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Ask the Legal Advisory Board

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

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Our work proves change is constant. Ongoing regulation and code updates force us to stay on top of new developments every day, and it can be a struggle keeping current with everything.

Already this year we are adapting to the first ICD-10 changes in five years (more than 7,000 across CM and PCS), as well as more than usual CPT® (700+) and HCPCS Level II code changes (600+). A provision of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) began last month, requiring eligible clinicians to collect quality data in this first performance year of the Merit-based Incentive Payment System (MIPS). A new president and a unified Congress point to sweeping changes in what healthcare programs will be supported and how they’ll be administered.

As I’ve traveled to meet members, it’s exciting to learn how you face these challenges. Members share information through local chapter meetings and events, our national and regional conferences, our online forums, social media, and through the many friendships founded by our work. Many volunteer to mentor individually, through classes, or via our blog and Healthcare Business Monthly.

AAPC’s Commitment: Helping You

AAPC continues to help you stay on top of the unfamiliar parts of your work through our inexpensive or free educational resources — providing avenues through which information about changes affecting your work and workplaces can be obtained. Special workshops, presentations, HEALTHCON national conference, regional conferences, and a newly expanded Knowledge Center (www.aapc.com/blog/) provide deep dives into how you can adapt to these changes.

We always look for new ways to help educate and inform you. Recently, we launched the Learning Center (http://learn.aapc.com/lms/), a growing resource of online courses on all facets of coding, billing, compliance, practice management, and other healthcare topics. Our new Recognition Program provides additional, heavily discounted education for the most important topics in healthcare. Coming later this year is a social media project for members (internally titled “AAPC Connect”) where from a desktop or mobile device instant exchanges of ideas can be shared and consumed and where professionals within our industry can stay connected to the people, topics, and resources most relatable to the work they do.

What Will Help You?

Naturally, we can’t do this without member participation. Without members contributing content, making presentations, letting us know what topics need to be discussed, or what tools need to be created, we can’t provide necessary support. What could help you be more effective in your role and more valuable to your employer? How can we provide this content, tools, or resources to you? Please let us know.

I hope you’re looking forward to 2017 as much as I am. A great deal is going to change this year, and together we will all manage it. The changes will be exciting, as will the result of what we accomplish.

Sincerely,

Bevan Erickson
AAPC President

Our new Recognition Program provides additional heavily discounted continuing education units for the most important topics in healthcare.
Letters to the Editor

HCCs May Go Beyond Current Encounter

Regarding “Diagnosis: Code the Current Encounter” (December 2016, page 22): Although the article is correct from the standpoint of matching the reason for the encounter, it’s important to note that more and more payers want additional codes, such as chronic condition codes used to track Hierarchical Condition Categories (HCCs). Be aware of the other uses for billing, beyond that of getting paid, and code accordingly.

Charlotte L. Kobler, RN, CPC, CPA, CVA, CRCE-I, CHBC

Pisiform Is Part of the Proximal Row

In the article “Properly Coordinate Your Wrist Coding” (January 2017, page 30), there is reference to the pisiform being part of the distal row in the wrist. This is not correct. CPT® Assistant (January 2005) states:

The proximal row of carpal bones consists of the scaphoid, lunate, and triquetral bones, which articulate with the radius and the articular disk of the ulna. The articulation of the distal radius with the scaphoid and lunate is the radiocarpal joint. These bones also articulate with each other and with the bones of the distal row. The pisiform bone is part of the proximal row but lies on the anterior surface of the triquetral bone, with which it articulates exclusively. The distal row of carpal bones is made up of the trapezium, trapezoid, capitate, and hamate bones.

This is extremely important when it comes to codes such as 25215 Carpectomy; all bones of proximal row and 25210 Carpectomy; 1 bone. Per the CPT® codebook and the American Society for Surgery of the Hand, the pisiform does not have to be excised to report 25215.

Healthcare Business Monthly

Laterality Matters for Wrist Coding

In Case 1 of the “Properly Coordinate Your Wrist Coding,” (January, page 24) the last code listed as ICD-10-CM code S52.532A Colles’ fracture of left radius, initial encounter for closed fracture is incorrect. The scenario stated the right radius. The correct code is S52.531A Colles’ fracture of right radius, initial encounter for closed fracture.

I’m a student member studying for my Certified Professional Coder (CPC®) exam and finding that typo boosted my confidence.

Michelle L. Griffin

Color Swap in 2016 Salary Survey Graph Legend

The legend is wrong in Graph D: Percentage of Where Members Work (“2016 Salary Survey: Pay Climbs for Credentials,” January 2017, page 17). The colors were inadvertently switched during printing: In the graph, 2015 data is represented in gold and 2016 data is represented in purple. Much thanks to Jena White, CPC-A, for catching this error.

Healthcare Business News

IPPS/LTCH Rules for 2017

Along with the yearly codebook changes, OIG Work Plan, and 2017 Hospital Outpatient Prospective Payment System update, let’s not forget the 2017 Medicare payment policies and rates under the Long-Term Care Hospital (LTCH) Inpatient Prospective Payment System (IPPS). The rule, which the Centers for Medicare & Medicaid Services (CMS) says applies to approximately 3,330 acute care hospitals and approximately 430 LTCHs, affects discharges occurring on or after Oct. 1, 2016.

The rule addresses payments, a needed reduction in acquired conditions and readmissions, and other activities that will help bring facilities closer to the overall vision of the Affordable Care Act and other regulations.

I Am AAPC

Khushwinder Singh
MBBS, MHA, CPC, CPMA, CRC, CPCO

Calling on Clinical and Business Expertise
I enjoy working with clinicians, especially training and giving provider feedback for clinical documentation improvements. With ICD-10, medical documentation needs to be very clear and specific. I have witnessed many issues with the implementation, and I hope the newer generation of medical providers adopt the right practices to document their own work more efficiently. This will improve medical records and the quality of healthcare delivery to the patients that physicians see and treat every day.

I now work as the program manager of risk adjustment and reporting for Community Health Plan of Washington, a non-profit health plan. This job gives me an opportunity to make and suggest improvements in healthcare delivery through data capture of claims and to focus on risk-adjustment. Every day is a new opportunity to figure out how to meet quality measures more effectively and capture the right image of healthcare issues of our Medicaid and Medicare population and to help serve them better.

Always Looking for Improvement Opportunities
There are so many opportunities to improve quality of healthcare just by looking more deeply at claims data. It gives us an opportunity to make small improvements in healthcare delivery that can go so far in improving the quality of life for patients. For example, a timely medical intervention can prevent complications of diabetes, hypertension, renal failure, emergency utilization, costly inpatient admissions, etc. We, as coders and auditors, should make a clear point to our providers to complete the documentation the right way. With accurate medical records, clinicians can fully understand what the patient needs next to mitigate their health challenges, become healthier, and improve their quality of life.

Digging Deep into AAPC’s Knowledge Centers
AAPC has been an excellent source of coding and auditing knowledge for me. Attending their webinars and the Orlando HEALTHCON in April 2016 has given me more confidence and knowledge, and has made me more inquisitive about coding, auditing, and compliance. In the future, I wish to work in the field of clinical documentation improvement and quality.


My journey into the field of coding is far from the usual AAPC stories. Trained to be a medical doctor in India, I moved to the United States with my family more than 10 years ago.

Early on, I pursued the management side of healthcare business, as I’ve always been keen on working towards improving the quality of healthcare delivery. To that end, I began learning and implementing Lean strategies in healthcare.

While pursuing a Doctor of Medicine residency in the United States, I job shadowed many physicians in their practices, and came across coding and compliance issues. I learned coding more easily than most because of my medical education, but I found coding and compliance guidelines the most challenging to understand. They are complex concepts, but they are very important for keeping the business of healthcare ethical.
Whether you’re an officer or a member, it’s natural to have questions about local chapter operations. You can find most (if not all) the answers to your questions in the AAPC Local Chapter Handbook. The more informed you are of chapter operations, the better your chapter will serve you and your fellow members and officers.

**Find It**

The Local Chapter Handbook is updated annually in October, so chapter officers should review the handbook annually for changes. To find the most current version, log into your AAPC website account and go to the link www.aapc.com/documents/2016lc_handbook.pdf. All changes made to the handbook from the prior year are noted in bold, italic, and red type.

**Crack It Open**

The Local Chapter Handbook is divided into chapters for easy reference. The chapters include information on each local chapter officer position, including:

- Requirements and responsibilities
- Chapter meetings and chapter sponsored events
- Certification exams and proctoring
- Chapter financials and infractions, with consequences by local chapter officers that can affect the well-being of the chapter

Each chapter provides guidelines and policies that will help officers maintain a viable chapter for members to enjoy.
Answer Your Questions

Just to show you how useful the Local Chapter Handbook is, we’ll use it to answer some common questions:

How are continuing education units (CEUs) determined at chapter meetings?

According to Chapter 7 — Local Chapter Meetings and Other Chapter Sponsored Events (section 8.1.2) of the handbook, CEUs offered for chapter meetings are determined based on 15 minute increments of time. Anyone arriving more than 15 minutes late to the educational portion of a meeting or seminar, or leaving early, does not receive full credit for the meeting and must manually enter the information in their CEU tracker.

How does my chapter make money if we don’t have a seminar and we don’t charge for our meetings?

As described in Chapter 12 — Financial Information of the handbook, chapters receive a quarterly reimbursement from AAPC for member attendance at meetings, as well as for the number of candidates who sit for a chapter sponsored certification exam. Chapter reimbursement is based on members signing the registration at the meeting and providing their member number. Here’s how the reimbursement works:

- Chapters are reimbursed $2 for every registered member who attends a meeting, regardless of their chapter affiliation.
- For every examinee who presents for a certification exam, a chapter is reimbursed $10.
- Chapters who hold more than five certification exams in a year receive $15 per examinee.

An item that costs over $200 or a group of items that cost over $300 must be approved by the general membership of the chapter. As a member, you have the right to know how your chapter earns and spends funds. This information should be presented to members on no less than a quarterly basis.

Give It a Try!

Find the answer in the Local Chapter Handbook to this question: How do chapters earn the honor of Chapter of the Year?

The criteria for this award is in the Local Chapter Handbook. Once you have the answer, you’ll be one step closer to helping your chapter become eligible for this prestigious award.

Ruby O’Brochta-Woodward, BSN, CPC, CPMA, CPB, COSC, CSFAC, is AAPC Chapter Association treasurer and Region 7 representative. Woodward, a clinical technical editor and educator for Decision Health, has over 40 years of experience in the medical arena, serving 30 of those years in both nursing and the business of medicine. She has expertise in coding, education, auditing, and compliance, as well as orthopedic regulations. Woodward has presented at AAPC regional and national conferences, as well as at the local level. She was a member of the AAPC ICD-10-CM training team, and has been twice selected as the Member of the Year for the Minneapolis, Minn., local chapter. Woodward has held offices of president, vice president, and member development officer of her local chapter.
This month, the National Advisory Board (NAB) is shining the spotlight on Region 2 – Atlantic and its representatives. The Atlantic region is comprised of New Jersey, Pennsylvania, Delaware, Maryland, and the District of Columbia. This region showcases the beauty of four seasons, and features picturesque mountains and coastal waterways. From football, hockey, and baseball, to golfing, boating, and snow skiing, the Atlantic region is a sportsperson’s paradise.

This region is also home to over 12,500 AAPC members and 37 local chapters. With the help of the many wonderful, knowledgeable, and dedicated PMCCs, Region 2 will continue to thrive.

Region 2 representatives are Christina A. LaRosse, CPC, from New Florence, Pennsylvania, and Sharlene A. Scott, RHIT, CPC, COC, CPC-I, CPMA, CDEO, CCS-P-P, CCP-P, from Baltimore, Maryland. Both women bring an energy and commitment to their region.

