bell, CPC Baton Rouge LA
Ashley M Falcon, CPC Baton Rouge LA
Angela Knight Guillot, CPC, CPMA Baton Rouge LA
Domonique Perkins, CPC Baton Rouge LA
Jamey Hill, CPC Covington LA
Judy Jenkins, CPC-H Covington LA
Shan McDaniel, CPC, CPMA Covington LA
Allyson Berteau, CPC Gonzales LA
Kimberly Sylve, CPC Gretna LA
Tammy Boudreaux, CPC Houma LA
Janie Brown Zehner, CPC Houma LA
Ashley R Begnaud, CPC Lafayette LA
Brandy Harris, CPC Mandeville LA
Angela Buwe, CPC Marrero LA
Amber M Theodore, CPC Marrero LA
Gwendolyn Perkins, CPC Metairie LA
GayLynn Resor, CPC Metairie LA
Mitzi Stockstill, CPC New Iberia LA
Janet K Annis, CPC, CPC-H, CPC-P New Orleans LA
Antigone Chandler, CPC New Orleans LA
Gaynell Vaccaro, CPC, CPMA Prairieville LA
Mary Mauthe, CPC Slidell LA
Mary Harvey, CPC Boston MA
Carol Margeson, CPC Boston MA
Lee Ann Seyller, CPC-H, CPMA Brockton MA
Karen Baker, CPC Fall River MA
Geraldine Shea, CPC Fall River MA
Sydney Vanderpool, CPC Indian Orchard MA
Monte Demon Whiteside, CPC, CPC-H Lowell MA
Judith Jenkins, CPC Oxford MA
Greg Perkins, CPC-P South Boston MA
Jason Lerner, CPC Wrentham MA
Elizabeth Rabe-Canada, CPC, CPC-H Baltimore MD
Courtney Sinagra, CPC Baltimore MD
Linda Ann Rossmark, CPC Bel Air MD
Deborah Rackley, CPMA Columbia MD
Laurie Tierney, CPC, CPC-H Columbia MD
Anne Elkins, CPC Gaithersburg MD
Adjoavi Noamessi, CPC Germantown MD
Brenda Marie Adams, CPC Rockville MD
Myong H Choi, CPC Rockville MD
April Lenore Jenkins, CPC Rockville MD
Vanessa E Santis, CPC Rockville MD
Yvonne West, CPC Lewiston ME
Lorraine Melendy, CPC Mechanic Falls ME
Dianne Weeks Collins, CPC Rockland ME
Elizabeth Nisenbaum, CPC Ann Arbor MI
Bonnie A ODonnell, CPC East Lansing MI
Barbara Boughner, CPC Grand Rapids MI
Samantha J Bridenstein, CPC, CPC-H Grand Rapids MI
Laurene Ann McAuley, CPC, CPMA Lansing MI
Dana Zawada, CPC Lapeer MI
Lynda Donaldson, CPC Macomb MI
Lisa Jean Muller, CPC Merrill MI
Kimberly Banks, CPC Midland MI
Ewa Urszula Wolek, CPC Mulliken MI
Mary Ann Halmekangas, CPC, CPMA Parma MI
Cheryl R Clasen, CPC Alexandria MN
Penny G Cell, CPC, CPMA Blaine MN
Jane Bitzan, CPC Brandon MN
Susanne Nippert, CPC Eagan MN
Kari Belevender, CPC Harris MN
Leslie Roos, CPC-H Isanti MN
Carrie Witt, CPC-P Mankato MN
Agnes Kotek, CPC New Prague MN
Debra Freudenrich, CPC Pierz MN
Margaret R Newman, CPC, CPMA Saint Paul MN
June Huang, CPC, CPC-H Ballwin MO
Carol Ratliff, CPC-H Battlefield MO
Christina G Feeback, CPC-H Fordland MO
Lucy J Sitton, CPC Lebanon MO
Shelly Allen, CPC Nixa MO
Donna H Williams, CPC Richland MO
Michael Keith Hornback, CPC Siveston MO
Phyllis Finnell, CPC Springfield MO
Catherine Grady, CPC St Louis MO
Richard Sexton, CPC Willard MO
Cindy Johnson, CPC Helena MT
Brenda G Laws, CPC Elk Park NC
Cheryl F Sherrill, CPC Gastonia NC
Aisha Bhatti, CPC Goldsboro NC
Deborah Epps, CPC Goldsboro NC
Dana E Quinn, CPC Pineola NC
Denise Dixon, CPC Roxboro NC
Tiffany B Cooper, CPC Spindale NC
Katherine Hicks, CPC Sugar Grove NC
Kelly L Rogers, CPC, CPMA Timberlake NC
Dorothea Kelligrew, CPC Waxhaw NC
Jamie L Boltz, CPC, CPC-H, CPC-P, CEMC Omaha NE
Martin Smith, CPC-H Hudson NH
Michelle L Capilli, CPC Audubon Park NJ
Nicole Caroline Reitano, CPC Blackwood NJ
Feleta Ann Owens, CPC, CPC-H Cherry Hill NJ
Linda L Hodson, CPC, CPC-H Gloucester City NJ
Sean Willis, CPC, CPC-H Jersey City NJ
Ann Buchanan, CPC Marlton NJ
Deborah Gilman, CPC Marlton NJ
Gerri S Anthony, CPC Moorestown NJ
Margaret D Tzap, CPC Pennsauken NJ
Dina Benedetto, CPC, CPC-H, CPMA Sewell NJ
Sandra Gonzales, CPC Albuquerque NM
Jolene Homolka, CPC Albuquerque NM
Angela Martinez, CPC Albuquerque NM
Susan J Welker, CPC Albuquerque NM
Rose Armijo, CPC Sante Fe NM
Kengel Rankin, CPC Las Vegas NV
John Thomas King, CPC, CPC-H Armonk NY
Pooja Gujar, CPC Brewster NY
Chariza Brenner, CPC Bronx NY
Rodolfo Guzman, CPC Bronx NY
Janette Ortiz, CPC Bronx NY
Jivan Rodriguez, CPC Bronx NY
Libby Rodriguez, CPC Bronx NY
Kamilla Seeteram, CPC Bronx NY
Nilda I Teutsch, CPC Bronx NY
Stephanie Wright, CPC, CPMA Canaseraga NY
Talia Bellini, CPC Centereach NY
Colleen Mary Marigliano, CPC Cold Spring NY
Nicole Ade, CPC Elmont NY
Cheryl M Aldrich, CPMA Glen Cove NY
Lakisha T Andrews, CPC Hempstead NY
Kristi Lee Nowakowski, CPC Hoosick Falls NY
Susan Goldstein, CPC Jackson Heights NY
Elizabeth E Mason, CPC Jackson Heights NY
Patria A Davis, CPC Jamaica NY
Leila Alexis Taruashvili, CPC Mount Kisco NY
Juana M Obispo-Comas, RHIT, CCS, CPC Mt. Vernon NY
Drucilla Brown, CPC New York NY
Evelyn Santiago, CPC New York NY
Lilia Stodart, CPC North Babylon NY
Jason M Rivera, CPC Rego Park NY
Lynn A McCoy, CPC Yonkers NY
Demetria Lee, CPC Akron OH
Cynthia Ann Buchholz, CPC Cincinnati OH
Anita Ann Jackson, CPC Cincinnati OH
Ana L Tannert, CPC, CPC-H Cincinnati OH
Yolanda Bates, CPC Cleveland OH
Teresa Cooper, CPC Harrison OH
Suzzanne Burgess Bower, CPC Mansfield OH
Nikki Romano, CPC-H Mayfield Heights OH
Lisa Martin, CPC Mentor On The Lake OH
Deann Meyers, CPC Perrysburg OH
Tina Badley, CPC South Euclid OH
LuCinda Bradshaw, CPC Timberlake OH
Randi Baker, CPC Toledo OH
LaVonne Davis, CPC-H Wauseon OH
Lina Ortiz, CPC Oklahoma City OK
Catherine Gillette, CPC Milwaukie OR
John Edward Hearst, CPC Portland OR
Frances Oswald, CPC Allentown PA
Arlene Wivell-Kozar, CPC, CPMA Coraopolis PA
Inna Bazilevskaya, CPC Pittsburgh PA
Rhonda L Stewart, CPC Westmoreland City PA
Gina Maria C Tassinari, CPC Hope RI
Dixie F McMahan, CPC, CPMA, CEMC Charleston SC
Karen Alford, CPC Columbia SC
Jamie Berry, CPC Easley SC
Angel Weathers, CPC Easley SC
Roberta Gadsden, CPC Goose Creek SC
Martha Ann Eppley, CPC Laurens SC
Vickie L Lamb, CPC Scranton SC
Larhonda Nealy, CPC Summerville SC
Carrie Jane Maus, CPC Mitchell SD
Kara Marie Krumvieda, CPC White Lake SD
Jamie Forsythe, CPC Chapmansboro TN
Adana Carter, CPC Chattanooga TN
Kristie Dawn Hooks, CPC Clinton TN
Kathleen Mooney, CPC Fairview TN
Tina Greer King, CPC Jonesborough TN
Michael Ann Fowler, CPC Knoxville TN
Bonnie Grubb, CPC Knoxville TN
Beth Cunningham, CPC Lebanon TN
Stacy McGahee, CPC Lebanon TN
Sandra Stevens, CPC Nashville TN
Frances Y Rice, CPC Big Spring TX
Carolyn Campbell, CPC, CPMA Burleson TX
Lori Gonzales, CPC Coahoma TX
Tiffany Baker, CPC Converse TX
Patricia Adkins, CPC, CPC-H, CPMA Coppell TX
Irene Fira, CPC Crosbyton TX
Rebecca Harder, CPC Dallas TX
Daralynn Gay Stewart, CPC Dallas TX
Shannon C Lee, CPC Desoto TX
Valerie Ditterline, CPC Fort Worth TX
Tanya Rogers, CPC Glenn Heights TX
Jeanette Garza, CPC Houston TX
Nicole M Jones, CPC Houston TX
Linda Martinez-Dominguez, CPC-H Houston TX
Cindy L Miller, CPC Houston TX
Megan Olewe, CPC-H Houston TX
Joan Raper, CPC, CPMA Houston TX
Youlanda Smith-Jones, CPC Houston TX
Marti J Geron, CPC, CPC-H, CPMA Hurst TX
Carol Wellington, CPC-H Katy TX
Jermillah N Ashton, CPC, CPC-P La Marque TX
April Molinar, CPC Lubbock TX
Brandi Lynn Tadlock, CPC, CPMA Lubbock TX
Kathryn Whitfield, CIRCC Magnolia TX
Andra Chowdhury, CPC McAllen TX
Kimberly Poore-Nedwetzky, CPC Mesquite TX
Trena Marie Sterling, CPC Mesquite TX
Norma Paisley, CPC-H, CPMA Ovilla TX
Kimberly Yvette Gilbert, CPC, CPMA Pearland TX
Melissa Petersen, CPC San Antonio TX
Antonette Yvette Johnson, CPC Seagoville TX
Yulia Miller, CPC, CPMA Woodland TX
Mitzi Neal, CPC Highland UT
Sheri Winnie, CPC Provo UT
Ella Louise Lattimore, CPC Alexandria VA
Tamara Ja'net Doss, CPC, CPMA Fredericksburg VA
Deborah Lynn Hawkins, CPC Lynchburg VA
Cynthia T Youngblood, CPC Lynchburg VA
Robin Douglas, CPC Brandon VT
Margaret Suzanne Standley, CPC, CIRCC, CEMC Battle Ground WA
GayLyn Concienne, CPC Prosser WA
Rona Smith, CPC Spokane WA
Leslie Huck, CPC, CPC-P, CPMA Vancouver WA
Brian Cody, CPC-H Milwaukee WI
Yvonne Bess Smith, CPC, CPMA, CEMC Milwaukee WI
Della M Hughes, CPC Beckley WV
Nettie Patricia Kirby, CPC Boursville WV
Susan Johnson, CPC Charleston WV
Chris Brown, CPC Kincaid WV
Melinda Fisher, CPC Red House WV
Carla J Blatchford, CPC Casper WY

