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April 2014

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Marcia

Marcia Brauchler

Marcia L. Brauchler, MPH, CPHQ, CPC-P, CPC-H, CPC-I, is a healthcare consultant and founder of Physicians' Ally, Inc. She advises physicians and practice administrators on managed care contracts, reimbursement, coding, and compliance. Brauchler 's firm is selling updated HIPAA Policies and Procedures at www.physicians-ally.com/hipaacompliance. She is a member of the Denver, Colo., local chapter.

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Coding/Billing

Obesity: New Technology Advances Bariatric Surgery

Laurette Pitman, RN, CPC-H, CGIC, CCS

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COMING UP

- Spinal Cages
- ICD-10 Revenue Benchmarks
- Injury Coding
- Uterine Stent Placement
- 2014-15 AAPC Chapter Association

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On the Cover:
Laurette Pitman, RN, CPC-H, CGIC, CCS, explains what's required of healthcare business professionals to properly code bariatric surgery. Cover design by Tina Smith.

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April 2014

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

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HEALTHCON: Cooperation, Change, Innovation, and Community

Big changes are coming to our industry this year, and we are working together to assure these changes improve the business of healthcare and patients' lives. I'm pleased to participate with you to help make this happen.

AAPC's annual national conference, HEALTHCON, in Nashville, Tenn., April 13-16, includes additional sessions and tracks that embrace the complete healthcare business process. It's an example of how we're seeking to improve healthcare delivery and quality by inviting all stakeholders.

During HEALTHCON, you'll have a chance to learn more about your areas of interest as well as others'. By becoming more knowledgeable about the many facets of healthcare business, you'll become better at what you do and achieving your goals. An example of this cooperation is implementation of ICD-10 October 1.

ICD-10 Implementation Set for October 1

This change impacts coding, billing, auditing, compliance, and practice management. Providers, facilities, and payers must begin using ICD-10-CM October 1, and Marilyn Tavenner, administrator of the Centers for Medicare & Medicaid Services (CMS), said in February there will be no delay in the implementation of the new code set. It's time to ensure we're ready.

AAPC provides a number of resources to members, providers, and their employers to help ease the transition, and we'll continue doing so well after October. We want to provide the resources you'll need to secure a successful transition for yourself, practices, facilities, and patients.

Take advantage of the national conference and other resources, such as *Healthcare Business Monthly*, to be ready for ICD-10 implementation. Demonstrate your ICD-10 proficiency, not only to yourself but also to your colleagues and employers. They will be looking to you for your help and expertise when the deadline looms.

Annual Milestone for AAPC Boards

HEALTHCON is always pivotal for our advisory boards.

National Advisory Board

The National Advisory Board (NAB) advises AAPC leadership and always plays an important role at national conference: meeting with members, presenting, helping conduct proceedings. During the rest of the year, they represent members to the AAPC national office staff and participate in policy decisions. Attending their mid-term national conference, this independent board is keen to interact with members to better understand how AAPC can be of greater service.

AAPC Chapter Association

Few elements of AAPC demonstrate working together and cooperation as well as the AAPC Chapter Association board of directors. The board, which will introduce new members at HEALTHCON, helps AAPC's Local Chapter department by acting as advocates for the chapters to better serve local chapter members. While I'll miss the five members leaving, I'm also looking forward to working with new members.

Introduce yourself to members of these boards and take advantage of their programs; it's a chance to share your thoughts and learn from experts in the industry.

7Atlis and AAPC Coder

While ICD-10 will be the talk of HEALTHCON, implementation of the Affordable Care Act (Obamacare) also means providers will need to focus on more stringent compliance and quality of care measures. I'm proud to introduce you to 7Atlis, a compliance solution by AAPC for small to medium physician practices. Both professionals and those new to compliance can confidently establish and manage all seven components outlined by CMS in official program guidance. 7Atlis allows users to create, modify, and search all policies and other official documents, yet requires no installed software.

Another innovation is AAPC Coder, which provides coders, biller, and auditors a whole suite of tools in one place. Its ability to access codes, guidelines, rules, and CMS resources makes work a little easier through greater accessibility and speed. AAPC Coder was developed with the help of members, and it continues to evolve to meet your needs. Many have tried and adopted it. Check it out.

AAPC Community

I'm grateful to meet and work with you; and I look forward to seeing you, not only at HEALTHCON, but also at local chapters and other events. We have the opportunity and responsibility to improve the business of healthcare, which will enhance the experience and care of patients. And that benefits all of us.

Sincerely,

Jason J. VandenAkker
AAPC CEO

Medical Necessity Drives Code Selection

I am writing to you regarding Case No.1 on page 22 of the January issue. I do not have a problem with the codes selected, but if I were a Medicare investigator, I would have a problem with the documentation, diagnostic studies ordered, and treatment for this patient.

This 81-year-old patient has no history of chronic obstructive pulmonary disease or smoking, nor elevated temperature. Her exam revealed her to be in no acute distress, and with a temperature of 97, pulse of 76, respirations of 16, and no wheezing or crackles on chest exam.

There is not sufficient documentation to warrant pulmonary function testing. It would seem more appropriate to order a nasal swab culture and CBC with differential to rule out bacterial infection vs. viral. If, in fact, this is viral, then the ordering of antibiotics would not be necessary.

Bruce C. Brunson, MD, CPC

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

Dedicated Coding Educator's Impact Recognized

Angie Brown, CPC, CPC-H, CPC-I, CPMA, CRCA, CMC, CMIS, CMOM, CMA, CRCR, has been recognized as Administrator of the Year by South Carolina Technical Education Association for her educational innovations, dedication to students, and program development at Greenville Technical College in South Carolina.

She supervises, manages, and instructs more than 100 courses in several programs serving 2,000 students, including inpatient and outpatient coding, healthcare administration, electronic health records, and ICD-10.

Angie's dedication to students and employees is noted as professional and constant, and she is always looking for better ways to prepare Greenville's students for a satisfying, productive career.

Kudos to Angie for her contribution to our industry and colleagues.

Give a Pat on the Back, Get One Back

We want to recognize our members' accomplishments. Have you had a recent promotion? Do you have a colleague who does wonderful things for the coding profession? Send your success stories to kudos@aapc.com.

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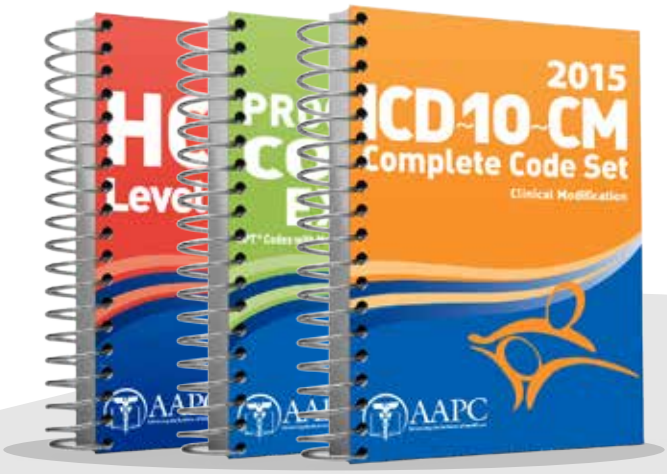

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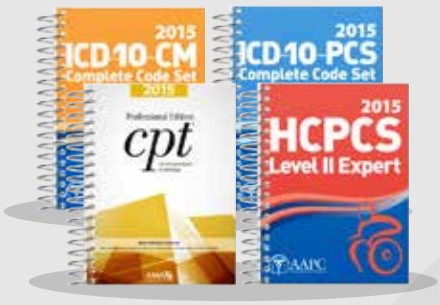

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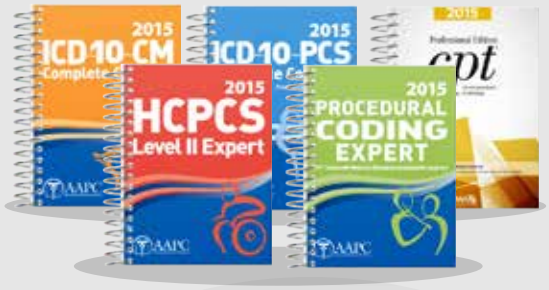

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By Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC

Convey the Three P's at HEALTHCON

Use professionalism, a positive attitude, and passion to make a good impression.

Attending the AAPC national conference, recently renamed HEALTHCON, affords members incredible education and endless opportunities to network with coders, administrators, billers, payers, compliance officers, physicians, and other professionals who work in the business side of medicine. As you prepare for HEALTHCON, I hope you'll take a moment to consider what lies ahead, and how professionalism, a positive attitude, and passion (the three P's) can open doors in your career.

HEALTHCON Builds Leaders, Careers, and Friendship

Many local chapter officer opportunities are offered during HEALTHCON, starting with pre-conference sessions such as "**Get to Know Successful Chapter Leadership**" (see the Local Chapter Handbook column in this issue for more information). Then there is, "**How to Become a Local Chapter Officer**," for those who are considering this important position.

The exhibitor reception provides an opportunity to visit vendors—including companies with employment opportunities. You'll also find networking breaks with specialty-specific sessions, such as cardiology, interventional radiology, orthopaedic, obstetrics/gynecology, anesthesia, family practice, behavioral health, and outpatient facility.

New this year is the "**Business of Healthcare Expo**," where you can experience in-depth concepts about how healthcare professionals affect patient care and hospital and practice revenue. This expo provides an excellent opportunity to learn from and network with presenters and attendees who represent all walks of business medicine.

The Three P's

The people you meet during HEALTHCON—as well as regional conferences, workshops, chapter seminars, and local chapter meetings—can change your career direction in ways you may not have considered. Think about how you can make the most of your interactions at these events.

✔ Professionalism

You are a professional and, as such, you should act and dress like one. What does that mean? It means HEALTHCON isn't Club Med. In other words: comfortable shoes, yes, flip flops, no; cocktails, yes, whisky shooters, no. You get the point. Consider how you want to convey yourself and the "vibe" you want to give off when you meet people. It's important to leave a great lasting impression if you're looking to advance your career.

✔ Positive Attitidue

Perception is complicated. That's because people are very intuitive. You can dress to the nines, but still come off as unprofessional if you have a negative attitude. To ensure you are perceived in the best light at HEALTHCON, come with a positive attitude.

✔ Passion

You are an honest, hardworking person with a passion for healthcare, and you want to take your career a step further. You are excited about the opportunities that lie ahead at HEALTHCON. Bring that passion and positive intention with you to this event. Network, learn, and listen.

By Kathy Burke, CPC, CPB

Receive Officer Training at HEALTHCON

Think about how you can make the most of your interactions at these events.

HEALTHCON is a chance for you to expand your network of colleagues and friends; and just maybe, one of those contacts holds the key to your career advancement. HBM

Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC, is coding and billing manager for Travis C. Holcombe, MD. She has over 20 years of coding and billing experience, is an AAPC workshop presenter and AAPC ICD-10 expert trainer, and served on the 2007-2009 National Advisory Board. Ward was the 2012 president of the Glendale, Ariz., local chapter, and has held offices with the Phoenix, Ariz., local chapter. She is a member of the 2013-2014 AAPC Chapter Association board of directors, region 8-West.

The AAPC Chapter Association board of directors is excited to present local chapter officer training at HEALTHCON's "**Get to Know Successful Chapter Leadership**" session this year. Although you can find the responsibilities of each officer's position in chapter 5 of the *Local Chapter Handbook*, it's advantageous to have someone walk you through each role. The session is an opportunity to connect with other officers and receive role-specific training from the AAPC Chapter Association and Local Chapter Department staff.

Also at HEALTHCON, you can attend a special hour-long session devoted to learning about becoming a chapter officer. This is an exciting time filled with changes in our profession, and our chapters are at the forefront of providing education and networking opportunities to members. If you want to step forward as an officer, but aren't sure what is involved, this session is for you.

With so many resources available to officers (*Local Chapter Handbook*, online forums, AAPC's website, etc.), it can be overwhelming to take it all in. It's usually best to learn new things "straight from the horse's mouth."

See you at HEALTHCON!

CMS Says No Delays for ICD-10

There will be no delay for the Oct. 1 implementation of ICD-10, Centers for Medicare & Medicaid Services (CMS) Administrator Marilyn Tavenner told attendees at the Healthcare Information and Management Systems Society (HIMSS) convention in Orlando, Fla., in February.

Several HIMSS attendees were hopeful for a reprieve from the Oct. 1 deadline, but Tavenner said that no extension will be given. "Let's face it guys, we've delayed this several times and it's time to move on," she said, according to *Modern Healthcare*.

Likewise, deadlines for Stage 2 of the EHR incentive programs stand firm. "Now is the time for us to start moving forward," Tavenner said.

Tavenner explained to attendees that meeting Stage 2 requirements will be key to interoperability, quality measures, and ICD-10. Case-by-case exemptions will be made for providers and vendors having a tough time meeting Stage 2 targets, she said, but even with those exemptions, CMS expects everyone to meet all Stage 2 criteria by 2015.

Source: *ModernHealthcare.com*, Joseph Conn, "ICD-10 Deadline Won't Be Delayed, Tavenner Tells HIMSS," Feb. 27.

Get EHR Incentive Program Answers

Here are some important dates to mark on your calendar if your practice or facility is participating in either of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs:

- **March 31** is the 2013 attestation deadline.
- **Sept. 30** is the end of the 2014 reporting period for eligible hospitals.
- **Nov. 30** is the 2014 attestation deadline for eligible hospitals.
- **Dec. 31** is the end of the 2014 reporting period for eligible professionals.

There are also new and updated frequently asked questions (FAQs) for both Medicare and Medicaid EHR incentive programs, which are organized by subcategory. Search by subtopics in the navigation bar on the left side of the webpage at: https://questions.cms.gov/faq.php?id=5005&rtopic=1979.

For more information on the Medicare and Medicaid EHR incentive programs, go to CMS's "Medicare and Medicaid EHR Incentive Program Basics" webpage at: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html.

A&P Tip

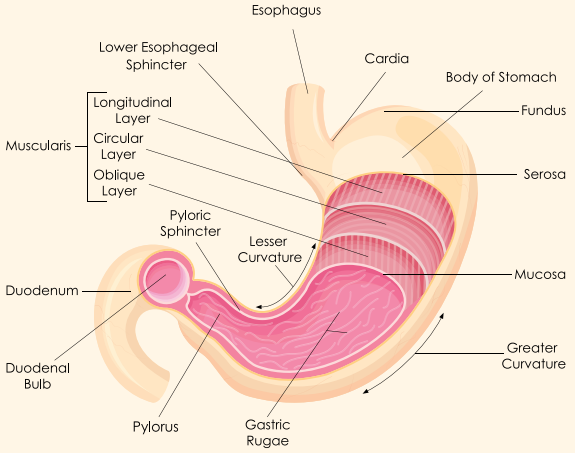
Due to the clinical nature of ICD-10-CM—the diagnosis code set the healthcare industry will begin using Oct. 1, 2014—a strong understanding of anatomy and physiology (A&P) will be required for accurate reporting of patients' medical conditions. To help you prepare, look for this tip in each issue of *Healthcare Business Monthly*.

Stomach Structure

The human stomach is made up of four main areas: the cardia, fundus, body, and pylorus. Food enters the stomach through the cardia from the esophagus and exits through the pylorus into the small intestine. The body of the stomach is the primary location of gastric digestion, which involves the churning of food together with proteases (enzymes) and hydrochloric acid to partially break down proteins, kill bacteria, and adjust pH.

The stomach wall is composed of four layers (from inside to outside): mucosa, submucosa, muscularis, and serosa. These layers are responsible for the secretion, innervation, churning and constriction, and connectivity with the peritoneum.

Unlike the rest of the gastrointestinal tract, which has two layers of muscle, the stomach wall has three layers of smooth muscle (located within the muscularis layer): the inner oblique layer, the middle circle layer, and the outer longitudinal layer.



Stomach

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By Olga Khabinskay, COO

[Added Edge]

What Makes a Professional Biller?

Ask the first Certified Professional Biller (CPB®) from Brooklyn, N.Y.

Zukhra Kasimova, CPC, CPB

Medical billing is the livelihood of healthcare practitioner revenue, and it has become more complex over the years. Submitting clean claims requires knowledge of coding guidelines, insurance requirements, and state and federal regulations. Additional expertise is necessary to ensure claims are properly paid. Qualified medical billing professionals who possess these skills are your best line of defense to proper reimbursement and a healthy revenue cycle.

