Bone-up on Anatomy for Arthroscopy Procedures

Denis Rodriguez, CPC, CIRCC, CCS, CASCC, and Lisa Weston, CPC-H, CASCC, LHRM

Plus: ZPICs • Radiology • 2011 ICD-9-CM • Claim Scrubbers • Ob/Gyn • Meaningful Use
FALL INTO CODING

Join us at the Sheraton Springfield Monarch Place Hotel for three days of practical instruction on the topics crucial to your facility’s success. The AAPC’s Regional Coding Conference will provide a wide range of educational topics and a balanced program of new information and coding fundamentals. With more than 25 educational sessions, attendees will take away an increased understanding of what it takes to avoid the pitfalls of lost revenue.

TOPICS INCLUDE:

- 2011 ICD-9-CM Updates
- Fraud and Abuse
- An Overview of RACs
- Effectively Communicate with Payers
- HITECH Act - HIPAA on Steroids
- Neurovascular Interventional Coding
- Understanding ERISA
- ICD-10-CM
- Neurological Procedures
- Auditing E/M Services
- Effective Collection Methods
- Inpatient and Observation Hospital Services: Physician Coding Rules
- Coding for pulmonary and allergy offices
- Coding the Anesthesia Record
- Auditing E/M Services

REGISTER TODAY!

REGISTER AT WWW.AAPC.COM/SPRINGFIELD OR COMPLETE THE ATTACHED FORM
Features

14 Seven Tips for Diagnostic Radiology Coding Success
   Terry Leone, CPC, CPC-P, CPC-I, CIRCC, and G.J. Verhovshek, MA, CPC

18 ICD-9-CM for 2011 Aimed at Diagnostic Specificity
   G.J. Verhovshek, MA, CPC

22 Wisely Choose Between Modifier 25 and Modifier 57
   Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC

26 Arthroscopic Gems: Hints for Accurate Coding
   Denis Rodriguez, CPC, CCS, CIRCC, CASCC

32 Evaluate and Manage Medicare Teaching Physician Rules
   Jenny Berkshire, CPC, CEMC, CGIC

34 Maximize Coding for Minimally Invasive Ob/Gyn Surgeries
   Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC

36 Claim Scrubbers Are Not Infallible
   Dorothy Steed, CPC-H, CHCC, CPC-I, CPUM, CPUR, CPHM, CCS-P, CEMC, CFPC, ACS-OP, RCC, RMC, PCS, FCS, CPAR, CPMA

42 Get the Most Out of EHR Meaningful Use
   Renée Dustman

44 ZPICs: Medicare Audits Expands
   By Anna M. Grizzle, Esq., and Lynn Keaton-Cockrell, CPC, CPC-H, CPC-I, CEMC

Serving 97,000 Members – Including You

American Medical Association ......p. 17, 21
www.amabookstore.com

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

The Coding Institute
CodingCert.com .........................p. 9
www.CodingCert.com
Coding Conferences LLC
www.CodingConferences.com

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

Contex Media ..........................p. 49
www.contexmedia.com

HealthcareBusinessOffice LLC ....p. 28
www.healthcareBusinessOffice.com

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

Inhealthcare, LLC .....................p. 47
www.supercoder.com

Medicare Learning Network® (MLN).....p. 29
Official CMS Information for Medicare Fee-For-Service Providers
www.cms.gov/MLNGenInfo

NAMAS/DoctorsManagement ..........p. 52
www.drsmgmt.com

Navicure ....................................p. 12
www.navicure.com

PMIC .......................................p. 30
http://PmicOnline.com

Chairman
Reed E. Pew
reed.e.pew@aapc.com

President and CEO
Deborah Grider,
CPC, CPC-I, CPC-H, CPC-P, COBGC, CPMA, CEMC, CPCD, CCS-P
deb.grider@aapc.com

Vice President of Marketing
Bevan Erickson
bevan.erickson@aapc.com

Chairman, Pre-Certification Education and Exams
Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC
Raemarie.jimenez@aapc.com

Vice President, Post Certification Education
David Maxwell, MBA
david.maxwell@aapc.com

Director of Editorial Development
John Verhovshek, MA, CPC
g.john.verhovshek@aapc.com

Directors, Member Services
Brad Ericson, MPC, CPC, COSC
brad.ericson@aapc.com
Danielle Montgomery
danielle.montgomery@aapc.com

Senior Editors
Michelle A. Dick, BS Renee Dustman, BS
michelle.dick@aapc.com renee.dustman@aapc.com

Production Artist
Tina M. Smith, AAS Graphics
tina.smith@aapc.com

Advertising/Exhibiting Sales Manager
Jamie Zayach, BS
jamie.zayach@aapc.com

Address all inquiries, contributions and change of address notices to:
Coding Edge
PO Box 704004
Salt Lake City, UT 84170
(800) 626-CODE (2633)

© 2010 AAPC, Coding Edge. All rights reserved. Reproduction in whole or in part, in any form, without written permission from the AAPC is prohibited. Contributions are welcome. Coding Edge is a publication for members of the AAPC. Statements of fact or opinion are the responsibility of the authors alone and do not represent an opinion of AAPC, or sponsoring organizations. Current Procedural Terminology (CPT®) is copyright 2009 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT®. The AMA assumes no liability for the data contained herein.

CPC®, CPC-H®, CPC-P®, and CIRCC® are registered trademarks of AAPC.
10TH ANNUAL INGENIX ESSENTIALS CONFERENCE IN VEGAS

What if every claim you submitted was accurate and on time? For coders, that's a perfect 10. Attend our Ingenix Essentials conference to learn how you can nail it—every time. Visit www.ingenixessentials.com to find out more.

November 29 - December 1, 2010
JW Marriott Las Vegas Resort & Spa

The new ShopIngenix.com—redesigned by an expert in the industry…

YOU.

Redesigned with the user-friendly features you asked for, the new ShopIngenix.com is ready to make your online shopping a snap.

You asked. We’ve answered.
Check out the new ShopIngenix.com

SHOP INGENIX.
ASHIM Health Information Technology Professional is an online course that gives you the flexibility to learn at your own pace and from the comfort of your home or office. ASHIM programs are specifically designed to give you the skills you need for a career in today’s fastest growing field: Health Information Technology.

- Expertise in the new right-now technology can make you irreplaceable
- Study online at any time and at your own pace
- Be prepared to pass the rigorous Certified Health Informatics Systems Professional (CHISP™) exam

In 12 weeks you can be on your way to a new career, higher pay or that promotion you’ve been waiting for. Students entering the program with previous clinical experience (i.e. CPC, CCS, and RN) may work in health IT job roles such as: Clinical Software Trainers, EHR Implementation Specialists, Health Systems Integration Professionals, Practice Work Flow Analysts, and more.

ashim.org 877.263.1261
Members: The Backbone of AAPC

With more than 97,000 members, AAPC membership has risen dramatically to become the nation’s largest medical coding training and certification organization. Our membership consists of coders, billers, physicians, auditors, business owners, lawyers, consultants, students, etc. We are a diverse group at different stages in our careers. We are a melting pot of individuals with a common goal for coding excellence, which creates a strong, credible presence in the health care community.

Knowledge Gives Us Credibility
AAPC members are dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. In turn, physicians and their staff see AAPC credentialed members as exemplary employees.

Our certified members are the experts on compliant coding, proper physician documentation, ICD-10-CM, EHRs, PQRI, billing, auditing, etc., and we are gaining a stronger foothold in our industry through that knowledge. Physicians and other medical professionals look to us for guidance because AAPC prepares us and provides important current coding information to membership. That readily available education is ours to share with others in the industry.

If you’d like to see an example of how news sources in the health care industry see us as credible experts, go to http://news.aapc.com/index.php/category/aapc-in-the-news/.

Members Bolsters Coding Confidence

As members, we value each other’s expertise. We form relationships through networking, teaching, and mentoring. Our members and AAPC staff are the resources that are tapped into to boost coding know-how and confidence.

Sometimes student members feel overwhelmed by curriculum or are anxious about finding their first coding job. Experienced members, chapter officers, and other students help ease these worries because they have been through it. Their guidance prevents new members from getting lost in the coding shuffle and feeling discouraged.

I encourage you to explore the huge resource that AAPC membership offers by building relationships with other members. The education and networking opportunities are limitless if you see the worth of our membership. The best way to realize this is by attending chapter meetings, posting questions on our forums, attending coding conferences, and looking for ways to learn and share your knowledge with the coding community. Put yourself out there.

When we realize our membership’s worth as a growing presence in the health care industry, we become its leaders.

Sincerely,

Terrance C. Leone,
CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board
through Dec. 31, 2009 received after Dec. 31, 2010 will be past the timely filing deadline and denied; and

- Claims with service dates Jan. 1, 2010 and later received more than one calendar year beyond the service date will be past the timely filing deadline and denied.

Key points of timely filing in CR 7080 are:

- For institutional claims including span service dates (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim will determine the service date for claims filing timeliness.

- For professional claims (CMS-1500 Form and 837P) submitted by physicians and other suppliers including span service dates, the line item “From” date is used to determine the service date and filing timeliness. (This includes supplies and rental items). Physicians and other suppliers billing span date claims cannot exceed one month.

- Warning: If a line item “From” date is not timely, but the “To” date is, Medicare contractors will split the line item and deny untimely services as not timely filed.

- As an example, you should fill out claims with a Feb. 29 service date by Feb. 28 of the following year to be considered as timely filed. If the service date is Feb. 29 of any year and is received on or after March 1 of the following year, the claim will not meet the timely filing requirement and will be denied.

Make billing staff aware of these changes. You can find CR 7080 at www.cms.gov/Transmittals/downloads/R734OTN.pdf on the CMS website.

New Rules for HHAs Providing DME in Competitive Bidding Areas

If you are home health agency (HHA) submitting claims to regional home health intermediaries (RHHIs) for providing durable medical equipment (DME) to Medicare beneficiaries residing in competitive bidding areas, CR 7041’s (www.cms.gov/Transmittals/downloads/R741OTN.pdf) information is for you. Effective Jan. 1, 2011, edits will be in place for HHAs who bill competitively bid DME items in competitive bidding areas to prevent the inappropriate payment of DME items to HHAs. In a competitive bidding area, a supplier must be awarded a contract by Medicare to bill Medicare for competitively bid DME.

Here’s what you need to know:

- Medicare contractors will return HHA claims (types of bill 32x, 33x, and 34x) containing HCPCS Level II codes identified as being for items or services subject to competitive bidding in a competitive bidding area.

- For HHAs to bill competitively bid items they must also be a contract supplier under Medicare’s DME competitive bidding program.

- All suppliers of competitively bid DME must bill the DME Medicare administrative contractors (MACs) for these items and can no longer bill for competitive bid items to Medicare contractors processing HHA claims. HHA claims will be returned to the provider (to remove the affected DME line items) when submitted for HCPCS Level II codes subject to a competitive bidding program.

- Look for applicable HCPCS Level II codes and ZIP codes for competitive bidding areas on the “Supplier” page of the Competitive Bid Implementation Contractor (CBIC) website at www.dmecompetitivebid.com/Palmetto/Cbic.nsf/DocsCat/Home.

- DME claims furnished by HHAs not subject to competitive bidding may be submitted to appropriate HHA claims processing contractors.

CMS Defines Ambulance Services

CMS issued CR 7058 which affects ambulance suppliers submitting claims to Medicare contractors for ambulance services provided to Medicare patients. CR 7058 updates the Medicare Benefit Policy Manual (chapter 10, section 30.1.1) by providing examples for application of Basic Life Support (BLS)—Emergency, Advanced Life Support Level 1 (ALS1), and Emergency and Advanced Life Support Level 2 (ALS2) information. Although there is no new policy, CR 7058 updates the relevant manual section to reflect current policy. The updated manual section is attached to CR 7058 (www.cms.gov/transmittals/downloads/R130BP.pdf).
Join us on Dec. 2-4, 2010 in sunny Orlando, FL and receive all ICD-9, CPT and HCPCS code changes for your specialty plus your guide to the dramatic reimbursement changes ahead! This 2-1/2 day conference will arm you with all the tools necessary to help you select the correct codes from the start, avoid claim denials, maximize your productivity, and increase your practice's bottom-line. Best of all - You can jump between any of the specialty tracks below FREE of charge!

- Ambulatory Surgery Center
- Anesthesia
- Billing & Collections Track
- Cardiology
- Emergency Medicine
- Family Practice & Internal Med.
- Ob-Gyn
- Ophthalmology & Optometry
- Otolaryngology
- Pathology & Clinical Lab
- Pain Management
- Pediatrics
- Radiology
- Surgical Track
- Urology

Register Today! Call 866-251-3060 and mention code VCEDG910 or at www.CodingConferences.com

Prepare to Become a Certified Coder in just... 3 Days!

3-Day Coding Certification Training Camps!
- Attend 3 full days of top-notch preparation and an insider’s guide to the AAPC’s CPC® exam you won’t find anywhere else!
- Exam-taking tips guaranteed to boost your confidence
- AAPC approved instructors
- 550+ convenient locations nationwide
- Payment plans available

For additional information please contact CodingCert.com at (866) 458-2962 and mention code VCPCE910 or visit us online at www.CodingCert.com
Test Your Specialty Expertise with

Experience real coding simulation to go beyond learning for continuing education units.

By Michelle A. Dick

Code-A-Round is an online coding simulation that mimics the real world. The program was designed and developed by in-house AAPC staff to bring low cost, specialty-specific coding education to your computer. AAPC’s Director of Education Raemarie Jimenez, CPC, CPMA, CPC-I, CANPC, CRHC, said Code-A-Round is “extremely beneficial to members who hold a specialty credential and need specialty CEUs and it is beneficial to coders wanting more practice in a particular specialty.”

Here’s how it works: You view actual, redacted patient notes onscreen and code them, inputting correct ICD-9-CM, CPT®, and HCPCS Level II codes for that note. The answers are not multiple choice unlike most online practice tests – and you can’t guess from multiple choice answers. The correct codes must be typed in. Incorrect answers are flagged for re-coding, but the answers and rationales for those are not given. This most closely simulates the on-the-job environment.

Send in Your Reports

AAPC’s Vice President of Product Management David Maxwell said that Code-A-Round is unique because the program only operates through the willing participation of AAPC members. Members contribute operative notes, allowing AAPC to create the program. The good news is: “When we send out a call for notes, our members are eager to respond,” Maxwell said. “It’s a way for our members to ‘give back’ and to help each other grow and learn in the profession.”