Apprentices

Dana Ferguson, CPC-A APO AE
Pamela Halley, CPC-A APO AE
Jane Frances Hamilton, CPC-A APO AE
Maricruz Olivarez, CPC-A APO AE
Laura Allgood, CPC-A Birmingham AL

Maria Luttrell, CPC-A Birmingham AL
Patricia Raymond, CPC-A Birmingham AL
Rebecca Sue Parker, CPC-A Daleville AL
Ashley Evans, CPC-A Gardendale AL
Jennifer Berger, CPC-A McCalla AL
Lindsey Wingate, CPC-A McCalla AL
Karen Mosley, CPC-A Montgomery AL
Deborah T Jackson, CPC-A Mountain Brook AL
Ashley Merritt Dickens, CPC-A Ozark AL
Alecia Dawn Williams, CPC-A Ozark AL
Pamela Rose, CPC-A Little Rock AR
Heather Crouch, CPC-A Avondale AZ
Sayira Linares, CPC-A Buckeye AZ
Lou Ann Langston, CPC-A Chandler AZ
Barbara Gibbons, CPC-A Gilbert AZ
Dannon Lesueur, CPC-A Gilbert AZ
Lynn Kruk, CPC-A Peoria AZ
Virginia Muller, CPC-A Peoria AZ
Nikki J Filter, CPC-A Phoenix AZ
Barbara Lang, CPC-A Phoenix AZ
Kay E Weaver, CPC-A Tucson AZ
Michelle Rebul, CPC-A Altadena CA
Sheila Brooks, CPC-A Antioch CA
Alisa Rose Blickman, CPC-A Atherton CA
Susan Relerford, CPC-A Bakersfield CA
Daryline B Panganiban, CPC-A Beaumont CA
Emily Swan, CPC-A Canyon Country CA
Desiree Berry, CPC-A Chatsworth CA
Suzanne Annette Kissick, CPC-A Chino Hills CA
Jennifer Edwards, CPC-A Cloverdale CA
Cynthia Lopez-Dee, CPC-A Cotati CA
Grace S Almacen, CPC-A Daly City CA
Jeffrey Buchholz, CPC-A Escondido CA
Marisol Garcia, CPC-A Fontana CA
Ashleigh Arias, CPC-H-A Garden Grove CA
Nanci Gudelia Juarez, CPC-A Hawthorne CA
Elizabeth Esparza, CPC-A Hemet CA
Jackie Thomas, CPC-A Heyward CA
Eve Salvador, CPC-A Irvine CA
Fernanda G Garcia, CPC-A La Habra Heights CA
Ada Rodriguez, CPC-A Laguna Niguel CA
Rachael Annette Lopez, CPC-A Lake Elsinore CA
Brenda Douglas-Lamadrid, CPC-A Loma Linda CA
Judith Blumenberg, CPC-A Los Angeles CA
Nenita Esplana, CPC-A Los Angeles CA
Ji Youn Lee, CPC-A Los Angeles CA
Debra A Johnson, CPC-A Menifee CA
Christina Jeanne Rose, CPC-A Moss Beach CA
Nita Credo, CPC-A Murrieta CA
Lynette Farrell, CPC-A Murrieta CA
Kelly Ann Landford, CPC-A Murrieta CA
Lorna Mantuano, CPC-A Murrieta CA
Lary R Horton, CPC-A Newhall CA
Seda Minasyan, CPC-A North Hills CA
Jose Luis Jaucian, CPC-A Northridge CA
Tiffany Cardona, CPC-A Palm Desert CA
Carolyn Craig, CPC-A Pittsburg CA
Marie Tumbokon, CPC-A Pomona CA
Marcella Wallace, CPC-A Porterville CA
Chang Yeol Lee, CPC-A Rancho Cucamonga CA
Carolina Pedace, CPC-A Rancho Cucamonga CA
Angie Rogers, CPC-A Rialto CA
Heather Zirwas, CPC-A Riverside CA
Susan Moore, CPC-A San Bruno CA
Judy Ollis, CPC-A San Clemente CA
Jeff Courtney, CPC-A San Diego CA
M. E. Lee, CPC-A San Diego CA
Doris Rejon Guevara, CPC-A San Diego CA
Tonya Michelle McCoy, CPC-A San Fernando CA
Alma Salazar, CPC-A San Fernando CA
Diana Juan, CPC-A San Francisco CA
Randall Kikukawa, CPC-A San Francisco CA
Roxanne DeLuna, CPC-A San Jacinto CA
Dora P Kline, CPC-A San Jacinto CA
Jeannett Diestro, CPC-A San Jose CA
Ellen Kwan, CPC-A San Mateo CA
Tami Marie Bushong, CPC-A Santa Clarita CA
Judy Moulder, CPC-A Santa Maria CA
Judith G Arellana, CPC-A Santa Monica CA
Toni Street, CPC-A Santa Rosa CA
Cindy Williams, CPC-A Sun City CA
Belinda Santos, CPC-A Temecula CA
Kimberly Smith, CPC-A Temecula CA
Alyona Mortimeyer, CPC-A Truckee CA
Ashli Rene Washington, CPC-A Union City CA
Patricia A Bell, CPC-A Upland CA
Jennifer Tennille, CPC-A Valley Center CA
Hannah Brigham, CPC-A Ventura CA
Leanna M Burgum, CPC-A Victorville CA
Lara Koontz, CPC-A Vista CA
Hassan M Alkhouli, CPC-A, CPC-H-A Westminster CA
Zandra Afanador, CPC-A Aurora CO
Anji McConnell, CPC-A Castle Rock CO
Tania M Dudnikow, CPC-A Denver CO
Rhonda Rae Henderson, CPC-A Denver CO
Teri McCormick, CPC-A Evans CO
Kristi Anderson, CPC-A Greeley CO
Virginia Denton, CPC-A Lakewood CO
Kellie Hall, CPC-A Lakewood CO
Heidi Farris, CPC-A Northglenn CO
Mike Pollock, CPC-A Thornton CO
Sheri Kobobel, CPC-A Westminster CO
Nora Hung, CPC-A Branford CT
Donna L Roberts, CPC-A Brookfield CT
Caroline Rebecca Alphonso, CPC-A Danbury CT
Michele L Henry-Johnston, CPC-A Danbury CT
Marcia Ann Neves, CPC-A Danbury CT
Rachel B Roth, CPC-A Danbury CT
Janice Peles, CPC-A Granby CT
Lakshmi Abbaraju, CPC-A Hartford CT
Emilie LaRocque, CPC-A Manchester CT
Christine M Gonzalez, CPC-A Meriden CT
Terri A Vitti-Perillo, CPC-A Milford CT
Endea J Bryant, CPC-A New Haven CT
Kathy Miller, CPC-A New Mulford CT
Anna Gagnon, CPC-A Plainville CT
Megan Bergin, CPC-A Terryville CT
Linda Tarullo, CPC-A Thomaston CT
Doreen Mancini, CPC-A Trumbull CT
Gretchen Martin, CPC-A Vernon CT
Michael Smith, CPC-A Vernon CT
John Morettini, CPC-A Waterbury CT
Louise Rodrique, CPC-A Wethersfield CT
Karen J Brissette, CPC-A Wolcott CT
Rebecca Ann Mercado, CPC-A Alachua FL
Marty Bias, CPC-A Beverly Hills FL
Maria C Vazquez, CPC-A Bokeelia FL
Hazel Martin, CPC-A Bradenton FL
Melinda Lopez, CPC-A Brandon FL
Kami Pauly, CPC-A Brandon FL
Carolyn Perkins, CPC-A Brandon FL
Kandi Taylor, CPC-A Brandon FL
Michelle Lambert, CPC-A Brooksville FL
Rhonda K Beitelshies, CPC-A Cape Coral FL
Delsia V Garcia, CPC-A Cape Coral FL
Shannon Tracy Wilkins, CPC-A Cape Coral FL
Margaret Hartsfield, CPC-A Clearwater FL
Meredith Mcneil, CPC-A Clearwater FL
Eileen Sickel, CPC-A Clearwater FL
Charles Tucker, CPC-A Clearwater FL
Stacey Fitzgerald, CPC-A Cocoa FL
Kathleen Winn, CPC-A Cocoa Beach FL
Patricia Bowen, CPC-A Deland FL
Lizzette Jarmon, CPC-A Dover FL
Alesha Usher-Mullen, CPC-A Dover FL
Sharon Morgan, CPC-A Edgewater FL
Lisa J Edwards, CPC-A Fort Myers FL
Michelle Thornton, CPC-A Fort Myers FL
Natasha Bennett, CPC-A Fort Pierce FL
John J Sabatella, CPC-A Gainesville FL
Xiomara Gonzalez, CPC-A Hialeah FL
Shannon Bradley, CPC-A Jacksonville FL
Juan Genao-Homs, CPC-H-A Jacksonville FL
Bethany Montgomery, CPC-A Jacksonville FL
Davita Williams, CPC-A Jacksonville FL
Phyllis Williams, CPC-A Jacksonville FL
Marilyn Adames, CPC-A Kissimmee FL
Yaquelin De Los Santos, CPC-A Kissimmee FL
Marina Diaz, CPC-A Kissimmee FL
Cathleen Norman, CPC-A Kissimmee FL
Denise Ortiz, CPC-A Kissimmee FL
Josleydi Tamayo, CPC-A Kissimmee FL
Melissa Coffey, CPC-A Lakeland FL
Frank Ketcham, CPC-A Lakeland FL
Lorena Ragunath, CPC-A Lakeland FL
Brittany Smith, CPC-A Largo FL
Angela Faye Walton, CPC-A Lehigh Acres FL
James Leddy, CPC-A Melbourne FL
Patricia Wilkens, CPC-A Melbourne FL
Elizabeth Graves, CPC-A Miami FL
Karen Ranero, CPC-A Miami FL
Marge Morris, CPC-A New Port Richey FL
Darlene Lisi, CPC-A New Smyrna Beach FL
Sandra K DePretis, CPC-A North Port FL
Olivia Mack, CPC-A Ocala FL
Vantrice Biggs, CPC-A Ocoee FL
Linda T Brock, CPC-A Orange FL
Esther Crisanto, CPC-A Orange City FL
Miriam Correa, CPC-A Orlando FL
Jane' Farrow, CPC-A Orlando FL
Brittany Harbers, CPC-A Orlando FL
Sara Hornburger, CPC-A Orlando FL
Fildres Jordan, CPC-A Orlando FL
Contrena Randle, CPC-A Orlando FL
Neyza Ruiz, CPC-A Orlando FL
Annie Thomas, CPC-A Orlando FL
LaToya Thomas, CPC-A Orlando FL
William Bethea, CPC-A Ormond Beach FL
Christine McKenzie, CPC-A Palm City FL
Courtney Grossl, CPC-A Palm Coast FL
Karen Leigh O'Hare, CPC-A Palm Harbor FL
Paula Reppin, CPC-A Palm Harbor FL
Greg Hammac, CPC-A Pensacola FL
Linda Jones, CPC-A Pinellas Park FL
Phillip Sharpe, CPC-A Port St Lucie FL
Richard Lubell, CPC-A Safety Harbor FL
Carin Wiese, CPC-A St Augustine FL
Diana Arroyo, CPC-A St Cloud FL
Janette Walters, CPC-A St Petersburg FL
Morgan Eden Hicks, CPC-A Tallahassee FL
Sherry Cascio, CPC-A Tampa FL
Sarah C Heithaus, CPC-A Tampa FL
Danee V Lundy, CPC-A Tampa FL
JoEllen Mills, CPC-A Tampa FL
Marilyn Riling, CPC-A Tampa FL
Monica Rivera, CPC-A Tampa FL
Sha'Terrika Kitt, CPC-A Valrico FL
