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- Bipolar Disorder
- Virtual Teams
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Two years ago, when I began my role as president of AAPC’s National Advisory Board (NAB), I put out a challenge to all members: Look at where you are in your career, and decide where you would like to be. AAPC heard my challenge, and upped the ante in its efforts to provide valuable resources to members. Whether you have yet to take the challenge, or it’s time to reassess, AAPC can help you to meet, or even exceed, your goals. Consider these resources as you set along the path to success.

Conference
Local, regional, and national conferences offer fantastic educational experiences, which are sure to boost your career.

We had such an incredible turnout at HEALTHCON in Las Vegas this year. I was overjoyed to hear so many members talk about how they are taking their career to the next level. Motivation was a definite takeaway!

The conference team created a speaker committee that was challenged with selecting hot topics and knowledgeable speakers for HEALTHCON. The final lineup was amazing! Based on attendee feedback, the committee exceeded expectations, and attendees were presented with invaluable information. AAPC pulled out all the stops to ensure attendees left conference feeling like winners with an upper-hand advantage in a competitive job market.

Free Online Resources and Tools
When not at conference, be sure to access AAPC’s website, which houses essential reference materials and tools designed to help you navigate through your work day. The NAB worked with AAPC to create a host of tools they could offer members at no additional cost. Look for these free or low-cost materials and tools under the “Resources” tab in the Coding/Billing Solutions section at www.aapc.com:

- Code Lookup with AAPC Coder
- Coding Data Files
- ICD-9 to ICD-10 Code Converter
- Other ICD-10 Codes/Resources
- CPT® codes
- HCPCS Level II codes
- E/M Analyzer
- CPT® RVU Calculator
- Risk Adjustment Search
- Health Plan/Provider Policy Search
- MACRA Calculator
- Denied Claims Calculator

Whether you have yet to take the challenge, or it’s time to reassess, AAPC can help you meet, or even exceed, your goals.

Get on Track for a Successful Career
Whether it’s online or in person at an event, AAPC strives to get you on track and keep you there. But you must choose your own track. What are you waiting for? Take the challenge, today! As you move forward toward your goals, remember that your NAB representatives are here for you. We’ve got your back!

Take care,

Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC, AAPC Fellow
President, National Advisory Board

Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC, AAPC Fellow
President, National Advisory Board
As an engaged woman, I was content on becoming a stay-at-home wife and mother. But then, while looking in the job classifieds one day, I realized I was not qualified for anything other than a fast food position. That prompted me into continuing my education.

I made an appointment with a technical institute in my hometown to learn what they offered. I knew I wanted to work in the medical field, but I wasn’t sure doing what. The institute offered Medical Assistant (MA) and Medical Office Administration and Coding (MOAC) courses, so I researched both. After talking to my fiancé and weighing the differences of each field, I went with the MOAC course. I scheduled my intake appointment, and one week later I was enrolled in an upcoming session.

Education Plans Come to a Grinding Halt

One month later, my world came crashing down on the scariest day of my life. I landed in the emergency room, fighting for life, with a fever of 106.4 degrees Fahrenheit and excruciating pain. My mother was called by the hospital to take me there right away because I was going to die if medical intervention didn’t happen immediately. A week later, I was paralyzed from the mid-waist down and unable to walk. When it hit me that I wasn’t going to be able to start school, I was devastated. I felt as if everything was taken away and I wanted to die. My fiancé, his son, and my parents were my biggest supporters. I was transferred to a rehabilitation unit to start my journey of learning how to walk and care for myself again.

Keep on Truckin’

When I was released to go home, one month later, the first thing I did was get in touch with the technical institute. What happened to me wasn’t going to stop me from reaching my goal of becoming a Certified Professional Coder (CPC®). I re-enrolled, ready to start my journey of becoming a CPC®. And I was walking!

I did everything in my power to obtain the information necessary to become a CPC®. I spent many occasions in my instructor’s office, in tears, afraid of not being strong enough and failing my exam. I failed my first mock exam and barely passed my second mock exam. I showed up for the exam, nervous and prepared for the worst. It was the fastest 5 hours and 40 minutes of my life. I felt really good about how I did on the exam, and kept a positive attitude about passing. When I got back to school, I logged onto my AAPC account, and there it was: my name, “Shana Hall,” with “CPC-A” under it. I had done it!

Everything Is Possible

Today, I am a full-time student and have earned the President’s List Award five out of the six quarters I’ve been in school.

The best advice I can offer is to never, and I mean never, give up on yourself. Only you can control your future. Nothing is impossible.
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This year’s AAPC HEALTHCON national conference proved to be everything it was promised to be—a venue to learn and teach, a forum for discussion, and place to make and renew friendships. Very little of what happened there will be left in the desert oasis (despite what Las Vegas’ advertising campaign says) because what was discussed is so important to our day-to-day work and future.

Revenue Stream’s Hub

More than 2,500 members attended the three-day event at the Rio Hotel and Casino, which included over 90 informative sessions, pre- and post-sessions, and events. Presenters spoke about all aspects of the revenue cycle, from coding to regulations, Obamacare repeal to Medicare Access and CHIP Reauthorization Act (MACRA), compliance to quality measures, and personal growth to our role in a reformed healthcare system.

That was the theme of the whole conference: It’s important to grow as professionals because we are key to the successful repair of our healthcare system.

AAPC President Bevan Erickson emphasized the opportunities for personal and professional growth in his welcoming speech. AAPC continues to look for ways to serve and empower members, he said, providing several examples. Most importantly, he asserted, it’s up to us to pursue growth through:

- Networking via local chapters, conferences, and social media;
- Continuing education opportunities AAPC and other sources provide; and
- Being watchful for changes to healthcare from which we can each benefit.

Brian Ingles followed with a powerful presentation on emotional intelligence, a skill essential to achieving the growth Erickson encourages. The ability to know ourselves helps us to understand others, discern our potential, and manage our futures, he explained.

Mike and Raemarie Explain It All

Former U.S. Department of Health and Human Services Secretary and Governor of Utah Mike Leavitt opened the next morning with an explanation and a surprisingly calm assessment of the evolution of our healthcare system (See “HEALTHCON: A Challenge to Lead,” page 13). We learned about what’s happening in Washington, that we’re only so far in the process, how the industry is “mothering-up,” and that AAPC members are key players to make it happen.
Where Leavitt showed us the map, Raemarie Jimenez, CPC, CDEO, CPB, CPMA, CPPM, CPC-I, CANPC, CRHC, vice president of member services at AAPC, led us down the trail of the immediate future, detailing the mechanics and deciphering the acronyms of MACRA and other initiatives that will help our providers to understand and master the changes. She introduced wide-eyed audience members to the features of our new quality-based reimbursement world.

The take-away from this conference? Coders and the roles we perform in practices and facilities are a core component of the country’s healthcare system and its reform. It may be unsettling and slow, and we don’t know what it will look like in the future, but we are the hub of its development and implementation. We will interpret the changes, implement them, educate providers, and help commercial and federal payers to understand what works.

**Where Peer Pressure is a Good Thing**

The Rio conference center is an island amidst Las Vegas’ garden of earthly delights. It’s a reminder how small-town you are when you mistake the over-the-top restrooms for the over-the-top elevator lobbies. And it’s exciting to be at the event. It’s easy — even if you’re reserved and introverted — to find a hug. And even without assistance, inhibitions drop. Friends greet friends, strangers greet strangers, and laughter is constant. Introductions are easy and promises to keep in touch run rampant throughout the hallways. Peer pressure prompts members to attend sessions outside their comfort zone.

Judy Wilson, COC, CPC, CPCO, CPC-P, CPB, CPPM, CPC-I, CANPC, AAPC Fellow, told Healthcare Business Monthly, “Of all the conferences I have attended over the last 10-15 years, this was by far the best one to date. The speakers were awesome and gave very much needed information on an advanced scale. I heard nothing but good remarks from the attendees about the conference. There were a lot of new attendees; and with the Facebook page, they could connect and network while at conference. Kudos to the whole conference team.”

There was a fun-run and other events off-site. There was the casino and entertainment. There was food and a lot of giggling. And if you asked somber, business-like members if they were having fun, the answer was usually accompanied by a wink.
Breakout Sessions for Everyone

At HEALTHCON, clinical sessions were balanced by sessions about career growth, such as a presentation by C.J. Wolfe, MD, on how to become an auditor. Basic coding and billing sessions competed for attention with abstract issues or specific topics such as cardiology changes in ICD-10-PCS.

And special trainings, such as Anatomy Expo, helped to cement the real reason to be there — enhanced competency and career growth. The breakout sessions are the protein of the conference, fueling participants' minds with expertise. Menu items in the conference program covered nearly every coder's need and curiosity. Evaluation and management, documentation, chargemaster, integrity plans, and compliance joined sessions on new physical therapy, diabetes, and cardiovascular codes. UPIC, NCCI, MACRA, MIPS, OPPS, and other acronyms kept attention from wandering.

Teresa Bartrom, CPC, CPB, said, “I think the 2017 HEALTHCON was one of the best received conferences ever.” She added, “As a door greeter, I was amazed at how many attendees at general sessions reached out and touched us, thanking us and wanting us to let AAPC know how pleased they were with this conference.” Bartrom observed that the sessions were more interactive in some cases, and attendees liked that. “They loved the panels, the food, and their options for after-hours entertainment,” she said.

A Village Grows in Vegas

It takes AAPC's village to put HEALTHCON on. AAPC Live Events staff Melanie Mestas, Amy Evans, Kira Golding, Rachel Momeni, and Taylor Traveller spent the year organizing the logistics, and they managed the conference. AAPC customer care, IT, sales, marketing, CEU, and publishing departments assist with various parts of preparation. And the National Advisory Board (NAB) and AAPC Chapter Association board of directors help the Live Events team make things happen. Rachel Momeni manages the store. Local chapters participate in chapter events and raising funds for the scholarships and other funds supporting disadvantaged members. Local chapter members pitch in, as do some partners. The mix of plans, volunteers, presenters, and members comes together to assure we’re all prepared for the future.

2016 Member of the Year Patti Frank, CPC, and Chapter of the Year, Tulsa, Okla., were recognized at Wednesday’s member luncheon, and departing participants expressed their satisfaction with HEALTHCON this year. Bartrom told Healthcare Business Monthly that she heard attendees comment on, “how well everything was set up, the registration process, the great product store, the Meet the NAB session, the great quilt with Hardship Scholarship Fund, and the Run4One event.” She said attendees were excited because they were “already thinking about next year as they exited the NAB and AAPCCA's 'send-off tunnel of cheers' when they left the final luncheon on Wednesday.”

Applying HEALTHCON

There’s so much learned and shared, it’s hard not to rush into work and start implementing what you’ve brought back. It’s a chance to educate management at your practice or facility, speak at your local chapter, and share your newfound knowledge with coworkers and students.

Back home, when the piles of conference clothing are sorted in the laundry room, the HEALTHCON bag emptied, and session notes filed, it’s difficult to go back to a less friendly day-to-day existence. Just remember: In this village, you’re never really alone.

Editor’s Note: The village will band together later this year at regional conferences in Honolulu, Hawaii; St. Louis, Mo.; and Salt Lake City, Utah. Find out more at www.aapc.com.
HEALTHCON: A Challenge to Lead

Leavitt says coders must take the lead on healthcare reform.

HEALTHCON keynote speaker Mike Leavitt, former Utah governor and U.S. Department of Health and Human Services secretary, challenged AAPC members to be the leaders in health reform. Leavitt detailed the history and future of the movement in his speech to a full house, telling attendees the country is in the 25th year of a 40-year process. He assured HEALTHCON attendees that recent political posturing in the executive and legislative branches would not derail the outcome, which he predicts will be a more efficient and effective form of healthcare.

The nationally-known healthcare reform expert said the United States needs to heed the lessons of countries like Argentina, which bankrupted itself with social programs. A worldwide movement of “dispassion” has become prevalent as governments and economies realize not all can be done for all citizens. This dispassion drives many of the political proposals for the healthcare system, as the United States seeks to remain economically powerful. But he cautioned against losing compassion, which he believes is an inherent American value.

This means two forces pull on the development of health reform, which dates back to before Richard Nixon, and continues to progress like a glacier. Early adopters of recent initiatives are excited about the change, which introduces efficiency into the system, he said, but many are digging in their heels.

Mothering Up

Leavitt explained that in the old model providers are the general contractors of the healthcare process, much as in building a house. Everyone else is a subcontractor to the provider. That’s changing. All participants, including providers, will be subcontractors to the organization coordinating care for the patient.

The Utah native showed an image with audio of cattle being moved to summer pasture. He explained the mooing was from cows and their calves trying to find each other, or “mothering up.” If cows don’t get to mother up, he explained, they stampede back to the place where they were last together. Good cowhands periodically stop the herd so everyone can find their kin. Providers and other slow adopters of health reform need time to mother up, he said.