LaRosse has been working in healthcare for 25 years, primarily in practice management. She holds a Bachelor of Science degree in Healthcare Management and obtained her Certified Professional Coder (CPC™) credential in 1993. She is employed as business manager for a multi-specialty physician group. LaRosse is involved in implementing electronic health records (EHRs) and is a CGM Enterprise EHR™ Certified Professional. She has served as adjunct faculty for Pennsylvania Highlands Community College and Westmoreland County Community College. LaRosse was one of the founding members of the Johnstown, Pennsylvania, local chapter and has served in several officer positions.

In her spare time, LaRosse enjoys spending time with her family, boating, camping, motorcycle riding, and recumbent biking.
Sharlene A. Scott, RHIT, CPC, COC, CPC-I, CPMA, CDEO, CCS-P-P, CCS, CCP-P

Scott has been working in the healthcare arena for more than 26 years. She is a senior healthcare consultant/educator for the Coding Academy of America, LLC, and American Coding Centers, LLC, and she is an ICD-10-CM trainer. Scott received her first AAPC certification 18 years ago and now has multiple certifications, and she has been a designated PMCC instructor for the last 12 years. Scott provides coding and documentation education and training for physician-based specialties, as well as inpatient and outpatient hospital services. She is also an expert trainer for physicians and support staff in the government and private sector. Scott is a member of the Baltimore East, Maryland, local chapter, and has helped countless members obtain national certification through AAPC. She further shares her expertise by speaking at national conferences on topics related to documentation and coding. In addition to consultant work, Scott is the director of coding and coding education for a large health system in the area. She uses her Epic certification to assist in building compliant workflows to better the provider experience.

In her spare time, Scott enjoys traveling, reading, a quiet beach, and roller skating.

Making Region 2 Stronger
You may catch LaRosse or Scott speaking at a local chapter near you. We encourage you to reach out to them. Contact LaRosse via email at Christina.larosse@aacnab.com, or by calling her office at (814) 535-7576 or her cell at (814) 659-5654. Contact Scott at saspmc@yahoo.com or sscott@codingacademyofamerica.com, or by calling her office at (410) 356-CODE, or her cell at (443) 418-1927.

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A quote from the “The Great Debaters” has stuck with me since I saw the movie five years ago: “You do what you have to do, so you can do what you want to do.” It became my mantra, and it has gotten me through some tough times. If ever you lose your way on the path to medical coding and certification, take these words and my advice to get back on track.

Get Back on Your Horse

Whatever has you at an impasse, I encourage you (as my pastor encouraged me) to get back on your horse and ride. When I did not pass my Certified Professional Coder (CPC®) exam at first, I knew I had two options: I could give up, or I could try again. I decided on the later. Luckily, AAPC offers two tries for the price of one!

Give It All You Got

I thought I was doing everything possible to prepare for the exam, and yet I didn’t pass. Then I heard a motivational speaker say, “When you give it 70 percent, you get 70 percent. When you give it 80 percent, you get 80 percent,” and so on. I asked myself, “Am I giving this 100 percent?” There was more in me, but I had to develop it. AAPC provides you with all the information you need to pass the exam, but it’s up to you to make the most of it.

Prepare for the Exam the Right Way

The reality is that AAPC isn’t going to just hand you a CPC® certification. You have to get it the old fashioned way — you have to earn it, and you’re going to have to give it your all. This means:

- **Examining your study habits:** Are you studying the way that works for you? Determine whether you are a visual, auditory, or kinesthetic learner and adopt the appropriate study habits.
- **Diving in deeper to concepts:** If you’re having a hard time with a particular concept, and you’re a visual learner, watch the procedure online rather than just read about it. You will gain far more clarity and understanding.
- **Continuing to do practice exams:** Practice does make perfect, eventually. When you’re doing practice exams, don’t concentrate on speed. The goal is accuracy. Speed comes with understanding.
When you get a question on a practice exam wrong, don’t move to the next question until you fully understand the answer. Mark your codebooks accordingly with tips and other notes. For example, I would write, “Watch out for this!” or “Don’t be fooled!” and “You got this!”

Keep the Faith
Failure means you’re trying. Have faith in yourself, and believe that you will be a certified coder. I actually wrote an email to myself before I took the exam again. It said, “Congratulations Danita, you are now a CPC!” I think it worked because I later got a very similar note in the mail from AAPC.

Danita M. Ruszkowski, CPC, CPC-I, is a remote surgical coder, instructor, coding consultant, and founder of Integrity Coding. You can contact Ruszkowski with questions at faithg1217@gmail.com. She is available for one-on-one tutoring and coaching through her website at www.integritycoding.com. Ruszkowski is a member of the Haverhill, Mass., local chapter.

AAPC provides you with all the information you need to pass the exam, but it’s up to you to make the most of it.

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CPT® 2017 introduces new codes to capture new vaccines.

The influenza virus is not a single entity, but an ever adapting “family” of viruses. To keep pace, researchers must constantly develop new vaccines, and CPT® must periodically update the codes used to report those vaccines. For 2017, CPT® introduces one vaccine code, and revises the reporting criteria for nine others.

**New Code for Quadrivalent Vaccine**

Code 90674 *Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use* is added to improve reporting of quadrivalent vaccine (e.g., Flucelvax®). Quadrivalent vaccines contain two Influenza A strains and two Influenza B strains that the World Health Organization predicted to be prevalent during the current flu season. Note that the descriptor identifies the dosage as 0.5 mL, by intramuscular injection.

**90661 Now Specifies Trivalent**

Because of the addition of 90674 to describe quadrivalent vaccine ccIIV4, code 90661 is revised to indicate trivalent vaccine ccIIV3. For consistency, the code also now indicates dosage (underlined text in the descriptor is new): 90661 *Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use*.

**Additional Vaccines Now Reported by Dosage, Not Age**

Finally, eight previously-existing influenza vaccine codes are now reported by dosage, rather than patient age (deleted text is crossed out, new text is underlined):

- **90655** *Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to children 6-35 months of age, 0.25 mL dosage, for intramuscular use*
- **90656** *Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, when administered to individuals 3 years and older, 0.5 mL dosage, for intramuscular use*
Because of the addition of 90674 to describe quadrivalent vaccine cclIV4, code 90661 is revised to indicate trivalent vaccine cclIV3.

Per CPT® Changes 2017: An Insider’s View, “The revision is intended to better define the influenza vaccines and further encourage reference to the products prescribing information with a licensed age indication. These revisions also need to simplify coding by avoiding expansion of coverage based on age population.”

Report Coding/Billing

You may report administration of a vaccine, in addition to the vaccine itself, using the Immunization Administration for Vaccines/Toxoids codes 90460-90472.

Code 90460 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered describes vaccination administration for patients 18 years old or younger, when the provider counsels the patient and/or guardian on the risks, benefits, and potential side effects of the vaccination.

Note: Although a vaccine may target several strains of influenza, it is a “single” vaccine. Do not report +90461 Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure) for administration of an influenza vaccine.

When no counseling is given for patients 18 years of age and younger, or for vaccine administration for patients over 18 years of age, turn to 90471-90474. These codes are billed per vaccination, with either 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid) or 90473 Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid) for the first vaccine (depending on the method of administration).

If additional vaccines are administered at the same visit, you also may call on 90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure) or +90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).

Medicare Rules Are Different

For administration of a flu vaccination to Medicare patients, report HCPCS Level II code G0008 Administration of influenza virus vaccine, rather than any of the aforementioned CPT® codes. Medicare pays for a single influenza virus vaccination per influenza season (rather than every 12 months). Annual Part B deductible and coinsurance amounts do not apply. Physicians, non-physician practitioners, and suppliers who administer influenza vaccinations must be assigned on the claim for the vaccine. 

John Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Hendersonville-Asheville, N.C., local chapter.
To file accurate claims when coding and billing nail procedures, be familiar with the nuances of nail anatomy, common conditions, treatments, services, and procedures. Here are some tips to point you towards better nail reporting.

**TIP 1: Nail Down Your Anatomy**

Nails are thin, horny coverings that grow over the upper tip of a finger or toe. They are composed mainly of keratin (a hard protein) and provide protection and sensation. The basic parts of the nail include:

- Nail plate
- Nail bed
- Nail matrix
- Nail walls
- Nail grooves
- Lunula
- Cuticle
- Mantle
- Hyponychium
- Free edge

**TIP 2: Know What Ails Your Nails**

Common causes of fingernail or toenail changes include trauma, aging, infection, skin diseases, and severe malnutrition. Common diseases of nails include the following:

- **Erythronychia:** Red streaks in the nail that may present as a single or paired band in one nail, or as multiple bands in multiple nails.
- **Koilonychia:** Also called spoon nail because the outer surface of the nail becomes concave, resembling a spoon. May be associated with iron deficiency anemia.
- **Melanonychia:** Brown or black discoloration of the nail.
- **Onychia/Onychitis:** Infection of soft tissue surrounding the nail, leading to inflammation and loss of nail.
- **Onychocryptosis:** A common nail disease also known as an ingrown toenail, or unguis incarnates, in which the growing nail cuts either
one or both the sides of the nail bed, causing pain, inflammation, and possible infection. May be caused due to pressure from a tight fitting shoe or improper cutting of toenails.

**Onychodystrophy:** Dystrophic changes of the finger or toe nail such as change in nail texture or composition, discoloration, or malformation. May be congenital or acquired due to illness, injury, or infection.

**Onychogryphosis:** Overgrowth resulting in long, curved nails that resemble claws. The nails become thick and deformed, with discoloration. Occurs due to tight shoes, infection, trauma, decreased blood supply, and poor hygiene.

**Onycholysis:** Lifting of the nail from the underlying nail bed or from the sides. May be caused by external irritants such as harsh chemicals and detergents. Can be a sign of skin disease, an infection, or injury. Most cases are seen in women with long fingernails.

**Onychomadesis:** Complete shedding of nail from nail bed, causing localized infection, minor injury to the matrix bed, or severe systemic illness.

**Onychomycosis:** A fungal infection of the nail, also called tinea unguium. The nail becomes rough, thick, and brittle.

**Onychoptosis:** Brittle nails with splitting at its free edge, which may result from strong soap, nail polish remover, anemia, etc.

**Onychopschizia:** Splitting of the distal nail plate into layers at the free edge.

**Onyxis:** Ingrown nail.

**Onychomatricoma:** A benign nail matrix tumor clinically characterized by a thickened, curved nail plate, with multiple holes at the distal margin of the nail plate.

**Paronychia:** Bacterial or fungal infection of the finger or toe where the skin and nail meet at the side or base. May progress to an abscess.

**Subungual hematoma:** A collection of blood under the nail due to trauma.

**TIP 3:**

**Get Familiar with Common Services**

Common nail procedures include trimming of nondystrophic and dystrophic nails, debridement of nail(s), avulsion of nail plate, evacuation, excision of nail and matrix, biopsy of nail unit, repair and reconstruction of nail bed, and wedge excision of nail fold skin.

- **Onyxis:** Ingrown nail.
- **Onychomatricoma:** A benign nail matrix tumor clinically characterized by a thickened, curved nail plate, with multiple holes at the distal margin of the nail plate.
- **Paronychia:** Bacterial or fungal infection of the finger or toe where the skin and nail meet at the side or base. May progress to an abscess.
- **Subungual hematoma:** A collection of blood under the nail due to trauma.
When a complete nail avulsion is performed, another avulsion should not be required for at least 12 weeks on the same digit.

Per CPT® Assistant (December 2002), when amputation is part of the procedure:

The tuft at the end of the distal phalanx is dissected free and removed with a cutting instrument (eg, bone cutter or rongeur). The edges of the stump are smoothed with a rasp, and the adjacent soft tissues are brought over it and sutured in place. The wound is closed in layers.

Nail biopsy is a surgical procedure in which a tissue specimen is obtained from the growth plate of a fingernail or toenail, reported with 11755 Biopsy of nail unit (eg, plate, bed, matrix, hyponychium, proximal and lateral nail folds) (separate procedure). Per CPT® Assistant, “When a biopsy of the nail bed is performed after avulsion of the nail plate, it is inclusive of the avulsion procedure and is not coded separately.”

