How to Attract and Retain Staff

MEMBER OF THE MONTH
Karen Bowman, FACMPE, CPC, CPMA
Join our 2-day virtual conference dedicated to medical auditing. Whether you’re thinking of breaking into auditing or already thriving in it, we’ve tailored each track to maximize what you can take away from the conference. AUDITCON features three tracks:

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Get in-depth information on steps required to complete an audit from start to finish. Each session builds off the previous one. To fully understand and benefit from each session, participants must attend the entire beginner’s track.

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The two advanced tracks take a comprehensive look into audits for the 2021 E/M guidelines for office/other outpatient services, risk adjustment, payer recovery, telemedicine/telehealth, and service-specific audits. We’ll discuss changes coming for 2023, and more. Participants can choose from any of the advanced sessions.

Don’t miss out!
Register today at aapc.com/auditcon
Reflecting on the Pandemic

I recently read a Centers for Medicare & Medicaid Services (CMS) blog titled “Creating a Roadmap for the End of the COVID-19 Public Health Emergency.” CMS implemented a public health emergency (PHE) in March 2020 as a response to the COVID-19 pandemic. The PHE remains in effect as of this writing, having recently been extended through October. In the past two and a half years, we have seen many waivers implemented and many enforcement activities suspended to ensure our healthcare industry could focus on making it through the health crisis. We also saw new regulations designed to keep our populations healthy and safe, including new infection control regulations for long-term care facilities and an expansion of telehealth services. CMS urged in its blog for the healthcare industry to start preparing for the end of the PHE as we return to a state of normalcy.

Coming Out of the Darkness

The blog made me pause and reflect on all we have been through over the past few years, not only personally, but as an organization. I am proud to say that I think the pandemic has made us stronger. Our membership continued to grow not only here in the United States but globally, as well. We were able to quickly pivot from in-person conferences to virtual. This allowed us to continue to provide best-in-class education to our membership and allowed our members to stay connected. Our local chapters, which are at the heart of all we do at AAPC, offered virtual meetings as another way for us to stay connected and share knowledge. We were able to offer the Certified Professional Coder (CPC®) exam online so members could continue their educational and professional goals. We not only survived this pandemic, we came together and thrived as an organization.

A Bright Future

Now, as we look to a brighter, healthier future, I challenge myself to ask what a return to a state of normalcy looks like. I ask you to do the same. Will you pursue a new certification to seek out new learning opportunities and show that you are dedicated to your profession? Will you share your knowledge with others by contributing an article to Healthcare Business Monthly? Will you sign on to the Mentorship Program to seek out a mentor or mentor someone who can benefit from your experience? Will you step out of your comfort zone and consider becoming an officer in your local chapter? Personally, my goal is to start attending as many in-person local chapter meetings as my schedule permits. While virtual meetings have been great, I miss the camaraderie and networking that comes from gathering with others in person to connect and share ideas.

As we continue to move forward and plan for gathering at HEALTHCON 2023 in Nashville, I think it is appropriate to end with a quote from Dolly Parton: “Storms make trees take deeper roots.” We have weathered this storm and have come out stronger. I wish you all continued health and success.

Sincerely,

Colleen Gianatasio, MHS, CPC, CPCO, CPC-P, CPMA, CRC, CPC-I, CCS, CCDS-O
2022-2025 NAB President

“Now, as we look to a brighter, healthier future, I challenge myself to ask what a return to a state of normalcy looks like. I ask you to do the same.”
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On the Cover: Member of the Month, Karen Bowman, FACMPE, CPC, CPMA, shares her career story on page 10.
Cover photography by Fred Castleberry.
Cover design by Mahfooz Alam.
Healthcare Business Monthly

When you advertise in Healthcare Business Monthly, you’ll reach the largest and most engaged audience of medical coders, billers, auditors, compliance officers, and practice managers anywhere on the planet!

HBM reaches more than 200,000 AAPC members every month who read both the proprietary content in real time and archived past issues as a valuable reference.

To get in front of our audience, contact Michelle Miller at 385-207-2317 or michelle.miller@aapc.com.
I have been an AAPC member and active member in my Greenville, South Carolina local chapter since 2017. I started my career in healthcare working in patient transport at my local hospital. This was my way of getting my foot in the door, as at the time I was attending college to earn my associate degree in administrative office technology with a medical concentration.

I couldn’t find a job with my degree since everyone wanted experience, so I went back to school to gain my unit secretary certification and then transferred to the local mental hospital. It was there that I talked with a colleague who was a medical coder, which started me on the path to becoming a coder, as well.

Learning and Achieving
After I earned my Certified Professional Coder (CPC) credential, I got a job at the urgent care center doing registration, where I was later given the opportunity to code orthopedic surgery.

I currently work as part of the ambulatory coder denials team for the same hospital. I love it there. It’s a very rewarding job getting claims paid for the hospital after working hard appealing the high-dollar charges.

A Great Community
Being a member of AAPC has helped me in many ways. The Healthcare Business Monthly magazine is a great perk, as I love learning new things. Also, the member groups on social media come in handy when I have questions on coding. My advice to those working hard to earn new credentials and land their ideal job is this: Don’t give up on your dreams. Stay positive and keep growing in knowledge.
**Time to Check NCDs and LCDs**

Are you wondering which National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) will be affected by the thousands of diagnosis code changes going into effect Oct. 1? A Centers for Medicare & Medicaid Services (CMS) transmittal tells all.

A CMS transmittal, issued Aug. 4, is a one-time notification to Medicare Administrative Contractors shared-system maintainers for ICD-10-CM conversions and other coding updates to NCDs.

Check whether your office or facility provides any of the services for which there is an NCD or LCD and then check if they are affected by the ICD-10-CM code set update for fiscal year (FY) 2023.

Read more about it at [www.aapc.com/blog](http://www.aapc.com/blog).

**Flu Vaccine Payments**

For the 2022-2023 influenza season, the Centers for Disease Control and Prevention (CDC) recommends everyone 6 months of age and older be vaccinated against the flu “ideally by the end of October.” This advice has not changed from previous years, but the Medicare Part B payment allowances for the flu vaccines have changed.

For the most part, Medicare Part B payment allowances increased slightly for the 2022-2023 flu season. The Medicare Part B payment allowance limits for influenza vaccines are 95 percent of the average wholesale price (AWP) except when the vaccine is furnished in a hospital outpatient department, rural health clinic (RHC), or federally qualified health center (FQHC), where payments are based on reasonable cost.

It’s important to note that the annual flu season runs Aug. 1 through July 31, so it’s possible for a Medicare patient to receive two fully covered flu vaccines in one calendar year. For example, if a patient was vaccinated for the flu on Jan. 5, 2022, and again on Aug. 29, 2022, Medicare would pay both claims. As always, annual Part B deductible and coinsurance amounts do not apply for influenza virus vaccinations.

Medicare instructs to report ICD-10-CM code Z23 Encounter for immunization on the claim, along with the administration code G0008 Administration of influenza virus vaccine. Unlike the vaccine product pricing, which is updated Aug. 1, the pricing for G0008 is effective Jan. 1 through Dec. 31. The locality-adjusted 2022 Medicare Physician Fee Schedule (MPFS) payment rates for influenza, pneumococcal, and hepatitis B vaccine administration file is available for download from the CMS website.

Go to [www.aapc.com/blog](http://www.aapc.com/blog) for the list of vaccine codes and payment allowances.
Your Vote Matters

If you frequent AAPC’s Knowledge Center blog, you may have noticed the polls on our website. If you’ve already participated in one or more polls, thank you! New questions go up on the second and fourth Tuesdays of each month. View the latest poll at www.aapc.com/blog. Here are the results for polls posted in July 2022.

### Poll Results - July 12, 2022

You have 5 minutes before a virtual job interview. What would you spend the most time on?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
<th>Votes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirming internet connection</td>
<td>37.32%</td>
<td>318</td>
</tr>
<tr>
<td>Reviewing questions to ask the potential employer</td>
<td>29.81%</td>
<td>254</td>
</tr>
<tr>
<td>Doing calming or confidence-building exercises</td>
<td>26.06%</td>
<td>222</td>
</tr>
<tr>
<td>Positioning yourself with the best light and angle</td>
<td>6.81%</td>
<td>58</td>
</tr>
</tbody>
</table>

### Poll Results - July 26, 2022

ICD-10-CM 2023 updates are out! Have you started learning changes?

