HEALTHCARE BUSINESS MONTHLY
Coding | Billing | Auditing | Compliance | Practice Management

April 2017

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Lorraine Sivak, CPC, Director of Auditing and Coding Compliance at Aviacode

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On the Cover: Bill Wong, CPC, CPMA, CDEO, CHPC, CCS, explains how advancing telemedicine technology can allow providers a more convenient method of care delivery to patients. Cover design by Mahfooz Alam and Michelle A. Dick.

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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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Letter from the President

Invest in Yourself by Maximizing Your Benefits

Being an AAPC member is an investment in yourself and your career. Your association with AAPC shows dedication to your role in accurate reporting and payment of healthcare services. It highlights your interest and expertise in a complex, dynamic field. And it marks you as a professional and a leader amongst your peers. But are you using your membership benefits to their fullest?

Know the Full Scope of Benefits

Research indicates many members easily list their credentials and Healthcare Business Monthly as benefits, and stop there. AAPC membership opens the door to many professional and personal benefits to enhance career enjoyment. Here are some of the many opportunities you should be utilizing:

• **Local chapters.** Belonging to a local chapter is your opportunity to meet with peers to learn, have fun, and support each other. Unique to AAPC and a core value of our organization, our local chapters provide regular meetings and special events geared to your needs, but I’m surprised by how few take advantage. If you are looking for free and low-cost CEUs, your local chapter is a good place to earn them. If you are looking for a job, start by checking with your colleagues at your local chapter. And if you have questions, ask them at your local chapter. So much is open to you at these regular meetings, if you attend and actively participate.

Let us know what we can do to make your local chapter more valuable and accessible to you. Find your chapter at: [www.aapc.com/chapter](http://www.aapc.com/chapter).

• **Four (4) More Free CEUs (per year).** We recently began presenting quarterly 1-hour webinars (1 CEU each) for members but have been surprised by how few members access these free events covering Quality Payment Programs, ICD-10-CM and the Future of Coding, Post-Election Policy Insights, code updates, and other important topics. View the webinars at: [www.aapc.com/freewebinar](http://www.aapc.com/freewebinar).

• **Learning Center.** AAPC offers dozens of online, easy-to-access classes on nearly every topic associated with working and excelling in our field. While each of the courses requires a small fee, we’ll soon be bundling much of this library with membership packages. For a list of titles, go to: [www.aapc.com/catalog](http://www.aapc.com/catalog).

• **Knowledge Center.** Get the latest updates and find answers to your questions at the Knowledge Center, a resource containing more than 5,000 articles such as MACRA, telehealth, inpatient coding, E/M, Medicare, and more, written by AAPC members and other professionals. Start reading at: [www.aapc.com/blog](http://www.aapc.com/blog).

• **Free tools.** Try our E/M Analyzer and Work RVU calculator. Access our Health Plan Search, a free connection to most payers’ payment rules, federal local coverage determinations, and other guidelines needed to report accurately. Visit [https://goo.gl/208mPA](https://goo.gl/208mPA) to access these and many other free and low-cost resources.

• **Discounted learning, books, and software.** AAPC offers the best coding education, books, and software at exclusive member-only pricing (25 to 70 percent off). Our distance and contracted learning programs are inexpensive and convenient. Our code books are user-friendly and reliable, and our AAPC Coder software is easy to use.

• **Savings Connection.** This perk alone can more than offset the annual membership fee, yet it’s one of the least utilized. Looking for discounts from local restaurants or vendors? Want to get the most out of your vacation through hotel, airline, and activity discounts? Seeking a discount on a service or household item? Your membership entitles you to save money practically everywhere you go. I personally use this benefit every year to save hundreds of dollars on activities, products, and services. Learn more at: [www.aapc.com/savings](http://www.aapc.com/savings).

• **Discounted insurance.** AAPC just added a liability carrier to health and life insurance payers you can access through the Member Perks program. Ideal for the individual member or small businesses with employees, these discounted plans add protection when you really need it. Look to: [www.aapc.com/memberperks](http://www.aapc.com/memberperks).

We’re Always Expanding Our Perks

AAPC offers networking, education, events, acknowledgment, and savings, and we’re improving and developing new perks all the time.

We look to you to let us know what benefits will help you most in your career. Let us know what you need to make your association with AAPC more valuable. Your feedback is always appreciated.

Sincerely,

Bevan Erickson, President
Not Every Nurse Fits CMS’ Definition of “Other Qualified Healthcare Provider”

“Get Pumped for CPT® 2017 Cardiology Updates” (February, page 37) states that 36456 Partial exchange transfusion, blood, plasma, or crystalloid necessitating the skill of a physician or other qualified health care professional, newborn may be performed by a nurse. To clarify, the CPT® codebook defines a “physician or other qualified healthcare professional” as an “individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service.”

Section 1842(b)(18)(C) of the Social Security Act further defines a practitioner as a:

- Physician assistant;
- Nurse practitioner;
- Clinical nurse specialist (Section 1861(aa) (5) of the Act);
- Certified registered nurse anesthetist (Section 1861(bb)(2) of the Act);
- Certified nurse-midwife (Section 1861(gg) (2) of the Act);
- Clinical social worker (Section 1861(hh)(1) of the Act);
- Clinical psychologist (42 CFR 410.71 for purposes of Section 1861(ii) of the Act); or
- Registered dietitian or nutrition professional.

The Act specifies, “Other types of licensed healthcare professionals have a more limited scope of practice and are generally not eligible for hospital medical staff privileges, unless their permitted scope of practice in their State makes them comparable to the above types of practitioners.”

I have worked two years and have had more chances than I could have imagined (seven, to be exact) to get where I am. I took the Certified Professional Coder (CPC®) exam on Oct. 8, 2016, and I’m proud to say I passed — with a little help from my friends.

**Nothing Is Impossible with Cheerleaders**

I am blessed to have so many “BossChicks” in my circle. Some of them are in the coding business and totally understand my journey, and others became my biggest cheerleaders simply because that’s what my “sista-friends” do. And then, there is my circle of men: my mister and our three boys. Each time I took the test they would say, “Momma you got this!” When I fell short, they would say, “Get back on it.” They did not allow me to feel sorry for myself, nor to quit on myself.

**People Come into Your Life to Help with Your Goals**

AAPC’s Facebook page has also been a great inspiration for helping me earn my certification. It showed me that I wasn’t alone on this journey. When I met my study buddy Sharon Sircia, CPC, we connected first because we were both testing. Our relationship has become much more, a solid friendship. This journey has truly been a testament that God will place you in situations and provide like-minded people to help you along the way.

**Surround Yourself with Like-minded Winners**

My five-year goal is to become a remote coder, and I am certainly open and excited about where my coding journey will take me.

Thank you to all who have pushed, encouraged, bullied, and simply told me to get it done. See you in the winners’ circle.
CHAPTER MEETINGS
Shouldn’t Feel Like a Side Effect

Affect members positively so they can’t wait to come back.

Knowing the difference between a side effect and an affect can make all the difference in the outcomes of your chapter meetings. A side effect is “any accompanying or consequential and usually detrimental effect.” To affect someone is “to influence or make a difference” in their life.

Your Attitude Affects Chapter Experience

Even when a chapter meeting topic is of no interest to you, at first, you may become intrigued and learn something new. This is because the presenter’s expertise affected you, making you want to learn.

Unprofessionalism Creates a Bad Side Effect

Meetings conducted unprofessionally can create lasting side effects for members. Examples include disruptive behavior, negativity, side line chatter, and attendees on their phones.

Here are some ideas to help with these types of interruptions:

• Give a friendly reminder at the beginning of each meeting about cell phone etiquette.
• If questions create negativity, ask everyone to hold their questions until after the presentation. The questions may be less important an hour later.

Humor Is the Best Medicine

Humor is a great way to break the ice during a presentation. For example, you might use a humorous cartoon that everyone can relate to. It should be tasteful and relative to the subject matter. Humor is also a powerful communication tool. You can constructively turn a negative into a positive with tasteful humor (not humiliation) to avoid potential problems escalating to unwanted side effects.

Example: I attended a seminar that took a quick turn of events within 5 minutes of the speaker’s introduction: A critic kept interjecting rude comments. I could feel the unease of attendees. The speaker stopped, looked in the direction of the person, and said, “Didn’t I tell you to stay in the truck?” Everyone laughed and we didn’t hear another word from the heckler. This particular response may not be appropriate in every event, but the point is that the speaker took control of the environment using humor, and set expectations.

Make Enemies into Allies

An attendee who loves to challenge authority and argue with others can create a side effect of animosity. Here are several different techniques that work to defuse a potential negative environment:

• Acknowledge the challenger’s comments without getting defensive.
• Ask the group for other opinions.
• Recognize and invite the challenger’s expertise and comments.

Soon, you will have an ally instead of an enemy.

Set a Tone that Affects Chapter Engagement

The person conducting the meeting typically sets the tone. To set a tone and impression of professionalism at your meetings, consider both the content and how it will be presented.

Most meetings are held without incident, with amazing speakers and remarkable chapter officers. Which type does your chapter present to their members: a meeting with side effects or a meeting that positively affects members? Strive for the latter. Your meetings should affect members positively, so they can’t wait to come back.

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

If you post on AAPC’s Facebook page, many AAPC members and employees read your threads. Our staff enjoys reading and answering your posts and receiving feedback, and especially loves when you spread positive messages to other members. February proved to be a month of support for AAPC members who are gearing up to take certification exams. Two posts in particular, from Julia Giddens, CPC-A, and Katia E. Nelson, CPC, (Montenegro is her maiden name) proved to be a source of encouragement and inspiration for members who feel like giving up on obtaining certification.
A reward for being a member of the National Advisory Board (NAB) is helping at HEALTHCON, AAPC’s annual national convention. It’s a privilege to work alongside AAPC staff and AAPC Chapter Association members. With a unified goal of making conference the ultimate experience for everyone, we roll up our sleeves and get to work.
We’ve Arrived!
NAB members arrive to the venue the day before HEALTHCON begins. We come from different parts of the country so we are excited to see each other; and we can’t wait to meet new members and catch up with old friends who we only see once a year, at conference. After we meet with the Conference Team, it’s time to get busy. There are conference t-shirts to be counted, folded, and sorted; registration packets to organize; store products to set up or fully stock, and the list goes on. After we stuff and stack more than 1,000 conference bags and transport them to the registration area, we explore the venue and the locations of each room to be sure we are expert tour guides for attendees who are looking for their next session or lunch.

Let’s Rally!
The night before the big day, AAPC staff, NAB members, AAPC Chapter Association members, and ambassadors meet to discuss what the Conference Team has been planning all year. Everyone gets a conference staff handbook, and we discuss the events of the week and our assignments. After the meeting, some of us retire to our rooms for a good night’s rest before the big day. Others go for a walk or jog. Some of us get together for dinner and talk half the night away.

The Big Day
It’s 6 a.m. and we’re in the conference center, putting everything out that we prepared the night before. It’s just two hours until registration opens, where we’ve been assigned. As we’ll be the initial point of contact, it’s important that we greet each member with a smile and a positive attitude. We’re so excited about the coming events, that won’t be a problem. NAB President Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC, AAPC Fellow, has been working registration at conference for many years. “Nowhere else do I get the surge of excitement, adrenaline, and happiness that runs through me while working registration, watching all the members come in, and seeing their excitement.”

When registration begins, we make sure each member has downloaded the HEALTHCON app to their smartphone and give them their schedule, t-shirt coupon, lunch tickets, name badge, conference program, lanyard, and bag full of goodies. We also take a minute to review the program, so they know where to log continuing education units (CEUs) and find their agenda for each day. Then, we point attendees in the direction of the ribbon wall and conference t-shirt pick-up area. Working registration is an important job, but that’s not all NAB members do at HEALTHCON. Once conference gets underway, we get to help members in a variety of ways.

Room Chaperones
Each session room has a team of three chaperones who assist with the transition between sessions and during the session. We check schedules, provide directions to those looking for their sessions, and oversee the standby line. We also help members locate their seat, answer questions, and hand out speaker evaluations. We also help late arrivals to find empty seats, monitor the door during the session, pick up the speaker evaluations, and look over the room for anything left behind by accident. The real bonus to being a room chaperone is meeting and talking with so many members over the course of conference. It’s an opportunity to learn about members and to ask them about their conference experience. Plus, being assigned to the same room for the entire conference allows you to listen in on some amazing presentations.

Speaker Liaison
Speaker liaisons are responsible for the speaker’s experience and to make sure they get to the session room in time to get set up. Just like a room chaperone, the speaker liaison is assigned to a room for the entire conference. We help the speakers get their computers set up and call audio-visual staff for assistance if there are issues. We also verify speakers have the correct CEU number for each session and introduce the speaker. Then, we get to sit back and enjoy the session. As soon as the speaker is finished, the speaker liaison whisks the speaker to the back of the room or hall to field questions. Then, it’s time to get ready for the next speaker.

Nowhere else do I get the surge of excitement, adrenaline, and happiness that runs through me while working registration, watching all the members come in, and seeing their excitement.

— NAB President Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC
During conference, NAB members pitch in with restocking the store and answering members’ questions. A bonus is that we can skip the gym because weightlifting, squats, and cardio are covered with this job!

**Product Store**

Running the product store actually begins before conference kick-off. The products are purchased, branded, and shipped to the venue. There are boxes to unpack, signs to make and print, clothing to fold and hang, and items to be unwrapped and displayed. AAPC goodies are placed on tables and shelves: books, cups, mugs, hats, scarfs, blankets, bracelets, highlighters, key chains, jump drives, etc.

During conference, NAB members pitch in with restocking the store and answering members’ questions. A bonus is that we can skip the gym because weightlifting, squats, and cardio are covered with this job!

“The AAPC product store is a great place to work because you come in contact with so many different people,” said Ann Bina, CPC, COC, CPC-I, AAPC Fellow, NAB secretary. “You get to talk with attendees looking for a souvenir and chapter officers looking for gifts or prizes for their members. It’s been a great way to expand my networking.”

NAB representative Annie Boynton, RHIT, CPC, COG, CPC-P, CPC-I, CPMA, CCS, CCS-P, AAPC Fellow, said, “We make it fun by singing, dancing, laughing, and pulling the members into the fun of conference and getting good deals.”