AAPC uses the submitted notes to help specialty credential holders obtain their required continuing education units (CEUs) and to help students learn as part of their classroom instruction.

Get Specialty Coding Experience

Code-A-Round provides a great specialty-specific educational opportunity. Because Code-A-Round requires you to answer all codes correctly before completing the round, you have the opportunity to “learn by doing” while working through the notes. Maxwell said, “We receive calls at the national office from our members who are stumped by a certain aspect of a note.” He continued, “After providing some hints to help them complete the note, the comment we hear most often is I’ve been coding for 10 years and I can’t believe I missed that!” This lets us know that Code-A-Round stretches both experienced and beginner coders’ knowledge.

For coders who don’t have specialty experience, Jimenez said that Code-A-Round provides “the ability to practice coding for a specialty that interests them that they may not have experience in.”

Earn Specialty and Core CEUs

Each Code-A-Round contains five patient notes and is approved for one AAPC CEU. Code-A-Round provides members with the opportunity to earn CEUs in two ways:

1. By submitting five redacted op notes to AAPC, members can receive one free round of Code-A-Round (Submit notes to Kris Taylor, kris.taylor@aapc.com). After the member codes the notes and finishes round, he or she is credited with one CEU.

2. Members can purchase Code-A-Round rounds online. When the notes are coded, they receive one CEU. Although Code-A-Round was conceived primarily for specialty credential holders, it also satisfies CEU requirements for the Certified Professional Coder (CPC®), Certified Professional Coder-Hospital (CPC-H®), and Certified Professional Coder-Payer (CPC-P®) credentials.

Each five-note round is $9.95 and takes approximately one hour to complete.
Add-on Codes Don’t Require Modifier 51
I have a question about the article “Expose the Layers of Abdominal Wall Reconstruction,” by John Bishop (July 2010 Coding Edge, pages 44-46). The table on page 46 depicts 14302 with modifier 51. Isn’t 14302 an add-on code exempt from modifier 51?

Jeannie FG
You’re absolutely correct. All add-on codes, including 14302 Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (List separately in addition to code for primary procedure), are exempt from the multiple procedure concept, according to CPT® instructions. As such, you never would append modifier 51 Multiple procedures to a designated add-on code.

Other important points to remember about add-on codes include:
- They are denoted in CPT® with a “+” to the left of the code.
- The CPT® code descriptor will include some variation of the phrase, “list separately in addition to code for primary procedure.”
- Always use them with a “primary” procedure (parent) code.
- Never list an add-on code as a primary procedure.
- Payment for these services should not be lowered as a multiple-surgery reduction.

A complete list of add-on codes may be found in CPT® Appendix D, “Summary of CPT® Add-on Codes.”

Take Out the Mandibular in RME
“Sleep Apnea: The Not So Silent Bed Partner,” page 27, in the August issue, should read “A subsequent sleep medicine consultation, sleep studies (if indicated), and appropriate treatment (e.g., surgery, rapid maxillary expansion (RME), nasal continuous positive airway pressure (nCPAP), maxillomandibular advancement (MMA), etc.), can help restore sleep, correct deficient growth patterns, eradicate bed wetting, eliminate reflux, and improve school performance.” “Rapid maxillary, mandibular expansion (RME)” was printed in error.

Please send your letters to the editor to: letterstotheeditor@aapc.com.

Code-A-Round for More than CEUs
The Code-A-Round concept goes beyond earning CEUs. It is used also as an education tool for PMCC instructors to teach students how to code. Maxwell said, “Students receive homework assignments in Code-A-Round and code the notes to complete the assignment. The instructor can then review the answers to see which students need help in learning coding concepts.”

“We will soon be launching a new hiring exam using the submitted notes that will help hiring managers in the decision-making process by placing applicants in a real-world coding simulation,” Maxwell said. The objective is to “help hiring managers better evaluate potential candidates and we are certain our AAPC credentialed members will stand out from the crowd.”

For more information, visit AAPC’s website at www.aapc.com/medical-coding-education/code-a-round.aspx.

Disclaimer: Code-A-Round notes and answers are intended for educational purposes only, not as a reference standard for coding. Each note has been coded twice by independent certified coders and then quality checked for accuracy by a senior coder. However, due to the nature of the coding process, answers should not be considered definitive.

Michelle A. Dick is senior editor at AAPC.
How’s your cash flow? Find out how to get your electronic claims paid 21% faster with Navicure*.

The most technologically advanced clearinghouse solution, now more affordable than ever.

www.navicure.com • 1-877-290-4825

*During 2009, the average Navicure client saw an average 21% reduction in days between electronic claim submission date to payment date between the time they began using Navicure and the end of their first year using Navicure’s solution.

All of our solutions are supported by the Navicure 3-Ring Policy™. Your call will be answered by a member of our highly skilled client services team within three rings. Guaranteed.
When Compliance Is No Longer an Option

Voluntary compliance programs are ending. With the passage of the Patient Protection and Affordable Care Act of 2010, amended by the Health Care and Education Reconciliation Act of 2010 (Health Care Act), Congress mandates compliance for providers and suppliers, which includes physician services. According to this new law, providers and suppliers must adopt a compliance program as a condition of Medicare enrollment. Although regulations for the new mandatory compliance are not issued yet, I encourage every health care organization to ensure a compliance plan is in place or in progress. Your providers must be more diligent in the compliance program effort. Failing to implement a compliance program will promote further regulatory scrutiny in the health care industry.

For the past several years, the U.S. Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) have strongly encouraged but have not mandated compliance programs even though the OIG has provided guidance for many entities including physician practices. The OIG has settled thousands of cases involving alleged fraud, abuse, and civil allegations in the form of Corporate Integrity Agreements (CIAs) and other similar settlements mandating compliance for those fined and penalized. Undoubtedly, HHS will consider these elements when determining what compliance elements will be mandated. The Health Care Act’s compliance programs are divided into two categories: 1) nursing facilities and 2) other providers and suppliers.

When Will It Happen?
By Dec. 31, 2011 the secretary of HHS will implement a quality assessment and performance improvement program (QAPI) for nursing facilities addressing best practices. By March 23, 2012 the secretary of HHS working with the OIG will create regulations for nursing facility compliance that will vary depending on the size of the organization and the facilities they own. All skilled nursing facilities (SNFs) must be in compliance by this date. There is not a set date for compliance for physicians and other suppliers; however, the law does state “as a condition of enrollment” a compliance program must be established with certain core elements which will be established by HHS and OIG. The requirements have not been defined yet. Congress also has extended the requirement for mandatory compliance in the Medicaid program. Each state must require providers and suppliers under a state Medicaid plan to establish a compliance program.

What Does This Mean for You and Your Organization?
If you have a compliance program in place now, review the plan, update it, and ensure it is followed. If your organization or practice does not have a compliance program in place, consider adopting one now.

What Are AAPC’s Plans for Compliance?
Compliance is on the forefront of AAPC’s radar in 2010 and beyond. In 2011, we plan to add a compliance certification to our credentials and expand on existing credentials. We want to make sure health care professionals, including auditors, coders, compliance officers, physicians, etc. are kept up to date on the knowledge necessary to maintain compliance.

What Can You Do Now?
Proactively undertake compliant activities by at least beginning to audit and monitor for coding compliance. Review physician documentation relative to coding, which ultimately improves documentation. Review and stay on top of Medicare national and local coverage determinations (NCDs and LCDs) as well as Medicaid policies. Carefully monitor coding and billing to ensure services rendered are reported correctly.

Sincerely,

Deborah Grider,
CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPCD, CCS-P
AAPC President and CEO
Diagnostic radiology encompasses a variety of services, including diagnostic radiology (plain film), diagnostic ultrasound, computed tomography (CT), magnetic resonance imaging (MRI), diagnostic nuclear medicine, positron emission tomography (PET), and mammography. The following seven tips pertain to diagnostic radiology coding guidance as per American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and American College of Radiology (ACR) instructions, and are intended to help coders submit accurate claims during a time when imaging services are being avidly scrutinized by public and private payers. Remember that individual payer rules take priority when billing that payer. Ask for payer requirements in writing, and be sure that billing and coding staff have access to, and are familiar with, all payer rules.
Tip 1: Be Sure Reports Meet Minimum Requirements
To meet ACR guidelines, all dictated radiology reports must contain:
- Heading (study name)
- Number of views or sequences (name of views – what was done)
- Clinical indication (reason for exam)
- Body of report (findings)
- Impression or conclusion (synopsis of findings)
- Physician signature
- Diagnostic studies (plain films)

Tip 2: Separate Professional and Technical Components
Most radiology procedures include both a technical component and a professional component. As a basic requirement of radiology coding, the coder must know whether to report a technical, professional, or “global” service.

The technical component (TC) of a service includes the provision of all equipment, supplies, personnel, and costs related to the performance of the exam. To report only the technical portion of a service, append modifier TC Technical component.

There is one important exception to this rule. For services performed in a hospital, it is assumed the hospital is billing for the technical component of each study so hospitals are exempt from reporting modifier TC.

The professional component of a service includes the physician work in providing a dictated report or dictated report and supervision. To report only the physician work portion of a service, append modifier 26 Professional component. When applied, modifier 26 should be placed in the first designated modifier field because it affects how the claim will be paid.

A global service occurs when the physician both bears the expense of equipment, supplies, etc., and provides supervision and/or prepares the report. Global services generally take place in an office setting, where the physician group owns the equipment and provides the dictated reports. When reporting global services, modifiers TC and 26 are not required.

For example, if the radiologist reads a two-view chest X-ray in the hospital, you would report 71020 Radiologic examination, chest, 2 views, frontal and lateral with modifier 26. If the radiologist supplies, in his own office, the equipment on which the X-ray is performed, report 71020 without modifiers.

Tip 3: Report Only the Number of Views Documented
The number of views claimed must meet the basic requirements of the CPT® code reported. If your department or office has a list of “standard views,” or the number of views to be imaged on a patient, you cannot use it for coding purposes. The medical report must state the number of views. It is the coder’s responsibility to count the number of views and select the correct corresponding CPT® code.

For example, a knee exam may be reported using one of four CPT® codes. To report 73564 Radiologic examination, knee; 4 or more views, documentation has to substantiate four or more views. If the physician does not state “four views,” but rather documents “AP, lateral, and both obliques,” that is also acceptable documentation. If, however, the physician uses the phrase multiple views of the knee, the rules state you must report the lowest-level corresponding CPT® code for the particular study (73560 Radiologic examination, knee; 1 or 2 views).

This holds true for referring physician orders, too. If the views or the number of views are not listed in the order, the radiology office cannot impose their department standards of, for instance, four views. Instead, the radiology department or office should contact the referring physician and ask for a new order indicating the views he would like performed.

Note, however, that some diagnostic studies require specific view names. For example, if the physician dictates the number of abdomen views instead of the precise names of the views, you must report the lowest-level code (74000 Radiologic examination, abdomen; single anteroposterior view) for that service.

Tip 4: Distinguish Scout View and Contrast Studies
A scout view is a single supine view of the abdomen taken prior to gastrointestinal (GI) examinations. It may be referred to as a KUB (Kidney, Ureters, and Bladder). The physician must document that film was taken, and he must dictate any findings from the film separately.

During a single contrast study, the patient ingests a thin liquid barium sulfate contrast. A double contrast upper GI study uses a thicker (heavy density) barium sulfate and effervescent crystals taken with water. When mixed and swallowed, the patient’s
stomach fills with air or gas from the crystals. The thicker barium coats the walls of the stomach so the physician can look for ulcers, etc.

**Note:** A cervical (neck) esophagram study is bundled to single and double upper GI studies; however, if there is documented medical necessity to warrant a separate exam, the esophagus study (74210-74230) may be reported with modifier 59 *Distinct procedural service*, in addition to the upper GI studies.

When reporting barium enema (colon) study, determine if the procedure used single or double contrast. Single contrast study uses a thin mixture of barium sulfate and water instilled through a tube in the patient’s rectum. When performing a double contrast barium enema, the colon first is instilled with heavy density barium and air. During the second contrast, air is pumped into the colon to coat the walls of the bowel with the barium. Whether a preliminary abdomen KUB is performed does not change the code set.

If any one of the required anatomy is not documented, the study must be down-coded to a limited exam (76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)*).

A complete retroperitoneal study (76770 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete*) consists of documentation of the kidneys, abdominal aorta, and common iliac artery origins. Alternatively, imaging of the kidneys and urinary bladder also constitute a complete retroperitoneal study when the clinical indication for the exam consists of urinary pathology.

**Tip 6: Oral/Rectal Administration Doesn’t Count as Contrast**

Whether intravenous contrast was injected determines coding for CT and MRI. Only intravenous administration of contrast changes the code sets. Oral and/or rectal contrast is not billable as a “with contrast” study. To report contrast, the technique section of the dictated report must state, “with IV or intravenous contrast.”

**Tip 7: Don’t Forget Supplies**

Diagnostic nuclear medicine studies and PET do not include radiopharmaceuticals. Hospitals and privately-owned nuclear medicine and PET departments/offices should report the radiopharmaceutical kit separately utilizing the correct supply code(s).

Terry Leone, CPC, CPC-P, CPC-I, CIRCC, is president of AAPC’s National Advisory Board (NAB) and is a specialist in radiology coding, interventional coding and consulting. His career spans over 30 years with experience in various aspects of management, billing, and coding. Since 1996, Terry has been the principal owner and president of Catamount Associates, LLC—a physician billing company. He is the founder and past president of the Western New York Chapter at Buffalo. He is a certified instructor at Bryant & Stratton College, Rochester, N.Y. teaching Professional Medical Coding Curriculum (PMCC).

G. John Verhovshek, MA, CPC, is director of editorial development/managing editor at AAPC.
The Clinical Examples in Radiology newsletter is the easiest way to improve claims reporting and reimbursement accuracy when it comes to radiology coding. Published by the American Medical Association and the American College of Radiology, this newsletter was developed to help coding professionals understand the practical application of CPT® codes with regard to radiology coding.

Each issue of this quarterly, 12-page newsletter provides you with:

- **Clinical Examples:** Several carefully selected procedure reports dissected and annotated by nationally-recognized experts in radiology coding
- **Documentation Challenge:** A real-life radiology operative report, along with insightful and detailed commentary, will help you tackle difficult cases and provide concrete suggestions to improve procedure reporting and coding
- **Radiology Coding Q&A:** Answers to radiology coding questions submitted by newsletter subscribers
- **Self Quiz:** Test your knowledge with each issue’s radiology test case and compare your answer to the correct answer and explanation provided
- **Earn CEU credits** toward AAPC, AHIMA and RCC with online, interactive tests

Subscribers also receive two special report bulletins a year that cover ongoing code changes, brief clarifications of existing CPT codes, “hot” coding topics in radiology, and more.