For repair of nail bed, report 11760 Repair of nail bed. Report reconstruction of nail bed with 11762 Reconstruction of nail bed with graft. Per CPT® Assistant:

The intent of reconstruction of the nail bed is to correct a defect from trauma, excision of a lesion, or other condition and, to the extent possible, restore its structural and functional integrity. The details of reconstruction will differ in each case, depending on the nature and extent of the defect. Generally, a split thickness graft is obtained from the nail bed of the great toe; however, full thickness grafts may be utilized in some cases.

Wedge excision of the nail fold skin (11765 Wedge excision of skin of nail fold) is performed typically to remove hypertrophic lateral nail folds that result from chronic ingrown toenails. CPT® Assistant explains:

… a longitudinal incision is made on the affected side of the digit, extending from the proximal nail fold along the nail groove to the distal end of the nail. A second incision is made so that it curves slightly outward from the lateral nail fold and meets the first incision at each end. The wedge of tissue is removed and the edges of the wound are approximated with sutures.

TIP 4: Research CMS Policies

Be sure to check payer guidelines related to specific procedures. For example, Medicare Local Coverage Determination (LCD) L33833 for Surgical Treatment of Nails, relative to nail avulsion (11730, 11732) specifies:

- When a complete nail avulsion is performed, another avulsion should not be required for at least 12 weeks on the same digit. Services performed more often than every 12 weeks on the same digit are not reasonable and necessary and will be denied.
- In the unusual circumstance of a repeat partial avulsion of the same digit within a 12-week period, the medical record must be specific as to the indication, such as ingrown nail of opposite border or new significant pathology on the same border recently treated.
- Partial nail avulsion of separate borders of the same nail is a single procedure.
- Both avulsion and routine trimming/debridement is not allowed on the same nail on the same day.

TIP 5: Watch Out for Separate E/M

In some cases, an evaluation and management (E/M) service may be prompted by a symptom or condition occurring when a procedure or service is also provided during the same visit. You may report this circumstance by adding modifier 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service to the appropriate E/M service code. Different diagnoses are not required to report the E/M service and procedure on the same date.

Sivaraj Ramesh, CPC, CEMC, CCS, is assistant manager, coding at Global Healthcare Resource. He has a professional degree in physical therapy, a master’s degree in Psychology, and more than 10 years of experience in medical coding.

Resources

CPT® Assistant, December 2002
CMS, Local Coverage Determination (LCD): Surgical Treatment of Nails (L33833):
www.cms.gov/medicare-coverage-database/
Should You Code from the Encounter Form or Patient Chart?

Q Is it appropriate to use the encounter form/routing slip to code and bill, rather than to code and bill from the patient chart?

A This question raises an important distinction between coding and billing. The only way to code a service is from the actual record of the service, but it’s possible to bill from an encounter form if the provider has already coded the service.

It’s important to understand your job responsibility. If you are expected to determine the appropriate code, you must do so from the chart. If you are instead expected to bill the code selected by the provider, the encounter form is all you need. If your role is mixed, the chart is necessary for either coding or code validation.

There is no regulation or statutory rule at issue here that defines these roles, or the responsibilities of administrative staff by role. When the provider is a contracted or “in network” provider, there is usually a contractual obligation that the provider bill the appropriate codes for the medically necessary services performed. How the provider meets that obligation is up to the provider.

Michael D. Miscoe, Esq., CPC, CASCC, CUC, CCPC, CPCO, CPMA, is president-elect of AAPC’s National Advisory Board, serves on AAPC’s Legal Advisory Board, and is the AAPC Ethics Committee chair. He is admitted to the practice of law in California as well as to the bar of the U.S. Supreme Court, the Third Circuit Court of Appeals, and the U.S. district courts in the southern district of California and the western district of Pennsylvania. Miscoe has over 20 years of experience in healthcare coding and over 18 years as a forensic coding and compliance expert. He has provided expert analysis and testimony on coding and compliance issues in civil and criminal cases and represents healthcare providers in post-payment audits. Miscoe is a frequent lecturer and is published widely on a variety of coding, compliance, and health law topics. He is a member and past president of the Johnstown, Pa., local chapter.
The 2017 CPT® codebook features some important changes for coding pelvic ring fractures, including the deletion of two codes, the addition of two new codes, and an added parenthetical instruction. Here’s what you need to know about the updates.

**Greater Specificity, Differing Treatments, Justify New Codes**

Codes 27193 and 27914 were deleted for 2017, and replaced by two new codes:

- **27197** Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation

- **27198** Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)

To explain why these code changes were necessary, you must first understand some basic anatomy.

The pelvis is a ring-like structure composed of two innominate bones (joined at the pubic symphysis) and the sacrum (joined to the innominate bones at the sacroiliac (SI) joint). The pelvic ring consists of two arches: a posterior arch that includes the sacrum, SI joints, and posterior ilium, and a weaker anterior arch that includes the pubic rami bones and symphysis.

Deleted codes 27193 and 27914 referred generically to “pelvic ring fracture, dislocation(s), diastasis or subluxation;” whereas new codes 27197 and 27198 specify “posterior pelvic ring fracture, dislocation(s), diastasis or subluxation.” The distinction is important because posterior fractures and anterior conditions may require different treatment. CPT® 2017 Changes: An Insider’s View explains, “Because posterior pelvic ring fractures may require more observation and may require surgery, separate codes have been established to specifically identify the efforts needed for these distinctly different treatments that were previously identified by a single code.”

**New Codes Specify with or without Manipulation**

Code 27197 describes closed treatment of posterior pelvic ring fracture, or related acute pathological conditions of the pelvis or adjacent structures, without manipulation. Closed treatment means no incision is made (the provider does not expose the bone). Code 27198 describes the same procedure, with manipulation (the provider manually “moves” the fragments of bone to reduce the fracture and

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**Learn the Latest in Pelvic Fracture Coding**

Don’t let 2017 CPT® changes break your perfect score for clean claims.
Pelvic fracture is typically the result of trauma, such as from a motor vehicle accident, a fall from height, or a crushing injury. Pelvic fracture often is associated with other serious injuries. CPT® 2017 Changes offers the following clinical example of 27198:

A patient who was involved in a vehicular crash presents with pelvic pain and pain with attempted weight bearing. Imaging studies show minimally displaced fractures of the anterior and posterior portions of the pelvic ring, with ipsilateral fractures of the pubic rami and sacrum. The patient’s fractures are treated with manipulation under nonlocal anesthesia.

**When to Report an E/M Code, Instead**

Do not report 27197 or 27198 for closed treatment of anterior (vs. posterior) pelvic ring fracture and dislocation(s) of the pubic symphysis and superior/inferior rami (unilateral or bilateral). CPT® now instructs us to report an appropriate evaluation and management (E/M) services code.

John Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Hendersonville-Asheville, N.C., local chapter.
E/M CODING: Benefit or Burden?

Payer guidelines have created a beast and it’s time to advocate for change.
Healthcare expenditures account for an estimated 18 percent of the United States’ gross domestic product. A 2014 BMC Health Services Research study (“Billing and Insurance-related Administrative Costs in United States’ Health Care”) found that in 2012 billing and insurance-related administrative costs alone totaled $471 billion — nearly one-fifth of all healthcare costs. While I celebrate the coding profession’s growth, also I understand that coding is an administrative cost. Due to my experiences, I feel coding evaluation and management (E/M) services is a particularly onerous administrative burden. I attribute this burden to these primary factors:

• The complexity of E/M coding is out of proportion to the dollar value of the services.
• The E/M code set and guidelines are out of date, and no longer work well with the changing healthcare system.
• There is no consensus about the specific requirements of E/M documentation, which allows for subjective interpretations and creates unproductive disputes over correct coding.
• Excessive scrutiny of E/M codes, with a focus on technicalities, forces providers to document more than is necessary and diverts time away from patient care.

Let’s consider the E/M rules and problems we face when coding an E/M service.

**Category of Service — Multiple Definitions Hinder Selection**

Selecting the category of service requires identifying the place of service, which is not always clear. As patients move between hospital departments, their assigned status of inpatient, outpatient, or emergency room may change (sometimes after the fact) based on regulations or payer guidelines. Even a location’s designation as a “facility” or “office” can be in question.

Whether a patient is “new” or “established” depends (in part) on the provider’s specialty and group. This distinction may have been more meaningful when small, single-specialty practices were the norm. Now it is less so because many providers have training in subspecialties and work in large and complex organizations that may share medical records, services, and ownership within and across groups. To complicate matters, payers define specialties differently. Medicare, for example, identifies a provider’s specialty based on enrollment; whereas, many commercial payers use the provider’s taxonomy code from the National Provider Identifier registry.

Mid-level providers (non-physician practitioners (NPPs)) present unique problems because they, too, may practice across multiple specialties. And because Medicare enrollment does not allow for NPPs to identify a specialty, all physician assistants or nurse practitioners are classified the same way; a patient becomes established to all providers in the group with that credential, regardless of specialty.

**E/M Service Level Descriptors — Requirements Penalize Providers**

All new, initial, and emergency department codes must meet three of three defined levels for history, exam, and medical decision-making (MDM). Many providers find this requirement problematic because the omission of a small (and possibly irrelevant) detail in documentation can cause significant down-coding and undervaluation of their work. For example, a review of systems counted as nine systems instead of 10; an exam of seven organ systems instead of eight; or missing one required bullet point could result in a service being downgraded by as many as two service levels. To avoid this, providers may populate notes with canned statements such as “all systems reviewed and negative,” or they may add information that is not clinically useful, but satisfies auditors’ demands.

**Leveling — Inconsistent Rules Create Gray Areas**

The 1995 and 1997 Documentation Guidelines for E/M Services and point-based systems for auditing are meant to allow coders to quantify the key E/M components of history, exam, and MDM. In practice, these systems allow enough leeway to present a defensible argument to up- or down-code many E/M services.
Without transparent and mutually shared rules to determine E/M codes, additional costs associated with denials, appeals, audits, and payment disputes accrue for physicians and payers.

Counting the history of present illness elements of location, quality, severity, etc., may work for symptoms, but fitting complex history into these categories can quickly become challenging as the definitions are stretched beyond recognition (e.g., counting a patient’s diabetes as having a type II “quality” or a “location” in the pancreas).

Under some audit guidelines, an exam documented “NAD, EOMI, no focal deficits, skin clear, respiratory effort normal, Aox3” could qualify as “detailed,” although there is little information of clinical value. Different auditors might count an identical exam in different ways because, for example, elements such as “alert and oriented” could be psychiatric, neurological, or constitutional. As a result, the levels of exam used for coding may have little relationship to the content or quality of the documentation.

Using points to evaluate MDM proves to be unreliable: A provider who reviews extensive laboratory results receives the same data point as one who orders a single test; and a provider treating a sore throat with an antibiotic might be credited with the same “moderate” risk level for prescription drug management as a provider managing a complex medication regimen for a patient with multiple diseases.

Existing guidelines fail to address these gray areas, and need revision to add clarity and reduce subjectivity. With few authoritative sources to guide coders, some organizations develop their own internal guidelines; but this added expense does nothing to promote consistency throughout the profession. Without transparent and mutually shared rules to determine E/M codes, additional costs associated with denials, appeals, audits, and payment disputes accrue for physicians and payers.

Medical Necessity — Who’s to Say?

Payers want assurance that claims are based on necessity and not on volume of documentation. As a result, coders are sometimes asked to consider medical necessity and to determine whether the content of the documentation represents work that was really necessary to treat the patient’s problem(s). But coders and auditors generally do not have the medical qualifications or training to make these decisions. Coders are often advised to involve providers’ in these decisions, but this is yet another use of providers’ time that arguably would be better spent in patient care.

Are E/M Codes Worth the Trouble?

In 2015, Medicare paid for more than 426 million E/M services, according to a Centers for Medicare & Medicaid Services report (Medicare Part B Physician/Supplier National Data CY2105 Evaluation and Management Codes by Specialty). In aggregate, this represents a substantial expenditure.