Zulima Santiesteban, CPC-A West Palm Beach FL
Shamika Pollard, CPC-A Winter Garden FL
Sharon Vasquez, CPC-A Winter Haven FL
Iris Delia Abreu, CPC-A Winter Park FL
Nathaniel Richard Atkins III, CPC-A Winter Park FL
Kelli Hobby, CPC-A Ashburn GA
Joshua Caillouet, CPC-A Atlanta GA
Agatha Okonofua, CPC-A Atlanta GA
Angelica Virata, CPC-A Augusta GA
Michelle Dennison, CPC-A Buford GA
Nikeya C Ealey-Johnson, CPC-A Conyers GA
Kimberly-Jo Aneesha Webb, CPC-A Conyers GA
Darneda Sherie Harvey, CPC-A Decatur GA
Cornelia Conner, CPC-A Flowery Branch GA
Karen Watters, CPC-A Flowery Branch GA
Jacqueline Mincer, CPC-A Hephzibah GA
Mahagany Green, CPC-A Jonesboro GA
Radhika Katragadda, CPC-A Kennesaw GA
Ellen Lawson, CPC-A Lawrenceville GA
Valerie Searcy White, CPC-A Lawrenceville GA
Tracy D Hood, CPC-A Leesburg GA
Elizabeth Melathe, CPC-A Lilburn GA
Karen Dorsey, CPC-A Macon GA
Mary Catherine Patrick, CPC-A Marietta GA
Lakesha Taylor, CPC-A Marietta GA
Lamonte Joel Washington, CPC-A Marietta GA
Donna Cufaude, CPC-A Martinez GA
Cynthia Amaihe, CPC-A Smyrna GA
Sarah Barber, CPC-A Tifton GA
Wendy Payne, CPC-A Woodstock GA
Arlinda Wendland, CPC-A Fort Madison IA
Jackie Poggemiller, CPC-A Mediapolis IA
Lana Foster, CPC-A Rathdrum ID
Deborah Skortz, CPC-A Bartlett IL
Carol Augustine, CPC-A Bloomington IL
Anjana Patel, CPC-H-A Buffalo Grove IL
Kristen N Williams, CPC-A Carol Stream IL
Jodi Creswell, CPC-A Crest Hill IL
Jamie Vanderhyden, CPC-A Crestwood IL
Melissa A VanBaren, CPC-A Crete IL
Carlo Muyco Ponte, CPC-A Des Plaines IL
Shelby Elizabeth Drummond, CPC-A Franklin IL
Pam Snider, CPC-A Freeburg IL
Charles S Gentile, CPC-A Hickory Hills IL
MerryBeth Lisa Gentile, CPC-A Hickory Hills IL
Bonnie Rosinski, CPC-A Huntley IL
Phyllis T Hulden, CPC-A Johnsburg IL
Kimberly Smith, CPC-A Lake in the Hills IL
Margaret Ellen Hezlep, CPC-A Marion IL
Crystal Starks, CPC-A Matteson IL
Maureen Ann Rapata, CPC-A Mokena IL
Kristina L Brewer, CPC-A Mt Olive IL
Renee Ries, CPC-A New Lenox IL
Susan Lynn Griswold, CPC-A Oak Forest IL
Vallorie Brewer, CPC-A Oquawka IL
Nancy K Hogel, CPC-A Orland Park IL
Nghi Loi Pappas, CPC-A Palatine IL
Nancy Ann Wojcik, CPC-A Palos Hills IL
Mark Eugene Ushman, CPC-A Pawnee IL
Michelle L DeLavern, CPC-A Peoria IL
Jacklyn Anne Hatchett, CPC-A Peoria IL
Julie Deanne Atwater, CPC-A Peoria Heights IL
Melissa Miller, CPC-A Plano IL
Justine Basa Asilo-Daelo, CPC-A Schaumburg IL
Allison Renee Beagle, CPC-A Springfield IL
Ericka A Stout, CPC-A Springfield IL
Jeri Kay Trueblood, CPC-A Springfield IL
Sandra L Wells, CPC-A Springfield IL
Julia Stewart, CPC-A St Charles IL
Mallory May, CPC-A Taylorville IL
Cynthia M Saenger, CPC-A Villa Park IL
Julia A Morton, CPC-A Virginia IL
Sherry L Murray, CPC-A Washington IL
Jason Adam Behnken, CPC-A Waterloo IL
Debra Evans, CPC-A Fort Wayne IN
Mary Montoya, CPC-A Fort Wayne IN
Daniel George Pyle, CPC-A Fort Wayne IN
Cindy Bozarth, CPC-A Kokomo IN
Deborah Dunning, CPC-A Lowell IN
Sandra K Thies, CPC-A Rising Sun IN
Deborah L Gribben, CPC-A Wabash IN
Christy Lynn Hobbs, CPC-A Benton KS
Langia Lee Brown, CPC-A Goddard KS
Jennifer Renee Wilson, CPC-A Goddard KS
Krystyna Capra, CPC-A Olathe KS
Nancy G Clark, CPC-A Wellington KS
Rebecca Sue Cage, CPC-A Wichita KS
Conraya Jerrlinne Carpenter, CPC-A Wichita KS
Courtney A Clapp, CPC-A Wichita KS
Amber Lynn Hovious, CPC-A Wichita KS
Christie D Louthan, CPC-A Wichita KS
Lisa R McDowell, CPC-A Wichita KS
Regina Caeli Miller, CPC-A Wichita KS
Lauren Rose Miritello, CPC-A Wichita KS
Dorothy E Mohney, CPC-A Wichita KS
Douglas Edward Russell, CPC-A Wichita KS
Jennifer I Simmons, CPC-A Wichita KS
Deena Michelle Thompson, CPC-A Wichita KS
Wendy Ann Womack, CPC-A Wichita KS
Heather Fiessinger, CPC-A Benton KY
Melody Cleveland, CPC-A Berry KY
Patricia Kathleen Ribbing, CPC-A Ft Mitchell KY
Misty Branham, CPC-A Grayson KY
Karen Stauffer, CPC-A Junction City KY
Kimberly A Watson, CPC-A Kevil KY
Colby Lytch, CPC-A Lexington KY
Kelly Metzler, CPC-A Lexington KY
Santha Tharappel, CPC-A Lexington KY
Stephanie Nichole Franklin, CPC-A Louisville KY
Sylvia Rose Mond, CPC-A, CPC-H-A Louisville KY
Shanna M Sweeney, CPC-A Louisville KY
Andrea Marie Ward, CPC-A Louisville KY
Judy Carol Leake, CPC-A, CPC-H-A Mt Washington KY
Kimberly Muse Tingle, CPC-A, CPC-H-A Pewee Valley KY
Kristy Lee McKenzie, CPC-A Shelbyville KY
Leah Bilyeu, CPC-A Sheperdsville KY
Vonda Young, CPC-A Stanford KY
Susan H May, CPC-A Abita Springs LA
Leslie Manuel, CPC-A Alexandria LA
Tanya Bridges, CPC-A Covington LA
Debra Watkins, CPC-H-A Covington LA
Susie Vallee, CPC-A Folsom LA
Elizabeth Barron, CPC-A Harahan LA
Dori Traina, CPC-H-A Mandeville LA
Cheryl R Berzat, CPC-A New Orleans LA
Dayna Cefalu, CPC-A Slidell LA
Jeannie Galbreath, CPC-A Woodworth LA
Kerry Lucchesi, CPC-A Baldwinville MA
Jerie Tervo, CPC-A Blackstone MA
Patricia Giovannucci, CPC-A Charlton MA
Samantha Douchette, CPC-A Chicopee MA
Sharon Mary Thompson, CPC-A Chicopee MA
Xiomara Gonzalez, CPC-A Dracut MA
Christine Brown, CPC-A Franklin MA
Ronald Robert Gauthier, CPC-A Lunenburg MA
Terri J Allard, CPC-A Milfrod MA
Susan Ahern, CPC-A Quincy MA
Elizabeth Ryan Perry, CPC-A Quincy MA
Lori Noons, CPC-A Rehoboth MA
Judith McNamara, CPC-A Rockland MA
Rachel Krasowski, CPC-A Saugus MA
Shannon M Maston, CPC-A Seekonk MA
Jody Tsihlis, CPC-A Shrewsbury MA
Nur Terpis, CPC-A South Orleans MA
Deanne Rheaume, CPC-A Springfield MA
Michele DiPalo, CPC-A Waltham MA
Crystal Griswold, CPC-A Ware MA
Traci Farnum, CPC-A West Springfield MA
Donna Schaeffler, CPC-A West Springfield MA
Denise Wadsworth, CPC-A West Warren MA
Denise Tanguay, CPC-A Williamsburg MA
Cheryl Nitkowski, CPC-A Abingdon MD
Jennifer Christophel, CPC-A Baltimore MD
Avinoam Miller, CPC-A Baltimore MD
Mariya Trojanovs, CPC-A Baltimore MD
Ariwulan Chibbaro, CPC-A Brookeville MD
Sammie Zaw, CPC-A Ellicott City MD
Elma de Leon Sulit, CPC-A Fort Washington MD
Wanpijid Wang-itti, CPC-A, CPC-H-A Odenton MD
Amy Seaman, CPC-A Pikesville MD
Faiza Mohamed, CPC-A Silver Spring MD
Theodore Bunker, CPC-A Union Bridge MD
Maria Fatima Lidback, CPC-A Bowdoin ME
Amy Wyeth Buck, CPC-A Gardiner ME
Fury Alina Collins, CPC-A Shapleigh ME
Melanie Lynne Chamberlin, CPC-A Topsham ME
Dolores Cormier, CPC-A Waterboro ME
Jennifer Marie Zack, CPC-A West Gardiner ME
Jaime L Wing, CPC-A Winthrop ME
Christian Bradley, CPC-A Ann Arbor MI
Karen Frazho, CPC-A Bloomfield Hills MI
Lynn Wilson, CPC-A Cedar Springs MI
Tammy McBride, CPC-A Center Line MI
Kimberly Clausen, CPC-A Chesterfield MI
Rodney D Adache, CPC-A Clarklake MI
Kim Moss, CPC-A Clinton Township MI
Kathryn Pfeifer, CPC-A Clinton Township MI
Sharon Wilson, CPC-A Clinton Township MI
Linda Rhodes, CPC-A Detroit MI
Julie Krebs, CPC-A Grosse Pointe MI
Erica Carlson, CPC-A Grosse Pointe Park MI
Rebekah Joy Prebble, CPC-A Ionia MI
Catherine Sue Fleming, CPC-A Jenison MI
Marilyn Shapiro, CPC-A Lansing MI
Annette Spare, CPC-A Lansing MI
Sandra Knuth, CPC-A Lapeer MI
Linda Mastrovito, CPC-A Lowell MI
Wendy Fuhrman, CPC-A Macomb MI
Debra Green, CPC-A Macomb MI
Richelle Taylor, CPC-A Madison Heights MI
Kimberly Birchmeier, CPC-A Milan MI
Jacqueline Burdo, CPC-A Redford MI
Linda Grant, CPC-A Rochester Hills MI
Christina M Russo, CPC-A Rockford MI
Barbara Eskuri, CPC-A Roseville MI
Sandra Holliday, CPC-A Southfield MI
Mary Manzella, CPC-A Sterling Heights MI
Linda Watkins, CPC-A Troy MI
Meredith Taylor, CPC-A Walled Lake MI
Wanda Bown, CPC-A Warren MI
JoAnn M Reynolds, CPC-A Webberville MI
Kathy Franklin, CPC-A Westland MI
Lindsey Silbernick, CPC-A Alexandria MN