Subscribe today! Visit **www.ama-assn.org/go/radiology-coding** to learn more.
The new year begins early for ICD-9-CM: Code revisions for 2011 are released and go into effect Oct. 1, 2010. Changes are relatively few and aim primarily to increase diagnostic specificity.

For instance, “disorders of iron metabolism” (275.0) are deleted and replaced by several new codes:

- **275.01** Hereditary hemochromatosis
- **275.02** Hemochromatosis due to repeated red blood cell transfusion
- **275.03** Other hemochromatosis
- **275.09** Other disorders of iron metabolism

Hemochromatosis is an iron metabolic disorder, which causes the body to absorb and store too much iron. The excess iron accumulates in the organs—most significantly the heart and the liver—and damages them. New fifth-digit classifications not only identify hemochromatosis specifically (rather than classifying it generically as a “disorder of iron metabolism”), but allow for distinction among hereditary hemochromatosis, hemochromatosis due to repeated red blood cell (RBC) transfusion, or other hemochromatosis (for instance, hemochromatosis resulting from alcoholism).

Additional examples follow the same logic, whereby a four-digit code is deleted and replaced by two or more, five-digit codes that provide greater detail.

Secondary thrombocytopenia (287.4) is deleted and replaced by:

- **287.41** Post-transfusion purpura
- **287.49** Other secondary thrombocytopenia

Other anomalies of the uterus (752.3) is deleted and replaced by:

- **752.31** Agenesis of uterus
- **752.32** Hypoplasia of uterus
- **752.33** Unicormuate of uterus
- **752.34** Bicornate uterus
- **752.35** Septate uterus

- **752.36** Arcuate uterus
- **752.39** Other anomalies of the uterus

Encounter for insertion of intrauterine device (V25.1) is deleted and replaced by:

- **V25.11** Encounter for insertion of intrauterine contraceptive device
- **V25.12** Encounter for removal of intrauterine contraceptive device
- **V25.13** Encounter for removal and reinsertion of intrauterine contraceptive device

**Note:** Previously, the routine checking, removing, and any subsequent reinserting of an IUD was coded V25.42 Surveillance of intrauterine contraceptive device.

Categories for Body Mass Index (BMI) are refined with the deletion of “BMI 40 and over, adult” (V85.4), which is replaced by five new codes:

- **V85.41** Body Mass Index 40.0-44.9, adult
- **V85.42** Body Mass Index 45.0-49.9, adult
- **V85.43** Body Mass Index 50.0-59.9, adult
- **V85.44** Body Mass Index 60.0-69.9, adult
- **V85.45** Body Mass Index 70 and over, adult

**Blood Incompatibility Categories Expand Significantly**

Extensive additions now describe more precisely blood incompatibility reactions.

A hemolytic transfusion reaction (HTR) is a reaction of increased destruction of red blood cells (RBCs) due to incompatibility between blood donor and recipient. Hemolytic transfusion reactions can be either acute (an accelerated destruction of RBCs immediately within 24 hours of a transfusion) or delayed (accelerated destruction of RBCs, usually between 24 hours and 28 days after a transfusion), and can be due to either ABO or non-ABO incompatibility.
Previously, four-digit codes 999.6 *ABO incompatibility reaction* and 999.7 *Rh incompatibility reaction* did not distinguish between ABO and non-ABO HTRs, and between acute HTRs and delayed HTRs. These codes are deleted, to be replaced by:

- **999.60** ABO incompatibility reaction, unspecified
- **999.61** ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
- **999.62** ABO incompatibility with acute hemolytic transfusion reaction
- **999.63** ABO incompatibility with delayed hemolytic transfusion reaction
- **999.69** Other ABO incompatibility reaction
- **999.70** Rh incompatibility reaction, unspecified
- **999.71** Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed
- **999.72** Rh incompatibility with acute hemolytic transfusion reaction
- **999.73** Rh incompatibility with delayed hemolytic transfusion reaction
- **999.74** Other Rh incompatibility reaction
- **999.75** Non-ABO incompatibility reaction, unspecified
- **999.76** Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed
- **999.77** Non-ABO incompatibility with acute hemolytic transfusion reaction
- **999.78** Non-ABO incompatibility with delayed hemolytic transfusion reaction
- **999.79** Other non-ABO incompatibility reaction
- **999.80** Transfusion reaction unspecified
- **999.83** Hemolytic transfusion reaction, incompatibility unspecified
- **999.84** Acute hemolytic transfusion reaction, incompatibility unspecified
- **999.85** Delayed hemolytic transfusion reaction, incompatibility unspecified

**Revisions Encourage Better Documentation**

Where codes undergo revision for 2011, code descriptors become more specific, and one or more additional, related codes are added to increase the diagnostic detail.

As an example, 724.02 is revised to specify *Spinal stenosis, lumbar region, without neurogenic claudication* (new text is underlined). Neurogenic claudication describes a syndrome associated with significant lumbar spinal stenosis, which leads to compression of the lumbar nerves (cauda equina). A new code, 724.03, has been added to report *Spinal stenosis, lumbar region, with neurogenic claudication*.

Similarly, V13.69 is revised to describe *Personal history of other (corrected) congenital malformations* (new text is underlined). Due to medical advances, many congenital conditions may be repaired and leave little or no residual condition. When a congenital condition is corrected, *Coding Guidelines* directs, “a personal history code should be used to identify the history of the anomaly.” The descriptor revision recognizes and emphasizes this directive.

Whereas V13.69 previously was a catch-all category, however, ICD-9-CM now includes seven location/system-specific codes to describe personal history of corrected congenital malformations:

- **V13.62** Personal history of other (corrected) congenital malformations of genitourinary system
- **V13.63** Personal history of other (corrected) congenital malformations of nervous system
- **V13.64** Personal history of other (corrected) congenital malformations of eye, ear, face, and neck
- **V13.65** Personal history of other (corrected) congenital malformations of heart and circulatory system
- **V13.66** Personal history of other (corrected) congenital malformations of respiratory system
- **V13.67** Personal history of other (corrected) congenital malformations of digestive system
- **V13.68** Personal history of other (corrected) congenital malformations of integument, limbs, and musculoskeletal system

Report “other” code V13.69 only if a more precise location/system is unknown or not specified.

**All-New Codes**

**Describe Multiple Gestation, Ectasia, and More**

Among the “all new” changes for 2011, the most significant is the creation of new category V91. Birth defects and loss of fetuses is closely linked to the number of placenta and amniotic sacs present during fetal development (thus, the risk of complications is higher and the treatment plan may differ depending on these same factors). Category V91 allows tracking and reporting of the number of placenta and amniotic sacs for multiple gestation pregnancies:

- **V91.00** Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs
- **V91.01** Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)
- **V91.02** Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)
- **V91.03** Twin gestation, dichorionic/diamniotic (two placenta, two amniotic sacs)
- **V91.09** Twin gestation, unable to determine number of placenta and number of amniotic sacs
- **V91.10** Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs
Where codes undergo revision for 2011, code descriptors become more specific, and one or more additional, related codes are added to increase the diagnostic detail.

V91.11 Triplet gestation, with two or more monochorionic fetuses
V91.12 Triplet gestation, with two or more monoamniotic fetuses
V91.19 Triplet gestation, unable to determine number of placenta of placenta and amniotic sacs
V91.20 Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs
V91.21 Quadruplet gestation, with two or more monochorionic fetuses
V91.22 Quadruplet gestation, with two or more monoamniotic fetuses
V91.29 Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs
V91.90 Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs
V91.91 Other specified multiple gestation, with two or more monochorionic fetuses
V91.92 Other specified multiple gestation, with two or more monoamniotic fetuses
V91.99 Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs

All-new codes also are created to describe ectasia, a weakening (with some dilation) of the aortic wall:

447.70 Aortic ectasia, unspecified site
447.71 Thoracic aortic ectasia
447.72 Abdominal aortic ectasia
447.73 Thoracoabdominal aortic ectasia

Although distinct from aneurysm, ectasia previously was reported using 441.9 Aortic aneurysm, unspecified (thereby explaining why the new codes were necessary).

Other new codes effective on Oct. 1 include:

560.32 Fecal impaction
(Previously reported with 560.39 Other impaction of intestine.)
784.92 Jaw pain
(Previously reported with 526.9 Unspecified disease of the jaws.)
E000.2 Volunteer activity
(Previously reported with E000.8 Other external cause status.)

Military Requests Drive Several Additions
The Department of Defense (DoD) proposed a new code for history of combat and operational stress reaction (COSR) in 2008. For 2011, an inclusion term for combat and operational stress reaction is added in category 308 Acute reaction to stress.

With this change, V11.4 Personal history of combat and operational stress reaction is accommodated. The personal history code provides the capability of tracking patients who later have symptoms related to having had COSR.

The DoD also requested new codes for embedded fragment status. Injuries from explosions often include fragments or splinters from the explosive device, which become embedded in the injured person. Sometimes these cannot be removed, and noting them is important—for instance, because an embedded magnetic object may contraindicate magnetic resonance imaging (MRI) exam, or because embedded fragment(s) (such as those composed of lead) pose long-term health risks.

V90.01 Retained depleted uranium fragments
V90.09 Other retained radioactive materials
V90.10 Retained metal fragments, unspecified
V90.11 Retained magnetic metal fragments
V90.12 Retained nonmagnetic metal fragments
V90.2 Retained plastic fragments
V90.31 Retained animal quills or spines
V90.32 Retained tooth
V90.33 Retained wood fragments
V90.39 Other retained organic fragments
V90.81 Retained glass fragments
V90.83 Retained stone or crystalline fragments
V90.89 Other specified retained foreign body

Although this category is useful primarily for the military, the codes are applicable to any injury resulting in embedded fragments. The codes do not, however, apply to or overlap with internal medical devices.

Go to the Source for More Information
The above covers many of the most significant changes to ICD-9-CM for 2011, but is not an exhaustive listing. The final addendum providing complete information on changes to the diagnosis part of ICD-9-CM is posted on Centers for Disease Control and Prevention’s (CDC’s) webpage at: www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm#addenda. Scroll to the bottom of the page to find the 2010 Addenda, which are available as downloadable PDF files, in either tabular or index form.

Additional ICD-9-CM changes subsequently released as addenda or errata will be posted on the AAPC website: www.aapc.com.

G. John Verhovshek, MA, CPC, is director of editorial development/managing editor at AAPC.
Superior ICD-9-CM products developed by coding professionals and industry experts with more than 40 years of combined coding experience

- **Design improvements for increased functionality and readability** include lighter weight paper, new dictionary-style headings, vivid colors, prominent black strike-through deleted information and more!
- **Full-color coding tables** simplify complex coding issues and speed code searches
- **Official Guidelines for Coding and Reporting (OGCR)** listed in the front matter and again within the codes to which they refer for fast, easy access to coding rules
- **Intuitive color-coded symbols, icons and annotations** easily identify codes that require important coding criteria including age and sex edits, reimbursement edits, additional digit, manifestation, code first, omit and others throughout, helping to ensure accurate reporting
- **Detailed disease explanations** provide more information on common diseases and conditions, helping you code more effectively
- **American Hospital Association's (AHA) Coding Clinic for ICD-9-CM** references throughout help you find expanded information about specific codes and their usage
- **Coding Tips and Notes** developed by coding experts define terms and provide additional coding instruction to aid in understanding difficult terminology, diseases and conditions, and coding in a specific category
- **Companion ICD-9-CM Web site** features access to the latest code updates, ICD-9-CM to ICD-10-CM crosswalk—new for 2011, MS-DRG information and more

AMA ICD-9-CM coding resources—your foundation for coding success.

For more information or to order today go to: [www.amabookstore.com](http://www.amabookstore.com) or call (800) 621-8335.
Wisely Choose Between Modifier 25 and Modifier 57

E/M coding can be difficult enough without throwing a modifier monkey wrench into the mix.

By Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC

A participant in an online coding discussion board to which I belong recently posted a question regarding the appropriate use of modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, versus that of modifier 57 Decision for surgery. After years of taking part in such forums, attending coding conferences, and serving as a coding consultant, I’ve heard the same question dozens of times, and I always respond the same way.
Determine First: Major or Minor Procedure?

Both modifiers 25 and 57 apply to evaluation and management (E/M) service codes only, and both allow the provider to report an E/M service separately with another procedure or service. For most payers, the distinction between the two modifiers depends on the nature of other, non-E/M service(s) reported.

- **Modifier 57** applies when an E/M service results in the initial decision to perform a major procedure, which usually is defined as a procedure with a 90-day global surgical period.
- **Modifier 25** applies when the provider performs a significant, separately identifiable E/M service on the same date as a minor procedure/service. A minor procedure/service has a global period of fewer than 90 days (for instance, 10 days or zero days).

The concept of major and minor procedures derives not from CPT®, but from the Centers for Medicare & Medicaid Services’ (CMS) Physician Fee Schedule Relative Value File, which assigns a global period for all CPT® and HCPCS Level II codes. CPT® (Appendix A – Modifiers) states only that modifier 25 applies when the significant, separately-identifiable E/M service occurs on the day of a procedure or service; whereas modifier 57 applies when an E/M service results in the “initial decision to perform the surgery.” CPT® does not, however, precisely define “procedure,” “service,” or “surgery,” or assign global days for any of these categories.

If your payer isn’t Medicare, ask for further guidance. The major and minor procedure designations apply definitively only for Medicare and those payers who follow CMS guidelines expressly. Third-party payers often follow CMS in this regard, but may designate their own rules. For example, in defiance of CMS (and CPT®) instruction, Florida Medicaid does not recognize modifier 57 and instead calls for modifier 25 anytime an E/M service and another procedure or service are reported together. The advice I give here assumes a payer follows CMS guidelines; for other payers, inquire specifically as to the rules for applying modifiers 25 and 57 and get those specific payer instructions in writing.

**Modifier 57 Parameters**

To apply modifier 57, the E/M service must have led to the decision to perform the major procedure that follows. For example, if surgery was scheduled June 17 and the surgeon sees the patient again the day of the surgery, June 25, do not report a separate E/M with modifier 57 for the encounter on June 25 because the decision for surgery was not made at that visit. Rather, the June 25 visit is bundled into the surgical package.