The mechanics of Obamacare and the Merit-based Incentive Payment System (MIPS) — a provision of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) — along with the penetration of accountable care organizations (ACO) offer a glimpse of the future. Leavitt maintains the elements for success of the new health system are:

- Changing both patient and provider behavior and expectations
- “Branding” the new healthcare system so it’s easily understood and accepted
- Assuring availability of capital so service is affordable
- Aggregating lives into a supportive risk pool that will support the system
- Managing the risk presented by the pool
- Guaranteeing a big enough clinical footprint for all who need services
- Developing the right collaborative IQ to make it work

Where We Fit In

Never fear, coders’ roles will be central to the drive for quality and efficiency in the new healthcare system. Leavitt sees coders coordinating the data collected and disseminating it to care managers, payers, and regulators. It will be up to us, Leavitt said, to educate providers on changing documentation requirements; to interpret payers’ policy guidelines; to help build useful and standardized electronic health record templates; to gather and report the right information to payers; and to monitor the reporting of this information to the care coordinators who may be private payers, governmental entities, or some entity yet to evolve.

Don’t let the political rancor rattle you. The politics are all for show, and they won’t stop the move toward quality and efficiency in our new healthcare environment. Both political parties are anxious for quality and efficiency to be the hallmark of the new system — a system that relies on good coding to work.

Brad Ericson, MPC, CPC, COSC, MACRA Proficient, is the publisher at AAPC and a member of the Salt Lake City, Utah, local chapter.
What’s the Facebook Buzz? **HEALTHCON 2017**

May proved to be a month of excitement, with AAPC members posting on Facebook enthusiastic sentiments about HEALTHCON 2017. Members became social media cheerleaders by inspiring, thanking, congratulating, and supporting each other, and by sharing their experience. A Facebook snapshot depicts the buzz felt by attendees at the Las Vegas HEALTHCON. Thanks for spreading the cheer HEALTHCON attendees!

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Life ebbs and flows for everyone. AAPC and I have grown a lot since 1999, when I became a certified coder. I think about what pushed me into the coding field: How did I end up as an instructor, a local chapter officer, and a member of the National Advisory Board (NAB)? It’s more than a thirst for knowledge and the drive to win at this game where the rules are always changing; it’s the people. AAPC is family, a team — similar to my military experience.

Military Service Builds a Strong Medical Foundation

For as long as I can remember, medicine has been where I wanted to be. During my years of active duty in the U.S. Navy, I learned about medicine from a variety of specialties and virtually every department in the hospital and its clinics. When I’d stand duty in the hospital, I’d spend the night in the operating room, in case someone needed surgery. There was always a core group ready. I would roam the hospital looking for something to do:

- If they needed help in labor and delivery, great! Teach me!
- If a Marine was in a fight and they were wiring his jaw in the emergency room, I was there to help.
- If they needed help in labor and delivery, great! Teach me!
- If a Marine was in a fight and they were wiring his jaw in the emergency room, I was there to help.

Adapting to Medicine in the Civilian World

After leaving military services, I didn’t know what to do with that training. I knew no one in the civilian world was going to let me suture a wound or cast a leg. And I knew there were many pieces of military medicine that would not transfer to the civilian sector. For example:

- I trained for and practiced triage for mass casualty.
- I was stationed at a submarine base that housed nuclear powered subs, and I trained for nuclear spill accidents.

Military medicine allowed me to experience so much. As a surgical scrub tech, I took part in a variety of surgical procedures. I was educated on disease and anatomy, and I was trained to first-assist surgeons. I learned about casting, suturing, and a host of procedures and scenarios that prepared me for any military event.

It was an awesome experience.
What would I do with that knowledge?
But with my experience in medicine, I felt sure there would be ample opportunity for me to work in the civilian world. Not true.
I knew a lot about medicine, but unless someone had prior active duty or had a family member who was, they didn’t understand my abilities. It was not until there was an emergency, and my training just took over, that they realized — with amazement — that I really did know a thing or two. They would ask, “How did you know to do that?” It’s because I trained with some great doctors and nurses.

Adapt or Be Left Behind
Working in the civilian world made me realize the mindset in the military is very different. One morning, when I was working in the operating room, we all gathered at the front desk as everyone was reviewing their caseload for the day. A woman from a temp agency showed up to scrub. She stood at the front desk and told the charge nurse what cases she wasn’t going to be part of because she was not comfortable. I was baffled. “I will not do this …” was never part of my vocabulary. The military motto was, “See one, do one, teach one.” You were taught to rise to the occasion, and get in there and do it. The navy always touted, “The chain is only as strong as the weakest link.” The takeaway was: Don’t be that weak link!
Another thing I learned from the military was to be resilient and grow with change. I think this defines a medical coder, as well. If it’s one thing we all understand in the world of medicine, change is inevitable. You either adapt or you get left behind.

Civilian Transition Is Difficult for Many
For some personnel who had a military occupation specialty (MOS) or Navy-enlisted classification, there is no translation in the civilian world. Some do translate very closely, but for many others, such as grunt (infantry) or parachute rigger, there is nothing. Injuries received while on active duty complicate matters even more.
Remember: You are the change. You are the future of AAPC. Get uncomfortable, stretch and grow, and above all, be proud of what you do.

I’d like to hear from other veterans out there. AAPC is working toward ways to honor and acknowledge veterans. Contact me at Caren.Swartz@AAPCNAB.com.

Proud Veterans Transition to Proud Coders

I want to highlight several fellow AAPC military veterans. I hope to meet up with many more of you. The experiences of these men and women of the armed services always leaves me with a sense of pride for our mutual military service as well as what we have in common today: AAPC. Here is how their military experience brought them to AAPC.

Amy Laursen, CPC

Laursen spent nine years in the Army National Guard. She was just 18 when she began her MOS training to be a firefighter. Laursen’s thought process was, “If I’m a firefighter, the natural next step is an EMT.” But after achieving more certification and working for years as an emergency medical technician (EMT), she became burned out. Too many lost lives and frustration with what she could and couldn’t do, she said. Laursen went to work as a phlebotomist. From there, she transitioned into order entry. She also took online classes to become a Certified Professional Coder (CPC®). The whole journey took 16 years, but along the way the learning never stopped. And it’s a family affair because Laursen’s husband Craig Laursen, CPC, is an AAPC employee and was her instructor.

Stephanie Moore, CPC, CPMA

Moore served six years as a Marine. After finishing boot camp, she trained for 18 months to become a first level Harrier jet mechanic. Moore was frustrated when transitioning from active duty to civilian. She was told she was over qualified for positions, and she desperately missed the comradery that comes with military experience. The timing for a job in aviation was bad for job placement, and she recognized the need to go in a different direction. Finally, Moore obtained a position as a dispatcher with local law enforcement, which restored her sense of teamwork. Moore said, “Employers did not seem to support the military in the early ’90s as much as they do now, post 9/11. The police department was very receptive of individuals with prior military experience.” Today, she sits on the AAPC Chapter Association board of directors for Region 1 and works as an auditor/educator for the coding department at Wentworth-Douglass Health System.

Tim Yonish

Yonish served seven years and three months in the Marine Corps as a truck driver and avionics technician. His transition was difficult because of a service-connected disability. “Transitioning, with a service-connected disability is extremely difficult,” said Yonish. “I did not know what I was getting into, needing to be retrained in an industry I knew nothing about. I find myself playing catch-up.” It took him years to recognize the need to retrain and then get into school (he used the military vocational rehabilitation program). Yonish graduated with a bachelor’s degree in Business, and now is employed by the Department of Veterans Affairs. He is a member of AAPC, and is working towards his CPC® credential.

There is a theme that resounds among all these AAPC military veterans, as does with my fellow NAB members who are veterans. And Yonish hits the nail on the head, “Hard work, dedication, and educating oneself pushes you to persever through any obstacle.” It won’t be overnight, and it may take years, but the tenacity in these men and woman, be it soldier, sailor, airmen, Marine, or “Coastie,” is relentless.

Employers did not seem to support the military in the early ’90s as much as they do now, post 9/11. The police department was very receptive of individuals with prior military experience.
Think back to your first day on the job. Remember how “green” you were? There was so much to learn — deciphering priorities and trying to remember all the rules and regulations. If you were lucky, you had someone to look up to and to learn from. I did. Her name was “Sally.” She was my supervisor, leader, and mentor who basically held my hand throughout my developing career.

After several years of working side by side, Sally encouraged me to become a Certified Professional Coder (CPC®); the beginning of my career started with that first test. I received my CPC® certification, but her mentoring never stopped. Sally’s guidance and patience affected my entire life. I may not be able to repay her for the continuous encouragement she gave me to strive for greatness, but I can pay it forward — and so can you.

**Others Succeed when You Give Back**

There are so many new CPC-A® who could benefit from your years of experience. And without realizing it, you may experience the many benefits of becoming a mentor:

- Achieve personal growth
- Boost peer recognition
- Improve self-esteem
- Develop professional relationships
- Share in the success of others

Mentoring is a pledge to help another person, but it’s not a 24/7 commitment. Don’t confuse mentoring with an intern/externship. **Mentoring** is when a person seeks your advice and wisdom in the field and you give it readily for however long possible. Your goal is to simply guide them as they develop professionally in their career.

An intern/externship is a commitment to train someone how to fulfill specific job requirements during a specified length of time.

It’s a Win/Win for Everyone Involved

I have mentored individuals who were not successful at their first attempt of the CPC® exam. We would focus on the area they scored the lowest, and they were then successful in passing the exam on their next attempt. What a great feeling to help another individual experience success.

Spending a little time talking with people — whether it be email, in person, or via phone — gives individuals the encouragement to move forward. It provides that extra boost they may need just to say, “I can do this!”

I asked other colleagues about their experiences as mentors. Here’s what they had to say:

**Judy A. Wilson, CPC, COC, CPCO, CPPM, CPC-P, CPB, CPC-I, CANPC, CMRS, AAPC Fellow**

I have mentored not just the coding part, but also the billing part, and explained how members can sell themselves to employers. It can be anywhere from a 10-minute phone call once a week to a one-on-one sit down once a month. I have done both, and it really doesn’t take that much time.

Some of my best employees were CPC-As who came through the Project Xtern program (www.aapc.com/medical-coding-jobs/project-xtern/) and had a one-on-one experience. It’s so rewarding when you have helped someone reach the goal of landing their first job.

**Roxanne Thames CPC, CPC-I, CEMC**

I mentor many times via email or conference call to give a member support. AAPC Forums are also a resource for mentoring and for me to give advice.

Some students just want a “confirmation” of how they are doing, and will ask me to send them a scenario to code and send it back to me to check.

Some members want to interview me, asking me questions for their schooling about how I got into coding.

Some members are in school and just want me to interview me to help them decide what they like and/or what they want to do once they graduate. I try to guide them by asking questions about their strong areas and I build from there.

Mentoring for chapter officers is an excellent way to get members on the path to local involvement and networking. For those who fear public speaking, I encourage them to speak at a chapter meeting on a topic they are familiar with or one that is near and dear to their hearts.

**Take That First Step**

The best place to find out more about mentoring is your local chapter; ask your officers for more information. You also can read the articles, “Chapter Mentoring Program Needs YOU!” (www.aapc.com/blog/31739-chapter-mentoring-program-needs-you/) or “The Give and Take of Mentoring” (www.aapc.com/blog/36518-the-give-and-take-of-mentoring/), both available in AAPC’s Knowledge Center. The AAPC website also has forums (www.aapc.com/memberarea/forums/) where you can offer up your expertise.

As the saying goes, “it takes a village” to create an indelible network of support capable of weathering the business of healthcare. Put yourself out there, network, and get ready to reap the rewards!

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**Melody S. Irvine, CPC, CPMA, CEMC, CFPC, CPB, CPC-I, CCS-P, CMRS, AAPC Fellow** is an AAPC Fellow with over 30 years of experience in the medical profession. She is the founder of Career Coders, LLC, Online Medical Billing and Coding School. She specializes in physician auditing, education, and curriculum development, and is an approved PMCC instructor with AAPC. Irvine’s background includes director of coding, auditing, compliance, and urgent care for a 48 multi-specialty physician practice. She was a contract auditor for the State of Colorado Attorney General. Irvine started the Loveland, Colo., local chapter and is education officer. She is a past member and officer of the AAPC National Advisory Board and is an AAPC Chapter Association Region 7 representative.

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**By Melody S. Irvine, CPC, CPMA, CEMC, CFPC, CPB, CPC-I, CCS-P, CMRS, AAPC Fellow**
Make Cleft Lip and Palate Repair a Priority in July

You’ll need a strong background in anatomy and medical terminology to code it right.

July is National Cleft and Craniofacial Awareness and Prevention Month, making this a great time to learn more about these types of birth defects and how to code the surgical procedures surgeons perform to repair them.

Know the Facts About Craniofacial Defects

Orofacial clefts (clefts of the lip and palate) are the second-most common birth defects in the United States (Down syndrome is the first). A study published by the Centers for Disease Control and Prevention (CDC) and the National Birth Defects Prevention Network concluded that, between 2004-2006, one in 1,574 babies was born with a cleft palate and one in 940 babies was born with a cleft lip.