At an average payment of approximately $95 per code, there isn’t enough at stake in each individual service to justify the effort required to code these services with such a high level of precision. If you consider coder training and the effort spent assessing notes, and the provider time taken away from patients to learn rules and add to documentation, multiplied by millions of services, the cumulative cost becomes apparent.

With the healthcare system’s resources stretched to its limits, it makes sense to question whether there is any benefit to investing in proper E/M code assignment. How much value is gained when a visit should be a 99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity, instead of 99213
E/M coding is a sorting process that roughly classifies a variety of provider services into one of several tiers. If this cannot be done quickly and efficiently, and with benefits proportionate to the costs, perhaps a new system is necessary.

Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity if this only shifts payment between payers and providers, but does not change the actual cost or effectiveness of the care?

Ultimately, E/M coding is a sorting process that roughly classifies a variety of provider services into one of several tiers. If this cannot be done quickly and efficiently, and with benefits proportionate to the costs, perhaps a new system is necessary.

There Has to Be a Better Way

As coders, our training and experience give us an opportunity to advocate positive change. Together, we can:

- Work to revise and propose new guidelines with simplified and shared standards that are easily understood and can be widely adopted across organizations.
- Advocate for revisions and simplifications to the E/M code set that more accurately capture the value of provider work, reduce the need to document irrelevant information, and eliminate complexities that do not add value.
- Develop auditing models that yield valuable documentation quality and compliance feedback without penalizing providers for technicalities that do not affect patient care.
- Raise awareness among payers and providers that the costs of disputing E/M level differences may consume more resources than the savings it achieves.

There are already signs of positive change. CMS, in 2014, eliminated E/M levels for outpatient hospital clinic visits, replacing them with the single HCPCS Level II code G0463 Hospital outpatient clinic visit for assessment and management of a patient, which pays a single weighted average for each service. This simplification benefits both payers and providers, and a variant of this could be possible for professional reimbursement, too.

CMS and commercial payers continue to adopt quality-based payment models such as the Merit-based Incentive Payment System, accountable care organizations, and other shared saving programs. If successful, these new payment models could eliminate the need for coding E/M visits, as reimbursement would be based on overall care rather than individual services.

Whether coding E/M services or another specialty area, coders are in a unique position to understand the problems and propose solutions. We have a role to play in advancing these changes, and in helping to make the administration of healthcare more efficient.

Thomas Field, CPC, CEMC, has 22 years of experience in healthcare and has worked for both providers and payers in patient care, billing, coding, auditing, and claim payment analytics. He works as a healthcare economics consultant in payment integrity for Optum. He is a member of the Torrington/Waterbury, Conn., local chapter.

Resources


CPT® Category III codes describe emerging technologies and allow for data tracking. If a Category III code is available, you must report it instead of a Category I unlisted procedure code. CPT® 2017 includes substantial Category III code changes, of which you’ll need to be aware to ensure proper coding. Here are the highlights.

Deletions
A Category III code is deleted because it has either been replaced by a Category I code or it has not been replaced by a Category I code in five years. In the latter case, most often you will return to reporting an unlisted procedure Category I code in place of the deleted Category III code. Table 1 provides a full listing of deleted Category III codes, as well as their replacement codes for 2017.

Revisions
Descriptor revisions are relatively few this year. Codes 0274T and 0275T, which describe Percutaneous laminotomy/laminectomy (inter-laminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral, by spinal region, are revised to remove the phrase “with or without the use of an endoscope.” For percutaneous decompression of the nucleus pulposus of intervertebral disc using need-based technique, see instead 62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar.

CPT® no longer defines moderate sedation as an inherent part of any procedure (including Category III procedures). Per the 2017 Medicare Physician Fee Schedule Final Rule, “This coding change [provides] for payment for moderate sedation services only in cases where it is furnished.” Moderate sedation, when performed and properly documented, now is reported separately using new codes 99151-99157.

A Category III code is deleted because either it has been replaced by a Category I code or it has not been replaced by a Category I code in five years.

### New Codes

**Cardiac contractility modulation**

Cardiac contractility modulation (CCM) delivers non-excitatory electrical signals to improve ventricular function. The complete system includes a pulse generator with one atrial and two ventricular electrodes (leads). New codes 0408T-0418T describe procedures and services related to CCM devices, such as insertion, replacement, and removal of components, as well as device programming and interrogation. Many of these services include associated catheterization and imaging guidance.

**Destruction of neurofibroma**

New codes 0419T *Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); face, head and neck, greater than 50 neurofibromas* and 0420T *Destruction of neurofibroma, extensive (cutaneous, dermal extending into subcutaneous); trunk and extremities, greater than 100 neurofibromas* describe destruction of extensive neurofibroma on the face, head, and neck (0419T), and trunk and extremities, respectively. For excision of neurofibroma, report 64792 *Excision of neurofibroma or neurolemmoma; extensive (including malignant type).*

**Transurethral waterjet ablation of prostate**

Benign prostatic hyperplasia may lead to chronic bladder-outlet obstruction and symptoms such as urinary retention, urinary frequency, incomplete bladder emptying, blood in the urine, and renal insufficiency. Transurethral waterjet ablation (e.g., an aquablation system) delivers a high-velocity saline stream under ultrasound guidance to ablate prostatic glandular tissue without heat. New code 0421T *Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)* describes waterjet ablation of the prostate with ultrasound guidance.

**Tactile breast imaging**

The tactile imaging system uses a handheld scan head equipped with pressure sensor elements and a magnetic position tracker that the physician strokes over the breast. A computer digitizes the tactile pressure images and locations to help evaluate and size lumps in the breast(s). Code 0422T *Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral* describes unilateral (one breast) or bilateral (both breasts) tactile imaging.

**Neurostimulator system for treatment of central sleep apnea**

The neurostimulator system for treatment of central sleep apnea includes a breathing sensor and a stimulation lead powered by a small battery. During sleep, the system senses breathing patterns and delivers mild stimulation to the tongue and other soft tissues of the throat to keep the airway open. New codes 0424T-0436T describe services and procedures related to such a system, including...

### Table 1: 2017 Deleted CPT® Category III Codes

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<th>Deleted Category III Code</th>
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insertion, replacement, and removal of the components, as well as device interrogation and programming with or without sleep study.

**Synthetic implant (e.g., polypropylene) for fascial reinforcement**
Polypropylene may be used to reinforce the fascia in the abdominal wall (for example, to repair ventral hernia). You may report +0437T *Implantation of non-biologic or synthetic implant (eg, polypropylene) for fascial reinforcement of the abdominal wall (List separately in addition to code for primary procedure)*, in addition to a primary surgical service, for use of non-biologic or synthetic implant, only. For mesh or other prosthesis for open incision or ventral hernia repair, or for closure of a necrotizing soft tissue infection wound, see +49568 *Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)*, which carries over unchanged from 2016.

**Transperineal placement of biodegradable material**
New code 0438T *Transperineal placement of biodegradable material, periprostatic (via needle), single or multiple, includes image guidance* replaces HCPCS Level II code C9743 to describe placement, via needle, of a biodegradable implant(s) that is meant to temporarily position the anterior rectal wall away from the prostate during radiotherapy for prostate cancer. This reduces the radiation dose delivered to the anterior rectum.

**Nerve cryoablation**
Cryoablation (freezing) may be used to ablate nerves for pain relief. Report this service with new codes 0440T *Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve* and 0441T *Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve*.

**Drug-eluting ocular inserts**
Drugs used to treat the eye and surrounding tissues can be dispensed via an ocular insert, as can drugs that will pass through the eye and surrounding tissues to the bloodstream, but which are not used in therapy of the eye itself. New code 0444T *Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral* reports an initial unilateral (one eye) or bilateral (both eyes) placement of the insert, including fitting and training. Report 0445T *Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral* for subsequent placements. For insertion and removal of each drug-eluting implant into lacrimal canaliculus, report 0356T *Insertion of drug-eluting implant (including punctual dilation and implant removal when performed) into lacrimal canaliculus, each.*

**Interstitial glucose sensor**
Glucose sensors are employed to help normalize blood glucose in diabetic patients. An implantable system allows for constant monitoring. Codes 0446T-0448T describe procedures and services related to such glucose sensor systems, including creation of a subcutaneous pocket to house the sensor, removal, and revision. For placement of a non-implantable interstitial glucose sensor without a pocket, use 95250 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.*

**Insertion of aqueous drainage device**
An aqueous drainage device is a method to reduce intraocular pressure in patients with glaucoma. Code 0449T *Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device* describes insertion of an initial device into the subconjunctival space, by internal approach.
CPT® provides an extensive explanation of these systems, and how they differ from other services for the implantation, revision, and removal of existing aortic balloon pumps. The device is comprised of several parts: the counterpulsation device, vascular graft, implantable vascular hemostatic seal, mechano-electrical skin interface, and subcutaneous electrodes. CPT® lists additional included services (e.g., all vessel catheterizations, diagnostic angiography, etc.).

New codes 0451T-0463T describe procedures related to the insertion/replacement, removal, and relocation of system components, as well as programming and interrogation device evaluation.

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

Our coding courses with AAPC CEUs:
- Charting E/M Audits (11 CEUs)
- Primary Care Primer (18 CEUs)
- E/M from A to Z (18 CEUs)
- Dive Into ICD-10 (18 CEUs)
- The Where’s and When’s of ICD-10 (16 CEUs)
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Congratulations to AAPP’s First Fellow, Brenda Edwards

Longstanding member sets the bar for this honorable designation.

On Dec. 9, 2016, Brenda Edwards’, CPC, CPB, CPMA, CPC-I, CEMC, CRC, big announcement went up on Facebook: “I’m the first AAPC Fellow — join me!” The majority of members had no idea what she was talking about, but it sounded prestigious, and many members have already followed her lead.

Because of Edward’s years of dedication and hard work to our profession, she was selected by AAPC Vice President of Products Stephanie Cecchini, CPC, CEMC, CHISP, to be become AAPC’s first Fellow. This designation shows you have put in the time and are ready for an expert-level position. After Cecchini explained the Fellow designation to Edwards, she was honored to fill out the application.

“I was excited because in addition to being a beneficial tool for employers, this truly is a way to recognize the years of hard work that so many of us have put in to achieve our current positions,” said Edwards. "I appreciate that my experience and participation in local chapters, conferences, blogs, articles, etc., is also recognized," she said.

Edwards is often asked, “How do I get a job like yours?” to which she replies, “Experience and putting the time in to learn as many things about the entire billing/coding/compliance/management process as you can.” In Edwards’ opinion, “I really don’t think you can step into a consulting/auditing/education role without that background.”

It’s a Win/Win for Employers and Members

Edwards is very happy that AAPC recognizes the importance of the above-and-beyond, hard-working members who contribute to our profession.

“There are so many loyal and supportive members in our local chapters who give countless hours mentoring, acting as officers, proctoring, and supporting their local chapter who can be recognized with this designation,” she said. “It really is a way to see what you’ve given back or paid forward!”

The AAPC Fellow is “a great tool for employers to use to narrow down applicants for a particular position,” Edwards said. “I read Facebook posts from members asking what should they do next after achieving certification — well, here is a goal that can be set to work towards.”

It’s Contagious

Edwards gets excited with each person who announces they have been accepted into the recognition program. “There are so many deserving members!” she said.

All members can achieve the Fellow status. “I don’t look at it as an ‘exclusive’ group, but a group to strive to be a part of — every member can meet the requirements and apply,” Edwards said.

Be Recognized for Your Commitment

The AAPC Member Recognition Program recognizes ongoing excellence and commitment in the business of healthcare. There are three tiers of excellence:

- **AAPC Fellow** - A designation of distinction reserved for top performers who are the best in the business (www.aapc.com/recognition/aapc-fellow.aspx).

Michelle A. Dick, BS, is executive editor for AAPC and a member of the Flower City Coders, Rochester, N.Y., local chapter.
AAPC Members Recognized for Commitment, Contributions

The following members are part of a select group who dedicated themselves to their career and the health community. They have achieved the designations of AAPC Fellow, Professional, and Associate, proof of their dedication to the ethical standards of AAPC, achievements throughout their career, and reputation among their peers.