Erin Armitage, CPC-A Apple Valley MN
Alyssa Kay Duggan, CPC-A Chanhassen MN
Michelle James, CPC-A Coon Rapids MN
Nathan Schreier, CPC-A Eden Prairie MN
Edward Neilsen, CPC-A Lake Crystal MN
Bev Falteysek, CPC-A Owatonna MN
Heidi Kujath, CPC-A Owatonna MN
Traci O'Connell, CPC-A Wyoming MN
Tammy Knight, CPC-A Arnold MO
Kandice Epperson, CPC-A Bloomsdale MO
Jana Straub, CPC-A Branson MO
Iva Wagner, CPC-A Cape Girardeau MO
Michele Ann Cross, CPC-A Cedar Hill MO
Joe Raymond Missey, CPC-A DeSoto MO
Patricia A Kolde-Campbell, CPC-A Ellisville MO
Carmen Duncan, CPC-A Excelsior Springs MO
Carla S Konersmann, CPC-A Fenton MO
Heather Murphy, CPC-A Kansas City MO
Miranda J Heil, CPC-A O'Fallon MO
Renee Marie Long, CPC-A O'Fallon MO
Rhonda O'Neal-DePuy, CPC-A O'Fallon MO
Timna Lowes, CPC-A Perryville MO
Shawn Benefiel, CPC-A Saint Peters MO
Debra S diZerega, CPC-A Saint Peters MO
Deborah Kay McMahon, CPC-A Scott City MO
Monique D Funkenbusch, CPC-A Springfield MO
Mary Ann Sackman, CPC-A St Charles MO
Chris Allen Harrington, CPC-A St Louis MO
Laurel Alicia Koenig, CPC-A St Louis MO
Martina Pavelski, CPC-A St Louis MO
Jamie Lynn Becker, CPC-A St Peters MO
Karen Michelle Diethelm, CPC-A Wildwood MO
Adrien Denise Stewart, CPC-A Biloxi MS
Dennis Ray Tharpe, CPC-A Biloxi MS
Tamara Elizabeth Taylor, CPC-A Gulfport MS
Kristen Nicole Foster, CPC-A Hickory Flat MS
Roslin R Smith, CPC-A Horn Lake MS
Gloria Vandenweghe, CPC-A Jayess MS
Sonya Elisha Nettles, CPC-A Moss Point MS
Merrilee S Jones, CPC-A Olive Branch MS
Deanna C Daffer, CPC-A Southaven MS
Theresa M Houser, CPC-A Southaven MS
Danielle M Johns, CPC-A Southaven MS
Shannon Ann Jahn, CPC-A Deborgia MT
Alisa Courchane, CPC-A Helena MT
Taquita Eason, CPC-A Charlotte NC
DaLice Madison, CPC-A Charlotte NC
Stacy Parker, CPC-A Charlotte NC
Tammy Renee Philemon, CPC-A Charlotte NC
Angela Denise Robinson, CPC-A Charlotte NC
Gloria Moss, CPC-A Creedmoor NC
Kimdi Bethea, CPC-A Durham NC
Elvis E Draughn, CPC-A Durham NC
Christy Lehman, CPC-A Durham NC
Delores Carter Hamrick, CPC-A Ellenboro NC
Amy M Bass, CPC-A Franklinton NC
Tanya Sharpe, CPC-A Gastonia NC
Mary LaRue Rimmer Irby, CPC-A Hurdle Mills NC
Angel Slaven, CPC-A Icard NC
Rhonda Lynn Bishop, CPC-A Jacksonville NC
Donna Day, CPC-A Jacksonville NC
Connie Green, CPC-A Jacksonville NC
Brandon Antonio Lattimore, CPC-A Jacksonville NC
Danielle Marie Ringgold, CPC-A Jacksonville NC
Gurdeep Singh, CPC-A Leland NC
Cynthia Christie, CPC-A Midway Park NC
Jeannie P Beaton, CPC-A Newland NC
Sheryl Smith, CPC-A Providence NC
Teresa Phifer, CPC-A Raleigh NC
Kimberly Saxon Taylor, CPC-A Raleigh NC
Reba Wesley, CPC-A Roxboro NC
Bonnie Lynn Frandrup, CPC-A Selma NC
Michelle Dagenhart, CPC-A Statesville NC
Pixie Dellinger, CPC-A Statesville NC
Kathleen McDade, CPC-A Statesville NC
Lori Turpin, CPC-A Statesville NC
Sonya Davis, CPC-A Sunset Beach NC
Samantha Nixon, CPC-A Tarawa Terrace NC
Renita Richardson, CPC-A Tarawa Terrace NC
James E Boyd, CPC-H-A Thomasville NC
Sandy L Heath, CPC-A Timberlake NC
Jan Plummer, CPC-P-A Waynesville NC
Maria C McElligott, CPC-A Wilkesboro NC
Tonya Choplin, CPC-A Youngsville NC
Cathy A Hill, CPC-A Hastings NE
Amanda Chamberlain, CPC-A Goffstown NH
Anne Bole, CPC-A Holderness NH
Christina Johnson, CPC-A Litchfield NH
Patricia Neal, CPC-A Weare NH
Janice Miller, CPC-A Chatsworth NJ
Eduardo A Cabello-Martin, CPC-A Hamburg NJ
Robert C Kirkpatrick, CPC-A, CPC-H-A Lafayette NJ
Smith Won, CPC-A Leonia NJ
Lori Hanneman, CPC-A Mount Laurel NJ
Deborah Temple, CPC-A Pennsauken NJ
Stacey Cash, CPC-A Roebling NJ
Allison Pagano, CPC-A Springfield NJ
Lisa Ernst, CPC-A Succasunna NJ
Anita M Mazza, CPC-A Wantage NJ
Wendy Howard, CPC-A, CPC-H-A Albuquerque NM
Monica Backus, CPC-A Chaparral NM
Jessica R Morales, CPC-A Chaparral NM
Jennifer Denise Brackeen, CPC-A Reno NV
Carol Gillies, CPC-A Reno NV
Jessica Rose Helms, CPC-A, CPC-H-A Reno NV
Hope Marlene Witt, CPC-A Sparks NV
Elizabeth Heckman, CPC-A, CPC-H-A Washoe Valley NV
Louise Renee Farrington, CPC-A Adams Center NY
Jodi Marie Jones, CPC-A Barneveld NY
Tracy D Barnes, CPC-A Beacon NY
Deborah Ann Podmore, CPC-A Buffalo NY
Lisa M Bertrand, CPC-A East Aurora NY
Shabnam Shah, CPC-A East Meadow NY
Victoria Tan Chang, CPC-A Fresh Meadows NY
Monica Ortiz, CPC-A Fresh Meadows NY
Ignazio Antonio Sutera, CPC-A Glendale NY
Janet Mavroudakis, CPC-A Greenlawn NY
Pamela R Charron, CPC-A Greenwich NY
Angel Marie Ware, CPC-A Hempstead NY
Margaret Haggerty, CPC-A Holbrook NY
Andrea Fenti, CPC-A Hornell NY
Edward Walters, CPC-A Jackson Heights NY
Yvonne A Gonski, CPC-A Maspeth NY
Dina Miranda, CPC-A Middle Island NY
Kelly James, CPC-A N Tonawanda NY
Mary Kate Basile, CPC-A Nesconset NY
Emelda N Nkwain, CPC-A New Rochelle NY
Lucinda C Sutherland, CPC-A Newfane NY
Amy E Dennis, CPC-A Newfield NY
Partricia Lynn Jordan, CPC-A, CPC-H-A Niagara Falls NY
Kari Lyn Stickney, CPC-A North Bangor NY
Susan A McCarthy, CPC-A Queensbury NY
Andrea Murray, CPC-A Rome NY
Doreen Wallace, CPC-A Rosedale NY
Kyna Marie Dedeaux-Larsen, CPC-A Scotia NY
Debra A Dantonio, CPC-A Tonawanda NY
Sheila N Hardy, CPC-A Warsaw NY
Stacie Wilson, CPC-A Waverly NY
Denise A Nagode, CPC-A, CPC-H-A West Seneca NY
Ana Cachon, CPC-A Woodside NY
Donna Conner, CPC-A Burghill OH
Susan Irene Miller, CPC-A Cincinnati OH
Becky Domyanich, CPC-A Delaware OH
Laurie Custer, CPC-A Eastlake OH
Kimberlee Williams, CPC-A Farmdale OH
Laurie Ann Ganoski, CPC-A Hartville OH
Kara Dietsch, CPC-A Marion OH
Jacqueline Sparks, CPC-A Milford OH
Penelope Smith, CPC-A Moraine OH
Candice Butchko, CPC-A Mt Gilead OH
Angela Marie McKenzie, CPC-A Napoleon OH
Christine Metz, CPC-A Niles OH
Geri A Pietrolungo, CPC-A Solon OH
Melissa Feltz, CPC-A Springboro OH
Kathleen Ann Berry, CPC-A Toledo OH
Kolleen M Kiefer, CPC-A Toledo OH
Chelsea Lynn Odom, CPC-A Toledo OH
Sharon K Odom, CPC-A Toledo OH
Angela O'Brien, CPC-A Warren OH
Tamara Kazlauckas, CPC-A Willowick OH
Pamela M Wolfe, CPC-A Wilmington OH
Donna Lynne Cowens, CPC-A Youngstown OH
James N Little, Jr, CPC-A Youngstown OH
Whitney Felder, CPC-A Catoosa OK
Jennifer Eades, CPC-A Duncan OK
Ebony Boyd, CPC-A Tulsa OK
Rhonda A Ferrell-Copes, CPC-A Tulsa OK
Sarah Short, CPC-A Tulsa OK
Amanda Hamell, CPC-A Boring OR
Jenelle Bostwick, CPC-A Milwaukie OR
Irina Andreyuk, CPC-A Portland OR
Bethaney Phillips, CPC-A Portland OR
Jenny Steinbach, CPC-A Portland OR
Carol Lorrane Phillips, CPC-A Salem OR
Jennifer Dolan, CPC-A Springfield OR
Tamara Ann Carovano, CPC-A Tualatin OR
Laurie Osborne, CPC-A Clark PA
Nancy Ann Sheppard, CPC-A Hermitage PA
Gloria A Itjen, CPC-A Milford PA
Laquesha C Garland, CPC-A Philadelphia PA
Jernine Racquel Le Gendre, CPC-A Seven Valleys PA
Karla Diane Sinocruz, CPC-A Bel-Air Village PHI
Jeremias Tel-e, Jr, CPC-A Bel-Air Village PHI
Grace Ann Mag-apan Caloza, CPC-A Makati City PHI
Irish Respuesto Dequito, CPC-A Makati City PHI
Karen Ann Uriarte Ty, CPC-A Makati City PHI
Dawn Marie Virtudez, CPC-A Makati City PHI
Brenda Melone, CPC-A Cranston RI
Carol Ullrich, CPC-A Cranston RI
Lauren Silva, CPC-A East Providence RI
Carmen Lourdes Arroyo, CPC-A Providence RI
Susan Pires, CPC-A Providence RI
Diane M Alves, CPC-A Warren RI
Terry J Smith, CPC-A Campobello SC
Barbara Austin, CPC-A Columbia SC
Joanna Baird, CPC-A Goose Creek SC
Thywann Scott, CPC-A Hollywood SC
Julie Ann Bee, CPC-A Lexington SC
Wendy Sullivan, CPC-A Little River SC
Tina Catalano, CPC-A Myrtle Beach SC
Landa Fire, CPC-A Myrtle Beach SC
Barbara Oesterlin, CPC-A Myrtle Beach SC
Carl Pierce, CPC-A Myrtle Beach SC
Peter Davidyock, CPC-A Pawleys Island SC
Sherry L Morrison, CPC-A Pawleys Island SC
Jessica Jackson, CPC-A Rock Hill SC
Vera Wade, CPC-A Antioch TN
Candy Mertie, CPC-A Brentwood TN
Melissa Dawn Timmons, CPC-A Chapel Hill TN
Suzanne M Christoffer, CPC-A Clarksville TN
Beverly Hearn, CPC-A Clarksville TN
Shelia Mcdaniel, CPC-A Columbia TN
Ronda Pope, CPC-A Columbia TN
Maurita Roland, CPC-A Cordova TN
Jocelyn F Jones, CPC-A Johnson City TN
John Hanna, CPC-A La Vergne TN
Susan White, CPC-A La Vergne TN
Darlene Elaho, CPC-A Memphis TN
Brittany Hendrix, CPC-A Milan TN
Leigh Keathley, CPC-A Milan TN
Larissa Kelley, CPC-A Milledgeville TN
Robin Burch, CPC-A Mt Juliet TN
Kyon D Adams, CPC-A Nashville TN
Regina Reed, CPC-A Nashville TN
Telisa Harville, CPC-A Savannah TN
Beverly Ross, CPC-A Thompson Station TN
Sharlene Claytor, CPC-A Allen TX
Amy Wiedeman, CPC-A Azle TX
Jan Corrine Andrews, CPC-A Dallas TX
Kathy Lyon, CPC-A Dallas TX
Nelsy Mojica, CPC-A Dallas TX
Nawana LaFaye McCoy, CPC-A Desoto TX
Joanna Linda Conway, CPC-A El Paso TX
Candace Michelle Dominguez, CPC-A El Paso TX
Marisol Elizabeth Munoz, CPC-A El Paso TX
Anthony Manuel Silva, CPC-A El Paso TX
Tabitha Ann Emmitte, CPC-A Houston TX
Gina Renee Garcia, CPC-A Houston TX
Kay L McGraw, CPC-A Houston TX
Anly Nguyen, CPC-A Houston TX
Ahmed Omar, CPC-A Houston TX
Gloria Humphries, CPC-A Katy TX
Kimberly Tanner, CPC-A Katy TX
Prince Thomas, CPC-A Lewisville TX
Anna Cheyenne Davenport, CPC-A Lubbock TX
Melinda Ramos, CPC-A Lubbock TX
Hina Yousuf, CPC-A McKinney TX
Brandy Carpenter, CPC-A Melissa TX
Kimberly Hamilton, CPC-A Mesquite TX
Jennifer Hudgeons, CPC-A New Braunfels TX
Sijo Augustine, CPC-A Pearland TX
Jacquelyn Howell, CPC-A Pearland TX
Mozhdeh Asadidezfouli, CPC-A Plano TX
Nancy Ellis, CPC-A San Antonio TX
Ann E Potter, CPC-A San Antonio TX
Delilah Miriam Nunez, CPC-A San Elizario TX
Jill Eisnaugle, CPC-A Texas City TX
Lori Slack, CPC-A The Colony TX
Holly Moore, CPC-A Victoria TX
Lyndsey Ampuero, CPC-A Midvale UT
Annalise Arnold, CPC-A Salt Lake City UT
Somer Moser, CPC-A Salt Lake City UT
Frederic Mugiraneza, CPC-A Salt Lake City UT
Stephanie M Wade, CPC-A South Jordan UT
Melissa DeMaranville, CPC-A Taylorsville UT
Mandeara Frye, CPC-A Taylorsville UT
Saundra B Pegnato, CPC-A Taylorsville UT
Pamela Morales, CPC-A Tooele UT
Vicki Morales, CPC-A Tooele UT
Jenny Gunn, CPC-A West Jordan UT
Jean Wilson, CPC-A West Jordan UT
Ibtissam El Fajri, CPC-A West Valley UT
Anjalia Magdaleno, CPC-A West Valley UT
Sonya Mitchell, CPC-A West Valley UT
Ann Clark, CPC-A Alexandria VA
Amanda Galitz, CPC-A Blacksburg VA
Henriette Azimi, CPC-A Burke VA
Margaret Massey, CPC-A Centreville VA
Tiffany Sisson, CPC-A Lively VA
Renee Washington, CPC-A Lynchburg VA
Aimee Akers, CPC-A Norfolk VA
Eugene G Colden, CPC-A Richmond VA
Bruce Croskery, CPC-A Springfield VA
Tonya McGraw, CPC-A Stafford VA
Elaine Lankford, CPC-A Suffolk VA
Danielle Charlebois, CPC-A Williston VT
Tamara Hardy, CPC-A Camas WA
Tricia Hendrickson, CPC-A Newport WA
Wendy O'Neil, CPC-A Puyallup WA
Navita Puri, CPC-A Sammamish WA
Melanie Moody, CPC-A Spokane WA
Denise Paulson, CPC-A Spokane WA
Debbie L Tysel, CPC-A Spokane Valley WA
Kerrie Brugato, CPC-A Vancouver WA
Catherine Grayson, CPC-A Vancouver WA
Stephanie Boley, CPC-A Washougal WA
Debra Marie-Shay Anderson, CPC-A Holmen WI
Cali Ann Kline, CPC-A Holmen WI
Shari Arndt, CPC-A Janesville WI
Timothy Solles, CPC-A Janesville WI
Connie L Clements, CPC-A LaCrosse WI
Bruce J Steinhoff, CPC-A LaCrosse WI
Erica Schloesser, CPC-H-A Madison WI
Erika Wahl, CPC-A New Berlin WI
Andrea Janette Modlin, CPC-A West Salem WI
Lori J Peters, CPC-A West Salem WI
Nancy Stanton, CPC-A Charleston WV
Dawn K Selbe, CPC-A Winfield WV

