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- **Instagram**: @aapcstaff
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On the Cover: Sarah Todt, RN, CPC, CPMA, CEDC, explains the guidelines and auditing tools that can help with scoring medical decision-making when coding evaluation and management services in the emergency department. Cover design by Mahfooz Alam.

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March 2019

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HEALTHCON 2019 will be the largest revenue cycle management event of the year. April 28 to May 1, at Caesar’s Palace in Las Vegas, Nevada, you can expect to network with approximately 3,000 healthcare professionals, visit over 75 vendors, and choose from nearly 100 educational sessions at which you can earn up to 18 continuing education units (CEUs). If that’s not enough, here are three more good reasons you should consider attending HEALTHCON — especially if you’ve never attended in the past, each of which supports the goal of “Achieving a Higher Standard.”

Think of All the Education
HEALTHCON provides the widest variety of educational offerings to help you either advance your knowledge of areas you currently work in or dive into new areas to further develop your professional skillset. HEALTHCON 2019 will include a variety of topnotch General Session speakers, including the very popular Legal Trends and Issues panel with the AAPC Legal Advisory Board.

I will be presenting “Forensic Auditing – Defining the Process and Purpose” and “Auditing Services Reported under the Incident-to, Locums, and Reciprocal Billing Rules.” I hope to see you for these engaging sessions.

Approximately 80 Breakout Sessions will be offered, as well. For a list of educational offerings at HEALTHCON 2019, go to www.healthcon.com/agenda.php.

Think About All the Networking
Networking opportunities HEALTHCON provides will help you connect with peers to share ideas, problems and solutions, and obtain perspective on issues that will help you grow professionally. In addition to networking with thousands of your peers, you’ll have the opportunity to meet AAPC Chapter Association (AAPCCA) and National Advisory Board (NAB) members, industry experts, and thought leaders.

Both the AAPCCA and NAB welcome the opportunity to hear your thoughts and ideas on issues affecting you. NAB members specifically look for feedback that allows us to better advise AAPC on how to enhance the value of credentials and membership. And if you are thinking about serving at the national level, speaking with current board members about their experiences may help you in that decision-making process.

Think About All the Fun!
Everyone knows what Las Vegas has to offer; but if you’ve never attended HEALTHCON, you have no idea what you’ve been missing! Once you go, you’ll be hooked.

I have attended every HEALTHCON for the past 11 years and I wouldn’t miss it. I receive incredible education value from each one, as well as value in the people I’ve had the pleasure of meeting. I encourage everyone to attend and experience what an AAPC conference has to offer. Be sure to introduce yourself to me, as well as each NAB member.

For all the information on HEALTHCON, visit www.healthcon.com.

Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, CEMA, AAPC Fellow
Stereotactic Biopsy Is Always Guided

I note a typo in “Fine-tune Your Stereotactic Procedure Coding” (February 2019, pages 28-29). Example 1 cites CPT® 61750 Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion as proper coding, but this is not accurate. The example clearly describes computed tomography (CT) and magnetic resonance imaging (MRI) being used for the procedure; therefore, the correct code for Example 1 is 61751 Stereotactic biopsy, aspiration, or excision, including burr hole(s), for intracranial lesion; with computed tomography and/or magnetic resonance guidance.

CPT® 61750 rarely, if ever, should be used because this code describes a stereotactic biopsy without CT or MRI guidance. Historically, before CT and MRI, guidance was provided by pneumoencephalogram or ventriculogram. This technology is not used anymore.

Kim Pollock, RN, MBA, CPC, CMDP

ALPHABET SOUP

Make deciphering clinical documentation easier by recognizing common medical terms, abbreviations, and acronyms. Below are hospital acronyms for floors and units as you may see them in physician documentation.

APC  Ambulatory patient care
AMB  Ambulance
Cath Lab  Heart catheterization laboratory
CCU  Coronary/cardiac care unit or critical care unit
CICU  Cardiac intensive care unit
ED  Emergency department
ER  Emergency room
ICU  Intensive care unit
Lab  Laboratory
L/D or L&D  Labor and delivery
MICU  Medical intensive care unit
NBN  Newborn nursery
NICU  Neurological intensive care unit or the neonatal intensive care unit
OR  Operating room
ORTHO  Orthopedics
PACU  Post-anesthesia care unit
PICU  Pediatric intensive care unit
Pre-Op  Preoperative
SICU  Surgical intensive care unit
SDCU  Special diseases care unit
TICU  Trauma intensive care unit

BECOME FAMILIAR with Clinical Lingo
Over 25 years ago, I had my first job in healthcare as a family planning counselor for a federally qualified health center. I was only 25 years old, a couple of years out of undergraduate school, and not sure what I wanted to do in my professional life. That job started me on the career path that led me to the great job I have now, working for a large health insurance company in Philadelphia, Pennsylvania.

Clinical Path Leads to Coding
In 2013, I was contacted, along with 15 other registered nurses (RNs), to code retrospective risk adjustment for an insurance company. That opportunity led to a fulltime position with the company. At that time, I had already obtained a master’s degree in Public Health and an RN license. Having those credentials were great, and one of the reasons I was given the opportunity; however, they didn’t show proficiency in coding. In 2014, I obtained my Certified Professional Coder (CPC®) certification through AAPC, which wasn’t a requirement for that position, but it was the only reason I was able to apply for and obtain my current position as a clinical analyst. In this position, I am responsible for auditing the accuracy of the diagnosis codes submitted for reimbursement from the Centers for Medicare & Medicaid Services (CMS) through risk adjustment data validation and risk adjustment mitigation.

Education Is Key to Continued Success
Continuing education as both a registered nurse and a coder is necessary and invaluable. I obtained my Certified Risk Adjustment Coder (CRC™) in July 2018 to show proficiency in risk adjustment. Obtaining that credential ultimately played a huge role in my promotion to a senior clinical analyst in October 2018. My job as a risk adjustment auditor is critical to validate the accuracy of the diagnoses codes we submit for reimbursement to ensure we have the proper resources to care for our chronically ill members. I am required to make recommendations and draft policies and procedures as they relate to risk adjustment. Having my coding credentials, as well as clinical background, gives my leadership confidence in my professional advice in the healthcare arena.

My professional growth as a nurse coder inspired me to be more active in the Greater Philadelphia, Pennsylvania local chapter, so I applied for and was accepted as the education officer. My journey has been awesome; I attribute landing in my current role, becoming active in my chapter leadership, and having other professional and personal opportunities come to fruition to my AAPC membership and credentials.

Having my coding credentials, as well as clinical background, gives my leadership confidence in my professional advice in the healthcare arena.

#IamAAPC
Healthcare Business Monthly wants to know why you chose to be a healthcare business professional. Explain in less than 400 words why you chose your healthcare career, how you got to where you are, and your future career plans. Send your stories and a digital photo of yourself to Michelle Dick (michelle.dick@aapc.com).
Let’s face it: HEALTHCON is a big investment for a person. Even if your company is paying for you to attend the Las Vegas venue, April 28 to May 1, you’ll still need to take time off from work, eat, and pay for transportation. I’ll tell you why and how you can — and should — make this year’s AAPC national conference a priority.

Education: More Comprehensive than You Think

HEALTHCON is chock full of educational breakout sessions — 90+ this year. Topics include auditing, billing, specialty-specific coding, compliance, facility coding, practice management, revenue cycle management, risk management, career help, and technology. Some of those topics are broken down further, such as the session “What you MUST do to land a job in healthcare,” presented by yours truly.

A long time favorite among attendees is the Anatomy Expo. This session alone makes the trip worthwhile!

The variety of session topics provides an opportunity for you to grow out of your comfort zone. For example, if you’ve been a pro-fee coder your entire career, check out a facility session. Maybe you have always been interested in the compliance part of coding but are afraid to take the leap. This is your opportunity to see if you like it.

Plus, after just three days, you leave with 18 continuing education units (CEUs), depending on how many sessions and pre-conference events you attend!

Networking: More Connections than You Can Imagine

At HEALTHCON, you can rub elbows with thousands of other professionals in your field. With specialty-specific breakout sessions, you’ll find yourself in a room of 150 peers with a wealth of knowledge. This is networking at its finest. There are so many professionals with various experience levels under one roof. Whether you have been in the field for six months or 40 years, your network is here. These contacts are not limited to the people attending the sessions; it includes the professionals teaching the sessions, as well. At the beginning or end of every session, the presenter will give you contact information. They fully welcome you to reach out.

And the networking doesn’t end when HEALTHCON ends; you’ll take these new contacts home with you. For example, I remember at my first conference I attended a session presented by AAPC NAB President Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO, CPMA, CEMA, AAPC Fellow. A few days later, I had a compliance question and I reached out to him via email. Not only did he respond within hours, he also provided resources and made it a teachable moment. This is the stellar networking that you’ll be hard-pressed to find anywhere else.

Employer Benefits: More than They Realize

Now that I’ve sold you on why you should attend, here is how to get there. Start a HEALTHCON savings account. If it’s too late to save up for this year, begin putting money away for next year. Ask your employer to contribute to the cause. Employers statistically pay over 80 percent of AAPC’s attendees’ costs (www.healthcon.com/employer.php). Sit your boss down and explain how your attending HEALTHCON will benefit your company:

• Provide a list of the educational sessions and the specific sessions you plan on attending. Give specific instances in how this education will help you in your job.
• Offer to summarize the experience when you return. When you do this, also explain how you will implement what you learned into your current processes and how these changes will benefit the company. This will show that you are accountable and help your employer to see that you’ve used their time and money wisely.

I’m Going to HEALTHCON

Here is why you should, too.
• Point out that your HEALTHCON education will favorably affect their bottom line, and you are willing to train coworkers.

• Let your employer know you can work during breaks at HEALTHCON. Organizers understand you may need to be working, even when away. The Wi-Fi is strong, and the schedule allows breaks to check email, work, and stay connected.

• Remind them AAPC offers corporate discounts and lodging.

• If your employer objects due to finances, remind them that HEALTHCON is an investment with a positive return on investment. Here are some more helpful hints in convincing your boss: www.healthcon.com/employer.php.

If it is a solid, “No,” negotiate: Perhaps they can cover a portion of the expenses or you can share a room. Where there’s a will, there’s a way!

**Tips to Make Your HEALTHCON Experience a Success**

Once you’re registered for the largest healthcare revenue cycle management conference of 2019, build your schedule as soon as possible because sessions fill up quickly. Follow this list of Do’s and Don’ts to help enjoy the conference and make the most of your time:

• “Do” pack for the weather. Dress code is business casual. Look professional because your next employer may be there, too.

• “Do” bring comfortable shoes. You will walk a lot. Bring your fitbit® tracker because we have contests!

• “Do” drink a lot of water and take vitamin C. Crowds this big ultimately bring germs.

• “Do” bring your business cards, paper, and pen for notes.

• “Don’t” sit on the floor of the presentation rooms, especially for the General Sessions. There are always seats. You may have to walk to the front of the room because they generally fill up from back to front. Your AAPC Chapter Association board representatives will assist you to find seats.

• “Don’t” be on your phone. Stay off social media. Put your phone down and on vibrate. Our presenters have spent hours on these presentations; be courteous and excuse yourself if you need to take a call or answer an email.

• “Don’t” leave the session before it’s over. Even if the continuing education unit (CEU) information is on the screen, the session is not over until your presenter says so.

This will be one of the best experiences of your life. You will have FUN and make lasting friends. You’ll learn and won’t regret your decision to go. When you get there, come find me and we will celebrate one of your best decisions with a high five! HBM
Maria Puerto
Fredericksburg, Va., Local Chapter

This month’s spotlight shines on Maria Puerto, COC, CPMA, CRC, CCS, of the Fredericksburg, Virginia, local chapter. She is the 2019 president, which is not a new role for her; she has served as this chapter’s president a few times since joining in 2006 and has served all over the chapter officer board.

Puerto’s coding career started in 1989 as an entry-level file clerk. She worked her way up the work chain and is now a compliance officer for a healthcare system. Puerto has collected a few certifications since her first one, the Certified Outpatient Coder (COC™), in 2006.

Supporting Each Other Is What It’s All About

Puerto became active in her chapter immediately after attending her first meeting. “What stood out to me was that everyone was so welcoming and kind at my first meeting,” she said. Puerto knew then that she wanted to be part of AAPC and support its members. When looking back over the years, she said, “It is my privilege to serve as an officer.”

Puerto has had great mentors, as well. Tammy Danek, COC, CPC, and Debbie Zorn took her under their wing and developed her into the officer she is now. “I am very grateful for their support,” Puerto said.

Gives the Gift of Speaking and Education

When Puerto is not serving her members as an officer, she is providing education and guidance at the chapter meetings. “I believe it is important to set an example and speak at meetings,” she said. One of the ways Puerto recruit speakers is to look within the Fredericksburg chapter, relying on member feedback for relevant topics.

The chapter strives to keep events fun. For example, they kicked off the year with the meeting “Welcome 2019 — The Power of Yoga” to promote mental health and ways to reduce stress.

Provides a Sense of Community

Puerto and the Fredericksburg chapter feel a big sense of community. They have had food drives and donated to the AAPC Chapter Association Hardship Scholarship Fund.