**End-of-conference Debriefing**

The last day of conference, everything is torn down to be shipped back to Salt Lake City. The product store, which took a day and a half to put together, is packed up by every available AAPC employee, AAPC Chapter Association, and NAB member in less than 2 hours.

Conference is over and now it’s time to share our experiences and what we’ve learned while it’s all still fresh in our minds. This meeting is just as important as the pre-conference meeting. We discuss what worked and what didn’t work, and what to keep and what to fix. We also share the feedback each of us received from AAPC members and other attendees — the compliments and the complaints. The most difficult part of the meeting is the end, when it’s time to say our goodbyes.

**Hard Work Pays Off**

Conference is a lot of work, but it’s also a lot fun. It’s a treat to meet members to spend time with after sessions end for the day. Every venue offers an opportunity to coordinate dinner plans, explore entertainment options, and shop. We not only have a great time, but expand our networks, too! We hope to see you at HEALTHCON 2017 in Las Vegas so we can add you to our list of friends.

Angela Jordan, CPC, COBGC, AAPC Fellow, is managing consultant at Medical Revenue Solutions, LLC, with more than 25 years of experience in the healthcare field, and has been a member of AAPC for 15 years. Her career path has taken her from a small family practice, radiology, large physician services group to a managing consultant. Jordan is on the AAPC NAB and has held many offices in the Kansas City, Mo., local chapter, including president. In 2009, she served on the AAPC Chapter Association board of directors and was the chair in 2012.

Angela Clements, CPC, CPC-I, CEMC, CGSC, COSC, CCS, AAPC Fellow, is the physician coding auditor/educator consultant at Medkoder. She has more than 17 years of experience in the healthcare industry. Clements serves on the AAPC National Advisory Board (NAB) as the member relations officer and has served on the NAB as Region 5 representative from 2013-2015, and is involved in the Covington, La., local chapter. She has extensive experience in multi-specialty coding, documentation, and auditing. Clements is a frequent speaker at local medical managers’ meetings, as well as other AAPC local chapters in her region.
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Definitive drug testing code descriptors may contain terms not familiar outside the laboratory. To better understand these codes (G0480-G0483), let’s look at a typical descriptor and discuss relevant concepts.

HCPCS Level II code G0480 is a perfect example:

G0480  Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMI, EPIA) and enzymatic methods (eg, Alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing per day, 1-7 drug class(es), including metabolite(s) if performed.

How Isomers Affect Drug Testing

The terms “structural isomers” and “stereoisomers” are probably your first roadblocks. CPT® describes these as “compounds that have the same molecular formula but differ in structural formula.” For example, butane has a molecular formula of C₄H₁₀ (four carbon atoms and 10 hydrogen atoms). Isobutane has the same chemical formula but, whereas butane has four carbon atoms bonded in a continuous chain, isobutane has a branched structure, as shown in Figure 1.

![Figure 1: This is a structural isomer. Source: Encyclopedia Britannica: www.britannica.com/science/isomerism]

The structure of pharmaceuticals is more complex, but the concept is the same.

Stereoisomers have the same molecular formula, but differ in how they are structured in space. An example is cis-2-butene and trans-2-butene. Both have a molecular formula of C₄H₈, but differ in structural orientation, as shown in Figure 2.

![Figure 2: These are stereoisomers. Source: McGraw-Hill Dictionary of Scientific & Technical Terms, 6E, Copyright© 2003 by The McGraw-Hill Companies, Inc.]

The prefix cis is Latin for “on this side,” and trans means “across.” In this orientation, the CH₃ groups are on the same side in the “cis” orientation and across from each other in the “trans” orientation.

Definitive test methods can distinguish between structural isomers (isobutane and butane), but not always stereoisomers (cis and trans orientation).

Understand Chromatography and Spectrometry

The next terminology that may hang you up is gas chromatography/mass spectrometry (GC/MS), which is an analytical method that combines the differentiation ability of gas chromatography with the identification ability of mass spectrometry.

Gas chromatography vaporizes a solution containing the substance (drug). The vaporized sample is carried by the gas (mobile phase) through a microscopic layer of liquid or polymer (stationary phase) inside a piece of glass or metal tube, referred to as a column. Different chemicals will flow through the column at different rates, allowing for separation of materials carried by the gas. As the chemicals are separated, they enter a mass spectrometer for identification, as shown in Figure 3.

![Figure 3: A mass spectrometer identifies chemicals.]

Break down the code descriptors for proper drug test reporting.
The mass spectrometer is used to determine the chemical constituents or analytes in a chemical sample. The results of a mass spectrometer analysis are generally in the form of a graph showing the distribution of components. Software is used to match the components to known standards to identify the sample. **Figure 4** shows the mass spectrometer results for heroin.

Mass spectrometers use the difference in mass-to-charge ratio of ionized atoms or molecules to separate them, allowing for quantitation and structural information by identifying distinctive fragments. The sample enters the spectrometer, where it is ionized into a gas. It then enters the mass analyzer, where its ions are sorted and passed onto the ion transducer that detects the ions. Information gathered is sent to a signal processor, where software analyzes the results, as shown in **Figure 5**.

### Make Sense of Liquid Chromatography/Mass Spectrometry (LC/MS)

In simple terms, the difference between gas and liquid chromatography is the carrier method — either an inert gas for gas chromatography or an inert liquid for liquid chromatography. Metabolites — our final buzz word — are the breakdown products of a compound. For example, heroin is metabolized as shown in **Figure 6**.

When monitoring or diagnosing patients with a positive screen for morphine, clinicians must consider that heroin and codeine, among other compounds, metabolize into morphine.

### Put It All Together

Definitive drug testing is used to test a sample for identifying compounds contained within. Gas or liquid chromatography is used to separate the constituent compounds, and mass spectrometry is used to definitively identify them. These methods can differentiate between isomers or shapes to distinguish between biologically active and inactive forms.

Drug testing is useful for monitoring patient treatment compliance with prescribed medications that have addictive properties (e.g., opioid pain medications, sedatives, and attention-deficit/hyperactivity disorder medication). Test results determine whether patients have recently taken their prescribed medication and if non-prescribed or illicit drugs have been used. A provider may order a urine drug screen (HCPCS Level II code G0431 Drug screen, qualitative; multiple drug classes by high complexity test method (eg, immunosay, enzyme assay), per patient encounter), for example, to obtain a baseline before initiating pain management treatment. If the screen comes up positive for opioids and barbiturates after the patient has denied medication use, the provider may order definitive drug testing (HCPCS Level II code G0480) to determine exactly what medications were in the patient’s urine.

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TAKE MENTAL HEALTH OUT OF DRUG SCREENING

Awareness plays a role in recent and forthcoming code changes.

Over the past four years, major changes have occurred in mental health coding and drug screen services. These originated partly due to CPT® codebook changes, as well as political pressure, high profile deaths, and changes in the Centers for Disease Control and Prevention (CDC) guidelines. The evolving public awareness of mental health, parity laws, revisions to CDC guidelines, and HCPCS Level II dual coding for drug screen services prompted more changes in 2017.

History of Changes

In 2013, CPT® created separate reporting guidelines for physicians and other mental health clinicians. Because physicians focus on the medication management of the patient, with referrals to therapists and psychologists, CPT® instructed physicians to report medication management through evaluation and management (E/M) codes (99201-99499), with psychotherapy reported as an add-on code.

For clinicians practicing only psychotherapy, CPT® created new psychotherapy codes. This prompted the creation of new guidelines, new definitions, and clarification on time reporting. Time-based psychotherapy codes began to adopt the Time Rule, which can be found in the introduction section of the CPT® codebook.

In 2015, CPT® changed drug screening services to define them as either presumptive or definitive. The Centers for Medicare &
Medicaid Services (CMS) still required providers to use an appropriate HCPCS Level II code, which CMS subsequently updated in 2016.

**Drug Screen Services**

HCPCS Level II codes adopted by CMS in 2016 for presumptive drug screen services became popular among coders and payers, forcing CPT® to adopt these code definitions in 2017. With the adoption of the new CPT® codes, CMS deleted the dual coding methodology for presumptive drug screen services in the HCPCS Level II codebook, creating a uniformed coding system for presumptive drug screen services.

The new CPT® codes are:

- **80305** Drug test(s), presumptive, any number of drug classes, any number of devices or procedures (e.g., immunoassay); capable of being read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service [The old code was G0477.]

- **80306** read by instrument assisted direct optical observation only (e.g., dipsticks, cups, cards, cartridges) includes sample validation when performed, per date of service [The old code was G0478.]

- **80307** Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (e.g., utilizing immunoassay (e.g., EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA)), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed per date of service [The old code was G0479.]

Presumptive drug screening services may be performed prior to definitive drug screen testing when a provider wants to:

- Rule out illicit drug uses;
- Confirm the presence of a particular drug class without identifying individual drugs; or
- Distinguish between structural isomers.

For example, a patient using prescription opioids for pain management may receive a randomized drug screen service to test for the presence of opioids and illicit drugs, or other prescription drugs that may cause risk to the patient when on opioids. One such risky combination, per a CDC warning, is the use of benzodiazepines with opioids.

According to CPT® guidelines, sample validation in each of the codes “may include, but are not limited to, pH, specific gravity, and nitrite.” These sample validation tests are included in the drug screen services, so urinalysis, immunoassay tests, and other lab tests bundle into these codes, by definition. It is not appropriate to use modifiers 59 Distinct procedural service, XE Separate encounter, XP Separate practitioner, XS Separate structure, or XU Unusual non-overlapping service to override the bundling combination.

Chapter 10 of the National Correct Coding Initiative (NCCI) Policy Manual confirms providers should not separately report the validity testing (p. X-7).

CPT® also limits each of these codes to one unit per billing. Because CPT® is adopting the CMS model, CMS advises providers to report these codes for presumptive drug screening services, and is including these codes in the Clinical Laboratory Fee Schedule.

**Mental Health Services**

Because substance abuse requires mental health intervention, it’s important to address mental health changes, as well.

When the original psychotherapy codes were created in 2015, the term “with patient and/or family” was included in psychotherapy codes 90832-90838. This caused confusion, and may have caused coders and providers to use these codes erroneously for family psychotherapy (which should be reported with 90846-90847).

To correct this, CPT® has removed this terminology from the codes and clarified the guidelines. The guidelines now state:

Codes 90832, 90833, 90834, 90836, 90837, 90838 describe psychotherapy for the individual patient, although times are for face-to-face services with patient and may include informant(s). See codes 90846, 90847 when utilizing family psychotherapy techniques, such as focusing on family dynamics.

This clarification instructs us not to use the individual psychotherapy codes for family psychotherapy, and directs us to the correct code. Doing so ensures 90832-90838 remain as individual psychotherapy codes that may involve an informant(s) to help the clinician better treat the individual patient and their individual needs.
In making these changes and to provide consistency, CPT® made psychotherapy codes 90846 and 90847 time-based, 50-minute codes. Coders are further advised not to report family psychotherapy services less than 26 minutes in length.

**Examples and Documentation Requirements**

A 62-year-old individual moved from the Northeast to the Southwest to be closer to family. The individual has a long-term use of opioids for chronic regional pain syndrome (CRPS). Due to the relocation, the patient needed to find a new physician within the insurance network. The new provider referred the patient to a psychiatrist who specializes in pain management. The goal is to offer pain relief without opioid addiction.

The psychiatrist conducts a new patient evaluation and management (E/M) service and reviews the patient’s records from the former pain management specialist, who was not a psychiatrist. The provider conducts a comprehensive history, including an active medication list and social history for use of illicit drugs and alcohol. A comprehensive examination focusing on the body and the patient’s mental health is performed. Finally, the provider orders a urine drug screen to verify the presence of known drug classes and notes alcohol use and illicit drugs, as reported in the history.

While waiting for the results of the urine drug screen test, the psychiatrist provides 30 minutes of supportive psychotherapy, focusing on the risks of substance abuse and methods for coping with chronic pain without dependence on opioids. During this time, the drug screen dipstick is read by instrument-assisted direct optical observation, which includes a pH validation. The provider then questions the patient’s spouse on medication compliance and verifies the results with the former prescriber. These informants confirm the results the drug screen test already provided. Because the drug screen test can only detect recent drug usage, the informants were able to assist in assessing long-term compliance. The physician refills the patient’s hydromorphone and orders a follow-up for medication management in 30 days. The physician also recommends that the patient visit the surgeon to examine potential revision or new surgery for long-term pain relief.
Based on this scenario, the provider bills:

99204  Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity.

+90833  Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

80306  Proper Documentation for Psychotherapy Services

Documentation for determining the correct codes is essential. When reporting psychotherapy services, the documentation must clearly indicate, at minimum:

• Type of psychotherapy (supportive, cognitive behavioral, insight-oriented, etc.)
• Time spent performing psychotherapy
• Focus of psychotherapy (individual or family dynamics/marriage)
• Medical necessity (goals, mental health diagnosis, patient response/benefit to treatment)
• E/M (if performed, and to determine whether the add-on code is to be used)

When reporting drug screen services, the documentation at minimum must include:

• A valid order
• Medical necessity (reason for test)
• Results
• Instrumentation used (if any, and type for reporting 80306 and 80307)
• Any sample validation (if performed, not coded separately)
• Documentation for Clinical Laboratory Improvements Amendment (CLIA) waiver and/or name of the performing laboratory (if the specimen is collected in the office and sent to a reference/outside laboratory)

Remember appropriate modifiers 26 Professional component, TC Technical component, and 90 Reference (outside) laboratory if the laboratory is not billing the insurance carrier.

Fraud and Abuse Potential in Mental Health and Drug Screens

With the use of electronic healthcare records, auditors and payers are concerned about rolling templates, copy and paste, cloning, documenting to the code, and medically unnecessary services. For example, a patient who is returning for prescription management for a medication refill may not require a comprehensive history or exam, depending on the chief complaint and nature of the presenting problem. Likewise, an individual with a mental health diagnosis who is stable on medication may simply require a medication refill and no further intervention.

Auditors and payers will also be looking at coding based on time:

• Did the documentation support the time spent performing the services?
• Did the physician use time for both the E/M and the psychotherapy for the same encounter, against coding guidelines?
• Did the clinician actually perform psychotherapy, or was only medication management performed?
• Did the service meet the time criteria for the psychotherapy services?