In contrast, if a patient presents with a burst appendix and the decision for appendectomy is made immediately, the E/M service (for example, 9928x) with modifier 57 appended may be billed separately with 44970 Laparotomy, surgical, appendectomy.

Note that the global period for all major procedures begins one day prior to the actual procedure; so, if the decision for surgery occurs one day prior to the surgery, you may report that E/M service separately with modifier 57.

For example, a surgeon is following an inpatient with an obstructed colon. On day five, the surgeon decides that if the obstruction does not resolve by the next day, the patient will be brought to surgery for an exploratory laparotomy (and perhaps more extensive surgery). Based on this, the day-five visit (9923x) may need to be reported with modifier 57, if the surgeon decides to perform surgery on the following day. The surgeon should not report the service until day six, when he’s certain whether the laparotomy will occur. If the service is reported without modifier 57, and surgery does occur on day six, the day-five E/M service will be bundled inappropriately into the laparotomy (or more extensive surgery).

If the obstruction begins to resolve on day six, and laparotomy is not required, the day-five visit (9923x) may be reported without modifier 57, and the day-six evaluation also may be reported.

**Modifier 25 Parameters**

Because all minor procedures include an E/M component, you get paid separately for an E/M service with a minor procedure only if the E/M service is “significant and separately identifiable.” Here are three conditions when this happens:

**1. There is a different diagnosis for the E/M and the procedure.** The two diagnoses may be related (i.e., a sign or symptom diagnosis for the E/M and a definitive diagnosis for the procedure). The E/M results in a decision to perform the procedure, either diagnostic or therapeutic.

For example, a patient goes to an orthopedist complaining of shoulder pain. The orthopedist works up the patient, performing a complete history, exam, and medi-
If documentation indicates the physician was unable to ascertain the condition of a “bullet,” but findings then are documented via a diagnostic procedure, you can get credit on both the E/M exam section and the procedure. Be able to identify these distinct parts in the chart.

For example, a patient visits her primary care physician to follow up on hypertension and diabetes. The internist performs a history, exam, and MDM for the chronic conditions. After the E/M service has been completed, and the care plan has been reviewed, the patient says to the doctor, “Oh, by the way, can you look at this lump on my back?” The physician examines the mass and decides to perform a biopsy. The encounter for the day will include an E/M with modifier 25 for hypertension and diabetes. The minor procedure, 11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion also is billed, with the diagnosis of 782.2 Localized superficial swelling, mass or lump.

**Keep E/M, Procedure Notes Separate**

Whenever modifier 25 is used, the documentation must contain a separate history, exam, and MDM, apart from the procedure note. If findings are indicated on the procedure note, you cannot count it towards the exam portion of the E/M. If documentation indicates the physician was unable to ascertain the condition of a “bullet,” but findings then are documented via a diagnostic procedure, you can get credit for both the E/M exam section and the procedure. Be able to identify these distinct parts in the chart.

Note, as well, that (unlike modifier 57) modifier 25 applies only if the E/M service and separate procedure occur on the same day.

For example, a patient comes in on Monday and the physician performs an E/M service. Because there is limited room in the schedule, the physician cannot excise a lesion that is identified “of suspicious nature.” The patient is scheduled to come back Tuesday to have the lesion removed. Because the E/M took place on Monday, and the lesion removal (a minor procedure that includes an E/M on the day of the procedure only) took place on Tuesday, there is no need to append modifier 25 to Monday’s E/M service code.

2. A procedure lacks a specific, separate diagnosis.

Medicare guidelines state specifically there is no requirement for separate and distinct diagnoses for an E/M with modifier 25 and a same-day procedure. See CMS Transmittal 954, issued May 19, 2006 (Medlearn Matters MM5025, Change Request (CR) 5025): “The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.”

For instance, the E/M service may be linked to a sign or symptom, and a same-day minor diagnostic procedure results in no definitive finding. As such, the sign or symptom also is linked to the procedure. Once again, the E/M service led to the decision to perform the procedure.

As an example, a physician sees a patient who is complaining of recurring hoarseness. During the patient workup (including a history, exam, and MDM for the hoarseness), the physician finds he cannot visualize adequately the larynx via mirror exam, due to gag reflex. He then performs a flexible laryngoscopy (31575 Laryngoscopy, flexible fiberoptic; diagnostic), but ultimately finds no reason for the hoarseness. In this case, both the E/M (with modifier 25) and the flexible laryngoscopy should be reported, and may be linked to the same sign and symptom diagnosis (hoarseness).

3. An “Oh, by the way” scenario. This is when a patient comes in for one problem for which the E/M is performed and just before leaving the patient states, “Oh, by the way, can you look at my …” This may result in the performance of a minor procedure that is totally unrelated to the original reason for the visit and the diagnosis for the E/M service and the minor procedure is entirely unrelated.
Evaluation and Management coding can be challenging for all coders. E/M is the most commonly coded professional service and can often be the most confusing. There are so many hurdles to overcome from documentation deficiencies, EMR over-documentation, medical necessity and giving the appropriate credit for the elements for the key components. Not only are there two sets of guidelines to choose from, but coders also need to know the variations of the documentation guidelines according to the MAC in their region.

Coders need to know the resources available to them to make confident decisions for the gray areas in E/M code selection. Navigation of the online resources available from CMS and MACs can provide the answers needed to select a code with confident and know the E/M level will stand up to any audit.

This workshop will help you:

- Translate the documentation requirements for the 1995 and 1997 E/M Documentation Guidelines
- Maneuver through the variations of documentation requirements for E/M specific for your MAC
- Identify compliance hot spots regarding E/M and know what you must do to avoid them
- Learn how to use E/M modifiers with confidence
- Know where to look and how to navigate to the right answer

Register at www.aapc.com/complianceworkshop
Arthroscopic Gems:
Hints for Accurate Coding

Look at three general principles, your understanding of anatomy, and AMA guidance for each joint.

By Denis Rodriguez, CPC, CCS, CIRCC, CASCC

Arthroscopy refers to less invasive procedures in which an endoscope is placed within the joint for the performance of diagnostic and therapeutic procedures. As technology advances, procedures previously performed through large incisions are now performed arthroscopically. To accommodate this emerging technology, new arthroscopy, CPT® Category III codes, and HCPCS Level II codes, have been added over the past few years.

There are three general principles of arthroscopic coding:

1. If a procedure is started arthroscopically and finished open, it is coded using the open procedure code only. In such a case, assign diagnosis code V64.43 Arthroscopic surgical procedure converted to open procedure to report the arthroscopic component.

For example, a patient presents with intra-articular fracture of the distal radius. The surgeon attempts arthroscopic reduction of the fracture fragments after synovial debridement for visualization. The surgeon finds the fragments are not sufficiently mobile for arthroscopic reduction, and converts to an open reduction and internal fixation of the three distal radial fragments. CPT® coding is 25609 Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments. The arthroscopic attempt at reduction and synovectomy for visualization is included in the open completion of that procedure, as indicated by V64.43, which also is reported.

2. Seven CPT® codes describe arthroscopically aided procedures. This means that even though part of the procedure is performed open, the arthroscopic procedure codes should be assigned. The codes are:
   - 29850 Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)
   - 29851 with internal or external fixation (includes arthroscopy)
   - 29855 Arthroscopically aided treatment of tibial fracture, proximal (plateau); unicondylar, includes internal fixation, when performed (includes arthroscopy)
   - 29856 bicondylar, includes internal fixation, when performed (includes arthroscopy)
   - 29888 Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
   - 29889 Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
   - 29892 Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy)

3. Diagnostic procedures for each arthroscopic code family are included in any surgical procedures performed from that same family. The families are:
   - temporomandibular (29800-29804)
   - shoulder (29805-29828)
   - elbow (29830-29838)
   - wrist (29840-29847)
   - hip (29860-29863)
   - metacarpophalangeal joints (29900-29902)

Within these families, the initial code describes the diagnostic procedure and subsequent codes describe surgical procedures. The code families for the ankle (29891-29899) and the subtalar joints (29904-29907) do not contain diagnostic codes.
The knee is a hinged joint and ... is composed of three compartments: medial, lateral, and patellofemoral. The compartment coding concept is important for coding arthroscopic procedures in the knee accurately.

**Note:** Two codes in this section (29848 Endoscopy, wrist, surgical, with release of transverse carpal ligament and 29893 Endoscopic plantar fasciotomy) are not technically arthroscopies (that is, they are not endoscopies within a joint), but rather are musculoskeletal endoscopies.

Although these general rules always apply, due to the unique nature of the different joints, many arthroscopy rules are specific to each joint, as shown here:

**Shoulder**

Shoulder arthroscopy codes encompass two joints in the shoulder area: the glenohumeral joint (typically called the shoulder joint) and the acromioclavicular joint. The acromioclavicular joint is the smaller of the two and there are arthroscopy codes specific to it; excision of the distal clavicle, 29824 Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure) and decompression of the subacromial space, 29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release, which includes partial excision of the acromion or acromioplasty.

Arthroscopic debridement of the labrum and of the undersurface of the rotator cuff (29822 Arthroscopy, shoulder, surgical; debridement, limited) may be reported separately when performed with subacromial decompression (29826), according to the May 2001 CPT® Assistant. Per the same edition, Subacromial decompression includes acromioplasty, arch decompression, excision of bursa, and coracoacromial ligament release.

Open procedures 23410, 23412, and 23420 differentiate between whether the tear is acute or chronic or how many tendons are repaired. The arthroscopic code for rotator cuff repair (29827 Arthroscopy, shoulder, surgical; with rotator cuff repair) makes no such distinctions, and can be reported whether the tear is acute or chronic; whether one, two or three tendons are repaired, or; whether one or more portals is required to repair the cuff (February 2008 CPT® Assistant).

Often the surgeon will perform a biceps tenotomy (i.e., tendon release) via arthroscopy, and then perform a tenodesis via an open procedure. In such cases, the code for open biceps tenodesis (23430 Tenodesis of long tendon of biceps) is most appropriate. Only assign the code for arthroscopic biceps when the tenodesis portion of the procedure is performed via arthroscopic.

Arthroscopic capsular shrinkage (i.e., thermal capsulorhaphy) is at times used to treat joint instability. For

**Knee**

The knee is a hinged joint and, per the American Medical Association (AMA), is composed of three compartments: medial, lateral, and patellofemoral. The compartment coding concept is important for coding arthroscopic procedures in the knee accurately.

The code for arthroscopic abrasion arthroplasty, multiple drilling and/or microfracture (29879 Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture) may be coded per compartment so you should code microfracture of both medial and lateral femoral condyles as 29879, 29879-59

**Distinct procedural service.**

As the descriptor states, chondroplasty (29877 Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)) is included in 29879 when chondroplasty is performed in the same compartment. However, a chondroplasty performed in a separate compartment may be reported separately to 29877-59 (August 2001 CPT® Assistant).

For Medicare, G0289 Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee may be reported once for a chondroplasty and/or loose body removal performed in each compartment where it is the only procedure performed. In contrast to 29879, report code 29877 only once per knee, regardless of the number of the compartments in which it is performed (December 2005 CPT® Assistant).

An often overlooked code is 29884 Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure), which may be assigned for excision of fibrosis/adhesions/scar due to previous procedures or injuries. Debridement of cyclops lesions after total knee replacement(s) is a common condition for which arthroscopic lysis of adhesions is performed. Code 29884 is considered to be included in any other major arthroscopic procedure performed in the knee, regardless of whether it is performed in a separate compartment.
When synthetic plugs are used for osteochondral grafting of the knee (i.e., mosaicplasty), 29867 Arthroscopy, knee, surgical; osteochondral allograft (eg, mosaicplasty) may be assigned, even though the descriptor refers to allograft, per the December 2008 CPT® Assistant. The same, however, does not apply for the ankle. Rather than assign code 29892 Arthroscopically aided repair of large osteochondritis dissecans lesion, talar dome fracture, or tibial plafond fracture, with or without internal fixation (includes arthroscopy) for placement of synthetic material, report unlisted code 28899 Unlisted procedure, foot or toes.

Wrist

In contrast with knee arthroscopies, compartments do not matter for wrist arthroscopies. For example, 29846 Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement includes a synovectomy (29845 Arthroscopy, wrist, surgical; synovectomy, complete), regardless of whether the synovectomy was performed in a separate compartment (CPT® Assistant, December 2003).

Ankle

Note that CPT® does not have an arthroscopic complete synovectomy code for the ankle. A total synovectomy is not anatomically possible because it would cause dislocation of the joint. When synovium is debrided from the medial and lateral aspects of the ankle, report a partial arthroscopic synovectomy (29895 Arthroscopy, ankle (tibiotalar and talibulotalar joints), surgical; synovectomy, partial), according to CPT® Assistant, December 2008.

Coding arthroscopies can be challenging; however, with a good understanding of anatomy and with applying AMA’s guidance for each joint, you can code with accuracy.

Denis Rodriguez, CPC, CCS, CRCC, CASCC, is senior ambulatory surgery center (ASC) coder and compliance auditor for The Coding Network, LLC. He has 20 years experience in the medical field, the last eight of which have been spent exclusively in ASC coding, auditing, and education.
Medicare Reimbursement?
We Understand You Are Looking For Answers.

You know the information is out there. But where? The Centers for Medicare & Medicaid Services can help. We developed the Medicare Learning Network®, the source for a variety of educational products and resources — many focused on helping reimbursement specialists submit claims correctly the first time. And all at no cost to you. Look us up. There’s an answer waiting for you on our website.

Please visit us at http://www.cms.gov/MLNGenInfo
Can you believe it’s time to order 2011 coding books?

AAPC MEMBERS SAVE 25% – 50% ON ALL PMIC PUBLICATIONS!

Order Today and Get a Reward Card Worth up to $100

1-800-MED-SHOP pmiconline.com
Construct Your CAREER One Skill at a Time

Enroll in AAPC’s Medical Billing and Reimbursement Course today.

AAPC’s medical billing and reimbursement course is a great way to enhance your coding expertise. For more information visit www.aapc.com/billingcourse
Teaching physicians provide a valuable service training resident physicians preparing to join the ranks of practicing physicians. A physician who provides services to Medicare patients as a teaching physician with residents in an academic setting must follow specific Centers for Medicare & Medicaid Services (CMS) guidelines when billing for these services.