Puerto’s plan for 2019 is to bring more networking to the chapter and to reach out to other local chapter meetings. She also recommends others to serve their chapter board. Puerto assures, “You will be incredibly proud in knowing you made the decision to serve and continue to support AAPC commitment.”

Just like you and me, Maria Puerto, COC, CPMA, CRC, CCS, is AAPC. HBM

If you are interested in becoming certified in medical coding or in healthcare revenue management, like Maria Puerto, COC, CPMA, CRC, CCS, go to www.aapc.com/certification/ to find out more.

You will be incredibly proud in knowing you made the decision to serve and continue to support AAPC commitment.

Gina Piccirilli, CPC, CPMA, the author, is director of HIM at Ellenville Regional Hospital. She also consults in documentation improvement and E/M auditing. She is a Region 2 – Atlantic AAPCCA representative for 2017-2020 and can be reached at gina.piccirilli@aapcca.org.
Make the Most of May MAYnia

May MAYnia is a showcase meeting for many chapters. It’s a time to reach out and increase membership, and an opportunity to show everyone how much AAPC and your local chapter have to offer.

Start Planning!

If you’re not sure how to plan a May MAYnia event, take to the web. There are many amazing ideas out there. For ideas that are sure to knock attendees’ socks off, check out the May MAYnia section on the Officer Resource pages on AAPC’s website. Also reach out to your sister chapters and your regional AAPC Chapter Association representative to get or share great ideas.

When planning, arrange for a bigger crowd, and consider this:

• Date and Time: Hold this special meeting any time in May. You may want to make this a slightly longer meeting because you’ll have more activities than usual.
• Speakers: Arrange for an expert to speak on a topic that all your members will enjoy.
• Prizes: Pull out all the stops for top-notch prizes: gift certificates, baskets, AAPC merchandise. Be sure to take advantage of the free giveaways AAPC provides (one item for each attendee, based on your chapter’s meeting attendance the previous year).
• Decorating: Pick a theme and run with it. Plan the food, decorations, music, etc., around your theme. Consider having a photobooth or a selfie backdrop that depicts your theme. Make it fun!

Spread the Word

Involve your chapter in the planning and send members a Survey Monkey questionnaire to find out what they would like to see at May MAYnia. This is a fantastic opportunity to reach out to not just past and present members, but potential new members, as well. Ask your chapter members to invite workplace colleagues to the event and show them what AAPC is all about.

Catch May MAYnia fever — it’s contagious!

Heather Allen, LPN, COC, CPMA, has more than 15 years of experience in coding, billing, auditing, management, and consulting in addition to her clinical experience. She has worked for hospital inpatient, solo and group practices, and insurance defense auditing. Allen has been employed the last eight years with RevCycle+, where she oversees coding, auditing, and client management for 40-plus emergency departments and urgent care clinics. She is 2018 president of the Jefferson City, Mo., local chapter.

THINK MATCH.COM MINUS THE ROMANCE

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Widely known for his salesmanship, business acumen, and motivational speeches, Zig Ziglar once remarked, “You don’t build a business. You build people, and then people build the business.” Even if this belief were widely held among organizations, convincing decision-makers to invest in employees requires information-gathering and careful planning.

The Odds Aren’t Even
AAPC collected some very interesting data towards the end of last year when surveying our membership. Of the participating respondents who purchased various products or services, many indicated they had to cover their own costs:

<table>
<thead>
<tr>
<th>Product/Service</th>
<th>Individually Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webinars</td>
<td>54%</td>
</tr>
<tr>
<td>Conferences</td>
<td>37%</td>
</tr>
<tr>
<td>Online Courses</td>
<td>63%</td>
</tr>
<tr>
<td>Exam Study Materials/Exams</td>
<td>74%</td>
</tr>
<tr>
<td>Membership</td>
<td>61%</td>
</tr>
<tr>
<td>Code Books</td>
<td>51%</td>
</tr>
<tr>
<td>AAPC Coder Software</td>
<td>33%</td>
</tr>
</tbody>
</table>

These percentages revealed some workplaces still struggle to buy into the employee investment ideal, which is especially unfortunate considering the research to validate the concept. The American Society for Training and Development (ASTD) found staggering numbers when evaluating the training expenditures (or lack thereof) from 575 U.S.-based, publicly traded businesses.

ASTD divided the companies into four even groups depending on how much money was being invested on training, as measured by average per-employee expenses. In comparing the companies from the top and bottom quarters, those that spent the most on training saw 24 percent higher profit margins and 218 percent more income per employee!
Happiness Equals Loyalty

In addition to the growing evidence of return on investment organizations can expect to see, these employment extras rank highly among desired job perks. A recent survey, conducted by Zenefits® (an HR software company) of 600 small and medium-sized businesses, noted the following:

- 68 percent of employees think “work perks” are just as important as health coverage, life insurance, and other traditional benefits.
- Education programs were identified as the second-most important of the possible perks (just behind wellness programs).

Training employees and investing in the resources they need to do their jobs proves how much the organization values them and wants them to remain. Employees who receive these kinds of bonuses perform better and demonstrate dedication in return. One IBM study found that employees who feel they cannot develop in the company and fulfill their career goals are 12 times more likely to leave.

Employers who are still hesitant to pay for their employees’ continual training to develop skills necessary to fulfill their work responsibilities should consider the costs of hiring and training a replacement.

A Legal Leg to Stand On

One emerging trend is the intervention of the law on behalf of employees. As of 2019, nine states (California, District of Columbia, Iowa, Illinois, Massachusetts, Montana, New Hampshire, North Dakota, and South Dakota) have mandated that employers reimburse employees for expenses incurred in carrying out their job duties, according to Lexology™. Although the wording of these laws varies from state to state, and we recommend consulting a legal professional for further investigation, you could certainly make a strong argument for why the most recent code books or software is a “necessary expenditure.” If holding a certain credential is one of your job requirements, membership and training (to maintain your certification) might qualify.

Consider federal minimum wage laws, as well, because the U.S. Department of Labor notes, “Wages must be paid free and clear of impermissible deductions – such as the costs of operating the vehicle or traveling on the road – that would reduce pay below the federal minimum.” In other words, if the job requires a business trip, the employee spends their own money on reasonable food expenses, and no reimbursement is made; the employee is effectively reducing their wage by these costs. If that reduction drops the employee’s pay to below the federal minimum wage, there could be negative consequences for the employer. Again, please consult a legal professional for further investigation if you feel this applies to your situation.

From the perspective of the organization, tax professionals should be involved to determine deductible business expenditures because certain resources and trainings may qualify as “ordinary and necessary.”

Steps to Success

Preparing a request for your employer to cover the costs of work-related educational advancement or a job resource can be time-consuming. Make sure you give yourself enough time to develop each aspect of your pitch. Let’s break the process down into steps.

1. Understand the Process

Talk to your organization’s human resources department/representative or approach your supervisor directly to find out:

- What similar products or services have been approved in the past?
As you become more adept in asking your employer to cover reasonable work-related expenses, start including your co-workers in the same solicitations.

• What will you need to do to get approval?
• Is there a formal process/form you will need to follow?
• Are there certain individuals you will need to get buy-in from?
• What expectations or standards are in place as you begin these efforts?

2. Plan for Obstacles
• What is the current financial climate of your organization?
• If you’re asking for a training, is it taking place during a particularly busy time of month or year?
• How will your workplace and co-workers handle your absence?
Recognizing challenges up front will help you prepare to address them in ways that satisfy your employer.

3. Do Your Research
This will be the largest step in the process. Ask:
• What is the total cost of what you are requesting?
• Are there discounts available, and if so, what is required to qualify for them?
• If you are asking for an off-site training, what associated costs will be incurred (travel, food, lodging, etc.)?
• Is there a registration deadline?
• What is the facilitator’s reputation?
• What do you expect to learn or gain from the education?
• What materials will you receive?
• What will you bring back to the organization, both short term and long term, both personally and for your co-workers?
• What alternatives did you consider, in terms of both competing facilitators and costs?

4. Anticipate Concerns
Although you may prepare to address employer concerns in the research step, your employer may not be completely convinced by logic and reasoning. Imagine the most likely questions you may hear and practice responding to them professionally. You’re not trying to win a debate; you’re trying to make a persuasive, convincing case. Common issues that may come up will likely relate to the cost and how your workload will be addressed while you are away. Employers making more substantial investments may expect a signed commitment plan.

5. Email, then Follow Up
By compiling your pitch into a succinct but informative email, you will ensure you haven’t forgotten crucial information. Following up shortly thereafter with a brief conversation will offer you a second chance to negotiate a successful outcome. Make sure you stay professional, not pushy. If the answer is “No,” evaluate the response (this may require a follow-up question in the moment). Is this a bad timing “No,” a request for more info “No,” or a hard “No?”

Practice!
Start with small requests that you feel more comfortable making, and slowly escalate into the bigger needs. As you become more adept in asking your employer to cover reasonable work-related expenses, start including your co-workers in the same solicitations. Your employer will benefit that much more as your team becomes more capable.

David Blackmer, MSC, is the director of member experience at AAPC. He is a member of the Salt Lake South Valley, Utah, local chapter.

References and Resources


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100% Effective Ltd, “How to convince your employer to pay for your training”: www.100peffectiv.com/blog/convince-employer-pay-training/


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PROPS TO AAPC REPRESENTATIVES

We appreciate feedback from members about their experiences with AAPC staff. We especially love receiving props! Here’s what one member said recently:

I wanted to send a note regarding the help I received in my CPC prep course. I emailed many, many times with all kinds of questions. Lindsay-Anne replied quickly every time and answered all my questions. She went BEYOND simply sending me an answer. She replied with examples, tips, and other things to think about. She suggested a few phone calls and set those up with me. Those calls were invaluable! She reviewed sections I had asked about and gave me necessary tips and strategies to practice in preparation for the exam. She even took the time to answer my questions about gaining experience, finding a job, and the various work possibilities at different types of facilities. I really wanted to pass the test the first time. I did, and I know it likely would not have happened without those phone calls. Thank you for providing us with such wonderful people as resources!

Lindsay-Anne is an incredibly dedicated coach, and we receive this kind of feedback about her frequently. We asked about her perspective, given her position and constant interactions with students. Here is what Lindsay-Anne said:

All of us on the team are thrilled when we see an email with “I got my CPC.” Many students who get their CPC have a new sense of pride and confidence and are excited about new possibilities. That is what I like about teaching this course—helping students see that they can do it and will be amazed by all they learn.

Courses may be challenging, particularly for those without a background in healthcare, but you can always count on amazing coaches and resources to help you succeed!

To nominate an AAPC employee for excellent service you received, send an email to thanks@aapc.com.

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2019 OPPS Reflects More Site-of-service Payment Equalization

Meet outpatient quality reporting requirements or prepare for a payment reduction.

Using Hospital Outpatient Prospective Payment System (OPPS) methodology, the Centers for Medicare & Medicaid Services (CMS) based 2019 OPPS payments on 2017 claims data submitted by hospital providers, resulting in an estimated 1.35 percent increase. Hospitals that fail to meet the hospital outpatient quality reporting (OQR) requirements will continue to incur a 2.0 percent payment reduction. Claims data reflecting modifier PN Non-excepted service provided at an off-campus, outpatient provider-based department of the hospital is available for the first time and was excluded from the rate-setting, as these claims are reimbursed under the Medicare Physician Fee Schedule (MPFS) methodology.

CMS adopted a policy to maintain the rural adjustment for certain sole community hospitals and essential access community hospitals until data indicates this adjustment is no longer needed. The payment adjustment for specific cancer hospitals continues, as well. Let’s see what else CMS has in store for us this year.

New Comprehensive APCs for 2019

Three new comprehensive ambulatory payment classifications (C-APCs) were established: level 3 ear, nose, and throat (ENT) procedures and two vascular procedure C-APCs. This brings the total number of C-APCs to 65.

Some procedures assigned to a New Technology APC have very low volumes (less than 100 claims) due to being new technology/procedures. Beginning in 2019, payment for these low-volume procedures will no longer be packaged into a C-APC when reported on a claim with a primary procedure (status indicator J1). Packaging of the low-volume procedures has diluted the data available for establishing the actual cost for the service, which in turn negatively affects CMS’ ability to assign the New Technology service to a regular APC. In addition, CMS broadens the time period of claims data that may be used to four years to increase the number of claims included in rate-setting for these services and to prevent wide payment swings.

Inpatient-only List Continues

Four procedures were removed from the inpatient-only list, identified by CPT® codes 31241, 01402, 00670, and 0266T. One procedure was added to the list: C9606 Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass grafts, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel.

Devices and Drugs

Seven devices were submitted for pass-through consideration. Only one, the remede® System transvenous neurostimulator, met the criteria and was approved for pass-through status for 2019. The description for HCPCS Level II code C1889 was revised to “Implantable/insertable device, not otherwise classified” for reporting devices that do not have an applicable device HCPCS Level II code.

This revision removes the restriction of using this code only for a device-intensive procedure.