Regarding drug screen services: Auditors and investigators look for orders, lab results, medical necessity, frequency, and custom panels. All lab studies require orders, results, and medical necessity. Frequency is important, particularly with drug screen services for an individual who is compliant with medication regimen and no risk of illicit drug use, for example. Custom panels do not provide convincing evidence of medical necessity because the ordering provider determines what tests are required. The lab should not bill for services not ordered and not deemed medically necessary. Just as a pharmacist cannot dispense a prescription not ordered, a lab cannot bill for tests not ordered.

Unanswered Questions

Time will tell what changes are to come for definitive drug screen services, given the dual set of coding under the CPT® and HCPCS Level II codebooks. It also remains to be seen how telemedicine and medical necessity policies or authorization for 60 minutes of psychotherapy will affect mental health coding.

Michael Strong, MSHCA, MBA, CPC, CEMC, is the bill review technical specialist at SFM Mutual Insurance Company. He is a former forensic investigator and has years of experience performing investigations into fraud and abuse. Strong also is a former EMT-B and college professor of health law and communications. He is a member of the St. Paul, Minn., local chapter, and can be contacted at michaelallenstrong@yahoo.com.
Both doctors gave wonderful insight to the procedures as well as the whys and wherefores procedures are done and what is seen in disease processes. This was my first time to ZHealth presentation and loved it!

--Heidi Gnos Kuban CPC, CIRCC, CEDC, FBO Specialty Coder

Dr. Z's seminar is always the best seminar for me.

--Gemma Perez, CPC, CIRCC, CCS, APC Liaison

These classes were very informative and I truly learned a lot. Everyone I met was very nice and welcoming. The hotel and the food were great. I hope to come back next year.

--Deborah Berry, Clinical Coordination

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Have a good day, Kathleen
Modifier 99 Multiple modifiers doesn’t get a lot of attention — maybe because it’s rarely needed — but knowing when to apply it can make the difference in getting a claim paid.

Refer to CPT® Guidance

Appendix A — Modifiers tells us:

Under certain circumstances 2 or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

In practice, call on modifier 99 only if a single line item requires five or more modifiers. The reason is the standard 1500 Health Insurance Claim Form (or electronic equivalent) field 24D accommodates the entry of up to four modifiers:

![1500 Form](Image)

If a single line item requires more than four modifiers, enter modifier 99 (and only modifier 99) in the first space available for modifiers in field 24D. All other applicable modifiers should be entered in field 19 “Additional Claim Information,” or the equivalent electronic data field. You may use modifier 99, when applicable, with any CPT® code.

Medicare Carriers Manual Part 4 - Professional Relations, Transmittal 25, Change Request (CR) 1910 (Nov. 1, 2001) further specifies, “If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and ‘mod’ represents all modifiers applicable to the referenced line item.”

Sequencing Modifiers

When listing multiple modifiers for the same line item, take care to sequence the modifiers affecting payment first. Level I payment modifiers include:

- 26 Professional component
- 50 Bilateral procedure
- 53 Discontinued procedure
- 54 Surgical care only
- 55 Postoperative management only
- 56 Preoperative management only
- 62 Two surgeons
- 66 Surgical team
- 78 Unplanned return to operating/procedure room by the same physician or other qualified healthcare professional following an initial procedure for a related procedure during postoperative period
- 80 Assistant surgeon
- 81 Minimum assistant surgeon
- 82 Assistant surgeon (when qualified resident surgeon not available)
- 91 Repeat clinical diagnostic laboratory test

Informational or statistical modifiers (any modifier not classified as a payment modifier) are sequenced after payment modifiers. If multiple informational/statistical modifiers apply, you may sequence them in any order (as long as they are sequenced after any payment modifiers).

For example, if a procedure defined as unilateral is performed on both sides of the body, modifier 50 applies. If the same physician performs the procedure during the global period of an unrelated, previous procedure, modifier 79 Unrelated procedure or service by the same physician during the postoperative period is also appropriate. Modifier 50 is a payment modifier, so it is sequenced first, and modifier 79 (an informational modifier) is sequenced second. HBM

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Resources

Relieve Coding Pressures of CARPAL TUNNEL SYNDROME

From conservative to invasive treatments, understand what codes are covered.

Carpal tunnel syndrome is diagnosed when there is pressure on the median nerve in the wrist. Some symptoms include pain, numbness, tingling, and weakness in the hand. The physician may order physical therapy, or prescribe a wrist brace or nonsteroidal anti-inflammatory drugs (NSAID). To achieve coverage and payment, the provider should document the conservative treatment provided, along with the patient’s response to these methods.

Injection
Following more conservative treatments, an injection performed in the wrist with corticosteroids and/or anesthetics can provide temporary relief of the symptoms. The injection is reported with 20526 Injection, therapeutic (eg, local anesthetic corticosteroid), carpal tunnel. If you perform this service in an office setting and purchase the medication, don’t forget to code for the corticosteroid using the appropriate HCPCS Level II code (In a hospital or outpatient setting, the facility codes for the drug).

CPT® 20526 is a unilateral code. To bill bilateral injections, either append modifier 50 Bilateral procedure or report the code on two lines and append modifiers RT Right side and LT Left side. Know the insurance carrier’s preference to determine if you should append modifier 50 or anatomical modifiers RT/LT.

Note: Novitas Solutions has a local coverage policy for CPT® 20526. Under the utilization guidelines it states, “More than 3 injections per anatomic site in a six month period will be denied. More than two anatomic sites injected at any one session will be denied.” It’s important to check these guidelines with the different payers.

Surgery
A more productive intervention is for the physician to perform a release of the ligament, through either an endoscopic or open approach.

Endoscopic Approach
The endoscope is placed into the wrist through a small incision in the wrist joint. The scope is used to identify the carpal ligament, which is divided to relieve pressure on the median nerve and tendons. An endoscopic carpal tunnel release is reported with CPT® code 29848 Endoscopy, wrist, surgical, with release of transverse carpal ligament.

Open Approach
In an open approach, an incision is made over the carpal tunnel. The ligament is divided to release pressure on the median nerve, or the nerve may be relocated to relieve the pressure. An endoscope is not used in this procedure. The CPT® code to report this procedure...
is 64721 Neuroplasty and/or transposition; median nerve at carpal tunnel.

Both endoscopic and open carpal tunnel release surgeries are unilateral codes. To report bilateral injections, either append modifier 50 to the single code or bill the code on two lines and append modifiers RT and LT, depending on the insurance carrier’s preference.

When Endoscopy Turns Open
The National Correct Coding Initiative Policy Manual for Medicare Services, updated Jan. 1, states:

CPT code 29848 describes endoscopic release of the transverse carpal ligament of the wrist. CPT code 64721 describes a neuroplasty and/or transposition of the median nerve at the carpal tunnel and includes open release of the transverse carpal ligament. The procedure coded as CPT code 64721 includes the procedure coded as CPT code 29848 when performed on the same wrist at the same patient encounter. If an endoscopic procedure is converted to an open procedure, only the open procedure may be reported.

Documentation
Whether the patient is having an injection or surgery, consent is needed. Consent may be verbal for an injection given in a physician office, but must be in writing for surgery in a hospital or other outpatient setting. Most hospitals require consent forms to be filled out by the provider and signed by both the provider and the patient. For verbal consent, the provider must document that consent was obtained by the patient or the patient’s guardian.

Additionally, the physician should document the prep, the location, the needle, aspiration (if performed), drug, dosage, and how the patient tolerated the procedure.

ICD-10-CM
ICD-10-CM breaks down carpal tunnel syndrome based on laterality. The codes are in Chapter 6, Diseases of the Nervous System:

- G56.00 Carpal tunnel syndrome, unspecified upper limb
- G56.01 Carpal tunnel syndrome, right upper limb
- G56.02 Carpal tunnel syndrome, left upper limb
- G56.03 Carpal tunnel syndrome, bilateral upper limb

Post-op
Carpal tunnel surgery has a 90-day global period. Global periods can be found in the Physician Fee Schedule. Any evaluation and management (E/M) visits to the surgeon or the surgeon’s associates related to the carpal tunnel surgery are inclusive in the reimbursement for the surgery and cannot be separately reported.

Add-on Procedures
If the physician performs internal neurolysis (such as a pain block) using an operating microscope during a carpal tunnel release using an open approach, report add-on code 64727 Internal neurolysis, requiring use of operating microscope (List separately in addition to for neuroplasty) (Neuroplasty includes external neurolysis) in addition to 64721. A parenthetical note states, “Do not report code 69990 in addition to code 64727.”

Check with the insurance carrier to verify if they require modifier 51 Multiple procedures when billing bilateral procedures on two lines using the anatomic modifiers RT/LT.

Resources
Many coders struggle with coding operative reports because there are so many guidelines and policies that affect code selection. The process is easier when you break it into seven steps:

1. Review the header of the report.
2. Review the CPT® codebook (start in the Index).
3. Review the report/documentation.
5. Review the guidelines (for the preliminary codes).
6. Review policies and eliminate the extras.
7. Add any needed modifiers.

These seven steps will ensure all the factors that may affect code selection are accounted. Let’s look at an example, and walk through the steps together.

**STEP 1  Review the Header of the Report**
What did the provider say was performed and why?

**PREOPERATIVE DIAGNOSIS:** Left medial compartment osteoarthritis of the knee.

**POSTOPERATIVE DIAGNOSIS:** Left medial compartment osteoarthritis of the knee.

**PROCEDURE PERFORMED:** Left unicompartmental knee replacement.

Based on the documentation above, an unicompartmental knee replacement on the left knee was performed. A unicompartmental knee replacement indicates only one of the three compartments of the knee (medial, lateral, or patellofemoral) was altered during the procedure. The postoperative diagnosis field indicates the altered compartment was the medial compartment of the left knee. Verification of the statement will take place as part of Step 3.

**STEP 2  Review the CPT® Codebook (Start in the Index)**
What code options exist? What is required for each?

Based on the header information from the report, review the CPT® codebook to identify the code options. Also identify the differences between the codes and the documentation required to support one service over another.

Continuing with the example given, the Index is reviewed first to identify all possible code options for knee replacement procedures. Replacement

**Knee**

  - Arthroplasty
  - Intraoperative Use, Kinetic Balance
    - Sensor ............................................................. +0396T
    - Partial ............................................................... 27446
    - Total ................................................................. 27447

Three options are given: +0396T Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (List separately in addition to code for primary procedure), 27446 Arthroplasty, knee, condyle and plateau; medial OR lateral compartment, and 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty).

Upon reviewing the three options, 0396T is found to be an add-on code, so it may not be reported alone, nor may it be the first-listed
CPT® code reported. But it does indicate a specific technology was used during the procedure. If that technology is included in the full report (which will be reviewed in Step 3), +0396T will be included in Step 4 (Preliminary Code Selection).

CPT® codes 27446 and 27447 differ based on one key word: “OR” vs. “AND.” Code 27446 indicates a partial knee replacement (including either the medial OR the lateral compartment) was performed; whereas, 27447 indicates a total knee replacement (including both the medial AND lateral compartments) was performed. When the documentation is reviewed fully (Step 3), the primary focus will be to determine which compartments were altered during the procedure.

**STEP 3 Review the Report/Documentation Details**

*What does the documentation say?*

Based on the documentation, a unicompartmental knee replacement using a Biomet, Inc., prosthesis was performed. The components were cemented into the tibia and distal femur after the necessary cuts and trial fit/placement were performed. According to the Cleveland Clinic, “Medial knee joint degeneration is the most common deformity of arthritis.”
Review all relevant CPT® guidelines, including parenthetical references, to ensure all rules are followed, additional, supported services are captured, etc.

**STEP 4  Make a Preliminary Code Selection**

*Which codes are supported by the documentation?*

The emphasis here is to make a preliminary code selection based on the documentation. It’s preliminary because reviewing the guidelines, policies, etc., may lead to eliminating certain codes, or the need for additional codes and/or modifiers.

Based on the documentation above, a unicompartmental knee replacement is supported. A unicompartmental knee replacement is also referred to as a “partial” knee replacement, so based on the code options, CPT® code 27446 is supported, preliminarily. Guidelines, policies, and the like still need to be reviewed (Steps 5-7).

**Note:** If coding for a facility (as this procedure is fairly common in the outpatient facility or ambulatory surgery center setting), the implant also needs to be reported.

**STEP 5  Review the Guidelines**

*Are there other services to report separately? Is anything missing?*

Review all relevant CPT® guidelines, including parenthetical references, to ensure all rules are followed, additional, supported services are captured, etc. Steps 5, 6, and 7 are all related, and are frequently performed concurrently.

The “Femur (Thigh Region) and Knee Joint/Repair, Revision, or Reconstruction” CPT® codes do not include specific subsection guidelines. But there are two parenthetical references below code 27447 to review, and the general surgery guidelines (at the beginning of the Surgery section of CPT®) still apply.

The parenthetical references under 27447 read:

(For revision of total knee arthroplasty, use 27487)

(For removal of total knee prosthesis, use 27488)

Both parenthetical references are specific to total knee arthroplasties — particularly revision or removal of previously placed prosthesis — and are not relevant.

Based on the documentation for this scenario, a partial knee arthroplasty was performed in a knee without a previous prosthesis or implant. No additional CPT® guidelines appear to be relevant for this scenario.

**STEP 6  Review Policies and Eliminate the Extras**

*Are any of the services bundled?*

Because there is only one service supported based on the documentation and steps above, it does not appear there are any extras.

Review all of the relevant edits and policies (National Correct Coding Initiative (NCCI) edits, local and national coverage determinations (LCDs, NCDs), payer contracts, medical policies, etc.) to ensure bundled services are appropriately eliminated (and tracked internally, if applicable).

This step is essential in scenarios where more than one service is performed and more than one code may be warranted. Reviewing the NCCI edits and payer policies will help you identify bundled services, instances where modifiers may be needed, or situations where a contract limitation restricts reporting a service that would otherwise be reportable (e.g., a colonoscopy in which multiple procedures were performed such as snare polypectomy, biopsy polypectomy, and submucosal injection).