<table>
<thead>
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<th>Response</th>
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<tbody>
<tr>
<td>No, I’ll learn closer to Oct. 1</td>
<td>49.94%</td>
<td>385</td>
</tr>
<tr>
<td>Yes</td>
<td>33.07%</td>
<td>254</td>
</tr>
<tr>
<td>No, I learn them as I use them</td>
<td>13.23%</td>
<td>102</td>
</tr>
<tr>
<td>They aren’t relevant to what I do</td>
<td>3.76%</td>
<td>26</td>
</tr>
</tbody>
</table>

Get Published and Earn CEUs

*Healthcare Business Monthly* accepts article submissions from AAPC members and other industry experts.

If you have news or know-how that can benefit other healthcare business professionals, share it with AAPC’s over 220,000 members by becoming an author for *Healthcare Business Monthly* or AAPC’s Knowledge Center blog.

You don’t have to be an experienced writer; our editors will work with you to translate your ideas to the page and screen. Write what you know about a coding, billing, auditing, compliance, or practice management topic.

Along with the satisfaction of helping your peers, authoring an article is a great way to raise your professional profile. And, it can earn you continuing education units (CEUs) to support your AAPC credentials.


**Submit your article via our website** ([www.aapc.com/resources/publications/healthcare-business-monthly/contribute.aspx](http://www.aapc.com/resources/publications/healthcare-business-monthly/contribute.aspx)).
AAPC Recognizes Karen Bowman

Meet a member who finds inspiring others the best reward of all.
Each month, AAPC selects a member who demonstrates exemplary leadership qualities. This month, we’ve chosen Karen Bowman, FACMPE, CPC, CPMA, for her lifelong service in the business of healthcare. Bowman has worked in healthcare for the past 40 years in a variety of roles, with the last 28 years in healthcare management. We think her professional journey will inspire you.

Starting Out
Bowman decided to focus on a career in healthcare after spending many days visiting her father in the hospital. She had no desire to be a nurse, however, and instead chose to work in the administrative side of healthcare for physician practices. Bowman began her career working at the front desk of a gastrointestinal (GI) practice and soon transitioned to a psychiatrist’s office for four years, where she was responsible for all aspects of the front office, billing, coding, and medical records, including transcription.

Creating Her Own Path
Bowman has been the practice administrator at Gastrointestinal Associates of Cleveland for more than 18 years and is most proud of the support staff her office has built over time. “We have staff who have been here for more than 20 years, over 18 years, and over 12 years. That says a lot about our physicians and how our practice is led,” said Bowman. “Our staff are experts in their field, and we depend on them to keep us at the top of our game so we can give patients the care they deserve.”

She has also worked as an adjunct faculty member at South College and Cleveland State Community College, where she taught medical coding and billing.

Offering Advice
When asked for career advice, Bowman tells up-and-coming coders to never give up. “When you first become a coder, you may feel defeated — that you will never get that coding job you want,” said Bowman. “Never give up. As coders, sometimes what helps you most is starting in the front office or medical records to see the processes. Be a sponge, absorb all the information you can. Be open-minded and look at new job requirements to become a better employee. By the way, it will look good on your resume!”

Personally Speaking
Bowman has been married to her soulmate for over 41 years, has two children, one special grandson she loves to watch marching in the high school band (the same field on which she used to march), and three Yorkies who rule the house.

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, N.Y., and has worked as a writer and editor for 17 years.
Save Money With AAPC

Make the most of your membership by taking full advantage of our Savings Connection.

As an AAPC member, you qualify for a host of discounts and special offers on hundreds of products, services, resources, and more. It’s easy to take advantage of your member benefits. Simply log in to your member account at aapc.com and go to My AAPC > My Account > Savings Center. Here you’ll find four tabs:

- CEUs
- Code Books
- Insurance
- Savings Connection

Let’s explore each of these areas to see what you’ve been missing.

**CEUs**

Continuing education units (CEUs) are a requirement to maintain your credentials, but you don’t have to spend a lot of money earning them. Click on this tab to find plenty of free and low-cost opportunities for earning CEUs. For example, you can earn 1 CEU for every:

- Local chapter meeting you attend;
- Healthcare Business Monthly Test Yourself quiz you take; and
- Free Quarterly webinar you watch.

That’s potentially 28 CEUs earned in one year at no additional cost!

**Code Books**

Medical coding books are another necessity of your profession, and they can be expensive. AAPC members receive discounts on all the code books, guides, and other materials we sell. Some specials are time-sensitive, so you can save more if you don’t procrastinate buying the reference materials you know you’ll need for the coming year. Click on the Code Books tab to find the latest deals.

**Insurance**

Insurance is something none of us can afford to be without — especially health insurance. If you’re in the market for a particular type of insurance, click on the Insurance Savings tab to find insurance options for:

- Liability
- Health
- Accident
- Life
- Auto
- Home

Select the tab for the insurance you are shopping for to find the best option for you!

**Savings Connection**

Last, but certainly not least, click on the Savings Connection tab to find special offers and discounts for just about everything you can think of:

- Car rentals
- Dining
- Entertainment and recreation
- Electronics
- Health and beauty
- Home and business services
- Travel
- Grocery coupons, and more!

The deals are so good, I couldn’t resist! I just saved 45 percent on a care package of healthy snacks shipped for free to my daughter in college!

Get the AAPC Savings Connection app (available at the App Store and Google Play) and use it to search for deals on your smartphone while you’re on the go. You can specify your location so the app only displays relevant offers wherever you may be in the continental United States.

What are you waiting for? Start earning back the cost of your membership every time you shop!
CODIFY TIP

By Deborah Marsh, JD, MA, CPC, CHONC

Find Upcoming Code Changes Easily

Jumpstart preparations with new, revised, and deleted codes at a glance.

CPT® and HCPCS Level II code changes happen throughout the year. And, because of COVID-19, even ICD-10 has seen changes outside of its usual October 1 update. Knowing what’s coming can help your team transition quickly and apply the changes as soon as they’re effective. To streamline your preparations, check out the Upcoming Changes tab in Codify. Here’s how.

- Log in. Then select Code Sets/Upcoming Changes from the top menu (Figure 1).
- Click the code set you want to view. Your access may vary depending on the Codify package you have.
- When the Upcoming Changes page opens, select the tab you want to view, such as New or Revised (Figure 2).

Helpful hints: After the codes become effective, don’t look for them on the Upcoming Changes page. Instead, select the code set from the left menu of your home page and look for an entry for Code Changes (Figure 3).

Deborah Marsh, JD, MA, CPC, CHONC, is a senior development editor at AAPC. She has explored the ins and outs of coding for multiple specialties, particularly radiology, cardiology, and oncology.
2021 Officer of the Year: BARBARA WILLIAMS

The AAPC Chapter Association Board of Directors recognizes Williams for her dedication and drive.

The AAPC Chapter Association Board of Directors (AAPCCA BOD) is honored to announce Barbara Williams, CPC, CDEO, CRC, as 2021 Officer of the Year. Williams serves as president of the Greater Pittsburgh Chapter and is a project manager for the Coding and Quality Team, Revenue Program Management, at Highmark Inc. She is also program director for the Medical Insurance Specialist Program at Community College of Allegheny County.

Always Serving
Williams has a bachelor’s in business management and two associate degrees in finance and pre-health professions. She is also a 20-year veteran of the United States Army Reserve. While serving, she received a Meritorious Service Medal, multiple other commendations, and was named Soldier of the Year in 1986 and 1987 and Non-commissioned Officer of the Year in 1993.
 Williams is an outstanding member of our AAPC family, as well, and always has time for her chapter, as evidenced by the 14 previous nominations from her fellow officers and chapter members. The AAPCCA BOD chose Williams for this award out of 18 candidates. She was chosen for her engagement and leadership of her chapter. Her fellow chapter members value her time volunteering as an officer and had wonderful comments about her. Here are just a few:

“Barb is supportive and upbeat.”
“Barb excels in the leadership role because it’s not about her, it’s about others.”
“She has led all of the meetings with style and grace.”
“Barb is a true role model for all chapter members. She has dedicated time and effort to members both personally and professionally.”
“Barb is consistent, responsible, reliable, and goes above and beyond to assist the chapter in a variety of ways. Many years ago, she was my instructor for a course I took, and she was excellent helping all of her students. Over the years, she continues to grow and improve not only herself, but the many others that she continues to help along the way.”