The packaging threshold for drugs increased to $125. Pass-through payment expired for 23 drugs as of Dec. 31, 2018 (Table 37). Twenty drugs will receive separate payment and three will be packaged. Sixty drugs and biologicals have pass-through status for 2019; but watch the quarterly OPPS updates because pass-through status is assessed on a quarterly basis to assure three full years of payment. Four drugs whose pass-through status ended in 2017 have had payment extended from Oct. 2, 2018, through Sept. 30, 2020 (Table 30). For these specific items, payment will be the greater of ASP + 6 percent or the payment rate in place on Dec. 31, 2017.
Separate payment and pass-through payment continue at ASP + 6 percent. If ASP data is not available, payment is made based on wholesale acquisition cost (WAC) + 3 percent.

**Non-opioid Pain Management Treatments**

In response to the recommendations from the Trump administration’s Commission on Combating Drug Addiction and the Opioid Crisis, and CMS’ initiatives to affect this crisis, CMS is reversing their packaging policy for non-opioid pain management therapies in ambulatory surgery centers (ASC), but NOT in hospital outpatient departments (HOPD). Current policy packages the payment for drugs used as supplies for a surgical procedure into the payment for the procedure. Exparel was U.S. Food and Drug Administration (FDA)-approved for relieving post-operative pain at the surgical site and was granted pass-through status when new to the market. Claims data reflect that when the pass-through payment for Exparel expired, usage in the ASC decreased significantly, but continued to increase in HOPDs. The data also reflects that payments to HOPDs are adequate to cover the procedure and the Exarel because the incidence of use continues to increase and there are no barriers to access for Medicare patients. CMS surmises that because ASCs provide more limited range of services, and receive 55 percent of OPPS payments, the usage dropped because there are pain management options with less cost. For 2019, Exarel and other non-opioid medications will be separately reimbursed to ASCs to incentivize their use.

**Extension of Site Neutral Payment Policy**

Off-campus provider-based hospital departments (PBDs) existing prior to November 2015 are “excepted” PBDs and are paid under the standard OPPS methodology and identified by modifier PO.

Three new comprehensive ambulatory payment classifications (C-APCs) were established: level 3 ear, nose, and throat (ENT) procedures and two vascular procedure C-APCs.
provider-based outpatient departments. CMS states there have been “unnecessary increases in the volume of covered OP department services,” and attributes this increase to the higher payment provided under the OPPS. To mitigate this increase, the site-neutral payment methodology now extends to clinic visits (HCPCS Level II code G0463 Hospital outpatient clinic visit for assessment and management of a patient) provided in excepted off-campus PBDs. This change will be phased in over two years, with a 30 percent OPPS payment reduction applied for 2019. Services provided in a non-excepted PBD are identified by modifier PN and are reimbursed at 60 percent of the OPPS rate, comparable to the payment rate for services provided in a physician’s office.

The concept of site-neutral reimbursement has also been extended to payment for drugs purchased under the 340B program when provided in a non-excepted PBD. Modifier JG Drug or biological acquired with 340B drug pricing program discount must be reported on the line item for each separately paid drug, which are reimbursed at ASP -22.5 percent unless the drug is assigned pass-through status or is a vaccine. Critical access hospital (CAHs), rural sole community hospitals, children’s hospitals, and PPS-exempt cancer hospitals are excluded from the payment adjustment, but must report informational modifier TB Drug or biological acquired with 340B, reported for informational purposes for drugs purchased under 340B.

CMS continues to monitor changes in billing patterns and utilization of services in excepted off-campus PBDs to determine if expansion of services is occurring. CMS has not determined the exact methodology to prevent expansion of services in off-campus provider-based departments, but is considering either limiting services to those provided as of Nov. 2, 2015, (the date of the Bipartisan Budget Act) or capping payments under the OPPS at the amount

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**Medicare Physician Fee Schedule Items that Apply to Hospitals**

**Appropriate Use Criteria**
This program is in the implementation stages. Mandatory reporting begins Jan. 1, 2020, with an education and operational testing period in which the information must be reported, but payment is not affected. Independent diagnostic testing facilities were added to the list of reporting providers. In addition, the Centers for Medicare & Medicaid Services (CMS) clarified in the 2019 Medicare Physician Fee Schedule (MPFS) final rule that the appropriate use criteria consultation information must be provided on the furnishing professional and facility claims to incorporate both the professional and technical components of the service. CMS finalized that this reporting will be accomplished with HCPCS Level II G codes and modifiers, and any concerns expressed regarding technical issues and claims processing will be addressed during implementation.

**Payment for Outpatient Therapy Services Furnished by Therapy Assistants**
CMS has established two new modifiers for the reporting of a physical therapy assistant (PTA) or occupational therapy assistant (OTA):

- Modifier CQ Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant
- Modifier CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

These payment modifiers are to be reported in addition to therapy modifiers GP Services delivered under an outpatient physical therapy plan of care and GO Services delivered under an outpatient occupational therapy plan of care to indicate that a therapy assistant provided the service. These modifiers will be tied to a payment reduction beginning in 2022.

CMS has also finalized a “de minimis standard:” A service is provided by a PTA or OTA when more than 10 percent of the service is furnished by the assistant. Specific examples of scenarios and types of services for application of the de minimis standard and modifiers will be included in 2020 rulemaking.

**Good News!** The requirements for reporting functional limitation G codes and severity modifiers were removed beginning Jan. 1, 2019. The codes will remain active until 2020 to allow time for provider and private insurer billing systems and policies to be updated.
reimbursed prior to the Bipartisan Budget Act implementation. Any services provided after the cap is met would be reimbursed under the MPFS. CMS will continue to consider additional methodologies in future rule-making.

New modifier ER Items and services furnished by a provider-based off-campus emergency department was established for collecting data regarding outpatient hospital services furnished in an off-campus provider-based emergency department. CAHs are exempt from this requirement. CMS notes that this was an announcement of the modifier and its application and not a proposal for public comment.

That’s Not All Folks!

We’ve only looked at the highlights of the OPPS changes for 2019; there are many nuances. Review the OPPS and MPFS final rules for complete details on changes that affect your specific healthcare organization. 

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

The concept of site-neutral reimbursement has also been extended to payment for drugs purchased under the 340B program when provided in a non-excepted PBD.
If you report hospital inpatient services for Medicare patients, you need to know about the two-midnight rule. If you haven’t heard of it, or could use a reminder, here are the facts.

Cost Containment Matters
The Centers for Medicare & Medicaid Services (CMS) instituted the two-midnight rule, in part, to reduce what it considers to be medically unnecessary inpatient admissions — thereby, reducing costs, as well.

Not all care provided in a hospital requires inpatient admission. Generally, if a procedure can be performed safely and effectively on an outpatient basis, doing so is preferred. One reason for this is because the cost of providing inpatient hospital care is comparatively higher for a given service. The higher cost of inpatient care is reflected in different Medicare payment rates for inpatient (Part A) and outpatient (Part B) hospital services. Whether services are provided on an inpatient or outpatient basis also affects patient cost sharing.

The two-midnight rule was effective beginning Oct. 1, 2013. Per CMS’ “Fact Sheet: Two-Midnight Rule,” the original rule established:

- Inpatient admissions would generally be payable under Part A if the admitting practitioner expected the patient to require a hospital stay that crossed two midnights and the medical record supported that reasonable expectation.
- Medicare Part A payment was generally not appropriate for hospital stays expected to last less than two midnights. Cases involving a procedure identified on the inpatient-only list or that were identified as “rare and unusual exception” to the two-midnight benchmark by CMS were exceptions to this general rule and were deemed to be appropriate for Medicare Part A payment.

To summarize: A hospital inpatient admission is reasonable and necessary (and eligible for Medicare Part A payment) only if the admitting provider expects the patient to require hospital care that spans at least two midnights. With some exceptions (see The Rule Isn’t Absolute, below), if the provider anticipates a patient will be able to leave the hospital safely prior to that time, an inpatient admission is not supported (and will not be reimbursed by Medicare) and observation or other outpatient status is more appropriate.

On the flipside, it’s generally not appropriate to hold a patient in observation status for an extended time (e.g., three or more days). In

Meet Medicare requirements when a provider expects a patient to be admitted for an inpatient stay of at least two midnights.
such cases, inpatient admission may better meet the patient’s medical needs.

For example, if the provider treats a patient and expects she will be able to leave the hospital the following day, an inpatient admission likely isn’t medically necessary, per the two-midnight rule (the patient is staying in the hospital past one midnight, only). But if the provider treats the patient on Monday and believes the patient will require continued care until at least Wednesday, an inpatient admission is appropriate because the patient will stay in the hospital past two midnights (Monday/Tuesday and Tuesday/Wednesday).

The Rule Isn’t Absolute

The two-midnight rule has always allowed for exceptions. And as part of the 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule (following extensive feedback from providers and other stakeholders), CMS revised the two-midnight rule to allow flexibility “for determining when an admission that does not meet the benchmark should nonetheless be payable under Part A on a case-by-case basis.”

As outlined in the CMS Fact Sheet:

For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary and is subject to medical review.

In other words, there are two exceptions to the two-midnight rule:

1. The provider performs a procedure that is on CMS’ “inpatient only” list. In this case, the length of the hospital stay isn’t a factor because inpatient admission is mandatory if the provider is to receive Medicare payment for an “inpatient only” procedure. The list of inpatient-only procedures is revised annually and is included within the OPPS final rule each year.

2. The provider decides, based on their expertise and the patient’s circumstance, that an inpatient admission is medically necessary, even though the patient is not expected to remain an inpatient across two midnights.

This means that if the provider believes the patient’s condition requires inpatient care and a supporting explanation is provided in the documentation, the length of the inpatient stay doesn’t matter. But CMS stresses, “It would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight.”

Meet the Expectation of a Two-midnight Stay

CMS says the requirements of the two-midnight rule are met as long as the admitting provider expects the patient to remain an inpatient across at least two midnights (and documentation supports the provider’s conclusion). Per the CMS Fact Sheet, “This includes stays in which the physician’s expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice.”

John Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Hendersonville-Asheville, N.C., local chapter.
Make the Connection
“With” Causal Relationships

When diagnoses are linked by “with,” ICD-10-CM presumes a causal relationship, but should you?

There are 11 possible definitions of the word “with,” according to Merriam-Webster’s dictionary. In ICD-10-CM, “with” has a single, specific meaning that must be applied with care. This may be a challenge because you are taught to report only the conditions stated in the clinical documentation.

When “With” Assumes a Causal Relationship

ICD-10-CM guidelines, Section I. A.15, says, “The classification presumes a causal relationship between the two conditions linked by these terms [i.e., “with”] in the Alphabetic Index or Tabular List.” In other words, you may presume a relationship between two conditions if those conditions are linked within the ICD-10-CM Alphabetic Index or Tabular List — even if documentation does not explicitly state that the two conditions are related.

For example, diabetes mellitus is a common condition subject to the “with” convention within the Alphabetic Index and Tabular List. If documentation says …

1. Type 2 diabetes mellitus
2. Chronic kidney disease stage 3,

… the two conditions are coded together, as if they are related, using E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease and N18.3 Chronic kidney disease, stage 3 (moderate).

Do not forget to add the stage of the chronic kidney disease, which is prompted in the tabular list with the “use additional code” note, as shown in Figure 1.

Know the Exceptions

There are some exceptions to the “with” convention:

- If another guideline specifically requires a documented linkage between the two conditions, do not link the diagnoses (e.g., “Acute organ dysfunction that is not clearly associated with the sepsis.”).

- If a term (condition) is not listed under the Alphabetic Index or Tabular List, it’s not appropriate to code the conditions as related unless the clinician’s documentation clearly indicates the two are related. This may come into play when reporting “not elsewhere classifiable” (NEC) diagnoses (e.g., kidney complication NEC or ophthalmic complication NEC, as shown in Figure 2). Unless documentation states an NEC condition is related, you may not report an NEC diagnosis “with” another diagnosis.

For example, when reporting diabetes, a variety of conditions are subject to the “with” convention, including cataract, chronic kidney disease, foot ulcer, and others. But if documentation indicates the patient is diabetic and has glaucoma, the correct coding is E11.39 Type 2 diabetes mellitus with other diabetic ophthalmic complication and H40.9 Unspecified glaucoma. Even though there is a “code additional” note stating, “Use additional code to identify manifestation, such as diabetic glaucoma (H40-H42),” it is inappropriate to use the NEC diagnosis code E11.39 because glaucoma is not a term found in this list, and documentation does not link the two together.

Some conditions automatically can be associated with one another based on the “with” convention, just like “coffee and cream” or a “burger and fries,” however, there are times when “tea and cream” or “burger and soup” may not go together until it is verified and supported. In these cases, review the documentation to be sure there is indeed a relationship based on the ICD-10-CM conventions and guidelines. HBM
Some conditions automatically can be associated with one another based on the “with” convention, just like “coffee and cream” or a “burger and fries” …

Figure 2

Diabetes, diabetic (mellitus) (sugar) E11.9

Resources

Merriam Webster’s Dictionary: www.merriam-webster.com/dictionary/with
2019 ICD-10-CM Professional for Physicians
Revenue Integrity
The Importance of a Solid Program

It’s well worth the investment to review nine areas in your revenue cycle where integrity may be at risk.

Revenue integrity is ensuring all charges are captured appropriately, documented sufficiently, and paid correctly. Every organization — whether a private physician practice or a major academic medical center — needs a comprehensive revenue integrity plan. Federal agencies and commercial insurance companies are quick to retract payments for unsupported claims. Providers must be confident that attested claims are accurate and that all charges are supported. Examine nine key areas to develop an effective, comprehensive revenue integrity plan.