We congratulate all below on their recognition and offer our kudos to them for their achievement.

AAPC Fellow
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Angela M Jordan, CPC, COBGC
Angelica M Stephens, COC, CPC, CPMA, CIC, COBGC
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Barbara Reed, CPC, CPC-I
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Brenda L Allen, CPC
Brenda Stevens, CPC, CPMA, CRC
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Deborah Ann Santos, COC, CPC, CPMA, CPC-I, CEMC
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Susan J. Moore, COC, CIC, CRC
Susan Moran, CPC, CPMA
Suzan Berman Hauptman, CPC, CEDC, CEMC
Terrica Alanda Jackson, CPC, CASC, COBG
Teresa B Deas, CPC, CGIC, COSC
Tiffany Morgan, CPC, CPMA, CPC-I, CEMC
Tina W Rodman, CPC, CPMA, CPMA, CRC, CPPM, CRMA
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GET PUMPED FOR CPT® 2017 CARDIOLOGY UPDATES

Correct coding requires you to know what’s changed for this medical specialty.

CPT® 2017 codes are in effect and February is American Heart Month; it’s a perfect time to give you the rundown of the significant changes to the Cardiology section that will affect your coding this year.

New Code for Watchman® Type Implants

New code 33340 Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial ap-
A cardiologist may recommend this procedure as an alternative to long-term oral anticoagulants to deter emboli formation and prevent stroke.

Illustrations ©Optum 360

**Revised Valvuloplasty Coding**

Previous valvuloplasty codes 33400, 33401, and 33403 are deleted and replaced by two new codes, which are classified as either simple or complex, depending on the details of the procedure.

- **33390** Valvuloplasty, aortic valve, open, with cardiopulmonary bypass; simple (i.e., valvotomy, debridement, debulking, and/or simple commissural resuspension)
- **33391** complex (e.g., leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty)

The provider repairs an aortic valve (to treat aortic valve stenosis or narrowing) via an open approach with the patient on cardiopulmonary bypass. Code 33390 describes a “simple” procedure, such as one involving valvotomy, debridement, debulking, and/or simple commissural resuspension. Code 33391 describes a “complex” procedure, such as one involving leaflet extension, leaflet resection, leaflet reconstruction, or annuloplasty.

As *CPT® 2017 Changes: An Insider’s View* explains, “The revision of codes 33405, 33406, and 33410 [aortic valve replacement] was necessary to indicate that these are now open procedures.”

**Note:** A Nov. 29, 2016 corrections document to *CPT® 2017 Changes: An Insider’s View* revises the description of the procedure for codes 33390 and 33391 to clarify that the patient was heparinized (treated with heparin).

**Code Added for Partial Exchange Transfusion**

A partial exchange transfusion removes and replaces the patient’s blood (or components of it) with other blood or blood products. Partial exchange may be used to treat polycythemia (an abnormally increased concentration of hemoglobin in the blood) or anemia.

*CPT® 2017* adds 36456 Partial exchange transfusion, blood, plasma, or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn to report partial exchange transfusion for a newborn. Requiring the “skill of a physician or other qualified healthcare professional” allows nurses to perform this procedure.

Do not report 36456 with transfusion services 36430, 36440, or 36450. For complete exchange transfusions in a neonate, report 36450 Exchange transfusion, blood; newborn.

**Mechanochemical Is an Option for Varicose Veins**

Endovenous ablation therapy is performed to eliminate varicose veins, which are incompetent veins typically visible just below the surface of the legs and feet. New codes 36473 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechnochemical; first vein
The use of sclerosant injected by either needle or catheter, followed by a compression technique, does not qualify for 36473 or +36474.

treated and +36474 Subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to the code for primary procedure) involve a combination of mechanical and chemical methods to ablate the compromised veins. An intraluminal device is used to disrupt blood flow and “scratch” the interior surface of a vein into which medication is then infused. Per CPT® 2017 Changes: An Insider’s View, “… to report codes 36473 and +36474, both mechanical and chemical modalities … must be performed.” The use of sclerosant injected by either needle or catheter, followed by a compression technique, does not qualify for 36473 or +36474.

Code 36473 describes the first vein treated and add-on code +36474 describes each subsequent vein treated in the same extremity through a different access site. The physician must document the use of separate access sites to report +36474. The procedures are performed under local anesthesia, and include all imaging guidance, monitoring, and — when preformed in the office setting — all required supplies and equipment.

For catheter injection of sclerosant without concomitant endovascular mechanical disruption of the vein intima, or for catheter injection of an adhesive, CPT® instructs you to report 37799 Unlisted procedure, vascular surgery.

Per CPT® instructions, do not report 36473 or +36474 with 29581, 29582, 36000, 36002, 36005, 36410, 36425, 36475, 36476, 36478, 36479, 37241, 75894, 76000, 76001, 76937, 76942, 76998, 77022, 93970, or 93971 in the same surgical field.

**Transluminal Balloon Angio**

**Codes Include Radiological S&I**

CPT® 2017 deletes eight codes to report transluminal balloon angioplasty, plus the related radiological S&I codes, and re-
CPT® 2017 deletes eight codes to report transluminal balloon angioplasty, plus the related radiological S&I codes, and replaces them with four new codes.

places them with four new codes that include all necessary imaging and radiological S&I.

37246  Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery

This new code, which is listed out of sequence, describes transluminal balloon angioplasty in an initial artery — except for those arteries in the lower extremities for occlusive disease, intracranial arteries, coronary arteries, or pulmonary arteries.

+37247  Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)

This new add-on code, also listed out of sequence, describes transluminal balloon angioplasty in each additional artery beyond an initial artery — except for those arteries in the lower extremities for occlusive disease, intracranial arteries, coronary arteries, or pulmonary arteries. Report in addition to 37246 (initial artery).

37248  Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein

This new code, listed out of sequence, describes transluminal balloon angioplasty in an initial vein — except for those veins in the lower extremities for occlusive disease, intracranial veins, coronary arteries, or pulmonary veins.

37249  Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)

This new add-on code, listed out of sequence, describes transluminal balloon angioplasty in each additional vein beyond an initial vein — except for those veins in the lower extremities for occlusive disease, intracranial veins, coronary arteries, or pulmonary veins. Report in addition to 37248 (initial vein).

Per CPT® 2017 Changes: An Insider’s View, “Codes 37246 (artery) and 37248 (vein) should be reported for the primary vessel treated, as appropriate, and codes 37247 (artery) and 37249 (vein) are add-on codes that should be reported for each additional vessel treated.”

Conscious Sedation Changes Affect Coding

CPT® no longer bundles conscious sedation as part of any procedure; beginning in 2017, moderate sedation may be reported separately (using new codes 99151-99157) when it is appropriately provided and documented. Codes affected by this change in the Cardiology section include:

- 33010-33011 (pericardiocentesis)
- 33206-33223 (pacemaker procedures)
- 33233-33235 (removal of pacemaker generator and lead(s))
- 33240-33264 (defibrillator procedures)
- 33244 (removal of defibrillator electrodes by transvenous extraction)
- 33249 (insert or replace defibrillator system)
- 33282, 33284 (patient activated event recorder, implantation and removal)

Editor’s note: Look for a separate article in a future Healthcare Business Monthly for a full rundown of the new Dialysis Circuit codes 36901-36909. HBM
The Office of Inspector General (OIG) 2017 Work Plan targets home visits conducted by physicians and mid-level providers for claims review. Will your home visit claims pass muster if an auditor pays your practice a visit? Here’s what you need to know to ensure your home visit claims meet Medicare billing requirements.

Home Visits Are on the Rise

Although home services are not new to the medical profession, there has been a significant change in utilization. “House Calls,” an article published by the American Family Physicians in April 2011, noted that in 1930 almost 40 percent of patient encounters occurred in the home. This rate dropped to 10 percent by 1950, and to 1 percent by 1980.

Changes to Medicare regulations and a reimbursement increase in 1998 resulted in the number of claims for home visits increasing from 1.4 million in 1999 to 2.3 million in 2009. Continued increases in recent years, along with the Centers for Medicare & Medicaid Services (CMS) also expressing concerns about medical necessity, led the OIG to add home visits to its 2016 and 2017 Work Plans.

Home Services Must Be Necessary, Not a Convenience

Like all services, home visits must be medically necessary to be covered. According to Medicare.gov, “medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its complications.” It is important to ensure that the medical necessity for a home visit is documented in the patient’s medical record.

2017 OIG Work Plan: Physician Home Visits – Reasonableness of Services

A home visit is when a physician provides evaluation and management (E/M) services in a patient’s home. From January 2013 through December 2015, Medicare provided $718 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not “reasonable and necessary” (SSA § 1862(a) (1) (A)). The OIG will determine whether Medicare payments to physicians for E/M home visits were reasonable and made in accordance with Medicare requirements.

OAS: W-00-17-35754 Expected issue date: FY 2017

Now is a good time to clean house and get rid of any skeletons in the closet.
Changes in Medicare regulations and an increase in reimbursement in 1998 resulted in the number of claims for home visits increasing from 1.4 million in 1999 to 2.3 million in 2009.

symptoms and that meet accepted standards of medicine.” The services cannot be for the convenience of the patient, the patient’s family, or the physician.

The provider must be able to prove that the home visit was based on the patient’s inability to come to the office either this one time, or on an ongoing basis, due to physical or mental issues and not due to financial or other personal reasons. Physicians also cannot provide home services at their convenience (for example, visiting senior independent living facilities on a routine basis, without requests for or by patients).

Medicare rules (Medicare Claims Processing Manual, Chapter 12, Section 30.6.14.1.B) further define homebound status:

Under the home health benefit the beneficiary must be confined to the home for services to be covered. For home services provided by a physician using these codes, the beneficiary does not need to be confined to the home. The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.

Example: A patient has advanced Alzheimer’s disease and has become increasingly agitated. She would not cooperate sufficiently to be brought to the office so a home visit was initiated.

CPT® Coding for Home Services

Codes 99341-99350 report E/M services provided in a private residence (place of service 12). Other services (e.g., advanced care planning, diagnostic services, and some minor procedures), if performed and documented, can be billed in addition to the visit code in this setting.

CPT® has included average time in the description of home visits, to be used when counseling/coordination of care dominate the visit (e.g., comprises over 50 percent of total face-to-face time between the provider and patient), as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Relative Value</th>
<th>Average Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99341</td>
<td>Home visit new patient; problem focused</td>
<td>1.55</td>
<td>20 min</td>
</tr>
<tr>
<td>99342</td>
<td>expanded</td>
<td>2.23</td>
<td>30 min</td>
</tr>
<tr>
<td>99343</td>
<td>detailed</td>
<td>3.66</td>
<td>45 min</td>
</tr>
</tbody>
</table>

Determine Place of Service

A particular area of confusion is deciding the place of service: The place of service (POS) code terminology does not always line up
2016 was a big year for coding and billing managers, who saw a 3.5 percent increase in wages between 2015 and 2016 (from $59,679 to $61,794).

with CPT® E/M terminology and codes. For example, is the patient in an independent living/private residence, or living in a unit that also provides healthcare services? Patients living in senior complexes may have different options and services, so providers will need to confirm patient status to code services correctly.

For example, CPT® defines 99324-99337, domiciliary, rest home (e.g., boarding home), or custodial care services, as occurring in a “facility which provides room, board, and other personal assistance services generally on a long term basis. They are also used to report evaluation and management services in an assisted living facility. The facility services do not include a medical component.” As such, these codes could be POS 13 Assisted living facility, 14 Group home, 33 Custodial care facility, or 55 Residential substance abuse treatment facility. CMS further defines POS 13 as “congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange services including some health care and other services” (Medicare Claims Processing Manual, Chapter 26).

If a patient is seen in their home, then the POS is 12 Home.