This raises an important question:

What defines a qualified professional capable of handling your medical billing needs?

Certify Proficiency

AAPC's certification for medical billers—Certified Professional Biller (CPB®)—ensures personnel have the right tools and training to handle a full range of billing, coding, insurance, and collections procedures. It also provides a reliable measure of proficiency and expertise for medical billing staff, who provide an important service on behalf of the practice.

When AAPC launched the CPB® certification, WCH (We Can Help) Service Bureau, Inc. nominated **Zukhra Kasimova, CPC, CPB**, to take the exam. With plenty of studying and support from her coworkers, she successfully passed the 200-question exam, adding a CPB® to go with the Certified Professional Coder (CPC®) credential she already earned.

CPB® Experience, from the Source

Kasimova was named the first CPB® in Brooklyn, N.Y. She shares her thoughts on earning the billing certification:

Q: *Tell us about your experience when studying for the certification. What did you learn?*

A: Having five years of experience in medical billing prior to taking the nationally-recognized CPB® course, I found the training materials to be very well organized and structured. There are 16 chapters, with a core focus on medical billing for the provider side of healthcare. The course also provides some coding basics, including two chapters solely devoted to diagnosis coding in both ICD-9-CM and ICD-10-CM. Various aspects of revenue cycle management education material are also covered.

Although most of the information you need is provided in the education materials, AAPC recommends having prior knowledge of anatomy and medical terminology. I studied the materials at my own pace, covering one or two chapters per week. Each module contained links to additional study resources, enabling me to learn a lot on each topic. Chapters include post-study questions, so it's possible to cross check the comprehension of the materials right away after you complete each chapter.

I took a web-based practice test containing 50 questions, which was very similar to the actual testing questions. The online practice test allowed me to self-evaluate my overall progress and material comprehension.

Q: *What value does CPB® certification bring to your work in medical billing?*

A: Healthcare business requires CPBs® who can handle all aspects of the revenue cycle. The claims billing/submission process should include following all government regulations and insurance requirements. Improper billing may lead to audit reviews, reduced reimbursement, and insurance disputes, all of which negatively affect a practice's revenue cycle. For these reasons, professional expertise is crucial to perform successful billing services.

Q: *How does the training you received help you in your daily tasks in medical billing?*

A: Training for the exam helped me to incorporate and enhance my knowledge in the different aspects of medical billing, such as billing regulations, HIPAA and compliance issues, case analysis, reimbursement procedures, etc. It continues to help me in navigating the complex process of medical billing and solving issues that I come across on a daily basis. It also serves as an additional source of materials to train new employees.

Healthcare business requires CPBs® who can handle all aspects of the revenue cycle.

Q: *Why do you think CPB® certification is important for the medical billing professional?*

A: Because requirements and technologies of healthcare are constantly developing and updating, anyone working in the billing and coding field should continue education and training throughout his or her career. It's important to advance your knowledge and skills, so you can continuously deliver high-quality service to healthcare providers and be confident in your work as a professional.

Understand Certification's Impact on Business

WCH Service Bureau is a global multi-service provider headquartered in Brooklyn, N.Y., specializing in medical billing and credentialing services, coding, chart auditing, and customized medical software solutions. Continuing education and certification adds value to the medical billing and coding services provided by WCH's medical billing department. WCH staff consists of 80 full-time medical billers, reimbursement specialists, programmers, customer service representatives, sales, and administrative personnel who serve private clinics, hospitals, laboratories, imaging centers, pharmacies, and supply companies. Their staff holds a variety of AAPC credentials (CPC®, Certified Professional Medical Auditor (CPMA®), Certified Family Practice Coder (CFPC®), etc.), which help them in their everyday work in medical billing. AAPC certification provides WCH staff with the tools necessary to protect clients and take responsibility for the coding and billing process.

Following Kasimova's success, WCH is promoting CPB® certification for many of its staff. HBM

Olga Khabinskay, COO, is chief operating officer of WCH Service Bureau, Inc., (www.wchsb.com) and Credentialing Department manager. Khabinskay graduated with a Bachelor of Arts from Adelphi University and is working on her master's degree in healthcare management. She is a member of the Jamaica, N.Y., local chapter.

By Betty Hovey, CPC, CPC-H, CPB, CPMA, CPC-I, CPCD

[Roadmap to ICD-10]

Coding Acute Conditions: Eliminate Chronic Concerns

Accurate ICD-10 coding requires proper documentation and an understanding of clinical conditions.

Coding acute conditions in ICD-10-CM can be tricky for a few reasons: For starters, the term "acute" has various meanings in the diagnosis code set scheduled to go live Oct. 1. Second, there are timeframe factors to consider. And, third, there's a new concept of acute recurrent conditions. To help clear up any coding confusion you may have, first consider Merriam-Webster's definition of *acute*:

> **(1): characterized by sharpness or severity, "acute pain" (2): having a sudden onset, sharp rise, and short course, "acute disease" (3): being, providing, or requiring short-term medical care (as for serious illness or traumatic injury) "acute hospitals" "an acute patient."**

Next, consider acute condition criteria and look at a few telling examples, as follows.

Myocardial Infarctions (MI)

Coronary arteries are a network of arteries that supply blood to the heart muscle. The left main coronary artery and the right coronary artery stem from the aorta. The left main coronary artery bifurcates into the left circumflex and left anterior descending arteries, supplying blood to the left ventricle. The right coronary artery branches into the right marginal artery and posterior descending artery, supplying blood to the right ventricle.

Coronary artery disease is the result of the accumulation of atheromatous plaque within the walls of the coronary arteries. If blood flow is blocked long enough, a portion of the heart muscle is damaged or dies. This is an MI, or heart attack. More than a million people in the United States each year suffer MIs. The site of the MI will reflect the coronary artery experiencing the ischemia. For example, an MI of the anterior wall is caused by ischemia in the left anterior descending coronary artery.

ST elevation myocardial infarction (STEMI) occurs when there is a transmural infarction of the myocardium, which means the entire thickness of the myocardium (endocardium, myocardium, and pericardium) has undergone necrosis. This results in ST elevation on an electrocardiogram (ECG).

There are no codes for chronic symptomatic MI in ICD-10-CM. If the patient is still symptomatic after 28 days … the appropriate aftercare code should be assigned.

Non-ST elevation myocardial infarction (NSTEMI) occurs when there is a partial dynamic block to coronary arteries. There will be no ST elevation or Q waves on the ECG because transmural infarction is not seen.

According to ICD-10-CM, an MI is considered acute (AMI) when it's specified as acute or is stated to persist four weeks (28 days) or less from onset. In this case, acute is tied to the duration.

Example 1: A patient presents to the clinic. Per documentation, the patient is here for a hospital follow up for an MI of the left anterior descending artery.

Without MI timing information, you'll need to query the provider to assign the correct ICD-10-CM code. From an ICD-10-CM standpoint, if the MI occurred within 28 days, it's acute.

There are no codes for chronic symptomatic MI in ICD-10-CM. If the patient is still symptomatic after 28 days, the guidelines (I.C.9.e.1) state that the appropriate aftercare code should be assigned. It's imperative for the physician or other provider to understand the importance of documenting the timeframe and for the coder to understand how to use that information for coding purposes.

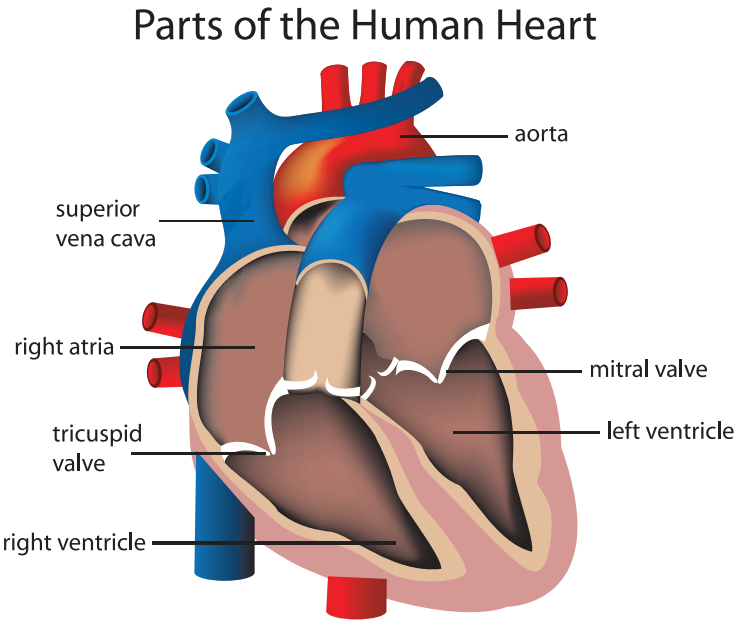
Example 2: A patient presents to the clinic. Per documentation, the patient is here for hospital follow-up for an MI of the left anterior descending artery suffered 10 days prior. The patient is still symptomatic.

In this example, there is sufficient information to support assignment of code I21.02 *ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery.*

Heart Failure

Congestive heart failure describes a condition in which the heart isn't able to pump enough blood to meet a body's needs. This may happen when the heart muscle is weaker than normal, or when there is a defect in the heart that prevents blood from circulating. When the heart doesn't circulate blood normally, the kidneys receive less blood. The kidneys then filter less fluid out of circulation into urine. The extra fluid in circulation builds up in the lungs, the liver, around the eyes, and sometimes in the legs. This is called fluid "congestion;" thus, the condition "congestive heart failure."

Heart failure can be systolic, diastolic, or combined systolic and diastolic:



- When the left ventricle can't contract enough, it's systolic heart failure.
- When the left ventricle can't fill with enough blood, it's diastolic heart failure.

Heart failure can also be acute, chronic, or acute on chronic. In this case, acute heart failure is heart failure that happens when there has been sudden damage to the heart—for example, due to an MI, thrombus in the heart, or severe infection. Acute heart failure is life threatening.

Chronic heart failure happens slowly and is typically due to an underlying condition, such as hypertension or heart disease. Acute on chronic is seen when a patient has chronic heart failure and suffers an acute exacerbation.

Example: A patient presents to the emergency department with no prior cardiac history and no chronic diseases. He is found to have suffered an AMI and to be in systolic heart failure due to the AMI.

Note: For a better understanding of coding chronic conditions in ICD-10, read "Coding Chronic Conditions: An Acute Problem" on pages 16-17 of February's *Healthcare Business Monthly.*

An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, although an exacerbation may be triggered by an infection.

In this case, the documentation stating that the heart failure is brought on by the sudden MI renders the diagnosis acute systolic heart failure, indicated by ICD-10-CM code I50.21 *Acute systolic (congestive) heart failure*.

Asthma

Asthma is a chronic lung disease that inflames and narrows the airways. People with asthma experience symptoms when the airways tighten, inflame, or fill with mucus. According to the American Lung Association, asthma is one of the most common chronic disorders in childhood, with an estimated 7.1 million children under 18 years of age affected. It's the leading cause of absenteeism from school.

Common asthma symptoms include:

- Coughing, especially at night
- Wheezing
- Shortness of breath
- Chest tightness, pain, or pressure

Asthma is categorized by severity:

- **Mild intermittent:** The patient is symptomatic two or fewer days per week, awakens at night two times or fewer per month, uses a rescue inhaler two or fewer days per week, has no interference with normal activity, and has greater than 80 percent predicted lung functions and normal lung function between exacerbations.
- **Mild persistent**: The patient is symptomatic more than two days per week; awakens at night three to four times per month; uses a rescue inhaler more than two days per week, but not daily; has minor limitation with normal activity; and has greater than 80 percent predicted lung function.
- **Moderate persistent:** The patient is symptomatic daily; awakens at night more than once per week, but not nightly; uses a rescue inhaler daily; has some limitation with normal activity; and has 60-80 percent predicted lung functions.
- **Severe persistent:** The patient is symptomatic throughout the day; awakens nightly; uses a rescue inhaler several times per day; has extreme limitations with normal activity; and has less than 60 percent predicted lung functions.

Asthma is also categorized by complication:

- Without complications
- With acute exacerbation
- With status asthmaticus

According to ICD-10-CM guidelines (I.C.10.a.1), an acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, although an exacerbation may be triggered by an infection. Status asthmaticus is an acute exacerbation of asthma that remains unresponsive to initial treatment with bronchodilators.

Example: An asthmatic patient presents for a check-up. The patient states that she uses her rescue inhaler daily; her asthma awakens her a few nights per week; and she has some limitations to normal activities. She has been coughing and running a fever. She is found to have pneumonia.

This case is not asthma in acute exacerbation, but moderate persistent asthma with pneumonia—a chronic condition with the pneumonia superimposed. There is no indication of a sudden worsening of the asthma itself.

It All Comes Down to Proper Documentation

It's important to review these issues with your physicians and other providers to ensure documentation in the medical record supports the more specific code assignment possibilities in ICD-10-CM. You must also understand the differences in verbiage in ICD-10-CM to assign the correct codes. Working in cooperation with your peers will allow you to piece together the ICD-10-CM puzzle. HBM

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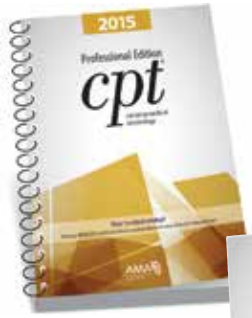

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By Susan Theuns, PA-C, CPC, CHC

Have a Realistic Approach to Developing ICD-10-CM Superbills

The process is fairly simple, but it requires time, analysis, and research.

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ICD-10 implementation is quickly approaching, and many practices are relying on vendors to make sure all of the pieces are in place to "go live." But what if they aren't ready? For practices using manual superbills/encounter forms, a contingency plan will ensure an uninterrupted revenue stream for Part B services billing beyond Oct. 1, 2014.

Create a Timeline

Updating a superbill can be a time-consuming process, and you must anticipate time for printing (especially if you use an "outside" vendor) and distributing forms. The following timeline is recommended for internal superbill conversion from ICD-9-CM to ICD-10-CM:

- **Early 2014:** Review existing form(s) and begin process (see "Step Out the Process" section) using 2014 ICD-10-CM codes.
- **June 2014:** Send updated form(s) with ICD-10-CM codes to your print vendor for proof set up.
- **August 2014:** When 2015 ICD-10-CM codes are released, review and update the superbill proof. Return the final, updated form(s) to the print vendor for final proof.
- **September 2014:** Submit a print order to vendor, with a delivery date to sites prior to the Oct. 1 effective date.

Hire a Print Vendor

Selecting a reliable print vendor is critical when updating your superbill. Look for a vendor with a reputation for putting out a good product, with reasonable prices, and a quick turnaround. To ensure your forms are printed and ready for use in offices by Oct. 1, agree on a timeline with your vendor. When the timeline is finalized, the process to create the superbill can begin. Maintain close communication with the print vendor to ensure everything stays on course.

Step Out the Process

The steps below will yield a single two-sided superbill, with header and services on the front and diagnosis codes on the back. The front of the form should already be set with current codes from the January 2014 updates.

Here is a basic process for updating a single-specialty form:

1. Review existing ICD-9-CM codes on your current forms. Compare it with a "top 100 most used diagnoses" report, using frequency reports from the appropriate billing system(s).
2. Revise the list of ICD-9-CM codes based on report data and changes in practice.
3. Select the top 20-50 diagnosis codes (as space allows, for a single page).
4. Refer to the Centers for Medicare & Medicaid Services' (CMS) general equivalence mappings (GEMs) to compile a new list of codes using ICD-10-CM. Note that GEMs are not 100 percent accurate, so it's best to code directly from the ICD-10-CM code book, when possible.
5. For each specialty, include applicable manifestation codes for the most commonly used diagnostic conditions in the category.
6. For the top 20 most-used codes (based on the frequency report), include all codes to the most specific character (i.e., if the code requires six characters, the reported code must include all six characters, or it will be invalid for billing purposes).

To ensure your forms are printed and ready for use in offices by Oct. 1, agree on a timeline with your vendor.

Table A: Your superbill should include the most common diagnoses seen in your practice.