According to guidelines published in the Medicare Claims Processing Manual, internet-only manual, Pub. 100-04, chapter 12, section 100 (www.cms.gov/manuals/downloads/clm104c12.pdf), a teaching physician may receive Medicare payment if:

1. An evaluation and management (E/M) service is provided by a resident with the teaching physician physically present for the critical or key portion of the service; or
2. Certain E/M services are provided by the resident in a primary care exception clinic.

In the teaching setting, E/M services are typically provided to patients in one of the following scenarios:

1. The teaching physician performs the complete service without a resident. The resident may or may not have provided the service independently;
2. The resident performs the service in the presence of or jointly with the teaching physician; or
3. The resident performs the service without the teaching physician who later independently performs the critical or key portion of the service.

Teaching Physicians Must Take Part in Care

For payment purposes, the teaching physician must document that he or she performed the service, or physically was present during the key or critical portion of the service provided by the resident, and that he or she participated in the management of the patient. Documentation must be dated and include a legible signature or identity.

The teaching physician must document his or her physical presence and participation in the patient’s care; the resident’s documentation may not be used to establish the teaching physician’s presence and/or participation in the patient’s care. For auditing purposes, the resident’s documentation may be combined with the teaching physician’s documentation to determine the care level for billing and to establish medical necessity.

An example of minimally acceptable documentation described in the CMS manual includes: “I saw the patient with the resident and agree with the resident’s findings and plan.” This statement clearly and concisely establishes the presence of the teaching physician and links to and confirms the information documented by the resident.

Examples from the manual of unacceptable documentation include these phrases: “Agree with above,” “Seen and agree,” or even a resident note followed by the teaching physician’s counter-signature. According to the manual, none of these examples make it clear that the teaching physician was present, evaluated the patient, or had involvement in the care plan.

Frequently, medical students are incorporated in patient care in teaching settings. CMS does not allow any documentation by a medical student—except for a past, family, and social history and a review of system (ROS) (documentation anyone may document in a record)—to be used for billing purposes. Although medical students’
documentation may be clinically appropriate, anything (except for the above exclusions) documented by or referenced in a medical student's note must be re-documented for billing and auditing purposes.

Teaching physicians may bill for certain services provided by residents in a setting granted as a primary-care exception. In this setting, the resident may see patients and the teaching physician may bill for lower and mid-level E/M services without the presence of the teaching physician. The specific CPT® codes appropriate for primary care exception billing include new patient codes 99201, 99202, and 99203, and established patient codes 99211, 99212, and 99213 (see infobox "Does IPPE Allow for Primary Care Exception?"). For the primary care exception to apply, the center must attest in writing that particular criteria outlined in the Medicare Claims Processing Manual are met.

Documentation to support the services of the teaching physician may be dictated and typed, handwritten, or computer-generated. CMS specifically allows the use of macros with an electronic health record (EHR). A macro is a command in a computer generating a pre-determined text that is not edited by a user. This macro, when personally added in a secure, password-protected system may serve as the required teaching physician’s personal documentation. These macros should be developed by the teaching physician in the presence of a compliance person to assure that the macros satisfy Medicare’s teaching physician documentation and attestation guidelines. Best practice would be to design a macro statement mirroring verbatim one of the acceptable examples provided in the carrier’s manual.

Billing for services based on time (e.g., critical care or prolonged care), must be based on the time the teaching physician was present with the patient, either alone or with the resident. Time the resident spent alone with the patient is not billable for time-based codes.

Apply Modifiers GC, GE as Necessary

Medicare contractors may require services provided by a teaching physician to be billed with an informational HCPCS Level II modifier. Modifier GC This service has been performed in part by a resident under the direction of a teaching physician indicates the service was provided by a teaching physician in collaboration with a resident. Modifier GE This service has been performed by a resident without the presence of a teaching physician under primary care exception indicates the service was provided in a primary care exception clinic.

Assure E/M Compliance for Teaching Physicians

Health care reform is focusing on fraud and abuse, and audits are a necessary part of controlling it. Reimbursement for care teaching physicians provide to the Medicare population is legitimate, but federal guidelines for documenting services must be followed to assure teaching physicians are paid appropriately. As an auditor reviewing services provided by teaching physicians, I have seen many variations of acceptable and unacceptable teaching physician documentation and have also seen no teaching physician statement. I have found the most common error is the omission of a reference or link to the resident’s documentation.

Does IPPE Allow for Primary Care Exception?

Along with E/M services 99201-99203 and 99211-99213, Chapter 12, Section 100.1.1.C of the Medicare Claims Processing Manual allows that, effective Jan. 1, 2005 an initial preventive physical exam (IPPE) as reported by G0344 is included under the primary care exception (PCE). Code G0344 was deleted as of Jan. 1, 2009 to be replaced by G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment. The most recent Medicare Manual reference does not reflect the change, however, and I am awaiting a clarification from my carrier on the code payable for the IPPE in a PCE clinic. Those readers who wish to report the IPPE as a primary care exception also should seek clarification from their carrier.
In recent years, minimally-invasive gynecological procedures have become more widely available and increasingly popular with surgeons and patients. Minimally-invasive techniques offer various advantages over traditional open surgery, including faster recovery and fewer complications. Such techniques not only differ clinically from their traditional equivalents, but also require unique, dedicated CPT® coding.

**Hysteroscopy**

A hysteroscope is a thin, telescope-like device that contains a small camera, which is inserted through the vagina and into the cervical os (opening of the cervix) to gain entry into the uterine cavity. Diagnostic hysteroscopy—for instance, to investigate abnormal uterine bleeding—should be reported with CPT® code 58555 *Hysteroscopy, diagnostic (separate procedure).*

Hysteroscopy also may be used to perform therapeutic procedures. For instance, if a biopsy is obtained or a polyp removed, either with or without dilatation and curettage (D&C), during a hysteroscopy, report 58558 *Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C.* Additional surgical hysteroscopy procedures include:

- **58559** Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
- **58560** Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)
- **58561** Hysteroscopy, surgical; with removal of leiomyomata (fibroid)
- **58562** Hysteroscopy, surgical; with removal of impacted foreign body

Remember that surgical laparoscopy/hysteroscopy procedures always include diagnostic laparoscopy/hysteroscopy so if it was necessary to perform a surgical intervention during a diagnostic procedure, you would report only the surgical hysteroscopic code. For instance, if during a diagnostic hysteroscopy for evaluation of abnormal or postmenopausal bleeding, a polyp/submucous or grade 1 leiomyoma is identified and removed, you would report only 58561.

**Endometrial Ablation**

Endometrial ablation is an alternative to hysterectomy to treat irregular uterine bleeding. There are several methods available, all performed via hysteroscope and with the common goal to remove or ablate the uterine lining:

- Gynecare Thermachoice® uses a small, silicone, fluid-filled balloon inserted into the uterus, which is heated gently.
- NovaSure® uses a slender surgical device inserted through the cervix into the uterus to deliver electrical energy.
- The Hydro ThermAblator® System (HTA® System) circulates a heated saline solution.

Regardless of which system the surgeon chooses, report endometrial ablation using 58563 *Hysteroscopy, surgical; with endometrial ablation (eg. endometrial resection, electrosurgical ablation and thermoablation).*

Maximize Coding for Minimally Invasive Ob/Gyn Surgeries

**Keep coding current for the newest gynecological surgery techniques.**

By Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC
Hysteroscopic Sterilization
As an alternative to laparoscopy sterilization, two procedures for fallopian tube cannulation—Essure® and Adiana®—are available. Using either method, inserts are placed via hysteroscope just inside the fallopian tube. This stimulates tissue growth in the body, and scar tissue that is formed around the inserts occludes the tube. This is reported 58565 Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants, with ICD-9 code V25.2 Admission for interruption of fallopian tubes or vas deferens. If performed in the office setting, the HCPCS Level II supply code is A4264 Permanent implantable contraceptive intratubal occlusion device(s) and delivery system.

Laparoscopic Sterilization
Laparoscopic sterilization is a minimally-invasive alternative to abdominal hysterectomy. Correct billing and coding depends on knowing how these different procedures are performed. The procedures may be classified as:

- **Total laparoscopic hysterectomy (TLH):** When a total hysterectomy is performed with only the assistance of a laparoscope, the uterus, adnexa, and cervix are morcellized and removed through endoscopic tools, and the vaginal cuff is repaired endoscopically. This procedure is reported using CPT® code range 58570-58573. Code selection depends on uterine weight and if the tubes and ovaries were removed, as shown in Table A.

- **Laparoscopy with vaginal hysterectomy (LAVH):** If the provider uses the laparoscope to perform the initial operative portion of a vaginal hysterectomy (where the uterus is detached from surrounding upper supporting tissue) and then completes the hysterectomy vaginally, apply 58550-58554. Code selection depends on uterine weight and if the tubes and ovaries were removed, as shown in Table A.

- **Laparoscopic supracervical hysterectomy (LSH):** A laparoscopic hysterectomy where the cervix is preserved is called a supracervical hysterectomy. The uterus, tubes, and ovaries are removed using the laparoscope. Coding from 58541-58544 depends on uterine weight and if the tube(s) and/or ovary(s) are removed, as shown in Table A.

Laparoscopic hysterectomy is a minimally-invasive alternative to abdominal hysterectomy. Correct billing and coding depends on knowing how these different procedures are performed.

For example: During diagnostic laparoscopy for pain, a stage four endometriosis is found in a patient who has completed childbearing. The decision is made to eradicate the endometriosis by performing a TLH/BSO. The appropriate code would be either 58571 (uterine weight of less than 250 g) or 58573 (more than 250 g). Modifier 22 Increased procedural service could be appended for extensive lysing of adhesions, if documentation supports significant additional time and/or effort.

Robotic Surgery
Robotic surgery represents the newest category of minimally-invasive surgery. The daVinci® system lets a surgeon sit at a computer console to control arms that move over the patient according to the surgeon’s commands, thereby accomplishing a laparoscopic procedure robotically.

No separate CPT® code describes robotic surgery. Rather, you should code as if the physician were doing a standard laparoscopic procedure. For those payers who accept HCPCS Level II codes, you additionally may report S2900 Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure). There is no additional reimbursement for the physician using a robotic system, by Medicare or the majority of commercial carriers.

Table A: Laparoscopic Hysterectomies Quick Coding Chart

<table>
<thead>
<tr>
<th>TLH procedures</th>
<th>LAVH procedures</th>
<th>LSH procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uterus 250 g or less:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58570 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;</td>
<td>58550 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;</td>
<td>58541 Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;</td>
</tr>
<tr>
<td>58571 ... with removal of tube(s) and/or ovary(s)</td>
<td>58552 ... with removal of tube(s) and/or ovary(s)</td>
<td>58542 ... with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td><strong>Uterus 250 g or more:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;</td>
<td>58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;</td>
<td>58543 Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;</td>
</tr>
<tr>
<td>58573 ... with removal of tube(s) and/or ovary(s)</td>
<td>58554 ... with removal of tube(s) and/or ovary(s)</td>
<td>58544 ... with removal of tube(s) and/or ovary(s)</td>
</tr>
</tbody>
</table>

Kerin Draak, MS, RN, WHNP-BC, CPC, CEMC, COBGC, has worked in health care for more than 18 years. She has more than 11 years of clinical experience in women’s health, and was coding educator for a 220-plus multispecialty clinic since 2004. She is the president for her local AAPC chapter, and a member of AAPC’s National Advisory Board (NAB). She was a presenter for the Wisconsin Medical Society’s 2007 and 2008 Annual Symposiums, and has conducted several audio and day seminars on its behalf. She spoke at AAPC national conferences in 2008, 2009, and 2010.
Claim Scrubbers Are Not Infallible

Strong billing skills trump computer-assisted functions.

By Dorothy Steed, CPC-H, CHCC, CPC-I, CPUM, CPUR, CPHM, CCS-P, CEMC, CFPC, ACS-OP, RCC, RMC, PCS, FCS, CPAR, CPMA

Electronic billing systems usually have built-in claim scrubber edits that prompt the biller to enter information to the claims. Although this can be helpful, these edits are computer-assisted functions and do not take the place of strong billing skills.

How Claim Scrubbers Function
Various billing software vendors offer packages to providers. These systems are designed to review the information on the claim and search for inconsistencies and missing information. Some systems are more sophisticated than others, but all usually function in a similar manner.

In most cases, each payer requires certain specific entries to the claim to pass their internal claims processing edits. As a result, it is very difficult for any one billing system to edit entirely for all payers. Unless the biller is utilizing direct data entry specific to that payer, such as the Fiscal Intermediary Standard System (FISS) for Medicare facility billing, the system may not edit completely. Some electronic systems allow the provider to implement certain payer edits, while others may require the provider to request edits from the vendor. Most systems connect with a clearinghouse that distributes the claims to the specific payers.

Resist Claim Scrubber Misconceptions
Several disturbing misconceptions have emerged regarding electronic claims and scrubber software.

• Providers should not assume the scrubber will eliminate the need for quality billing skills. The biller should be well trained and knowledgeable about multiple payer requirements. Regardless of whether the system prompts the biller for certain entries, it is essential for the biller to recognize certain claims requirements, such as number of units, appropriate modifier usage, and suitable matches of information. Claims submitted with inappropriate edits cause claim rejection.

• Successful resolution of rejected claims still requires the biller to understand the reasons for the rejection, and know what steps are necessary to correct the claim. Most consultants and auditors have encountered multiple instances of rejected claims backlog that are not being worked on due to inexperienced billers and lack of knowledge about payer requirements. Staff members who do not possess adequate billing and coding knowledge are not likely to resolve these problems within the payer time limit for correction and/or appeal. Often, this involves very significant revenue dollars. When discussing this issue with providers, it is not unusual to receive the response, “We followed the system edits, but the payer still rejected the claim.” Remember: Repeat submission of erroneous information may be deemed billing abuse and trigger a payer audit.
Medical billing and coding is a hot industry attracting attention as a relatively stable market with significant growth potential. I have received a number of inquiries from the general public about employment opportunities. More than a few have said they were advised by “someone already in the field that it is not necessary to receive training because the computer will tell you what to enter.” I always respond that this is a gross misconception, and that most providers would require training and demonstrated skills.

Common Problem Areas to Watch

Ineffective modifier reporting can result from lack of understanding about payer processing edits. For example, when two modifiers are required, some payers allow reporting of the service code one time, with both modifiers on the same line. Other payers may want the service code reported on two separate lines with the specific modifier appended to each line.