**Document Medical Necessity for Home Services**

Providers must document clearly the reason for all E/M visits. For home visits, documentation must include how the visit was initiated (patient request, family or other source) and should detail the patient’s conditions that prevented him or her from traveling to the provider’s place of service. As with any E/M service, documentation must include a chief complaint; history of presenting illness (HPI); review of systems; and past, family, social history elements that are the key to making any note support medical necessity.

History provides the “why” of the note, and supports the level of exam to be performed and the complexity of the patient. If there is a clear description of the patient and his or her conditions in the HPI, medically necessity will be supported. The plan of care should also provide an indication of the need for future visits, and the expectation of whether the patient will be able travel to the physician’s office.

**Don’t Skip Patient Demographics, Business Forms**

The home visit with a new patient has the same business requirements as a visit to the office, so providers need to gather the necessary demographic and insurance information, and provide patients with the appropriate forms. Maintaining a complete and accurate medical record for each patient is critical. Forms should include:
- Notice of Privacy Practices
- General consent for treatment
- New patient intake form
It’s no surprise that health systems are growing in staff, while smaller facilities are succumbing to attrition.

LuAnn Jenkins, CPMA, CPC, CEMC, CFPC, is president of MedTrust, LLC, a practice management consulting firm located in Michigan. She has been a speaker on coding and reimbursement issues for the Michigan State Medical Society and is past president of the Michigan Medical Billers Association and 2006 AAPC Coder of the year. Jenkins is a member of the Grand Rapids, Mich., local chapter.

Home Visits: A Look into the Future

The Centers for Medicare & Medicaid Services (CMS) implemented the Independence at Home Demonstration project in 2012 to test the effectiveness of delivering primary care services by selected providers at patients’ homes. Originally authorized for three years by Section 3024 of the Affordable Care Act, the Demonstration was extended through September 30, 2017, by the Medicare Independence at Home Medical Practice Demonstration Improvement Act of 2015.

The demonstration provides chronically ill patients with a complete range of primary care services in the home setting. Medical practices, led by physicians or nurse practitioners, provide primary care home visits tailored to the needs of patients with multiple chronic conditions and functional limitations. The demonstration also tests whether home-based care can reduce the need for hospitalization, improve patient and caregiver satisfaction, improve health outcomes for patients, and lower costs to Medicare.

Participation in this home-based care demonstration is voluntary for Medicare patients. Selected primary care practices provide home-based primary care to targeted chronically ill beneficiaries for a three-year period. Participating practices make in-home visits tailored to patients’ needs and coordinate their care. CMS tracks each beneficiary’s care experience through quality measures. Practices that succeed in meeting these quality measures while generating Medicare savings have an opportunity to receive incentive payments after meeting a minimum savings requirement.

Resources


CMS, Independence at Home Demonstration: https://innovation.cms.gov/initiatives/independence-at-home/
2017 OIG Work Plan: Part B Risk Areas

Time to give your physician office’s compliance plan an annual preventive exam.

The Office of Inspector General (OIG) publishes annually a Work Plan describing new, ongoing, and revised areas within the U.S. Department of Health and Human Services (HHS) it will investigate throughout the year for potential fraud, waste, and abuse. It’s wise for providers to review this Work Plan and update their compliance plans accordingly. Here’s a summary of the areas within Medicare Part B on which the OIG plans to focus this year.


Yearly Recovery Statistics

In addition to the 2017 Work Plan, the Office of Inspector General (OIG) separately published its semi-annual report to congress, in which it announced expected recoveries of $5.56 billion from its fraud and abuse efforts in 2016. This amount is up substantially from the $3.3 billion recoveries the OIG projected for 2015. OIG also reported the following statistics relative to its enforcement efforts:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal actions</td>
<td>844</td>
<td>925</td>
<td>971</td>
</tr>
<tr>
<td>Civil actions</td>
<td>708</td>
<td>682</td>
<td>533</td>
</tr>
<tr>
<td>Exclusions</td>
<td>3,635</td>
<td>4,112</td>
<td>4,017</td>
</tr>
</tbody>
</table>

Although criminal action and exclusion figures have fallen, civil actions — which include false claims or unjust enrichment lawsuits, civil monetary penalty settlements, and administrative recoveries relative to provider self-disclosure matters — have risen. The dramatic increase in expected recoveries suggests there is no slowdown in the government’s enforcement efforts, and the importance of compliance cannot be understated.


Durable Medical Equipment (DME) and Supplies

NEW! Part B services during non-Part A nursing home stays – DME: In cases where a beneficiary continues to reside in a skilled nursing facility (SNF) after 100 days (non-Part A stay), Medicare Part B may provide coverage for certain therapy and supplies. A July 2009 OIG study found that Medicare Part B made $30 million in inappropriate DME Prosthetics, Orthotics, and Supplies (DMEPOS) payments. The OIG will evaluate the extent of inappropriate payments under Part B for DMEPOS provided to nursing home residents during non-Part A stays. The OIG also intends to determine if the Centers for Medicare & Medicaid Services (CMS) has a system in place to identify and recoup such overpayments from suppliers.

NEW! Medicare market share of mail-order diabetic testing strips (DTS): The OIG will develop a required report of the market share of DTS prior to each subsequent round of the competitive bidding program.
The dramatic increase in expected recoveries suggests there is no slowdown in the government’s enforcement efforts, and the importance of compliance cannot be understated.

NEW! Positive airway pressure device supplies – supplier compliance with documentation requirements for frequency and medical necessity: Medicare paid approximately $953 million for continuous positive airway pressure or respiratory assist devices (PAP). Prior OIG analysis found evidence of automatic shipping of PAP supplies when no physician orders for refills were in effect. The importance of compliance cannot be understated. Orders of certificates of medical necessity must specify the type of supplies needed and the frequency of use, replacement, or consumption consistent with the Medicare Program Integrity Manual (publication 100-8, chapter 5, sections 5.2.3, 5.9). Automatic shipment of resupplies is not permitted. The documentation must show a request for resupply by the beneficiary or caregiver before supplies are dispensed, according to the Medicare Claims Processing Manual (publication 100-4, chapter 20, section 200).

Other areas of focus include:
- Orthotic braces – Reasonableness of Medicare payments compared to amounts paid by other payers
- Osteogenesis stimulators – Lump-sum purchase versus rental
- Power mobility devices (PMDs) – Lump-sum purchase versus rental
- Competitive bidding for medical equipment items and services – Mandatory review
- Orthotic braces – Supplier compliance with payment requirements
- Access to DME in competitive bidding areas

Other Providers and Suppliers

NEW! Monitoring Medicare payments for clinical diagnostic laboratory tests: Consistent with the requirements of section 216 of the Protecting Access to Medicare Act (PAMA) of 2014, OIG will analyze the market rates for the top 25 laboratory tests as a means of monitoring CMS’ implementation of the new payment system for these tests.

NEW! Medicare payments for transitional care management: Medicare-covered services, including chronic care management, end-stage renal disease, and prolonged services without direct patient contact cannot be billed during the same service period as transition care management (TCM). OIG will determine whether payments for TCM services were in accordance with Medicare coverage requirements.

NEW! Data brief on financial interests reported under the open payments program: Section 6002 of the Affordable Care Act, sometimes referred to as the Physician Payments Sunshine Act, requires manufacturers to disclose to CMS payments made to physicians and teaching hospitals. OIG intends to analyze the 2015 reporting data to determine the number and nature of financial interests, and will evaluate how much Medicare paid for drugs and DMEPOS ordered by physicians with financial relationships with the supplying entity. The OIG also continues to evaluate the accuracy of the data reported by manufacturers to the open payments system.

NEW! PMD equipment – Portfolio report on Medicare Part B payments: OIG previously identified inappropriate payments for PMDs that were unnecessary, not documented in accordance with Medicare requirements, cheaper to rent than purchase, or fraudulent. OIG will compile results of prior audits, evaluations, and investigations of PMD equipment paid by Medicare to identify trends in payment, compliance, and fraud vulnerabilities. OIG will make recommendations to CMS of any necessary actions.

REVISED! Ambulance services – Supplier compliance with payment requirements: The OIG found that Medicare made inappropriate
... you are encouraged to review the Work Plan in its entirety to ensure applicable risk areas are well understood.

payments for advanced life support (ALS) services, and based on prior work will determine whether ambulance services including basic life support (BLS), ALS, and specialty care transports were billed in compliance with Medicare requirements.

REvised! inpatient rehabilitation facility (IRF) payment system re-quirements: The OIG will determine whether IRFs nationwide have submitted claims in compliance with Medicare documentation and coverage requirements, based on prior reviews that identified substantial Medicare overpayments to IRFs.

REvised! histocompatibility laboratories – supplier compliance with payment requirements: From March 31, 2013, through Sept. 30, 2014, histocompatibility labs reported $1.31 million in reimbursable costs on their most recent cost reports. Because allowable costs must be related to the care of beneficiaries; be reasonable necessary and proper; and be an allowable cost under the regulations, the OIG will determine whether payments to histocompatibility labs were made in accordance with Medicare requirements.

Other areas the OIG is focusing on (and you should, too):

• Ambulance services – Questionable billing, medical necessity, and level of transport
• Payments for Medicare services, supplies, and DMEPOS referred or ordered by physicians – compliance
• Anesthesia services – Non-covered services
• Anesthesia services – Payments for personally performed services
• Physician home visits – Reasonableness of services
• Prolonged services – Reasonableness of services
• Chiropractic services – Part B payments for non-covered services
• Chiropractic services – Portfolio report on Medicare Part B payments
• Selected independent clinical laboratory billing requirements
• Physical therapists – High use of outpatient physical therapy services by independent therapists
• Portable X-ray equipment – Supplier compliance with transportation and setup fee requirements
• Sleep disorder clinics – High use of sleep testing procedures (CPT® codes 95810 and 95811)

Follow Through
This is a summary of the Part B portion of the 2017 Work Plan; you are encouraged to review the Work Plan in its entirety to ensure applicable risk areas are well understood. For each of your focus areas, be certain to review appropriate CMS interpretive guidance and local coverage determinations, as well as any referenced regulatory provisions cited in the OIG Work Plan to ensure you completely understand and comply with CMS’ expectations, particularly with respect to documentation content and coverage limitations.

Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, is president-elect of AAPC’s National Advisory Board, serves on AAPC’s Legal Advisory Board, and is the AAPC Ethics Committee chair. He has over 20 years of experience in healthcare coding and over 18 years’ experience as a forensic coding and compliance expert. Miscoe has provided expert analysis and testimony on a wide range of coding and compliance issues in civil and criminal cases, and represents healthcare providers involved in post payment disputes with payers. He is a frequent lecturer and is published widely on a variety of coding, compliance, and health law topics. He is a member and past president of the Johnstown, Pa., local chapter.

Resources
INSIDE ZHP
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VIDEO SEMINARS
REFERENCE eBOOKS
ANATOMY CHARTS
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Jan. 1, 2017, primary care practices and payers across 14 regions in the United States embarked on a five-year plan to change the face of primary care. The goal of the Comprehensive Primary Care Plus (CPC+) medical home model is to empower primary care practitioners to deliver high quality, patient-centered care.

Building Primary Care Success
The Centers for Medicare & Medicaid Services (CMS) hope to build on the successes of the model’s predecessor: the CPC initiative. In CPC+, practices will be guided by these Comprehensive Primary Care Functions:

- Access and Continuity
- Care Management
- Comprehensiveness and Coordination
- Patient and Caregiver Engagement
- Planned Care and Population Health

Making Payment Incentives Work
This incentive payment plan is designed to pay participating practices a monthly, prospective, risk-adjusted care management fee for each of their Medicare fee-for-service beneficiaries. The care man-
management fee is a non-visit-based payment. Participating practices also receive a performance-based incentive payment centered on patient experience, clinical quality, and utilization. The amount of these payments vary, depending on the provider's designated track. There are two tracks a practitioner can select in CPC+. Providers in either track need to report on clinical quality measures and patient care experience. They also need to have health information technology (IT) modules that meet the definition of certified electronic health record technology (CEHRT) according to CMS guidelines, and meet technology guidelines enabling them to report electronic Clinical Quality Measures (eCQMs). Track 2 pays a higher performance-based incentive payment rate, but also requires a supporting vendor to assist with the more advanced IT needs. Track 2 providers are reimbursed for taking care of beneficiaries with more complex needs. The practices that achieve the performance standards are able to keep their performance-based incentive payment. If a practice does not achieve the desired goals, they are required to repay all or some of that payment. The provider is responsible to report on their projected expenses and provide a summary at the end of each year on actual expenses.