Doing What She Loves
It takes a serious mind and dedication to achieve so much, but Williams is also quite fun, enjoys her hobbies, and admittedly laughs a lot. She has been a Master Gardner with Phipps Conservatory in Pittsburgh since 2011, where she has assisted with installation of shows and educating the public on proper plant care and identification of garden pests. When you think Williams cannot do anything else, she surprises you by renovating and transitioning her 1900 farmhouse.

In Her Own Words
When asked about her reaction to winning Officer of the Year, Williams said:

When I received the email from the Board of Directors asking to set up a meeting for a professional development opportunity, I originally thought they were going to try and recruit speakers. Then, while in the meeting, I noticed I was the only attendee who was NOT a member of the board. Now I was suspicious!
The first thing I did when Tabitha [Iverson] told me I was selected was cry! (In fact, I think I cried for the remainder of the meeting.) I didn’t even know I was nominated! Sneaky, sneaky officers, and I love them all.

I am humbled — truly humbled — by their gesture and by this honor. Our chapter members and officers are the best. They keep me going.

Many Thanks!
The AAPCCA congratulates all of the nominees and thanks you for all you have done to support our local chapters. The 2022 Officer of the Year nominations will start in December and the winner will be announced in May 2023. If you know an outstanding local chapter officer who deserves recognition, please consider nominating them for 2022 Officer of the Year.

#weareAAPC
Have you ever wondered how to become AAPC’s Officer of the Year? Do you know the criteria for the award and how to undertake the application process? Here’s how to meet the requirements and tips to help you prepare for the application process.

Applying for Officer of the Year

Officer of the Year is awarded to a chapter officer who has gone above and beyond to ensure that their chapter and its members succeed. The officer is nominated by other officers (be sure to tell new officers about the award), but members are encouraged to work with their current officers to complete the nomination form. You’ll find the nomination form on AAPC’s Officer Facebook page, in the forums, or you can request your regional representative to email it to you.

Criteria considered for Officer of the Year include:

• Did the officer play an active role in scheduling and holding at least four certification exams, ensuring that at least two had options for ADA accommodations?
• Did the officer participate in elections and call for nominations completed prior to September?
• Did the officer attend at least six approved chapter meetings or five approved meetings and a seminar?
• Is the officer a mentor?
• Did the officer attend officer training the previous year?
• Did the officer go above and beyond in their role as a chapter official?

Be prepared to explain why you think a nominee should be the Officer of the Year and include a high-resolution electronic image of the officer with the nomination form.

Recognizing the Best

Do you think you know a local chapter officer who deserves to be recognized for their dedication and commitment to success? Then check out the Local Chapter section on www.aapc.com or contact your AAPC Chapter Association representative for the application and get them the recognition they deserve!

Tammy Vannatter-Berger, BHSA, CPC, CMA, RMA, has worked in healthcare for 25 years, currently as a coding manager for a Metro-Detroit healthcare system. She teaches coding and billing online for a local college, as well. Vannatter-Berger is on the 2022-2023 AAPCCA BOD and has held a variety of officer positions in the Macomb Township, Mich., local chapter.

On Sept. 1, AAPC membership lost a shining star suddenly and unexpectedly. Look for a tribute to Tammy in the November issue.
In October, we raise awareness for breast cancer — the second most common cancer in women in the United States, according to the Centers for Disease Control and Prevention (CDC). Every year in the United States, there are about 264,000 new cases in women and 2,400 in men. The mortality rate is higher for women at 42,000 compared to 500 for men. Medical coders have a distinct opportunity to help patients by ensuring their diagnoses and treatments are billed correctly.

**Identify Breast Anatomy**

When reporting the diagnosis and treatments for a breast cancer patient, it’s important to understand the breast anatomy and the tissue types:

- **Lobules** are glands that produce milk.
- **Ducts** carry milk to the nipple.
- **Connective tissue**, both fibrous and fatty, surrounds the lobules and ducts, holding them together.

Breast cancer can spread to other surrounding tissues, into the lymph nodes, and then travel elsewhere in the body. Early detection is essential for early treatment to prevent cancer from spreading (metastasis) and increase the chances of survival.

**Take Preventive Measures**

When a patient reaches a certain age, insurance carriers will cover preventive exams such as mammograms, and upon diagnosis, an ultrasound may be needed for follow-up.

CPT®, HCPCS Level II coding for mammography:

77067, G0279 – Screening mammography – This service is performed on asymptomatic patients as a preventive measure once they reach a certain age or have a family history indicating its need. Coverage for these services for Medicare and many commercial payers is indicated as once in a lifetime for women aged 35-39, once every 12 months for women age 40 or older, or more than once a year if medically necessary.

77065-77066 – Diagnostic mammography – This service is covered by Medicare and many third-party insurance payers if there are signs and symptoms of breast disease, a personal history of breast cancer, or a personal history of biopsy-proven benign breast disease with a physician’s interpretation of the results.

These tests have professional and technical components, so append modifier 26 Professional component when billing the physician’s interpretation only or TC Technical component when billing the test only. Do not use either modifier if the provider performed both components.

Additionally, a physician may decide it is medically necessary to perform a diagnostic breast ultrasound. Coding depends on whether all or some structures are analyzed:

76641 Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; complete

76642 Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed, limited

In a complete ultrasound, the physician examines all four quadrants of the breast — upper outer (UO), upper inner (UI), lower outer (LO), and lower inner (LI) — and the retroareolar region (the
region within 2 cm from the nipple). In a limited exam, the physician examines one to three areas.

In both codes, the axillary region (low, mid, apical) is viewed or is intended to be viewed. The anatomy of the axillary region is often confused for an extremity or musculoskeletal structure due to its proximity to the upper extremity. The physician may analyze the axilla, but the main portion of the test is looking at the breast tissue; looking at the axillary region may indicate lymph node involvement.

Breast Cancer Diagnosis and Staging

After a diagnosis of breast cancer or for those who are at high risk of breast cancer, magnetic resonance imaging (MRI) may be indicated for the extent of the disease. MRI detection is more sensitive, especially for women with dense breast tissue. It can even detect invasive breast cancer a lot sooner than in women who only receive a mammogram. The codes that utilize MRI guidance or computer-aided detection (CAD) are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77046</td>
<td>Magnetic resonance imaging, breast, without contrast material; unilateral</td>
</tr>
<tr>
<td>77047</td>
<td>Magnetic resonance imaging, breast, with contrast material(s), including computer-aided detection (CAD) real-time lesion detection, characterization, and pharmacokinetic analysis when performed; unilateral</td>
</tr>
</tbody>
</table>

Once a diagnosis is confirmed and treatment of a surgical nature is recommended, the physician will use what they have learned through imaging to order the best, most effective treatment for the patient. Working closely with the surgeon to accurately report these codes is vital. Michael J. Cross, MD, FACS, (Certified by The American Board of Surgery), a breast surgical oncologist in Northwest Arkansas, states:

Accuracy in coding and the intention of the code is at the top of the list. This requires a collaborative effort between the doctor and the coder. A surgeon is familiar with the anatomy of the breast including the axilla. Most of the time it will be a surgeon who also will want to take their ultrasound to the OR and use it to place wires, to evaluate the location of cancer, or use it for axillary evaluation. Ultrasound of the surgical specimen can be used to determine the margins and to remove a specific lymph node in surgery as well as used in the office for diagnostic imaging and confirmation of the location of cancer that has been diagnosed. A coder can help the surgeon include essential information that needs to be present that will lead to a clean code, clean claim, and hopefully a clean reimbursement.

Surgical Treatment Challenges

After a patient has been diagnosed with breast cancer, the next process is weighing the surgical and medical options for treating the disease. The physician will discuss with the patient the best treatment options depending on the type of breast cancer, the stage, the size, sensitivity to hormones, and if it has metastasized.

Treatment options are considered based on the stage and may consist of surgical options such as excision of a breast lesion (19120, 19125), lumpectomy (19301-19302), and mastectomy (19303, 19305).