Diabetes	Type 1	Type 2	Other
w unsp complications	E10.8	E11.8	
w/o complications	E10.9	E11.9	
w unsp DM retinopathy	E10.31	E11.31	
w unsp neuro complications	E10.40	E11.40	
w other spec complication	E10.69	E11.69	
Other DM Dx:			

Hand	Right	Left	Unspecified
Boutonniere deformity finger(s)	M20.021	M20.022	M20.029
Carpal tunnel	G56.01	G56.02	G56.00
Reiter's disease	M02.341	M02.342	M02.349
Rhematoid nodule	M06.341	M06.342	M06.349
Swan-neck deformity finger(s)	M20.031	M20.032	M20.039
Other deformity finger(s)	M20.091	M20.092	M20.099

Preventive Care		
General adult checkup	Z00.00	
w abnormal findings	Z00.01	code add'l dx
Routine well woman	Z01.419	
w abnormal findings	Z01.411	code add'l dx
Screen for prostate cancer	Z12.5	

7. In each category listed, include blank lines for the provider to include more specific information or additional codes and information not listed on the superbill.
8. Furnish additional codes that cannot fit onto the form (on a single side) using laminated reference guides (either produced in-house or purchased).

Be Realistic

No one expects every possible code to fit on a standard superbill. But with some planning and knowledge of the most commonly diagnosed problems by specialty and provider, you certainly can cover the codes that are used most frequently. Knowing your clinicians and patient population is key.

For example, there are many different types of diabetes that can be coded in ICD-10-CM, but the two most commonly diagnosed types are type 1 and type 2. Do not try to fit every possibility on the form. Clinicians can write in diagnoses outside of the norm for look-up or use a reference guide to assign a code.

As you transition to ICD-10-CM, the goal should be to code to the highest level of specificity without getting bogged down with details that will not affect care or billing. Finding this balance may take time. **Table A** shows examples for various specialties.

The process of developing a superbill is fairly simple, but it requires time and a lot of analysis and research. Having a back-up plan for tentative vendor failure, however, will add peace of mind, as well as familiarize staff and providers with the new codes and nomenclature. Recognition and familiarity may help to alleviate the "fear factor" of the upcoming transition.

Healthcare business professionals, including compliance professionals, coders, billers, auditors, and clinicians, need to be ready to meet the requirements of ICD-10-CM because they are directly tied to reimbursement. It's up to coding and compliance professionals to lead the way, to implement the tools for billing, to provide training for a smooth and successful transition to ICD-10-CM, and to provide reassurance that it can be done! HBM

Susan Theuns, PA-C, CPC, CHC, is administrative director of physicians' practices at MedStar Union Memorial Hospital and has an extensive background in healthcare, business management, facilities/operations, and compliance, spanning more than three decades. She holds a master's degree in leadership and education and a Bachelor of Arts degree in business management. Theuns is a certified physician assistant, coder, and healthcare compliance professional. She serves on the advisory board for OptumInsight and is a contributing author for *The Business of Medical Practice*. She is a member of the Baltimore, Md., local chapter.

By Debra Mitchell, MSPH, CPC-H

S52.222A

Initial, Subsequent, or Sequela Encounter?

Take the patient's perspective when appending the seventh character in ICD-10-CM.

A diagnosis is meant to describe the patient at a particular encounter. That may sound obvious, but it's a fact with important implications. As we move toward ICD-10 implementation in October, remember that the new code set requires us to append a seventh character for injuries and most external cause reporting.

The seventh character indicates:

A - Initial encounter

D - Subsequent encounter

S - Sequela

Put Yourself in the Patient's Shoes

A, D, and S do not represent the provider encounter, but the diagnosis from the *patient's perspective*. Is this a patient's initial encounter for *active treatment* of this injury? If so, it's an initial encounter. Has the patient previously received (by any provider) active treatment for this condition? If so, it's a subsequent encounter.

For example: The patient had an injury treated at a previous encounter by a different provider, and is following up with your provider. Even though this is your provider's first encounter with this patient, it's the patient's subsequent encounter for this injury, and you should classify the visit with a seventh character D.

"Initial" Is a Subtle Concept in ICD-10

There is a wrinkle: The ICD-10-CM definition of *initial* is more complicated than the usual understanding of the word. Specifically, guidelines state that a seventh character A is "used for the initial encounter for the injury or condition *while the patient is receiving active treatment for the injury*. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician" [emphasis added].

The statement "evaluation and treatment by a new physician" can be a source of confusion, but you will code correctly if you are able to answer the basic question, "Has the patient previously received *active treatment* for this condition in any setting or by any provider?"

For example: The patient is evaluated in the emergency room (ER) for a displaced transverse fracture of the left ulna that cannot be managed at this time. The ER applies

There is a wrinkle: The ICD-10-CM definition of *initial* is more complicated than the usual understanding of the word.

immobilization and ice and instructs the patient to follow up with orthopedics in the morning. This would be reported using S52.222A *Displaced transverse fracture of the left ulna, initial encounter for closed fracture.*

When the orthopedist evaluates the patient and reduces the fracture the next day, the patient is receiving initial active treatment for this fracture. That is, this is the first encounter at which the patient receives definitive care (the ER was able to apply comfort care only). Per ICD-10 guidelines, you would again report S52.222A for an initial encounter.

Now, let's change the scenario: The patient has a greenstick fracture of the shaft of the left ulna, which is definitively managed in the ER with a cast or splint. You would report this with S52.212A *Greenstick fracture of the shaft of left ulna, initial encounter for closed fracture.*

When the patient is evaluated for the injury in the orthopedic office at a later date, it is a subsequent encounter (from the patient's point of view). This is true even if the cast or splint is removed and a new one is applied because the patient already received definitive fracture care in the ER.

Subsequent Is Simple

ICD-10-CM defines subsequent encounters as "encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following injury treatment."

Continuing with our example: If the fracture is healing as it should, the orthopedic office would report S52.212D *Greenstick fracture of the shaft of left ulna, subsequent encounter for fracture with routine healing.*

What Is Sequela?

ICD-10-CM says the seventh character S is "for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn." In other words, sequela are the late effects of an injury.

Perhaps the most common sequela is pain. Many patients receive treatment long after an injury has healed as a result of pain. Some patients might never have been treated for the injury at all. As time passes, the pain becomes intolerable and the patient seeks a pain remedy.

For example: A patient suffers a low back injury that heals on its own. The patient isn't seeking intervention for the initial injury, but for the pain that persists long after. The chronic pain is sequela of the injury. Such a visit may be reported as G89.21 *Chronic pain due to trauma* and S39.002S *Unspecified injury of muscle, fascia and tendon of lower back, sequela*.

The bottom line: With ICD-10 CM, it's important to stay focused on the patient's diagnoses and code only from that perspective. HBM

Debra Mitchell, MSPH, CPC-H, is a coding and compliance consultant and auditor, as well as a professional instructor in coding, billing, and medical terminology. She has developed several courses for adult education programs in medical coding and billing, and has contributed to the development of a coding certification program. Mitchell was recently named to the Biltmore's Who's Who in America's Professional Women. She is a member of the Colombia, Mo., local chapter.

By Terri Brame, MBA, CHC, CPC, CPC-H, CPC-I, CGSC

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CPT® 2014 Groups Drainage Codes with S&I

Familiarize yourself with new image-guided percutaneous fluid collection drainage codes, understand the rules, and apply them to scenarios.

A review led by the American Medical Association's CPT® Editorial Panel last year showed that codes for the surgical portion of percutaneous fluid drainage procedures were being reported with the codes for imaging supervision and interpretation (S&I) more than 75 percent of the time. Based on this review, the consensus reached was that a single code representing both services may be more appropriate. As a result, CPT® 2014 brings major changes for reporting percutaneous fluid drainage by catheter.

Many Changes to 2014 Coding

Several drainage codes were deleted for CPT®2014 and replaced by only a handful of new, more inclusive codes.

Deleted CPT® codes, effective Jan. 1, 2014:

32201 Pneumonostomy; with percutaneous drainage of abscess or cyst

44901 Incision and drainage of appendiceal abscess; percutaneous

47011 Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages

48511 External drainage, pseudocyst of pancreas; percutaneous

49021 Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous

49041 Drainage of subdiaphragmatic or subphrenic abscess; percutaneous

49061 Drainage of retroperitoneal abscess; percutaneous

50021 Drainage of perirenal or renal abscess; percutaneous

58823 Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)

New codes were created specifically to describe draining fluid collections by catheter, defined within the code descriptors as an abscess, hematoma, seroma, lymphocele, cyst, or other similar contained fluid collection.

New CPT® codes, effective Jan. 1, 2014:

10030 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

49405 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

49406 peritoneal or retroperitoneal, percutaneous

49407 peritoneal or retroperitoneal, transvaginal or transrectal

Note: Code 49407 requires the needle or catheter to be passed through the vagina or rectum to reach the fluid collection within the rectum. This code is not reported for draining fluid from the vagina.

Percutaneous fluid drainage involves inserting a large bore needle or catheter into fluid collection to drain that fluid. The device is often left in place to allow continuous fluid drainage, as needed. Because the procedure is performed without an open approach, many physicians use imaging—including fluoroscopy, ultrasound, computed tomography (CT), or magnetic resonance imagery (MRI)—to guide the needle insertion and confirm the needle accesses the fluid. S&I of the imaging is always included.

Never report the following radiologic S&I CPT® codes with percutaneous image-guided fluid collection drainage codes:

75989 Radiologic guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation

76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

77012 Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation

77021 Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation

Percutaneous image-guided fluid collection drainage codes may be reported once for each fluid collection drained, but may not be reported more than once per fluid collection, regardless of the number of times the fluid collection is accessed.

Clinical Scenario 1

Indications: A 67-year-old patient presents with fever and left, upper-quadrant pain increasing over the past 36 hours. The pain is not associated with eating a meal or other event. Patient has known cirrhosis secondary to alcoholism. CT indicates a right hepatic abscess.

Procedure: The physician identifies the right hepatic lobe abscess using imaging guidance. The abscess is accessed using a guidewire. The physician aspirates purulent material, which is sent for culture. The access point is dilated to allow placement of a drainage catheter, which is sutured in place without complication.

Coding: 49405

Many new parenthetical instructions have been added to CPT® to redirect you to other drainage codes.

Clinical Scenario 2

Indications: A pediatric patient with a history of chronic throat infections presents with continued swelling and pain in the neck, not associated with a current infection. The physician suspects retropharyngeal abscess secondary to lymph node breakdown, versus cellulitis. CT confirms there is an abscess.

Procedure: Using CT imaging, the physician identifies the retropharyngeal abscess and enters the fluid collection with a guidewire. Purulent material is aspirated and sent for culture. The access point is dilated to allow placement of a drainage catheter, which is sutured in place without complication. The patient is kept inpatient until the drain can be removed.

Coding: 10030

New Codes Apply to Percutaneous Drainage, Only

The new codes only apply to percutaneous drainage by catheter and certain transvaginal and transrectal drainages. Many new parenthetical instructions have been added to CPT® to redirect you to other drainage codes. In all, CPT® added or revised 30 parenthetical notes regarding correct coding for fluid drainage. For example, following 49407, parenthetical notes direct the coder to thoracentesis, percutaneous pleural drainage, open drainage, and peritoneal drainage codes.

CPT® retains existing codes to report specific percutaneous procedures. For example, percutaneous cholecystostomy (creating a surgical opening in the gallbladder using a percutaneous approach) is still reported using 47490 *Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation*; and cavity drainage is still reported with codes for thoracentesis (32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance*, 32555 *Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance*) and abdominal paracentesis (49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance*, 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance*). HBM

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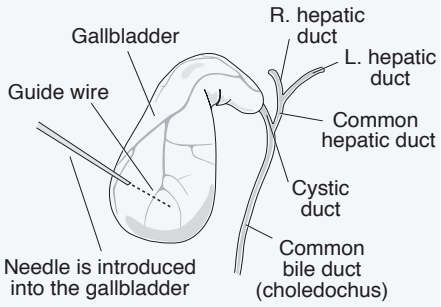
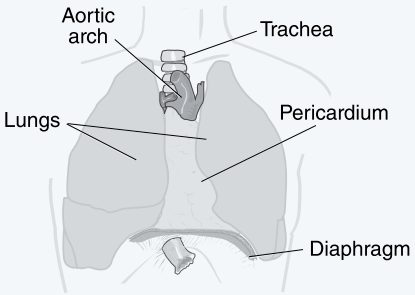
47490

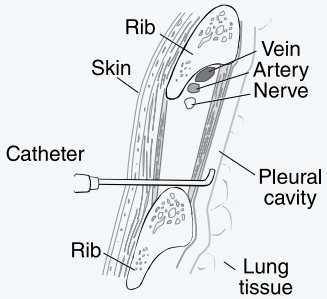


The gallbladder is accessed subcutaneously. Using ultrasound guidance, a needle is introduced into the gallbladder. A guide wire is passed through the needle. The needle is withdrawn and a catheter is fed over the guide wire and into a set location

32554-32555



The pleural space is aspirated



Unusual Code Placement

In a departure from common CPT® formatting, the CPT® Editorial Panel determined it was more important to group similar procedures together than to create new codes in each surgical section.

As a result, some percutaneous image-guided fluid collection drainage codes are not found in the associated organ system section. For example, code 10030 is categorized as an integumentary system code, but includes soft tissues usually coded from the musculoskeletal system, including fascia and muscle.

As well, lung/mediastinum drainage is included in 49405, rather than being coded from the 30000 series.

By J.C. Cortese, MS, DC, CPC

Rise to Psychiatry Coding Challenges

When following DSM-5 to ICD-10 crosswalk recommendations, look out for dead ends.

The introduction of *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) to the psychiatric community brought with it new challenges for the coder. With its predecessor, DSM-IV, we enjoyed a relative harmony with ICD-9-CM, but ICD-9-CM is on its way out, soon to be replaced by ICD-10-CM.

During development of DSM-5, there became an awareness that DSM-IV and ICD-10-CM diagnoses do not always agree. Although DSM-5 includes the American Psychiatric Association's crosswalk from DSM-5 to ICD-9-CM and ICD-10-CM, crosswalk recommendations do not always lead to the codes we're used to seeing when following ICD-9-CM guidelines.

Significant Changes from DSM-IV to DSM-5

To use DSM-5 for proper code assignment, be aware of how it differs from DSM-IV. Here's a run-down:

1. The multi-axis system (I-V) introduced with DSM-III has been eliminated. Coding would regularly use the first three axes for diagnoses:
   - **Axis I:** Mental and clinical disorders
   - **Axis II:** Personality and clinical disorders
   - **Axis III:** Physical problems that may be relevant to the diagnosis and treatment of mental disorders

   DSM-V combines all three axes into a single list that contains mental and personality disorders, intellectual disabilities, and other medical diagnoses.

There is a host of diagnoses that were replaced with new codes or combined into a single code.

Tip: Frequently, physician documentation notes the designated "active problem list" with no primary diagnosis indicated. If the documentation does not clearly support a primary diagnosis (reason for encounter), query the provider for clarification.

2. Not otherwise specified (NOS) has been replaced with "other disorder" or "unspecified disorder."
3. DSM-IV listed 22 codes as the ICD-9-CM factors influencing health status, while DSM-5 lists 88 codes.
4. Codes describing abuse increase from five to 44.
5. There are 17 new disorders, 28 nomenclature changes, and 14 new combination codes.
6. The words "probably" (17X) and "possible" (4X) have been added to the name of some neurocognitive disorders. These are non-existent in DSM-IV and ICD-9-CM.
7. Severity scales (e.g., mild, moderate, severe) have been added to many codes.