A “cleft” is a gap between the baby’s upper lip and/or palate where cells and tissues didn’t join properly during the embryonic period. A baby’s facial features are formed by the end of the first trimester, making a cleft easy to detect in an anatomy screening ultrasound, generally between 18 and 26 weeks gestation.

A cleft lip, as shown in Figure A (on page 22), can be a small slit (incomplete) or a large opening that goes through the lip into the nose (complete). And it can be on one side (unilateral) or both sides (bilateral) of the lip or, rarely, in the middle of the lip. A cleft palate, as shown in Figure B (on page 22), may involve both the front (hard) and back (soft) parts of the palate, or just one part. Left-sided clefts are more common than right-sided clefts. Approximately one-third of clefts involve the lip and alveolar ridge. Two-thirds extend through the entire palate. Some clefts may involve the lip and hard palate, but not the soft palate.

Less common craniofacial defects are craniosynostosis (the baby’s skull fuses too early); microtia (the external portion of the ear does not form properly); and anotia (the external portion of the ear is missing).

Complications Associated with Orofacial Defects

After a diagnosis of a cleft lip and/or palate is made, there is nothing to do but wait. After the baby is born, surgery to repair the orofacial defect is necessary to allow for normal functions of the mouth — to eat and speak, for example. Other complications associated with clefts include ear infections, hearing loss, and misplaced teeth.

Surgeons generally work with a care team to address these issues in a coordinated way. A care team may include: a surgeon, a speech-language pathologist, a pediatric dentist, an orthodontist, a geneticist, a nurse, a psychologist, an audiologist, a pediatrician, and other specialists.

Clinton Morrison, MD, team leader at the Cleft and Craniofacial Center, University of Rochester Medicine’s Golisano Children’s Hospital, in Rochester, N.Y., says it’s important for coders to understand that surgery is medically necessary and not just cosmetic.

“I think there is a common misconception that the issues surrounding cleft lip and palate are handled entirely at the initial operations, and that secondary issues are largely cosmetic,” Morrison said. “Really,
After the baby is born, surgery to repair the orofacial defect is necessary to allow for normal function of the mouth — to eat and speak, for example.

Confirm Proper Procedure Coding

Surgery to repair a cleft lip usually occurs in the first three to four months of life and is recommended within the first 12 months of life. Surgery to repair a cleft palate is recommended within the first 18 months of life, or earlier if possible.

Medical codes for cleft lip and palate repairs are found under the Digestive System in the Surgery section of the CPT® codebook.

Lip Repair (Cheiloplasty)

CPT® code 40700 Plastic repair of cleft lip/nasal deformity; primary, partial or complete, unilateral describes a partial or complete repair of a cleft lip on one side. If the cleft lip affects both sides and is repaired in a single surgery, report 40701 Plastic repair of cleft lip/nasal deformity; primary bilateral 1-stage procedure. If the repair will require a second surgery, report 40702 Plastic repair of cleft lip/nasal deformity; primary bilateral, 1 of 2 stages for the first surgery and 40720 Plastic repair of cleft lip/nasal deformity; secondary, by recreation of defect and reclosure for the second surgery. If the secondary procedure is performed on both sides of the face, append modifier 50 Bilateral procedure to 40720.

A parenthetical note instructs, “To report rhinoplasty only for nasal deformity secondary to congenital cleft lip, see 30460 [Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only], 30462 [Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies].”

CPT® Assistant (December 2014, Vol. 24, Issue 12) elaborates on when it’s appropriate to use these codes:

Question: A physician performs a primary lip and nose repair on an infant for cleft lip and palate deformity. Does the assignment of code 40700 … include the lip repair as well as repair and reshaping of the nose (rhinoplasty)?

Answer: No. Code 40700 does not include cleft lip rhinoplasty, which may be reported separately with codes 30460 or 30462. In a cleft lip repair, because the defect is closed, the nostril sill […] is re-established and the nostril is narrowed. This procedure is referred to as the cleft lip/nasal deformity (ie, the soft tissue of the nose that may be corrected with the cleft lip repair) and it is included in code 40700. Codes 30460 … and 30462 … are used to report cleft lip rhinoplasty procedures involving cartilaginous work and columellar lengthening. These procedures are not considered an inclusive component of the plastic repair of cleft lip codes (40700-40720), and can be reported separately with codes 30460 and 30462, when performed.
**Orofacial Defects**

**Figure A:** There are varying degrees of cleft lip.

**Figure B:** There are varying degrees of cleft palate.

### Coding from the Operative Report

Following is an operative report for surgery to repair a left, complete cleft lip and palate. The highlighted text provides the necessary information to properly code the procedure.

- **Date of Surgery:** ***
- **Surgeon:** ***, MD
- **Assistants:** ***, MD
- **Pre-operative Diagnosis:** Left complete cleft lip and palate
- **Post-operative Diagnosis:** Same
- **Operative Procedure:** Left primary cleft lip repair with tip rhinoplasty and septal repositioning
- **Anesthesia:** General
- **Indication for Procedure:** *** is an 18 wk.o. male who has been diagnosed with left complete cleft lip and palate. *** is being taken to the operating room today for elective lip repair. Risks and benefits of the procedure were discussed. All questions were addressed. The family was eager to proceed.
- **Findings:** Left complete cleft lip and palate with associated cleft nasal deformity
- **Complications:** None
- **Immediate Postop Condition:** Stable to PACU
- **Disposition:** PACU, admit
- **Estimated Blood Loss:** 5 cc
- **IV Fluids Given:** 50 cc
- **Urine Output:** Not recorded
- **Drains/Implants:** None
- **Specimens:** None
- **Antibiotics:** Ancef
- **DVT Prophylaxis:** Not indicated for age
- **Description of Procedure:** The patient was taken to the operating room and placed supine on the operating table. After the smooth and routine induction of general anesthesia, the patient was prepped and draped in the usual sterile fashion. A formal time-out was performed in the room and all were in agreement.

### Palate and Uvula Repair

Coding cleft palate repairs is more complicated because the structure is more complicated. The codes are:

- **42200** Palatoplasty for cleft palate, soft and/or hard palate only
- **42205** Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only
- **42210** with bone graft to alveolar ridge (includes obtaining graft)
- **42215** Palatoplasty for cleft palate; major revision
- **42220** secondary lengthening procedure
- **42225** attachment pharyngeal flap
- **42235** Repair of anterior palate, including vomer flap

*CPT*® Assistant (July 2014, Vol. 24, Issue 7) clarifies use of some of these codes in a Q&A.

**Question:** Our surgeon performed 2-flap palatoplasty to repair a bilateral cleft palate. The surgeon repaired the hard palate using vomer flaps and during the same session performed an intravelar veloplasty to repair the soft palate. Alloderm was placed over the nasal lining around the junction of the soft and hard palate. Should we report both 42200 and 42235, or should we report 42200 alone (along with the unlisted code for the Alloderm placement)?

**Answer:** If both the hard and soft palates (secondary palate) are repaired concomitantly, report code 42200 ... because this includes the maneuvers necessary to effect closure of the hard and soft palates posterior to the incisive foramen. Code 42235 ... is reported for the primary palate (anterior to the incisive foramen) and would not be appropriate to report in this case. The Alloderm placement is reported with code 42299, Unlisted procedure, palate, uvula. When reporting an unlisted code to describe a procedure or service, it is necessary to submit supporting documentation (eg, procedure report) along with the claim to provide an adequate description of the nature, extent, and the need for the procedure, as well as the time, effort, and equipment necessary to provide the service.

![Illustrations](https://example.com/illustration.png)
A 2014 surgeon general’s report confirmed that maternal smoking during early pregnancy can cause orofacial clefts in babies.

Verify Diagnosis Codes
Diagnosis codes for cleft lip and cleft palate are in the Q35-Q37 range in chapter 17 of the ICD-10-CM codebook. Selection is based on the location and extent of the defect. For example, coding for the adjacent operative note is Q36.9 Cleft lip, unilateral and Q30.2 Fissured, notched and cleft nose.

Be Aware of Your Environment
Craniofacial birth defects can be genetic or environmental. A 2014 surgeon general’s report confirmed that maternal smoking during early pregnancy can cause orofacial clefts in babies. According to the CDC, approximately 6 percent of orofacial clefts in the United States are caused by smoking during early pregnancy (i.e., first five weeks). “This means that over 400 babies could be born without orofacial clefts each year in the United States if women did not smoke early in pregnancy,” the CDC said.

Renee Dustman, BS, MACRA Proficient, is executive editor at AAPC and a member of the Rochester “Flower City Coders,” NY, local chapter.

Resources
MedlinePlus.com https://medlineplus.gov/cleftlipandpalate.html
CDC Features, Life Stages & Population: www.cdc.gov/features/cleft-lip-prevention

I began by marking out a Fisher anatomical subunit cleft lip repair. This included a 3 mm substitution triangle above the white roll, as well as a Nordhoff type dry vermilion substitution triangle. Once I was happy with my markings, I tattooed the key points with ink and injected Marcaine with epinephrine for hemostasis. I inserted a throat pack. After waiting appropriately for hemostasis, I began with the medial lip incisions, including the back cut above the white roll. I then continued incision intraorally mucosally to the cleft margin. I then trimmed the marginal tissues. I then performed a limited muscle dissection medially taking care not to disrupt the marginal component of the orbicularis. I also freed the abnormal medial muscle attachments to the anterior nasal spine. Subsequently, I performed my cutaneous lateral lip incisions, heading to the cleft margin intraorally, and then extending along the alveolus laterally to allow the mucosa to advance. I elevated the abnormal muscle attachments to the maxilla in a supraperiosteal place, taking care to preserve the infraorbital nerves. I also released the muscle from the lateral ala. I then performed muscle dissection on the cutaneous and mucosal segments to free this up for approximation.

Next, I dissected the anterior nasal spine to find the nasal septum, and performed a limited anterior septoplasty. I freed the septum from its abnormal attachments pulling it to the non-cleft side, and brought it to midline. I held this in its new location with a 4.0 PDS suture anchored to periosteum.

I then set about closing the cleft lip proper. I closed the oral mucosa with 5.0 interrupted chromic sutures. I also inset the Nordhoff flap with 5.0 chromic. I closed the nasal floor with 5.0 Monocryl interrupted sutures, and performed muscle closure with 4.0 Monocryl interrupted sutures. I then inset the cutaneous lip with 5.0 Monocryl. 8-0 Vicryl was used for cutaneous closure of the Fisher triangle and white roll. Dermabond was used for the vertical limb of closure.

Using 5-0 PDS, I performed lower lateral redraping sutures in buried fashion. The wound was cleaned, the throat pack was removed, and he was transferred back to anesthesia for extubation.

*** tolerated the procedure well and was transferred to the recovery room awake and in good condition. I was present and scrubbed throughout the entire operation.

Based on this documentation, coding is: 40700, 30460
Approach Matters for Spinal Arthrodesis

Understand the procedures and approaches for better coding of operative reports.

There are different surgical approaches for spinal fusion. When coding arthrodesis, you must be sure to match the approach on the surgical report to the CPT® code description. Let’s review arthrodesis treatments for spinal conditions and then look at a case study showing why approach matters when coding.

Corrective Treatments

Spinal arthrodesis is the surgical fusion of the spinal vertebrae, which immobilizes the spine to relieve pain at the vertebral segment. Spinal fusion is used for treatment of scoliosis, deformity, degenerative disc disease, fractures, and other conditions of the spine.

Immobilation is accomplished by use of bone graft. Bone graft can be obtained from the patient’s own body (autograft), from a cadaver (allograft), or manufactured (synthetic bone-like material). The use of a graft promotes the formation of a new bone by the cells contained within the graft. Instrumentation (such as screws, rods, metal plates, etc.) also may be used to hold the vertebrae together.
Spinal fusion is used for treatment of scoliosis, deformity, degenerative disc disease, fractures, and many other conditions of the spine.

**Consider This Scenario**

A patient with a C4–C5 large central herniated nucleus pulposus presents for arthrodesis.

After obtaining informed consent from the patient, which included full understanding of the risks, benefits, and alternatives to surgery, the patient was taken to the operating room and underwent successful induction of general endotracheal anesthesia. Prophylactic IV antibiotic was given. Bilateral compression hoses were placed. The patient was placed supine on the operating table in the halter traction with five pounds of weight and a roll under the neck and the shoulders.

Anterior neck was then prepped and draped in the standard surgical fashion. A right para midline incision was made at the upper skin crease, and the dissection was carried down through the platysma. Blunt dissection technique was used to dissect between the carotid sheath and the midline structures to the prevertebral fascia. Preoperative X-ray was then obtained to confirm the level of surgery. The longus colli muscle along both sides of the vertebral bodies was freed up using the Bovie cautery, and the Cloward retractor was placed under the muscle. Having identified the C4–C5 level using the cross table X-ray, the disk space was incised and the disk material was removed in a piecemeal fashion with the pituitary rongeur and a curette. Two Caspar pins were placed, and the Caspar pin distractor was used to distract the interspace. The residual disk materials were then removed with a curette and pituitary rongeur. There was a posterior longitudinal ligament (PLL) that was torn, and several large herniated disk pieces were posterior to the PLL.