Specialties

Deborah Jeanne Braswell,
CPC, CEMC APO AE
Thomas Holzberger,
CPC, CEMC APO AE
Kathy Floyd,
CASCC Mesquite AE
Kimberly Koi Kerckhoff,
CPC, CUC Anchorage AK
Mark Maldia,
CEMC Birmingham AL
Susan E Pedota,
CPC, CGSC Birmingham AL
Edna Carol Hurt,
CPC, CEMC Brilliant AL
Catherine Burton,
CPC, COSC Selma AL
Angie Lam,
CPC, CEMC Daly City CA
Linda Hinkle,
CPC, COBGC Vista CA
Gina D Belafonte,
CPC, CPC-H, CGSC, COSC Denver CO
Patricia Kresch,
CPC, CPC-H, CPMA, CCC Denver CO
Machelle Morningstar,
CPC, CPC-H, CEMC, COSC Washington DC
Barbara J Daigle,
CPC, CASCC Boca Raton FL
Joni Moreno,
CPC, CEDC Cape Coral FL
Jennifer Buxton,
CPC-A, CEMC Fort Lauderdale FL
Jennifer Lynne Godreau,
CPC, CPMA, CPEDC Naples FL
Kimberly Hollins,
CPC-A, CPRC Palm Coast FL
James Burke,
CASCC Tallahassee FL
Jodi Mazzone,
CPC, CPMA, CEMC Weston FL
Robin Via,
CPC, CANPC Augusta GA
Kim-Marie Walker,
CPC, CCVTC Dallas GA
Helen Royals,
CPC, CPCD Marietta GA
Megan Massner,
CCC Mediapolis IA
Sarah Dargis,
CPCD Arlington Heights IL
Karen Bartrom,
CPC, CEDC, CEMC Carmel IN
Stephanie Jill Meierant,
CPC, CHONC Olathe KS
Lena Gail Holbrook,
CPC, CCVTC, CEMC Brodhead KY
Dana Abney,
CPC, CEMC Clay City KY
Sheila Proffitt,
CIMC London KY
Toni McDaniel,
CEMC Mayfield KY
Rebecca L Clark,
CPC-A, CEMC Somerset KY
Steve Young,
CPC, CANPC Middletown MD
Leslie M Tibbetts,
CPC, CEDC Bar Harbor ME
Lynn Girouard,
CPC, CPEDC Lewiston ME
Kelly J Olsen,
CPC, CHONC Lewiston ME
Harland Bruce Redmond,
CPC, CGIC, COSC Old Orchard Beach ME
Susan Olsen,
CPC, CEDC Portland ME
Jessica Dufault,
CPC, COBGC Sabattus ME
Kathleen M Muma,
CPC, COSC Grand Rapids MI
Kristi A Rickert,
CPC, COSC Grand Rapids MI
Toni Rysdyk,
CPC, COSC Grand Rapids MI
Andrea C Webb,
CPC-A, COBGC Grand Rapids MI
Darla Timmerman,
CPEDC Hastings MI
Robyn Mileski-Iacoangeli,
CPC, CHONC Monroe MI
Cheryl Ann George,
CPC, CEMC Roseville MI
Deanna M Zimpel,
CIMC Brooklyn Center MN
Peggy Price,
CCC Farmington MN
Cheryl A Kluge,
CIMC Forest Lake MN
Jolene Sheppard,
CCC Mankato MN
Summer D Hunsaker,
CCVTC Brighton MO
Angelina Hamilton,
CPC, CEMC Crocker MO
Amie M Snelling,
CPC, CCVTC Linn Creek MO
Sheryl P Miller,
CCC Horn Lake MS
Kristina Erika McNary,
CPC, CANPC New Albany MS
Angelica M Stephens,
CPC, CPC-H, COSC Albuquerque NM
Vicki Davis,
CPC, CGIC Horseheads NY
Therese Warren,
CPC, CPMA, CGSC Avon OH