Crosswalked Codes Reveal Inconsistencies

Nomenclature changes and new disorders represent the most significant challenge to the psychiatry coder. Not only are they not found in the ICD-9-CM indices, but the "crosswalk" codes provided in DSM-5 do not always reflect the actual code arrived at through established coding guidelines. There is a host of diagnoses that were replaced with new codes or combined into a single code. Some major changes in DSM-5, as compared to ICD-9-CM, include:

- **Autism spectrum disorder** (299.00 Autistic disorder, current or active state) eliminates pervasive development disorder (299.90 *Unspecified pervasive developmental disorder, current or active state*) and Asperger's syndrome (299.80 *Other specified pervasive developmental disorders, current or active state*).
- **Somatic symptom disorder** (300.82 *Undifferentiated somatoform disorder*) replaces somatization (300.81 *Somatization disorder* and 306.9 *Unspecified psychophysiological malfunction*) and somatoform disorder (300.82).
- **Major neurocognitive** disorder (294.XX) with a separate code for "possible" (331.83 *Mild cognitive impairment, so stated*, 331.9 C*erebral degeneration, unspecified*), dementia.
- **Social (pragmatic) communication disorder**—new (315.39 *Other developmental speech or language disorder*)
- **Language disorder** (315.39) no longer differentiates expressive language disorder (315.31 *Expressive language disorder*) and mixed receptive expressive language disorder (315.32 *Mixed receptive-expressive language disorder*).
- **Catatonic, disorganized, paranoid, residual, and undifferentiated schizophrenia** are replaced with schizophrenia (205.9X).
- **Social anxiety disorder** (listed as 300.23 *Social phobia* in DSM-5, but codes to 300.09 *Other anxiety states ICD-9-CM*) replaces social phobia, which codes to 300.23.
- **Binge eating disorder** (307.51 *Bulimia nervosa*) codes to eating disorder (307.59 *Other disorders of eating*) in ICD-9, and changes from binge-purge syndrome (307.51)—not listed in ICD-9-CM or ICD-10-CM.
- **Drug/Alcohol abuse** (305.90 *Other, mixed, or unspecified drug abuse, unspecified* and 305.00 *Alcohol abuse, unspecified*) are now referred to as addictions (304.80 *Combinations of drug dependence excluding opioid type drug, unspecified* and 303.90 *Other and unspecified alcohol dependence, unspecified*)
- **Disruptive mood dysregulation** (296.99 *Other specified episodic mood disorder),* new, is not listed in ICD-9-CM or ICD-10-CM.
- **Social communication disorder** (315.39 *Other developmental speech or language disorder*), new, is not listed in ICD-9-CM or ICD-10-CM.
- **Disinhibited social engagement** (313.89 *Other emotional disturbances of childhood or adolescence*), new
- **Panic disorder without agoraphobia** (300.1 *Dissociative, conversion and factitious disorders*) and panic disorder with agoraphobia (300.21 *Agoraphobia with panic disorder*) are now coded to 300.01 *Panic*

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The challenge lies in whether to code the physician's diagnosis using DSM-5 nomenclature as referenced … or to select a code from ICD-9-CM and, in doing so, ignore the clear intent of the physician's documentation.

disorder without agoraphobia. DSM-5 lists panic disorder as recurrent unexpected Panic attacks 300.01. It separately lists agoraphobia as 300.22 *Agoraphobia without mention of panic attack*s. If both are present, you need to use both codes.

- **Hoarding** (300.3 *Obsessive-compulsive disorders*), new, is not listed in ICD-9-CM or ICD-10-CM.
- **Excoriation/Skin picking** (698.4 *Dermatitis factitia [artefacta*) is dermatitis factitia (neurotic excoriation) in ICD-9-CM and is instructed to use a code for any associated mental disorders. If "unspecified excoriation or other specified" is selected, it will code to 919.8 *Other and unspecified superficial injury of other, multiple, and unspecified sites, without mention of infection*.
- **Provisional tic disorder** (307.21 *Transient tic disorder*) provisional nomenclature replaces transient tic disorder (307.21).
- **Persistent depressive disorder** (300.4 *Dysthymic disorder*) replaces dysthymia in DSM-5.

One of the most significant changes is the classification of personality disorders. These are now divided into Cluster A (301.0, 301.20, 301.22), B (301.7, 301.83, 301.50, 301.81), C (301.82, 301.6, 301.4), or "Other." If the specific personality disorder is not documented, communication with the provider is vital to selecting an accurate code.

DSM vs. ICD

The challenge lies in whether to code the physician's diagnosis using DSM-5 nomenclature as referenced, which does not translate to the same code in ICD-9-CM, or to select a code from ICD-9-CM and, in doing so, ignore the clear intent of the physician's documentation. If you do the former, you are coding from DSM-5. If you do the latter, you run the risk of assigning a code that doesn't accurately reflect the diagnosis assigned by the provider.

For example, consider two possible coding scenarios based on physician documentation, shown in **Table A**.

Table A: Documentation leads to two possible coding scenarios.

Diagnosis	ICD-9-CM	DSM-5
Social anxiety disorder	300.09	300.23
Panic disorder with agoraphobia	300.21	300.22 Agoraphobia without mention of panic attacks, and 300.01
Moderate alcohol use disorder	305.00	303.90
Asperger's disorder	299.80	299.00
Attention deficit hyperactive disorder (predominately inattentive type)	314.01 Attention deficit disorder with hyperactivity	314.00 Attention deficit disorder without mention of hyperactivity

Work Together

To help you accurately represent the patient's diagnoses, it's vital to consider psychiatric coding challenges and answer reporting questions. Demonstrate good communication with your provider during the transition to ICD-10-CM to ensure the patient's diagnoses accurately reflect his or her state of health. HBM

J.C. Cortese, MS, DC, CPC, has worked for the University of Iowa Hospital and Clinics, Department of Psychiatry, Coding Intelligence Division since 2012. She has a Doctor of Chiropractic degree from Northwestern Health Sciences University and a Master of Science from Vanderbilt University. After retiring from chiropractic practice, Cortese spent 12 years translating orthopedic research from Czech to English at Motol Hospital, First Faculty of Orthopedics, Prague, Czech Republic.

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Author: Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

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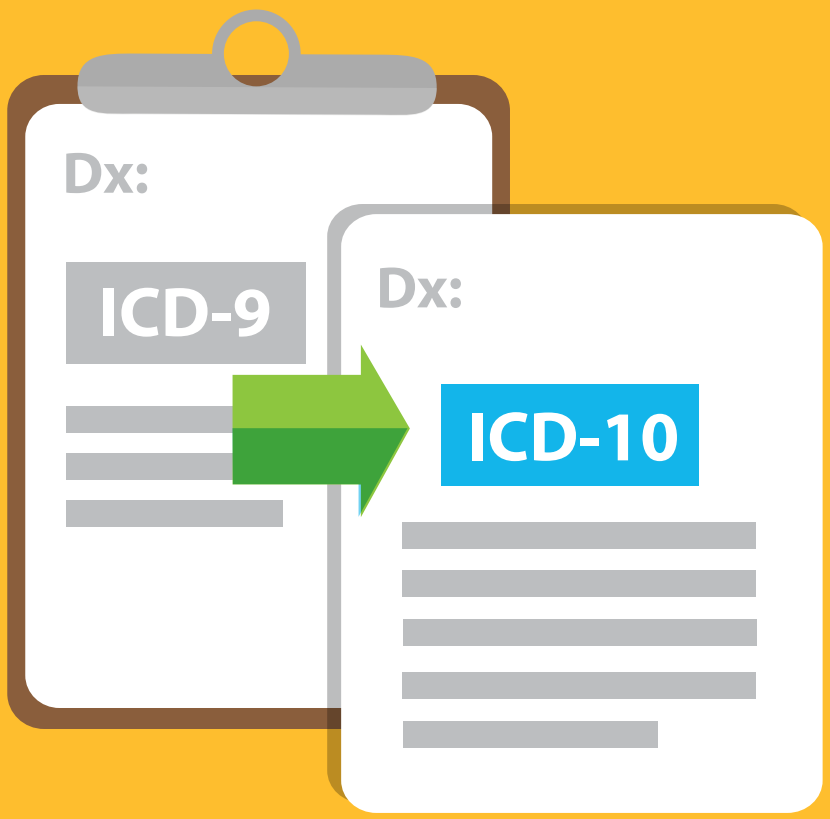

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Tissue Expansion After Mastectomy

Coding breast reconstruction can be difficult, but knowing procedures and diagnoses helps.

By Victoria M. Moll, CPC, CPMA, CPRC

The provider should document if the capsule was particularly thick or tight to support the extra effort involved for billing the higher service.

Breast cancer is responsible for the death of one in every 36 women in the United States. Women who undergo a mastectomy to remove malignant tissue are faced with an array of reconstructive options, including flaps and implants. Most commonly, implants are placed in a staged fashion. More insurers are covering these services, but the details of coding a reconstruction can be tricky.

Expansion Follows Mastectomy

Immediately after a patient's mastectomy, a reconstructive surgeon will evaluate the skin flaps and prepare to insert a tissue expander. Following placement of the expander, the patient will present for subsequent fills of saline until the breast has expanded to the patient's liking.

CPT® 19357 *Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion* describes this first stage. The use of a dermal matrix, such as AlloDerm®, facilitates a higher initial expansion and is additionally billable with add-on code +15777 *Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure).*

Insertion of the tissue expander apparatus into the chest wall includes all office visits for progressive expansion within the 90-day global period. Because this process can extend beyond the 90-day global for the initial surgery, any office visits past that period may be billed using the appropriate evaluation and management (E/M) code.

For example, the patient has bilateral tissue expanders with dermal matrix placed on May 1. This surgery is coded 19357-50 and 15777-50. The patient presents for her first fill on June 1, and has subsequent fills on June 17, June 30, and July 19. On Aug. 5 the patient returns again. This service is outside of the 90 day global period for the tissue expander insertion. During her visit for the fill, the physician completes a problem focused history and exam with straightforward medical decision-making. This visit is billed as 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.*

Exchanging Prosthesis Includes Shaping

The tissue expander may serve as the final prosthesis, but the majority of patients have the expander exchanged for a silicone or saline implant. A general exchange of the tissue expander for the permanent prosthesis is reported with 11970 *Replacement of tissue expander with permanent prosthesis*. However, if extensive capsular work is performed, you may instead report 19342 *Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction*.

Per *CPT® Assistant* (January 2013):

> … code 11970 includes some minor adjustments to the capsule. However, when significant adjustments are made to the capsule, many of which comprise a significant part of the procedure, and when appropriately documented, code 19342, *Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction*, may be reported to represent the additional maneuvers that involve more surgeon time and work. For example, sometimes the capsule must be significantly modified, the infra-mammary crease must be lowered or raised, or partial or total capsulectomy must be performed.
>
> Another example of the type of work associated with the use of code 19342 is breast reconstruction with expander in a patient undergoing postoperative expansion. When the tissue expander is replaced, it may be that the capsule is found to be very tight and multiple radial incisions may be required in the capsule to accommodate the permanent prosthesis and form a symmetric contour to the opposite breast. CPT code 11970 alone does not account for this additional work, which is over and above removal of an expander and replacement with a permanent implant.

The provider should document if the capsule was particularly thick or tight to support the extra effort involved for billing the higher service. If this portion falls within 90 days of the expander placement, use modifier 58 to indicate a staged procedure.

Case Scenario 1

"I came down upon the previous scar with the scalpel and excised it as an ellipse. I incised and came down upon the expander, which easily peeled free and was removed. The pocket was washed with antibiotic solution. Under super sterile conditions, the final implant was placed and the wound was stitched closed in a layered fashion."

In this case, the physician removed the tissue expander and exchanged it for an implant in a straightforward fashion, without any extra work done to the breast or the capsule. CPT® 11970 is the correct code for this procedure.

Side Matters

CPT® breast procedure codes are unilateral. Providers must document on which side (or both) they are operating. When documenting a bilateral procedure, the physician might describe the first side in full and state that a mirror procedure was done on the other side. If the bilateral procedures are not identical, the process for each side should be detailed in the operative report.

Note that payer requirements may differ regarding application of modifier 50 *Bilateral procedure* and modifiers LT *Left side* and RT *Right side*. Review your individual payer rules when assigning the anatomical modifiers.

Billing for 19380 at the time of an exchange would be like filing an auto claim for a car that's still on the assembly line.

Case Scenario 2

"Attention was turned to the left breast where the patient had an oncologic mastectomy for breast cancer. The lateral portion of the previous scar was incised with a #15 blade and an ellipse of the tissue was passed off the field. Bovie was used to deepen down to the capsule, and the expander was removed. The capsule was found to be very tight and thick, so multiple radical incisions were made and a complete capsulectomy was performed. The capsule tissue was sent to pathology. The capsule was washed several times with saline and was found to be hemostatic. A high profile textured smooth gel silicone implant was opened and deployed into the pocket before closing the wound in a layered fashion."

The breast capsule was tight and required radical incisions to remove it in its entirety. Code 19342 would be appropriate due to the extra amount of work involved with the surgery.

Shaping, Tattooing Are Included

Any revision done at this time to properly shape the breast is included in the expander exchange. Because the breast is not fully reconstructed until after all stages are complete, 19380 *Revision of reconstructed breast* may be reported only when correcting later contour irregularities, deformities, etc. Billing 19380 at the time of an exchange would be like filing an auto claim for a car that's still on the assembly line.

The nipple is reconstructed in the final stage. Any nipple-areolar reconstruction, such as skate flap, C-V flap, or cartilage graft, may be reported with 19350 *Nipple/areola reconstruction*. The graft or flap is included in 19350 and may not be billed separately. Nipple tattooing, which can be done as an office procedure, is also included in 19350.

Tattooing may be billed only if no other reconstruction has been done on the nipple, or when performing touch-ups. Correct coding in such cases is 11921 *Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.1 to 20.0 sq cm* for the first 20 square centimeters and +11922 *Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; each additional 20.0 sq cm, or part thereof (List separately in addition to code for primary procedure)* for each additional 20 sq cm.

For example, a patient presents to her surgeon's office three years after her breast reconstruction. She previously had bilateral skate flap nipple reconstruction with tattooing, but the tattoos have faded and the patient desires a touch-up. Each nipple is approximately 20 sq cm, equaling a total of 40 sq cm for both nipples. Because nipple tattooing is calculated based on the total size of the areas, this is coded as 11921 and 11922.

Watch Your Diagnosis Placement

Because many payers reimburse breast reconstruction services only in relation to breast cancer, it's prudent for providers to document current or past history of breast cancer in the operative report. Although there are other applicable diagnoses for these cases, listing a cancer code as primary diagnosis may prevent the claim from hitting insurance edits designed to deny services not meeting that criteria. HBM

Common Related Diagnoses	
174.0-175.9	Malignant neoplasm of breast
198.81	Secondary malignant neoplasm of breast
233.0	Carcinoma in situ of breast
V10.3	Personal history of malignant neoplasm of breast
V16.3	Family history of malignant neoplasm of breast
V45.71	Acquired absence of breast and nipple
V51.0	Encounter for breast reconstruction following mastectomy
V84.01	Genetic susceptibility to malignant neoplasm of breast

Victoria M. Moll, CPC, CPMA, CPRC, is a coder for a large physician group. She has over seven years of experience in billing and coding for hospitalists, obstetrics/gynecology, transplant services, general surgery, and plastic and reconstructive surgery. She previously worked as a coding instructor at a local technical school, and now serves as education officer in the Allentown, Pa., local chapter.

Why I Code

Kelly Mitchell, CPC, CGCS

In 2009, I was preparing for some major changes that were about to take place in my life: I was getting married, selling my house, and moving to a new location to live with my husband. I was also faced with finding a new job. I had been working in state law enforcement for 18 years, and I was ready for a major change in that area of my life, too.

Change is Good

I've always been interested in anatomy, and a job in healthcare appealed to me. While researching healthcare jobs, I discovered that my local career center offered an introductory course to their Medical Coding program. By the time I completed the course, I knew I had found my second career. I started school in September 2009, a few weeks after I got back from my honeymoon.

Knowing experience with the local hospital/healthcare system would help, I began working part time at a pediatric clinic as a patient service representative. Because the clinic was usually short staffed, part-time work became full-time hours, and I quickly gained front desk experience. During this time, I also took a Certified Professional Coder (CPC®) exam preparatory class two nights a week and I completed 62 hours of professional/clinical hands-on training with an obstetrics-gynecology reimbursement group.

One Foot in the Door

I completed the preparatory course in October 2010 and passed the AAPC certification exam the following month. I continued to work at the pediatric clinic until I was hired by the University of Missouri Health System as a certified reimbursement assistant, coding internal medicine. My primary responsibility is gastroenterology (coding consults and procedures). I also have learned to code for hospitalists, pulmonary, nephrology, rheumatology/immunology, infectious disease, and echocardiograms. After 2-½ years as a physician coder, I now code for the emergency room at Women and Children's Hospital and work with bills and denials. I love to learn continually, and this new job is giving me experience that will open more doors to other coding and healthcare opportunities.