**STEP 7  Add Necessary Modifiers**

*Do the codes alone tell the full story of the service(s) provided?*

Based on the description for 27446, there is no indication as to which knee was repaired. The story is incomplete. A modifier is needed to indicate which knee was affected.

Modifier options are:

- **LT**  Left side
- **RT**  Right side
- **50**  Bilateral procedure
Based on the documentation, the left knee was replaced because the patient had a right-side replacement previously. For this scenario, modifier LT is added to the procedure to indicate the procedure was performed on the left knee. Without this modifier, a denial or request for additional information may be received from the payer because the patient had the previous knee replacement.

Final code selection for this scenario is: 27446-LT.

Although the scenario used in this example is fairly straightforward, these seven steps will work for any level of sophistication in an operative report. Use them for consistent review of all relevant factors, and correct coding is certain. HBM

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Review all of the relevant edits and policies NCCI edits, LCDs and NCDs, payer contracts, medical policies, etc. to ensure bundled services are appropriately eliminated.

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Resources
http://my.clevelandclinic.org/health/articles/partial-knee-replacement
For more information on the Biomet device and procedure, see www.biomet.com/web_accents/biomet_products/oxfordPartialKnee.cfm.
The National Correct Coding Initiative (NCCI) was developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Medicare Part B claims. Although the NCCI policies were initially established for the Medicare program, several commercial insurers have adopted it.

**Becoming knowledgeable about** National Correct Coding Initiative (NCCI) policies and edits may be the difference between having a profitable revenue cycle or placing your facility at risk for denials. In recent years, NCCI policies and edits have become key factors in outpatient facility and professional claims denials. You must have a strong understanding of these guidelines to ensure coding compliance and to mitigate risk. Let’s discuss some key concepts of the NCCI that may be placing your practice or facility at risk.

**Follow NCCI Policy Manual Annual Updates**

The NCCI Policy Manual is updated annually. The new guidance becomes effective Jan. 1 of each year. Because the purview of some external reviewers may extend back as far as three years, become familiar with the last three years of the NCCI Policy Manual.

**Action Item:** Pay special attention to claims denied during the first quarter of the year to ensure you are consistent with the most recent published guidelines.

**NCCI Edits Are Updated Quarterly**

NCCI edits are updated quarterly and are effective Jan. 1, April 1, July 1, and Oct. 1 each year. Because the NCCI Policy Manual is
updated only annually, the quarterly updates may not correlate with
the information published in the NCCI Policy Manual.
For example, the July 2016 NCCI updates eliminated the procedure-
to-procedure code edits precluding the assignment of code 29823
Arthroscopy, shoulder, surgical; debridement, extensive with several
other ipsilateral shoulder surgeries; however, the 2016 NCCI Policy
Manual maintained the following language, “With the exception
of the knee joint, arthroscopic debridement should not be reported
separately with a surgical arthroscopy procedure when performed
on the same joint at the same patient encounter.”
In this case, the encoder would no longer flag the debridement
as not separately reportable by the procedure-to-procedure edits,
but the language in the NCCI Policy Manual would still preclude
the assignment of a debridement code with another ipsilateral
arthroscopic shoulder surgery.

Action Item: Review the quarterly updates when they are published
and compare them to the guidance published in the NCCI Policy
Manual.

Not Every NCCI Policy Guideline Has an Edit
You may think that, if there isn’t an edit to preclude a particular code
assignment, you can combine codes as you please.
Remember: Not every NCCI policy has an associated NCCI edit.
Per the NCCI Policy Manual, “Providers are obligated to code
correctly even if edits do not exist to prevent use of an inappropriate
code combination.”
Action Item: Become familiar with guidelines published in the
NCCI Policy Manual. Do not rely on your encoder, alone, to flag
NCCI edit violations for code pairs.

CPT® Assistant Versus NCCI Policy Guidance
You may encounter cases where the guidance published in the
NCCI Policy Manual differs from that published in CPT® Assistant.
When this occurs, establish which set of guidelines has precedence.
For Medicare claims, the NCCI policies prevail. According to page
I-28 of the NCCI Policy Manual:
The American Medical Association publishes CPT® Assistant which contains coding guidelines. CMS does not
review nor approve the information in this publication.
In the development of NCCI PTP edits, CMS occasionally disagrees with the information in this publication. If
a physician utilizes information from CPT® Assistant to report services rendered to Medicare patients, it is possible
that Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries may utilize
different criteria to process claims.

Action Item: For commercial claims, know whether the payer
follows NCCI edits prior to code assignment to ensure compliance.

Apply Policies to Your Healthcare Organization
These are just a few of the potential risks your practice or facility
may prevent by having a thorough understanding of the NCCI
policies.

Action Item: Coding managers should review the NCCI Policy
Manual, and ensure their coding staff receives training on the
sections applicable to their place of service.

Resources
The NCCI Policy Manual may be downloaded for free from the CMS website:
www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
NCCI Quarterly Updates may be downloaded from the CMS website:
www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html

Susan J. Moore, MSHS, RHIT, CIC, COC, CRC, CCS, CDIP, CHTS-TR, CCDS, AAPC
Fellow, is an ICD-10-CM/PCS trainer and an independent coding and CDI professional, with
over 20 years of experience in revenue cycle management. She is the education officer for
the Cleveland Area, Ohio, local chapter. You can contact Moore with questions at
smoore3000@zoominternet.net.

Become familiar with guidelines published in the
NCCI Policy Manual. Do not rely on your encoder,
alone, to flag NCCI edit violations for code pairs.
Defining a “DETAILED” E/M Exam

Ambiguities in the 1995 documentation guidelines create uncertainty.

Within the Centers for Medicare & Medicaid Services’ (CMS) 1995 Documentation Guidelines for Evaluation and Management Services, the definition of a detailed exam has been causing dissention among the troops for years.

The source of contention is that, although the 1995 guidelines define a detailed exam as an “extended exam of the affected area(s) and other symptomatic or related organ system(s),” neither CPT® nor CMS defines the term “extended.” This oversight leaves much open to interpretation by Medicare administrative contractors (MACs).

After a quick review of the offending section in the 1995 exam guidelines, we’ll review how MACs have responded to the situation.

Guidelines Open to Interpretation

A review the 1995 guidelines reveals multiple discrepancies.

B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- Problem Focused - a limited examination of the affected body area or organ system.
- Expanded Problem Focused - a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed - an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive - a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

For purposes of examination, the following organ systems are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

Documentation Guidelines

Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of “abnormal” without elaboration is insufficient.

Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.

A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.

The number of body areas or systems for the problem-focused exam is one, and the general multi-system exam must include at least eight systems. As such, both the expanded problem-focused and detailed exams may be composed of two to seven body areas and/or systems. Nothing specifies that the examination of body areas and organ systems can’t be combined, that a detailed exam must include more than two systems, or that more than a statement of “normal” is sufficient for an exam of an area without abnormal findings.

Payer Requirement Discrepancies

Magnify the Problem

Five MACs — Cahaba, CGS, First Coast Service Options, Noridian, and WPS — follow the CMS definition as it stands.

National Government Services (NGS) states, as shown in Figure A, that six systems must be examined and, for documentation purposes, requires “more than checklists.” Normal/abnormal findings must be expanded upon; although, “expanded upon” isn’t defined. This represents a change from their instruction in 2015, shown in Figure B, which requires only two systems. This is also a reversal to their position in 2011, when NGS stated that “6-7 body areas or organ systems must be documented.”

Novitas offers an interactive online tool that requires either an undefined extended exam of at least four body areas or scoring by the “4 by 4” method (four 1997 bullets from each of four organ systems). Unlike CMS guidelines, Novitas does not allow mixing of areas and systems; although, Novitas’ paper scoring tool, shown in Figure C, defaults to the CMS standard with minimal modification.
Palmetto’s interactive online tool requires an undefined extended exam of either two body areas or organ systems, similar to the CMS guideline. As with Novitas’ tool, however, Palmetto does not allow mixing of areas and systems.

In requiring more than two areas or systems with an extended exam of the affected area, NGS and Novitas exceed CMS guidelines, rather than clarify the CMS guidelines by defining what an extended exam of the affected area is. The other MACs do not address the subject.

**Figure A:** NGS Evaluation & Management Documentation Training Tool, January 2017

**2—Examination**

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

**Note:** Choose 1995 or 1997 rules, but not both.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Calculation – Choose either 1995 or 1997 rules to calculate result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body areas:</strong></td>
<td></td>
</tr>
<tr>
<td>Head, including face</td>
<td>□ One body area or system</td>
</tr>
<tr>
<td>Chest, including breast and axillae</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Back, including spine</td>
<td></td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td></td>
</tr>
<tr>
<td>Each extremity</td>
<td></td>
</tr>
<tr>
<td><strong>Organ systems:</strong></td>
<td></td>
</tr>
<tr>
<td>Constitutional (e.g., vitals, gen app)</td>
<td>□ 1–5 bullets (1 or more body areas or system)</td>
</tr>
<tr>
<td>Ears, nose, mouth, throat</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>GI</td>
<td></td>
</tr>
<tr>
<td>GI/</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
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<tr>
<td>Skin</td>
<td></td>
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<tr>
<td>Neuro</td>
<td></td>
</tr>
<tr>
<td>Psych</td>
<td></td>
</tr>
<tr>
<td>Hem/lymph/imm</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td><strong>Final Results</strong></td>
<td>Problem Focused</td>
</tr>
</tbody>
</table>

**Figure B:** NGS Evaluation & Management Documentation Training Tool, January 2015

**2—Examination**

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5.

**Note:** Choose 1995 or 1997 rules, but not both.

<table>
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<th>Calculation – Choose either 1995 or 1997 rules to calculate result</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Back, including spine</td>
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</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>Each extremity</td>
<td></td>
</tr>
<tr>
<td><strong>Organ systems:</strong></td>
<td></td>
</tr>
<tr>
<td>Constitutional (e.g., vitals, gen app)</td>
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<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td><strong>Final Results</strong></td>
<td>Problem Focused</td>
</tr>
</tbody>
</table>

**Defining and Quantifying an Extended Exam**

Extended is a qualitative term, not a quantitative one. A challenge for MACs is to interpret the qualitative term extended by equating it to a reasonable quantitative definition. The use of the 4 by 4 method by Novitas demonstrates that a first step toward this might be to use the 1997 E/M documentation guidelines to help quantify.

Table 1 shows the number of 1997 exam elements identified for each specialty.
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)
- Demystifying the Modifiers (16 CEUs)
- Medical Coding Strategies: CPT® O’view (15 C’s)
- Walking Through the ASC Codes (15 CEUs)
- Coding with Heart — Cardiology (12 CEUs)

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- Add’l user licenses — great value for groups

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Check out our great ICD-10 follow-up course, The Where’s and When’s of ICD-10.
Using the 1997 bullets as a basis for numeration, what quantitative terms are suitable replacements?

All bullets is not acceptable because that probably equates to a comprehensive level in the 1995 system (a complete exam of a single system). Likewise, one or two bullets probably best cover the 1995 limited exam. That leaves two most likely candidates: multiple and majority.

Using the majority approach yields the results shown in Table 2 for each specialty exam. Using the multiple approach results in a three-bullet minimum for each specialty exam.

Using the 1997 bullets as a basis for numeration, what quantitative terms are suitable replacements?

All bullets is not acceptable because that probably equates to a comprehensive level in the 1995 system (a complete exam of a single system). Likewise, one or two bullets probably best cover the 1995 limited exam. That leaves two most likely candidates: multiple and majority.

Using the majority approach yields the results shown in Table 2 for each specialty exam. Using the multiple approach results in a three-bullet minimum for each specialty exam.

**Table 1: 1997 Exam Elements Per Specialty**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Possible Bullets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>5</td>
</tr>
<tr>
<td>Cardiology</td>
<td>8</td>
</tr>
<tr>
<td>ENT</td>
<td>9</td>
</tr>
<tr>
<td>GU Male</td>
<td>9</td>
</tr>
<tr>
<td>GU Female</td>
<td>11</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>11</td>
</tr>
<tr>
<td>Skin</td>
<td>12</td>
</tr>
<tr>
<td>Eye</td>
<td>12</td>
</tr>
<tr>
<td>Neurology</td>
<td>16</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>25</td>
</tr>
</tbody>
</table>

**Table 2: Majority Approach**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of Bullets Needed for Majority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>3</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5</td>
</tr>
<tr>
<td>ENT</td>
<td>5</td>
</tr>
<tr>
<td>GU Male</td>
<td>5</td>
</tr>
<tr>
<td>GU Female</td>
<td>6</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>6</td>
</tr>
<tr>
<td>Skin</td>
<td>7</td>
</tr>
<tr>
<td>Eye</td>
<td>7</td>
</tr>
<tr>
<td>Neurology</td>
<td>9</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>13</td>
</tr>
<tr>
<td>Mean</td>
<td>6.6</td>
</tr>
<tr>
<td>Median</td>
<td>6</td>
</tr>
</tbody>
</table>

From a practical standpoint, the majority approach may seem excessive for some specialties and the multiple approach (minimum of three), not significant enough. And, although Novitas’ 4 by 4 method implies that four bulleted items qualify as an extended exam of a system, they insist that four extended system exams are needed for a 1995 detailed exam. All the specialties above have at least four bullets to choose from. This number is closer to the majority mean (6.6), which is beyond the ability of all but four of the specialties to meet, and the majority median (6), which is beyond the ability of four of the specialties to meet.

CMS and MACs Aren’t on the Same Page

MACs have adopted differing standards for various issues involving claims payment and auditing, which is not inherently problematic because it’s what CMS has given them the authority to do when the CMS regulation is not fully expressed or interpreted. It’s not clear if they have the authority to override CMS regulation. If a claim appeal relating to a conflict between CMS regulation and a MAC’s override of the regulation rises to the level of a Medicare final court of appeal administrative law judge (ALJ) hearing, the ALJ will favor the CMS regulation.

Many MACs have changed and/or reversed their positions on this issue more than once, creating confusion and frustration among providers and those instructing them on how to code and bill for their services. It’s little wonder that the Office of Inspector General calculated the national E/M coding error rate to be over 40 percent in a 2014 published study of 2010 E/M billed services.