1. Revenue Integrity Self-assessment
The first step to a successful revenue integrity program is conducting a self-assessment to identify the biggest risks to the organization. This self-assessment will shape the foundation of the revenue integrity program.

Keep in mind: Self-assessment is not a one-time reflection. Successful organizations need to be nimble enough to continuously assess and change the needs of the program, as internal and external influences exude pressure on the system.

Consider following these guidelines for a self-assessment audit plan:

a. Maintain a calendar of which departments or areas should be reviewed monthly.
b. Randomly select a minimum of 30 records from those areas to be reviewed.
c. The ideal auditor should be familiar with what is happening to the patient clinically; understand how the account was coded; and understand the organization’s charge description master (CDM).
d. When the audit is complete, review findings with the department leader.
e. Develop corrective action plans that reflect the findings.
f. Ensure the department review is not adversarial: department leaders should perceive the review as a positive experience.
g. The auditor should follow up on the corrective action plans and re-audit, if necessary.

2. Charge Assurance
Charge assurance is attesting that all charges on the claim are correct. Charges can easily be erroneous — from selecting the incorrect line, keying an inaccurate quantity, or simply forgetting to enter some or all of the charges.

A great place to start developing a plan is to look at the Office of Inspector General’s (OIG) website. The OIG maintains a work plan for healthcare providers, which is updated continuously. Keeping up with changes and documenting action plans will immediately reduce your risk of noncompliance.
3. Routine CDM Reviews
All codes in the CDM should be up to date. Common areas of opportunity to find erroneous charge capture are:
- Missing charge for the service
- Charges are too high or too low
- Improper revenue or procedure codes
- Obsolete charges
- Pricing inconsistency
- Inadequate charge descriptions
- Miscellaneous charge codes
- Markup policies for drugs and supplies

4. Charge Reconciliation
Charge reconciliation is often forgotten or ignored, but when done correctly at the department level, it’s the fastest way to identify charging errors and to ensure compliance. Revenue generating departments should “own” this function. Operationally, this can be difficult to enforce, but working collaboratively with the organization’s compliance officer can reinforce the importance of the issue.

5. Information Systems
An organization’s health information system (HIS) often lends itself to revenue leakage. This risk increases exponentially when there are multiple ancillary systems interfacing with each other. In this scenario, a charge or CDM needs to be built both in the organization’s HIS, as well as in the external systems. When systems interface with one another, a check and balance is needed to ensure the system mapping occurs appropriately. A typographical error in mapping could allow the end user to believe they are charging for one service while something completely different is entered on the claim.

6. Charge Entry
Charge entry can range from old fashioned hand-keying of charges to a pick list that clinical or non-clinical staff selects from, which includes charges mapped in the background based on the documentation generated from clinical staff. Clinicians often do not receive proper training on charge entry and accuracy, so attention to detail often is diminished.

7. Price Justification
Healthcare is one of the only products/services where organizations typically are not setting the price as a function of cost. Most healthcare organizations price their services as a function of maximizing reimbursement, rather than the cost to perform the services. Maximizing reimbursement is critical to a practice’s livelihood, but it’s not the most ideal method for price justification.

For more information on charge description masters (CDM), read Robert Gilbert, COC, FHIFMA, article “Charge Description Master: Use It to Optimize Revenue” on pages 48-50 of the December 2018 issue of Healthcare Business Monthly, also in AAPC’s Knowledge Center at www.aapc.com/blog/44984-charge-description-master-use-it-to-optimize-revenue.
Medicare’s paper-based manual section 2202.4 states, “Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient.”

8. Medical Coding

Coding reports the medical encounter in a variety of ways. From a revenue integrity standpoint, ICD-10 diagnosis codes tell the story of the patient’s clinical presentation and support the medical necessity of the services for payment purposes; whereas ICD-10 procedure codes (inpatient facilities) and CPT® codes (outpatient facilities) tell the story of what services the patient received.

Often, coding accuracy is thought of only when factoring the accuracy of the final claim. This is critical, but what is often overlooked is the accuracy of coding on the order for service.

Providers are responsible for selecting diagnosis codes that define the reasons why services are ordered. These are the codes that hospital staff should look at to see if a diagnosis supports the payer-defined medical necessity guidelines. If the code does not support the payers’ policy, then the patient should be made aware that the service is not covered and that they will be financially responsible. Without this step, denials will occur and the organization will be liable for the charges.

9. Denial Management

Organizations often feel payer requirements make it difficult to receive payments for their medical services. To optimize revenue integrity, organizations are turning to fully-integrated, centralized financial clearance center teams. Financial clearance is a concept that, at its very basic element, ensures the patient is aware of their insurance eligibility, benefit coverage, and out-of-pocket expense.

A fully functioning financial clearance center is the most effective way to mitigate denials. It should validate the following four items prior to scheduling a service:

- Verify the patient’s insurance eligibility for the service.
- Evaluate if the patient’s insurance requires a referral or an authorization:
  - If a referral is required, the rendering provider must validate that there is a referring provider and that they have initiated and approved the referral.
  - If an authorization is required, the facility must validate that the ordering provider has obtained the authorization.
- Establish if the patient’s insurance has a medical necessity payment policy for the ordered service. If a payment policy exists, validate the order has an ICD-10 diagnosis code(s) that will support the medical necessity for the service.

If at any point one of these four items (eligibility, referral, authorization, medical necessity) fails to be validated, inform the ordering provider and the patient that the service may not be fully covered. For some items, such as referrals or authorizations, payers may require a timeframe for processing. Providers and patients often do not understand this requirement, and want services provided expeditiously. This is the best opportunity for organizations to proactively prevent denials. In any event, the patient should be given a financial liability waiver, or an Advanced Beneficiary Notice of Noncoverage (ABN) for Medicare patients, to assign financial liability to the patient.

Simplify Revenue Integrity

Revenue integrity comes down to three simple tenets: Ensure every dollar going out of your healthcare organization is:

1. Correct;
2. Supported and justified in the medical record; and
3. Reimbursed accurately according to the terms of contracts.

Ensuring revenue integrity can be difficult in an evolving healthcare environment, but the effort is well worth the investment.

Robert Gilbert, COC, FHFMA, is senior manager in the Healthcare Consulting Practice at Baker Newman Noyes. He specializes in operational areas including charge capture, revenue cycle, revenue integrity, change master, claims, provider reimbursement, and business systems. Gilbert has dedicated his career to assisting healthcare organizations with revenue cycle. He is a member of the Dover-Seacoast, N.H., local chapter.
Need to Giggle?

Sometimes we need to laugh on the business side of healthcare. To help lighten your spirits, Healthcare Business Monthly started this feature, where members can share their creative side with other AAPC members through humorous healthcare and coding-related cartoons.

Send your healthcare and coding-related cartoons to Michelle Dick (michelle.dick@aapc.com) or Brad Ericson (brad.ericson@aapc.com) for possible inclusion in Healthcare Business Monthly. We reserve the right to turn down any cartoon submissions that we deem inappropriate for a professional publication.

By Linda McInnis, CPC

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Ready to try coding software?

Try AAPC Coder's 14 day free trial.

Sign-up for a free 14 day trial at www.aapc.com/code/
Avoid Overpayments for Intensity Modulated Radiation Therapy

A recent Office of Inspector General (OIG) review found $25.8 million in hospital overpayments for intensity modulated radiation therapy (IMRT) planning, which suggests a need for greater education around reporting of these services. This article will provide insight into what IMRT is, its uses, and coding compliance.

What Is IMRT?
IMRT is an advanced type of radiation procedure, also known as conformal radiation, that is used to treat difficult-to-reach tumors. Radiation therapy, including IMRT, slows or stops tumor growth by preventing cancer cells from dividing and growing. In many cases, it will kill all types of cancer cells, and shrink or eliminate tumors.

IMRT uses a medical linear accelerator (LINAC) to generate photons or X-rays, delivering precisely adjusted, high-intensity radiation doses to the targeted area while preserving surrounding normal tissue.

How Is IMRT Used?
The LINAC generates 10 million volts of energy that penetrates the body to deliver radiation treatment to the target site. In a typical treatment, the LINAC will deliver multiple beams of radiation from various directions for between 10 and 30 minutes. What makes this therapy so powerful is that the intensity of each beam can be varied according to the treatment plan. IMRT often requires multiple or fractionated treatment sessions.

IMRT is currently used for the treatment of various cancers, including:
- Prostate (C61 Malignant neoplasm of prostate);
- Head and neck (C76.0 Malignant neoplasm of head, face and neck); and
- Central nervous system (C72.9 Malignant neoplasm of central nervous system, unspecified).

IMRT therapy has also been used in the treatment of breast cancer (C44.501 Unspecified malignant neoplasm of skin of breast), thyroid cancer (C73 Malignant neoplasm of thyroid gland), lung cancer (C34 Malignant neoplasm of bronchus and lung), gastrointestinal cancer, gynecologic malignancies (C56 Malignant neoplasm of ovary), and certain types of sarcomas.

IMRT is provided in two treatment phases: planning and delivery:
- The planning phase is a multistep process. Imaging, calculations, and simulations are performed to develop an IMRT treatment plan. A radiation oncologist prescribes a dose to a target area. A dosimetrist works with a medical physicist to calculate the IMRT exposures and beam configurations necessary to deliver the prescribed dose. Prior to delivery to the patient, the final treatment plan is verified on the machine and measured by the medical physicist.
- During the delivery phase, the IMRT treatment plan is followed to deliver radiation to the patient’s treatment site at various levels as prescribed.

Bundled Services
Reimbursement for the required pre-therapy, computer-based planning is made as part of a bundled Ambulatory Payment Classification (APC) payment. According to the OIG report “Medicare Improperly Paid Hospitals Millions of Dollars for Intensity-Modulated Radiation Therapy Planning Services,” some hospitals incorrectly received a separate payment for the IMRT planning service, as well as payment through the bundled APC. Payments for complex simulations (CPT® 77290 Therapeutic radiology simulation-aided field setting; complex) accounted for $21.5 million in duplicate overpayments.

In response, the Centers for Medicare & Medicaid Services (CMS) implemented an edit to prevent improper payments for IMRT planning services that are billed up to 14-days prior to IMRT planning (77301 Intensity modulated radiotherapy plan, including dose-volume
Intensity Modulated Radiation Therapy, the following documentation and billing requirements are required for radiation therapy:

- Documentation to support all billed services were provided;
  - Dosimetry reports (Dose plan is optimized using inverse or forward planning technique for modulated beam delivery to create highly conformal dose distribution. Computer plan distribution must be verified for positional accuracy, based on verifying dosimetry of the intensity map with treatment set-up and interpretation of verification methodology) Inverse planning depends less on the geometric parameters but more on specification of volumes of tumor targets and sensitive structures, as well as their dose constraints. Forward planning mostly depends on geometric relationship between the tumor and nearby sensitive structures.
  - Physicist reports
  - Simulation reports
  - Oncology reports
- Documentation of each treatment billed;
- Radiological report or physician’s interpretation; and
- Documentation of provided contrast material.

IMRT is a valuable tool in the treatment of certain cancers. Be sure to maintain appropriate and compliant documentation to support the processes that go into this type of therapy. Knowing the guidelines for billing and coding IMRT is critical to proper payment.

**Documentation Requirements**

Per CMS’ Coding Guidelines: Radiation Oncology Including Intensity Modulated Radiation Therapy, the following documentation is required for radiation therapy:

- Detailed itemization and supporting documentation for all billed services;
- Documentation of the history of illness being treated;
- Documentation of physician involvement;
- Physician order(s) for treatment, including current dosage;
- Histograms for target and critical structure partial tolerance specifications). Payment for the services identified by the following CPT® codes is included in the APC payment for 77301:

- 77014: Computerized tomography guidance for placement of radiation therapy fields
- 77280: Therapeutic radiology simulation-aided field setting; simple
- 77290: complex
- 77295: 3-dimensional radiotherapy plan, including dose-volume histograms
- 77306: Teletherapy nodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
- 77307: complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
- 77321: Special teletherapy port plan, particles, hemibody, total body
- 77331: Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
- 77370: Special medical radiation physics consultation

Do not report the above codes in addition to 77301 when provided prior to, or as part of, developing the IMRT plan. Do not report CPT® 77280-77290 (simulation-aided field settings) for verification of the treatment field during a course of IMRT (see Medicare Claims Processing Manual, Chapter 4, Section 200.3.1).

Medicare and other payers will generate a bundled payment to hospitals that include a range of procedures that may be performed as part of the development of an IMRT treatment plan. When IMRT is furnished to patients in a hospital outpatient department that is paid under the Hospital Outpatient Prospective Payment System (OPPS), the bundled APC reimbursement includes payment for services identified with CPT® codes 77014, 77280, 77290, 77295, 77306-77321, 77331, and 77370 when they are performed as part of IMRT plan development (77301).

You may report a treatment device CPT® code for each complex IMRT field. Do not separately bill each segment within the field. The CPT® 77334 Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts) is typically billed multiple times — once for each of the separate IMRT fields, as required by the plan during the course of IMRT treatment. The typical case requires up to 10 devices. Submit claims for the use of more than 10 devices with documentation to support their use and rationale.