Melissa J Landrum,
CEDC Chesapeake OH
Emily Morrill,
CPC, CASCC Cleveland OH
Valerie Albert,
CPC, CUC Norman OK
Brenda J Petit,
CPC, CCC, CFPC Sioux Falls SD
Julie A Terveen,
CPC, CIMC Sioux Falls SD
Rhonda L Fletcher,
CPC, CPMA, CENTC, CFPC Church Hill TN
Kelley L Clark,
CPC, CEMC Decatur TN
Tracey Lee Champion,
CPC, CEMC Hillsboro TN
Cindy Haugen,
CPC, CCC Memphis TN
Drucilla A Luna,
CPC, CCC Memphis TN
Stacy J Vanderslice,
CPC, CHONC Dallas TX
Katrina M Moultrie,
CPC, CFPC, CPEDC Fort Worth TX
Dayse Orellana,
CGIC Fort Worth TX
Andrea Peters,
CPC, CHONC Rowlett TX
Andrea Peters,
CPC, CHONC Rowlett TX

Diana Wright-Lathem,
COSC Sugar Land TX
Helene M Dursteler,
CPC, CASCC Salt Lake City UT
Jacqueline V Roberts,
CPC, COSC Chesapeake VA
Christine Ann Oetman,
CPC, CPC-H, CEMC Newport News VA
Lisa Dawn Meredith,
CPC, CEMC Rural Retreat VA
Jennifer M Curley,
CPC, CCC Cambridge VT
Rebecca House,
CPC, CPMA, CGIC Spokane WA
Lenora Rodes,
CPC, CANPC, COBGC Madison WI

Magna Cum Laude

Ashlee Nicole Garner,
CPC-A Enterprise AL
Gretchen Johnson,
CPC-A Foothill Ranch CA
Neelima Yerneni,
CPC-A Irvine CA
Kerry N Menth,
CPC, CPC-H Temecula CA
Ingrid Moore,
CPC Templeton CA

Hassan M Alkhouli,
CPC-A, CPC-H-A Westminster CA
Barbara Ryan Morris,
CPC-H Apopka FL
Jennifer Parramore,
CPC-A Cape Coral FL
Shelley Fiorini,
CPC Delray Beach FL
Pablo Vazquez,
CPC-A Largo FL
Laura Hammett,
CPC-A New Smyrna Beach FL
Rachel Dyer,
CPC-A St Petersburg FL
Kathleen OHara,
CPC Sunrise FL
Christine Monk,
CPC-A Ellijay GA
Jennifer Burkett,
CPC Divernon IL
Aimee Eby,
CPC-A Pawnee IL
Bonnie Linn Pollock,
CPC-A Pekin IL
Tonya N Hill,
CPC-A Taylorville IL
Marsha Kochenour,
CPC-A Fort Wayne IN

Marcia Moore,
CPC, CASCC, South Bend, IN
Lee Ann Clark,
CPC Lexington KY
Michelle Renee Leininger,
CPC Lexington KY
Alexander Georges,
CPC-A Needham MA
Carla M Nadeski,
CPC-A Westborough MA
Sharon Francis,
CPC Rockville MD
Jeffrey A Wilson,
CPC, CPC-H Silver Spring MD
Karen Hall,
CPC Swanville ME
Nancy Mousseau,
CPC Alpena MI
Beth Skaggs,
CPC Canton MI
Mary Anita Tujaka,
CPC-A Grosse Pointe Farms MI
Kristen Leigh Graham,
CPC-A Wyoming MI
Maria Clark,
CPC-A Rogers MN
Jayne Anthony,
CPC Raleigh NC

Megan Lynn Kielman,
CPC-A Minot ND
Brandie Bazal Ulland,
CPC-A Minot ND
Gail Rounds,
CPC, CPC-H Bordentown NJ
Amanda M Grzeskowiak,
CPC Flanders NJ
Kimberly Romero,
CPC-A Rio Rancho NM
Heather Lynn Ertel,
CPC-A Amelia OH
Susan Michelle Baty,
CPC-A Canby OR
Rebecca Coleman,
CPC-A Nashville TN
Robert Pachciarz,
CPC, CPC-H Smyrna TN
Maryanne Peterson,
CPC-A Springfield TN
Tracey Engel,
CPC Waxahachie TX
Maureen McDaniels,
CPC-A Weatherford TX
Kaye F Reynolds,
CPC Orem UT
Sarah Hlavinka,
CPC-A Stephens City VA

ICD-10-CM
Analyze Productivity, Build Speed and Confidence

Analyze Productivity, Build Speed and Confidence

Learn how to increase the amount of charts you'll code in ICD-10

By Corrie Alvarez, CPC, CPC-I, CEDC

The United States is one of the last countries to adopt ICD-10-CM code sets, which is scheduled to occur Oct. 1, 2013. We can use this lag time to learn from other country's implementation lessons and experience a smooth transition with few surprises.

For example, when Australia adopted ICD-10 in 1999, the country suffered an unexpected productivity loss as high as 25 percent, which did not return to normal levels until six to 12 months after implementation. Imagine what a 25 percent loss in productivity that endured six to 12 months would mean for your practice today. An awareness of this likely impact and a solid plan to deal with it will ensure your practice survives ICD-10 implementation rather than become a casualty of war.

Evaluate Productivity

Every practice needs to evaluate productivity. How else are we to know how to budget or determine staffing models? How else can we establish expectation levels for our staff?

Let's begin by looking at how to develop a good sound productivity model. Every model begins by determining the inputs. In the coding world, this is the different type of source documents received for coding. You may receive electronic or paper documents, handwritten or transcribed. You also may want to divide records by specialty or claim type. For example, evaluation and management (E/M) documents could be one category, radiology reports could be another, etc. Different services take different skill sets to code. For example, an E/M encounter probably would take more time to measure and code than a routine X-ray. Each type and/or grouping should be listed separately to evaluate its significance to your productivity model.

Once you have categorized the different inputs, you need to understand how each one is handled. A flow chart is useful for a good overview, but a written procedure is critical. If you do not have these documents, ask the staff to explain the process. Then create a flow chart (your visual tool) and a standard operating procedure (your written tool). There are several software programs you can use to create flow charts: Microsoft's Excel, Word, or Visio are a few examples. This step may take you several days if you are to represent your current procedure accurately. At this point (however tempting it may be), try not to make any changes. Determine your baseline as it is. Later, when you're ready to make improvements, you can measure the difference. This will enable you to capture your savings.

Next, follow the flow chart and actually observe the coders in action. Watch at least two or three coders work with each input type (E/M services, lab services, etc.). Make sure you also time all action steps. This will be important for measuring the baseline.

During this step, you're likely to find varying degrees of adherence to the standard operating procedure (SOP). Some variations may be valid. During my audits, I have found employees develop process shortcuts. Most were great process improvements but, unfortunately, often were not shared with the entire group. Other variations may not be valid. It's important to identify both, so the procedure can be changed to reflect learned efficiencies, or to correct problems.

Keep in mind: This process can be very intimidating for staff. When meeting with them, emphasize that you are not there to point out their faults or deficiencies. Rather, stress that this is an important step to implementing ICD-10. This will help place staff at ease and make the task more pleasant.

... when Australia adopted ICD-10 in 1999, the country suffered an unexpected productivity loss as high as 25 percent, which did not return to normal levels until six to 12 months after implementation.

Determine Productivity Baselines and ICD-10's Impact

Once your observations are complete, re-evaluate the current process and make the necessary changes. At this point, record the productivity for each input type. When counting the documents completed per day, evaluate several different days over two to three weeks. Then average the production per day. Make sure you subtract any down time. Obvious down times are scheduled breaks (20-30 minutes per day) and staff meetings.

These steps are important for developing baselines. Without these baselines, you cannot determine the impact ICD-10 will have on productivity.

Once you've determined a baseline, the next step is to determine how much ICD-10 will impact productivity. One option for doing this is to take the work done on the prior day and have a trained ICD-10 coder from your group code the same charts again using ICD-10. Record the time the ICD-10 coder takes to complete the same amount of work your ICD-9 coder did the previous day. Repeat this process for several days to obtain an average. During this step, you may want to point out any documentation deficiencies you uncover to the team assigned to improving ICD-10 documentation. An increase in physician queries will impact productivity and create a backlog, so working closely with the documentation improvement team will benefit everyone.

Now is the time to make process improvements. Make the changes, re-measure using time studies, document the difference, and document savings. Don't forget to update flow diagrams and change standard operating procedures. Follow up in a few weeks to make sure your changes are still in use. Sometimes, old habits are hard to break.

Bridge Gaps in Your Productivity Model

Once you have documented the time differences, you'll need to create a productivity model. You will have to meet with the finance team to determine how you might bridge the gap. For example, you might offer overtime, and/or hire some temporary staff. When hiring temporary staff, you will need to decide how to utilize them best. For example, you might have them work on the ICD-9 backlogs while your team works on ICD-10.

If you plan to hire temporary staff, give yourself plenty of lead time. Train them on your system for at least 45 days before the implementation date. This also will give your current coders some time to practice their ICD-10 coding. Coders should practice taking several charts they have coded in ICD-9, and then code them in ICD-10. This should begin at least 120 days prior to implementation. Increase the amount of charts coded in ICD-10 each week. This will help them build both speed and confidence.

Creating a good productivity model takes a lot of time and effort. Start early and you will not only reap the benefits of your hard work but also prevent some of the productivity impacts others have encountered after transitioning to ICD-10.

Remember: The first six to 12 months will be a critical time for us all. Being well-prepared will be the key to a successful implementation.