Eliminating the 1995 guidelines in favor of the 1997 guidelines would address this issue, as would the adoption of another, better set of guidelines. Until then, CMS’ assignment of a quantitative definition of an “extended” exam would decisively and universally eliminate the difficulties the lack of it has caused.

**A Brief History of E/M Documentation Guidelines**

In 1995, the Centers for Medicare & Medicaid Services (CMS) published its first set of Documentation Guidelines for Evaluation and Management (E/M) Services. These guidelines expanded the CPT® E/M guidelines and attempted to make the code assignment criteria more objective and quantifiable.

Just two years later, at the behest of specialist providers, CMS issued 1997 guidelines, which counted the specific exam elements, or bullets, in each organ system to determine the level of exam performed — instead of counting the number of either “limited” or “expanded” examinations of organ systems.

Another revision in 2000 was driven by clinical vignettes instead of data, but proved too difficult to apply effectively and was abandoned.

Brian Meredith, CPC, is president and founder of Healthforce, Inc., a healthcare administrative consulting firm with a focus on revenue integrity through compliance, coding, and billing guidance. He has over 20 years’ experience in the healthcare industry, including director of billing compliance at Boston Children’s Hospital, compliance and coding consultant with Public Consulting Group, and compliance specialist with UMass Memorial Medical Group. Meredith is a member of the Holyoke, Mass., local chapter.

**Resources**

NGS, Evaluation and Management Services Documentation Frequently Asked Questions, April 17, 2011

Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010, Daniel R. Levinson, OIG, May 2014, OEI-04-10-00181, Executive Summary:

For 2017, the American Medical Association (AMA) deleted CPT® 77051, 77052, 77055, 77056, and 77057, and introduced three replacement codes to report mammography:

- **77065**: Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
- **77066**: bilateral
- **77067**: Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

The reason for the change is that the industry standard for mammograms now bundles computer-assisted detection (CAD) with mammograms. The new codes bring the description of service in line with current practice.

The descriptors for these new codes mirror, exactly, the HCPCS Level II codes for reporting mammography services:

- **G0202**: Screening mammography bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed
- **G0204**: Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
- **G0206**: unilateral

Codes G0202-G0206 are required when reporting mammography to Medicare payers. Codes 77065-77067 have not replaced G0202-G0206 for Medicare billing.

**Get to the Root of the Problem**

On Jan. 4, the Centers for Medicare & Medicaid Services (CMS) published an update to Change Request (CR) 9861 (originally released on Nov. 16, 2016) and its accompanying spreadsheets for the National Coverage Determinations (NCD) affected by the CR. Unexpectedly, CMS added a note in the Revision History for NCD 220.4 Mammograms, stating that it would not recognize the 2017 CPT® codes for mammograms. CMS explained, “This is the result of being unable to properly process claims using CPT codes 77065, 77066, and 77067 for 2017.” CMS said that it intends to recognize the 2017 CPT® codes for mammograms in 2018.
Screening Mammography Codes

On Jan. 1, 2015, CMS announced it would recognize CPT® 77063 Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure), per MLN Matters® number: MM8874. Per NCD 220.4, updated Jan. 4, Medicare continues to recognize 77063 in 2017 for screening digital tomosynthesis performed at the same time as G0202 for Medicare patients.

Diagnostic Mammography Codes

Per NCD 220.4, updated Jan. 4, CMS recognizes G0204 or G0206 with +G0279 Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206). Because G0279 is an add-on code, it must be reported with either G0204 or G0206. CMS instructs, “For the purpose of billing digital breast tomosynthesis the appropriate accompanying 2D image(s) may either be acquired or synthesized.” This applies to both G0279 and 77063. CGS Medicare administrative contractor directs:

HCPCS code G0279 has been assigned a bilateral indicator “2” in the Medicare Physician Fee Schedule Database (MPFSSDB). A “2” indicator means special payment adjustment for bilateral does not apply. Because of this, bilateral modifiers (e.g., CPT modifier 50, HCPCS modifiers RT/LT) are not to be included and the units field should indicate a quantity of “1.”

Professional Mammography Services

For 2017 professional (practitioner’s) claims, report mammography services using the G codes (G0202, G0204, G0206, G0279) or 77063. Be sure the service ordered and performed matches the description of the code. It is easy to confuse screening versus diagnostic and the accompanying tomosynthesis codes.

The CMS spreadsheet updated and released on Jan. 4 for CR9861 is confusing; it still contains the expired CPT® codes, but you may not use them for dates of service past Dec. 31, 2016.

Coding Examples

Let’s review some examples to see how you should code a mammogram service for a Medicare beneficiary patient versus patient with commercial insurance:

Codes 77065-77067 have not replaced G0202-G0206 for Medicare billing.

Mammography FAQs

Q – If we are only doing a screening mammogram, do we have to report G0202 plus 77063?
A – No, only report a tomosynthesis if it was ordered and performed. Use 77063 in conjunction with G0202, or G0279 in conjunction with G0204 or G0206.

Q – Is this only for Medicare patients?
A – This coding guidance only applies to Medicare patients for dates of service in 2017. Check with all other payers to be sure they are recognizing the new CPT® codes for mammograms.

Q – Are we supposed to report the G codes for the professional service?
A – Yes, for Medicare patients only, for 2017 dates of service, report the G codes for professional services. This likely will change in 2018.

Q – If we do not do the computer-aided detection (CAD) portion, what codes are we supposed to use?
A – For Medicare patients, for 2017 dates of service, use the G codes regardless if CAD is used.

Medicare

A screening mammogram without tomosynthesis is coded G0202. If the patient also has screening tomosynthesis, add 77063. Be sure to check the NCD for the covered diagnoses and allowable frequency. A diagnostic mammogram is coded as either G0204 (diagnostic bilateral) or G0206 (diagnostic unilateral). If tomosynthesis is ordered, also report G0279 to either G0204 or G0206, as appropriate.

Commercial Payers

Payers other than Medicare will likely use the new CPT® codes, but check with them to be sure. If a payer is using the CPT® codes, a screening mammogram is coded as 77067. If tomosynthesis is ordered, also report 77063.

For commercial diagnostic mammograms, code either 77065 or 77066, depending on the order. If tomosynthesis is provided, also report G0279.

Barbara Aubry, RN, CPC, CPMA, CHCOM, FABQAURP, is a senior regulatory analyst for 3M Health Information Systems (HIS). As a member of the 3M HIS team that creates and manages medical necessity and other coding data, she works directly with the ICD-10 code translation and assignment for NCD medical necessity policies. Aubry’s clinical background includes experience in hospital case management and utilization review. Her core focus is regulatory compliance and auditing, and she is member of the Upper Saddle River, N.J., local chapter.

Resources

CMS, Frequently Asked Questions for Mammography Services: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Mammography-Services-Coding-Direct-Digital-Imaging.pdf
NCD 220.4 Mammograms: www.cms.gov/medicare-coverage-database/
Medicare to Cover New Vaccine Code

The Centers for Medicare & Medicaid Services (CMS) recently implemented a new flu virus vaccine code: 90682 *Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intra-muscular use.*

This code will be payable by Medicare, but not until July 1. Medicare administrative contractors (MACs) have until Aug. 1 to implement the code, but will pay (at their discretion) claims for 90682 with dates of service between July 1 and July 31. Best practice is to contact your MAC and ask what their policy is before adding this code to your roster.

Virtual Groups in 2018

CMS is in the rulemaking phase for virtual groups — individual clinicians and small group practices joined together to report on Merit-based Incentive Payment System (MIPS) requirements as a collective entity — and is interested in learning what factors these providers would take into consideration when forming/joining a virtual group. For example, CMS is wondering:

- What potential barriers and challenges would you need to address to form/join a virtual group?
- How much time would you need to form a virtual group and be ready for reporting?
- What elements would be critical to include in a virtual group agreement?

CMS will be holding small, interactive feedback sessions through May. If you are interested in participating, email CMSQualityTeam@ketchum.com.

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World Health Day – April 7

According to new estimates of depression, released Feb. 23 by the World Health Organization (WHO), the number of people living with depression increased worldwide by over 18 percent between 2005 and 2018. In the United States, suicide and adolescents experiencing a major depressive episode are “getting worse,” according to the Office of Disease Prevention and Health Promotion’s Midcourse Review (HealthyPeople.gov).

World Health Day, April 7, allows WHO to mobilize action around a specific health topic of concern to people all over the world. Appropriately, the theme of WHO’s 2017 World Health Day campaign is depression.

The overall goal of this campaign is to increase awareness of mental illness, remove any stigma that may prevent those who need help from seeking it, and provide additional support to those who know someone who needs help.

To get involved, go to www.who.int/campaigns/world-health-day/2017 to access the campaign toolkit, handouts on depression, posters, and more.
In my work with clients, I often identify potential coding issues around the frequency of evaluation and management (E/M) visits compared to a benchmark. For example, based on Medicare distribution data, Chart 1 illustrates possible over-coding (relative to 46 percent level 3 and 53 percent level 4 visits) and under-coding (relative to 0 percent level 2 and 1 percent level 5).

Chart 2 shows another example of potential under-coding of established patient visits.

Medicare Data Sets the Standard for E/M Distribution

Because Medicare primarily serves patients aged 65 and over, Medicare claims data isn’t necessarily comparable to all patients in a practice; however, the “bell curve” that Medicare’s data illustrates for established and new patient visits is an industry norm. In the absence of electronic health record (EHR) benchmark data for a certain specialty, we use the Medicare MEDPAR claims database, which has data from 2015. You can find Medicare E/M distribution data on the CMS website: www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/Downloads/LEVEL1CHARG15.pdf?agree=yes&next=Accept
When we find E/M distributions like those illustrated, above, we recommend a small chart audit of E/M codes for the physicians. The resulting recommendations tend to be repetitive. Below, we’ll review the top findings from a sampling of recent E/M chart audits.

Common E/M Documentation Shortcomings
Support for E/M coding comes down to documentation. In addition to the NCQA Guidelines for Medical Record Documentation (see the accompanying sidebar “The Basics of Medical Record Documentation”), use the correct regional Centers for Medicare & Medicaid Services’ (CMS) E/M chart auditing scorecard for your practice. For clients in Colorado, we rely on the “Novitas E/M Score Sheet,” available at: www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00004968. Using this or a similar template, we have identified common weaknesses in E/M documentation for many practices.

New patient vs. established patient:
The perspective of a chart auditor is usually limited to the hard-copy printout of the chart received. Unlike the provider, the chart auditor needs to know, within each record, whether the patient is new or established. This is not clear on each date of service, but we often infer it. To support the higher reimbursing New Patient codes, it’s advantageous to note clearly, “This is a new patient,” or similar, within the entry.

Chief complaint:
Chief complaint (CC) is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient’s own words (e.g., “I’m here for a rash”). Don’t use CC as an internal note to the staff regarding scheduling, who needs to see the patient, or who referred the patient to the practice, for examples.

History:
• Review of systems (ROS): Often, all charts in a practice include a generic statement, such as, “All others negative except those mentioned in HPI.” This is not ideal. A simple change, including the patient’s ROS, can affect the level of history supported.

One tool you can use to look at the overall acceptability of a practice’s documentation is the National Committee for Quality Assurance (NCQA) Guidelines for Medical Record Documentation found at: www.ncqa.org/Portals/0/PolicyUpdates/Supplemental/Guidelines_Medical_Record_Review.pdf?ver=2007-02-08-105600-000. From experience, this is the industry standard for consistent, current, and complete documentation in the medical record. There are 21 elements that reflect commonly accepted standards for medical record documentation. The NCQA considers six of the 21 elements as core components, indicated by an asterisk (*). Of the 21 elements, there are usually problems with the practice’s medical records in the following areas (based on our sample of chart audits):

• Personal Biographical and Patient Data: The No. 1 item on the NCQA list is, “Each page in the record contains the patient name or ID number.” The second item on the list stresses the importance of having the patient’s basic demographic information, and that it is easy to read. You may augment personal biographical data to include address, employer, home and work telephone numbers, and marital status.

• Authorship: This is No. 3 on the NCQA list. All entries should contain the author’s identification. In most audited charts, there is no indication of who is entering the items in the medical record (e.g., scribe, medical assistant, physician, nurse). Be sure this function is turned “on” in your EHR by entry (not for the entire chart).

• Medication Allergies: This core component of the NCQA list is No. 7. Often audit findings show there is no documentation noting medication allergies, or adverse reactions, or no known allergies (NKA) status. If a patient has allergies, it should be noted prominently in the medical record — especially if it’s a medication allergy.

• Follow-up: Item No. 18 on the NCQA list is “Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.” Notes should include follow-up care, calls, or visits, if applicable. The specific time of return should be noted in weeks or months, or as needed.

• Chart Sign-off: This isn’t on the NCQA list, but Medicare requires that documentation in charts must be completed within 48 hours (https://bphc.hrsa.gov/). This is a significant, common area of problems. For example, one practice averaged nine days before physicians signed off on charts, with a range of 0-58 days. This meant that claims often were filed and paid before the chart was done.

Source: https://bphc.hrsa.gov/archive/technicalassistance/resourccenter/services/patientprogressnoteprotocol.pdf
Another example is to be sure that one additional vital sign, such as pulse, respiration, or height, is added to the EHR documentation template if only temperature and weight are included.

**Medications:**
With the list of medications is pulled forward from every prior visit, it’s rarely ever clear when it was updated. When auditing ask, “What was the old list? What are the new medications?” and “Was it really reviewed during this visit?” Physicians should use more specific language, not template entries such as, “Medication list reviewed and reconciled with the patient.”

**Exam:**
Often, it’s difficult to discern whether the 1995 or 1997 Documentation Guidelines for Evaluation and Management Services were used. Establish a practice policy on which exam guidelines are used (if used 100 percent of the time), or when exceptions are made.

Typically, comparing documentation templates (prompts for the providers) to the 1995 and 1997 guidelines reveals areas of extra documentation that can support additional organ systems or body areas examined. An example for vision providers is a prompt in the EHR to document both “Exam of lids” and “Exam of conjunctiva,” instead of a generic prompt, such as “Eyes.” Another example is to be sure that one additional vital sign, such as pulse, respiration, or height, is added to the EHR documentation template if only temperature and weight are included.