A partial C5 corpectomy (30–40 percent) was performed, as the disk fragments had migrated inferiorly behind the C5 body, to safely retrieve the fragments and to ensure that all the disk fragments were removed.

The uncovertebral joint was then decompressed bilaterally with a curette and Kerrison punch until there was no compression of the nerve roots on both sides. With the interspace distracted, a 9 mm bone graft was tapped into the C4–C5 interspace under direct vision, without difficulty.

After removing the Caspar pins, the wound was then thoroughly irrigated with bacitracin irrigation.

A 16 mm Synthes Vectra cervical plate was placed between C4 and C5 vertebral bodies for interbody arthrodesis. A crosstable lateral radiograph was obtained to ensure there was good placement of the screws. The Cloward retractors were then removed. The trachea and esophagus appeared to be in good condition. The neurovascular bundle immediately lateral was also in good condition. The wound was irrigated with bacitracin.

The wound was closed in layers using 2-0 Vicryl sutures, and the platysma was closed using inverted interrupted 3-0 Vicryl sutures at the dermal layer. Mastisol and Steri-Strips were then applied, followed by sterile 4 x 4 and coverall dressing. A soft cervical collar was placed around the neck.

**Code It**

Because the surgeon took an anterior approach to reach the damaged vertebral body, with an incision made through the neck for cervical vertebrae, report 22554 *Arthrodesis, anterior interbody technique, including minimal dissection to prepare interspace (other than for decompression); cervical below C2.*

Report 63081 *Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment for resection of a single vertebral body.* Per the operative report, the disk space was incised and the disk material was removed in a piecemeal fashion with the pituitary rongeur and a curette.

Report +20931 *Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)* because the physician prepared and inserted an allograft.

Report +22845 *Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)* for the anterior instrumentation of two to three vertebral segments.

Oby Egbunike, CPC, CDP, CPC-I, CCS-P, is a licensed instructor for AAPC. She has a Bachelor of Arts in Business Administration with concentration in Health Information Management from Northeastern University Boston. Egbunike has more than 10 years of experience in healthcare management, coding, billing, and revenue cycle. She is the director of professional coding and education at Lahey Health. Egbunike is a member of the Burlington, Mass., local chapter.
Although many factors affect procedural code selection in 2017, there is a calculator to make it easier.

Beginning Jan. 1, 2017, moderate sedation services are separately billed and paid using CPT® codes 99151-99153 and 99155-99157. To capture moderate sedation reimbursement appropriately, it’s important for you to calculate time and to report the new codes correctly. There is a calculator that can help, and here’s what you need to know to use it.

Provider, Time, and Age Are Factors
As shown in Table 1, moderate sedation is reported in 15-minute increments.

When selecting code(s) to report moderate sedation, intraservice time is used to determine the appropriate code to report moderate sedation services. The intraservice time begins with the administration of the sedating agent(s) and ends when the procedure is completed, the patient is stable for recovery, and the physician or other qualified healthcare professional providing the sedation ends personal, continuous face-to-face time with the patient.

Table 2 provides examples to help you select the appropriate code(s) to report time spent providing moderate sedation services.

Calculate the Services
As you can see from the explanation and tables provided, it can be overwhelming and time-consuming to code moderate sedation correctly. The professional coder teams at Lahey Health use a calculator tool made in Microsoft Excel (shown in Figure 1) to simplify matters. This intuitive and easy-to-use calculator is now available to all AAPC members at http://bit.ly/2rIP9hx.

Intraservice time is used to determine the appropriate code to report moderate sedation services.
To use the calculator, enter a Start Time and End Time, and answer two questions that relate to (1) whether moderate sedation and moderate sedation supports are both performed by the same provider, and (2) the age of the patient.

**Table 2: Moderate sedation coding guidance**

<table>
<thead>
<tr>
<th>Total intraservice time for moderate sedation</th>
<th>Patient age</th>
<th>Code(s) Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 minutes</td>
<td>Any age</td>
<td>Not separately reported</td>
</tr>
<tr>
<td>10–22 minutes</td>
<td>&lt; 5 years</td>
<td>99151 99155</td>
</tr>
<tr>
<td></td>
<td>5 years or older</td>
<td>99152* 99156</td>
</tr>
<tr>
<td>23–37 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 × 1 99155 + 99157 × 1</td>
</tr>
<tr>
<td></td>
<td>5 years or older</td>
<td>99152* + 99153 × 1 99156 + 99157 × 1</td>
</tr>
<tr>
<td>38–52 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 × 2 99155 + 99157 × 2</td>
</tr>
<tr>
<td></td>
<td>5 years or older</td>
<td>99152* + 99153 × 2 99156 + 99157 × 2</td>
</tr>
<tr>
<td>53–67 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 × 3 99155 + 99157 × 3</td>
</tr>
<tr>
<td></td>
<td>5 years or older</td>
<td>99152* + 99153 × 3 99156 + 99157 × 3</td>
</tr>
<tr>
<td>68–82 minutes</td>
<td>&lt; 5 years</td>
<td>99151 + 99153 × 4 99155 + 99157 × 4</td>
</tr>
<tr>
<td></td>
<td>5 years or older</td>
<td>99152* + 99153 × 4 99156 + 99157 × 4</td>
</tr>
<tr>
<td>83 minutes or longer</td>
<td>&lt; 5 years</td>
<td>Add 99153 Add 99157</td>
</tr>
<tr>
<td></td>
<td>5 years or older</td>
<td>Add 99153 Add 99157</td>
</tr>
</tbody>
</table>

Figure 1:
Moderate Sedation (MS) Calculator - 2017

To use the calculator, enter a Start Time and End Time, and answer two questions that relate to (1) whether moderate sedation and moderate sedation supports are both performed by the same provider, and (2) the age of the patient.

**Resources**


http://bulletin.facs.org/2017/01/2017-cpt-coding-changes/
As healthcare business professionals, we’re expected to know the meaning of an infinite number of terms. It’s inevitable for some terms to be misinterpreted. For example, the terms “global service,” “global surgical package,” and “global period” often are used interchangeably, but they are distinct. To create a united front, let’s look at the definition of each and discuss the differences.

- **Global service**: The entire service represented by a specific CPT®/HCPCS Level II code, which may be divided into professional and technical components.
The term global service describes all components of a service or procedure represented by a specific CPT® or HCPCS Level II code.

**Global Surgical Package**

According to CPT® 2017 Professional, in the Surgical Guidelines, under CPT Surgical Package Definition, each CPT®/HCPCS Level II code represents specific services, which include “the following surgery services when furnished by the physician or other qualified health care professional who performs the surgery:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified healthcare professionals
- Writing orders
- Evaluating the patient in the post-anesthesia recovery area
- Typical postoperative follow-up care”

Although the above services are always bundled into, or included in, each provided surgical service, depending on the payer, there may be additional services included. Many carriers, including Medicare, follow National Correct Coding Initiative (NCCI) edits. The NCCI Policy Manual for Medicare Services further details services included in more complex procedures.
Global Periods

For major surgical procedures, the surgical package begins the day before surgery, includes the day of surgery, and extends 90 days after surgery.

Example: Chapter 1: General Correct Coding Policies, Section A: Introduction states, “A physician should not unbundle services that are integral to a more comprehensive procedure ….” Section C: Medical/Surgical Package further defines services included in a variety of different procedure classifications. Specifically, for invasive procedures requiring vascular and/or airway access, the manual states:

The work associated with obtaining the required access is included in the pre-procedure or intra-procedure work. The work associated with returning a patient to the appropriate post-procedure state is included in the post-procedure work. Airway access is necessary for general anesthesia and is not separately reportable…Visualization of the airway is a component part of endotracheal intubation, and CPT codes describing procedures to visualize the airway (e.g., nasal endoscopy, laryngoscopy, bronchoscopy) should not be reported with an endotracheal intubation …

This is just one example of the procedures/services included in specific types of global surgical procedures, according to the NCCI Policy Manual for Medicare Services.

Global Periods

The global period accompanies the global surgical package and further defines the services included in it — specifically, during the post-operative period. The global period further classifies surgical procedures into two categories: major and minor.

Major surgical procedures are those with a 90-day global period. The 90-day global period is a bit of a misnomer, as the number of days included in the surgical package payment for these services is actually 92. For major surgical procedures, the surgical package begins the day before surgery, includes the day of surgery, and extends 90 days after surgery.

Minor surgical procedures are those with either a zero-day or 10-day global period. Each of these global periods refers to the number of post-operative days included; neither include any pre-operative days. For minor surgeries with a zero-day global period, only the services provided (including any E/M service other than the decision for surgery) on the day of surgery are included in the package payment. For minor surgeries with a 10-day global period, the global period is actually 11 days because the package includes the day of surgery and extends 10-days post-operatively.

Many encoder systems and health plans, particularly Medicare plans, offer a global period calculator providers and coders can use to calculate easily when a global period will end. Here are just two examples:

- Palmetto GBA (www.palmettogba.com/palmetto/global90.nsf/ Front?OpenForm)

The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule Look-up Tool (www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx) may be used to look up the global period/global days associated with each CPT®/HCPCS Level II code. Some global periods may vary from carrier to carrier. It is important to understand the global period descriptors that may appear next to a given CPT®/HCPCS Level II code.

000 = Zero-day post-operative period (endoscopies and some minor surgical procedures)
010 = Ten-day post-operative period (other minor procedures)
090 = Ninety-day post-operative period (major surgical procedures)
XXX = The global concept does not apply to the code
      The procedure/service is not considered surgical.
YYY = The global period is set by the carrier
      The global period may vary based on carrier.
ZZZ = Code is related to another service and always included in the global period of another service
      The procedure/service is usually an add-on code and is always bundled into the primary service
MMM = A service that is furnished in uncomplicated maternity cases, including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply.

The procedure/service is pregnancy related and the obstetrical package guidelines apply, rather than the global surgical package guidelines.

Use Appropriate Modifiers

Depending on the type of surgery performed and the associated global period, any modifiers may be needed to further describe the specific circumstances of the encounter and/or accurately divide, reduce, or increase the associated payment, etc. For more information on modifier use as it relates to global surgical package payment, see the CMS Medicare Learning Network (MLN) Global Surgery Fact Sheet.

Chandra Stephenson, CPC, CDEO, CIC, CPC, CPGO, CPMA, CPPM, CRC, CCS, CPC-I, CANPC, CCC, CEMC, CFPC, CGSC, CICM, COBGC, COSC, AAPC Fellow, is an independent consultant. She started out in healthcare over 14 years ago and has worked in various settings, including a centralized billing office, a family practice office, a cardiology office, and as a billing and coding instructor at a local technical college. Stephenson has worked as a coding and compliance auditor and enjoys conducting audits, researching coding and compliance issues, developing coding tools, and providing practitioner education.

Resources


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A s our lives become more intertwined with technology, so do our jobs. Many of us started with an ICD-9-CM tome, wondering how we’d ever digest its contents. We did it, though, as well as ICD-10 — and some of us really enjoyed it.

While taking an introductory coding course, I found it fun to use the alphabetic index in the book to pinpoint a code in the tabular list. It’s what initially drew me into medical coding. In my first coding job as the gastroenterology coder for the Department of Internal Medicine, I highlighted the codes I used in the index, and I would look back at the end of each year to see the pages became more and more yellow. At that time in my career, I printed consultations, progress, and operative notes off the computer, hand-coded them using the ICD-9-CM and CPT® codebooks, and then entered the diagnoses and procedure codes into our billing system.

What a difference five years make.

Fast Forward to Today’s Coding Technology

For facility coders and auditors, health data management system software (such as an encoder) is an essential part of day-to-day work. It’s crucial for computing diagnosis-related groups and sequencing codes for proper reimbursement. It also helps in evaluating Patient Safety Indicators and “hold bill” edits.

What Is an Encoder?

An encoder is a software program — a type of electronic “codebook” that assists in choosing codes by using a “tree” of terminology. This tree starts at a main level and then branches off, with selections for you to choose on each subsequent screen, until you find the most specific set of diagnosis and procedure codes available. Some encoders include a computer-assisted coding (CAC) element that suggests possible codes associated with diagnoses that may have been overlooked in the documentation.

Rely on coding technology for efficiency, but know your way around a codebook for accuracy.
Without a doubt, encoder software is important for more efficient work, and the use of an encoder helps speed up the coding process.

**Does an Encoder Replace the ICD-10-CM Codebook?**

The answer is no.

An encoder is a tool, and a tool is only effective when you understand how to properly use it. The paths in encoding systems are developed by people who may not have a medical coding background, but who understand nosology (i.e., the systematic classification of diseases). Relying on the software program alone, without using your book skills, could prove costly.

For example, the encoder may send you to the wrong location in the tree. This was especially true when transitioning from ICD-9 to ICD-10 — even with the mapping equivalents in place. There are a lot of additional codes in ICD-10, and the encoder had to learn along with us.

My facility was an encoder/CAC beta site, and we were dual-coding in ICD-9 and ICD-10 during August and September 2015. Our input helped the encoder software company fine-tune the coding paths to make the code mapping process more accurate for encoder users. Even after practicing dual-coding for two months, I spent many hours/days after the transition double-checking unfamiliar codes in my ICD-10-CM codebook. It was time well spent.