As an example, when reporting left knee arthroscopy with medial meniscectomy, professional component only, your payer may allow 29881-26, LT Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving) – Professional component, Left side on the same line, or may require 29881-26 on one line and 29881-LT on a second line.

As another example, bilateral services may be reported with modifier 50 Bilateral procedure, or on two separate lines with LT and RT Right side on each line. Both are correct; it is just a matter of knowing your payer’s system edits.

Poor understanding of National Correct Coding Initiative (NCCI) edits may be another problem for billers lacking fundamental experience. An effective claim scrubber should prompt for review of the services and whether both should be reported—but the biller will need to determine whether there is an unbundling issue or whether both can be reported with a correct modifier.

There may be situations when two separate errors override each other and the claim scrubber may fail to edit for either problem. A well-trained biller should review the information on the claim and determine whether it is complete and error free.

Providers should never remove multiple edits from the claim scrubber to “get claims out the door.” Edits will occur in the payer’s processing system and result in multiple claims rejections.

There may be occasions when the claim scrubber will flag for information changes when the claim is correct. These issues should be resolved with the billing software vendor.

Training Trumps Computing

When training a new biller, it can be very advantageous to have that person work rejected claims. He or she will see the reasons why claims were not paid, how different payers require data to be submitted, and how to avoid those same errors on initial claims.

Some of the better skilled billers I’ve worked with have developed the ability to “think like the payer.” Does the claim make sense as submitted? If not, why would it be paid? This thought process can go a long way in avoiding claims rejections, delays, and requests for additional information.

The bottom line is this: You may use claims scrubbers for their intended purpose, as a tool to provide assistance in submitting clean claims. Understand they are not infallible and are not to be substituted for adequate billing and coding skills and strong physician documentation. “The system did not flag for an error” will not be an acceptable argument in a payer audit.

In today’s environment of fraud, abuse, recovery audit contractor (RAC) investigations and other payer monitoring activities and penalty assessments, providers always should review closely the skills of each person responsible for billing and coding. Other solutions include the following:

- Make periodic internal review of adequate physician documentation standard practice.
- Consider at least annually external review by a trusted source.
- Quickly work rejected claims. Issues that appear to involve payer processing edits should be discussed with that payer and inconsistencies between the practice billing software and payer requirements should be resolved quickly.
- Take advantage of any training your payers provide. Many payers schedule periodic webinars, teleconferences, and occasional live workshops to educate their providers in claim requirements.
- Know your provider representative at each of your payers and request assistance and clarification from that person for claims problems. Ideally, you will use that source and your billing software vendor representative to resolve system issues.
- Invest in scheduled training for your billers and coders. The key word in this industry is change. Ensure your staff is ready for the challenge.

Dorothy Steed, CPC-H, CHCC, CPC-I, CPUM, CPUR, CPHM, CCS-P, CEMC, CPPC, ACS-OP, RCC, RMC, PCS, FCS, CPA, CPMA, is an independent consultant and educator in Atlanta, Ga. Formerly a Medicare specialist for a large hospital system with 33 years of experience in health care, she now works as a technical college instructor in Atlanta, performs coding reviews for the Quality Improvement Organization in Georgia, and conducts physician audits and education. She has been a technical contributor for several medical publications, presented at several healthcare conferences, and has developed training classes focusing on facility billing, coding, and reimbursement.
newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members

newly credentialed members
<table>
<thead>
<tr>
<th>Name</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Michelle Puryear, CPC-A</td>
<td>Louisville KY</td>
</tr>
<tr>
<td>Danelle D Newson, CPC-A</td>
<td>Louisville KY</td>
</tr>
<tr>
<td>Michael Myers, CPC-A</td>
<td>Louisville KY</td>
</tr>
<tr>
<td>Kevin Cuthbertson, CPC-A</td>
<td>Louisville KY</td>
</tr>
<tr>
<td>John Meredith, CPC-A</td>
<td>Lexington KY</td>
</tr>
<tr>
<td>Aaron Dutton, CPC-A</td>
<td>Brandenburg KY</td>
</tr>
<tr>
<td>Tracy Wigley, CPC-A</td>
<td>Wichita KS</td>
</tr>
<tr>
<td>Sherry Pullen, CPC-A</td>
<td>Wichita KS</td>
</tr>
<tr>
<td>Jessica Rae Smith, CPC-A</td>
<td>Carbondale KS</td>
</tr>
<tr>
<td>Nyree Sellars, CPC-A</td>
<td>Indianapolis IN</td>
</tr>
<tr>
<td>Beverly Kay Schwegman, CPC-A</td>
<td>Indianapolis IN</td>
</tr>
<tr>
<td>Sherryl Meyers, CPC-A</td>
<td>Indianapolis IN</td>
</tr>
<tr>
<td>Angela Margaret Hickman, CPC-A</td>
<td>Indianapolis IN</td>
</tr>
<tr>
<td>Stephany Elias, CPC-A</td>
<td>Indianapolis IN</td>
</tr>
<tr>
<td>Lacy M Eguia, CPC-A</td>
<td>Decatur IN</td>
</tr>
<tr>
<td>Sarah Skirvin, CPC-A</td>
<td>Beech Grove IN</td>
</tr>
<tr>
<td>Jennifer Mae Rogers, CPC-A</td>
<td>Sterling IL</td>
</tr>
<tr>
<td>Kate A Gillespie, CPC-A</td>
<td>Sterling IL</td>
</tr>
<tr>
<td>Jeremy A Izzard, CPC-A</td>
<td>Springfield IL</td>
</tr>
<tr>
<td>Robyn Alford, CPC-A</td>
<td>Schaumburg IL</td>
</tr>
<tr>
<td>Tiffany R Flack, CPC-A</td>
<td>Rock City IL</td>
</tr>
<tr>
<td>Debbie Platua, CPC-A</td>
<td>Louisville KY</td>
</tr>
<tr>
<td>Karon D Harpole, CPC-A</td>
<td>St Louis MO</td>
</tr>
<tr>
<td>Scott Crosby, CPC-A</td>
<td>St Ann MO</td>
</tr>
<tr>
<td>Charissa Marie Hauff, CPC-A</td>
<td>Eden Prairie MN</td>
</tr>
<tr>
<td>Debra J Kurt, CPC-A</td>
<td>Cohasset MN</td>
</tr>
<tr>
<td>Julie Meyer, CPC-A</td>
<td>Buckman MN</td>
</tr>
<tr>
<td>Shawn Sobaszko, CPC-A</td>
<td>Livonia MI</td>
</tr>
<tr>
<td>Marlene Khzouz, CPC-A</td>
<td>Livonia MI</td>
</tr>
<tr>
<td>Bridgette Ampey, CPC-A</td>
<td>Kalamazoo MI</td>
</tr>
<tr>
<td>Donna Leyman, CPC-A</td>
<td>Belleville MI</td>
</tr>
<tr>
<td>Melissa Fromm, CPC-A</td>
<td>Athens MI</td>
</tr>
<tr>
<td>Karen Begin, CPC-A</td>
<td>Sanford ME</td>
</tr>
<tr>
<td>Aziza Z Wilson, CPC-A</td>
<td>Laurel MD</td>
</tr>
<tr>
<td>Harinder Kaur, CPC-H-A</td>
<td>Edgewood MD</td>
</tr>
<tr>
<td>Barbara T Archer, CPC-A</td>
<td>Easton MD</td>
</tr>
<tr>
<td>Debbie Caldwell, CPC-A</td>
<td>Columbia MD</td>
</tr>
<tr>
<td>Kimberly Shorter, CPC-A</td>
<td>Chester MD</td>
</tr>
<tr>
<td>Kimberly Scroggins, CPC-A</td>
<td>Chesterfield MD</td>
</tr>
<tr>
<td>Janis M Sevier, CPC-A</td>
<td>East Helena MT</td>
</tr>
<tr>
<td>Shari B Lape, CPC-A</td>
<td>Helena MT</td>
</tr>
<tr>
<td>Mary Louise Barringer, CPC-A</td>
<td>Detroit MI</td>
</tr>
<tr>
<td>Aretha M Bell, CPC-A</td>
<td>Dayton MI</td>
</tr>
<tr>
<td>Brian W Coonan, CPC-A</td>
<td>Durango CO</td>
</tr>
<tr>
<td>Jennifer A Madorson, CPC-A</td>
<td>Woodridge IL</td>
</tr>
<tr>
<td>Robbin Dale Green, CPC-A</td>
<td>Friendsville PA</td>
</tr>
<tr>
<td>Nicole Yeager, CPC-A</td>
<td>Easton PA</td>
</tr>
<tr>
<td>Stephanie Larcinese, CPC-A</td>
<td>Eagleville PA</td>
</tr>
<tr>
<td>Belinda A Croak, CPC-A</td>
<td>Chadds Ford PA</td>
</tr>
<tr>
<td>Debra Scudder, CPC-A</td>
<td>Carlisle PA</td>
</tr>
<tr>
<td>Barbara Shubin, CPC-A</td>
<td>Turner OR</td>
</tr>
<tr>
<td>Teresa Marie Anderson, CPC-A</td>
<td>Troutdale OR</td>
</tr>
<tr>
<td>Mallory Espejo, CPC-A</td>
<td>McMinnville OR</td>
</tr>
<tr>
<td>Reid Sanders, CPC-A</td>
<td>Bend OR</td>
</tr>
<tr>
<td>Anne Catherine Alsabrook, CPC-A</td>
<td>Tulsa OK</td>
</tr>
<tr>
<td>Red Sanders, CPC-A</td>
<td>Bell Glen OK</td>
</tr>
<tr>
<td>Mary Olton, CPC-A</td>
<td>Lake Oklawahsa OK</td>
</tr>
<tr>
<td>Emily Littke, CPC-A</td>
<td>Northport NY</td>
</tr>
<tr>
<td>Malory Espey, CPC-A</td>
<td>Longview TX</td>
</tr>
<tr>
<td>Mary Ellen Griffith, CPC-A</td>
<td>Portland OR</td>
</tr>
<tr>
<td>Heather Smith, CPC-A</td>
<td>Portland OR</td>
</tr>
<tr>
<td>Zachary Poch, CPC-A</td>
<td>Rainier WA</td>
</tr>
<tr>
<td>Kathy DeMelo, CPC-A</td>
<td>Shewsbury NY</td>
</tr>
<tr>
<td>Tavleen Choudhary, CPC-A</td>
<td>East Hanover NJ</td>
</tr>
<tr>
<td>Tori Wambolt, CPC-A</td>
<td>Carlisle PA</td>
</tr>
<tr>
<td>Karen Lavington, CPC-A</td>
<td>Hanover PA</td>
</tr>
<tr>
<td>Jane Ball, CPC-A</td>
<td>Warrenton VA</td>
</tr>
<tr>
<td>Karon D Harpole, CPC-A</td>
<td>Lancaster PA</td>
</tr>
<tr>
<td>Susan M Watkins, CPC-A</td>
<td>Owings Mills MD</td>
</tr>
<tr>
<td>Joanne Bartlam, CPC-A</td>
<td>Easton PA</td>
</tr>
<tr>
<td>Joanne Bartlam, CPC-A</td>
<td>Roswell GA</td>
</tr>
<tr>
<td>April Bell, CPC-A</td>
<td>Westside VA</td>
</tr>
<tr>
<td>Melissa Garcia, CPC-A</td>
<td>Rockville VA</td>
</tr>
<tr>
<td>Susan Loucks, CPC-A</td>
<td>Gaithersburg MD</td>
</tr>
<tr>
<td>Lisa Y Litt, CPC-A</td>
<td>Alexandria VA</td>
</tr>
<tr>
<td>Kim Kehoe, CPC-A</td>
<td>Glen Allen VA</td>
</tr>
<tr>
<td>Jennifer L Berney, CPC-A</td>
<td>Reston VA</td>
</tr>
<tr>
<td>Wanda Mathers, CPC-A</td>
<td>Kensington VA</td>
</tr>
<tr>
<td>Delphina Jones, CPC-A</td>
<td>Falls Church VA</td>
</tr>
<tr>
<td>Sarah Ann Lees, CPC-A</td>
<td>Westover VA</td>
</tr>
<tr>
<td>Jennifer Mangel, CPC-A</td>
<td>Chantilly VA</td>
</tr>
<tr>
<td>Cheryl Lynn Wells, CPC-A</td>
<td>Manassas VA</td>
</tr>
<tr>
<td>Gloria Connors, CPC-A</td>
<td>Alexandria VA</td>
</tr>
<tr>
<td>April Bell, CPC-A</td>
<td>Vienna VA</td>
</tr>
<tr>
<td>Mark M Bugarek, CPC-A</td>
<td>Westfield IN</td>
</tr>
<tr>
<td>Davey C Ball, CPC-A</td>
<td>Framingham MA</td>
</tr>
<tr>
<td>Joseph E Tenney, CPC-A</td>
<td>East Providence RI</td>
</tr>
<tr>
<td>Cassandra Capener, CPC-A</td>
<td>Jobstown NJ</td>
</tr>
<tr>
<td>Elizabeth Ashley, CPC-A</td>
<td>Narberth PA</td>
</tr>
<tr>
<td>Paulina Montanez, CPC-A</td>
<td>Pemberton NJ</td>
</tr>
<tr>
<td>Denise Tyler, CPC-A</td>
<td>Sparta NJ</td>
</tr>
<tr>
<td>John Crossley, CPC-A</td>
<td>Brick NJ</td>
</tr>
<tr>
<td>Lois J London, CPC-A</td>
<td>Eatontown NJ</td>
</tr>
<tr>
<td>Caroline Stukenberg, CPC-A</td>
<td>Eatontown NJ</td>
</tr>
<tr>
<td>Emily Miga, CPC-A</td>
<td>Wilkesbarre PA</td>
</tr>
<tr>
<td>Kristin Hightower, CPC-A</td>
<td>Lansdale PA</td>
</tr>
<tr>
<td>Lesley Schiller, CPC-A</td>
<td>Bala Cynwyd PA</td>
</tr>
<tr>
<td>Audry D Edwards, CPC-A</td>
<td>Essington PA</td>
</tr>
<tr>
<td>Michelle Courtois, CPC-A</td>
<td>West Haven CT</td>
</tr>
<tr>
<td>Kelly Ferrell, CPC-A</td>
<td>North Arlington VA</td>
</tr>
<tr>
<td>Terry Maloney, CPC-A</td>
<td>Falls Church VA</td>
</tr>
<tr>
<td>Lisa D Winkler, CPC-A</td>
<td>Colonial Heights VA</td>
</tr>
<tr>
<td>Loretta Ray, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Pam Blevins, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Jill Root, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa D Winkler, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Aimee Flanders, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lisa A Seifer, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Mary L Stone, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
<tr>
<td>Lynn R Litt, CPC-A</td>
<td>Woodbridge VA</td>
</tr>
</tbody>
</table>
We seek coding-related articles for Coding Edge written by our members. If you have knowledge or experience you want to share with your colleagues, contact John Verhovshek at g.john.verhovshek@aapc.com, director of Editorial Development, for more information.