Further exam element clarifications allow the documentation to flow better with the Medicare exam documentation guidelines, which makes chart auditing foolproof. Examples include:

- For “Assessment of hearing,” a practice may want to add “conversational speech,” if this is how it’s done in an exam.
- Change an EHR prompt from “Facial mobility” to “Assessment of facial strength.”
- Change “Neurologic” from “Higher integrative functions: Normal orientation, memory, attention span and concentration, language, and fund of knowledge” to add “Orientation to time, place and person” and “Mood and affect (e.g., depression, anxiety, agitation).”

**Note:** We see the most “cloning” in the exam documentation in the EHR. Every chart looks identical, no matter the complexity. Be careful that the visit isn’t embellished beyond the reason why the patient is there for the exam.

**ICD-10-CM:**
There’s usually room to improve capturing diagnosis codes to create a full picture of the complexity of the patient’s story. For example, many conditions are alluded to in the medication list or past medical history, but are overlooked in the ICD-10 list.

Another area of omission is when a provider lists detailed ICD-10 codes in the plan/assessment, but doesn’t pull them into the claim form for the patient that day.

Another problem found is the “search and replace” error in an EHR: The ICD-10 codes are correct, but some descriptions remain as they were under ICD-9, or vice versa. For example, J01.90 may be listed as *Acute sinusitis, unspecified*; however, the updated ICD-10 diagnosis code description is *Acute bacterial rhino-sinusitis*. Also, be sure to verify how the ICD code is pulled from the chart, and how it is linked to each of the visit’s procedures.

**Medical decision-making:**
In general, the first two components of an E/M visit — history and exam — are relatively easy to audit. Code selection typically boils down to medical decision-making, and that documentation is

**Past/Family/Social history (PFSH):** PFSH should be incorporated into the patient paperwork at the practice. A simple change may affect the practice’s level of history (and, therefore, E/M code) supported.
Audit Findings

lacking. This is the most subjective part of the audit, and providers are well-served to improve their MDM documentation:

- **Number of diagnoses:** It is often difficult to ascertain if the condition is new or established to the provider, worsening or improving, etc. These documentation cues are useful to include and help auditors to “score” the first component of MDM.

- **Additional services:** Did the patient provide the history? Was another physician consulted on the case? Were records reviewed? Usually, the record is silent on these possible areas of additional MDM points.

- **Consultation, laboratory, and imaging reports** often are filed in the chart, but are not included in the documentation for the corresponding office visit. Verify the status and timeliness of reviewing results, and make sure follow-up plans are noted for abnormal results. If the order and results are kept outside of the E/M visit, and no mention is made, the provider gets no credit for reviewing/considering these additional sources of clinical information.

- **Table of Risk:** In the absence of a specialty-specific Table of Risk, we make a lot of interpretations (judgment calls) on where things fit in the Table of Risk (what is low? moderate? etc.) For example, do antibiotic injections at the time of the visit count as prescription drug management? We recommend additional research on what is supported here, and this might be a great area of collaboration for AAPC members. For another example, “Where would a nebulizer treatment fall in the Table of Risk?”

**Time:**

Rarely are face-to-face start and end times with the patient documented; however, providers often put in template language something as, “I spent 50 percent of the visit counseling and coordinating care.” Additional support is necessary if time — instead of history, exam, and MDM — is relied on to determine the E/M service level.

When auditing E/M visits, also look at the charges billed on the claim. We often see areas for improvement, such as billing for supplies, correct doses of injections, and arranging CPT® codes in descending relative value unit order.

Marcia L. Brauchler, MPH, FACMPE, CPC, COC, CPC-I, CPHQ, is president and founder of Physicians’ Ally, Inc., which provides advice and counsel to physicians and practice administrators, as well as education and assistance on how best to negotiate managed care contracts, increase reimbursements, and stay in compliance with healthcare laws. She is lead author of several compliance solutions for physician practices (HIPAA, OSHA, Compliance Plan) and online staff trainings through MGMA. She is a member of the South Denver, Colo., local chapter.
Telemedicine is expanding, and current studies and research support its effectiveness. Despite some challenges, high rates of patient and provider satisfaction have been the norm. Knowing the pros and cons of delivering healthcare via telemedicine can help you decide whether it’s time for your healthcare organization to make the leap into the future of patient care.

Studies Reveal Patient Satisfaction
In one case study, “Patient Satisfaction with Physician-Patient Communication During Telemedicine,” patients reported greater satisfaction with convenience for telemedicine, as compared to inpatient consultations. Despite physical separation, the study indicated...
that communication between the provider and patient during the session was not inferior to the communication built during inpatient consultations. In terms of video quality, “Videoconferencing for Clinical Management of Diabetes” reported the highest satisfaction rate of 100 percent.

In a July 2004 study, “Patient Satisfaction with Telemedicine,” Gustke, et. al., found patient satisfaction to be 98.3 percent, possibly due to ease of obtaining care as compared to non-telemedicine settings — where factors such as appointment scheduling, travel time, and patient involvement in the physical examination often led to lower approval ratings. Patient satisfaction was also found to be high due to increased accessibility to specialist expertise and reduced wait times, according to “Telemedicine and Patient Satisfaction: Analyzing the Future.”

Research was also conducted in areas without high speed internet. Using a standard telephone line, nurses and medical students were able to provide post-operative care in a patient’s home while a physician supervised remotely from the office via low resolution video and high resolution pictures. These types of scenarios reported extremely high satisfaction with the home visit, a rating of 4.8 out of 5, according to “Evaluation of the Effectiveness of Portable Low-bandwidth Telemedical Applications for Postoperative Follow-up: Initial Results.”

**Pros and Cons of Telemedicine**

There is much patient and provider satisfaction with telemedicine, but there are also challenges.

Telemedicine has experienced exponential growth, evolving from simple telephone communications to more complex algorithm-driven, smartphone-based applications. With this, potential dangers lurk: Many developers lack medical training, and don’t consult clinician experts when developing and implementing the mobile application. And many of these applications are marketed directly to consumers without proper vetting by the Food and Drug Administration or the Federal Trade Commission.

There is also some skepticism that providers can perform a thorough and accurate exam without physically touching the patient, and whether the results of a telemedicine visit equal those of a traditional office setting. Studies are positive, but reveal shortcomings.

When using commercial telecommunication tools, there is high reliability and agreement between bedside observers and telemedicine observers when assessing febrile children and children with respiratory distress, according to “Reliability of Telemedicine in the Assessment of Seriously Ill Children.”

For ophthalmology, physical therapy, and cardiac auscultation, 91.2 percent of the conventional medical findings and 86.5 percent of the telemedicine findings were identical or similar to the criterion standard. For tracings and images, both conventional and telemedicine findings showed 92 percent reliability. Reliability varied with the exam, experience of the telemedicine provider, and participant knowledge of system limitations. According to “Variation in Quality of Urgent Health Care Provided During Commercial Virtual Visits,” virtual physicians missed approximately 24 percent of diagnoses in 599 telemedicine cases; more seasoned telemedicine providers were correct with more than 90 percent of the patients they examined.

According to “Reliability of Telemedicine Examination,” those who reported higher error rates and often missed clinical findings tended to be clinicians with little experience or providers who do not acknowledge telemedicine limitations. The study “Patient Safety and Telephone Medicine: Some Lessons from Closed Claim Case Review” reviewed 32 cases with tragic outcomes, including deaths and malpractice settlements amounting to more than $12 million. Telephone communication leading to documentation errors was implicated as a significant root cause, raising issues regarding the importance of face-to-face visits in some circumstances.

**Where Telemedicine Can Make the Most Difference**

By knowing the convenience, patient satisfaction, and reliability of telemedicine, as well as its limitations, we have an opportunity to effectively and safely integrate it into mainstream medical practices. Aside from standard clinical practices, there are many places we can realize the full use and capability of telemedicine.

**Rural Health**

A challenge for rural health facilities is attracting, affording, and retaining specialist providers. Telemedicine solves this shortage by allowing live video conferencing with specialty providers, sometimes thousands of miles away. The specialist can, in real time, examine the patient, review vital signs, review patient history, and provide an assessment, diagnosis, and treatment without the need for travel.
TELEMEDICINE

Correctional Facilities
To provide prison facilities with high-quality healthcare without the cost and danger of inmate transportation, there has been a substantial growth of telemedicine use in U.S. federal prison systems and correctional facilities. Telemedicine has proven to be effective for primary care, disease prevention, dental, and obstetrics/gynecology healthcare needs in these settings.

School-based Health Center
School-based health centers have also seen an exponential growth of telemedicine. This has improved the quality of healthcare, keeping children healthier, while decreasing absences due to illnesses and doctor appointments. Chronic conditions such as asthma, diabetes, and obesity are more easily managed in these settings with the help of specialists from remote locations.

Mobile Health Clinics/Disaster Relief
Although not as prevalent, these telemedicine applications can have a profound affect during times of urgent need or crisis. Quality healthcare can be dispatched quickly and efficiently to provide necessary medical expertise and emergency triage capability that would not otherwise be possible.

Industrial and Transportation
Providing telemedicine aboard cargo ships, cruise lines, commercial airplanes, mines, drilling platforms, and industrial sites allow access to advance healthcare expertise while avoiding costly evacuation and unscheduled diversions.

Bright Future
Despite challenges, telemedicine is making great strides toward being accepted into mainstream medicine. The fact that Medicare has increased reimbursement by 1.2 percent this fiscal year and is expanding the list of eligible services to Medicare patients bodes well for telemedicine. We will wait, however, to see what the new Trump administration has in store for these services. HBM

Resources
“Videoconferencing for Clinical Management of Diabetes,” Farhad Fatehi, MD, MSc, 2015
“Reliability of Telemedicine in the Assessment of Seriously Ill Children,” Siew L, et al, February 2016: http://pediatrics.aappublications.org/content/early/2016/02/03/peds.2015-0712
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For many healthcare practitioners, collecting patient payments is a challenge. Using the proper tools, however, healthcare practitioners can implement streamlined payment acceptance practices to better sustain their business.

Don’t Leave Money on the Table when Billing
According to a study from global management firm McKinsey & Company, healthcare providers expect to collect between 50 and 70 percent of a patient balance following a visit. And what is collected comes in slowly: 70 percent of providers report that it takes on average a month or longer to collect. If turned over to a collections company, providers receive a mere $15.77 of every $100 owed.

Ensure Efficient (and Profitable) Patient Payments
As a rule, the more convenient payment options are for patients, the greater the odds the provider will receive full payment for rendered services. With proper application, an omni-channel patient payment system can be a cost-effective solution to address payment needs and to ease reconciliation.

An optimized patient payment solution allows for:

- **Card on file (COF)** – As the patient’s portion of the payment becomes larger, healthcare practitioners find it advantageous to obtain their payment method at check in. A complete patient payment system must allow for the safe, secure capture of the patient’s credit card or checking account information so all uncovered medical costs can be billed to and reliably collected from the patient, while also allowing for rapid processing of in-person co-pays and deductibles. With a COF solution, healthcare practitioners will see a significant decrease in uncollected patient payments over time.

- **Web payment self-service** – Enabling patients to easily pay online on the healthcare practitioner’s website is advantageous. This has become an expected payment channel, but need not be a costly investment. A comprehensive patient payment

Save time and make money by updating your payment processes.
system should provide an easy, low-cost web payment capability that is integrated into the overall payment system.

- **Phone and mail-in payments** – Remittance payments may be collected easily via a virtual terminal, with payment processing and electronic receipts instantly and securely emailed from an employee's desk to the patient. This method allows for less rework, maximizing staff efficiency, and is more secure than writing down a patient's payment account information for processing later. Make the virtual terminal capability part of your overall patient payment system reporting to ease patient account reconciliation.

- **In-house payment plans** – As an option for large outstanding balances, practitioners should have a flexible payment system that allows for easy set up of in-house payment plans to collect larger balances. Collecting smaller amounts over several months ensures payment and offers the patient a better solution than turning them over to a collection agency, or a costly third-party financing company.

- **Insurance carrier payments** – Increasingly, insurance carriers are paying healthcare providers with business/purchasing cards. These large dollar payments can be costly to accept. Have a complete payment system with a specialized plug-in designated to handle payments from insurance carriers. This will reduce processing fees by as much as 40 percent.

- **Validating patient obligation** – Healthcare and payment software providers are working to integrate tools to confirm patients’ insurance obligations. These estimation tools are improving in accuracy and insurance provider participation. Although the tools are costly, the ability to capture a large percent (if not all) of a patient's obligation for payment during the visit can greatly reduce outstanding receivables and write-offs.

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###改善支付流程

- **改善现金流** – 增加患者的支付流程将减少应收账款，从而减轻你的会计负担并增加利润。
- **减少支付对账时间** – 支付系统应提供全面的报告，使你的员工无需再担心对账。
- **增加安全性和合规性** – 优化的解决方案将解决安全问题，并确保你的业务是合规和安全的。
- **增加效率** – 通过多种方式接受支付，员工将不再需要等待旧的支付终端，意味着处理支付所需的时间更少。

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###寻找满足您需求的患者支付解决方案

收集支付是一个任何实践或医院的必要组成部分。有了合适的工具，它就不再是一个负担或低效的任务。如果你的实践仍然使用过时的、低功能的支付系统，探索更好的替代方案。

如果你不确定你的业务是否有最优化的患者支付解决方案，请寻求一位知识渊博的倡导者的帮助。支付处理费用的风险和潜在的更高支付处理费用因行业而异。同样，重要的是要进行一个完整的、细致的审查合同条款的支付处理服务提供商，以避免不必要的成本或罚款。与一位有经验的支付处理专业人士合作，谁可以识别这些风险并为你提供一个量身定制和成本有效的解决方案。

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**Steven D. Beene** 是MSP Consulting的联合创始人和前合伙人，他拥有25年的经验，专注于支付解决方案和相关技术的部署，特别是在医疗保健、特许经营和企业对企业市场。他拥有经济学和金融学的学士学位和MBA学位。
Childhood obesity is not an isolated condition. Children who are obese are also at risk of developing diabetes, sleep apnea, hypertension, and other co-morbidities. They may also experience social ridicule, low self-esteem, and depression. Many experts believe schools are a key setting for efforts to prevent childhood obesity. “Schools offer many other opportunities for learning and practicing healthful eating and physical activity behaviors,” reports the National Academy of Sciences in Preventing Childhood Obesity: Health in the Balance. Poor nutrition and physical inactivity are key factors for what causes excess weight gain (aside from genetics, metabolism, environmental factors, and social and individual psychology).