**Encoder Miscues Rely on ICD-10 Clarification**

Unfortunately, no amount of fine-tuning can make a system 100 percent reliable. You must know how to use the index in your codebooks to assess the accuracy of your encoder. Some issues are minor. For example, the encoder we use does not tree out to capture the external cause code for “perpetrator” when coding an assault (which is a coding guideline). I create my own path to arrive at that code. It also does not offer the option for hyperglycemia as a complication under diabetes (E11.65 Type 2 diabetes mellitus with hyperglycemia). I need to know to spell the complication under that option, rather than choose “other,” which results in a less specific code (E11.69 Type 2 diabetes mellitus with other specified complication).

Other encoder miscues can lead to greater issues. For example, if you code a case where a patient has an intestinal anastomosis, and you choose:

- Anastomosis
- Intestinal
- Other (with the only other choice being “complicated”)

You arrive at K63.89 Other specified diseases of intestine; however, the proper code is Z98.0 Intestinal bypass and anastomosis status, which is very different from having a specified disease of the intestine. Only by using the index in your codebook will you initially determine how to get to the code that the encoder did not find.

As another example, if you code vomiting in pregnancy and take this route:

- Vomiting
- Excessive in pregnancy (the only choice that is relevant)
- Other
- Gestation week

You arrive at O21.0 Mild hyperemesis gravidarum (a more severe form of morning sickness), when the better code is O21.9 Vomiting of pregnancy, unspecified. To get to the correct code in an encoder, you must start with:

- Pregnancy
- Complicated by
- Spell “vomiting”
- Unspecified
- Gestation week

**Accuracy Always Comes First**

Although technology is important to making you more efficient, it does not always lead to greater accuracy. Learning how to use the time-tested ICD-10-CM codebook should be your first step in becoming a proficient coder, and it should always be a readily available resource you rely on throughout your career.

Kelly Mitchell, MHA, MSHI, CPC, CGCS, CPMA, CCS, is the audit and quality monitoring coordinator for University of Missouri Healthcare’s Health Information Services Department. Her career path started seven years ago in physician coding, gastroenterology, and has progressed to facility coding and to auditing. Mitchell served as secretary of the Columbia, Mo., local chapter in 2014–2015.

You must know how to use the index in your codebooks to assess the accuracy of your encoder.
Coders can easily interpret and analyze medical record documentation and apply correct coding principles as defined by regulatory agencies. This version is ideal for everyone — from seasoned coders to students — who codes ambulatory surgery centers, hospitalists, emergency departments, diagnostic labs, outpatient clinics, and doctor’s offices.

**AAPC Coder – Hospital Inpatient Facility Coders**

The Hospital Inpatient Facility Coders version of AAPC Coder is made especially for inpatient facility coders. It’s perfect for coders and auditors who analyze documentation in patient medical records to assign the appropriate diagnostic and procedural codes for data retrieval, statistical analysis, and hospital reimbursement.

**Pick One that Suits Your Needs**

Each of the three products facilitates reviewing and discussing documentation and code selection discrepancies with physicians and providers. All AAPC Encoder versions provide quick access to the rules you need in your clarification and educational meetings. Researching and preventing denials is a snap with special tools built right in.

“I love the claim scrubber and cross reference the best,” says Sivak. “And because I can see what diagnosis codes are most commonly used together with procedure codes, I’m able to double-check myself and my specificity more quickly.”

AAPC Coder also makes maintaining knowledge painless. By reviewing coding and reimbursement newsletters, you can earn 20+ CEUs by doing your daily job. HBM

**Never Fear, AAPC Coder Is Here**

AAPC Coder is a software program that converts medical codes from codebooks and information from coding and billing references to dramatically increase coders’ speed. These tools use key words and look-up functions to access all related information more quickly than flipping pages and searching websites for different payer rules.

“AAPC Coder (the medical encoder developed by AAPC) was designed by coders who love books,” said Robin Sherman, a coder in Fort Lauderdale. “The complete ICD-10-CM Index, for example, is a feature in the program that many coders don’t know about. It’s exactly like using your book — only faster.”

Another coder, Lorraine Sivak, CPC, in Orlando, told us, “When I used books, I made notes in them. Now, I use AAPC Coder and I still make notes, but now they last forever until the code is updated or deleted.”

AAPC Coder allows you to access the latest codes, coding references, and billing regulations in a sophisticated and easy-to-use, online search engine. The results are fewer coding errors and, consequently, fewer coding-related denials. Coders save time and their employers save money.

In product tests, AAPC Coder increases coding speed an average of 33 percent over the use of coding books.

AAPC Coder accommodates coders based on their unique coding needs, and is priced to be the most cost-effective tool available in the market.

**AAPC Coder – Pro Fee Coders and Outpatient Facility Coders**

The Pro Fee Coders and Outpatient Facility Coders version of AAPC Coder is made especially for outpatient facility coders, physician and non-physician professional fee coders, and diagnostic lab coders. It’s perfect for coding and auditing E/M, surgical, radiology, testing, diagnostic labs, and other CPT® and HCPCS Level II procedural codes for claim submission.

**Payment reforms and other emerging healthcare rules require effective medical coders to review hundreds of references on a daily basis. In 2018, to get full credit for participating in the Merit-based Incentive Payment System (MIPS), coders must code chronic conditions and relationship and patient status codes that were never necessary before. And diagnosis coding is expected to significantly increase per claim. At the same time, coders are held to outdated productivity and accuracy standards that require them to do more coding in less time. Fortunately, there is a solution.**
For the first time ever we have combined the power of AAPC Coder with the hardcopy books you love! Our new bundles were created specifically for those seeking more efficient and faster medical coding lookup times while getting the best value for the money.

Learn More: aapc.com/addsoftware
Coding for shoulder procedures has changed significantly since 2004. If you haven’t stayed current, chances are you are under- or over-coding. To make sure you recoup proper reimbursement, let’s address CPT® codes 29821, 29822, 29823, 29824, 29826, 29827, 29828, 29806, and 29807, as well as arthroscopic superior capsular reconstruction (ASCR).

**Codes 29821-29823**

Three shoulder codes, in particular, cause a lot of confusion:

- **29821** Arthroscopy, shoulder, surgical; synovectomy, complete
- **29822** debridement, limited
- **29823** debridement, extensive

The American Medical Association (AMA) and the American Academy of Orthopaedic Surgeons (AAOS) agree that, to report 29821, the “entire intra-articular synovium” must be removed (CPT® Assistant, June 2013, and AAOS Bulletin, April 2006).

Regarding the difference between 29822 and 29823, most payers follow the April 2006 AAOS Bulletin guidelines, which state extensive debridement includes debridement of multiple soft structures, multiple hard structures, or a combination of both. Here are three examples of extensive debridement:

- A chondroplasty and a debridement of the labrum (a combination of hard and soft structures)
- An abrasion arthroplasty (microfracturing/drilling down to bleeding bone) and a biceps tenotomy (a combination of hard and soft structures) (see CPT® Assistant, September 2012)
- Debridement of a biceps tendon and a partial thickness rotator cuff tear (multiple soft structures)

The December 2016 CPT® Assistant further clarifies that an extensive debridement “additionally includes removal of osteochondral and/or chondral loose bodies, biceps tendon and rotator cuff debridement, and abrasion arthroplasty.”

Do not separately report the debridement if the surgeon also repairs the debrided structures. Also, most payers consider the labrum to be one structure, and do not divide it into upper or lower portions for debridement.

As of July 1, 2016, (and as further clarified in the updated National Correct Coding Initiative (NCCI) guidelines effective Jan. 1, 2017), 29823 may be reported separately with 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair, 29828 Arthroscopy, shoulder, surgical; biceps tenodesis, and 29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure).

With few exceptions, NCCI edits bundle arthroscopic debridement into all arthroscopic surgical codes for the joint being worked on. For example, when performing a superior labral tear from anterior to posterior (SLAP) repair (29807 Arthroscopy, shoulder, surgical; repair of SLAP lesion) and a debridement of a rotator cuff tear and biceps tear (29823), you cannot separately report 29823, per NCCI guidelines, because the debridement is considered inclusive (unless it’s for the opposite shoulder; see NCCI guidelines, chapter 4).

**Bonus tip:** For arthroscopic rotator cuff repair with debridement of the biceps tendon and debridement of the labrum, along with a bony...
Shoulder Coding

acromioplasty, you may report 29827, +29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure), and 29823 because the bundling edit is removed from 29827 and 29823.

**Codes 29824 and 29826**

When reporting 29824, documentation should support that the entire distal end of the clavicle was resected. Neither CPT® nor the Centers for Medicare & Medicaid Services (CMS) state how much bone must be removed to be considered the “entire” distal end. The AMA provided a clinical example when 29824 was first developed — but it was strictly an example, and not all-inclusive of the requirements for reporting. For years, AAOS referenced size in their CodeX and Global Service Data books to be sure surgeons were not reporting 29824 for removing only a spur. Since 2010, however, all “size” references were deleted from AAOS publications.

Many offices have stopped reporting 29824 unless there is a documented reference to size, but this is a mistake. If there is a question as to whether a procedure was done, query the surgeon. Some payers have placed size references in their own internal policies, but that is a payer-contracted issue.

CPT® made 29826 an add-on code several years ago; however, some payers — especially workers’ compensation carriers — have retained 29826 as a full-value code. You may want to double-check this with your contracted payers, also. Per CPT®, +29826 may be reported only with other shoulder arthroscopy codes. Medicare agrees, and allows +29826 to be reported with all other shoulder arthroscopy codes, including 29822 and 29823. Be sure there is clear documentation that bony work was performed on the acromion to support +29826.

Many payers are now requiring a “bony tool” to be referenced in the body of the report for +29826 to be paid. Documentation of converting the acromion from a type 3 to a type 1 can also be beneficial to support this code.

If only a subacromial bursectomy is performed, without any bone resection, report a debridement, not +29826.

Many surgeons continue to perform arthroscopic subacromial decompression alone, or with open shoulder procedures. The AAOS, the Arthroscopy Association of North America, and the AMA advise to report this scenario with an arthroscopic debridement code, 29822 (soft tissue only) or 29823 (bone and soft tissue). If done with an open rotator cuff repair (23410/23412), many payers do not allow separate reimbursement for acromioplasty, regardless of approach with an open or mini-open rotator cuff repair. Check payer policy (and get something in writing) before billing acromioplasty as a debridement code.

**Codes 29827 and 29828**

Only one rotator cuff repair code is allowed, per shoulder. Whether one or all four components that make up the rotator cuff (supraspinatus, infraspinatus, teres minor, and subscapularis (SITS)) are repaired in a single shoulder, report a single unit of 29827. If the surgeon begins a rotator cuff repair arthroscopically, but converts to a mini-open approach to finish, report only the appropriate “open” CPT® code (23410 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute or 23412 Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic). You may report 23410/23412 with modifier 22 Unusual procedural service appended to account for the arthroscopic work done prior to the open portion. Do not report both the open and arthroscopic codes because the work was in the same anatomic location and same session, which does not support the definition of modifier 59 Distinct procedural service.

ASCR is a newer arthroscopic procedure for an irreparable rotator cuff. This procedure involves placement of a fascia lata or similar graft that is attached to the top of the glenoid and greater tuberosity of the humerus. This is not a side to side or reattachment of the cuff tissue; it involves placement of graft material, which makes it a reconstruction, not a repair. There is no CPT® code to describe this
Shoulder Coding

Ideally, the surgeon documents where on the labrum the work was performed; referencing “clock” positions is the best form of documentation.

procedure. Per the AMA Coding Committee, CPT® guidelines, and April 2017 CPT® Assistant, ASCR may be reported as an unlisted procedure (29999 Unlisted procedure, arthroscopy). It’s inappropriate to report ASCR using 29827 (either with or without modifier 22).

Code 29828 Arthroscopy, shoulder, surgical; biceps tenodesis represents an arthroscopic biceps tenodesis. A mini-open biceps tenodesis should be coded as open with 23430 Tenodesis of long tendon of biceps.

Prior to biceps tenodesis, the surgeon often debrides and cuts the biceps (tenotomy). This is inclusive to the tenodesis, so do not report it separately.

Biceps tenodesis, or transferring the attachment of the biceps to the humerus (23430/29828), may be reported separately, according to CPT® Assistant (July 2016), and is not part of a normal rotator cuff repair.

Codes 29806 and 29807

When 29806 Arthroscopy, shoulder, surgical; capsulorrhaphy and 29807 were developed, William Beach, MD, of the AAOS Coding Committee stated the goal was to divide the labrum in half (29807 upper half, 29806 lower half). Ideally, the surgeon documents where on the labrum the work was performed; referencing “clock” positions is the best form of documentation. For example, “The patient had a labrum tear from 11 o’clock to 2 o’clock, with tacks/anchors/etc. placed at 11, 1, and 2 o’clock.” This documentation indicates the surgeon worked on the upper half of the labrum code, and supports 29807.