Why Stop There?

Last year, I was accepted into the Master of Healthcare Administration Executive Program and I began working on a dual master's degree in Health Administration and Health Informatics. After 24 years since obtaining my Bachelor of Science degree, it has been a challenge going back to school. My goal is to continue with my medical coding occupation and gradually work my way into a management/auditing/training career. I know that attaining a master's degree will give me a broader overview of the U.S. healthcare system and prepare me for the challenges I face.

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-Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, CPEDC, CENTC
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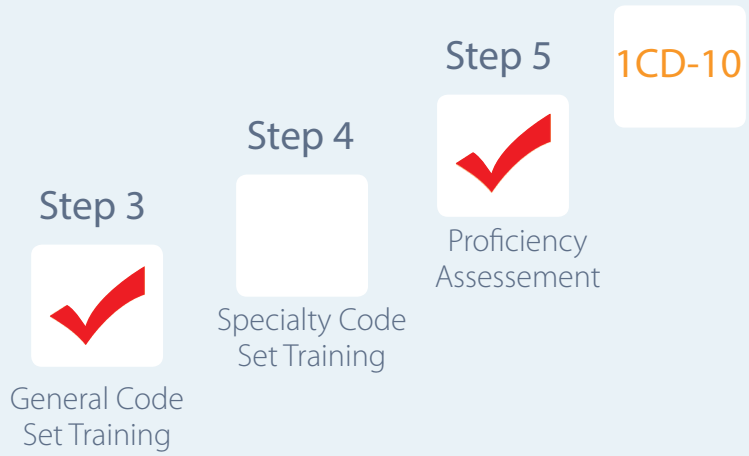

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By Laurette Pitman, RN, CPC-H, CGIC, CCS

[Cover]

New Technology Advances Bariatric Surgery

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For more precise coding, understand underlying causes, anatomy, and new treatment options for obesity.

Obesity has become a public health concern in the United States. In 2012, 26.2 percent of Americans were considered to be obese; of this population, 4 percent were considered to be morbidly obese.

Body mass index (BMI) is the primary measurement used to classify obese patients. In 1991, the National Institutes of Health provided the following definitions:

Category	Body Mass Index (kg/m2)	Over Ideal Body Weight (%)
Overweight	25.0 – 29.9	
Obesity (class 1)	30 – 34.9	>20%
Severe obesity (class 2)	35 – 39.9	>100%
Severe obesity (class 3)	40 – 49.9	
Superobesity	>50	>250%

Factors, Associated Conditions, and Non-surgical Treatment

Simply put, obesity occurs when a person takes in more calories than he or she burns through exercise and normal daily activities. The body stores the excess calories as fat. Additional factors that may contribute to the development of obesity include:

- Inactivity
- Unhealthy diet and eating habits
- Pregnancy
- Lack of sleep
- Certain medications
- Medical problems (Prader-Willi syndrome, Cushing's syndrome, polycystic ovary syndrome, hypothyroidism)

There are more than 30 co-morbid conditions associated with severe obesity. According to information from the Cleveland Clinic, the most common of these is insulin resistance and diabetes mellitus, which occur in 15-25 percent of obese patients. Other common obesity-related conditions include hypertension, heart disease, cancer, osteoarthritis of weight bearing joints, sleep apnea, respiratory problems, gastroesophageal reflux disease, depression, infertility, and urinary stress incontinence.

Obesity treatment may start with counseling on diet, exercise, and lifestyle modifications. In patients who fail to achieve weight loss goals through diet and exercise alone, or who have significant co-morbidities, pharmacologic therapy may be added.

Multiple drugs now on the market may be prescribed for appetite suppression. All have side effects. The choice of drug is usually dependent on the patient's ability to tolerate those side effects. According to the Cleveland Clinic, the amount of weight loss achieved through pharmacologic therapy is generally modest (< 5 kg at one year).

Surgical Intervention

In recent years, we have seen surgical options for morbid obesity become more common. Patients with a BMI >35 kg/m2 with obesity-related co-morbidities, and those with a BMI >40 kg/m2 with or without co-morbidities, are eligible for bariatric surgery. Other criteria for surgical candidacy include:

- Acceptable operative risk
- Documented failure of nonsurgical weight loss programs
- Psychologically stable, with realistic expectations
- Well-informed and motivated patient
- Supportive family and social environment
- Absence of active alcohol or substance abuse
- Absence of uncontrolled psychotic or depressive disorder

The National Institutes of Health guidelines recommend bariatric surgery to be limited to patients 18-60 years old.

The most commonly performed bariatric procedures are the Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding, and the sleeve gastrectomy. All of these procedures have a CPT® Category I code available for assignment when these surgeries are performed. Because coverage guidelines for each procedure vary by payer, you

There are more than 30 comorbid conditions associated with severe obesity.

Patients with a BMI >35 kg/m2 with obesity related comorbidities, and those with a BMI >40 kg/m2 with or without comorbidities, are eligible for bariatric surgery.

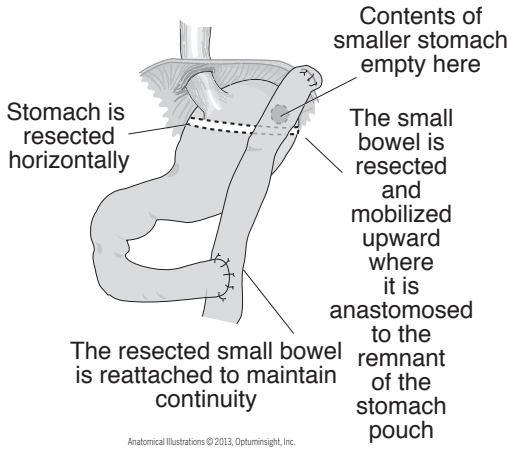
must know these individual guidelines to bill appropriately and receive reimbursement.

Roux-en-Y Gastric Bypass

The Roux-en-Y gastric bypass combines a restrictive component and a limited proximal intestinal bypass, and is the most common bariatric procedure performed in the United States. This procedure can be performed by open or laparoscopic techniques, with the laparoscopic procedure resulting in a faster recovery and fewer complications.

A small, 15 to 30 mL gastric pouch is created to restrict food intake, and a Roux-en-Y anastomosis bypasses the duodenum and proximal jejunum. This procedure has been found to result in superior weight loss and co-morbidity resolution.

CPT® codes for this procedure are 43644 *Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy* and 43846 *Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy*.



Adjustable Lap Band

The laparoscopic adjustable gastric band has been approved for use in the United States since 2001. A silicone band with an inflatable inner collar is placed around the upper portion of the stomach to create a small gastric pouch, and to restrict the gastric cardia. The band is connected to a port that is placed in the subcutaneous tissue of the abdominal wall. The inner diameter of the band can be adjusted by injecting saline through the port.

The Category I CPT® code for insertion of the lap band is 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)*. Several codes are available for the removal, revision, and replacement of the device.

Laparoscopic Sleeve Gastrectomy

The laparoscopic sleeve gastrectomy has been in use as a bariatric procedure for approximately 10 years. This procedure involves a vertical resection and removal of the body and fundus of the stomach, which leaves a tubular gastric lumen from the gastroesophageal junction to the antrum. The pylorus is left intact and no device is implanted nor bypass performed.

This procedure is reported with 43775 *Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)*.

Vagus Nerve Blocks

Medical science is constantly searching for newer, better, and less invasive means of treating diseases such as obesity. One method being investigated is vagus nerve blocking therapy, which uses high frequency, small electrical pulses to block the transmission of the vagal nerve signals to the brain.

The vagus nerve is the longest cranial nerve, containing motor and sensory fibers, and has the widest distribution in the body. The gastric branches of the vagus nerve supply the stomach and play a significant role in food processing, and in signaling the feeling of fullness and prolonging the absence of hunger.

Studies have shown that patients who undergo surgical vagotomy commonly experience weight loss. In some cases, the effects were found to be temporary, as the body is usually able to compensate for the anatomical disruption by regulating to normal function. Consequently, a technique for intermittent blocking of the vagus nerve by laparoscopically implanted electrodes (which prevent the nervous system and digestive organs from compensating for changes in bodily functions) was developed for potential management of obesity.

The procedure involves a laparoscopic approach, where the physician makes three to five, 1 cm incisions to implant the electrodes. Through the smaller incisions, the physician inserts small electrodes around the vagus nerve near the distal esophagus. A neuroregulator is then placed under the skin, at a location selected by the physician in collaboration with the patient.

Two weeks after completion of the surgical procedure, the vagal

blocking therapy is initiated in the physician's office with programming of the neuroregulator. Patients may eat normal foods as part of a sensible diet with this device.

The potential benefit to the vagal nerve blocking system is that it does not alter the patient's gastric anatomy and can be performed on an outpatient basis with regulation of the blocking system in the physician's office, or with wireless communication technology.

This procedure/therapy is not approved in the United States. Clinical trials are now being performed by EnteroMedics® in the ReCharge Study as part of the U.S. Food and Drug Administration premarket approval process. The device developed by EnteroMedics® is called the Maestro® Rechargeable System.

Call on Category III for Vagal Nerve Blocking Systems

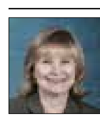
There are no CPT® Category I codes available for this new technology yet; however, CPT® does provide a set of temporary (Category III) codes for emerging technology, services, and procedures. If a Category III code is available for reporting a new procedure, it must be used rather than the Category I unlisted procedure code.

The Category III codes 0312T-0317T are to be used to report the laparoscopic vagus nerve blocking therapy for the treatment of morbid obesity (see the accompanying sidebar, "Category III Code Descriptions," for the full descriptions). The services identified by these codes include:

- Laparoscopic implantation of the neurostimulator electrode array and pulse generator (0312T)
- Revision or replacement of the neurostimulator array with connection to existing generator (0313T)
- Removal of the neurostimulator electrode array and pulse generator together (0314T)
- Removal of the pulse generator independent of the electrode array (0315T)
- Replacement of the pulse generator (0316T)
- Electronic analysis of the pulse generator with reprogramming, if performed (0317T)

The Category III codes for the vagus nerve blocking procedure are scheduled to sunset in January 2018. If this procedure is performed after the archiving of the Category III codes without Category I codes assigned to replace them, it would be necessary to use appropriate unlisted procedure codes.

With the increasing incidence of obesity seen by medical practitioners, you can expect in the future to see other new technologies and treatments geared toward this and other associated co-morbid diseases. As coding professionals, you should be aware of all new Category III codes, as well as the coverage implications that are associated with any new treatments or procedures. HBM



Laurette Pitman, RN, CPC-H, CGIC, CCS, is a senior outpatient consultant for SPi Healthcare. She has over 30 years' experience in the healthcare field, including ED and OR nursing, coding, and DRG and APC auditing. Pitman is also an ICD-10-CM/PCS trainer and a member of the Lafayette, La., local chapter. For more information, please reference www.spihealthcare.com or email her at laurette.pitman@spihealthcare.com.

Category III Code Descriptions

0312T Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming

- **0313T** laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator
- **0314T** laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator
- **0315T** removal of pulse generator
- **0316T** replacement of pulse generator
- **0317T** neurostimulator pulse generator electronic analysis, includes reprogramming when performed

By Wendy Grant, CPC

TCM: New 2013 Codes, Significant 2014 Changes

Secure payment for transitional care management by documenting all of the required elements.

The purpose of transitional care management (TCM) services is to improve care coordination between inpatient and primary care settings, with the ultimate goal of reducing hospital readmissions. Last year, two CPT® codes were created to facilitate reporting of TCM services:

99495 Transitional Care Management Services with the following required elements:

- **Communication** (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- **Medical decision making** of at least moderate complexity during the service period
- **Face-to-face visit**, within 14 calendar days of discharge

99496 Transitional Care Management Services with the following required elements:

- **Communication** (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- **Medical decision making** of high complexity during the service period
- **Face-to-face visit**, within 7 calendar days of discharge

Codes 99495 and 99496 describe care transition and care coordination activities for patients who are discharged *from* an inpatient hospital setting, acute hospital, rehab hospital, observation setting, or skilled nursing facility (SNF) *to* home, a domiciliary, a rest home, or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You may not bill for TCM if successful interactive communication within the 30-day period isn't documented.

an assisted living center. The 30-day TCM period begins on the patient's discharge day from the hospital setting and continues for the next 29 days.

Note: TCM services are *not* appropriate when a patient is discharged from the hospital setting and transferred to an SNF.

Know the Requirements

In 2013, the Centers for Medicare & Medicaid Services (CMS) allowed payment for 99495 and 99496 furnished to established Medicare patients only. Beginning in 2014, providers may report TCM services furnished to *new and established* patients. Payment will hinge on how well providers fulfill and document the requirements outlined in these codes.

To report 99495, you must show:

- Communication with the patient and/or caregiver occurred within two business days of discharge. This communication must be through direct contact, telephone, and/or email;
- Medical decision-making (MDM) of at least *moderate* complexity during the 30-day service period; and
- A face-to-face visit within *14 days of discharge*, in addition to the routinely provided non-face-to-face services.

To report 99496, you must show:

- Communication with the patient and/or caregiver occurred within two business days of discharge. This communication must be through direct contact, telephone, and/or email;
- MDM of at least *high* complexity during the 30-day service period; and
- Face-to-face visit within *seven days of discharge*, in addition to the routinely provided non-face-to-face services.

The patient communication within two business days of discharge must be interactive. For instance, the communication can't be a voicemail or email without a response from a patient. You may not bill for TCM if successful interactive communication within the 30-day period isn't documented.

The face-to-face visit must be furnished and documented within the time frame CPT® specifies. For 99495, a face-to-face visit must occur within 14 days of discharge; for 99496, the face-to-face visit must occur within seven days of discharge. This face-to-face visit is part of the TCM and may not be reported separately. Other subsequent visits provided within the 30-day TCM period are billable.

TCM at a Glance

Who may furnish transfer care management (TCM) services?

- Physicians (any specialty)
- Non-physician practitioners who are legally authorized and qualified to provide the services in the state where services are furnished
- Certified nurse midwives
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants

Who may receive TCM services?

- Medicare patients who meet requirements

How do you bill for TCM services?

- Only one healthcare professional may report TCM services per patient (no split-billing).
- Only one TCM service may be billed, per patient, during the TCM period.
- The same healthcare professional may discharge the patient from the hospital, report hospital observation discharge services, and also bill the TCM services. Remember that the required face-to-face visit may not take place on the same day the discharge day management is billed.
- Use the billing date of service as the 30th day from the date of the patient's facility discharge.
- If the patient gets re-admitted to the hospital during this 30-day period, only one TCM can be billed. The date of the second discharge should be used as the starting date for the TCM period.
- Document the initial post-discharge communication, the date of the face-to-face visit, and the non-face-to-face services provided, as well as the MDM (such as number of diagnoses managed, the amount of data reviewed, and the risk involved over this 30-day period).
- The patient is responsible for 20 percent of the Medicare allowable if he or she does not have a Medicare supplement policy to pick up the cost share.

Note: Do not bill care plan oversight codes (G0181, G0182) or end-stage renal disease codes (90951-90970) during a TCM period for which you billed.

Patients without the minimum complexity do not qualify for this service.

Non-face-to-face services are provided in combination with the face-to-face service. CMS considers these services to be an essential component of billing TCM codes. The non-face-to-face services distinguish TCM from services that are predominately or exclusively face-to-face in nature.

Who May Bill?

The physician or mid-level provider, or a licensed clinical staff under the physician's direction, may provide TCM services (see "**Transitional Care Management at a Glance**," on preceding page).

Typical non-face-to-face services that may be performed by clinical staff:

- Communicating (direct, phone, or email) with patient and/or caregiver within two days of discharge
- Communicating with home health agencies or other community services utilized by the patient
- Educating the patient and/or family caretaker to support self-management, independent living, and activities of daily living
- Assessing and supporting for treatment regimen adherence and medication management (must occur no later than the face-to-face visit)
- Identifying community and health resources
- Facilitating access to care and services needed by the patient and/or caregiver

Typical non-face-to-face services that may be performed by physician or midlevel:

- Obtaining and reviewing the discharge summary, as available, or continuity of care documents
- Reviewing the need for, or follow up on pending, diagnostic tests and treatments
- Interacting with other healthcare professionals who will assume or resume care of the patient's system-specific problems
- Providing education to the patient, family, guardian, and/or caregiver
- Establishing or re-establishing referrals and arranging for necessary community resources
- Assisting in scheduling of required follow up for necessary community resources

MDM must meet the elements of either moderate or high complexity. Patients without the minimum complexity do not qualify for this service.