It’s a great way to share your knowl-
edge and experience and earn some
CEUs at the same time.
“The current, paper-based medical records system that relies on patients’ memory and reporting of their medical history is prone to error, time-consuming, costly, and wasteful. With rigorous privacy standards in place to protect sensitive medical record, we will embark on an effort to computerize all Americans’ health records in five years. This effort will help prevent medical errors, and improve health care quality, and is a necessary step in starting to modernize the American health care system and reduce health care costs.”

— President Barack Obama

The American Reinvestment and Recovery Act of 2009 (ARRA) served to facilitate the president’s vision by establishing programs under Medicare and Medicaid that provide incentive payments to eligible professionals (and hospitals) who readily adopt, upgrade or demonstrate meaningful use of certified electronic health record (EHR) technology by 2015. Unfortunately, Congress left out of the bill one crucial piece of information: the definition of “meaningful use.” That was left up to the discretion of the Centers for Medicare & Medicaid Services (CMS) to define at a later time.

Nearly a year later, CMS released Jan. 13 a notice of proposed rule making (NPRM) defining meaningful use of EHR technology. The proposed rule, however, did not appease the health care industry’s concerns. CMS received more than 2,000 comments mainly stating that the proposed reporting requirements for earning incentive payments were impossible to achieve as written.

“We heard those comments and we have provided a degree of flexibility in the final rule,” CMS said.

In fact, CMS made some significant changes to the EHR Incentive Program Final Rule—put on public display July 13 and published in the Federal Register July 28.

**Note:** This article focuses on eligible professionals reporting under the Medicare Fee-For-Service (FFS) program and Stage 1 criteria.

**What Hasn’t Changed**

The EHR incentive program provides incentive payments to eligible providers (EPs) who demonstrate meaningful use of certified EHRs.

As in the NPRM, the final rule defines an EP as a licensed doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry.

Likewise, the maximum amount EPs can earn remains $44,000 ($48,400 for EPs who predominantly furnish services in geographic Health Professional Shortage Areas (HPSAs)) under Medicare. Specifically, qualifying EPs can earn an annual incentive payment as high as $18,000 if their first payment year is 2011 or 2012. The annual incentive payment limits in the first, second, third, fourth, and fifth years are $15,000, $12,000, $8,000, $4,000, and $2,000 respectively.

And as in the proposed rule, the final rule deploys the EHR incentive program in three stages. Stage 1 pertains to reporting years 2011 and 2012.

**What Has Changed**

Compared to the proposed rule, the final rule adds a degree of flexibility, designed to make it easier for EPs to demonstrate meaningful use and qualify for incentive payments.

**Meaningful Use Objectives**

Whereas the proposed rule expected EPs to meet all reporting objectives to demonstrate meaningful use, the final rule divides the proposed objectives into a core set and a menu set of procedures from which providers can alternately choose.

For Stage 1, there are 25 objectives/measures for EPs—20 on which EPs must report. Of the 20 required objectives/measures, 15 must be from the core set and five can be from the menu set.

**Core Set of 15 Objectives for EPs**

1. Computerized physician order entry (CPOE)
2. E-prescribing (eRx)
3. Report ambulatory clinical quality measures to CMS/states
4. Implement one clinical decision support rule
5. Provide patients with an electronic copy of their health information, upon request
6. Provide clinical summaries for patients for each office visit
7. Drug-drug and drug-allergy interaction checks

**Get the Most Out of EHR Meaningful Use**

Greater flexibility facilitates physicians’ ability to earn incentive payments.

By Renée Dustman
8. Record demographics
9. Maintain an up-to-date problem list of current and active diagnoses
10. Maintain active medication list
11. Maintain active medication allergy list
12. Record and chart changes in vital signs
13. Record smoking status for patients 13 years or older
14. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
15. Protect electronic health information

Menu Set Objectives for EPs
• Drug-formulary checks
• Incorporate clinical lab test results as structured data
• Generate lists of patients by specific conditions
• Send reminders to patients per patient preference for preventive/follow-up care
• Provide patients with timely electronic access to their health information
• Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate
• Medication reconciliation
• Summary of care record for each transition of care/referrals
• Capability to submit electronic data to immunization registries/systems
• Capability to provide electronic syndromic surveillance data to public health agencies

To meet these objectives/measures, 80 percent of patients must have records in the certified EHR technology; and at least one public health objective must be selected.

An EP who works at multiple locations, but does not have certified EHR technology at all of them, must have 50 percent of his or her total patient encounters at locations where certified EHR technology is available and base all meaningful use measures only on encounters at those sites.

Clinical Quality Measures
For 2011, EPs also must submit aggregate clinical quality measures (CQM) numerator, denominator, and exclusion data to CMS by attestation. For 2012, EPs will be required to electronically submit this data. In general, EPs must report on six clinical measures: three required core measures (substituting alternate core measures where necessary) and three additional measures from a set of 38 CQMs.

The CQM core set includes:
• Hypertension: Blood Pressure Measurement;
• Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention; and
• Adult Weight Screening and Follow-up.

The CQM alternate set includes:
• Weight Assessment and Counseling for Children and Adolescents;
• Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older; and
• Childhood Immunization Status.

Note: In the final rule, CMS changed the denominator requirement. For Stage 1, no measure requires manual chart review to calculate the threshold.

Registration Overview
EPs who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs may participate in only one program, and must designate the program in which they would like to participate. After a payment is made, EPs will be allowed to change their program selection once before 2015.

To participate in the EHR Incentive Program, providers must:
• Register via the EHR Incentive Program website at www.cms.gov/EHRIncentivePrograms
• Be enrolled in Medicare FFS, Medicare Advantage, or Medicaid (FFS or managed care)
• Have a National Provider Identifier (NPI)
• Use certified EHR technology to demonstrate meaningful use
• Be enrolled in the Provider Enrollment, Chain and Ownership System (PECOS)

EHR Incentive Program Timeline
Registration for the EHR Incentive Programs begins January 2011 and attestation begins April 2011. Payments will begin May 2011. Feb. 29, 2012 is the last day for EPs to register and attest to receive an incentive payment for 2011. Although participation in the EHR Incentive Program is voluntary, Medicare payment adjustments begin in 2015 for EPs who are not meaningful users of EHR technology.

More information about Meaningful Use will be provided in the October Coding Edge. A copy of the EHR Incentive Program Final Rule and related documents are available at www.cms.gov/EHRIncentivePrograms.

[Renée Dustman is senior editor at AAPC.]
Just when you thought you understood the alphabet soup of Medicare audits, the Centers for Medicare & Medicaid Services (CMS) adds a new contractor to the health care audit vocabulary. This new audit contractor, called the zone program integrity contractor (ZPIC), represents a new approach by CMS to enforce its benefit integrity activities.

Under the ZPIC program, CMS is replacing two other audit contractors and consolidating the benefit integrity activities for all Medicare providers in an assigned area to a single ZPIC. This streamlined approach is expected to lead to increased enforcement activities in the very near future. For this reason, health care providers should have a thorough understanding of the ZPIC program to prepare for upcoming ZPIC audits.

What Are ZPICs?

Prior to the implementation of ZPICs, program safeguard contractors (PSCs) and Medicare drug integrity contractors (MEDICs) conducted benefit integrity activities for Medicare providers. PSCs and MEDICs had no uniformity of jurisdiction, which allowed the possibility for one PSC overseeing Part A claims while an entirely different PSC was overseeing Part B claims in the same state.

To correct this piecemeal approach CMS is giving ZPICs the task of ensuring the integrity of all Medicare claims for their assigned zones.

According to an Oct. 6, 2008 CMS press release (“CMS Enhances Program Integrity Efforts to Fight Fraud, Waste and Abuse in Medicare”), ultimately ZPICs “will be responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid (Medi-Medi).”

To accomplish the goal of promoting integrity in the Medicare and Medicaid programs, ZPICs have several objectives.
First, ZPICs are charged with identifying, stopping, and preventing Medicare and Medicaid fraud, waste, and abuse and referring instances of such activity to appropriate law enforcement agencies.

Other objectives include:

- decreasing the submission of abusive and fraudulent Medicare and Medicaid claims;
- recommending appropriate administrative action, to ensure proper and accurate payments for services are made; and
- coordinating identified potential fraud, waste, and abuse with the appropriate Medicare and Medicaid entities.

To carry out these objectives, ZPICs are authorized to conduct audits, interview beneficiaries and providers; initiate administrative sanctions (including suspending payments, determining overpayments and referring providers for exclusion from Medicare); and refer providers and beneficiaries to law enforcement.

Cases meeting any of the following criteria may be referred to a ZPIC:

- Potential criminal, civil, or administrative law violations
- Allegations extending beyond one provider, involving multiple providers, multiple states, or widespread schemes
- Allegations involving known patterns of fraud
- Patterns of fraud or abuse threatening the life or well being of beneficiaries
- Schemes with large financial risk to the Medicare program or beneficiaries

ZPICs also are expected to use “innovative data analysis methodologies for the early detection and prevention of abusive use of services, as well as possible fraud, waste and abuse schemes,” according to Zone Program Integrity Contractors (ZPIC) Task Order, Statement of Work, Zone 1 – Parts A, B, DME and HH + H, at 3; See also Zone 1 Medi-Medi Task Order, Statement of Work, at 2.

How Will ZPICs Be Organized?
The ZPIC transition is taking place at the same time as CMS consolidates the work of fiscal intermediaries (FIs) and carriers into Medicare administrative contractors (MACs). The alignment of ZPIC and MAC jurisdictions serves to streamline the claims review and benefit integrity processes. The seven ZPIC zones will coincide with one or more complete jurisdictions of MACs:

<table>
<thead>
<tr>
<th>Zone</th>
<th>Geographic Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>American Samoa, California, Guam, Hawaii, Mariana Islands, Nevada</td>
</tr>
<tr>
<td>2</td>
<td>Alaska, Arizona, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming</td>
</tr>
<tr>
<td>3</td>
<td>Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin</td>
</tr>
<tr>
<td>4</td>
<td>Colorado, New Mexico, Oklahoma, Texas</td>
</tr>
<tr>
<td>5</td>
<td>Alabama, Arkansas, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, West Virginia</td>
</tr>
<tr>
<td>6</td>
<td>Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont</td>
</tr>
<tr>
<td>7</td>
<td>Florida, Puerto Rico, U.S. Virgin Islands</td>
</tr>
</tbody>
</table>

How are Providers Chosen for ZPIC Audits?
ZPIC audits are never random. A provider who is selected for a ZPIC audit should understand that it is under investigation for potential fraud or the ZPIC is trying to determine if a fraud investigation should be opened. The ZPIC’s initial request for records often gives insight into the nature of the investigation.

ZPIC audits can be generated in a number of ways. First, a ZPIC audit may be initiated from the ZPIC’s proactive data analysis. For example, a ZPIC could use data analysis to detect high frequency of certain services as compared to local and national patterns, trends of billing, or other information suggesting the provider is an outlier compared to his peers.

In addition to proactive identification of audit targets, ZPICs conduct audits in response to complaints, such as a report to the Office of Inspector General (OIG) hotline, Fraud Alerts, or even directly to the ZPIC. ZPICs also receive referrals from MACs or other contractors and law enforcement. Other examples of red flags that may prompt an audit include improper or inaccurate billing that may be identified through high claim rejection or recoupment rates, a mismatch of the claim with physician record, or lengths of stay outside the industry norm.

What Happens During a ZPIC Audit?
ZPIC audits typically are unannounced or occur with very little notice, and may consist of pre-payment or post-payment review. Providers typically receive a written request for records from the ZPIC, but representatives from the ZPIC sometimes visit providers to conduct the audit on-site. The ZPIC may
ZPIC audits are never random. A provider who is selected for a ZPIC audit should understand that it is under investigation for potential fraud or the ZPIC is trying to determine if a fraud investigation should be opened.

request a small number of records to review to determine if there is a fraud concern. Alternatively, the ZPIC might work with a statistician prior to contacting the provider to select a sample of claims for review, and ultimately may use statistical sampling to extrapolate the amount of any overpayment(s) made on claims based on the error rate within the sample claims.

In addition to requesting records, the ZPIC may conduct interviews with beneficiaries and the provider's employees. For example, if the ZPIC is investigating whether a provider appropriately billed a level IV evaluation and management (E/M) claim, it may ask beneficiaries such things as the amount of time the provider spent with the beneficiaries during the visit in question.

What Happens After a ZPIC Audit?
Following a ZPIC audit, providers face one of three potential outcomes.

1. The most serious potential outcome involves the ZPIC referring the case to law enforcement for criminal, civil monetary penalty (CMP) or other sanction. If a referral occurs, the provider may hear from the OIG of the U.S. Department of Health and Human Services (HHS) or a U.S. attorney preparing to bring a False Claims Act case against the provider. Notably, if an investigation was triggered initially by a complaint made by the provider's current or former employee, the ZPIC is required to immediately advise the OIG, which could then request the ZPIC to perform only a limited internal investigation and immediately refer the case to the OIG.

2. The ZPIC may refer the audit results, including the statistical calculation of an extrapolated overpayment, to the MAC for collection. In this circumstance, a provider has the right to appeal the overpayment determination through the five-step Medicare appeals process. Most providers typically choose to appeal the audit results due to the large overpayment amount demanded. If a provider successfully reverses the denial of even a few claims, the provider can undermine the basis for the ZPIC's ability to extrapolate an overpayment amount based on a sample of claims, and significantly reduce the provider's damages.

3. The ZPIC may determine provider education is the appropriate resolution for the audit. This result is the best outcome for a provider because it means the provider will not be assessed an overpayment demand or other potential sanction. In this instance, the ZPIC will inform the provider by letter of questionable or improper practices and the correct procedure to follow. The ZPIC will also notify the provider that continuation of the improper practice may result in administrative sanctions.