A 19125 is performed to remove abnormal breast tissue or lumps such as cysts or tumors. In a 19301, the surgeon removes a single lump or portion of the breast tissue; whereas in a 19302, a single lump or portion of the breast tissue is removed and lymph nodes between the pectoralis major and minor muscles and in the axilla are removed through a separate incision. A 19303 is a simple, complete surgery to remove the entire breast or both breasts (double mastectomy); and a 19305 is a radical mastectomy — removal of breasts, underarm lymph nodes, and chest muscles.

Lumpectomy

Lumpectomy is also termed partial mastectomy and is the complete surgical removal of a primary tumor, but not a complete removal of the breast. Types of lumpectomy procedures are excisional biopsy, wide local excision, and re-excision lumpectomy. The key to reporting a lumpectomy procedure is understanding how much tissue is being excised or removed.
Codes 19120 and 19301 can often be confused. The key to choosing the correct code is the intent of the procedure, the tissue involved, and the diagnosis. Cancer is not always a reason to go right to a 19301. Consider what is being excised; for example, with 19301, the surgeon will take a margin or rim of healthy tissue. The intent, of course, is to capture the mass within the breast tissue at the area of concern, but removal of additional structures may be required. If the intent is to remove the lump and the lymph nodes between the pectoralis major and the pectoralis minor muscles, in addition to the nodes in the axilla, this would be a complete axillary lymph excision, reported with 19302.

In many cases, the surgeon may not take the full axillary chain and just remove some of the axillary lymph nodes. Instead of utilizing a modifier, the appropriate step is to utilize additional CPT® codes to describe this work; 38500 and 38525 describe the extra work of excising the lymph nodes during a partial mastectomy without removing the full chain.

In cases where cancer is advanced, radiation therapy after a partial mastectomy may be utilized. Codes are assigned as add-on services to 19301 and 19302 for the placement of radiotherapy after loading expandable catheters, which includes imaging guidance either on the day of the procedure (19297) or on a separate day (19296). The surgeon will work with the radiation oncologist as the radiation is delivered at a frequency of twice daily for five to seven days, depending on the type of cancer.

Mastectomy
Mastectomy (simple or complete) involves the complete removal of all breast tissue. Types of mastectomy procedures are total mastectomy, double mastectomy, nipple-sparing mastectomy, and radical mastectomy. A complete mastectomy involves the entire breast and not just a lump and surrounding tissue. The nipple can be spared and preserved to use later in reconstruction. A radical mastectomy involves taking margins for removal of surrounding muscle tissue and nearby lymph nodes. What the surgeon takes will differ and necessitate use of various code options, so attention to detail and a clear understanding of anatomy are key when coding these procedures.

Surgical Reconstruction of the Breast
After a patient receives surgical treatment, breast reconstruction may be needed to restore shape to the post-surgical breast. Reconstruction can be done at the time of a mastectomy or afterward. A breast surgeon can perform a skin-sparing mastectomy to save as much skin as possible for the reconstruction phase.

Reconstruction may be done in two stages: First a tissue expander is placed that will be filled with saline at various visits post-mastectomy. Then, with hopefully enough healing taking place, the second stage is to remove the expander and insert the implant. There are many ways to reconstruct a breast using flaps and grafts from various anatomical sites on the body such as the abdomen, back, thigh, or buttocks.

The challenge with these procedures from a billing standpoint is that many insurances may view them as cosmetic and deny coverage. Clear documentation showing medical necessity is crucial not only for prior authorization but also to stand up to an appeal if a denial takes place.

To obtain proper reimbursement, review the Women’s Health and Cancer Rights Act of 1998 (WHCRA) for breast cancer patients. Under this law, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

This law applies to group health plans (provided by an employer or union) and individual health insurance policies (not based on employment).

Coding requires you to first determine what is being ordered, the reason, and what additional procedures are being performed at that time that may be bundled or included in the service. Common reconstructive procedures and ancillary services that are separately reportable include the following:

19361  Breast reconstruction; with latissimus dorsi flap

A surgeon will utilize tissue expanders, implants, skin or muscle flaps, and other reconstructive devices to reconstruct a breast after mastectomy. Additional procedures may be needed to achieve the desired size or shape. The reconstruction will utilize a latissimus dorsi flap. This involves a transfer of skin and muscle from the patient’s back to their affected breast to correct the defect created by the mastectomy, typically a radical procedure when the cancer was the reason for the mastectomy. It’s called a latissimus dorsi flap because the muscle and skin are taken from nearby structures. The flap under the armpit is rotated so that it can cover the mastectomy site.

Guidelines allow for separate reporting of a breast implant or tissue expander with the reconstruction, as necessary.

This is currently an inpatient-only code per the inpatient code list provided by the Centers for Medicare & Medicaid Services (CMS). Similar services include CPT® 19364, 19367, 19368, and 19369.
19380 Revision of reconstructed breast (eg, significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)

This code is utilized to reconstruct a breast or nipple after a mastectomy. Included in this code are tissue expanders, implants, skin or muscle flaps, and other reconstructive devices, when performed. There may be ancillary procedures performed and billed to allow for a desired size or shape. It’s important that the medical necessity criteria are met for this procedure. Payers may consider this procedure cosmetic, and they also may have a yearly limit on how many times this procedure can be performed.

19318 Breast reduction

This is also referred to as a reduction mammoplasty. While this can be done for cosmetic purposes, there are medically necessary reasons to perform the procedure and various policies that need to be consulted for coverage criteria. Make sure that documentation includes all the required information to support medical necessity. Physicians will typically document breast hypertrophy or an increase in the volume and weight of breast tissue as it relates to the general body habitus. This condition can affect other body systems such as musculoskeletal, respiratory, and integumentary. When one-sided hypertrophy exists, it may result in symptoms on the contralateral side where the mastectomy took place. The amount of tissue that must be removed to relieve symptoms will vary and depend upon such things as height, weight, and breast size.

The Schnur Sliding Scale method is generally used to evaluate the need for a reduction. If the patient’s combined body surface area and weight of breast tissue falls above the 22nd percentile, then surgery is considered medically necessary. To receive approval from the insurance provider, you will usually need to provide pre-op photos to confirm this evaluation. Documentation is key.

19328 Removal of intact breast implant

Last year, breast reconstruction CPT® codes underwent a major revision, 19328 included. The reason to perform a breast implant removal for medical necessity is due to infection or an abscess. The physician may state the procedure will be for the “removal of a breast implant with washout.” This code will include the drainage of any associated abscess cavity or infection. As with other areas of CPT®, debridement of nonviable tissue associated with the breast implant or soft tissues is not reported separately. In other revised codes for 2021, the removal of the implant is an integral part of the procedure and not separately billable, such as in 19370 or 19371, where part of the intracapsular contents is removed in a capsulectomy. (CPT® Assistant April 2021, Vol. 31 Issue 4)

+15777 Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)

This add-on code corrects a soft tissue defect of the trunk or breast. It’s important to check individual payer coverage policies for approved products for this type of graft. Just because prior authorization for 15777 has been received or is not required, you are not guaranteed payment; some commercial carriers have coverage criteria and require the use of an FDA-approved product and will deny payment for products deemed experimental or investigational.

In the Medicare Physician Fee Schedule (MPFS), 15777 has a medically unlikely edit (MUE) of 1, but an MUE adjudication indicator of 3. The MPFS identifies different procedures with indicators to allow for additional units on that claim line. If an indicator of 3 is used, per CMS, “appealed additional units are considered if there is adequate documentation of medical necessity to support reported units.” Do not let these slip by; claims can be appealed and paid.

Remember the Goal

With a good understanding of the guidelines, disease process, and regulatory guidance from Medicare and other payers, you can be successful in helping your patients obtain these much-needed services. The goal is always early detection, but when you understand the correct documentation and communication needed between these different service lines, your patients can get the care they need to improve their quality of life. 

Jennifer McNamara, CPC, CCS, CPMA, CRC, CGSC, COPC, AAPC Approved Instructor, is the director of education and coding for Oncospark. She has more than 20 years of proven healthcare revenue-cycle experience and effective instruction through Ozark Institute for more than 1,000 students. McNamara has worked in many specialized areas of coding including auditing, consulting, RCM services, credentialing, and compliance. She hosts the weekly podcast “Life as a Coder” every Wednesday, discussing health information management and tips for work-life balance.