Have an Action Plan

If your office provides TCM services, make a plan to capture and code the services. Discuss the plan with your providers and get their buy-in by stressing that proper documentation can aid reimbursement and patient care.

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For example:

- Verify on a daily basis all discharged patients and determine which ones would be candidates for TCM. Contact those patients within two business days, and schedule face-to-face visits with them within either seven or 14 days from discharge.
- Make a template to guide you in covering all of the required elements for documentation and billing (see the **Transitional Care Management 30-Day Worksheet**, on pages 43-44). Fields to include: date of discharge, date to bill (29 days from discharger), date of communication (within two days of discharge), date of the face-to-face visit, and any of the care coordination performed.
- Bill the TCM service within the date of service of the 30th day. Remember to report the place of service where the face-to-face visit occurred.

Relate this guidance to the physicians and clinical staff in your practice to ensure appropriate reporting and reimbursement for the TCM services they provide. HBM

Wendy Grant, CPC, has more than 30 years of experience in coding and reimbursement. She is the western division accounts receivable manager for Health Management Associates, where she provides analysis of coding trends and denials. Grant is president-elect of the Little Rock, Ark., local chapter.

AAFP

Transitional Care Management 30-Day Worksheet

Patient name: _____ DOB: _____

D/C physician: _____ D/C date: _____

Records requested: Records received: Reviewed:

Diagnoses on discharge:	
Date of interactive contact (2 business days post D/C):	☐ Phone ☐ Email ☐ Direct ☐ Other
Date of 7-day or 14-day, face-to-face visit:	
Family and/or caretaker present at visit:	
Medications on discharge	**Medication changes/adjustments**
Diagnostic tests reviewed/disposition:	
Disease/illness education:	
Home health/community services discussion/referrals:	
Establishment or re-establishment of referral orders for community resources:	
Discussion with other health care providers:	
Assessment and support of treatment regimen adherence:	
Appointments coordinated with:	
Education for self-management, independent living, and activities of daily living:	

TCM.January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

Transitional Care Management 30-Day Worksheet, continued

Medical Decision Making			
DIAGNOSIS and MANAGEMENT	**QTY**	**POINTS**	**TOTAL**
Self-limited or minor — stable, improv, or prog as expected		1	=
Established prob — stable, improving		1	=
Established prob — worsening		2	=
New prob — no further workup planned		3	=
New prob — additional workup planned		4	=
DIAGNOSIS and MANAGEMENT TOTALS		=	

DATA REVIEWED	
Review/order of clinical lab tests (80000 code series)	1
Review/order of radiology tests (70000 code series)	1
Review/order of medicine tests (90000 code series)	1
Discuss test w/performing or interpreting physician	1
Decision to obtain old records or history from someone other than patient	1
Review and summary of old records and/or ***obtaining*** history from someone other than pt and/or discussion w/another provider **with documentation of findings**	2
Independent visualization of actual image, tracing, or specimen **(not simply review of report)**	2
DATA REVIEWED TOTAL	

TABLE OF RISK		
Moderate	Presenting Problem	1+ chronic ill w/milk exac, prog, or tx side effects, 2+ stable chronic ill, Undx new prob with uncertain prog (lump in breast), Acute ill w/systemic symp (pyeloephritis, Pneumonitis, colitis), Acute comp injury (head inj w/brief loss of consciousness)
	Diag Procedure Ordered	Physiologic tests under stress, Diag endos w/no identified risk, Deep needle or inc bx, Cardio imag w/cont, no identified risk, Obtain fluid from body cavity (lumbar puncture, thoracentesis)
	Mgmt Options	Minor sx w identified risk, Elec major sx (open, perc, endos) w/no identified risk, Rx drug mgmt, Therapeutic nuclear medicine, IV fluids w/additives, Closed treatment of fx or dislocation w/o manipulation
High	Presenting Problem	1+ chr ill w/severe exac, prog, tx side effects; Acute/chr ill or inj posing threat to life/bodily func (trauma, MI, pulm emb, sev resp dist, prog sev rheum arth, psych ill w/pot threat to self or others, renal fail); Sz, TIA, weakness, sens loss
	Diag Procedure Ordered	Cardio img w/cont and risk; Cardio electrophysiological tests; Diag endoscopies w/identified risk factors; Discography
	Mgmt Options	Elective major sx (open, perc, endo w/risk); Emerg major sx; Parenteral cont subs; Rx therapy w/intensive monitoring for toxicity; Decision not to resuscitate or to de-escalate care because of poor prognosis

(2 of 3 elements must be met or exceeded for a level of decision making)

MDM:	SF	Low	Mod	High
DX MGMT Options	0-1	2	3	4+
Data	0-1	2	3	4+
Risk	Minimal	Low	Moderate	High

NOTES:

Physician signature: _____

Staff signature: _____

Staff signature: _____

Staff signature: _____

TCM.January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

By Marcia L. Brauchler, MPH, CMPE, CPHQ, CPC, CPC-H, CPC-I

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Answer Common HIPAA Questions

What is Protected Health Information (PHI)?

Under the HIPAA Privacy Rule, PHI refers to health information that can identify an individual or can be used with other available information to identify an individual. The rule applies specifically to "covered entities" and their "business associates." Health information that identifies an individual, but is not held by a covered entity or business associate, is most likely not subject to HIPAA's Privacy Rule.

Consider the following example to illustrate the distinction:

A 16-year-old girl is injured in an automobile accident and requires surgery at a hospital to repair a broken leg. Any health information the hospital possesses relating to the patient is considered PHI, and HIPAA's Privacy Rule protects the use and disclosure of that information. For example, a nurse who was in the operating room for the surgery could not share any information about the patient or the surgery with a news reporter without the patient's parents authorizing it because the nurse is a member of the workforce of a covered entity.

But if a news reporter interviews the patient's aunt, who freely shares health information about the patient, the reporter may disclose that information without the patient's authorization. The news reporter is not bound by HIPAA's Privacy Rule because news agencies are not covered entities or business associates under HIPAA.

What Makes It PHI?

PHI requires two things:

1. An identifier; and
2. A piece of health information.

PHI can come in many forms other than paper: telephone calls and voice mails, X-rays, photos and videos, verbal interactions (e.g., overheard conversations), faxes, and electronic format, such as in a patient's electronic health record.

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For example, a post-operative report from a hospital, together with the name of the patient who had the surgery, would be considered PHI. The same report by itself, without a name or other patient identifier, is not necessarily PHI. There must be some identifying information on the post-operative report for it to be considered PHI under HIPAA.

The HIPAA Privacy Rule provides a list of what the federal government considers to be "individual identifiers." These include: names, addresses, social security numbers, telephone numbers, email addresses, dates of birth, etc. Even a license plate number on a patient intake form can be considered PHI because it could be used to identify a person (think of a "John Doe" brought into the emergency department with no identification other than the license plate number the paramedics wrote down at the scene of the accident).

PHI can come in many forms other than paper: telephone calls and voice mails, X-rays, photos and videos, verbal interactions (e.g., overheard conversations), faxes, and electronic format, such as in a patient's electronic health record. PHI in an electronic format is protected doubly by HIPAA's Security Rule, as well as by the Privacy Rule.

PHI is not limited to current information. It can relate to:

- A patient's past, present, or future physical or mental health or condition;
- Healthcare provided to the individual; or
- The past, present, or future payment for healthcare to the individual.

For example, information about a patient hospitalized in a mental institution in his 20s, who is now 55 years old, is still considered PHI in the hands of the mental institution or another covered entity or business associate. The information is still protected under HIPAA today.

What PHI Is Not

HIPAA excludes some forms of health information from the definition of PHI, such as educational records held by schools. These records are covered by a different federal privacy law: the Family Educational Right and Privacy Act (FERPA).

Employment records that contain identifiable health information held by a covered entity acting as an employer are not considered PHI. For instance, if ABC Company requires drug testing of all applicants, and the company maintains files containing this health information in its human resources department, these files are not considered PHI.

Is This a HIPAA Violation?

Let's end with a final example. Consider the case of an intern working at a hospital who saw a neat-looking X-ray on a viewing box. He took a picture of the X-ray with his iPhone and posted it on Facebook as a learning aid for his fellow interns. When the picture is enlarged, however, you can see the patient's name and date of birth, and the hospital's name.

This is PHI and the act would be a HIPAA violation unless the patient had authorized the intern to take the picture and post it on Facebook (which isn't likely). The intern could be in big trouble with the hospital and the federal government.

A thorough understanding of what PHI is (and isn't) will help to ensure you can protect it (and yourself) appropriately. HBM

Marcia L. Brauchler, MPH, CMPE, CPHQ, CPC, CPC-H, CPC-I, is a healthcare consultant and founder of Physicians' Ally, Inc. She advises physicians and practice administrators on managed care contracts, reimbursement, coding, and compliance. Brauchler's firm sells updated HIPAA policies and procedures at www.physicians-ally.com/hipaacompliance. She is a member of the South Denver, Colo., local chapter.

Note: If you have HIPAA questions, send them to John Verhovshek at AAPC (**g.john.verhovshek@aapc.com**) and we'll do our best to answer them.

By Elin Baklid-Kunz, MBA, CHC, CPC, CCS

Prepare for Increased Audit Scrutiny

Part 2: Know where auditors are focusing and build a solid defense.

Evaluation and management (E/M) services are a continuous target for the Office of Inspector General (OIG), private payers, and Centers for Medicare & Medicaid Services (CMS) auditors. To keep your E/M services compliant and under the radar of auditors, correct potential errors in your practice using 16 stepped-out tips.

In February, we discussed the first eight steps to help you review your E/M utilization and documentation. This month, we conclude with eight more tips you can use to prepare for greater audit scrutiny, including how to develop a practice-specific audit plan, how to compare your utilization to national averages, and other ways to ensure compliance with government and payer standards.

1. Develop a Practice Audit Plan Using Specific Targets

If you've read and followed steps one through eight in Part 1, you already know the areas of weakness that payers and investigators are likely to target. Your next step is to customize this information to identify your practice's high-risk areas.

For example, a surgical practice that sees patients both in the office and hospital should include hospital E/M services (e.g., 99231-99233, subsequent hospital services and 99221-99223, initial hospital services) in its audit plan, in addition to office E/M services and surgical services. Be mindful that hospital E/M services are especially error-prone.

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E/M audits help to identify opportunities for increased revenue, as well as ways to reduce compliance risk.

Office managers usually have a better handle on their office visits than they do the hospital documentation because the progress notes are often hard to access. Special considerations should be given if:

- The hospital implemented a new electronic health record (EHR) system with a team of information technology staff or nurses who may not have knowledge of E/M documentation guidelines.
- Audit templates are used. Templates can be helpful if used carefully. They can be risky, however, when a physician documents all the necessary items to support the level of service billed, but does not indicate that services rendered for the presenting problem during the visit were medically necessary.

Other potential problems include:

- Evidence of cloning. For example, the documentation for a beneficiary is worded exactly like, or similar to, the previous entries (i.e., the whole history of present illness (HPI) is pasted into the note from a previous visit).
- Documentation shows conflicts between the review of systems (ROS) and patient history and/or presenting problem.
- Patients with the same presenting problems have identical documentation.
- HPI documented by nurses or auxiliary staff. Only HPI documented by the physician may be counted when determining the E/M service.
- Physician involvement is inadequate. Shared/split visits depend on the combined documentation of a physician and a non-physician practitioner (NPP) to determine the level of service. Often, however, the complete documentation is done by the NPP and the physician only signs the medical record. This is not enough for the visit to be billed under the physician's provider number.
- You are unable to determine the documentation's author. Sometimes a progress note will state, "dictated by NPP," but the signature is the physician's. This makes it difficult to determine if the physician or NPP performed the service.

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Additional, common documentation problems for hospital visits include:

- Chief complaint is not clearly stated, or is missing, which makes it hard to establish medical necessity.
- Time is not documented for critical care, prolonged care, and extended discharged visits.
- Time is not documented appropriately for "long discussions with patient" (counseling visits).
- Progress notes and test reports are not signed and/or dated.

2. Run Utilization Reports for All Providers

The following data should be gathered for all providers in practice, and should be available from practice software in daily, monthly, and annual format:

- Utilization (frequency) per CPT® code
- Utilization (frequency) for modifiers
- Total work relative value units (wRVUs)
- Total patients seen, per day (new, established, and post operative)
- Top 10 surgeries (or procedures)

Produce these reports for the specialty or practice as a whole, as well. Consider making a dashboard or scorecard for a snapshot that can easily be compared.

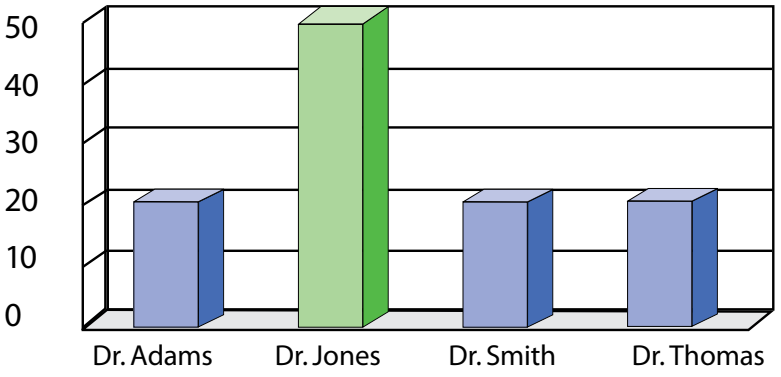
3. Compare Modifier Utilization Patterns

For instance, to identify outliers, you might compare use of modifier 25 *Significant, separately identifiable evaluation*

Which of the following four providers might an outside auditor or payer choose to target?

and management service by the same physician or other qualified health care professional on the same day of the procedure or other service for all the physicians in the practice, as shown in **Graph A**.

Graph A Modifier 25 Usage



Which of the above four providers might an outside auditor or payer choose to target? Having this data available provides an opportunity for the practice to discuss the correct use of modifier 25 and to ensure all physicians understand when the modifier is appropriate.

4. Compare Your Results Against National Benchmarks

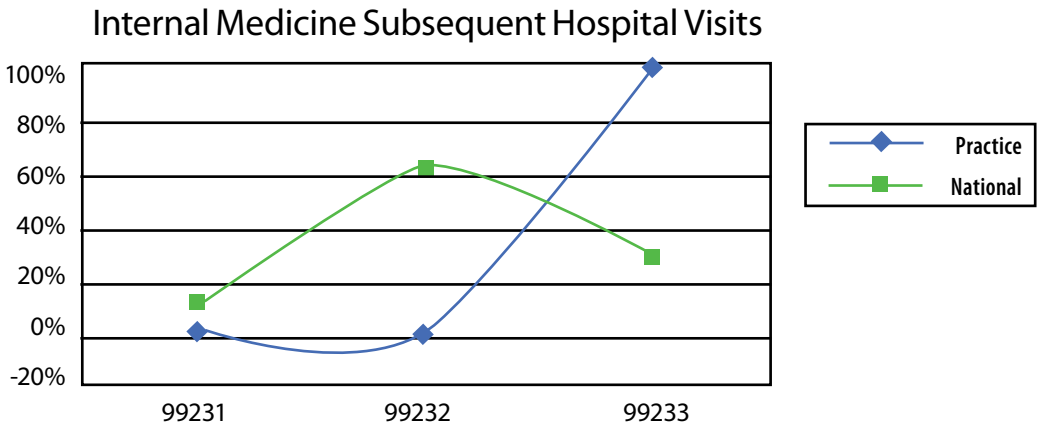
Compare the CMS national E/M data, by physician specialty, to yours. For example, **Graph B** (on the next page) shows an internal medicine physician using CPT® 99233 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity* (the highest level of subsequent hospital visits) 100 percent of the time. CMS average national data for internal medicine shows this code being used 30 percent of the time.