NCCI now bundles codes 29806 and 29807, and only allows one per shoulder, per session. Per the AAOS Bulletin, for top and bottom repairs of the labrum at the same session, append modifier 22 to the code to acknowledge the additional work performed. Check with private payers, as well as workers’ compensation carriers, to see if they allow either 29806 or 29807 on the same shoulder.

NCCI also bundles 29806 and 29827, and will only allow one of the codes per shoulder, per session.

To indicate procedures on different shoulders, you may use modifiers LT Left side and RT Right side. You can read about this issue under NCCI guidelines, chapter 4.

Remplissage (meaning “to fill in”) is becoming more common for a posterior Hill-Sachs lesion following an anterior dislocation. The surgeon fills in the lesion by capsulodesis and a tenodesis of the infraspinatus. The remplissage is considered inclusive to the Bankhart, according to the AAOS; however, American Hospital Association’s (AHA) Coding Clinic for HCPCS (third quarter, 2016) advises reporting both the capsulorrhaphy (29806) and an unlisted arthroscopy code (29999) for the remplissage procedure. This will come down to payer policy.

Keep Up with Updates

Coders, billers, and surgeons must stay up to date with information from official sources such as the AMA/CPT®, CMS, and specialty societies such as AAOS. Check your contracted payers’ policies quarterly to see if they have changed or updated their requirements.

Margie Scalley Vaught, CPC, COC, CPC-I, CCS-P, PCE, MCS-P, ACS-EM, ACS-OR, has over 30+ years of experience in the healthcare arena, with 25 of those years in orthopedics. She served as an AAPC National Advisory Board member for over 3 years. From 1998-2014, Vaught has been providing consulting services to CodeCorrect.com/Medassets.com. She also contributes and writes articles for the AAOS Bulletin and other journals. Vaught is a member of the Olympia, Wash., local chapter.

Ruby Woodward, BSN, CPC, CPMA, COSC, CSFAC, CPB, has over 40 years of experience in the medical arena, starting as an orthopedic nurse. She has spoken nationally on various coding and reimbursement issues. Woodward is coding and compliance manager at Suburban Radiology in Minnesota. She also codes and is a consultant for several orthopedic groups. Woodward’s areas of expertise include coding, documentation, policy interpretation, education, data quality, appeals, and denials. She is a member of the AAPC Chapter Association board of directors, served as the 2016-2017 treasurer, and is the 2017-2018 vice chair. Woodward held the offices of president, vice president, and membership development officer of the Minneapolis, Minn., local chapter.

Resources

CPT® Assistant, 2013, July 2016, December 2016, April 2017
AAOS Bulletin, April 2006
AHA Coding Clinic for HCPCS, third quarter, 2016
NASHVILLE
Gaylord Opryland Resort
TENNESSEE

INTERVENTIONAL RADIOLGY
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“What I liked best about the program was the ability to ask questions supplied examples and the anatomy explanations. It was very well presented. Well worth the time and energy.” -- Patricia Mauritz, Director of Cardiovascular Coding Services

“Dr. Z’s conversational style makes the info more easily absorbable. The description of how the procedures are done helps as well and love the devices being passed around.” -- Genie Vaughn, St. Thomas Health

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HIPAA: Are You an Expert or a Flunky?

See if your knowledge of Privacy and Security Rules is a help or a hindrance to your practice’s compliance.

Take this quiz and then score yourself to find out if you are a HIPAA expert, a HIPAA flunky, or somewhere in between.

Note: You will not earn any continuing education units (CEUs) for taking this quiz. It is just for the satisfaction and fun of testing your HIPAA knowledge.

Test Your HIPAA Knowledge

1. Today, what describes “HIPAA Rules” best?
   a. The Health Insurance Portability and Accountability Act of 1996
   b. The Privacy, Security, and Breach Notification Rules
   c. The HIPAA Final Rule, which took effect Sept. 23, 2013
   d. The Health Information Technology and Clinical Health Act (HITECH) of 2009

2. A business’ Notice of Privacy Practices is required to be:
   a. Posted in the waiting room in plain sight
   b. Available as a handout for any patient who requests a copy
   c. On the practice’s website
   d. All of the above

3. HIPAA training for a medical practice’s staff is required:
   a. Upon hire
   b. Monthly
   c. Bi-annually
   d. Upon hire, and whenever policies and procedures are updated that impact how staff protect privacy while doing their jobs

4. HIPAA training at a private practice is required of:
   a. Staff and volunteers, with the exception of minors
   b. Patients
   c. Physicians and other qualified healthcare professionals
   d. The entire workforce

If you answered 15 or fewer questions correctly, you may not want to admit it to anybody.
5. How many new patient rights are there under HITECH, and what are they?
   a. Two: Right to request protected health information (PHI) not be shared with your insurer when you pay in full; and Right to be notified of a breach.
   b. Two: Right to privacy; and Right to integrity of data.
   c. Six: Right to access, copy, and inspect their record; Right to amend; Right to accounting of certain disclosures; Right to request privacy protections; Right to complain about alleged violations; and Right to be notified when a breach occurs.
   d. Six: Right to privacy; Right to integrity of data; Right to complain; Right to edit their medical record; Right to request confidentiality; and Right to be notified of a breach.

6. HIPAA documentation must be maintained by a practice for how many years?
   a. Two
   b. Four
   c. Six
   d. Eight

7. HIPAA is enforced by:
   a. Centers for Medicare & Medicaid Services (CMS)
   b. Office of Inspector General (OIG)
   c. Office for Civil Rights (OCR)
   d. False Claims Act (FCA)

8. A covered entity is which of the following?
   a. Any provider who sends claims electronically
   b. Any provider who sends hard-copy claims
   c. Any provider
   d. Any provider who sees Medicare patients

9. Which is most likely not a HIPAA violation?
   a. Charging a patient a $50 fee for a copy of their five-page medical record
   b. Allowing a patient to amend their record
   c. Sending an unsecured email that contains PHI without the patient’s permission
   d. Leaving a detailed message with the patient’s administrative assistant that contains PHI

10. Which is a HIPAA violation?
   a. Sending a claim to an insurance company after a patient self-pays in full and requests no disclosure of their PHI to their insurance company
   b. Restricting communication according to the patient’s instructions on a “confidential communication” form
   c. Faxing an encounter form and copy of a patient’s insurance card to the practice’s billing company
   d. Mailing medical records to a patient’s primary care physician from a specialist’s office

11. Under HIPAA, which is a permissible use of a practice’s mailing list?
   a. Providing it to a drug company for a mass mailing of marketing materials
   b. Selling it for a fair market rate
   c. Anything you want, as long as patients provide verbal authorization
   d. To use PHI for a purpose not explicitly allowed for in the rule, written approval from each patient is required

12. The maximum fine HIPAA can impose on a physician, per violation, in a year is:
   a. $250,000
   b. $500,000
   c. $1,000,000
   d. $1,600,000

13. The highest category of fine imposed for a specific violation of HIPAA is:
   a. Willful neglect – not corrected within 30 days
   b. Willful neglect – corrected within 30 days
   c. Did not know
   d. Reasonable cause

14. Inpatient-based physicians who “borrow” or work under the Notice of Privacy Practices from the covered entity where they see patients are referred to by HIPAA as:
   a. Occupational Safety and Health Administration (OSHA)
   b. Covered entity
   c. Organized Health Care Arrangement (OHCA)
   d. Clinically-integrated
15. For OCR enforcement under HIPAA, business associates are:
   a. Only liable “downstream” from a covered entity
   b. Directly liable
   c. Always equally liable with covered entity
   d. Exclusively liable

16. Which is not typically considered a business associate?
   a. Subcontractor
   b. Document storage company
   c. Janitorial service
   d. Electronic health record (EHR) vendor

17. An organization or individual will be considered a business associate under HIPAA if they create, receive, maintain, or transmit which of the following to do their job?
   a. Medical records
   b. PHI
   c. Hospital records
   d. Insurance information

18. Which is not a type of safeguard that must be addressed in a practice’s security risk assessment?
   a. Administrative
   b. Procedural
   c. Physical
   d. Technical

19. The highest HIPAA civil monetary penalty (CMP) imposed to date is which amount?
   a. $1.5 million
   b. $2.4 million
   c. $3.5 million
   d. $4.3 million

20. What are covered entities that settle with the federal government for potential violations of HIPAA often forced into?
   a. Consent decrees, with no admission of guilt
   b. Settlements with resolution agreements, requiring a monitoring period of 2–3 years
   c. Corrective action plans that last 20 years
   d. Notices of apology and consumer credit card reporting

21. How many CMPs have been imposed against covered entities since 2003 when HIPAA first went into effect?
   a. 1
   b. 3
   c. 10
   d. 27
Answer Key

1. B: The Privacy, Security, and Breach Notification Rules are the regulations that are promulgated by the U.S. Department of Health and Human Services’ (HHS) OCR to implement the laws, which are now both HIPAA of 1996 and HITECH of 2009.

2. D: HIPAA requires a practice to provide the notice three ways: posted in the office, available for patients who come in, and on their website.

3. D: HIPAA requires training within a reasonable amount of time when someone joins the practice, and as business practices change. It’s worthy to note, however, that the expectation by OCR in audits is to ask for records of annual training.

4. D: HIPAA requires practices to train their workforce. The OCR operationalizes the definition of workforce members broadly to include all full-time and part-time employees, volunteers, etc.

5. A: HITECH added the right to restrict PHI from going to an insurer when the patient pays for the item or service out-of-pocket and in full. HITECH also added the Breach Notification Rule, which requires affected individuals to be notified when a breach of their PHI occurs.

6. C: HIPAA Rules require all documentation showing compliance with HIPAA to be maintained for six years after the date it was last in effect.

7. C: The Office for Civil Rights, which is in charge of ensuring individuals’ civil rights are maintained, enforces the Privacy, Security and Breach Notification Rules.

8. A: HIPAA was originally passed as a simplification rule, and targeted electronic transactions. The privacy and security portions were tacked onto the simplification of those electronic standards. HIPAA only applies to covered entities who conduct standard healthcare transactions electronically.

9. B: The patient has a right to amend their medical record. The other options are all allowed in certain circumstances, but are likely hard to justify.

10. A: Under HIPAA, a patient who pays in full, out-of-pocket, has the right to request no disclosure of their PHI to their insurance company.

11. D: Authorizations must be in writing and contain certain elements to use PHI for a purpose not explicitly allowed for in the rule (Treatment, Payment, or Operations).

12. D: HITECH allowed for increasing penalties up to $1.5 million per year, per violation. This was increased in late 2016 to $1.6 million for inflation adjustment.

13. A: HITECH increased enforcement in penalties surrounding “willful neglect.” Discretion is allowed in cases where the willful neglect is corrected within 30 days.

14. C: An OHCA is a clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. When organized in this manner, covered entities are allowed to work under the same Notice of Privacy Practices.

15. B: HITECH changed applicability of the HIPAA Rules to include business associates, who can now be audited, fined, etc.

16. C: HITECH clarified that certain entities, such as EHR vendors and document storage companies, must be considered business associates when they create, receive, maintain, or transmit PHI on behalf of a covered entity. Subcontractors are considered business associates if they fit the definition.

17. B: Under HIPAA, the definition of a business associate is a person or entity who, on behalf of a covered entity or an OHCA, creates, receives, maintains, or transmits PHI for a function or activity regulated by the Privacy Rule.

18. B: The HIPAA Security Rule requires that administrative, technical, and physical safeguards be addressed and implemented.

19. D: The HHS OCR fined Cignet Health of Maryland a CMP of $4.3 million for failing to comply with the patient rights under the Privacy Rule in October 2010. There have been higher settlement amounts, but Cignet was the highest CMP to date.

20. B: Most HIPAA enforcement actions levied since 2009 have included Resolution Agreements, which require the entity to put in place various safeguards and controls, and report progress to the federal government, with compliance for 2-3 years.

21. B: There were only three times since 2003 when OCR proceeded with CMPs against an organization for HIPAA violations, instead of settling.

How Well Did You Do?

If you got 100 percent, you’re a HIPAA expert! If you’re not already your practice’s HIPAA privacy or security officer, you may want to consider applying for the job.

If you answered 16-20 questions correctly, you are on the right track. Your knowledge on HIPAA is about average. Most likely, you’re not causing concerns for your practice. However, there might be more expertise you can attain.

If you answered 15 or fewer questions correctly, you may not want to admit it to anybody. We’d recommend immediate training in the essentials of HIPAA before you put yourself and your practice at risk.

Marcia L. Brauchler, MPH, FACMPE, CPC, CPC-I, CPHQ, is president and founder of Physicians’ Ally, Inc., which provides advice and counsel to physicians and practice administrators, as well as education and assistance on how best to negotiate managed care contracts, increase reimbursements, and stay in compliance with healthcare laws. Brauchler is lead author of several compliance solutions for physician practices (HIPAA, OSHA, Compliance Plan) and online staff trainings, which are available at the MGMA Store (www.mgma.com/store). She is a member of the South Denver, Colo., local chapter.
The HIPAA Security Rule makes a risk analysis mandatory for all HIPAA covered entities (CEs) and business associates (BAs). This section of the rule is found in the Administrative Safeguards and states: “Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity and availability of electronic protected health information (ePHI) held by the CE or BA.” The italicized words are defined in HIPAA rules. HIPAA definitions are both the foundation of HIPAA and part of the scope of HIPAA requirements.