Improving Patient Outcomes

The CPC+ model is just one vehicle CMS is using to achieve a goal of tying 50 percent of Medicare payments to alternative payment models by the end of 2018 for the ultimate goal of “better care, smarter spending, and healthier people.”

Editor’s Note: To help maximize money incentives for practices, read the article “Money Up Front for CPC+” on page 50.

Resources

For more information on CMS’ CPC+ innovation model, go to: https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus


Colleen Gianatasio, CPC, CPC-P, CPMA, CPC-I, CRC, has 18 years of experience in customer service, claims, quality, and coding. As a risk coding and education specialist, Gianatasio’s primary responsibilities are auditing medical charts and providing education to physicians and their staff. As a certified AAPC instructor, she enjoys teaching a variety of coding, documentations, and auditing classes. Gianatasio serves as president of the Albany, N.Y., local chapter and is a member of the AAPC National Advisory Board.
With value-based care and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)/Merit-based Incentive Payment System (MIPS) rollout, primary care practices are taking advantage of initiatives such as the Patient-centered Medical Home Program, accountable care organizations/Medicare Shared Savings Programs (MSSPs), and chronic care management (CCM) to increase revenue and establish the infrastructure necessary to provide more comprehensive and preventive care for patients with chronic diseases. Although these programs are well intended, the increased workload and delayed financial reward place significant stress on practices, and may limit their ability to participate.

With this in mind — and with the idea of putting more money in the pockets of practices embracing practice transformation — the Center for Medicare & Medicaid Services (CMS) is now offering the Comprehensive Primary Care Plus (CPC+) program to certain regions of the country, with monetary incentives provided on the front end to drive healthcare reform.

**Receive Money Up Front for Care Coordination**

The CPC+ is a five-year program that began in January and will include up to 5,000 practices and 20,000 physicians in 14 regions. The program is an advanced medical home model that CMS hopes will strengthen primary care through a regionally based, multipayer payment reform and care delivery transformation. It consists of five components (as discussed in the article “Make Primary Care Comprehensive with CPC+” on page 48) and two tracks.

Both Track 1 and Track 2 are paid a monthly care management fee for their attributed Medicare fee-for-service (FFS) patients. This fee is meant to allow practices to augment staffing and training in support of population health management and care coordination. Track 2 is intended for practices with more experience with practice transformation, and has enhanced health IT requirements, as well as enhanced payment.

**Let’s Talk Numbers**

The Center for Medicare and Medicaid Innovation estimates that a practice similar in size to the average practice participating in Track 1 of CPC+ will receive $126,000 annually, plus performance payments of $21,000. For Track 2, the figures are $235,200 and $33,600, respectively.

Although the practices selected for CPC+ have not yet been made public (at the time of this writing), those selected were recently noti-
... it’s imperative that all practices leverage any money on the table to build the necessary infrastructure for practice transformation and proactive patient care.

Components of a comprehensive population health management plan also should include chronic care oversight for non-attributed patients, as well as transitional care management (TCM). For a smooth patient care transition to home, practices have the option of reporting on two outcomes affected by TCM:

1. All Cause Readmission
2. Unplanned Hospital Readmission within 30 Days of Principle Procedure (designated as a High Priority Measure)

As shown in Table 1, significant additional money — totaling approximately 50 percent of available CPC+ reimbursement — can be gained by inclusion of non-attributed CCM and TCM in a practice’s care management plan.

Table 1: Theoretic Practice Transformation

<table>
<thead>
<tr>
<th>Eligible Patients</th>
<th>Monthly Financial Opportunity</th>
<th>Annual Financial Opportunity</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PMPM</td>
<td>Total</td>
<td>Management Fees</td>
</tr>
<tr>
<td>Medicaid PCMH</td>
<td>800</td>
<td>$4.00</td>
<td>$3,200</td>
</tr>
<tr>
<td>Insurance PCMH</td>
<td>800</td>
<td>$5.00</td>
<td>$4,000</td>
</tr>
<tr>
<td>MSSP ACO</td>
<td>450</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>CPC+ (Track 1)</td>
<td>450</td>
<td>$17.50</td>
<td>$7,875</td>
</tr>
<tr>
<td>TCM (above FFS)</td>
<td>8</td>
<td>—</td>
<td>$449</td>
</tr>
<tr>
<td>Outsourced CCM (Non-CPC+)</td>
<td>243</td>
<td>—</td>
<td>$3,647</td>
</tr>
<tr>
<td><strong>Annual Value Based Opportunity:</strong></td>
<td></td>
<td></td>
<td>$230,046</td>
</tr>
</tbody>
</table>

| Increased PCMH Overhead: | 1 Care Coordinator | $60,000 | | |
| | Misc. Expenses | $10,000 | |
| **Existing Fee For Service (FFS) Revenue:** | | $400,000 |
| **Total Revenue Less PCMH Expenses:** | | $596,421 |
| | | +33% |

If you’re comparing notes for CPC+ with the upcoming MACRA requirements, CPC+ will be counted as an Alternative Advanced Payment Model supportive of advanced primary care functions, while also providing an alternative to MIPS. This is an additional incentive for practices aiming to avoid the challenges of MIPS requirements.

Practices already participating in a MSSP are also allowed to participate in CPC+. The care management fee is paid directly to the participating practices, and included in the MSSP’s total expenditures for shared savings and loss. The practices forego the prospectively paid, retrospectively calculated, performance-based incentive payment, however, and will instead participate in the MSSP shared savings and loss arrangement.

**Cash-in on CCM and TCM**

With all that’s at stake with the upcoming changes in healthcare — most importantly the health of our patients — it’s imperative that all practices leverage any money on the table to build the necessary infrastructure for practice transformation and proactive patient care. Cashing in on non-attributed CCM and TCM are great opportunities, not to be forgotten by CPC+ participants.

If you didn’t send your application for CPC+ this round, you may be able to take advantage of the upfront money when CMS reopens the program this spring.

 básico y están probablemente planeando ya usar el adelanto de salario para impulsar su programa de atención primaria basado en el valor.

La inyección de efectivo desde el principio es beneficiosa, pero asegurarse de que no quede dinero en el bolsillo es crítico para la estabilidad del proceso de transformación del gabinete. Lonnie Robinson, MD, médico de práctica familiar en Mountain Home, Arkansas, y ex presidente de la Academia de Medicina Familiar de Arkansas (AAFP), habló sobre el valor de la atención en la conferencia AAFP del año pasado. Se detalló el impacto financiero teórico de estos programas en la transformación del gabinete (ver tabla 1).

<table>
<thead>
<tr>
<th>Eligible</th>
<th>Total</th>
<th>Management</th>
<th>Shared</th>
<th>Grand Total</th>
</tr>
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<tbody>
<tr>
<td>Patients</td>
<td>PMPM</td>
<td>Total</td>
<td>Fees</td>
<td>Savings</td>
</tr>
<tr>
<td>Medicaid PCMH</td>
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<td>$4.00</td>
<td>$3,200</td>
<td>$38,400</td>
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<tr>
<td>Insurance PCMH</td>
<td>800</td>
<td>$5.00</td>
<td>$4,000</td>
<td>$48,000</td>
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<tr>
<td>MSSP ACO</td>
<td>450</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>CPC+ (Track 1)</td>
<td>450</td>
<td>$17.50</td>
<td>$7,875</td>
<td>$94,500</td>
</tr>
<tr>
<td>TCM (above FFS)</td>
<td>8</td>
<td>—</td>
<td>$449</td>
<td>$5,388</td>
</tr>
<tr>
<td>Outsourced CCM (Non-CPC+)</td>
<td>243</td>
<td>—</td>
<td>$3,647</td>
<td>$43,758</td>
</tr>
<tr>
<td><strong>Annual Value Based Opportunity:</strong></td>
<td></td>
<td></td>
<td>$230,046</td>
<td>$36,375</td>
</tr>
</tbody>
</table>

| Increased PCMH Overhead: | 1 Care Coordinator | $60,000 | — | — |
| | Misc. Expenses | $10,000 | — | — |
| **Existing Fee For Service (FFS) Revenue:** | | $400,000 | — | — |
| **Total Revenue Less PCMH Expenses:** | | $596,421 | — | — |
| | | +33% | — | — |

Si no enviaste tu solicitud para CPC+ en esta ocasión, podrías aprovechar el dinero inicial cuando CMS reabrirá el programa este año.

**Recursos**

https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus
www.aapc.com/blog/36191-understanding-cpc-program/
https://qpp.cms.gov/measures/quality

Stephen J. Canon, MD, es un urologo certificado de la Universidad de Arkansas para Medicina (UAMS). También es jefe de Pediatría Urología de Arkansas Children’s Hospital, director de la Unidad de Urología de la UAMS y el 2010 recipiente inaugural del Arkansas Children’s Hospital Auxiliary y John F. Redman, MD, silla de silla en pediatría urológica. Canon recibió su título de la Universidad de Texas Medical Branch y completó una beca de Pediatría Urología en Columbus, Ohio. También fundó Phyzit, Inc. Phyzit TCM™ es una solución de software basada en la nube que optimiza el proceso de TCM.
As in past years, the Centers for Medicare & Medicaid Services (CMS) based 2017 Hospital Outpatient Prospective Payment System (OPPS) payments on claims data submitted by hospital providers. This year, that resulted in a 1.65 percent update. Hospitals that fail to meet hospital outpatient quality reporting (OQR) requirements will incur a 2.0 percentage point reduction, and certain sole community hospitals and essential access community hospitals continue to rural adjustments. Let’s take a look at what else CMS has in store for us in 2017.

**Claim Data Affects APC Assignments**

CMS continues to restructure families of Ambulatory Payment Classifications (APCs) to become less granular, while maintaining APC assignments based on clinical characteristics and resource similarities. Claims data continues to be the source of CMS determinations for procedural grouping and status indicator assignment. The Diagnostic Radiology APCs have been renamed “Imaging,” and consolidated from 17 to seven. Vascular interventional radiology procedures are reassigned to vascular service APCs.

For 2017, CMS finalized 25 new Comprehensive APCs (C-APC). Reimbursement continues to be an encounter-/claim-based payment. The J1 primary service and complexity adjustment methodologies continue.

A new C-APC, “Allogeneic Hematopoietic Stem Cell Transplantation,” was created to include the donor/product services. These services are not separately payable, as Medicare only covers the
recipient; however, the cost of the services related to the donor/product is part of the overall comprehensive procedure. CMS has instituted a new edit for 2017 requiring the claim to contain the combination of CPT® 38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor for the procedure, and revenue code 0815 for the acquisition costs. Revenue code 0815 is designated specifically for this service.

CMS reinforces in the 2017 final rule that it’s crucial for providers to report all services provided to a patient, regardless of whether a service warrants separate payment. Without reporting all services, CMS has no information in the claims data on which to base future payment. Individual line item payment should not be the sole reason for reporting services on a claim; and in fact, it’s crucial to report packaged items/services on the claim, or the cost is lost.

Device-intensive APC Edits Remain in Place, but Changed

CMS retained the device-to-procedure edits, but further refined the methodology and will base the device-intensive status on the individual HCPCS (Level I or II) procedure code, rather than at the APC level. This change allows the data to be more focused, and any device offset amount to be specific to the procedure rather than the entire APC. No specific procedure-to-device match is required; any device C code related to a device-intensive procedure will satisfy the edit.