There are many organizations helping schools become healthier places for kids. Action for Healthy Kids® is one such organization. Their mission statement is, “To mobilize school professionals, families, and communities to take actions that lead to healthy eating, physical activity, and healthier schools where kids thrive.”

Their fifth annual Every Kid Healthy™ Week, April 24-28, 2017, celebrates school health and wellness achievements. Participating schools promote and reinforce healthy eating, nutrition education, physical activity, and physical education throughout the year.

**Get Inspired**

There’s nothing like a success story to motivate others, and Action for Healthy Kids® has lots of them. “Our network of more than 70,000 volunteers across the country makes our work possible,” they say. Here are just a couple of stories from last year’s Every Kid Healthy™ Week:

**Trace Crossings Elementary, Hoover, Alabama**

Trace Crossings celebrated the great strides it made to increase healthy food offerings, nutrition education, and physical activity among its students by sampling healthy foods during lunch.

**James Madison Elementary, Sheboygan, Wisconsin**

James Madison celebrated its new grab-and-go breakfast program with a healthy breakfast. To encourage physical activity, each child who participated in the breakfast received a new football, soccer ball, Frisbee, jump rope, or hula hoop.

**Get Involved**

Anyone can make a difference during Every Kid Healthy™ Week. Schools are encouraged to engage families and communities. As a volunteer, your office, facility, or local chapter can offer kids new...
Healthcare professionals can have a significant impact on childhood obesity by making obesity prevention a part of routine preventive healthcare.

Recommendations include:

- Making body mass index (BMI) screening a standard part of care
- Talking to adult patients about breast feeding and first foods
- Prescribing activities and healthy habits
- Being a healthy lifestyle leader in your community

The U.S. Preventive Services Task Force recommends clinicians screen children aged 6 years and older for obesity, and offer or refer them to comprehensive, intensive behavioral intervention to promote improvement in weight status.

The American Academy of Pediatrics (AAP) encourages pediatricians to take a media history and ask two media questions at every well-child visit:

1. How much recreational screen time does our child or teenager consume daily?
2. Is there a television set or Internet-connected device in the child’s bedroom?

The AAP recommends limiting screen time to two hours per day. According to the President’s Council on Fitness, Sports & Nutrition (www.fitness.gov), children spend more than seven and a half hours a day in front of a screen (television, video games, computer, etc.).

The U.S. Department of Health and Human Services (HHS) “Physical Activity Guidelines for Americans Midcourse Report: Strategies to Increase Physical Activity Among Youth” recommends children (and adolescents) get 60 minutes or more of physical activity daily, consisting of:

- **Aerobics:** Most of the 60 or more minutes a day should be either moderate- or vigorous-intensity aerobic physical activity, and should include vigorous-intensity physical activity at least three days a week.
- **Muscle-strengthening:** Part of that 60 or more minutes should include muscle-strengthening physical activity at least three days per week.
- **Bone-strengthening:** Part of that 60 or more minutes should include some bone-strengthening physical activity at least three days per week.

Youth physical activity assessment and counseling are measured as part of determining the quality of preventive healthcare of children and adolescents through the Healthcare Effectiveness Data and Information Set (HEDIS) — a tool used to measure health systems’ quality performance.
What’s Happening to Our Children?

Here are some interesting facts and statistics regarding physical activity, nutrition, and obesity among children in the United States.

• The percentage of children with obesity has more than tripled since the 1970s. Today, about one in five school-aged children (ages 6-19) are obese (President’s Council on Fitness, Sports & Nutrition).

• Empty calories from added sugars and solid fats contribute to 40 percent of total daily calories for 2- to 18-year-olds, and half of these empty calories come from six sources: soda, fruit drinks, dairy desserts, grain desserts, pizza, and whole milk (Journal of the American Dietetic Association).

• Only one in three children is physically active every day (National Association for Sport and Physical Education. The Fitness Equation: Physical Activity + Balanced Diet = Fit Kids).

• Since the 1970s, the number of fast food restaurants has more than doubled (U.S. Department of Agriculture. Dietary Guidelines for Americans, 2010).

Resources


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

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AAPC’s goal is to provide members with the best educational resources in our industry. For healthcare business professionals, that means you can look to us for exam resources; networking through local chapters, conferences, and forums; coding updates and rules, compliance and auditing information; hospital and payer billing rules; continuing education units (CEUs); timely online blogs and printed articles; and much more. Because we offer so many education opportunities, many of our members forget about or overlook one of the most convenient and informative ways we offer free and low-cost CEUs: webinars. Let’s take a look at how our webinars rank, and how we can customize them to suit your education needs.

**Top-notch Ranking in a 5-star System**

Between January 2016 and March 2017, AAPC offered members 49 webinars on a wide range of healthcare topics. We used a 5-star ranking system for attendees to rate each webinar:

- 5 – Best
- 4 – Great
- 3 – OK
- 2 – Poor
- 1 – Awful

Our highest ranking webinars are:

<table>
<thead>
<tr>
<th>Top 5 Webinars</th>
<th>5 Star Rating</th>
<th>Peer Recommendation</th>
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</thead>
<tbody>
<tr>
<td>1. A&amp;P Series; Respiratory System</td>
<td>4.53</td>
<td>98.7%</td>
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<td>Sheri Poe Bernard, CPC, CPC-I</td>
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<td>2. The Good, the Bad, the Ugly: Ways to Improve E/M Documentation</td>
<td>4.49</td>
<td>98.2%</td>
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<tr>
<td>Brenda Edwards, CPC, CPB, CPMA, CPC-I, CEMC, CRC</td>
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<tr>
<td>3. A&amp;P Series; The Eye</td>
<td>4.47</td>
<td>97.8%</td>
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<td>Sheri Poe Bernard, CPC, CPC-I</td>
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<td>4. Risk Adjustment Coding in the Provider Office</td>
<td>4.46</td>
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<td>Sheri Poe Bernard, CPC, CPC-I</td>
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<tr>
<td>5. Current Trends in Arthroscopic Surgery</td>
<td>4.41</td>
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<tr>
<td>Lynn M. Anderanin, CPC, CPMA, CPPM, CPC-I, COSC</td>
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All but seven of the 49 webinars received more than four stars. Those seven webinars ranked with a favorable rating of 3.9, and more than 88.5 percent of the attendees said they would recommend them to their peers.

**FREE Quarterly Webinars Means FREE CEUs**

To provide all members with access to easy-to-obtain CEUs, AAPC offers free quarterly webinars. The topics are selected specifically for AAPC members by experts in our field. You can find them at: www.aapc.com/freewebinar. This quarter, “MACRA Overview” is the hot and timely topic.

To earn your free CEUs for watching these free quarterly webinars, be sure you are logged into your member account before you start the webinar.

**Tell Us the Webinars You Want and When**

To continue providing you with top-notch webinars, we need your input. We created a survey for you to let us know what webinar topics interest you most and how we can improve upon our existing lineup: www.aapc.com/webinar-feedback. Here, you can offer suggestions for new topics, as well. Some members like to attend live webinars, rather than previously recorded ones. On the survey, you can let AAPC know which day and time work best for your schedule.

If you have a particular expertise that you’d like to share with like-minded professionals, you can offer to present a webinar through the survey, as well.

So spill the beans, and tell us how our webinars can serve you better at www.aapc.com/webinar-feedback. We look forward to fulfilling your continuing education needs through our information-rich, high-ranking webinars.

Michelle A. Dick, BS, is an executive editor at AAPC and a member of the Flower City, Rochester, N.Y., local chapter.
What’s the first thing you do when you receive a new AAPC codebook for the upcoming year?

- Do you page through it, get oriented, and look for new information?
- Do you transfer essential notes you’ve moved from book to book for years?
- Do you contemplate a future of increased proficiency, new knowledge, and demonstrated experience?
- Do you use it as the ultimate settler of disagreements and a salve for concern?

Most coders and students tell us they do all of these things and more. Even with electronic coding aids, many still keep a physical copy of the latest code sets on hand. That’s why it’s so important to us to have the best books out there.

Looking Ahead to 2018 ICD-10-CM

AAPC’s books are unique because they are designed to accommodate students, educators, and credential examinees, while assuring ease of use in the office. They must be durable, easy-to-read, and inexpensive. And you need your books by Oct. 1, each year. That much you’ve told us. But, as we begin planning for 2018, we want to know how we can make our ICD-10-CM codebook even better.

In February, AAPC asked all book purchasers for feedback. We asked about price, format, binding, paper, usability, and format. We asked what enhancements you wished for and what features you didn’t want.

According to the feedback we received, you like our books, overall. You told us our books are easy to use and well organized. Here are other features you like:

- Almost three out of four prefer coil-bound books.
- Four out of five like the anatomy and pathophysiology added to each chapter.
- Nine out of 10 like the chapter-specific guidelines.
- Most of you like the ink color, paper color, icons, and illustrations.

A Work in Progress

There is always some enhancement that splits users’ opinions. This year, it is the lines we added to make the multi-leveled Index of Disease and Injuries easier to follow. Last year, users saw those lines in other publishers’ books and asked for them. An equal number of members like them or don’t. Is there a better way to accomplish the same thing? Let us know.

A major concern you have is font size. Below are some examples of what different font sizes look like:

8 pt – H52.12 Myopia, left eye
9 pt – H52.12 Myopia, left eye
10 pt – H52.12 Myopia, left eye
11 pt – H52.12 Myopia, left eye
12 pt – H52.12 Myopia, left eye

Let us know what font size you like best at publishing@aapc.com.

How to avoid a book’s physical limit is a tough call. Books can only be made so large before they collapse under their size and weight, not to mention the inconvenience to the user who might strain to use it. Making the font larger means some information, such as icons and appendices, must be removed to make room for the code set’s official indices, tables, and nomenclature.
Icons, additional information, and outpatient vs. inpatient information take up space, so we also asked you what you want next year. Are Z codes an issue? Do you need more information associated with Medicare severity-diagnosis related groups? Do you want more or fewer illustrations? Thanks to your feedback, we have a better idea. Your feedback is also helping us to resolve reported issues. For example, a significantly more reliable coil was put on the book for 2017, but some still report problems. And a less reflective paper was used, but some still find that it reflects too much in certain office environments.

**Exciting New Enhancements**

Focus groups, online surveys, and reviewing comments from members and other customers are helping us improve all of our codebooks. We think you’ll find AAPC’s 2018 ICD-10-CM book the best yet. Some changes are still being nailed down, and we don’t want to ruin the surprise when we unveil them, but we can tell you about three new features that should make everything you’re coding and studying much easier:

- **Highlighted Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) codes** – We’re identifying codes that will impact performance in the Quality Payment Program.
- **Adhesive pre-preprinted tabs** – Find what you’re looking for more quickly.
- **Exclusive AAPC coding tips** – Use exclusive tips from AAPC experts that will help you take your exam, report accurately, and educate providers.

We can’t thank you enough for your contribution to the design of AAPC’s ICD-10-CM codebook. The 2018 ICD-10-CM book is your book, and it will reflect your needs, whatever they may be. We know because you told us.

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Brad Ericson, MPC, CPC, COSC, is publisher at AAPC. He is a member of the Salt Lake City, Utah, local chapter.

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Books can only be made so large before they collapse under their size and weight, not to mention the inconvenience to the user who might strain to use it.
The following members are part of a select group who dedicate themselves to their career and the health community. They have achieved the designations of AAPC Associate, Professional, and Fellow — proof of their dedication to the ethical standards of AAPC, achievements throughout their career, and reputation among their peers.