Corrie Alvarez, CPC, CPC-I, CEDC, has 25 years of professional experience in the field of medical coding, auditing and practice settings. In 1998, Corrie obtained her teaching credential and started teaching medical billing and coding courses for the Los Angeles School District. She is also an approved instructor for the AAPC's PMCC course. Corrie is the founder of the Mission Hills, Calif. chapter and has held several officer positions. Corrie holds a bachelor's degree from California State University, Northridge.

Avoid the Dark Side of EHR Documentation

Don't let the point-and-click mentality entice your time-pressed provider

By Holly J. Cassano, CPC

Electronic health records (EHRs) promise to make the patient chart more inclusive, more legible, and faster to document. These advantages alleviate many of the headaches of paper charting. On the flip side—or the "dark side," as I call it—the ease with which EHRs allow time-pressed providers to add information to the medical record, or to bring forward information from a previous note, can lead to an uncritical point-and-click mentality.

For instance, most EHRs incorporate tools with defaults such as "reviewed past, family, and social history," designed to help the provider document more effectively and efficiently. But audit findings show these functions are not always indicated, or even performed, at each visit. If the provider does not review the record and make corrections to the default information, the EHR won't reflect the true nature of the patient's condition.

Point-and-click Can Lead to Documentation Danger

Inaccurate documentation poses obvious and very serious health dangers for the patient. More often, however, problems arise not because a provider diagnoses or prescribes incorrectly, but because inaccurate documentation leads to coding or compliance errors, which lead to audits and charges of abuse or fraud.

For example, with EHRs now the norm for the majority of medical providers and institutions, excessive documentation—rather than insufficient documentation—often is the problem. An EHR allows the physician to literally point and click through bullet points and other pertinent criteria, unwittingly navigating to a higher service level than is justified based on the nature of the presenting problem. Such documentation may add up to a high-level service based on bullet points, but fall short on medical necessity. Medical necessity—not medical decision-making (MDM) or any other component of an evaluation and management (E/M) service—ultimately drives coding.

The *Medicare Claims Processing Manual*, chapter 12, section 30.6.1 (www.cms.gov/manuals/downloads/clm104c12.pdf) defines medical necessity as "… the overarching criterion for payment in addition to the individual requirements of a CPT® code," while warning that the sheer volume of documentation shouldn't influence E/M leveling:

"It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

Coders who often complain about too *little* detail might think there's no such thing as too much documentation. But consider this blog post by an emergency department (ED) nurse (http://ermurse.blogspot.com/2007/10/templated-charting-sslippery-slope-to.html):

"The other day at work I was taking care of a patient that was in an MVC. She was in spinal precautions and complained of neck and leg pain. Our ED Physician came in and did his exam from the doorway holding his Tablet PC, marking off items into the Electronic T-sheet while he asked a few basic questions. He was in and out in less than a minute. Out of curiosity, I reviewed his documentation and not surprisingly there was a comprehensive assessment documented. Abdominal findings, lungs sounds, heart sounds, pupils and ocular movements, neuro exam, all beautifully documented in a long paragraph and all normal. Not bad for an exam conducted from the doorway. The same physician had the same general exam pattern on most of his patients and the same comprehensive documentation of his exams."

This is a good example of the point-and-click mentality. I would venture to say this is the exception and not the rule for providers. But, in my 14 years in this industry, fraudulent and abusive activity has crossed my path on a few occasions. If you encounter this type of behavior at your practice or facility, address with your compliance department immediately.

Cloning Gains OIG's Attention

A related concern, touched on in the aforementioned blog post, is documentation *cloning*. Centers for Medicare & Medicaid Services (CMS) contractors have been monitoring supporting documentation of E/M services, and have noticed among EHR users a high volume of records with identical documentation across services. In other words, information from previous encounters is brought forward without updating, which brings into question the validity of the entire service.

Office of Inspector General (OIG) statistics state that Medicare paid $25 billion—19 percent of all Medicare Part B payments—for E/M services in 2009 (see: www.fierce-

The results of a recent CMS study suggest the OIG will find plenty of E/M documentation problems among EHR users.

practicemanagement.com/story/oig-2011-work-plan-sends-physicians-back-basics/2010-10-05). Numbers like these get the OIG's attention. Documentation problems like the aforementioned examples have earned special attention in the OIG Work Plan, which states, "We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records [EHR] documentation practices associated with potentially improper payments" (http://oig.hhs.gov/publications/workplan/2011/FY11_Work-Plan-All.pdf).

The results of a recent CMS study suggest the OIG will find plenty of E/M documentation problems among EHR users. CMS audited four practices utilizing EHRs, reviewing 20 to 100 charts per physician. Twenty to 90 percent of the charts failed the audit. In the practice with the lowest failure rate, each physician had to repay $50,000. At the other practices, physicians repaid $150,000 to $175,000 each (www.modernmedicine.com/modernmedicine/article/articleDetail.jsp?id=590411&pageID=1&sk=&date=).

The seriousness of coding and compliance errors continues to rise as the stakes get higher for physicians. The OIG has defined health care fraud as an "intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party." Changes brought about by health care reform, including new language under the Health Insurance Portability and Accountability Act (HIPAA), now argue that fraud occurs when an individual knows or should have known about improper practices. The language change shifts responsibility to those submitting claims, and assumes that providers have a due diligence obligation to identify and prevent fraud proactively (www.morganlewis.com/pubs/FraudAbusePrgmIntegrityProvisions.pdf). Providers, practices, and facilities will have to be more vigilant than ever to avoid accusations of fraud if coding and compliance errors are uncovered during a payer audit.

Fight the Good Fight

Knowing the problem areas of EHR E/M documentation and what's at stake, how do we avoid the dark side?

- **Care and vigilance when clicking through the templates** – Take your time: The chart you are documenting may be the one you will be called on to defend on the witness stand.
- **Limit the copy and paste functions** – In an audit, copy and past functions can be perceived as cloning. Copy and paste also risks introducing documentation errors. As often as is possible, document in your own words.
- **Review, review, review before closing notes** – I can't stress this enough: Check the meds, the test results, and all interventions with the patient; and make sure that you are in agreement with the story you have depicted of the patient's encounter. Once you close the note, your only option for a correction is an addendum.
- **Addenda only pertinent clinical information, not just revenue based information** – Do not get into the habit of adding documentation to support a higher service level unless the documentation is reflective of medical necessity (e.g., adding information on radiograph interpretations or documenting medication or other interventions that can boost a visit level should be done at the time of service to reflect the presenting problem's severity).
- **Document your own notes** – Do not clone from other providers.

Coding Edge—sidebar

Watch for EHR E/M Documentation No No's

When using EHRS, here are the primary E/M documentation pitfalls to avoid:

- Templates and billing driving care and charting
- Point-and-click mentality vs. accurate and ethical documentation
- Copy and paste forward
- Charting for services that were not performed: use of default entries
- Documentation cloning
- Negatives listed vs. positives—hard to discern what is wrong with the patient
- Failure to review available information
- Inaccurate charting
- Addendums for increased reimbursement vs. for patient care
- Relative value unit (RVU)-driven care
- Signing of notes without reading them
- EHR revealing bad practice patterns

... with EHRs now the norm for the majority of medical providers and institutions, excessive documentation—rather than insufficient documentation—often is the problem.

- **Discuss EHR concerns with coders and compliance professionals at your facility/practice** — If you notice a deficiency, such as an incorrect ICD-9 or CPT® code that auto-populates, or verbiage that populates a field that is inconsistent with the review of systems (ROS) or the exam, be sure to alert the appropriate staff to have the problem corrected.
- **Review audits and documentation deficiencies to maintain compliance** – At minimum, auditing should be done annually. However, a good coder will review every record from an auditing perspective before assigning codes to ensure that the record is accurate.

For example: A patient presents to the ED with a chief complaint of acute abdominal pain. The HPI states that the pain severity is mild, and in the ED it is gone. The record claims that the patient has never had these symptoms before. The record further states there has been no constipation or additional symptoms. The ED doctor indicates that he reviewed the nurse notes and then moved onto the exam. The exam reflects that the abdomen is soft and non tender with no palpable masses, no guarding. The ED physician then orders an EKG, chest X-ray, full labs, a CT of the abdomen with contrast, a CT of the pelvis with contrast, a KUB, a pelvic sonogram, and gives morphine, Dilaudid, zofran®, and saline as the medication interventions. In the radiographs, it is noted that the colon is full with stool, indicating a mild fecal impaction. A review of the ED nurse note indicates that the pain level is six out of 10 and is burning, that the patient has had nausea and vomiting, that the patient has had these symptoms before, and that the patient has guarding of the lower left abdomen.

The clinical impression states: acute abdominal pain

The patient is discharged home and given a prescription for Colace® and Vicodin, and told to follow up with an appointment with Dr. Gastro.

As we look at this record, we see several obvious problems:

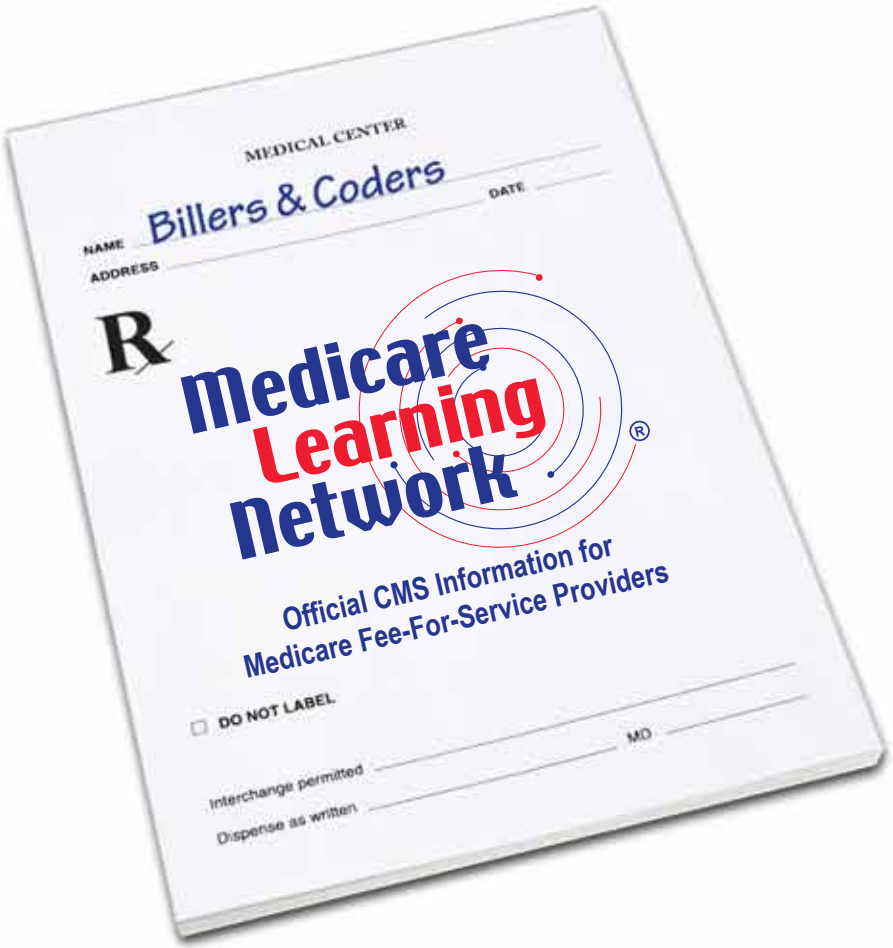
- The severity of the problem indicated in the HPI (history of presenting illness) does not support the tests and interventions ordered; this undermines medical necessity.
- The record contradicts itself, stating both that the patient has and has not experienced these symptoms before.
- The exam indicates that the abdomen is within normal limits, which also suggests a lack of medical necessity for the interventions ordered.
- The ED physician claimed to have reviewed the triage registered nurse's notes, but if this was so, he would have seen that the patient presented with acute pain, nausea, vomiting, and guarding of the lower left quarter, which would support an acute abdomen workup in the ED.
- In the clinical impression, the final diagnosis code is indicated as "acute abdominal pain," but acute pain has not been indicated in the ED physician's documentation (it is indicated in the nurse's notes, but you can't code from that). Lastly, the radiographs reflect a mild fecal impaction, which is not indicated in the clinical impression.