Although the rule does not say how often your business needs to do a risk analysis and assessment, the Office for Civil Rights (OCR) has said since 2009 that a CE and BA must do a risk analysis plus assessment every year — and more often if you upgrade technology, move offices, and expand services.

Know Your Vulnerability Risks

The parts of a HIPAA risk assessment to explore are your risks and vulnerabilities. These terms are not defined in the HIPAA rules, but they generally refer to anything that poses a danger or hazard to your business. In other words, risks and vulnerabilities are exposures that open your business to danger and liability. Another word for risk is insecurity.

The risks and vulnerabilities to your business include:

- Mobile tools:
  - Laptops
  - Tablets
  - Removable media (CDs/DVDs/memory sticks, etc.)
- Out-sourced work
- Off-shore work
- Cloud usage
- Spear phishing
- Ransomware

Protect Yourself

What can you do to protect your business?

- Perform a yearly risk analysis and assessment.
- Review and update HIPAA policies and procedures, yearly.
- Provide HIPAA training, yearly, and more often if necessary.

There are two free tools to help you perform a risk assessment:

- NIST HIPAA Toolkit at [https://scap.nist.gov/HIPAA/](https://scap.nist.gov/HIPAA/)

A HIPAA risk analysis and assessment is one of the major defenses for any CE or BA. And it’s one document the OCR asks for when scheduling your business for a HIPAA audit or investigating your business for a HIPAA breach.

Susan A. Miller, JD, is a national HIPAA and HITECH Act healthcare expert and strategist focused on covered entities, business associates, technology companies, federal agencies (including OCR, NIST, and CMS), accountable care organizations, regional extension centers, Medicaid agencies, states, and national and state trade associations. She developed the NIST HIPAA security risk analysis and audit tool used across the industry.

Resources

45 CFR 164.304 + 160.103, Definitions
Intelligent Auditing. Now with Analytics.

Take the guesswork out of deciding which providers to audit. With the power of Analytics inside of Audit Manager, you’ll save your audit staff time and effort by pinpointing providers who are a risk to your organization.

HEALTHICITY.COM/AUDITMANAGER
The U.S. Court of Appeals for the Third Circuit held recently that Title IX of the Education Amendments of 1972 (Title IX) can apply to residency programs at hospitals. The ruling may profoundly affect how hospitals respond to complaints of sex discrimination (including sexual harassment) by resident physicians, and it may necessitate hospitals to comply with federal Title IX regulations and guidance.

Title IX prohibits sex discrimination in the “education programs or activit[ies]” of entities receiving federal financial assistance. The ruling also opens the door for residents to sue under Title IX if they experience sex discrimination. Suing under Title IX avoids the complex administrative exhaustion process required to file a similar claim under Title VII of the Civil Rights Act of 1964, which generally governs sex discrimination in the workplace.

Case Determines Residency Sexual Harassment Is Not Title VII

In Jane Doe v. Mercy Catholic Medical Center, the plaintiff participated in an accredited residency program at Mercy Catholic Medical Center. The plaintiff alleged that Mercy had an affiliation agreement with Drexel University’s College of Medicine. As part of her residency in diagnostic radiology, the plaintiff alleged she was required to attend daily lectures and case presentations and had to take a mandatory physics class taught on Drexel’s campus. The
plaintiff alleged she was sexually harassed by the director of Mercy’s residency program and that Mercy retaliated against her when she complained. According to the plaintiff, she eventually resigned from the program to avoid termination in retaliation for raising her concerns.

Instead of filing a charge of employment discrimination against Mercy with the Equal Employment Opportunity Commission (EEOC) under Title VII, the plaintiff instead filed suit to recover under Title IX, alleging quid pro quo and hostile environment harassment, as well as retaliation. The district court dismissed the plaintiff’s Title IX claims, concluding that a residency program is not an “education program or activity” under Title IX; and even if it was, the plaintiff could not use Title IX to circumvent the procedural exhaustion requirements in Title VII that apply to sex discrimination claims in the workplace — a view taken by the Fifth Circuit and other circuit courts. On appeal, the Third Circuit acknowledged that the plaintiff likely fell into the category of “employee” protected by Title VII, and that Title VII requires a plaintiff-employee to exhaust certain administrative remedies prior to filing suit. The Third Circuit held that Title VII does not exclusively remediate the plaintiff’s alleged sex discrimination and that she was free to proceed under Title IX, despite not filing a pre-suit discrimination charge with the EEOC.

**Title IX Proceedings Determine Residency Is an “Education Program”**

With regard to the Title IX claim, the Third Circuit reversed the district court’s decision and ordered that it reconsider the claim. In concluding that a residency program can be an “education program or activity,” the Third Circuit first noted that the Civil Rights Restoration Act of 1987 amended Title IX to make clear that “all of the operations” of certain classes of federal funding recipients are “programs and activities,” subject to Title IX’s prohibition on sex discrimination if they are educational in nature. Among the classes of funding recipients are private organizations “principally engaged in the business of providing education, healthcare, social services, or parks and recreation.”

The court determined Mercy’s residency program is an “education program or activity.” The court held that a program or activity is “educational” if it has “features such that one could reasonably consider its mission to be, at least in part, educational.” The determination is based on whether the “defendant-entity’s questioned program or activity has educational characteristics,” not on the plaintiff’s subjective characterization of whether he or she learned something from the program.

### Factors that Determine if a Residency Falls Under Title IX

The court identified several factors that could support a program or activity educational in nature:

- The program is incrementally structured through a course of study or training, whether full or part time;
- The program allows participants to earn a degree or diploma, or qualify for a certification or certification examination, or pursue a specific occupation or trade beyond on-the-job training;
- The program provides instructors, examinations, an evaluation process or grades, or accepts tuition;
- The entities offering, accrediting, or otherwise regulating a program present it as educational in nature.

In light of its legal determinations, the court concluded that Mercy could be subject to Title IX, noting that the plaintiff alleged sufficient facts to show:

1. The program required her to learn and train under faculty, attend lectures, help present case presentations under supervision, participate in a physics class on a university campus, and sit for annual examinations;
2. Mercy held the residency program as a “structured educational experience;” and had the plaintiff completed the program, she would have been able to take and potentially obtain a certification from the American Board of Radiology; and
Mercy was affiliated with Drexel University’s medical school, a “university program plausibly covered by Title IX” in its own right. The affiliation between Mercy and Drexel included courses taught on Drexel’s campus and Mercy’s provision of the “clinical bases” for Drexel’s emergency medicine residency.

The Third Circuit assumed, without deciding, that:

- Mercy received federal financial assistance, triggering Title IX coverage (specifically, Medicare payments); and
- The plaintiff had pled a facially-valid Title IX claim based on:
  - The residency director’s offer of a quid pro quo;
  - Mercy’s failure to address the conduct leading to a hostile environment; and
  - The alleged retaliation that forced the plaintiff to resign.

What This Means to You

The Third Circuit’s decision immediately affects hospitals with residency programs in Delaware, New Jersey, Pennsylvania, and the U.S. Virgin Islands because the decision is binding on the district courts in those states. Under Mercy’s reasoning, those residency programs may qualify as education programs and activities subject to Title IX, especially if the sponsoring hospital has an affiliation agreement with a college or university indisputably subject to Title IX. Other jurisdictions also may adopt the Third Circuit’s reasoning, increasing the risk nationwide of medical residents filing sexual discrimination suits against the hospital under Title IX. An immediate result is that hospitals may not have warning of an impending lawsuit as they would through the Title VII EEOC process.

Since 2011, federal agencies, such as the Department of Education, have promulgated formal and informal guidance concerning an institution’s obligation to prevent, investigate, and remediate sex discrimination (including sexual harassment and sexual violence) in education programs and activities covered by Title IX. Although academic medical centers affiliated with a university system may already be aware of and in com-
pliance with this guidance, private hospitals that merely operate residency programs likely are not. The guidance covers a myriad of topics, such as:

• Training programs to prevent sexual harassment and sexual violence
• Components of an effective grievance policy for investigating and remediating sex discrimination
• Interim measures taken during the pendency of an investigation
• Trauma sensitivity
• Timelines for promptness

Plaintiffs filing Title IX claims against colleges and universities have argued that the department’s guidance sets a standard of reasonableness and that an institution’s failure to abide by such guidance constitutes deliberate indifference, subjecting the institution to Title IX liability. Plaintiffs may, in light of Mercy’s ruling, attempt to extend the reach of such guidance to residency programs. If successful, the effort requires substantial investment by hospitals into building Title IX compliance infrastructure, including policy revisions, training for residents and staff, developing an effective investigation office, and providing support and assistance services to reported victims of sexual harassment and sexual violence.

Become Familiar with Title IX

Roughly 700 hospitals throughout the country operate residency programs accredited by the Accreditation Council for Graduate Medical Education. Hospital administrators responsible for managing residency programs should familiarize themselves with Mercy and work with counsel to determine the likelihood that their program is covered by Title IX. If there is a high likelihood the program is covered, take steps to meet federal Title IX expectations to minimize the risk of future litigation and an adverse verdict.

Derek Teeter, JD, and Lorinda Holloway, JD, are partners with the national law firm Husch Blackwell and practice healthcare, education, and life sciences law. Teeter may be reached at derek.teeter@huschblackwell.com and Holloway may be reached at lorinda.holloway@huschblackwell.com.

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recently encountered a student who shared her story of going back to school and working to obtain a certification as a Certified Professional Coder (CPC®). She began her academic journey as a single parent and a working professional. After first completing her associate degree, she pursued the certifications required to enhance her education and career. After failing the CPC® exam several times, however, she questioned whether she would be successful, or even make it to the finish line. Her instructor would reassure her and say, “No worries! We’re here for you” and “You’ve got this.” Her instructor became her mentor, providing her with one-on-one tutoring after class until she passed the exam.

The point is: A good instructor can make all the difference in another person’s life and career. If you are an instructor, continue to set the best example you can for students. And if you are a student, remember that it isn’t important how many times you fall, but how many times you get up.

Here are some ways to reach your students and help them succeed.

**Set Clear Expectations**

Set clear expectations for your students, and have each student establish clear expectations for themself. Be clear about what is required of them as a student.

Instructors should set students up for success. Define your students’ strengths and weaknesses. Get to know your students before class and determine their individual goals. Take note of the different learning styles of your students. Be prepared to provide various teaching strategies for a diverse learning environment.

Let’s face the facts: Many students may have been out of school for some time and often come into class with self-doubt. It is important to provide a sense of community, and to send a message that “we are in this, together.”

**Value the Student, Not the Number**

Value each student. Invest in the success of your students, no matter how many attend class. Even if you have one student on a particular
Teaching

“The best teachers are inspiring leaders that show students how they should behave in all areas of life and in all types of situations.” — Teaching English with Magic (http://anaisacunha.blogspot.com)

day, be prepared to teach your class. Realize this is one of the most important goals this student has during this time. Stand behind your student as they pursue the goal of certification.

Small and intimate classes may provide a financial strain on the instructor; however, student retention and student success has a significant positive impact on the bottom line.

Offer One-on-one Tutoring
There are many learning styles. Students require the time and space to ask questions comfortably. When you notice a student needs additional help, or when a student asks for help, set time aside to spend with that student. There are several ways to do this, such as face-to-face, Skype, and phone conference. Show your students they can trust you to be there for them during this time of learning.

Be Resourceful
Provide resources to help students learn more. Suggest websites or books to provide additional information on the area of study. Provide tips on where to find the materials needed for class.

Teach Your Students About AAPC Benefits
AAPC offers abundant information, and as a new student or new member it can be difficult to navigate it all. Go over the AAPC website and show your students how to complete their profile, select local chapters, get free continuing education units (CEUs), access chapter forums, networking, and events in the area to help them enhance their career through education.

Encourage your students to become active at their local chapter. A great way for new students to network is through volunteering at their local chapter. For example, a student might volunteer to proctor an exam to see how the process works or volunteer to greet members at the meetings. Volunteer efforts do not go unnoticed, and rewards come for those who give their time to help others.

You might also take a class field trip to a local chapter meeting or ask a local chapter officer to come and speak to your students.

Prepare students for success:
- Be transparent in your teachings.
- Review resumes and provide tips.
- Practice interviews.
- Provide tips on dressing for success.
- Provide resources on key words when looking for employment.
- Educate on “foot in the door” opportunities.

Provide Constructive feedback
Constructive feedback encourages confidence and reassurance to students as they go through the learning experience.

Be respectful and explain to students where you see areas of struggle. Give them the tools to help strengthen those areas. Identify ways you can teach the information needed so they can understand it better. Provide useful feedback when grading assignments.

Be Human
The most effective educators bring their entire selves to the job. They celebrate students’ successes, show compassion for struggling parents, tell stories from their own lives, laugh at their mistakes, share their unique quirks, and aren’t afraid to be imperfectly human in front of their students.