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

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Make deciphering pulmonary documentation easier by recognizing common medical terms and acronyms:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABG</td>
<td>Arterial blood gas</td>
</tr>
<tr>
<td>BiPAP</td>
<td>Bi-level positive airway pressure</td>
</tr>
<tr>
<td>CF</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>CB</td>
<td>Chronic bronchitis</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>CXR</td>
<td>Chest X-ray</td>
</tr>
<tr>
<td>DAD</td>
<td>Diffuse alveolar damage</td>
</tr>
<tr>
<td>HAPE</td>
<td>High altitude pulmonary edema</td>
</tr>
<tr>
<td>LRI</td>
<td>Lower respiratory tract infection</td>
</tr>
<tr>
<td>OLD</td>
<td>Obstructive or occupational lung disease</td>
</tr>
<tr>
<td>OSA</td>
<td>Obstructive sleep apnea</td>
</tr>
<tr>
<td>PAP</td>
<td>Positive airway pressure</td>
</tr>
<tr>
<td>PH</td>
<td>Pulmonary hypertension</td>
</tr>
<tr>
<td>PI</td>
<td>Pulmonary insufficiency</td>
</tr>
<tr>
<td>RT</td>
<td>Respiratory therapist (or therapy)</td>
</tr>
<tr>
<td>SOB</td>
<td>Short of breath</td>
</tr>
<tr>
<td>TLC</td>
<td>Total lung capacity</td>
</tr>
<tr>
<td>URI</td>
<td>Upper respiratory infection</td>
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Karinne Amsberg, CPC-A
Katrin Blankenship, CPC-A
Kristian Roman Mangilinan Buna, COCA
Kristie Bost, CPC-A
Kristin Blankenship, CPC-A
Kristina Bain, CPC-A
Kristina Cassarino, CPC-A
Kristine Mace Vengo, CPC-A
Kristine Valenti, CPC-A
Kudikalyala Ajay, CPC-A
Kyleigh Stipp, CPC-A
Laarni Lacro, COCA
Lacey Williams, CPC-A
Laure Peach, CPC-A
Lavanya Dhandashramoorthy, COCA
Laxmi Batumuru, CPC-A
Laxmiprasanna Kuchipudi, CPC-A
Leah Jackson, CPC-A
Leah Word, CPC-A
Leigh Ann Davis, CPC-A
Leigha Decker, COCA
Leila Lou Dela Vega, CPC-A
Leonardo, Jr., Camo, CPC-A
Leslie Davidson, CPC-A
Linda Averill, CPC-A
Linda Kraft, CPC-A
Linda Naylor, CPC-A
Lindsay Averill, CPC-A
Lindy Jones, CPC-A
Lindsay Row, COCA
Lindsie Holmes, CPC-A
Jennifer Strang, CPC-A
Jennifer Wronski, CPC-A
Jennifer Zavala, CPC-A
Jessica Adams, CPC-A
Jessica Bradshaw, CPC-A
Jessica Cura Bandola, CPC-A
Jessica Fraker, CPC-A
Jessica Jenkins, CPC-A
Jessica Lee, CPC-A
Jessica Martell, CPC-A
Jessica Thagon, CPC-A
Jessy Medrano, CPC-A
Jethi Nagendra, CPC-A
Jill Frost, CPC-A
Jill M. Sayles, CPC-A
Jiyeon Hie, CPC-A
Joan Hazel, CPC-A
Joanna Griggs, CPC-A
Johnson Zutzm, CPC-A
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Juanita Palmer, CPC-A
Julie May, CPC-A
Julie Young, CPC-A
Julia Rahm, CPC-A
Julie Rolston, CPC-A
Julius M. Jordan, CPC-A
Jupelly Harish, CPC-A
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K Geetha, CPC-A
K P Girish Kumar, CPC-A
Kalthy Sudac, CPC-A
Kakara Prasanna, CPC-A
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Kara Hartley, CPC-A
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Karen Wilson, CPC-A
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Kari Jurecki, CPC-A
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Karissa McDowell, CPC-A
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Kimberly Pace, CPC-A
Kimberly York, CPC-A
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Konduru Sraya, CPC-A
Kothireddy Arvesh, CPC-A
Kottuwada Ramya Tulasi, CPC-A
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Kristen Buller, CPC-A
Kristi Servachko, CPC-A
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Mackenzie Cornett, CPC-A
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Madhavi Chekuri, CPC-A
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Meenakshi Muniyandi, CPC-A
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Samatha Troester, CPC-A
Sameena Begum, CPC-A
SaMora Johnson, CPC-A
Sandeep Kumar, CPC-A
Sandeep Sathaluru, CPC-A
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Sanidhya Selvaraju, CPC-A
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Sandra Cortina, CPC-A
Sand Recipe Morgan, CPC-A
Sandrach Shaw, CPC-A
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Santhoshkumar Jonna, CPC-A
Sara DePeano, CPC-A
Sara Folsom, CPC-A
Sara Martin, CPC-A
Sara Vancil, CPC-A
Sarah Findlay, CPC-A
Sarah Guillot, CPC-A
Sarah Jeanne Gaze, CPC-A
Sarah Jenkins, CPC-A
Sarah Mazzone, CPC-A
Sarah Raju Challaapali, CPC-A
Saretta Shomita Carter, CPC-A
Santia Dawkhar, CPC-A
Sasikala Appar, CPC-A
Sasikala Chalapathi, CPC-A
Sathish Rajreddy, CPC-A
Sayed Hussain, CPC-A
Seneca Johnson, CPC-A
Shabeesn Taj, CPC-A
Shahjahan Mohd, CPC-A
Shalaja A, CPC-A
Shana Hall, CPC-A
Shannon Bartlett, CPC-A
Shannon Bradford, CPC-A
Shannon M Foss, CPC-A
Shanthi Samidurai, CPC-A
Sharad Ravasoo Babar, CPC-A
Sharath Polasa, CPC-A
Sharece Prince, COC-A
Sharlene Meacci, CPC-A
Sharon Larson, CPC-A
Sharon M Brouillard, CPC-A
Shavonne Darby, CPC-A
Sheeba Saihi, CPC-A
Sheila Diethelm, CPC-A
Sheilli Stephens, CPC-A
Sherbin Suluthana P, CPC-A
Sheri O’Brien, CPC-A
Sherry Michal, CPC-A
Sherry Walker, CPC-A
Sheryl Hurd, CPC-A
Sheryl Lynn Walker, CPC-A
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Shinde Prema, CPC-A
Shinde Sheena, CPC-A
Shiva Doele Doely, CPC-A
Shivakumar Jaival, CPC-A
Shirishi Bhardwaj, CPC-A
Sindhu Nidadavolu, CPC-A
Sirajudeen Rajakooro, COC-A
Sireesha Opala, CPC-A
Siriuparam Sowjanya, CPC-A
Siimida Alvarez, CPC-A
Sivaperumal Shamgam, CPC-A
Smriti Panedy, CPC-A
Sonali Khandekar, CPC-A
Sonja Foster, CPC-A
Sreelatha Ramirezari gari, CPC-A
Srinathi Vaaka, CPC-A
Srinivas Gangadapuri, CPC-A
Stacy Gonzales, CPC-A
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Dana Downe, COC, CPC, CPMA
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Margaret Ann Wilson, CRCA
Maria Cecilia Castillo, CPMA, CRCA
Maria Cecilia Castillo, CPMA, CRCA
Maria Cecilia Castillo, CRCA
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Mary Krueger, CPC, CPMA
Mary Lornell, COC, CPMA
Mary Thomas, CRCA, CRCA
Mary Trainor, PKA, CRCA
Max McKink, CRCA, CRCA
Melinda Leigh Showers, CRCA, CPC
Melissa Ortiz, CPMA
Menissa Abercrombie, CRCA, CRCA
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<th>Name</th>
<th>Credentials</th>
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<tbody>
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<td>CPPM</td>
</tr>
<tr>
<td>Michael Sterling</td>
<td>CPC, CRC</td>
</tr>
<tr>
<td>Michelle Lynn Parr</td>
<td>CPC, COSC</td>
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<tr>
<td>Mindred H Hanna</td>
<td>CPC, CPCO, CPMA</td>
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<tr>
<td>Miranda G Jones</td>
<td>CPC, CPCO, CRC</td>
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<tr>
<td>Miriam Kraus</td>
<td>CPCO</td>
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<tr>
<td>Monique Jones</td>
<td>COBGC</td>
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<tr>
<td>Muthulakshmi Chandran</td>
<td>CPMA</td>
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<tr>
<td>N Devonna A</td>
<td>CPCO</td>
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<td>Nagaraju Abbadasari</td>
<td>CIC</td>
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<tr>
<td>Nagarjuna Siddu</td>
<td>CIC</td>
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While in the coding trenches, furry companions are working behind the scenes to support us and bring comic relief.

“Cat vs. Dog” has been a long-standing rivalry for pet enthusiasts. Coding professionals bring a whole new level to the competition. Those who work remotely often rely on their faithful companions to keep them company; and they fill social media with photos of their beloved pets. If you’ve been on AAPC’s Facebook pages, you’ve most likely seen a colleague or two post pictures of their affectionate cat sprawled across a codebook or their loyal dog sleeping beside their desk.

To see just how much AAPC members rely on their furry friends to get them through their coding day, we asked on Facebook the question, “Cat vs. Dog: Which Is a Coder’s Best Friend?” The responses were fantastic and fun.
Cat vs. Dog

CAT LOVERS PRESENT THEIR CASE

1. Stephanie Bartlett, CEDC

Bartlett is the owner of both cats and dogs, but feels, “Cats are the best coding companions for one simple reason: They sit on my lap and help me stay warm while I’m working, which is essential during our cold Northern Michigan winters.” One of Bartlett’s cats, Kalle, also loves to snuggle with her pitbull Remy while she works.

2. Deb Cramer, CPC

Cramer works from home and says her cat Diesel has many attributes any coworker would find ideal. He keeps her focused, relaxed, and is supportive:

… if I’m at my desk, Diesel is snuggled in my lap. He gets very indignant if I disturb him, so he ensures I stay focused on my tasks. If I’m away from my desk, he’s keeping the chair warm for me. Sometimes Diesel will hop on my desk to help, but his tail doesn’t have the same accuracy on the keyboard as my fingers do.

When I’m frustrated or stressed, I only have to run my hands through his soft fur to help me relax. Diesel’s purr never fails to bring a smile to my face. He headbutts my chin and trills at me to let me know I’m doing a good job (at least as a human couch). Diesel’s the best coworker ever!

3. Melissa Darling, CPC, CEMC

Darling has four cats and three of them love to lounge around in her office. She said, “Specifically, they like to lay near or on my coding books. I’m never alone while working or studying, and I can always count on one of them to be hanging out in my office.” Darling’s littlest coworker is particularly affectionate while she works. She said, “My baby kitty, Chloe, likes to cuddle with me while I am trying to work.” It gives her a much needed snuggle break when she works for long stretches of time.

4. Candice Fenildo, CHC, CPC, CPMA, CPB, CENTC, CPC-I

Fenildo is the proud owner of three fur babies: Penelope, Adeline, and Tris. She works from home a couple of days a week, and her cats assist. For example:

• They hold down the pages in her CPT® codebook (you know, so they don’t fly away);
• They lay in front of her keyboard (so she doesn’t type too fast and make mistakes); and
• When she sits for too long, her littlest one always manages to drag a roll of toilet paper down the hall (which reminds her to take a break and get a little exercise — cleaning up the mess).

“Such good kitties they are,” Fenildo said.

5. Dana Sutton, CPC

Sutton’s cat Tuxy brings her stress level down so low that she gets sleepy. “While I’m studying, my Tuxy sleeps on the job; and boy, it’s so tempting to join him!” she said.
DOG LOVERS PRESENT THEIR CASE

6. Donnalyn Dwyer, CPC
Dwyer, who owns both dogs and cats, feels dogs (particularly Sadie) are the ideal coder’s best friend. She said:
• “They, too, know how to sniff out the answer.
• They are determined to make the exact find.
• They can feel when their coder master is stressed from a long day, and can alleviate the stress with those big puppy eyes.
• They are always great listeners, and hardly ever argue.
“My cats would disagree,” Dwyer said. “But they are cats; they will get over it.”

7. Chandra Stephenson, CPC, CIC, COC, CPB, CPCO, CPMA, CPPM, CRC, CDEO, CPC-I, CANPC, CCC, CEMC, CFP, CGSC, CIMC, COBGC, COSC, CCS, AAPC Fellow
Stephenson votes for dogs as a coder’s best friend. She said, “My dogs, especially Buster, are by my side (and my coding books) day in and day out.” They’re great at reminding her to take a break every now and then. Stephenson said, “They may not help much when it comes to getting the work done (they prefer to sleep), but they definitely help me relax and have fun when the work is finished.”
Stephenson misses her two dogs when she travels. The good news is that dog lovers stick together and travel in packs. Stephenson said, “I’m especially fortunate to count many dog lovers among my friends and family, so that when I travel, I have their dogs to fill in for my crazy pair.”

8. Aja Trammel, CPC
Trammel’s dog Moby doesn’t mind when she spouts off from coding frustration. She said, “Moby is the best study buddy! He is a deaf boxer and had no problem with me grumbling over the new ICD-10 codes when I was studying.”

9. Judy Wilson, CPC, COC, CPCO, CPPM, CPC-I, CPB, CANPC, CPC-I, AAPC Fellow
Wilson says there is NO contest here: “Dogs are your best coding buddies, for sure.” Her dogs, Toofer and Krikit, lay at her feet to keep them warm as she works on coding classes. Wilson said, “They never jump on your books, like cats do.” Here are a few other reasons why she says dogs have cats beat:
• They love to look up at you while you explain a procedure to them, and they always agree with your coding of it.
• They enjoy the quiet time while you study for a new exam, and they agree with all your answers.
• They give you comfort when you don’t do well on a section or a presentation.

Wilson said, “[Krikit and Toofer] might fall asleep on my lap while coding, but never on my books. They are loyal; unlike cats, who are loyal only when it’s convenient for them. Any cat owner can tell you that.”

YOU DECIDE
Members on both sides of the fence gave compelling arguments, but it looks like 5 out of 9 coding professionals voted that cats are a coder’s best friend. As this is only a small sample of our members, the rivalry continues.

Michelle A. Dick, BS, is an executive editor at AAPC and a member of the Flower City, Rochester, N.Y., local chapter.
Tell us how you got into coding, what you’ve done during your coding career, and where you work now.

I have worked at WCH Service Bureau since 2014, first as a billing account representative, which included billing of several specialties and the collection process, and now as a coder. I can’t say it’s been very easy for me, especially at the beginning. But as I became more experienced in this field, I realized that successful and efficient claims reimbursement depends on my proficiency in coding. Knowing coding has helped me to better understand the full picture of the process, from the medical encounter to the claim payment. Since most of my providers are primary care physicians, I obtained the Certified Family Practice Coder (CFPC®) credential to help them more with coding. After that, I passed the Certified Professional Medical Auditor (CPMA®) and Certified Professional Coder (CPC®) tests.

What AAPC benefits do you like the most?
I like the education benefits most. I get excited when I realize how much more there is to learn. I try to attend all of the webinars and presentations, and I follow all of the updates provided by AAPC. It keeps me more involved in the field and expands my knowledge and skills. I also like the savings benefit, especially when I purchase a new book or course and get a good discount as a member.

How has your certification helped you?
My certification gives me confidence and professionalism when I solve questions arising at work. I feel I can do more than just simply bill and collect, I can code professionally. I give advice to my clients and healthcare providers in assigning particular ICD-10 and CPT® codes. I also audit charts and medical records, and I help my clients go through audits. It’s an amazing feeling when I get my appeals approved, after I explain to the payer that my providers’ notes support the services they bill.

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

Never give up and don’t panic. When you start a new study guide or you begin coding a new specialty, the challenge may seem too complicated. But when you get rid of the doubts, think positive, and take one step at a time, you can achieve any goal. Just keep your dream in mind and be patient. There is always an answer to any question, you just need to search for it in the right place.

What has been your biggest challenge as a coder?

My biggest challenge is keeping up with constant updates in the field of coding. At the same time, it’s exciting to keep my brain fit and ready to face a new challenge.

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

If I could go back in time, I would study medicine to become a healthcare provider, maybe a surgeon. I am always amazed at how far modern medicine can go and how many lives can be saved and made better. I believe the physician’s profession is the hardest and the most noble of all professions.

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

I do not have free time very often, especially after I started coding studies and examinations. I often dedicate out-of-office time to research. When I do have spare time, I go to the gym or ride my bike around the city. I love the feeling after the gym! When I want to rest, I spend time with people I am close to and simply watch a movie.
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