Resource

www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet

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Hone Your Breast Procedure and Dx Coding Skills

Sometimes unusual pathology cases make the best learning tools. Here’s an instance that provides lots of opportunities to illustrate principles for breast procedure coding. And because the case deals with a breast implant-related condition that clinicians are just beginning to define and understand, this case allows you to learn about a new diagnosis code, too.

The Case

Following is a layout of the case from background to diagnosis.

- **Background:** Patient with 3-year-old breast implant presents with pain and hardening in upper outer quadrant of right breast. Prior cytology results indicated possible non-Hodgkin’s lymphoma.
- **Specimen:** Surgeon separately submits a right sentinel lymph node for immediate evaluation, and right breast partial mastectomy that includes the breast implant surrounded by seroma in the fibrous scar capsule and adjacent breast tissue.
  - Right axillary sentinel lymph node.
  - Following frozen section evaluation, surgeon submits right axillary lymph resection.
  - Pathology service:
    - Gross exam of breast implant
    - Evaluation of partial breast resection submitted in four blocks
    - Wright-Giemsa enhanced cytology stain for seroma within breast capsule
    - Immunohistochemistry staining per tissue block for cluster of differentiation (CD30) and Anaplastic Lymphoma Kinase (ALK)
    - Intraoperative frozen section evaluation of two sentinel lymph node blocks Sentinel lymph node evaluation
    - Right axillary lymphadenectomy exam
  - Diagnosis: breast implant-associated anaplastic large cell lymphoma (BIA-ALCL).

Identify Separate Specimens

The case involves several distinct specimens that form the basis of your coding.

- The first specimen is the partial breast resection. You should code the pathologist’s exam of the four blocks of breast tissue and capsule as 88307 *Level V - Surgical pathology, gross and microscopic examination … Breast, mastectomy - partial/simple.*
- You should additionally report the gross exam to identify the implant as 88300 *Level I - Surgical pathology, gross examination only.*
- The sentinel lymph node is a separate specimen that earns another unit of 88307 … *Sentinel lymph node for the pathology exam.*
- The final specimen is the right axillary lymphadenectomy, which you should report as another unit of 88307 … *Lymph nodes, regional resection.*

**Bundling issues:** CPT® also provides 88309 *Level VI - Surgical pathology, gross and microscopic examination … Breast, mastectomy - with regional lymph nodes* to describe a breast mastectomy specimen that includes lymph nodes.

This case doesn’t reflect 88309 because the surgeon identified the breast specimen as a partial mastectomy, and the surgeon separately submitted the axillary lymphadenectomy following an intraoperative consultation. An 88309 specimen includes the entire breast (usually including skin, areola, and nipple), some or all of the axillary lymph nodes, and possibly chest wall muscle. You might see the surgical procedure called radical (or modified radical) mastectomy, complete mastectomy, or total mastectomy.

**Key:** “How you code a breast specimen and lymph nodes depends on how the specimen(s) are identified and submitted,” says R.M. Stainton Jr., MD, president of Doctors’ Anatomic Pathology Services in Jonesboro, Arkansas. You may separately bill an axillary lymph node resection submitted in addition to a distinct breast specimen that is not a complete mastectomy.
**Sentinel stands apart:** You should never bundle a lymph node identified as a sentinel node into another specimen, even if that specimen includes regional lymph nodes (as the complete mastectomy does). The surgeon separately submits a sentinel node identified as the first draining node in the lymph basin. “The pathologist examines a sentinel node with much greater detail involving multiple levels of serial sectioning and staining to identify any hint of the spread of cancer cells,” Stainton says. That service always earns a separate 88307 charge.

**Count Separate Stains for Full Pay**

The pathology service for this case includes several special stains that you need to report.

For the enhanced cytopathology smear of seroma within the breast implant capsule, the pathologist used a Wright-Giemsa stain to distinguish cell types to help evaluate possible lymphoma. You should code that procedure as 88112 Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal.

**IHC:** The pathologist evaluates two immunohistochemistry (IHC) stains: CD30 and ALK. Although the pathologist documents performing these stains on each of four tissue blocks of the partial mastectomy specimen, you should report just one unit of each stain. Because the unit of service is the partial mastectomy specimen, you should code the two IHC stains as follows:

88342 Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure

+88341 … each additional single antibody stain procedure (List separately in addition to code for primary procedure)

**Don’t Miss Intraoperative Service**

The surgeon requested an intraoperative consultation on the sentinel lymph node specimen in this case, and the pathologist completed a frozen section examination of two blocks from the sentinel node. Based on the pathologist’s reported frozen section results, the surgeon proceeded to perform an axillary lymphadenectomy.

You should code the pathologist’s intraoperative consult using the following codes:

88331 Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen

+88332 … each additional tissue block with frozen section(s) (List separately in addition to code for primary procedure)

**Dial In Diagnosis Coding**

Based on the pathologic findings, the final diagnosis for the case is breast implant-associated anaplastic large cell lymphoma (BIA-ALCL). The condition is not breast cancer, but is a type of non-Hodgkin’s lymphoma, which is an immune-system cancer. The cancer cells may be limited to the seroma within the capsule surrounding the breast implant and the capsule itself, but it can spread through the body.

ICD-10-CM 2022 added a diagnosis code for the condition — C84.7A Anaplastic large cell lymphoma, ALK-negative, breast. “The code came with the synonym of breast implant associated anaplastic large cell lymphoma (BIA-ALCL),” notes Amy Pritchett, CPC, CDEO, CPMA, CRC, CPC-I, CANPC, CASCC, CEDC, AAPC Fellow, senior consultant at Pinnacle Enterprise Risk Consulting Services LLC in Centennial, Colo.

A Use additional code note instructs you to use Z98.82 Breast implant status or Z98.86 Personal history of breast implant removal. Additionally, ICD-10-CM guideline I.C.2.s tells you not to “assign a complication code from chapter 19 [Injury, poisoning and certain other consequences of external causes].”

In other words, BIA-ALCL is “a type of non-Hodgkin’s lymphoma … found in the scar tissue and fluid near the implant [that] can spread throughout the body,” according to the Food and Drug Administration. BIA-ALCL is not a complication of a breast implant after rupturing or malfunctioning so you cannot use a code such as T85.79- Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts or T85.43- Leakage of breast prosthesis and implant with C84.7A.

Ellen Garver, BS, BA, CPC, regularly covers coding, billing, and compliance topics as editor of AAPC’s Pathology/Lab Coding Alert and General Surgery Coding Alert newsletters. Her 22 years’ experience in healthcare business management include writing for other publications and websites, as well as conference and webinar presentations.

This article is reprinted from the Pathology/Lab Coding Alert. For more articles like this, as well as other specialty-specific articles, check out AAPC’s full line of newsletters at www.aapc.com/newsletter.

**Resource**

Medical coders, billers, auditors, and other healthcare business professionals always come to AAPC’s HEALTHCON loaded with questions, in search of answers. This past conference, held virtually March 27-30, was no different. During the Evaluation and Management (E/M) Panel general session, an expert panel made up of a physician, coder, auditor, payer, and a representative from the American Medical Association (AMA) answered audience questions regarding the 2021 E/M guidelines for office/outpatient visits.

The panelists were AAPC’s Chief Product Officer Raemarie Jimenez, CPC, CDEO, CIC, CPB, CPMA, CPPM, CPC-I, CANPC, CRHC, Jaci Kipreos, COC, CPC, CDEO, CPMA, CRC, CPC-I, CEMC, Samuel Le Chase, MD, MPH, CPC, CRC, CPC-I, and CPT® Assistant Managing Editor Leslie Prellwitz, with 2022-2025 National Advisory Board President Colleen Gianatasio, CPC, CPCO, CPC-P, CPMA, CRC, CPC-I, moderating.

Here are five Q&As that came out of that session.

**Q:** For documentation purposes, for time-based 2021 E/M guidelines, is it correct if the provider documents time as, “I spent approximately 30 minutes …?”

**RJ:** It depends on whether the provider documents this for every patient. If they spend “approximately 30 minutes” on every patient, an auditor is going to question that. We know that they’re not going to count every single minute, but we want them to get as close as possible.

**JK:** From an auditor’s perspective, it’s not so much about the time statement as it is the lack of information on how they spent that time.