At the very least, this physician would have to explain how and why his patient population differs so dramatically from other physicians' in the same specialty.

The two E/M bell curves, **Graph C** and **Graph D** (on the next page), show different coding patterns for established office visits among physicians in the same practice compared to national peer data. The physician in **Graph C** (blue line for practice) is coding mostly levels three and four, while the physician in the **Graph D** is coding only level two. This would not be expected if the physicians are in the same practice, seeing the same patient population. Payers might see such conflicting distribution as an opportunity to audit the practice.

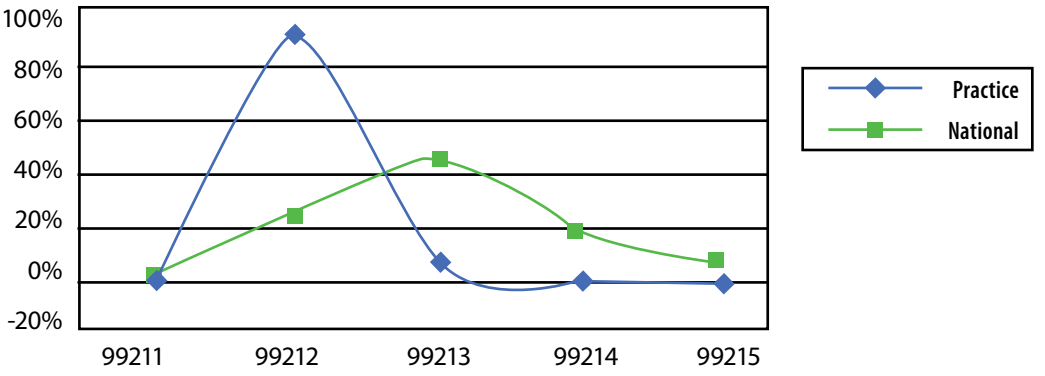
Billing all of your E/M services using a single CPT® code in a category is referred to as "clustering." Often, providers will use only the mid-level codes (such as 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity*) with the justification that some services are "higher" and some are "lower," but in the long run, they av-

Graph B

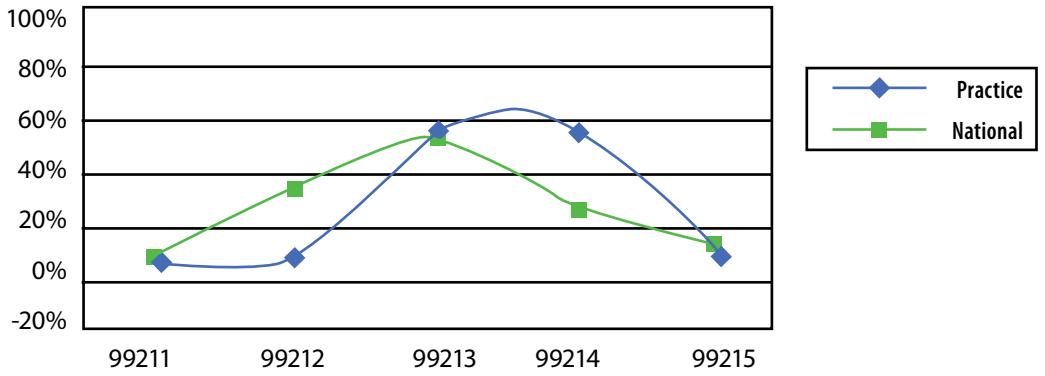


Coding Patterns for Established Office Visits Among Two Physicians in Same Pratice

Graph C



Graph D



erage out. This is not an acceptable practice. Codes should be assigned based on services performed and documented.

Comparisons might also reveal revenue opportunities. Under-coding often occurs because providers are uncomfortable billing higher-level services, for fear of becoming an outlier (although, consistently under-billing can also make you an outlier). E/M audits help to identify opportunities for increased revenue, as well as ways to reduce compliance risk.

Don't jump to conclusions: Distribution variances may have a logical explanation, and should be investigated. Knowing where to focus is important, especially if the practice has limited audit and coding resources.

5. Select a Sample and Perform Chart Review

Chart review is required to determine if documentation supports coded and billed services. Reviews are part of a practice's compliance program, and may be performed by outside consultants or internal staff. If the practice employs

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Targeted Audits Pay Dividends for Payers

CMS has set ambitious targets for reducing improper payments. In 2013, the target was 8.3 percent. It falls to 8 percent in 2014, and 7.5 percent in 2015. To achieve these rates, CMS is likely to ratchet up enforcement efforts—including payer audits—in the months ahead.

CMS and OIG have said that audits recover $8 in improper payments for every $1 spent in recovery; and a recent report released by Taxpayers Against Fraud Education Fund (www.taf.org) concludes that every dollar invested by the government in investigation and prosecution of federal healthcare fraud returns at least $20 back to the American people.

If you discover any overpayments during your audit, return them.

NPPs, the audit scope should include their services, as well (e.g., audit incident-to services, split/shared visits, and supervision requirements). Include also auditing for cloning in the EHR: The OIG and Medicare administrative contractors have identified an increase of cloned health records.

If the practice does not have a compliance plan, review the OIG Compliance Program for Individual and Small Group Physician Practices, available on the OIG website (http://oig.hhs.gov/authorities/docs/physician.pdf).

6. Provide Feedback and Education

Analyze audit findings and provide feedback and education to providers and coders. A group discussion on medical necessity may be helpful to ensure everyone is "on the same page" (especially regarding high-level E/M services). Also provide proactive, routine education to providers and coders. Document all training performed. If you discover any overpayments during your audit, return them.

7. Monitor and Follow Up

Identify opportunities for improvement and continue to monitor progress. This step is often overlooked: You should designate an individual to be responsible for follow up. Some providers may require a follow-up review in three months, while others may need to be on a prepayment review until the compliance rates are brought to appropriate levels.

8. Have a Plan to Deal with Outside Audits

Failure to respond to a documentation request will result in an automatic overpayment. Incomplete and inaccurate documentation can result in claims denials and revenue losses. Make sure your practice has a plan in place to manage audits, as well as appeals. HBM

Elin Baklid-Kunz, MBA, CHC, CPC, CCS, is director of physician services for Halifax Health in Florida. Her 20 years of healthcare experience includes seven years in finance and four years in compliance. Baklid-Kunz is a national speaker and published author on topics related to medical practice compliance, coding and reimbursement, chart audits, and federal regulations. She presents at workshops for AAPC and delivers keynote presentations for Eli Research Coding Institute and Audio Educator. Baklid-Kunz is a member of the Daytona Beach, Fla., local chapter.

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By Alicia Shickle, CPC, CPCO, CPPM

Face Compliance Program Challenges Head On

Create a plan, use seven keys to implement it, and then customize it.

A provision in section 6401 of the Patient Protection and Affordable Care Act of 2010 (ACA) mandates physicians to adopt a compliance program as a condition of Medicare, Medicaid, or Children's Health Insurance Program (CHIP) enrollment. Your practice may already have a program in place, but this ACA provision has opened a floodgate of additional regulatory and law enforcement scrutiny and liability. As a result, your practice will need to be more vigilant than ever in its compliance program efforts.

Compliance Program Obstacles

The biggest challenges providers face when implementing an effective compliance program are:

- Time
  - There are only so many hours in the day.
  - Providers are inundated with more pressing regulations such as ICD-10, meaningful use, the Physician Quality Reporting System, and quality accreditations (Patient-centered Medical Home models, etc.).
- Resources
  - Staff is limited; everyone has a full plate.
- Financial
  - Tools on the market are expensive and fragmented.
  - Practices are struggling and must do more with less.
- Getting Started
  - It's necessary to have a firm understanding of the requirements of a compliance program, as well as how to implement and manage it.
  - Without the right tools and staff, organizing and tracking compliance activities are daunting tasks.

Providers who aren't part of a larger, integrated system are less likely to have an effective compliance program in place because of a lack of financial and human resources. Efforts may be fragmented or incomplete as individuals with compliance responsibilities are asked to do more with less. The end result is a practice still at risk for noncompliance.

Providers must become more aware of the importance of an effective compliance program. Ultimately, they are the ones who are subject to the risks of noncompliance. Future penalties will likely be far more damaging to your practice's bottom line than what is required of it now to become a compliant organization.

Seven Keys Unlock an Effective Compliance Program

There are seven keys for an effective compliance program patterned after the Office of Inspector General's (OIG) *Guidance for Individual and Small Group Physician Practices*:

Providers must become more aware of the importance of an effective compliance program. Ultimately, they are the ones who are subject to the risks of noncompliance.

1. Policies and Procedures

One of the most important controls you can have for mitigating risk is to implement policies and procedures based on best practices. Communicate expectations to staff, board members, and external vendors. Establish a process, including a central library of policies and procedures, which includes creating, updating, sharing, approving, and archiving documents.

Link policies and procedures to laws and regulations, and have them readily available to everyone in the organization through the use of a simple search of key words. Include a system of alerts to trigger reminders to update policies periodically—at the least, annually—and if workflow or services change.

2. Training and Education

Conduct annual staff and compliance training, as well as job-specific training. Forcing compliance managers to manually track training schedules is a cumbersome and daunting task, and tracking compliance training requirements is nearly impossible, even for small practices. Track training compliance and to monitor scores for understanding and competency. You should have processes for receiving new and updated laws and regulations from a variety of external sources, and for providing education and training on new or revised regulations and policies.

3. Audit Management

All organizations, regardless of size, should conduct baseline audits as a benchmark for ongoing auditing and monitoring. Be sure to identify vulnerabilities and weaknesses through auditing and to prioritize compliance tasks based on the level of risk.

It's important to look in the right areas. If results are returned as acceptable, this is an indication your organization is not looking in the right places. The purpose of monitoring your processes is to identify personal vulnerabilities and areas of weakness. Implement plans for corrective action when necessary, and prevent noncompliance activities from reoccurring, to help you mitigate possible penalties and/or sanctions.

Systematic, consistent, and organized documentation is required when managing an audit process.

4. Designated Compliance Specialist

Although compliance is everyone's responsibility in an organization—all staff has an obligation and responsibility to report any observed or suspected noncompliance activity—you should designate a staff member as compliance officer, to be responsible for overseeing compliance activities.

The compliance officer should create a culture of compliance and report all incidents to the chief financial officer and board. Unfortunately, often the compliance officer is seen as an adversary, making it difficult to rely on employees' assistance in detecting noncompliance or fraudulent activities. The compliance officer must understand what constitutes fraud, waste, and abuse, know how to report it, and feel confident performing the task.

5. Open Lines of Communication and Disciplinary Non-retaliation Policies

You must have open communication and a non-retaliation policy, so employees will participate in "policing" the organization for noncompliant activities. Each employee should feel "deputized" to always do the right thing, the right way. Many hands make light work, and it's crucial for the compliance manager to get buy-in from everyone.

6. Noncompliance Management

Take all reported noncompliance issues seriously. Let employees know that if they report a potential incident, the compliance officer will investigate and correct the issue. Be sure all incidents are documented and investigated immediately, and determine if an incident requires further action. Self-disclosure may be required in some instances, and seeking legal counsel is important to help sort through those decisions and processes.

7. Risk Assessments and Management

Staying up to date on new regulations and changes in the industry goes a long way in mitigating your risk of penalties, sanctions, and exclusions. Understand what is unique to your organization because every practice is different. Don't use "out of the box" solutions, and make the most of available tools and resources. The key is to customize and adopt a solution that fits your organization's needs.

On a final note, remember to implement policies that are attainable. Be practical, use common sense, and seek the help of experts—including legal advisors—if you need it. When you have established a foundation, managing the program will become business as usual. HBM

Alicia Shickle, CPC, CPCD, CPPM, is director, Compliance Division

By Robin Ingalls-Fitzgerald, CPC, CEMC, CEDC, CCS

Achieving Patient Access Requirement Using Portals

Witness one hospital's plan for fulfilling Stage 2 meaningful use criteria.

Last September, the Centers for Medicare & Medicaid Services (CMS) published a final rule specifying the Stage 2 criteria that eligible professionals (EPs), hospitals, and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. One objective of the Stage 2 requirements is patient access to health information.

Table A (on the next page) shows how CMS has outlined the "patient access" objectives and measures.

Source: www.healthit.gov/sites/default/files/meaningfulusetablesseries2_110112.pdf

… how will the facility meet the requirement of 50 percent of its patient population signed up for the portal, with at least 5 percent using it?

Patient Portal Set into Action

Most EPs and hospitals are implementing patient portals to achieve the Stage 2 objective. To better understand what is involved in the process, let's take a look at one facility's patient portal implementation journey.

Scenario: After successful attestation of Stage 1 of meaningful use (MU1), "Hospital A" must quickly implement a plan for MU2 adoption and subsequent implementation of the patient portal.

Plan of Action: The information technology (IT) director summons the troops, engaging quality, medical, nursing, and health information leaders across the organization to formulate an implementation plan. The IT department spearheads the patient portal project, facilitating meetings, engaging organization leadership, and executing it.

At the first meeting, more questions than answers arise. Specifically, how will the facility meet the requirement of 50 percent of its patient population signed up for the portal, with at least 5 percent using it?

Identify Methods to Adopt Patient Portals

Organization leadership identifies several methods to facilitate patient portal adoption:

1. The Patient Access department collects patient emails through the registration process.
2. The IT department generates automated emails to the patients providing portal instructions.
3. Community engagement and awareness are keys to a successful implementation. The Case Management and Public Relations departments organize outreach events to increase patient portal visibility. The public relations representative works with a local marketing firm to integrate the patient portal into the organization's public website.
4. To increase information availability within the organization, the Health Information Management (HIM) department installs a patient portal kiosk to facilitate release of information.
5. The HIM department monitors incoming emails and fielding phone calls for the portal.

Stay Tuned for Results

The implementation of the Patient Portal is challenging the traditional way the HIM department handles information release. The HIM department now rotates three staff members to handle patient portal support. The system goes live April 1, 2014. Stay tuned for more lessons learned after that date. HBM

Robin Ingalls-Fitzgerald, CPC, CEMC, CEDC, CCS, has been in the healthcare industry for over 29 years and a coder for 19 years. Her expertise is in E/M coding, in both the emergency department and practice settings. Ingalls-Fitzgerald's knowledge of Medicare coding and billing guidelines, NCDs, LCDs, and CCI edits is an invaluable resource to facility and practice billing departments, facilitating accurate claims submission, reducing claims rejections, and eliminating costly rework. She is a member of the Manchester, N.H., local chapter.

Eligibility	Objective	Measure	Standard
Eligible hospital/EP	Provide patients the ability to view online, download, and transmit information about a hospital admission.	1. More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (within four business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2. More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.	§ 170.210(f) § 170.204(a) §170.205(a)(3) § 170.202(a) § 170.210(g)

By Judy A. Wilson, CPC, CPC-H, CPCO, CPPM, CPB, CPC-P, CPC-I, CANPC

Use Patient's Complaints to Improve Your Practice

Turn patient woes into corrective action.

Most healthcare professionals dread handling patient complaints. I used to hate it when I'd receive a page, saying that someone with a complaint wants to speak to the office manager. I'd think, "This is a waste of time. If the person is already mad, nothing I can say will make a difference."

I couldn't have been more wrong.

Most people who complain just want to be heard. More importantly, perhaps, complaints are an opportunity to resolve ongoing problems. For example, consider how the following list of complaints might improve your office policies.

1. The physician is always late! Why should I have to wait so long? My time is valuable, too!

This is something many of us have said ourselves. If your office gets many such complaints, consider reworking your scheduling so patients don't have to wait an unusual amount of time to

Present your billing policies up front, before services are provided, so no patient questions are left unanswered.

be seen (patients shouldn't have to wait longer than 20-30 minutes). If the wait time is longer than normal, be sure to inform the patient when she signs in, so she doesn't think you've forgotten about her. Above all, patients want to be informed and feel they are being taken care of.

2. Why am I getting a bill? I have insurance. You filed the claim wrong!

Present your billing policies up front, before services are provided, so no patient questions are left unanswered. Explain that your practice files with insurance as a courtesy, but the bill is ultimately the patient's responsibility. Except where the practice is specifically contracted with the insurer, insurance is primarily a contract between the patient and the insurer. In every case, you must have policies in place, and you must communicate those policies effectively, so each patient knows what is expected of him or her at the time of service.