**Resources**

Evaluate Medical Decision Making in the Emergency Department

Guidelines and auditing tools help with the decision-making process involved in coding E/M services.
Selecting evaluation and management (E/M) service levels in the emergency department (ED) can be a challenge, and the medical decision making (MDM) component is particularly difficult to score. E/M service guidelines are defined separately in the CPT® code book, by the Centers for Medicare & Medicaid Services (CMS) in the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, and by Medicare Administrative Contractors (MAC). A review of the various payer definitions and audit tools for scoring MDM will help you code E/M services in the ED, quickly and easily.

**MDM Scoring Is Consistent Across Guidelines**

All scoring methods consider the same three components of MDM, as defined in CPT® and CMS’ documentation guidelines:

- The number of diagnosis or management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, as well as comorbidities, and mortality associated with the patient’s presenting problem(s), the diagnostic procedure(s), and the possible management options.

MDM scoring is categorized into four types: straightforward, low, moderate, and high. All types require two of the three components to be met for all ED E/M services, regardless of the source or tool.

Shortly after the 1995 Documentation Guidelines for Evaluation and Management Services was published, the Marshfield audit tool was created to assist coders in valuing components of E/M. Although not a formal part of CMS’ documentation guidelines, some MACs, such as First Coast, National Government Services (NGS), Novitas, and Palmetto GBA, have created audit tools/score sheets that include a Marshfield-like audit tool. These tools provide definitions and values for the different components of MDM. Other MACs, such as CGS, Noridian, and WPS, do not use a specific tool, but reference information that focuses primarily on medical necessity. And some payers reference CPT® or other guidelines.

**Number of Diagnoses or Management Options**

To get to know the three components to MDM better, let’s first discuss the number of diagnosis or management options.

The ED E/M codes do not distinguish between “new” or “established.” Because patients present to the ED for unscheduled, episodic, emergent conditions, most are considered a new patient with a new problem to the examiner. As such, using a standard score sheet, most are considered either “new problem to the examiner, without additional work-up” (three points), or “new problem to the examiner, with additional work up” (four points). For nearly all MACs, the definition of “additional work-up” includes any diagnostic study performed during the ED evaluation, qualifying most patients for the four points in this area.

The American College of Emergency Physicians (ACEP) has also published Frequently Asked Questions (FAQs) in support of this position, stating, “When a treating physician in the ED orders diagnostic testing, consultation, or a referral while the patient is in the Emergency Department, ‘additional work-up’ has been planned and performed.”

For example, using the tool shown in Table A, four points are awarded for a patient presenting with new onset chest pain requiring a workup with labs, a chest X-ray, and electrocardiogram (EKG).
When scoring risk for ED E/M services, the categories for presenting problem(s) and management options selected typically score the highest.

**Table A:** Score the number of diagnoses or management options.

<table>
<thead>
<tr>
<th>A–Problem(s) Status</th>
<th>B–Number</th>
<th>C–Points</th>
<th>D–Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved, or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Established problem (to patient); stable, improved</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Established problem (to patient); worsening</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (to patient); no additional workup planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem (to patient); add workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

**Amount and Complexity of Data**

The second area of MDM is the amount and/or complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed (e.g., data points). This section is generally consistent with the categories and scoring audit tools/score sheets.

In the scoring of data, one point is given for each of the following:

- Review and/or order of clinical lab tests
- Review and/or order of tests in the Radiology section of CPT®
- Review and/or order of tests in the Medicine section of CPT®
- Decision to obtain old records or the history from someone other than the patient

Two points are given for:

- Review and summary of old records and/or the history obtained from someone other than the patient and/or discussion of the case with another healthcare provider
- Independent visualization of image, tracing, or specimen

For example, using the tool shown in **Table B**, a total of five points are scored with the order of lab tests (1 point), order of an X-ray (1 point), a discussion with the radiologist regarding the X-ray (1 point), and a summary of old medical records (2 points).

Four points are scored for the order of lab tests (1 point), order of medicine test – EKG (1 point), and independent visualization of tracing EKG interpretation (2 points).

**Table B:** Score the amount and complexity of data.

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Total**

**Risk**

The final category of MDM includes the risk of significant complications, morbidity, as well as comorbidities, and mortality associated with the patient’s presenting problem(s), the diagnostic procedures(s), and the possible management options — otherwise known as “risk.” This component is further defined in the Table of Risk in the 1995 Documentation Guidelines for Evaluation and Management Services, and typically consistent throughout most score sheets/audit tools.

The Table of Risk, shown in **Table C**, breaks down the three components of the presenting problem(s), diagnostic procedure(s)
High risk:

- One or more chronic illness with severe exacerbation, progression or side effect of treatment (presenting problem) - e.g., chronic obstructive pulmonary disease (COPD) exacerbation
- Acute or chronic illnesses or injuries that may pose a threat to life or bodily function (presenting problem) - e.g., chest pain
- Abrupt change in neurological status (presenting problem) - e.g., dizziness
- Parenteral controlled substances - e.g., intramuscular (IM)/IV Dilaudid
- Drug therapy requiring intensive monitoring for toxicity - e.g., Cardizem

Put It All Together

The final determination for MDM is made by the highest two components of the number of diagnoses or treatment options, amount and complexity of data, and risk, as shown in Table D. If the highest two are in the same type, that will determine the level. If the highest two score into two different types, the lower type of the two will determine the score.

---

**Table C: Use the Table of Risk to determine the level of risk.**

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>• One self-limited or minor problem, e.g., cold insect bite, tinea corporis</td>
<td>• Laboratory tests requiring venipuncture, chest X-rays, EEG/EEG, urinalysis, ultrasound, e.g., echo, KOH prep</td>
<td>• Rest, gargles, elastic bandages, superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>• Two or more self-limited or minor problems</td>
<td>• Physiological tests and procedures not under stress, e.g., pulmonary function tests, noncardiovascular images studies with contrast, e.g., barium enema, superficial needle biopsies, clinical laboratory tests requiring arterial puncture, skin biopsies</td>
<td>• Over-the-Counter drugs, minor surgery with no identified risk factors, physical therapy, occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>• One or more chronic illness with mild exacerbation, progression, or side effects of treatment</td>
<td>• Physiological tests under stress, e.g., cardiac stress test, fetal contraction stress test, diagnostic endoscopies with no identified risk factors, deep needle or incisional biopsy, cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac catheter, obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>• Minor surgery with identified risk factors, elective surgery (open, percutaneous or endoscopic with no identified risk factors), prescription drug management (continuation &amp; new prescription), therapeutic nuclear medicine, IV fluids with additives, closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>• Cardiovascular imaging studies with contrast with identified risk factors, diagnostic endoscopies with identified risk factors, discography</td>
<td>• Elective major surgery (open, percutaneous or endoscopic with identified risk factors), emergency major surgery (open, percutaneous or endoscopic), parenteral controlled substances, drug therapy requiring intensive monitoring for toxicity, decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

Items to consider in the Table of Risk relative to ED E/M include:

**Moderate risk:**
- Acute illness with systemic symptoms (presenting problem) - e.g., fever or hives
- Acute complicated injury (presenting problems) - e.g., fracture or facial laceration
- Prescription management (treatment option) - e.g., antibiotics

**Put It All Together**

The final determination for MDM is made by the highest two components of the number of diagnoses or treatment options, amount and complexity of data, and risk, as shown in Table D. If the highest two are in the same type, that will determine the level. If the highest two score into two different types, the lower type of the two will determine the score.
For accurate coding in the ED, be aware of the definitions and scoring methodologies available for scoring E/M services and, specifically, the MDM component.

Example 1:
- Number of diagnosis or management options: 4 points
- Data: 3 points
- Risk: High
- Overall MDM: High

Example 2:
- Number of diagnosis or management options: 4 points
- Data: 2 points
- Risk: Moderate
- Overall MDM: Moderate

Table D: Add up the components.

<table>
<thead>
<tr>
<th></th>
<th>A: Number of diagnoses or treatment options</th>
<th>≤ 1 Minimal</th>
<th>2 Limited</th>
<th>3 Multiple</th>
<th>≥ 4 Extensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Amount and complexity of data</td>
<td>≤ 1 Minimal</td>
<td>2 Limited</td>
<td>3 Moderate</td>
<td>≥ 4 Extensive</td>
</tr>
<tr>
<td>C</td>
<td>Highest risk</td>
<td>Minimal</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Type of decision making</td>
<td>Straight-Forward</td>
<td>Low Complexity</td>
<td>Moderate Complexity</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

For accurate coding in the ED, be aware of the definitions and scoring methodologies available for scoring E/M services and, specifically, the MDM component.
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CODING/BILLING

Product Specificity Matters when Using National Drug Codes

Be sure you are familiar with the identifier codes of drugs and vaccines, and their rules, when billing drug products.

The National Drug Code (NDC) number is a universal product identifier for drugs used in the United States. The Center for Medicare & Medicaid Services (CMS) has required NDC numbers to be reported when submitting claims for drugs and vaccines for more than 10 years. Many commercial payers also require NDCs, but rules vary. Here is what you should know for proper reporting.

What NDCs Identify

The NDC is product-specific. It identifies:

- The “labeler” (a term the U.S. Food and Drug Administration (FDA) uses to describe firms that manufacture, repack, relabel, or distribute a drug under its own name);
- Drug;
- Dosage form; and
- Strength or concentration of the active ingredient.

Generically, equivalent drugs (the same drug, concentration, and dosage form) from two different manufacturers have two different NDC numbers.

Compared to five-character alphanumeric HCPCS Level II codes, NDC numbers convey more information about “what’s in the box.” CMS requires the NDC number on Medicaid claims (including Medicare claims that cross over to Medicaid). This identifies drug products that may qualify for manufacturer rebates to the Medicaid program.

The FDA maintains a directory of NDC numbers at www.fda.gov. Current regulations require a labeler to update its drug listing data in June and December of each year, or whenever a change occurs. Due to frequent changes, the FDA updates the listing each weekday (but not in real-time). The directory includes prescription drugs, over-the-counter drugs, and insulin products that have been “manufactured, prepared, propagated, compounded, or processed by registered establishments for commercial distribution.” The directory is simply a list of products and does not imply that the drug is covered by any insurance carrier, or that the product has been tested or is endorsed by the FDA. Although the list is extensive, it may not include some listed drugs. Older products may not be included in the directory.
Generically, equivalent drugs (the same drug, concentration, and dosage form) from two different manufacturers have two different NDC numbers.

NDC numbers are 10 digits and consist of three segments separated by hyphens:

1. The first segment may be four or five digits, and it identifies the labeler. This segment is assigned by FDA. The rest of the NDC number is assigned by the labeler and is unique to each drug product.

2. The second segment, referred to as the product code, may be three or four digits. It is unique for each dosage form, strength, and formulation (such as tablets, capsules, liquid, or injection).

3. The third segment (one or two digits) is the package code and it identifies package sizes and types.

The NDC number is printed on the drug package and official literature (package insert), and the three segments of the number are separated by a hyphen. There are different formats for the 10-digit number (see Table A).

<table>
<thead>
<tr>
<th>Digit Format</th>
<th>Original 10-digit Format</th>
<th>11-digit Format Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-4-2</td>
<td>1234-1234-12</td>
<td>01234-1234-12</td>
</tr>
<tr>
<td>5-3-2</td>
<td>12345-123-12</td>
<td>12345-0123-12</td>
</tr>
<tr>
<td>5-4-1</td>
<td>12345-1234-1</td>
<td>12345-1234-01</td>
</tr>
</tbody>
</table>
Note: There is some confusion about the NDC because the number that CMS uses for billing purposes requires that the NDC be converted to an 11-digit number in a 5-4-2 format. This is done by adding a “0” to the beginning of the applicable segment, shown in Table A.

NDC Units
The units associated with NDC numbers are also different from the units reported for HCPCS Level II codes. NDC numbers express the unit of measurement associated with a product, and are shown in Table B.

Table B

<table>
<thead>
<tr>
<th>Unit of Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN - Unit</td>
<td>A designation that is typically used for vial, ampule, pellet, patch, kit, or device</td>
</tr>
<tr>
<td>ML - Milliliter</td>
<td>Used for solutions, suspensions, or liquids</td>
</tr>
<tr>
<td>GR - Gram</td>
<td>Inhalers, creams, ointments, or bulk powders</td>
</tr>
<tr>
<td>F2 - International Unit</td>
<td>Products distributed as IU/vial</td>
</tr>
</tbody>
</table>

When reporting for unit volume, the rule of thumb is:
- If a drug comes in a vial in powder form and is reconstituted before administration, bill each vial (unit/each) used.
- If a drug comes in a vial in a liquid form, bill in milliliters.
- Grams usually are used when an ointment, cream, inhaler, or a bulk powder in a jar are dispensed.
- International units are mainly used when billing for drugs such as Factor VIII-Antihemophilic Factors.
- It’s important to include the unit of measurement as well as the quantity of units reported so the bill accurately reflects the correct drug product and quantity used.