One new device code is initiated for 2017: C1889 Implantable/insertable device for device-intensive procedure, not otherwise classified. This code allows reporting of a device-intensive procedure performed under a new methodology due to advances in medical technology. For example, where a vascular embolization procedure was performed with a catheter, a C code for the catheter would’ve been reported. This procedure can now be safely performed, in some instances, using a needle. There is no device C code for a needle, but you now have C1889 to report as the device code.

Packaging Continues to Expand

CMS continues to expand packaging to provide a more “prospective” payment for outpatient encounters. Modifier L1 is deleted, and clinical diagnostic laboratory tests are unconditionally packaged when reported on a claim with other services. Status indicator Q4 is still in use to allow the claims processing system to pay for these tests when a “lab-only” claim is submitted.

Changes for Off-campus, Outpatient, Provider-based Departments

Section 603 of the Bipartisan Budget Act of 2015 relates to payment for certain items and services provided in off-campus, provider-based departments (PBDs) of a hospital. From July 2012 to July 2015, hospital ownership of physician practices increased by 855, and the number of hospital-employed physicians increased by 50 percent. When these services became provider-based, in accordance with regulations (42 CFR 413.65), reimbursement changed from the Medicare Physician Fee Schedule (MPFS) to the hospital OPPS. Section 603 states that to be reimbursed under the OPPS, the off-campus PBD must have been providing covered outpatient department services prior to Nov. 2, 2015. Those that were providing services are designated by CMS as “excepted,” and are eligible for continued OPPS reimbursement. Those that were not are considered “non-excepted.” This provision only applies to entities paid under Section 1833(e) of the Social Security Act: Indian Health Services, federally qualified health centers, and dedicated emergency departments, for example, are excluded from this provision.

Under Section 603, certain items and services are excluded from the definition of “covered outpatient department services” for the purpose of OPPS reimbursement and will be paid under “the applicable payment system” (the MPFS with some OPPS methodology included), beginning Jan. 1, 2017. CMS will use OPPS data to establish payment based on resources, but will not reimburse the APC amount. Packaging, wage index application, and billing rules will be consistently applied, as under the OPPS.
Beginning in 2017, a 20 percent payment reduction is required under the OPPS for imaging services that use film.

CMS has also established an “MPFS relativity adjuster” for 2017. This adjuster is based on the claims/cost analysis and comparison of the payment differential between the OPPS and ambulatory surgery centers. The relativity adjuster will decrease 2017 OPPS payment by 50 percent for non-excepted PBD services, which levels the reimbursement with that provided for a physician’s office and paid under the MPFS.

Apply modifier PN Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital to all non-excepted items and services billed, including those paid under a fee schedule, when provided in a non-excepted PBD. Excepted PBDs should continue to report modifier PO Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments.

To combat coding inconsistencies for outpatient visits and some radiation treatment services, CMS clarifies in the final rule that, under the OPPS, outpatient visits are reported with G0463 Hospital outpatient clinic visit for assessment and management of a patient, regardless of level; whereas, under the MPFS, there are 10 visit codes based on new and established patient status. G0463 will continue to be reported under the OPPS. Radiation treatment delivery is reported with CPT® codes under the OPPS and with G codes under the MPFS. Non-excepted PBDs are required to bill G codes for radiation treatment services.

The payment for separately paid drugs and biologicals are excluded from the relativity adjuster methodology, as these items are paid separately in a physician’s office setting. When the item becomes packaged, it’s included in the cost/payment of services that are affected by the adjuster.

The 2017 OPPS final rule contains detailed discussions regarding these changes.

New Modifier Requirements for Radiology

The Consolidated Appropriations Act of 2016, Section 502(b) of Division O, Title V, amended Section 1833(t)(16) of the Social Security Act regarding certain radiology procedures. Beginning in 2017, a 20 percent payment reduction is required under the OPPS for imaging services that use film. New modifier FX X-ray taken using film is established and must be appended to the procedure code. Providers will incur a payment reduction for procedures using computed radiography beginning in 2018. Look for details in future rulemaking.

Outlier Fixed-dollar Thresholds Updated

CMS annually updates the formula for calculating outlier payments. Consistent with prior years, 2017 outlier payments are triggered when costs for providing a service or procedure exceed both:

- 1.75 times the APC payment amount; and
- APC payment plus the $3,825 fixed-dollar threshold (increased $575 from 2016).
Packaging, Payments, and Pass-through Updates

Four HCPCS Level II codes remain eligible for pass-through payment for 2017:

C2623 Catheter, transluminal angioplasty, drug-coated, non-laser
C2613 Lung biopsy plug with delivery system
C1822 Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
Q4172 PuraPly, and PuraPly Antimicrobial, any type, per square centimeter.

The packaging threshold for drugs, biologicals, and radiopharmaceuticals increases $10 to $110 for 2017.

Payment for all separately payable drugs, biologicals, and radiopharmaceuticals (with or without pass-through status) continues to be made at average sales price (ASP) plus 6 percent.

Two drug manufacturers commented to CMS that they opposed packaging because they believe CMS wants the best products for beneficiaries, but packaging creates more incentive for hospitals to use less expensive products. CMS responds in the final rule:

… where there are a variety of devices, drugs, items, supplies, etc. that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the most cost-efficient item that meets the patient’s needs, rather than to routinely use a more expensive item, which often results if separate payment is provided for the items (78 FR 74925). The potential effect of this policy that the commenter is concerned about (hospitals choosing a lower cost stress agent) is precisely the outcome that we hope to encourage through this packaging policy.

Inpatient-only Procedures Thin Out

Seven procedures were removed from the inpatient-only list; none were added. Five of the seven are add-on codes and assigned status indicator N. Items and services packaged into APC rates:

+22585 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
+22840 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
+22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires), 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
+22845 Anterior instrumentation, 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
+22858 Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyrectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)

The remaining two codes are assigned status indicator J1 Hospital Part B services paid through a C-APC:

31584 Laryngoplasty, with open reduction of fracture
31587 Laryngoplasty, cricoid split

We’ve Only Just Begun

Anyone who’s been in the business of healthcare for more than a day knows Medicare policies are never static. The information related here merely highlights some of the changes CMS finalized for the 2017 OPPS. Be sure to review the final rule and the January update transmittal for complete details on changes that will affect your outpatient facility in the coming year, and stay tuned for revisions and corrections.

Denise Williams, RN, COC, is the senior vice president of revenue integrity services for Revant Solutions, Inc. She has been involved with APCs since their initiation. Williams has worked as corporate chargemaster manager for two healthcare systems, and is heavily involved in compliance and coding/billing edits and issues. She is a member of the Murfreesboro, Tenn., local chapter.

Resources

CMS Proposes Hospital Outpatient Prospective Payment Changes for 2017: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-06.html
CMS, Hospital Outpatient Regulations and Notices: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html
In this transition year of the Quality Payment Program, practices have the option to participate in an alternate payment model (APM). There are advantages to doing so, but you must do your homework. In 2017, some APMs will not meet statutory requirements to be categorized as advanced APMs. Clinicians who are eligible to participate in MIPS and who participate in such APMs are actually in MIPS APMs. It's important to know your clinicians' participation level to ensure proper reporting to and payment from the Centers for Medicare & Medicaid Services (CMS).

Identifying MIPS APMs
MIPS APMs meet three criteria:
1. APM entities participate in the APM under an agreement with CMS, or by law or regulation;
2. APM entities include at least one MIPS eligible clinician on a participation list; and
3. The APM bases payment incentives on performance (either at the APM entity level or eligible clinician level) on cost and quality measures.

Eligible Clinician or QP?
Medicare Part B clinicians billing more than $30,000 a year and providing care for more than 100 Medicare patients a year are eligible to participate in the Merit-based Incentive Payment System (MIPS). To be a qualifying participant (QP) of an advanced alternate payment model (APM), exempt from MIPS, clinicians must receive 25 percent of their Medicare payments or see 20 percent of their Medicare patients through an advanced APM (exceptions exist). Note that QPs are not only excluded from MIPS, but also receive a 5 percent lump sum bonus starting in 2019 and a higher Physician Fee Schedule update starting in 2026.

Not All APMs Are Equal
Some alternate payment models do not exempt clinicians from the Merit-based Incentive Payment System (MIPS).
MIPS APMs in 2017:

- Medicare Shared Savings Program Accountable Care Organizations (ACOs) - Tracks 1, 2, and 3 (tracks 2-3 are advanced APMs)
- Next Generation ACO Model (advanced APM)
- Comprehensive End-stage Renal Disease (ESRD) Care (CEC) Model (large dialysis organization (LDO) arrangement) (advanced APM)
- Comprehensive ESRD Care (CEC) Model (non-LDO arrangement one-sided risk arrangement)
- Comprehensive ESRD Care (CEC) Model (non-LDO two-sided risk arrangement) (advanced APM)
- Oncology Care Model (OCM) (one-sided risk arrangement)
- Oncology Care Model (OCM) (two-sided risk arrangement) (advanced APM)
- Comprehensive Primary Care Plus (CPC+) Model (advanced APM)
- Vermont Medicare ACO Initiative (as part of the Vermont All-payer ACO Model) (advanced APM)

If a MIPS eligible clinician does not meet the threshold of having sufficient payments or patients through an advanced APM to become a qualifying participant (QP), the eligible clinician is scored under MIPS and the APM scoring standard. These scores are aggregated to the APM entity level, and all eligible clinicians in the APM entity receive the same MIPS final score.

**APM Scoring Standard**

CMS will review MIPS APM participation lists on March 31, June 30, and Aug. 31 (instead of the proposed one-time date of Dec. 31). To be considered part of a MIPS APM entity for the APM scoring standard, an eligible clinician must be on an APM participation list on at least one of those dates during the MIPS performance year. Otherwise the eligible clinician or group must report MIPS data to Medicare through standard means by March 31 of the following year to avoid a negative payment adjustment.

**Important:** If the applicable data submission requirements include full-year reporting, the MIPS individual or group must report for the full year to receive credit.

**Score Big**

The performance categories — Quality, Cost, Improvement Activities, and Advancing Care Information — are the same for MIPS APMs as those for MIPS reporters, but the requirements are different. For example, for 2017, clinicians participating in a MIPS APM will receive full credit for improvement activities.

The weights applied to the improvement activities performance category under the APM scoring standard in the 2017 performance year are:

- The Shared Savings Program and the Next Generation ACO Model improvement activities performance category weight is 20 percent.
- MIPS APMs other than the Shared Savings Program and the Next Generation ACO Model (including the CPC+ Model, the CEC Model, and the OCM) improvement activities performance category weight is 25 percent.

**Watch Your Back**

Your MIPS APM entity doesn’t submit quality data on your behalf, it’s your responsibility to do so through MIPS reporting. Failing to report data in this category will earn you a big, fat zero and a negative payment adjustment in 2019.

Renee Dustman, BS, is an executive editor for AAPC, and a member of the Flower City Coders, Rochester, N.Y., local chapter.

**Resource**

Scores for Improvement Activities in MIPS APMs in the 2017 Performance Period, Dec. 29, 2016, [https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf](https://qpp.cms.gov/docs/QPP_APMs_and_Improvement_Activities.pdf)
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Zabun Nisa, CPB

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Make deciphering clinical documentation for the skin easier by recognizing common medical terms and acronyms:

- **AK**: Actinic keratosis
- **BCC**: Basal cell carcinoma
- **BMK**: Birthmark
- **Bx**: Biopsy
- **HPV**: Human papilloma virus
- **I&D**: Incision and drainage
- **ID**: Interdermal
- **LE**: Lupus erythematosus
- **MM**: Malignant melanoma or multiple myeloma
- **MMS**: Mohs micrographic surgery
- **PUVA**: Psoralens ultraviolet A treatment
- **SCCA**: Squamous cell carcinoma
- **SG**: Skin graph
- **SQ, SC, subcut, subq**: Subcutaneous
- **TBSA**: Total body surface area
- **TRAM**: Transverse rectus abdominis myocutaneous

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