**Q:** What are some examples of what time-based statements should look like?

**JK:** It should indicate how the provider’s time was spent — a history and an exam, for example — anything that counts toward time. As an auditor, I would like to know what the provider performed in that

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**5 FAQs About E/M Coding**

Industry experts explain the intricacies of the 2021 E/M guidelines.

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time. If separately reportable items were reported, I like a statement that says they were not included in the time.

Q: I would like thoughts on the audit risk for billing by time too often. Should time be used cautiously?
JK: In the audits I’ve been doing, very few providers are using time; I see it primarily with the 99215. I don’t call it a risk anymore; if it’s the more appropriate way to bill then I don’t see a problem with it.
SC: If you spend 60 minutes with every child who has an upper respiratory infection, you’re probably going to have some people looking at you. But if you’re in an area where there’s a lot of high-risk children and every parent is worried about their child’s cancer diagnosis, if you truly spend an hour with a parent counseling them, then you need to say so and claim it. Don’t feel bad to bill them more because it was just a cold; it wasn’t just a cold when the parent was worried to death.

Q: Please give feedback on provider referrals given with regards to the E/M level. The AMA chart doesn’t give this criterion under data or risk. Does it not count toward MDM?
RJ: In the guidelines, in the definitions, it states “the referral without evaluation,” meaning that the provider didn’t do a history, exam or any diagnostic workup. That’s not really going to count toward the MDM level; it depends on what essence you are referring a patient out.
LP: When we’re taking a look at the number and complexity of problems addressed at the encounter, one of the changes is that it’s not just that there’s a problem but the problem is actually addressed. So, the question will be, was there an actual addressing of this issue? We’ve seen some questions where the physician is speaking with a patient about a particular condition and they talk “off the record” about another condition, but there’s really no evaluation, there’s no assessment of that. And the question is, what is the work that the physician is doing there if they’re not really addressing the problem. I think that would be key in a situation like this.
JK: The question I get a lot is “but what if you’re referring because you think the patient is going to need a procedure that you don’t do, and you’re going to discuss that whole procedure with the patient and tell them that you’re going to refer them to this other provider. Are you going to give that provider any risk points for going through the procedure with the patient, even though they aren’t going to perform it? That’s where I get hung up. Often, it’s open to the documentation.
SC: Sometimes I’m not making the referrals until we’ve discussed risk of some of these procedures. If you’re not considering things at all then perhaps you’re not bringing it to that level of risk, but I think certainly there are times that I have used that level of risk if I’m sending someone elsewhere knowing that a procedure is going to be done. Usually, though, the risk level is already taken care of without the referral. I think providers get hung up on some of the other details when the level has already been met by other criteria.

Q: There are many payers that are not accepting consult codes as of 2020-2021. Will consult codes be fading out completely at some point?
RJ: I don’t think so, just from observing discussions on this before. There are payers that still see value in those codes, and there are still providers who say those codes resonate with what they’re performing. So, I don’t see any indication of them going away.
LP: From the perspective of the changes that were approved at the February 2021 CPT® Editorial Panel meeting, there is a new revision in the consultation section, including headlines and guidelines. Given that, unless there’s a large sea of change, consultations will still be around for 2023.

Note: HEALTHCON was held in March, before the final E/M guidelines were released. The advice in this article is subject to change.
ICD-10-CM Guideline Revisions Revealed

New guidelines remove ambiguity for some diagnosis coding in 2023.

The ICD-10-CM Official Guidelines for Coding and Reporting is updated every year, but if you’re not in the habit of reviewing the guidelines at least annually, chances are your diagnosis coding is noncompliant and your claim denial rate is high.

At HEALTHCON Denver Regional, Aug. 3-5, in the general session Diagnosis Coding Insights From the Experts Panel, medical auditor Jaci Kipreos, CPC, COC, CDEO, CPMA, CRC, CPC-I, CEMC, emphasized the importance of these guidelines. “If you don’t read those, you’re probably missing some of the story,” she said. The patient’s story, that is, as told by the healthcare professional.

Kipreos and the other panelists proceeded to review changes to the diagnosis coding guidelines that went into effect Oct. 1. Here’s an abridged version of what came out of that session.

Start at the Beginning

Diagnosis coding is only as accurate as the documentation on which it’s based. If there is missing or conflicting information, a coder’s only recourse is to query the provider. Under Section 1.A.19 Conventions for ICD-10-CM, the guideline is modified to support this. “If there is conflicting medical record documentation, query the provider,” it reads.

Section 1.B.16 Documentation of Complications of Care reiterates this point. “Query the provider for clarification if the documentation is not clear as to the relationship between the condition and the care or procedure,” it reads.

“I love when we see ‘query the provider,’” clinical documentation specialist Colleen Gianatasio, CPC, CPCO, CPC-P, CPMA, CRC, CPC-I, CCS, CCDS-O, said, “because it gives a nod to the way the industry is going. … Being able to truly partner with our providers in an effective way and give them actionable information at the point of care, that’s exciting.”

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Go From Chapter to Chapter

The panelists then went on to review changes to the chapter-specific guidelines. Surprisingly, there weren’t too many additions.

Chapter 1: Certain infectious and parasitic diseases (A00-B99)

When coding human immunodeficiency virus (HIV) infections, there is a new exception to the guideline that says the principal diagnosis should be B20 Human immunodeficiency virus [HIV] disease if a patient is admitted for an HIV-related condition. For fiscal year 2023, if the reason for admission is hemolytic-uremic syndrome associated with HIV disease, you will instead assign new code D59.31 Infection-associated hemolytic-uremic syndrome followed by B20.

Further down in this chapter, this same concept is applied to hemolytic-uremic syndrome with sepsis. “If the reason for admission is hemolytic-uremic syndrome that is associated with sepsis … Codes for the underlying systemic infection and any other conditions (such as severe sepsis) should be assigned as secondary diagnoses,” it reads.
In this case, it’s important to know the true reason for the admission. “In many cases, it may still be the sepsis,” said Lee Williams, MBA, RHIA, CPC, CPCO, CRC, CEMC, CHONC, CCS, CCDS, director of education at AAPC.

**Chapter 2: Neoplasms (C00-D49)**

You will find some added verbiage under 1.C.2.a Admission/Encounter for treatment of primary site and 1.C.2.t Secondary malignant neoplasm of lymphoid tissue. According to Williams, the update didn’t change the meaning of this guideline. “Documentation must show what is the primary malignancy, what is a secondary malignancy, and what is history,” she said.

**Chapter 5: Mental, behavioral, and neurodevelopmental disorders (F01-F99)**

The ICD-10-CM code set update for 2023 includes many new codes for reporting dementia under 1.C.5.d.

“One thing that is very important,” Kipreos said, “If a patient is admitted to an inpatient acute care hospital or other inpatient facility setting with dementia at one severity level and it progresses to a higher severity level, assign one code for the highest severity level reported during the stay.”

**Chapter 15: Pregnancy, childbirth, and the puerperium (O00-O9A)**

A new guideline at 1.C.15.a.7 clarifies how to code weeks of gestation. It states:

In ICD-10-CM, “complete” weeks of gestation refers to full weeks. For example, if the provider documents gestation at 39 weeks and 6 days, the code for 39 weeks of gestation should be assigned, as the patient has not yet reached 40 complete weeks.

Another new guideline added in this chapter at 1.C.15.q.4 clarifies proper coding of hemorrhage following elective abortion.

**Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)**

At Section 1.C.19.5.c. Underdosing, the following is added:

Documentation of a change in the patient’s condition is not required in order to assign an underdosing code. Documentation that the patient is taking less of a medication than is prescribed or discontinued the prescribed medication is sufficient for code assignment.

“When we’re talking about social determinants of health and about providing better outcomes, knowing which of our patients are not taking their prescriptions as prescribed is such an important piece of the story,” Gianatasio said. The reason why they aren’t taking them is equally important.

**Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)**

A guideline at 1.C.21.c.10 is added for new social determinants of health (SDOH) code Z71.87 Encounter for pediatric-to-adult transition counseling. It explains that if both counseling and medical treatment are provided during the same encounter, sequencing depends on the circumstances of the encounter.

Further down in this chapter, verbiage is added to clarify that Z codes “should only be assigned when documentation specifies that the patient has an associated problem or risk factor. For example, not every individual living alone would be assigned code Z60.2 Problems related to living alone.”