This visit, based on the interventions and workup, may qualify as a high-level ED visit (e.g., 99285 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity*). Unfortunately, the ED physician's documentation is not supportive of either this coding or the workup provided. More than likely, the ED doctor clicked-through the HPI and the exam and other pertinent areas out of habit and thereby missed documenting the correct information in the chart.

As a coder, it's your responsibility to speak to the ED doctor about inconsistencies in the record. EHRs are great tools, but used carelessly they can lead to the dark side. To bullet proof documentation in the event of an audit, it's imperative for the provider to document in an EHR the true clinical picture and correlating E/M level supported by medical necessity for appropriate level assignment and to lessen the potential for errors in patient care.

Holly J. Cassano, CPC, has been involved in practice management, coding, auditing, teaching, and consulting for multiple specialties for the past 14 years. She served two terms as an AAPC local chapter officer and has written several articles for Just-coding.com and writes a monthly column devoted to fighting fraud for *Advance for Health Information Professionals*. She is the coder and physician educator for the emergency room physicians/bariatrics at the Cleveland Clinic Florida.

Billing and Coding Questions?
Medicare Reimbursement Concerns?



Get The Official Answers.

You can find plenty of answers to your Medicare questions. Find the **accurate** ones from the Centers for Medicare & Medicaid Services' (CMS) Medicare Learning Network® (MLN). Get nationally consistent, accurate, timely and free information that will help providers correctly submit claims the first time. Please visit our website today.

http://www.cms.gov/MLNGenInfo

Job Hunting *Confessions* of a CPC-A

Consider the doors you open when you sign up for Project Xtern.

By Brianne Rivera, BA, CPC

For the past six months whenever I ran into someone I knew, many of the conversations began similar to this:

"So, what do you do for a living?"

My reply was: "I'm an extern."

"You work for free?!" came the astonished gasp of horror.

"I work for the gold that is experience. For a beginning coder, experience is worth more than money."

And that, fellow coders, was a day in the life of myself, a former apprentice.

Rocky Career Path Needs Stability

I didn't always want to be a coder. In fact, coding came to me. I struggled right out of college: I had a bachelor's degree in one hand and the skills to work in commercial radio in the other. Unfortunately, I graduated around the time of the digital revolution.

"We have computers to do what you went to school to learn," said more than one program director in response to my resume.

I eventually landed a job at a major radio station, but was let go during the economic crises. Feeling pretty glum about my job predicament, I decided my career needed stability. Seeking a total change from commercial radio, I applied to a temp agency. They immediately placed me in the Medicaid call center of the largest health care organization in Tennessee. It was there I learned all about the Health Insurance Portability and Accountability Act (HIPAA), different types of insurance, Medicare, and anything else you would want to learn about the business side of medicine.

Here's When Coding Enters the Equation

One day, I received a call from a provider who began spewing numbers and letters at me. Completely confused, I asked what they meant.

"They're called CPT®, ICD, and HCPCS codes," the woman said, and proceeded to explain how the coding system worked.

Fascinated, I began to study the coding system on my own time.

My job at the Medicaid call center ended just as the economy began to fizzle. Knowing the job market for media was not the best route to take again, I signed up for a Certified Professional Coder (CPC®) certification course at Doctors Management, a local coding company.

In just a few short weeks, my brain was stuffed with information about insurance and medical coding. Feeling confident, I signed up for the CPC® exam right away. I passed the exam (on the second try) in March 2010, hearing the news just a few days after my birthday. "What a gift!" I thought.

Feeling confident, armed with a CPC-A and coding knowledge, I set out on the job trail only to hit a brick wall. Employer responses such as, "You have almost no experience," and "We can't hire you if you don't have more than two years experience," were commonplace. Déja vu!

I quickly discovered that the coding field was just as hard to get into as radio. My head filled with questions. Did I need to know the secret code (pardon the pun) to get my foot in the door?

Look for Options to Overcome Obstacles

I went online to AAPC's website and researched Project Xtern. There were absolutely no participating health care practices in my area. The closest externship site was about 500 miles away; and knowing that it probably wasn't a paid externship, I didn't want to pack up and move.

Feeling dejected, I resumed sending feelers to every doctors' office I could find. "You need experience," was the familiar reply. "Once you have experience, then we'll talk."

Then, sitting at my computer one Saturday morning, I logged onto AAPC and clicked on "Project Xtern: Get Experience." Bingo!

Will Leap Over Tall Buildings

Hovis Orthopaedic Clinic flashed like a neon sign on my screen. I immediately clicked on the provided e-mail address and rushed my resume to the designated person. A few days later I was asked to schedule an interview. I was more than thrilled. After a few e-mails back and forth, I sat down with **Dawn Amato, CPC**, the billing manager at the office.

A week later, I was formally signed on as the first coding apprentice Hovis Orthopaedic Clinic had ever had.

Life as an Xtern

The first few weeks were nerve racking, as any new job would be. I had no clue what programs such as Code X or Centricity were used for, and I was confused by Navicure and the claims clearinghouses.

For the first month or so, I sat next to Dawn as she used her expertise to guide me through the billing procedures. She watched as I diligently took notes on everything she said. (I must have gone through three pads of self-stick notes, which I stuck to the wall above my desk in neat rows for easy reference.) By week six, I was in the driver's seat, entering surgical claims for doctors and physician assistants. There were times when I threw up my hands in utter frustration. But Dawn was there every step of the way to point me in the right direction. She never let any of my work leave that office without auditing it first.

By month two, I was given more responsibility in addition to coding and entering surgical charges. I began charge entry for the doctors and the physical therapy department. One day, Dawn asked me if I would like to learn how to post payments. I was curious about where the money goes after I write a check to my doctor, so I eagerly agreed. After just a few days, I was posting payments and adjusting balances for patients and insurance companies. I think payment posting is the most enjoyable aspect of a doctor's office, and I find it quite relaxing.

My third month had drawn rapidly to a close, and Dawn asked if I wanted to continue my apprenticeship with Hovis. I jumped at the chance and resumed entering charges and posting payments from my little corner desk. To make me well-rounded in the billing department, Dawn added a new challenge to my experience: aging accounts receivable (A/R) and insurance calls.

The first calls I made were scripted and very novice. Dawn would listen in and write down what I needed to say and which questions I needed to ask. If she felt the need, she would step in and speak to the agent at the other end of the line while I listened on speaker phone. Eventually, I felt confident enough to speak with the agents myself, with minimal to no assistance from Dawn.

By month five, I was doing some of the A/R on my own, only asking for assistance when necessary. I learned the lingo of the insurance company, and could find my way around worker's compensation claims and other forms of insurance. I also learned how to verify benefits and create new patient accounts.

Invaluable Experience

My time at Hovis came to an end in October 2010, but I take away from it a wealth of information and newfound colleagues. I recommend all apprentice coders consider local Project Xtern sites. If there isn't one in your area, call local providers and encourage them to be a mentor.

Good luck, and may you be given the same wonder opportunity that Hovis Orthopaedic Clinic gave to me.

Brianne Rivera, BA, CPC, is a former DJ, producer, and voice-over artist for several commercial radio stations. A New Jersey native, she is fluent in American Sign Language and German, and reads Braille. She has provided interpreting services in the physicians' office as well as the classroom setting.

Letter from a CPC-A

I'd like to share my experience in your Project Xtern program. I am currently enrolled in the Richmond, Virginia program through the Medical Society of Virginia.

I began this program three months after receiving my CPC-A designation. My instructor in the Professional Medical Coding Curriculum(PMCC) course was Rose Moore, CPC, CPMA, CPC-I, CEMC. I could not believe how she brought such humor and energy into her instruction, and as soon as I learned that she ran an Xtern program I knew I would go to any length to become her extern. It was worth the three month waiting list to get here, as I have learned countless skills and have become confident in my coding ability. Each day brings issues and questions about coding, and I have been encouraged to research and participate in every facet of this organization. My experience here has made me passionate about coding and I honestly believe this field will continue its growth to become a pivotal tool in medicine. My instructor and mentor, Rose Moore, has given me so much more than experience, she has given me a basis of knowledge that I want to expand and enrich. She has also become a dear and cherished friend.

I recently accepted a great job with a large teaching hospital and my success is due to my participation in Project Xtern. The contacts and networks made through this program as well as recommendations from my Xtern instructors generated my new career.

Having spent the last 15 years as an at-home parent, I knew re-entering the work force in challenging economic times was going to be difficult. Little did I realize that it would also be one of the most rewarding experiences of my life.

Sincerely,

Susan Satterfield Burtoff, CPC-A

Need CEUs

CodingWebU.com is the leading provider of books and online education geared towards Medical Coding and Billing.

Over 130 Approved CEUs starting from $30

Anatomy * Medical Terminology * Chart Auditing * RAC
ICD-9 and ICD-10 * E/M and OB/GYN * Specialty Coding
Interventional Radiology * Reimbursement ...and more

NOW AVAILABLE!
2011 Annual CEU Coding Scenarios

CodingWebU.com™

Providing Quality Education at Affordable Prices

(484) 433-0495 www.CodingWebU.com

AMA AMERICAN MEDICAL ASSOCIATION contexo media AAPC Find us on Facebook

PUZZLED BY YOUR NEXT CAREER STEP?

NAMAS GETS YOU THERE**!**

Certified Professional Medical Auditor (CPMA)® Training

NAMAS has the missing piece to help you move into your successful career as an auditor. Bring more value to your practice and increase your earning potential!

Instruction from the only AAPC-Approved CPMA® Trainer

- Receive expert training and preparation for AAPC's CPMA examination
- Enhance your career with auditing and compliance knowledge
- Build your skills in Auditing Abstraction, E/M, Surgery, and more
- Review of Vital Medical Record Documentation and Guidelines including RAC, CERT, MIC and ZPIC Audits
- Learn Scope and Statistical Methodologies
- Learn how to effectively communicate results and educate providers

Classes available nationwide!

Visit www.NAMAS-auditing.com
Or call 877-418-5564

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS
NAMAS

AAPC CEU APPROVED **Exam schedules at www.AAPC.com**