3. I've never had a co-pay before. Why now?

If you're hearing this complaint, a policy of collecting co-pays has not been followed in the past (meaning, someone has not been doing his or her job correctly), and the patient is upset by the "new" requirement.

Explain to the patient that you are very sorry she was not given that information at the time she made her appointment, but your policy states that all co-payments must be paid at time of service. Be sure all staff are aware of the policy and that they explicitly communicate it to patients before services are rendered.

Remember: Not collecting co-payments at the time of service can cost your practice large sums of money each year.

4. Why can't you just write off the rest of the bill? Aren't you paid enough?

Patients must understand it's a HIPAA violation to routinely wave co-insurance and co-payment on a patient account, and practices must make a good faith effort to collect due payment. The patient is also contracted with his or her insurance company to be responsible for applicable co-pays and co-insurance.

Proactive Is Better than Reactive

When hearing a complaint from a patient, listen until that patient is finished. If you interrupt, you'll only compound the patient's frustration (and yours). If you're hearing the same complaints again and again, it's not the patient who is at fault for getting upset—there's a problem in your practice that needs to be fixed. If you're not willing to improve your procedures, you'll lose business (and referrals) to practices that do.

Complaints such as these can be prevented by well-trained staff and strong, consistent office policies communicated to patients prior to their visit. It's not always easy, but you should look forward to complaints and use them to your advantage to improve your practice. HBM

Judy A. Wilson, CPC, CPC-H, CPCO, CPPM, CPC-P, CPB, CPC-I, CANPC, CMRS, has been a medical coding/biller for over 35 years. For the past 21 years, she has been the business administrator for Anesthesia Specialists, a group of nine cardiac anesthesiologists who practice at Sentara Heart Hospital. Wilson has served on the AAPC Chapter Association board of directors from 2010- 2014 and the Bryant & Stratton College board of directors in Virginia Beach, Va. She is an expert ICD-10 trainer for AAPC and a PMCC instructor, teaching classes in the Tidewater area. Wilson enjoys helping others become certified and offering continuing education opportunities. She has presented at several AAPC regional and national conferences and the AMBA conference. Wilson is a member of the Chesapeake, Va., local chapter.

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By Lauren White, MPH, CPC

[Coder's Voice]

Take a Closer Look at Professional Coding Models

When transitioning to a fee-for-quality system, evaluate coding processes and structure.

As accountable care organizations (ACOs) and other value-based healthcare arrangements become mainstream, provider compensation models are shifting. Providers are being paid based more on quality metrics than by relative value units (RVUs), and organizations are becoming more interested in documentation review. As a result, coders' responsibilities are evolving.

The coding profession is achieving a new level of excellence with specialty certification and ICD-10 proficiency, but strategic planning and goal setting are critical to create a sustainable coding program. Your coding department microsystem should perform in a way that enables you to grow, retain highly skilled coders, and support your organizations strategic goals, all while reducing risk.

Setting a Standard

Many physician-led organizations follow coding models that cater to individual provider and department needs. Organizations often rely on a hybrid coding model, consisting of code abstraction, documentation validation, charge review, and automation. The model may also rely on a combination of paper and electronic processes for both charge capture and documentation.

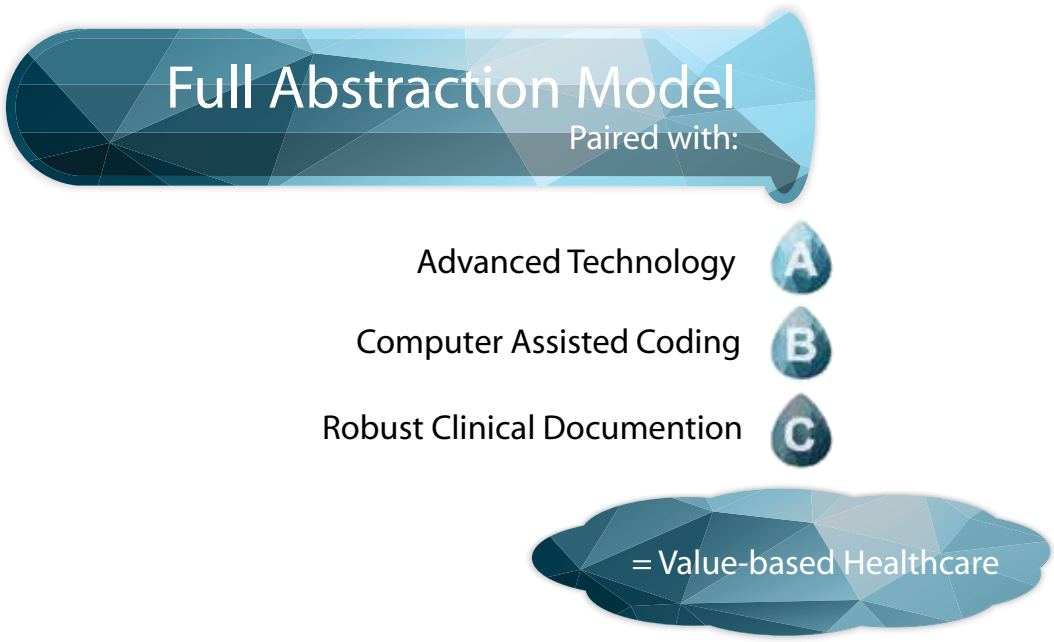
Such variation in processes makes it a challenge to set productivity standards, to conduct coder audits, and to document processes (all of which are important to expand remote coding programs). It also can lead to inconsistent coding support throughout an institution.

To understand how my peers are approaching these challenges, I contacted colleagues at like institutions using a standardized questionnaire. The questions were specific to the facility's coding models and current process for charge capture. Common themes were hybrid coding models, a focus on ICD-10 preparation, productivity metric development, computer assisted coding (CAC), and remote coding programs.

Coding Models for the Future

Most physician-led practices have always selected their own charge codes, and often do not include a coder's review. But coders are now being asked to review and abstract more services as specialty certifications increase.

Photo by Stockphoto/©Tashatuvango



With CAC, the coder shifts to auditing the product and supporting other coding.

Some private specialty practices have been using coders to fully abstract charges for years, but the staffing ratio for such a service seems more manageable for a small physician group, compared to a large provider group practice. Other organizations are at the opposite end of the spectrum and have moved away from coder intervention on the provider side.

I think the ideal professional coding model of the future mirrors that of a hospital coding program: Full abstraction paired with advanced technology, CAC, and a robust clinical documentation program with provider involvement. CAC for the professional side is available, and the technology is developing quickly.

Many facilities are already using CAC for inpatient and ancillary services, and are piloting this technology for professional services. This technology will help in the expansion of the full abstraction model and may minimize the need for additional coding resources. With CAC, the coder shifts to auditing the product and supporting other coding.

Coders Become Reviewers

Documentation review is essential for ultimate compliance and reduced risk. Hospital coders review all relevant documentation, and abstract services and diagnoses. Does it makes sense for the professional coder to do the same thing? Maybe you're a professional coder and already code this way.

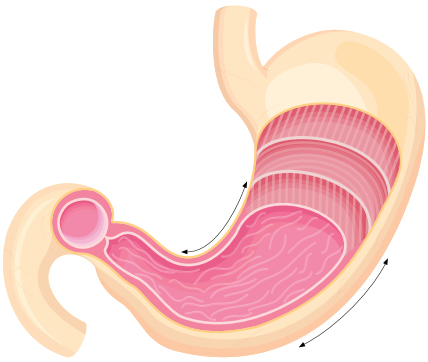
As an interim process, coders may have to review every note that includes more than just an office visit, and take a second look at submitted charges compared to documentation. This may allow you to explore additional documentation review and adjust staffing along the way. By streamlining the process and aligning skill sets to tasks, the coder is allowed to use his or her skills to decrease organizational risk by validating more services. You might even improve patient access by reducing the providers' time associated with charge capture.

Develop a strategic plan to assist in braving the unknown future. Put a focus on value and quality (the goal should be correct coding), while improving the patient experience and ensuring financial stability with timely and accurate billing. HBM

Lauren White, MPH, CPC, is the manager of professional coding at Dartmouth-Hitchcock in New Hampshire. She has a master's degree in Public Health, has been a CPC® since 2002, and is ICD-10 proficient. White has completed a certificate program from The Dartmouth Institute in Value-based Health Care and is a lean Six Sigma Green Belt in process improvement. She has spent her career in healthcare working in revenue management at large academic medical centers, with multi-specialty physician group practices. White is a member of the Manchester, N.H., local chapter.

By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Think You Know A&P? Let's See . . .



Stomach

The inner lining of the stomach consists of which four layers?

a. mucosa, submucosa, muscularis, serosa
b. serosa, inner oblique, middle circle, outer longitudinal
c. outer longitudinal, esophagus, pylorus, small intestine
d. mucosa, submucosa, inner oblique, pylorus

Check your answer on page 65.

Take this monthly quiz, in addition to AAPC's ICD-10 Anatomy and Pathophysiology advanced training, to prepare for the increased clinical specificity requirements of ICD-10-CM.

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A&P Quiz Answer

(from page 63)

The correct answer is A: The stomach walls are composed of four layers from inside to outside:

- mucosa,
- submucosa,
- muscularis, and
- serosa.

Bonnie Blazevich, CPC

Medical Billing and Coding Instructor and Externship Coordinator, Compass Career College, Hammond, La.

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

I got my first taste of the medical field before I even graduated high school, working in my town pharmacy on weekends and during the summer. After I graduated in 1981, I got a job as a pharmacy tech in a hospital. And there I stayed, until my husband's employer transferred him to a new city and we had to move. I took a job as a switchboard operator and desk receptionist at an area hospital. I also worked in the radiology department as a file clerk on weekends. Two years later, I landed an administrative assistant and ROI coordinator position in the health information management (HIM) department. It was this job that introduced me to coding and chart analysis.

When my administrator moved on, so did I—right into cardiopulmonary as an administrative assistant. I began billing and was responsible for insurance verifications for sleep studies. I also was the "minute man" (transcriptionist) during department meetings. I eventually moved on to the Patient Financial Service department, where I learned a great deal more about billing. Three years later, I was approached by a physician office looking for a billing and coding specialist for gastro and OB/GYN doctors. I jumped at the chance!

At this point, I was interested in becoming certified, so when I ran into an old friend who was the administrator of education at a community college, I asked her about billing and coding classes. Imagine my surprise when she told me the college was looking for an instructor and that I would be perfect. I just needed certification and to have worked more than eight years in the field. I already had the experience, and I wasted no time becoming certified.

I have been an instructor for seven years now. I have also worked as a business office manager for a small outpatient surgery center, a senior coder, a contract biller for various specialties, and have helped set up a new physician business office and staff. It has been a glorious journey. I love what I do.

What is your involvement with your local AAPC chapter?

I have been vice president and president of the Covington, La., chapter. I mentor many students in this field and bring many of them to chapter meetings for resource purposes. I also worked as a proofreader for the AAPC Certified Professional Coder (CPC®) exam, proctored the CPC® exam, and proofed medical billing and coding manuals for a major printing company.

What AAPC benefits do you like most?

I absolutely love the AAPC website; it's a great resource for job postings, materials/products, updates, continuing education unit tracking, education, motivation, and communication. I can log on at any time and get all of my questions answered. During hurricane Gustav, I saved $60 on a hotel room, thanks to my AAPC discount. I also use the prescription card offered through AAPC.

What has been your biggest challenge as a coder?

People don't understand what I do. When I tell them, they say, "Ooohh," and make a face, like it's a bad thing. I just simply say that I love what I do, and that my work affects patient, physician, and student lives. I keep it positive.

How is your organization preparing for ICD-10?

I am now stepping into ICD-10. I know some may find it to be tedious, but I find it so exciting. The books from which I teach offer great ICD-9-to-ICD-10 transition instruction. I have taken AAPC's boot camp and training course to become an ICD-10 trainer, attended local chapter meetings, read all of the resources, and taken sample quizzes online.

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

I will never stop teaching or learning. This field was chosen for me. All of my hospital, physician office, and teaching experiences have prepared me for where I am today. My future goal is to have my own billing/coding company so area doctors can outsource *locally* and I can hire locally. I don't think doctors should have to outsource to other states.

How do you spend your spare time?

I love reading, fishing, and "chillaxin'." I am always buried in emails; and reading insurance, Medicare/Medicaid, and coding updates, and coding magazines. I am going through empty nest syndrome, and getting many home improvement projects completed. My husband and I enjoy planning meals and cooking together, and hanging out on our patio. HBM

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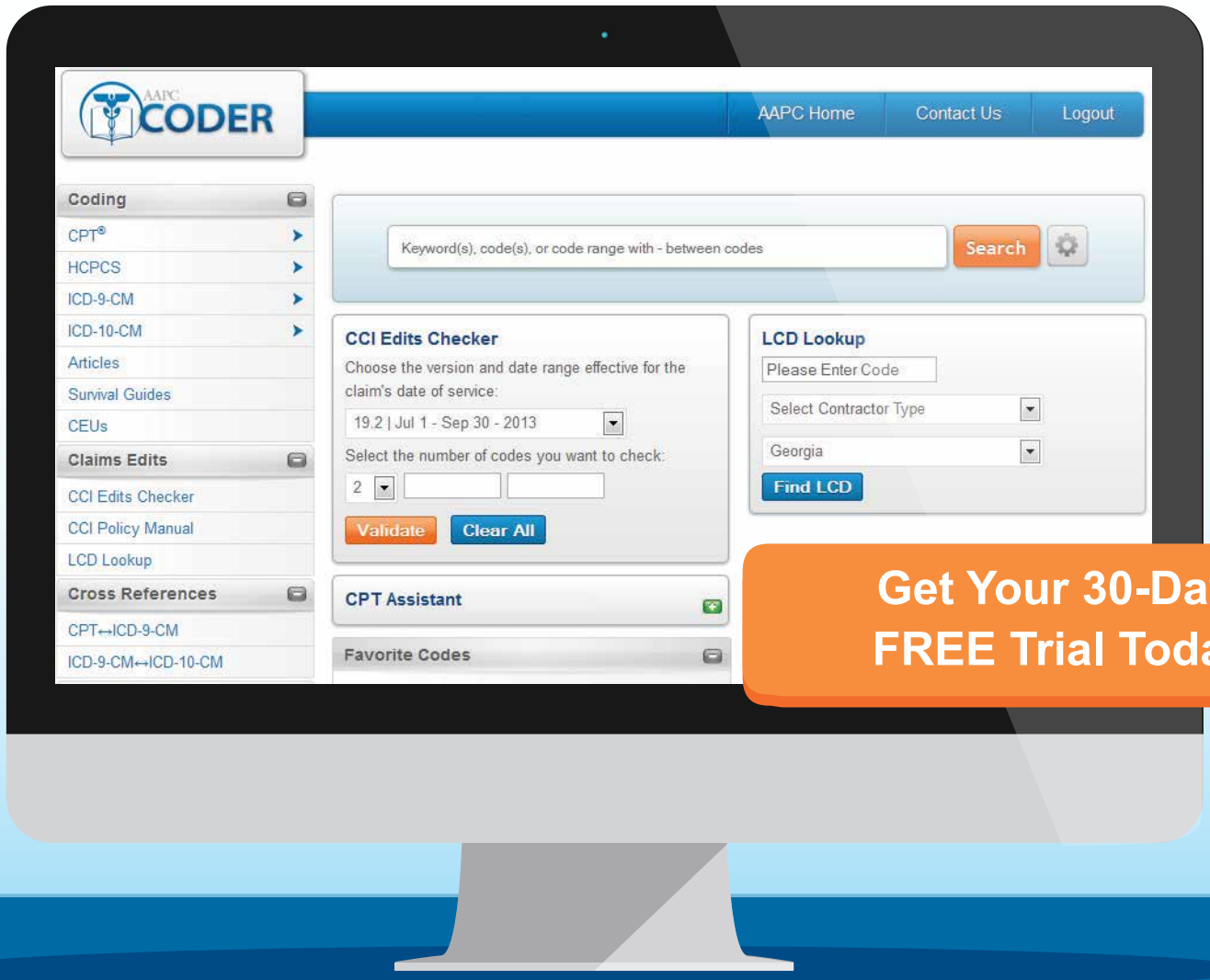

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