Celebrate Your Students
Celebrate your students’ success as if it is your own, and keep in touch. For example:
- Place their testimonies on your website or blog.
- Provide a newsletter with resources for CEUs.
- Encourage students to continue their education to advance their career.

When a student hears from an instructor, it serves as a reminder of where they came from and how far they’ve come. This brings peace to where we are and motivates us to go further.

Elizabeth Martin, RHIT, CPC, CPC-I, is the senior healthcare consultant for Physicians Revenue 1st, LLC. She has more than 17 years of coding and billing education for physician practices. Martin offers tutoring and mentoring. She is also a remote risk adjustment HCC auditor. For education and billing questions, Martin can be reached at emartinjsr@physiciansrevenue1st.com. She is the president of the Charlotte N.C., local chapter.

www.aapc.com July 2017
You created the perfect cover letter and resume, and submitted it with a job application for that coding, billing, or practice management position you really want. And now, your golden opportunity has come: You've been called back for an interview. Here are five tips that will help you ace the interview and get that job.

1. **Do Your Research**

The most qualified applicant is not always the one who is hired. Qualifications matter, but so does self-presentation. Interviewing successfully starts by having knowledge and understanding of the employer. Research the facility or practice, know the job requirements, and get some background on the person who will be interviewing you. The more information you have on the organization, and the more you understand the employer, the better you will do in the interview. It will also prepare you to ask questions that are relevant to the job.

In the interview, try to maintain composure and provide concise answers that focus on specific examples and accomplishments you’ve achieved. Don’t memorize your responses ahead of time, or you’ll seem like a robot; rather, come with a mental outline of the specific points that highlight your skills and job-related attributes.

2. **Dress the Part**

We’ve all heard the advice, “Dress for success.” The goal is to present yourself as a professional. Plan what you’ll wear and make sure it’s appropriate based on the organization’s dress code. Keep jewelry to a minimum, and use little or no perfume. Strong scents can be unpleasant, and may cause allergic reactions or exacerbate asthma for some people.

3. **Be on Time and Be Prepared**

There is *never* an excuse for arriving late to an interview. It is wise to arrive approximately 15 minutes before your interview time, in case there is paperwork or testing you need to complete prior to the interview. It also gives you time to settle down and take a breath before the interview. Use this time to observe the workplace and see how everyone interacts with each other.

Make sure to have extra resumes on hand, and bring pens and paper for note-taking. Turn off your cell phone — completely. A vibrating phone can be just as distracting and rude as a ringing phone.
4. Be Polite, Honest, and Aware of Your Body Language

Always be polite and greet everyone you meet — from the receptionist to the hiring manager. How interviewees treat office staff matters. Hiring administrators will note how you interact with others.

First impressions matter, too. When someone comes to bring you into the interview, stand, smile, and offer a handshake. Most importantly, make eye contact. During the interview, have a positive attitude, and be enthusiastic about the job and the possibility of working at that office. Usually, a hiring manager makes a decision within the first 15 minutes of the interview.

Be truthful when responding to interviewers’ questions, and don’t stray from the subject. Focus your answers so they showcase your job-related skills and experiences. The goal is to show that you’re a good fit for the healthcare organization, and that you’re a team player who also can work independently, when needed. Most importantly, never “bad mouth” your previous or present employer, supervisor, or co-workers.

It’s also important to pay attention to your body language. Don’t fidget or look around the room during the interview. Keep eye contact with your interviewer, and smile. Pay attention to your posture (attentive but comfortable, not slouching), and show that you’re a good listener.

As the interview ends, ask when a decision will be made on the position.

5. Be Grateful

Finally, make sure to thank the interviewer at the end of the interview. As soon as you can, send the interviewer a thank you email, followed by a Thank You note in the mail. Being kind and gracious might put you in first place for the job, especially if the other applicants don’t take this step.

Judy A. Wilson, CPC, CCDC, CPCO, CPC-P, CPB, CPC-I, CANPC, CMRS, is an AAPC Fellow who has been a medical coder/biller for over 35 years. For the past 25 years, she has been the business administrator for Anesthesia Specialists, a group of nine cardiac anesthesiologists who practice at Sentara Heart Hospital. Wilson served on the AAPC Chapter Association board of directors from 2010-2014, and is serving again on the 2015-2017 board. She is also on the board of directors of Bryant & Stratton College in Virginia Beach, Va. Wilson is a PMCC instructor and teaches classes in the Tidewater area. She serves on the National Advisory Board for American Academy of Billers for AMBA. Wilson has presented at several AAPC regional and national conferences, and is a member of the Chesapeake, Va., local chapter.
Become published through AAPC to boost your coding credibility among healthcare professionals.

Many of you have written for AAPC and been published in *Healthcare Business Monthly*, and some of our pioneering members have written for our Knowledge Center (www.aapc.com/blog/). Thanks for your contributions and for spreading your knowledge throughout our organization. AAPC is expanding its online presence, and we are encouraging you to keep sending us your contributions. There are many beneficial reasons for you to share your expertise, and it’s relatively easy to do so.

**Help Your Career**

Maryann C. Palmeter, CPC, CENTC, CPCO, CHC, says she often will submit an article on a topic that she has researched for work. “I think the best way to fully understand a subject is to research it and then try to explain it to someone else,” she said.

Palmeter says writing has benefited her career in four ways:

1. It affords her the opportunity to learn something new;
2. It educates her peers;
3. It validates her written communication skills to her employer (or future employer); and
4. It provides her with a creative outlet.

**Reduce Claim Errors**

Michael Strong, MSHCA, MBA, CPC, CEMC, is a frequent contributor to *Healthcare Business Monthly*. He finds it’s “an excellent opportunity to share knowledge with other coders in the industry,” and it helps to improve the error rate on claims.

“We all learn so much through our jobs, but we often don’t take enough time to share that with our peers,” Strong said. “Between the payers, providers, regulators, and the industry, we all learn something different.” He recommends we use that information to help each other pass exams and improve fraud rates.

“New students sitting for the coding exam need 70 percent to obtain their certification,”
Contribute

Strong said. “This means coders mistakes may occur up to 30 percent. However, healthcare fraud is about 10 percent of all dollars spent in healthcare. Sharing our knowledge will hopefully reduce the 30 percent errors and 10 percent fraud,” he said. For example, “The errors can be supported by OIG reports on modifiers 25 and 59.” By sharing this knowledge, Strong said, “we all make a difference and improve the respect and appreciation of our industry and certifications.” When we understand our healthcare specialty a little better and share it, he said, “the results are more well-rounded coders with advanced knowledge.”

Earn CEUs and More

Earning continuing education units (CEUs) are essential to maintaining your AAPC credentials. Now, you can earn continuing education units (CEUs) for writing. For every 700 words you write and AAPC publishes, you earn one CEU.

It’s not all about the CEUs, however. Brenda Edwards, CPC, CDEO, CPB, CPMA, CPC-I, CEMC, CRC, AAPC Fellow, said, “You get CEUs for writing, but there is so much more than that. It forces you to step out of your comfort zone; and when you do that, you open up an entirely new world to explore.”

Reach More People

Healthcare Business Monthly and Knowledge Center blogs are included in AAPC membership. That gives you quite an audience. Your articles can be accessed and read by 165,000 members.

“We get to reach more people than webinars or conferences that might be cost prohibitive for some in our industry,” Strong said.

Make Writing Easy

To make the editing process run smoothly, we ask our contributors to follow a few guidelines:

• **Format** – Articles should be submitted electronically as a Word document. We cannot publish PowerPoint presentations, but we can help you turn them into articles.

• **Length** – Healthcare Business Monthly articles should be between 500 to 2,000 words. If your article runs longer than 2,000 words, you may want to break it into a two-part article. Knowledge Center blog articles are usually a little shorter, and average 400 words. Remember: An article must be at least 700 words (after editing) to receive CEU credit.

• **Citations or sources** – Make sure you quote anything that is not in your own words. List the source separately at the end of the article or attribute sources in the text. You may include website URLs at the end of your article.

• **Codes** – On first use in your article, CPT®, ICD-10-CM, and HCPCS Level II codes must be accompanied with full code descriptions. Avoid confusing your readers by paraphrasing descriptions or using unofficial short descriptions.

• **Acronyms** – Spell out acronyms and abbreviations on first use. Not everyone is familiar with the acronyms and abbreviations unique to your specialty.

• **About you** – Include a 50-word or less biography at the end of the article and a digital photo for each author. Be warned that photos taken off the Web are usually low resolution and don’t print well, so send the original photo before it was adjusted for the internet. Send the photo as a separate attachment from the Word document (i.e., don’t embed it into the document).

Keep Calm and Write On

Don’t let your inexperience in writing stop you from sharing your experience in the business of healthcare. Our editors will help you make your article look its best. Not sure where a comma should go, or if you should use “then” or “than”? Don’t worry about it, we’ve got you covered.

Here is where to send your articles:

**Michelle Dick:** Send all facility-based or member-focused articles to michelle.dick@aapc.com.

**Renee Dustman:** Send all quality-based payment and MACRA-related articles to renee.dustman@aapc.com.

**Brad Ericson:** Send your telehealth and any other articles to brad.ericson@aapc.com.

**John Verhovshek:** Send your coding and clinical articles, as well as risk management articles to g.john.verhovshek@aapc.com.

AAPC reserves the right to edit and/or reject any submission.

Step Out of Your Comfort Zone

As an experienced writer, Edwards has a challenge to her fellow AAPC members. She encourages you to give it a shot. “You may not think you have what it takes — I never thought I would be writing articles and blogs — but when you get going, it becomes hard to stop at that word limit,” said Edwards. “Challenge yourself and see where it takes you!”

Michelle A. Dick, BS, is executive editor at AAPC and a member of the Flower City Coders in Rochester, N.Y.
The following members are part of a select group who dedicate themselves to their career and the health community. They have achieved the designation of AAPC Associate, Professional, or Fellow — proof of their dedication to the ethical standards of AAPC, achievements throughout their career, and reputation among their peers.

Kudos to all below on their achievements and well-earned recognition.

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<thead>
<tr>
<th>Member Name</th>
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<tbody>
<tr>
<td>Carol Skelton, CPC, CPMA</td>
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<td>Kim A. Wells, CPC, CPMA, CEMC</td>
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<td>Cindy Neal-Keltner, CPC</td>
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<td>Michelle Ann Hinson, CPC, CPMA, CRC</td>
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<td>Ellen Hinkle, CPC, CPMA, CRC, CPC-I, CEMC, CFPC, CGSC, CIM</td>
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Megan Olson, CPC-A
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Abraham Sharmumma Sundaram,
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Sadiah Dayala, CPC
Sagamayami Micheal Nadar, CPC
Salina Johnson Glover, CPC, CBP
Sally Strand, CBP
Samantha Kühnmann, CRC, CNPC
Samantha Mitchell, CPC, CRC
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<tr>
<th>Name</th>
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<td>Sampath Malladi</td>
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<tr>
<td>Samuel Rablom</td>
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<td>Sandra Britton</td>
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<td>Sarah Mendiola</td>
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Minute with a Member

Courtney Beth Gainey, CPC-A
Student, Florida Technical College

Tell us a little bit about how you got into coding, what you’ve done during your coding career, and where you work now.

I got into coding because I love computers and I wanted to be in the medical field, so I thought working in an office setting would be a perfect job for me. I work at Office Depot and I am a student at Florida Technical College. I only have one online class left, and then I can go on my externship. After that, I will search for a career in my field.

I don’t want my education to stop there, however. After I finish the 11-month Medical Billing and Coding program, I’ll go back to school and obtain an associate degree in Medical Assisting, and then onto a bachelor’s degree in Allied Health Management.

What is your involvement with your AAPC local chapter?

I am a newly certified coder and member of the Daytona Beach, Fla., local chapter.

What AAPC benefits do you like the most?

The AAPC benefits I like the most are the job forum boards (www.aapc.com/memberarea/forums/employment-general-discussion); they have some good information on them. I also like all the discounts on books. I always love learning and being more involved with my studies.

How has your certification helped you?

My certification helped me to believe I can accomplish anything I set my mind to. It also will help me in the future to find a good job.

Do you have any advice for those new to coding and/or those looking for jobs in the field?

My advice to those who are new to coding is to never give up. It’s a lot of information to process at first, but you will get the hang of it.

What has been your biggest challenge as a coder?

My biggest challenge as a new coder right now is finding the right place to extern so, hopefully, I can get hired on after I’m done with my program. I would like to do my externship at Synergy Billing in Daytona Beach.

If you could do any other job, what would it be?

I would like to manage a doctor’s office. That is my main goal after I complete my educational experience at Florida Technical College.

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

In my spare time, I look for opportunities to grow in my education and work, and to help my job search. I also enjoy spending time with my boyfriend Bruce, family, and my dog Cleopatra. I am content just watching the sunrise at the beach, when I can.

My advice to those who are new to coding is to never give up. It’s a lot of information to process at first, but you will get the hang of it.
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