“This is about painting that whole picture,” Gianatasio said. “Let’s tell that patient story on why they’re not receiving either the care that they need or we’re not seeing the outcomes in one population versus another population.”

Renee Dustman, BS, is managing editor of content and editorial for AAPC. She is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

**Resource**


Bonus: Watch a snippet from the HEALTHCON Denver Regional session when panelists talk about why they think providers are not documenting risk appropriately available in the electronic version of Healthcare Business Monthly, accessible at www.aapc.com via your My AAPC account.
Recently, the Centers for Disease Control and Prevention (CDC) posted a list of almost 1,500 ICD-10-CM 2023 changes scheduled to take effect Oct. 1, 2022. Among those changes are more specific ways to report grief and stress as well as past and present drug and alcohol use.

Here’s a breakdown of the codes and why they matter.

**Capture Patient Mental Health More Thoroughly**

Primary care practitioners (PCPs) play a big role in mental health care. PCPs are often the first point of contact for people who aren’t feeling well mentally or physically. “Many reports during the pandemic showed patients having extended levels of grief due to isolation, inability to gather for funerals, and so on,” says Chelle Johnson, CPMA, CPC, CPCO, CPPM, CEMC, AAPC Fellow, billing/credentialing/auditing/coding coordinator at County of Stanislaus Health Services Agency in Modesto, Calif.

The new codes you need to know are:

- F43.81 Prolonged grief disorder
- F43.89 Other reactions to severe stress

ICD-10 currently offers you only F43.8 Other reactions to severe stress, which is inclusive of “Other specified trauma and stressor-related disorder.” The change makes F43.8- the parent code, with fifth characters 1 and 8 allowing for more specificity. “Having this specific section get more definitive coding is reassuring to see,” says Maureen Leahey, CHC, CPC, primary care coding team leader with Sentara Healthcare in Norfolk, Va. “This area of coding as
it relates to stress certainly needs more attention since stress can lead to so many more clinical issues, whether chronic condition(s), autoimmune disorders, or both,” Leahey adds.

**Depend on These Codes for Drug and Alcohol Use Specificity**

Next, you can expect to see other code families impacted by the 2023 changes, including these new F10.- to F19.-:

- **F10.90** Alcohol use, unspecified, uncomplicated
- **F10.91** Alcohol use, unspecified, in remission F11.91 Opioid use, unspecified, in remission F12.91 Cannabis use, unspecified, in remission
- **F13.91** Sedative, hypnotic or anxiolytic use, unspecified, in remission F14.91 Cocaine use, unspecified, in remission
- **F15.91** Stimulant use, unspecified, in remission F16.91 Hallucinogen use, unspecified, in remission
- **F17.91** Inhalant use, unspecified, in remission
- **F18.91** Other psychoactive substance use, unspecified, in remission
- **F19.91** Other psychoactive substance use, unspecified, in remission

The most noticeable change here is the addition of specific drugs, as well as the assignment of “in remission” to alcohol and drug use, rather than abuse or dependence. Each of the code families referenced above currently include remission codes, but only in the case of abuse (F--.11) or dependence (F--.21). For instance, in the F10.- family there is F10.11 Alcohol abuse, in remission and F10.21 Alcohol dependence, in remission, and in the F19 family, there is F19.11 Other psychoactive substance abuse, in remission or F19.21 Other psychoactive substance dependence, in remission.

For the 2023 code set, reporting is based on clinical judgment and thorough documentation as before, but the ability to code specific drug and alcohol use (rather than abuse or dependence) in remission allows you to communicate past use easier than you could previously because there’s no need to clinically establish abuse or dependence first. This could be particularly helpful for a new physician who may not be able to determine a patient’s precise level of dependence, abuse, or use, or a new patient who hasn’t yet disclosed much about their past drug or alcohol use.

**Understand the Far-Reaching Effects of Reporting Remission**

Remission implies that something happened in the past, but it also implies the possibility of recurrence. Because of that, remission is an important part of a patient’s medical history, but also in their personal lives, and something that comes up during routine checkups. “The current classifications are simply lacking and focus on how the dependency is creating physical and mental health issues.

Providers will now be able to report a successful outcome. Remission is a win!” adds Leahey.

These particular remission codes will also allow practices to fill out a more complete patient record, which is particularly helpful when prescribing medication. “It’s important for a physician to acknowledge past drug use in order to help a patient maintain their sobriety,” Johnson says.

Note: The one code in the list above that doesn’t describe remission is F10.90. The addition of F10.90 allows you to code unspecified alcohol use without having to make the leap to F10.92-Alcohol use, unspecified with intoxication, F10.93-Alcohol use, unspecified with withdrawal, or a series of other codes that describe alcohol use with related disorders.

Lara Kline, AS, BS, is the development editor for the Primary Care Coding Alert and Gastroenterology Coding Alert. She is also an internationally published writer with a commitment to lifelong learning and mental health advocacy.

This article is reprinted from the Primary Care Coding Alert. For more articles like this, as well as other specialty-specific articles, check out AAPC’s full line of newsletters at www.aapc.com/newsletter.
Physician practices are always busy, and any wasted time will impact revenue. Instituting an efficient, compliant clinical documentation process is a key component to making the best use of time. However, many practices have noticed an increase in note bloat in recent years.

Note bloat is not a gastrointestinal disease but rather a euphemism for when a healthcare provider’s encounter note contains far too much irrelevant information. We began to see note bloat crop up with the implementation of electronic health record (EHR) systems. The use of templates, default text, drop-down lists, and copy-forward features make it too easy to add extraneous information into an encounter note.

One of the primary goals of the 2021 evaluation and management (E/M) guidelines was to reduce administrative burden on clinicians and their practices. The American Medical Association (AMA) has an initiative beyond the 2021 guidelines to reduce clinical documentation by 75 percent by 2025. Dr. Christine Sinsky with the AMA said, “If we can document it with smart phrases and dropdown boxes, we should reconsider whether we should document it at all.” She went on to say, “None of us like to read through a maze of all that structured text output — it’s a waste going in and it’s a hazard to the next user. It simply isn’t possible to document to a scale of one-to-one everything that happened within a human encounter.”

We couldn’t agree more! The consequences of note bloat are serious, potentially impacting revenue and patient care.

Consequences of Note Bloat
In a recent litigation case, an urgent care group paid $2 million to resolve allegations of false billings for inflated and upcoded E/M services. The claim stated the practice required clinical staff to increase documentation even when it was not medically necessary. The clinicians used an EHR template that utilized defaulted text not filled out by them. The Department of Justice (DOJ) stated medical record documentation should be medically necessary to the patient’s complaint. Performing a full review of the patient’s history and a comprehensive examination may not be clinically relevant nor medically necessary, the DOJ contended.

We all know that lost time equals lost revenue. Many studies show clinical staff spend anywhere from 30 to 50 percent of their day reviewing, documenting, and entering orders into an EHR. This often results in patient appointments getting backed up or clinicians documenting on their own time.

Note bloat can also weaken the interprofessional communication between physicians within or outside of the organization. For example, when another clinician must pore over lots of pages within a medical record, clinical nuances could be missed, which can hinder the development of a patient’s narrative.

“Clogging the medical record documentation with labs and other diagnostic tests from several years past can result in inaccurate coding.”
Identify Note Bloat

There are many areas in the medical record where we see note bloat, including the problem list. EHR systems make it easy to drop a problem list into the assessment for the encounter. The issue with these lists is that they are rarely accurate, often including outdated, unrelated, and/or unaddressed problems.

We also see note bloat due to clinicians pulling forward previous notes or portions of previous notes. In outpatient and inpatient visits alike, elements such as history of present illness, a complete review of system, and a comprehensive medical, family, and social history may not be clinically pertinent to the reason the patient was last seen if the clinician does not update the information.

Clogging documentation in the medical record with labs and other diagnostic tests from several years past can also result in inaccurate coding. The documentation may not clearly indicate which tests were actually reviewed at the visit and clinically relevant for inclusion into E/M leveling.