What Can I Do to Prepare for a ZPIC Audit?
With the implementation of the ZPIC and other audit contractors, providers should expect to see a significant increase in audits. Providers can take steps to potentially avoid being a target of these audits and to develop a response plan if they are targeted.

Stay Out of the ZPIC Spotlight Through a Strong Compliance Program. In preparing for these increased audits, apply the old adage, “an ounce of prevention is worth a pound of cure,” and implement robust compliance programs to reduce the likelihood of being a ZPIC target. In particular, confirm that your provider is following all Medicare policies and procedures, including any applicable coverage decisions, when billing Medicare claims.

The inquiry should not end with confirming compliance with the appropriate Medicare policies. Ensure also that providers document fully and completely all necessary elements before submitting claims to Medicare. Stay up-to-date on any changes in Medicare policies and procedures, and conduct regular training on coding and billing practices. Finally, conduct periodic internal audits. If billing vulnerabilities are identified, correct the problems and repay any overpayments resulting from the billing mistakes.

Have A Plan in Place if the ZPIC Shows Up.
Although a robust compliance program should reduce the likelihood of a ZPIC audit, there is no guarantee that a provider will not be targeted. Prepare your provider for the possibility of an audit by taking the following steps:

- Designate a point person, such as the compliance officer or other administrator, for coordinating a response to a ZPIC audit. The point of contact is the person who coordinates the audit, answers questions regarding where records are located, and assists the ZPIC in setting up interviews with requested individuals. After this point of contact is designated, instruct personnel to immediately direct all ZPIC audit requests to this designated individual.
Establish specific policies and procedures for responding to a ZPIC audit. The policies and procedures include the name and contact information of the point of contact and the designation of responsibilities for others in the organization who will participate in the investigation. Include a list of where all of the provider’s medical records are located in the policies and procedures. Identifying the location of records in advance of an audit assists a provider in responding fully to an audit request within the time frame established by the ZPIC.

Create an intake and tracking system. Because there are multiple types of audits with different time frames for response, it is important to have a tracking mechanism to ensure the designated deadlines are met. For small organizations, this can be as simple as a spreadsheet. Larger organizations may consider investing in software designed to manage the intake and tracking of audit requests.

Because of their potential ramifications, ZPIC audits are one of the more serious of the Medicare initiatives. Providers should understand ZPICs are looking for fraud, not simply billing errors. Accordingly, take steps to reduce the likelihood of a ZPIC audit by ensuring your provider is billing Medicare claims appropriately and that there is a plan in place to respond to a ZPIC audit. These steps can decrease the chance of your provider being targeted, and hopefully remove the ZPIC alphabet soup from the menu.

Resources:
OIG HHS, “Medicare’s Program Safeguard Contractor Activities to Detect and deter Fraud and Abuse” (July 2007) is available at www.oig.hhs.gov/oei/reports/oei-03-06-00010.pdf.
Brian Perry, CMS, Transition from PSCs to ZPICs, 57 Health Care Fraud 46, 47-50, 53 (Jan. 2009).
Zone Program Integrity Contractor (ZPIC) Umbrella Task Order, Statement of Work at 11.
Zone Program Integrity Contractor (ZPIC) Umbrella Task Order
Zone Program Integrity Contractors (ZPIC) Task Order, Statement of Work, Zone 1 – Parts A, B, DME and HH + H, at 3; See also Zone 1 Medi-Medi Task Order, Statement of Work, at 2.

Anna M. Grizzle, Esq., is a partner of Bass, Berry & Sims PLC in Nashville, Tenn. where she represents health care providers and companies in operational and compliance matters, investigations, and litigation. She counsels on health care operations and compliance matters, such as fraud and abuse, quality, and risk management issues. She also works with clients in all stages of government and commercial payer claims audits, including those performed by RACs, ZPICs, and MICs. Anna is a member of the Health Care Compliance Association and the American Health Lawyers Association.

Lynn Keaton-Cockrell, CPC, CPC-H, CPC-I, CEMC, is president of LCA Medical Consulting and a member of the AAPCCA board of directors. She has more than 25 years of experience in the health care industry. She assists clients with solutions to enhance efficiency and opportunities in the health care delivery system and physicians with third-party payer audits, including RACs at various stages of appeals. She is a PMCC trainer and provides consulting services to Hickman Community Health Services (part of Saint Thomas Health Services). She has provided coding workshops for the Tennessee Medical Association and serves as president of the Professional Coders of Columbia, Tenn. and the Cahaba Physician Outreach and Education Committee for Tennessee.

Lightening Fast Code Searches Available Now at Supercoder.com for only $9.97/month!

Just look at what you get:
- File claims in 1/10th the time using 3 fully searchable codesets.
- CCI Edits are a breeze with Supercoder’s Revolutionary CCI Edit Check Tool.
- LCDs in 1 spot!
- Coding Updates Made Affordable with No Books to Buy!
- Training from the experts w/out leaving your office with monthly webinars.
- Easy-to-navigate CMS Info Center – updated within 24 hours!
- Answers to your burning coding questions in forums manned by the experts.
- Fee schedule info you can understand.

This limited time offer is available only to AAPC members, but we can’t keep prices this low for long! Head on over to Supercoder.com/aapc

supercoder.com
Each year, AAPC’s National Conference generates many special moments for our members. One event in particular that holds fond memories and has been a staple at conference is “Meet Your Local Chapter.” Through the years, this event has metamorphosed into the popular and very well attended “Get to Know Your Local Chapter” (G2KYLC). This year’s conference in Jacksonville, Fla. was no exception and proved to bear great anticipation and expectations for participating local chapters and attending members who shared in G2KYLC.

With 24 participating tables composed of 20 local chapter tables, three “joint tables,” (which are multiple chapters presenting one table), and one table for all users of AAPC’s Forum; this event displayed unique collaborations.

Participants were challenged to showcase their chapters using several elements. The criteria our judges looked for to score each table were:

- Best use of region color;
- Best display of education info;
- Best use of chapter information; and
- Most original display.

Surprises Around the Corner
Each judge also picked a favorite table, and scores were tallied to formulate an overall score for each table. The top five scorers were awarded with ribbons. No one knew who the winners were until the doors opened and the event started. It was exciting to watch participants return to their tables and find a ribbon acknowledging their efforts!

The top five tables were:

- **Best in Show**: Kansas City, Mo.
- **First Place**: Joint table of several Florida chapters
- **Second Place**: Columbia, S.C. (Capital City Coders)
- **Third Place**: Jacksonville, Fla.
- **Honorable Mention**: Savannah, Ga.

**Jacksonville Community Participates**
New this year was the use of outside judges. It was very important to the G2KYLC planning committee to involve members of the Jacksonville community. Community participants were Derek Igou, deputy chief of Administrative Office from the City of Jacksonville, Lt. Diego Esguerro, department head for Patient Administration of the Naval Hospital in Jacksonville, and Lt. Nicole Duffy, RN, clinic manager in general surgery at the Naval Hospital in Jacksonville. I would like to personally thank these individuals for the time they invested judging our tables.

**Chapter Participation Calls for Teamwork**
Participating in this event involved getting fellow chapter members on board to help with:

- Making planning decisions
- Logistics on getting your display to the conference
- Coming up with creative ways to finance your giveaways and decorations
- Finding time in an already full schedule of events to set up your display
- Enjoying the hundreds of members who want to learn about your chapter

We are so thankful to the chapters who participated in this year’s G2KYLC event. Our hope is to see at least 30 local chapters in Long Beach, Calif. Start planning now for another unbelievable G2KYLC in 2011. ■

Freda Brinson, CPC, CPC-H, CEMC, is compliance auditor for St. Joseph’s/Candler Health System in Savannah. She has 30 years of health care experience, ranging from receptionist to office management for physician practices and charge description master and charge auditing in the hospital setting. She was the 2008 AAPC Networker of the Year and chapter president when Savannah was named 2008 AAPC Chapter of the Year.
It’s what’s on the INSIDE that matters in ICD-10

Get the new Advanced Anatomy and Physiology for ICD-10 book today!

Advanced Anatomy and Physiology for ICD-10 provides the in-depth information you need to prepare for the most dramatic change in coding ever:

- Detailed review of each body system – with in-depth information on cells, tissues, and organs that comprise each body system
- Clarifies the new anatomical and physiological documentation requirements – for code capture in ICD-10-CM and ICD-10-PCS
- Quizzes at the end of every chapter – assists in testing your knowledge on what you have just learned
- Detailed, full-page anatomy illustrations plus code-specific illustrations that have been integrated into the book – allows better interpretation of clinical notes to help code with more specificity
- Extra help on new, revised and deleted codes – unique symbols identify new procedure codes and substantially altered procedure descriptions alert you to changes in the ICD-10 code sets
- And much more…

Call us today at 1-800-334-5724 and mention promo code APCE910
Order online at www.codingbooks.com/api and enter promo code APCE910
Janelle Simpson, CPC
Billing Department Manager at Virginia Neurology & Sleep Disorders Center

CE: Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you're doing now, etc.

Janelle: I received in 1992 an associate degree for Medical Administrative Assisting. I began working for Tidewater Children’s Associates (TCA), a large pediatric practice, floating between medical assisting and billing. Eventually, I worked full time in the billing department where I first was exposed to coding. This was my first lesson on CPT®, ICD-9, and insurance do’s and don'ts. The hospital that owned the practice offered CPC® training and the exam, and I received my certification in 2003. After 11 years with TCA, I moved up to billing manager for a billing company, coding several specialties. Here I was introduced to the world of Medicare, which made me almost retire. While working as billing manager, I received a call from my former administrator to interview for a new billing manager position with a large diagnostic imaging practice. I jumped at the chance and started a new department from the ground up. With guidance I was exposed to a new world of coding and management.

In 2007, my husband relocated to Casper, Wyoming and I found a position with another imaging center and a billing company through the hospital. We recently returned to Virginia, thawed out from the winter blast of Wyoming, and I am now billing department manager for Virginia Neurology & Sleep Disorders Center. I have just completed my bachelor of science degree in health care law. I look forward to owning my own billing company very soon and lobbying on Capitol Hill to be a voice for health care reform.

CE: What is your involvement level with your local AAPC chapter?

Janelle: I helped start the only AAPC chapter in Wyoming and served as new member development officer. This was a great experience and I was able to work with other coders in Casper to help introduce AAPC and coding certification. The chapter is still growing under the wing of great people and I hope to see the chapter and coding certification opportunities expand in the state. I made life-long friends and colleagues at the Casper Chapter. Now, I am back in Virginia and hope to get involved with the chapter in my area.

CE: What has been your biggest challenge as a coder?

Janelle: My biggest challenge has been breaking barriers with physicians and letting them know certified coders are necessary and are a wealth of information for revenue and following guidelines, and are a resource for explaining to patients why their claim is coded correctly. On the insurance end, my head spins trying to keep up with carrier guidelines, fee schedules, modifiers, the ever-changing world of Medicare and last, but not least, setting up and monitoring Physician Quality Reporting Initiative (PQRI). A coder’s work is never done.

CE: How are you and/or your organization preparing for ICD-10?

Janelle: We are preparing for ICD-10 by looking at the top 25 ICD-9 codes used and cross referencing them with ICD-10. Working in neurology, we have a limited number of ICD-9 codes, which will make the transition easier than for some. We recently purchased an electronic medical record (EMR) system that will help with the technical side of the change. As for my billing staff, we have attended Centers for Medicare & Medicaid Services (CMS) webinars and are following the steps on the AAPC website as a guide.

CE: If you could have any other job, what would it be?

Janelle: Own my own billing company and lobbying health care. There is nothing outside of medicine that I would want as a career. I love medicine law and my goal is to be a voice for patients and physicians on Capitol Hill. Changes are coming and we all need to be a voice in those changes.

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

Janelle: My spare time is spent with my husband, David, and our two dogs. We are huge National Association for Stock Car Auto Racing (NASCAR) and football fans (go Dolphins!), so our Sundays in the summer are all about NASCAR (and food) and in the winter, football. Because we live on the beach, on any given evening, we’re fishing and watching the sunset. After living in Wyoming and experiencing what a real winter is, I am thankful to be back where it is not snowing in June and I can put my toes in the sand and ocean. I have two children, Amanda and Brittney, and a step-daughter, Jessica. They are all grown and out of the house trying to make their way in the world. 

Janelle Simpson, CPC
Billing Department Manager at Virginia Neurology & Sleep Disorders Center
Need CEUs

2009 & 2010 Annual CEU Coding Scenarios are approved by the AAPC for CEUs!
6.5 - 10.5 CEUs per course

Over 125 Approved CEUs starting from $30
Topics Include:
  Anatomy / Med Term
  Auditing / RAC
  ICD-9 and ICD-10
  Specialty Coding
  E/M and OB/GYN
  Interventional Radiology
  Reimbursement
  ...and more

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

CodingWebU.com
Providing Quality Education at Affordable Prices

(484) 433-0495  www.CodingWebU.com
Meet our instructors...

Shannon Smith, Founder/Director/Curriculum Development, CRTT, CPC, CPC-I, CEMC, CMSCS, CPMA (center)
Melody Irvine, Instructor/Curriculum Development CPC, CEMC, CPC-I, CCS-P, CPMA, CMRS (right)
Kevin Townsend, Instructor; CPC, CPMA, CMPE (left)

Available Now! Only $149.99

Medical Chart Auditing Study Guide
Preparation for the CPMA™ specialty exam

For more information and class/exam schedules visit www.NAMAS-Auditing.com or www.AAPC.com
800-635-4040 and ask for Heather Snyder

Medical Auditor Educational Training:
- Receive expert training and preparation for AAPC’s CPMA™ examination
- Broaden your career path and job opportunities
- Enhance your credibility with auditing knowledge

Auditing skills taught:
- Compliance; Documentation & Regulatory Guidelines
- Coding Concepts
- Scope & Statistical Methodologies
- Abstraction Ability
- Quality Assurance & Risk Analysis
- Communication of Results & Findings

2 Days—16 CEUs AAPC Approved

We can Help! for quick answers
Call our HOTLINE!
800-635-4040

We also offer -
- Medical Documentation Audits
- Consulting
- Customized Onsite Compliance Training
- Online instructor-led PMCC courses

Are you frustrated and have problems with….

Coding and billing efficiency?
Reimbursement issues and denied claims?
Compliance program updates?
Medicare documentation?
RAC requests?

Call for a free consultation with one of our auditing and coding experts to see how we can help you

Since 1956, DoctorsManagement has helped coders, billers, and practice administrators in all specialties touching every state across America.