Reporting the NDC
The NDC is reported to payers either electronically using the ANSI 837P or ANSI 837I or using the paper CMS-1500 claim form and reporting the NCD in box 24. The last major redesign of the CMS-1500 (in 2012) allow for supplemental information, such as the NDC number. Section 24 of the claim form accommodates six line items. Each line entry has a shaded portion above the service line. The shaded area allows for the entry of 61 characters from the

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- Primary Care Primer — CPT Coding (18 CEUs)
- E/M from A to Z (18 CEUs)
- Dive Into ICD-10 (18 CEUs)
- Charting E/M Audits (11 CEUs)
- The Where’s and When’s of ICD-10 (16 CEUs)
- Walking Through the ASC Codes (15 CEUs)
- Coding with Heart — Cardiology (12 CEUs)
beginning of 24A to the end of 24G. In practice, the HCPCS Level II code for a drug is reported in the unshaded portion of box 24, and the NDC appears above it in the shaded portion.

To enter an NDC in the supplemental information area, use a qualifier to indicate the nature of the supplemental information that appears in the shaded area. In the case of an NDC number, the qualifier is N4 NDC. There is no space between the qualifier and the NDC number, and no hyphens or spaces should be added. After the NDC number, allow for one space, followed by the unit/basis of measurement qualifier and quantity. The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use decimals or commas.

Coding Examples

Example 1: A patient received 4 mg Zofran IV. The NDC was 00173-0442-02, which is Zofran 2 mg/mL solution for injection. There are 2 mL per vial. Report J2405 Injection, ondansetron hydrochloride, per 1 mg with 4 HCPCS units. Because this drug comes in a liquid form, report the NDC units as 2 mL: N400173044202 ML2.

Example 2: A patient received an IM injection of one vial of aripiprazole that contained 9.75 mg per 1.3 mL. The NDC number is 59148-0016-65. Report the HCPCS Level II code for aripiprazole: J0401 Injection, aripiprazole, extended release, 1 mg with 2 units and the NDC units as 1.3 mL: N459148001665 ML1.3.

Example 3: A patient received one gram of Rocephin IM in the office. The product used was 2 vials of Rocephin, 500 mg per vial (in powder form), which needed to be reconstituted.

The NDC of the product used is 00004-1963-02. Bill J0696 Injection, ceftriaxone sodium, per 250 mg with 4 HCPCS units, and the NDC units as N400004196302 UN2.

Resources

www.fda.gov/drugs/informationondrugs/ucm142438.htm
The FDA site also produces the NDSE table which contains additional information regarding the billing unit www.fda.gov/ForIndustry/DataStandards/StructuredProductLabeling/ucm240580.htm
Carrier and other sites:
www.greenwayhealth.com/support/training/user_manual_release_notes_version_17_25_01/include_the_ndc_code_and_quantity.htm
www.idmedicaid.com/Reference/NDC%20Format%20for%20Billing%20PAD.pdf
www.aappublications.org/news/2016/04/21/Coding042116
www.nhp.org/provider/paymentguidelines/PhysicianAdministeredMedications.pdf

George J. Blake, CPC, is a manager at Deloitte and Touche, LLP, who has more than 25 years of healthcare experience as a pharmacist, physician practice manager, coding instructor, and recovery auditor. He is a specialist in Deloitte’s Risk and Financial Advisory practice, focusing on coding compliance matters. Blake is one of the founding members of the Blue Bell, Pennsylvania, local chapter and has served as chapter education officer, vice president, and president.
March is here and the luck of the Irish is upon us. This month hosts the Saint Patrick’s Day celebration, a cultural and religious celebration held on March 17 to commemorate the patron saint of Ireland. It was invented by Irish ex-patriots around the world looking for an excuse to celebrate their Irish roots. It’s a time filled with shamrocks and shenanigans, parades, music and dancing, feasting, and drinking, in which all cultures are welcome to join.

Here is a lighthearted list of ICD-10-CM codes that capture incidents when the celebratory merriment goes awry or too far.

**When Too Much Green Gets the Better of You**

Green! Green! Green! It’s everywhere, from beer and milk to hair and full body paint. Before you consume green dyes and put it on your skin, choose safe ingredients or you may experience ill effects:

- **T65.6X1** Toxic effect of paints and dyes, not elsewhere classified, accidental (unintentional)
- **L25.2** Unspecified contact dermatitis due to dyes

Kilts, as well as leprechaun and St. Patrick costumes, are common attire during the parade. If you see a leprechaun wearing a different color besides green, this could be why: **H53.50 Unspecified color vision deficiencies.**

**Glutton for Punishment**

It’s not St. Patrick’s Day without corned beef and cabbage; but too much corned beef, and you may get served with a side of “CABG,” instead: **I25.810 Atherosclerosis of coronary artery bypass graft(s) without angina pectoris.**
You may see people who imbibed on Irish beer and whiskey when participating in the festivities. For patients who don’t know when to say, “When,” look to these codes:

- **T51.91XA** Toxic effect of unspecified alcohol, accidental (unintentional), initial encounter
- **F10.129** Alcohol abuse with intoxication, unspecified

For those who have had so much to drink that they really believe in little green leprechauns, call on code **F10.151** Alcohol abuse with alcohol-induced psychotic disorder with hallucinations.

**When Irish Eyes Aren’t Smiling**

Northern cities, such as Boston, New York City, and Chicago, are hotspots for St. Patrick’s Day parades. If you live in the north, and celebrate this March holiday, you know that on parade day March temperatures can fluctuate from 60 degrees and sunny to 15 degrees and a blizzard. For those die-hard people who withstand wind, sleet, hail, or snow, this code may be a result: **X31 Exposure to excessive natural cold**.

Parades are filled with music and Irish dancers. When Great Uncle Seamus has had too much Guinness and starts in on an Irish jig, these codes may capture the purpose of the emergency room encounter: **Y93.49 Activity, other involving dancing and other rhythmic movements** and **M24.459 Recurrent dislocation, unspecified hip**.

Sometimes the Celtic bagpipes are just too much to bear for those sensitive to noise. If so, look to this code: **H83.3X9 Noise effects on inner ear, unspecified ear**.

**Don’t Kiss Me, I’m Irish**

The large gatherings at parties and parades don’t lend themselves to introvert participation. This ICD-10 code is your best bet when reporting anyone missing out on festivities due to their fear of crowds: **F40.11 Social phobia, generalized**. On the flipside, there are the overly-social party-goers who adhere to the popular slogan, “Kiss Me, I’m Irish.” They don’t think about the ramifications of their actions; for example, contracting or transmitting the “kissing disease” (**B27 Infectious mononucleosis**).

**When You’re Down on Your Luck**

Some celebrants may observe the religious day in the more traditional way, at a cathedral. If you trip on the steps of the cathedral, it’s a sure sign your good luck just ran out. You may need to call on this code to report the location of your injury: **Y92.22 Religious institution as the place of occurrence of the external cause**. Better luck next time!

**More ICD-10 Holiday Fun**

For more anecdotal holiday fun with ICD-10 codes, read these articles on AAPC’s Knowledge Center:

- Spooky ICD-10 Codes to Look Out for on Halloween (www.aapc.com/blog/44179-spooky-icd-10-codes-to-look-out-for-on-halloween/)
- Keep These ICD-10 Codes Handy for Holiday Mishaps (www.aapc.com/blog/44874-icd-10-codes-for-holiday-mishaps/)
- Heed ICD-10 Advice for St. Valentine’s Day (www.aapc.com/blog/45298-heed-icd-10-advice-for-st-valentines-day/)

Michelle A. Dick, BS, is executive editor at AAPC and a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

It’s not St. Patrick’s Day without corned beef and cabbage; but too much corned beef, and you may get served with a side a “CABG,” instead …
Audit to Promote Revenue Integrity

Follow this step-by-step guide to coding and documentation compliance.

It’s always better for a facility to find compliance issues before a government agency or payer does (who may respond by levying penalties and fines). Pre- or post-bill audits help facilities uncover minor concerns before they become major compliance issues, thereby promoting revenue integrity. Here’s how to conduct an internal coding and documentation audit in your outpatient facility.

What Is an Audit?

An audit is an independent and objective review to determine accuracy and efficiency relative to regulations, policies, procedures, or other criteria. Audits can be performed by internal staff or external experts. Almost anything can be audited (financial statements, business operations, payroll, expense reporting, etc.), but the focus of this article is on auditing the completeness and accuracy of coding and documentation in patient medical records.

The general goal of coding and documentation audits is to evaluate quality in both areas. This type of audit can be designed many ways, depending on the objectives, and may be conducted either prospectively (pre-bill) or retrospectively (post-bill).

Why Audits Are Important

Audits offer many benefits to facilities. For example, they:

• Provide a degree of assurance that coding quality meets expectations and complies with laws and regulations
• Ensure claims are submitted with accurate coding data
• Evaluate medical record documentation to ensure it supports coding
• Determine the need for focused coder and physician education and training

Most organizations prefer to identify issues internally, versus waiting for the government to find problems; this allows for remediation prior to government intervention. The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) recommend coding compliance audits; and in some cases, they may be required.

What to Audit

Planning is one of the most important steps to a successful audit. Take the time to assess potential areas of risk and thoughtfully outline the audit objective(s). The objective of an audit determines the scope and answers the question: “What is the overarching goal of this audit?” Audits may be designed to assess coder accuracy, overall facility accuracy, service line quality, revenue opportunities, etc. Other ideas to consider when planning audits include:

• Results of past internal or external audits
• Known areas of concern or weakness
• New service lines or procedures
• High-dollar and high-volume procedures, departments, and service lines
• OIG work plan topics and recovery audit contractor-approved issues
We've got more great articles on the Knowledge Center at: www.aapc.com/blog/.

- Newly-hired coder accuracy during an initial employment period

For more accurate results, a narrow scope is recommended (e.g., Medicare outpatient heart catheterization lab interventions for the past six months, new coder accuracy for the first 90 days of employment, etc.).

**Where to Start**

After the audit scope and objectives are defined, use those parameters to identify the universe of accounts that could potentially be reviewed based on that scope. For example, if the audit objective is to evaluate the accuracy of a new coder for her first 90 days of employment, the universe includes all accounts coded by that person for the specified time period.

After the universe has been identified and a report of those accounts has been obtained, determine how many accounts out of that universe will be reviewed for this audit. Preferably, all accounts in the universe can be reviewed, possibly via electronic or automated audit techniques that filter the database for outliers or exceptions, which can then be reviewed manually as needed. Depending on the audit objective and on the number of accounts in the universe, it is not always feasible to audit 100 percent of the accounts. In those cases, select a sample of accounts to review.

**Determine Sample Size**

The sample size depends on many factors. Sometimes a sample size of 10 is adequate, especially for initial probe audits to establish baselines or to probe for issues. Sometimes, a statistically valid sample is necessary, such as when issues are identified in an initial probe sample of 10 charts.

The concept of statistically valid samples indicates that a sample should be a good representation of the entire population. Naturally, this becomes more difficult as the population size increases. Because most coders and auditors are not professional statisticians, the OIG provides recommendations on their website, on the Provider Self-Disclosure Protocol page (see the Resources section at the end of this article for more information). They also offer free downloadable software that calculates sample size for you. Using the OIG recommended inputs and software, a sufficient sample size is about 30 claims. For self-disclosing issues to the OIG, a minimum sample size of 100 is required.

Need Auditing Solutions?

When you’re looking for an auditing solution, Healthicity™ has answers. They have auditing experts and the ultimate, all-in-one audit management solution to help you simplify your medical documentation and coding reviews. Go to Healthicity’s Audit Manager and Audit Services at www.healthicity.com/solutions/auditing for more information.
Select a Sample of Accounts

When the sample size is decided, select a random sample of accounts to have an independent, objective audit. There are several ways to select a random sample. For example:

- OIG offers a free download of RAT-STATS software. The user inputs the population file and parameters, and the software selects a random sample.
- ActiveData - Analytics For Excel can pull random samples using criteria entered by the user. Not everyone has access to licenses for ActiveData, as this is not free software.
- Using Excel, number each account in the population, and either:
  ° Select every five or 10 accounts (accounts No. 5, 15, 25, 35, 45 or No. 10, 20, 30, 40, 50); or
  ° Use free websites to select random numbers to use (for example, www.Random.org has a random integer generator).

After the accounts to be audited are selected, place them in a separate file that includes only the sample accounts you’ll use to generate an audit spreadsheet/checklist. This spreadsheet will become the main audit tool, with the addition of relevant columns (see example in Table 1).

Perform the Audit

To begin the heart of the audit, locate the billed claim for each account in the sample (for retrospective audits) or view the coding and abstracting for each account in the sample (for prospective audits). Review supporting documentation in the medical record for each account and compare documentation to the billed codes to ensure the codes are complete, accurate, and supported by documentation (also verify that each coded procedure has a valid order and final report, where appropriate). Record the results of each audited account on the audit spreadsheet or checklist.

After the spreadsheet is complete, summarize the results, as appropriate, based on the audit scope (by coder, by facility, by service line, etc.). For our initial example of newly-hired coders, the results would be summarized for each new coder and accuracy rates calculated. Depending on the audit scope, you may wish to consider revenue-impacting versus non-revenue-impacting errors. It is often more powerful to express results with a corresponding financial

<table>
<thead>
<tr>
<th>Patient Identifier</th>
<th>Date of Service</th>
<th>* Codes Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1/1/2018</td>
<td>12345</td>
</tr>
<tr>
<td>2</td>
<td>2/2/2018</td>
<td>23456-59 and 78901</td>
</tr>
<tr>
<td>3</td>
<td>3/3/2018</td>
<td>65432-50</td>
</tr>
<tr>
<td>4</td>
<td>4/4/2018</td>
<td>98765 and 45678</td>
</tr>
</tbody>
</table>

* Fictitious codes
impact (e.g., “Coding inaccuracies cost an estimated $250,000 in reimbursement.”). Errors which do not have a financial impact may be reported separately, or excluded, depending on the overall objective of the audit.

**Present the Audit Findings**

Above all, always present audit results professionally and objectively. New auditors may find it uncomfortable reporting less than stellar audit results; sticking to the facts and remaining objective and independent are keys to success. Whenever possible, review results in person, especially for high error rates. Start by presenting the audit spreadsheet or checklist in a summarized format.

Additional best practices include:

- Introduce the audit results by emphasizing strengths and following up on those with opportunities for improvement. Speaking in positive terms may soften the blow of negative audit results.
- Remind the auditee that the goal of these audits is to identify improvement opportunities before they become major compliance issues, and that all staff members must strive to minimize risk to the organization.
- Review each account in the sample with the coder and physician and explain any variances, allowing for discussion and questions.
- Provide open and honest feedback and ask clarifying questions where appropriate.

**Next Steps**

If trends are noted, work with the auditee or management to initiate corrective action plans such as training and education, as needed. Follow up after the training with monitoring and subsequent audits of similar accounts until improvement is realized. Remember to make corrections to all accounts with variances and rebill per payer guidelines, if necessary (For prospective/pre-bill audits, release the claims for billing after corrections are made.). When the corrective action plans have resulted in improvements, then it’s time to start planning the next audit.

**Table 2: Sample Audit Tool**

<table>
<thead>
<tr>
<th>Account</th>
<th>Date of Service</th>
<th>* Codes Billed</th>
<th>Valid Order?</th>
<th>Final Report?</th>
<th>Codes Audited</th>
<th>Payment for Codes Billed</th>
<th>Expected Payment for Codes Billed</th>
<th>Expected Payment Variance</th>
<th>Audit Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1/1/2018</td>
<td>12345</td>
<td>N</td>
<td>Y</td>
<td></td>
<td>$100</td>
<td>$-</td>
<td>$(100)</td>
<td>No order is found.</td>
</tr>
<tr>
<td>2</td>
<td>2/2/2018</td>
<td>23456-59 &amp; 78901</td>
<td>Y</td>
<td>Y</td>
<td>23456</td>
<td>$250</td>
<td>$200</td>
<td>$(50)</td>
<td>78901 is bundled; modifier 59 is not supported by documentation.</td>
</tr>
<tr>
<td>3</td>
<td>3/3/2018</td>
<td>65432-50</td>
<td>Y</td>
<td>Y</td>
<td>32654</td>
<td>$300</td>
<td>$225</td>
<td>$(75)</td>
<td>32654 is more appropriate based on documentation.</td>
</tr>
<tr>
<td>4</td>
<td>4/4/2018</td>
<td>98765 &amp; 45678</td>
<td>Y</td>
<td>Y</td>
<td>98765 and 34567</td>
<td>$500</td>
<td>$650</td>
<td>$150</td>
<td>34567 is more appropriate based on documentation.</td>
</tr>
</tbody>
</table>

* Fictitious codes

Remember to make corrections to all accounts with variances and rebill per payer guidelines, if necessary (For prospective/pre-bill audits, release the claims for billing after corrections are made.).
How Value-based Care Can Improve Everyone’s Outcome

Achieve better clinical outcomes, higher rankings, accurate reimbursement, and improved patient health.

If you work for a healthcare provider organization, you’ve probably heard of value-based care — perhaps, your organization is already in a value-based reimbursement contract. The transition from fee for service to value-based care means an increased focus on office and administrative efficiency. On the patient care side, we will see more patient-centered and team-based care that, ideally, will result in improved patient health outcomes.

Collaboration is Key

For value-based care to succeed, stakeholders must collaborate on several key metrics such as targeting health education opportunities, identifying sicker patients who would benefit from proactive case management, and predicting their future healthcare resource needs. Quality data must be shared to help contain the cost of care and to improve the health of populations. The increased transparency among patients, providers, and payers will change the way data is captured and used. For example:

- **Payers** can share actionable data to be used at the point of patient care.
- **Providers** must confirm their systems are capturing all relevant information accurately and share it with the health plans so they can design better care management strategies.
- **Patient** and member portals allow information to be accessed in real time.

This improved communication is needed to ensure that patients are receiving preventive care and care for chronic conditions. Improved data exchange allows the targeting of patients throughout the care continuum. In turn, this allows patients to receive the right care, in the right place, at the right time.

Accurate claims data — through the correct use of CPT®, HCPCS Level II, and ICD-10-CM codes — helps to identify patients with a potential gap in care. Accurate coding enhances communication between providers and payers. When health plans share all available
claims data with providers, they have the complete information available for their patients. This allows providers to determine if their patients are using services and seeing specialists as ordered.

With increased information available on patient portals, patients can better and more quickly identify incorrect or inaccurate information and be part of the process to ensure accurate data is shared.

**Risk Adjustment and HEDIS Play a Big Role**

Risk adjustment and quality programs, such as Healthcare Effectiveness Data Information Set (HEDIS), play an important role in value-based care:

- **Risk adjustment** is a form of predictive modeling to assess the relative risk that a patient will incur medical expenses above or below the average over a defined time. Inaccurate risk adjustment coding results in the possibility of reduced payment under certain performance-based payment models. It can also create missed opportunities if patients are not identified for care management and disease intervention programs.

- **HEDIS** is used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. It allows consumers to accurately compare health plans.

Both risk adjustment and HEDIS rely on complete and accurate documentation and coding. The programs are connected: Certain diagnosis codes captured in risk adjustment will trigger a quality metric that is measured by HEDIS. To illustrate, let’s look at an example of diabetes.

**Example:** Diabetes is a risk adjusted diagnosis. When a patient is identified with diabetes, the health plan is responsible to ensure the patient receives an annual diabetic eye exam and kidney attention because diabetes can affect these body systems. The plan also must be sure these patients have their blood pressure under control and get an A1c — a blood test commonly referred to as glycated hemoglobin, glycosylated hemoglobin, hemoglobin A1C and HbA1c, used to diagnose type 1 and type 2 diabetes and to determine how well diagnosed diabetics are managing their diabetes. Incorrectly labeling a patient as diabetic has a negative impact on the HEDIS scores because these tests are not appropriate for patients who don’t have diabetes.

**Reap the Rewards**

You can prepare for value-based care by learning about your office workflows, processes, and infrastructures. Be sure communication remains open between all parties responsible for documenting and coding diagnoses and procedures. Payers and providers who collaborate to improve the quality of patient care through accurate, complete documentation and coding create a positive outcome for everyone: Providers are rewarded for reducing unnecessary costs and improving their patients’ health outcomes, health plans receive higher rankings, and most importantly, patients are well cared for.

Colleen Gianatasio, MHS, CPC, CPC-P, CPMA, CPC-I, CRC, CCS, AAPC Fellow, has nearly 20 years of experience in the health insurance field, including customer service, claims, quality, and coding. As risk adjustment quality and education program manager for Capital District Physician’s Health Plan (CDPHP) Gianatasio’s primary responsibilities are provider engagement and clinical documentation improvement (CDI) for accurate coding. She specializes in developing innovative coding curriculum and instruction to support compliance with federal guidelines and appropriate reimbursement processes. Gianatasio enjoys teaching coding, documentation, and auditing classes and serves as president-elect of the AAPC National Advisory Board. She is a member of the Albany, N.Y., local chapter.

Quality data must be shared to help contain the costs of care and to improve the health of populations.
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RADIOLOGY
CARDIOLOGY &
VASCULAR SURGERY
CODING SEMINAR
WITH ICD-10

ZHealth Publishing
WWW.ZHEALTHPUBLISHING.COM
If you’ve trained Siri to call you Princess or talk to your Alexa like she’s one of your kids, you’re becoming a friend of artificial intelligence (AI). AI has been around for a few years, even affecting medical coding and billing, but it’ll have a greater impact on your career in the near future.

**Using AI to Enhance, Not Replace**

Provider groups, facilities, and payers are turning to AI to help handle all sorts of things — patient care, documentation, planning, and more. AI is the ability of computers to learn to act on the information they have, to evaluate and deduce. Real AI is a far cry from its popular image. Think more of a black box, like IBM’s Watson, rather than a murderous android from “Westworld.”

Watson and other supercomputers are helping providers and payers identify the most efficacious and efficient treatment options. Several medical centers, including Cleveland Clinic and MD Anderson, are not only feeding it information but participating in research to exploit AI to best help providers and their facilities better care for patients. AI can modify a provider’s behavior. For example, in an experiment in Chicago, an electronic health record (EHR) system was taught to monitor patients’ conditions and shift appropriate patients’ care and medication schedules so they could sleep longer. Nurses and providers were trained to follow the EHR’s recommendation rather than regularly, but needlessly, wake patients. Patients who the EHR let sleep longer did better than those treated in the standard way.

A provider’s diagnosis of a new patient doesn’t only support medical necessity, it spins the wheels of payment, utilization management, risk adjustment, quality management and reporting, retrospective review, and discharge management. An error releases a wave of miscalculations that affects the facility, provider, patient, and payer. AI can catch the error, suggest a different code, or alert an auditor in real time.

Does that mean coders are in danger of being pushed out of their cubicles by black boxes? Probably not.

**The EHR Craze and the Luddite Fallacy**

Back in the late 1800s, skilled weavers watched English fabric manufacturers install steam-powered machinery to speed production and lower costs. The angry workers put their bodkins and shears aside and started roaming the English countryside, following Ned Ludd,
and destroying the newly automated weaving racks in the factories. Despite their righteous rage at “deceitful practices,” some of the Luddite leaders were banished to Australia or hung. Followers adapted to working in their newly industrialized world.

The Luddites were on the wrong side of the Industrial Revolution, it appears, and they unknowingly made a fateful mistake. New technology usually doesn’t take away jobs or livelihood, but it can change them.

Coders faced this when the U.S. Department of Health and Humans Services (HHS) incented providers and facilities to install EHR systems. “Meaningful Use,” as outlined in the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, was intended to force facilities and providers to adopt EHRs to make documentation, billing, and payment more standardized and portable. Federal financial incentives prompted a rush of EHR start-ups and companies to pitch, among other things, that medical coders and billers would no longer be needed with the new technology.

Hearing this during the Great Recession of 2008, many medical coders panicked, naturally. But the threat proved hollow. EHRs didn’t provide what was promised, and healthcare facilities and providers didn’t replace their staff with machines. More coders were needed to help set up the systems, audit claims, and help providers improve their clinical documentation. Many EHR providers folded or merged with competitors, and some were sued into nonexistence by angry providers when the systems proved ineffective or too unwieldy. More coders were needed to audit the set-up and EHRs, monitor and teach physicians to document in the new technology and newly-implemented ICD-10-CM codes, and wrangle EHR data.

A decade later, the medical coding field has tripled in need. AAPC, for example, has gone from a membership of 73,000 to more than 180,000. The U.S. Department of Labor’s Bureau of Labor Statistics predicts our field will grow another 13 percent by 2026.

When technology threatens, it’s easy to panic, but we can’t commit what economists call “The Luddite Fallacy.” Workers assume there is only so much work, the way their work is done can’t change, and the future will be bleak, but this isn’t usually the case. Technology usually creates more work for those willing to adapt.

Robo Speak

The answer lies in our ability to transition to changing technology. Here are some of the AI-based initiatives affecting the revenue cycle:

Computer-assisted Coding (CAC)

CAC is one of the oldest forms of AI in our field. The original intent was for the computer to automatically assign the codes and submit the charges. But like flying cars and teleportation, the idea hasn’t fully materialized; however, CAC does help assign modifiers, catch correct coding edits, identify errors, and other tasks, freeing medical coders and billers to concentrate on other things. CAC proponents now concede that the human element is vital to accurate medical coding and billing. This technology also helps speed the reimbursement cycle. CAC can be a lifesaver, just like that timer on your coffee pot.

Computer-assisted Physician Documentation (CAPD)

CAPD is being added to EHRs to help providers address gaps in their clinical information. The AI reviews documentation and then guides the provider to adjust the documentation to assure it properly reflects the patient’s condition. The technology also helps capture complications and comorbidities that may affect the patient’s care and payers’ risk now or down the road.

Record Reconciliation

AI is the perfect tool to sort through old records to identify conflicting diagnoses, out-of-date medications, and other inconsistencies. This can also help identify quality measurement issues and protect the provider in the future.

Care Transition Analysis

This technology allows payers to identify suspicious or repetitively incorrect billing patterns, and they can use it to coach or exclude the provider or facility from participation. Large practices, facilities, and health systems will use this to self-identify problems in medical coding and billing. The data can help auditors and clinical documentation improvement staff create reviews and coaching to improve reimbursement cycles.

Scribing

EHRs not only did not replace coders, they helped fuel demands for better clinical documentation. Providers soon found themselves entering information as they assessed their patients, and visits turned
into “watch-the-doc-on-the-computer.” Scribes solve that by shadowing the provider during an office visit and inputting the needed information. They help assure the documentation is complete and ready for the EHR, and let doctors concentrate on their patients.

One Holy Grail of electronic data, however, is interoperability of all this technology. EHRs still don’t talk to each other very well, and the Centers for Medicare & Medicaid Services continues to encourage communication. As EHR manufacturers wrestle with standards, others are looking at new ways of doing it. Apple, for example, is experimenting with a way for patients to carry all personal health information with them from provider to provider, and the history, lab results, and other information can be pulled from an iPhone. Imagine the opportunities arising there!

Trust Your Inner Algorithm

None of this change comes without some personal disquiet and effort. Medical transcriptionists displaced by natural language programming (NLP) and EHRs are transitioning to medical coders, scribes, and related roles. Imagination, curiosity, and flexibility are key, AAPC members say.

Elcilene Moseley, CPC, CCS, admits she felt threatened when CAC was introduced to her work. “The idea of losing my job to a computer software wasn’t a pleasant one. But after using it for a few years, I’ve come to realize that coding is complex and multi-faceted and certain procedures are so complicated that it will take a long, long time before any AI can properly fully code a chart,” she said. Pointing to ICD-10’s complexity, she added, “I’m not sure if it ever will.

CAC has been a big help to Moseley. “One of its purposes was to help coders become more productive and accurate,” she said. “It has succeeded some. The software sometimes picks up diagnoses I might have missed and/or provides procedure codes that I may not be familiar with, making me research and learn about them.” She admits her CAC also picks up stuff it’s not supposed to. “It hasn’t quite mastered combination codes and bundling issues, guidelines, and the constant new changes we coders have to be on top of.”

One of the many ways to welcome your new AI coworker is to make good use of your lighter workload by partaking in activities, education, and credentials. Is your group, facility, or healthcare system expanding? Are there new roles you can take on or move to? Opportunities for improvement? How can you become a leader thanks to, or in concert with, your AI buddy?

“I’ve realized that my role as a coder is slowly, but surely, switching to an auditor one. I’m no longer threatened by the software. I’m enjoying auditing the codes put out by the AI, and I have also learned quite a bit from it. Future-wise, I see myself auditing more and more, as the software becomes smarter and learns from the code corrections I make. At some point, we coders will probably end up becoming auditors. We’re nowhere near it yet,” she said.

Seek Opportunities

There are a lot of opportunities out there: new roles, credentials, and jobs. Don’t be a Luddite; take some time to identify and pursue those opportunities.

Moseley agrees. “I started out coding by paper, flipping pages, 12 years ago. Now it’s all mostly automated. It’s all about going along with the new changes, and to never stop learning.”

Resources

The Luddites: www.historic-uk.com/HistoryUK/HistoryofBritain/The-Luddites/
The Luddite Fallacy: www.economicshelp.org/blog/6717/economics/the-luddite-fallacy/
The University of Chicago Medical Center, SIESTA Project Reduces Inpatient Sleep Interruptions: www.uchicagomedicine.org/forefront/patient-care-articles/2019/january/siesta-project-reduces-inpatient-sleep-interruptions
MEMBER APPRECIATION
APRIL 2019

What's happening during Member Appreciation Month?

- Share favorite AAPC moments on social media with #AAPC
- Participate in contests, giveaways and trivia
- Take advantage of discounts on your favorite products and services
- Network and expand your AAPC community
Everything you love about AAPC gets even better this April. You are one of AAPC's 180,000 members, it's time to celebrate you!

"Becoming a certified coder and joining the AAPC has provided me with many life-changing opportunities. My mentor, another local AAPC member, continues to inspire me. AAPC provides the opportunity to do the things I love: learn, share my knowledge and help others succeed."

Jacqueline S.
CPC, CPC-I, CEMC, CFPC, CIMC, CPEDC, CCP-P

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Let’s Get on the Same Page when Coding BMI and Obesity

Different interpretations of ICD-10-CM coding leave you at risk for improper quality scores and payment.

Medical record auditors see a wide range of interpretation among coders and medical organizations regarding when and how overweight, obesity, and morbid obesity diagnosis should be abstracted from records, and regarding body mass index (BMI) reporting. These variances can potentially affect quality scores under the Merit-based Incentive Payment System (MIPS), in which the expense of care for a patient population is weighed against that population’s comorbidities for each provider. Unreported diagnoses have the potential to lower the provider’s quality score because higher costs associated with comorbidities are not justifiable if comorbidities are unreported. Some diagnoses also provide justification for higher reimbursement in risk adjustment. Getting risk adjustment wrong translates directly into over- or underpayment.

Obesity Is a Common Diagnosis

According to the U.S. Department of Health and Human Services (HHS) National Institute of Health, 5.5 percent of men and 9.9 percent of women in the United States are morbidly obese. In all, more...
than 70 percent of Americans are overweight, obese, or morbidly obese, as defined by the American Heart Association/American College of Cardiology BMI standards. Confused interpretation about rules for coding these conditions has led to various obesity-reporting strategies across the country.

All weight diagnoses are not treated equal under MIPS and risk adjustment. Overweight and obese diagnoses do not affect quality scores or risk adjustment payment. Morbid obesity, however, affects both MIPS and risk adjustment calculations. Morbid obesity is weighted as the rough equivalent of cerebral palsy or chronic pancreatitis in risk and resource utilization. Remember to pay attention to the nuances of correct coding of morbid obesity to receive appropriate MIPS bonuses and proper risk adjustment reimbursement.

The American Hospital Association's (AHA) Coding Clinic for ICD-10-CM and ICD-10-PCS invested seven pages of its Fourth Quarter 2018 addressing the multiple issues it has seen for coding obesity, morbid obesity, and BMI. Because we can’t cover all that information within the pages of Healthcare Business Monthly, we have an abbreviated list of top 10 takeaways that should be integrated into coding practices everywhere, and especially when filing claims with the Centers for Medicare & Medicaid Services (CMS). CMS expects all claims to follow the ICD-10-CM guidance within the Coding Clinic.

### BMI as It Relates to Quality Reporting

Body mass index (BMI) is a computation based on a patient’s weight and height. This calculation is used as a screening tool for providers. In most electronic health records, a patient’s BMI is auto-generated into their vitals data from a height and weight measurement obtained at the beginning of the visit.

BMI screening can be reported as a quality measure (Quality ID #128) in the Merit-based Incentive Payment System (MIPS). This measure identifies the percentage of adult patients with a BMI outside of normal parameters, for whom a follow-up plan is documented. For MIPS, performance may or may not be met by reporting one of the following HCPCS Level II codes:

- **G8417**: BMI is documented above normal parameters and a follow-up plan is documented
- **G8418**: BMI is documented below normal parameters and a follow-up plan is documented
- **G8419**: BMI documented outside normal parameters, no follow-up plan documented, no reason given
- **G8420**: BMI is documented outside normal parameters and no follow-up plan is required
- **G8421**: BMI not documented and no reason is given
- **G8422**: BMI not documented, documentation the patient is not eligible for BMI calculation
- **G8938**: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible
- **G9716**: BMI is documented as being outside of normal limits, follow-up plan is not completed for documented reason

Note: Both denominator and numerator criteria must be met. Refer to MIPS quality measure specifications for requirements, available at qpp.cms.gov.

### ICD-10-CM and CDC Weight Classifications Don’t Match

The descriptions for weight-related diagnoses in ICD-10-CM do not use the same nomenclature as the Centers for Disease Control and Prevention (CDC). According to the CDC, extreme obesity or class 3 obesity usually indicates a body mass index (BMI) of 40 or greater. Obesity class 2 indicates moderate-risk obesity, with a BMI ranging from 35.0 to 39.9. Obesity class 1 is low-risk obesity, with a BMI of 30.0 to 34.9. There is no official published correlation between ICD-10-CM classifications for weight and BMI. You must rely on the documentation from providers to assign the type of weight disorder.
Top 10 Obesity and BMI Coding Takeaways

Apply these 10 coding practices to your obesity, morbid obesity, and BMI claims:

1. **Obesity and morbid obesity are significant diagnoses and coding should reflect that.**

Diagnoses of obesity and morbid obesity are always clinically significant and should always be reported. A diagnosis noted in the history of present illness (HPI), assessment, or discharge summary suffices without other support.

2. **Always report BMI when it is documented with obesity or morbid obesity.**

Always report BMI documented with other weight-related diagnoses when they are supported and abstracted from the medical record.

3. **Do not report a diagnosis of overweight without additional support.**

A diagnosis of “overweight” does not meet the definition of a reportable secondary diagnosis because it is not considered a significant health risk to the patient. If documentation further discusses the patient’s overweight condition or a plan of care for it, report the condition. For example, an overweight patient with prediabetes and a BMI of 29.7 is referred to a dietician for counseling on weight loss to reduce her risk of developing diabetes. Report:

- E66.3 Overweight
- R73.03 Prediabetes
- Z68.29 Body mass index (BMI) 29.0-29.9, adult

4. **A specific weight-related diagnosis is required for reporting a BMI code.**

Examples include underweight, malnutrition, failure to thrive, cachexia, anorexia nervosa, overweight, obese, morbidly obese, and abnormal weight gain or loss. Although some payers reject claims for BMI/weight diagnosis codes reported without support (e.g., the need for special inpatient equipment, nutritional counseling, lifestyle counseling), the BMI code only needs a weight-related diagnosis for support.

5. **Never convert a BMI code to a weight diagnosis.**

The provider must document a weight diagnosis for the BMI to be abstracted from a chart. For example, a chart of a patient with a documented BMI of 58.9 makes no mention of the patient’s weight in the notes. Both the BMI and weight must be documented for the BMI to be reported. In this case, the provider should be queried for the patient’s weight.

6. **Code the provider diagnosis, regardless of documented BMI.**

The BMI is a screening tool. If a BMI falls into the morbid obesity range, but the provider documents obesity, abstract obesity. Conversely, if the BMI falls into the range for obesity, but the provider documents morbid obesity, abstract morbid obesity. No query is necessary. For example, if a patient’s vitals record a BMI of 36.2 and the provider states the patient is morbidly obese, report:

- E66.01 Morbid (severe) obesity due to excess calories
- Z68.36 Body mass index (BMI) 36.0-36.9, adult

7. **BMI codes are not intended to be used for routine reporting.**

BMI codes must be accompanied by a weight diagnosis (HCPCS Level II codes are available for reporting BMI measurements for quality reporting purposes).

8. **Comorbidities do not change a documented diagnosis of obesity into morbid obesity.**

Comorbidities — including obstructive sleep apnea, hypertension, and diabetes — do not affect the weight-related diagnosis from the provider. The provider will consider the comorbidities when determining the weight diagnosis.

CMS expects all claims to follow the ICD-10-CM guidance within the Coding Clinic.
Never report BMI codes during pregnancy.

Assign a code from 099.21- Obesity complicating childbirth, with the specific obesity/morbid obesity code from category E66 Overweight and obesity, as appropriate.

Double check inpatient claims for attending physician’s weight diagnosis.

On inpatient claims, the attending physician’s weight diagnosis supersedes all other weight diagnoses during the hospital stay. If the anesthesiologist’s documentation states one diagnosis, and the attending states another, defer to the attending physician.

A diagnosis of “overweight” does not meet the definition of a reportable secondary diagnosis because it is not considered a significant health risk to the patient.

Resources
- AHA, Coding Clinic for ICD-10-CM and ICD-10-PCS, Fourth Quarter 2018: www.codingclinicadvisor.com

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Viviana Arteaga,
Viviana Sanchez,
Vigida Sasiudah,
Vignesh Pillai,
Vignesh Subakr,
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Vignesh S,
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Vimala Kaliyappan,
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Vimala Subramanian,
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NEWLY CREDENTIALED MEMBERS
Tell us a little bit about how you got into coding, what you’ve done during your coding career, and where you work now.

I started my career over 14 years ago in data entry and claims processing for a medical insurance company. In 2010, I accepted a position with SilverCreek RCM. I have held several positions within the company, including medical biller, team leader, and revenue cycle specialist, and education coordinator. I have an immense passion for this industry, and continuously seek education opportunities to increase my knowledge. I now provide education to all incoming and existing staff members and contribute to the development and implementation of billing and reimbursement methodologies for SilverCreek’s training curriculum. I also conduct coding audits, research coding and compliance issues, monitor payer updates, develop coding tools, create training videos, and provide practitioner education.

What AAPC benefits do you like the most?

I love reading Healthcare Business Monthly. Each issue is filled with a multitude of information and resources.

How has your certification helped you?

When I first considered obtaining my Certified Professional Coder (CPC®) credential, I didn’t think I wanted to be a coder. I just thought that earning the CPC® would help me be a stronger medical biller. Once I completed my course work and sat for the exam, I soon realized that I enjoyed the challenges a coder faces. Also, by obtaining my certification, I was offered career advancements with my employer.

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

Know your resources and network. Find a mentor, or three. Every day, you will learn something new. Never stop asking questions.

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

I’d be an interior decorator or travel blogger/photographer.

How do you spend your spare time?

I enjoy spending time with family and friends, traveling, restoring furniture, and decorating.
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