Eliminate Note Bloat

When training our clinical staff about the consequences of note bloat, we often focus only on the revenue cycle message. But some clinicians do not respond well to this approach. A different approach could be to train them on strategies from a medical perspective such as patient safety, communicating the patient story rather than filling out check boxes, documentation for clinical reasoning, and medical necessity.
Training coders on the basics of medical record documentation requirements is also essential to eliminating note bloat. The goal of medical record documentation is to paint a picture of what occurred with the clinician and patient, so that those who were not present during the visit can understand what was done. The more succinct the medical record, the more communications with other healthcare providers will improve, and the less likely an external auditor will question the medical necessity of services.

The general principles of medical record documentation did not change with the implementation of the 2021 E/M guidelines; however, E/M services vary in several ways, such as the type of visit, the amount of physician work required, and procedures and other tests performed and/or reviewed. Also, there are minimum elements that must be documented on every visit. Per the Centers for Medicare & Medicaid Services’ (CMS’) E/M guidelines, these include:

- reason for the encounter,
- relevant history,
- physical examination findings,
- prior diagnostic test results that are relevant to the visit and the physician’s clinical decision making,
- assessment (which is not just the ICD-10-CM codes/descriptions but the overall clinical impression), and
- medical plan of care.

These general principals do not require section headers for specific elements or need to be in a specific order in the record, contrary to the 1995 and 1997 E/M guidelines. The CMS E/M guidelines state, “If the rationale for ordering a diagnostic and other ancillary service is not documented, it should be easily inferred. Past and present diagnoses should be accessible to the treating and/or consulting physician.” Inference is accepted in this limited instance, and the problem list does not need to be in every note.

Try Team Documentation

Another approach to eliminating note bloat is utilizing team documentation. This process can improve overall patient care because the clinician is less focused on EHR documentation and more focused on the patient during the visit. It can also be an important cost-saving tool for organizations.

Team documentation, or multiple contributor documentation, is a process where nonphysician team members assist with documenting visit notes, entering orders and referrals, reconciling medications, and preparing prescriptions during a patient visit. Clinical team members, such as medical assistants and nurses, and nonclinical team members, such as scribes, can all support team documentation. The degree to which you can task share varies by state and local scope of practice regulations, however, so be mindful and do your homework before implementing this system.

No More Note Bloat

Eliminating unnecessary documentation (note bloat) will not only improve your practice’s clinical documentation, it will also improve communication between clinicians, give clinicians more time to see patients, and help decrease burnout. Reducing note bloat will also lead to improved efficiency and accuracy of coders and auditors, reduce denials due to poor medical documentation, and, as a result, increase your practice’s bottom line.
Note Bloat

Get Published and Earn CEUs

Healthcare Business Monthly accepts article submissions from AAPC members and other industry experts.

If you have news or know-how that can benefit other healthcare business professionals, share it with AAPC’s over 220,000 members by becoming an author for Healthcare Business Monthly or AAPC’s Knowledge Center blog.

You don’t have to be an experienced writer; our editors will work with you to translate your ideas to the page and screen. Write what you know about a coding, billing, auditing, compliance, or practice management topic.

Along with the satisfaction of helping your peers, authoring an article is a great way to raise your professional profile. And, it can earn you continuing education units (CEUs) to support your AAPC credentials.

Go here (www.aapc.com/medical-coding-education/help/#tab-3) for CEU information and writing tips.

Submit your article via our website (www.aapc.com/resources/publications/healthcare-business-monthly/contribute.aspx).

Resources


Stephani Scott, RHIT, CPC, vice president of AAPC Services, has over 25 years’ experience in the healthcare industry, working closely with physicians and staff in health information management. She has worked in a variety of settings including hospital, long-term care, large multispecialty physician practice, and electronic health record software design and development. Scott has extensive experience in inpatient and outpatient auditing and coding compliance and is responsible for overall project performance and client satisfaction. Scott was also a part-owner of a consulting company for many years, providing services in best practices for physician practice management services including coding, billing, and revenue cycle management audits.

CJ Wolf, MD, M.Ed., CPC, COC, has been involved in healthcare for over 22 years beginning with his years in medical school. Dr. Wolf made a career change to healthcare administration, reimbursement, and compliance. He has worked in various coding, reimbursement, and chief compliance officer roles for Intermountain Healthcare, the University of Texas MD Anderson Cancer Center, the University of Texas System, and an international medical device company. He currently holds faculty appointments at two universities and provides coding, compliance, and training services through Compliance Reality.
New Practicode Content is Here

AAPC’s online intern program offers new practicums and expanded specialty modules.

Practicode has been improving medical coders’ proficiency since 2016. Each iteration has offered enhanced content and an improved user experience, and this year AAPC has taken it up another notch.

We launched a new platform in March, adding the new Certified Risk Adjustment Coder (CRC®) practicum, which mimics an actual hierarchical condition category (HCC) client contract with 400 cases using both commercial and Medicare guidelines. And recently, we added a Certified Inpatient Coder (CIC®) practicum, expanded specialty modules, and two practicums for the Certified Professional Coder-Apprentice (CPC-A®) and Certified Outpatient Coder-Apprentice (COC-A™) credentials.

Why Practicode Is Important to Coders

Performing a task while on the job is quite different from studying and testing for a certification, especially for a discipline like coding. Most training programs offer short scenarios to code while you are learning or they offer some cases to code. Still, there’s not much variety of content, or it doesn’t mimic how providers really document. This makes entering the job market difficult for newly certified coders and for those who want to switch from one specialty to another.

The real-world applications in Practicode allow coders to practice the skills they will use throughout their careers such as critical thinking, querying, resourcing, and keeping current with coding updates.

Why Practicode Is Important to Educators and Employers

Standardized assessment tools and real-time data points help educators and employers objectively understand the skill gaps of learners. The impact on learning and quantified knowledge cannot be overstated.

Time and again in online research, the top five skills and abilities that make a coder successful are:

1. Attention to detail
2. Effective communication
3. Adaptability
4. Working autonomously
5. Expert knowledge of codes and coding guidelines

On the flip side, the top five skills identified as consistently difficult for new medical coding employees to master are:

1. Communication
2. Working with technology
3. Inpatient coding
4. CPT® coding
5. Using an encoder program

Practicode helps improve these skills by introducing coders to new technologies; using notes to practice communication skills; articulating questions or observations about a case to an instructor; application of all coding assignments; and using an encoder program.

Change is Good

This latest update to the Practicode platform has given AAPC the ability to continuously expand its capabilities and options for learners. Practicode has always been a way for coders to quantify their knowledge. The new platform goes even further, allowing users to truly improve their skills and understand knowledge gaps they may not be aware of.

Shelly Cronin, CPC, CPC-I, CPMA, CPPM, CGSC, CGIC, CANPC, is AAPC’s Director of Client and Product Success, with 17 years of coding experience working on AAPC’s product team. Cronin thrives on bringing new product ideas to our members and clients. In addition to managing products, she regularly meets with customers and clients to assist in product knowledge and usage.
October is Breast Cancer Awareness Month

If you've ever considered specializing in obstetrics and gynecology, now is a great time. Throughout the month, AAPC will donate a portion of proceeds from all COBGC exams sold to the National Breast Cancer Foundation. In honor of the month, here are a few facts about breast cancer.

**Early Detection**
When it’s detected early, in the localized stage, the 5-year relative survival rate is 99%.

**Most Common**
cancer in women in the US, except for skin cancers.

1 in 8 women are diagnosed with breast cancer yearly.

**Symptoms**
- Nipple tenderness or a lump/thickening in or near the breast or underarm area
- Change in skin texture like an enlargement of pores (similar to an orange peel’s texture)
- Not all lumps are cancerous, but all should be investigated by a healthcare professional
- Unexplained change in size or shape of breast
- Dimpling or unexplained swelling or shrinking — especially if isolated to one side
- Recent asymmetry
- Scaly, red, swollen, or pitted skin
- Any nipple discharge when not breastfeeding

**Myths**
Breast cancer is not caused by underwire bras, implants, deodorants, antiperspirants, mammograms, caffeine, plastic food serving items, microwaves, or cell phones.

Interested in coding for obstetrics and gynecology?
Learn more at: aapc.com/cobgc

Sources
- American Cancer Society
- National Breast Cancer Foundation
  https://www.nationalbreastcancer.org/
EDUCATION AND FELLOWSHIP BROUGHT HUNDREDS OF MEDICAL BILLERS, CODERS, AUDITORS, AND OTHER HEALTHCARE BUSINESS PROFESSIONALS TO AAPC’S HEALTHCON REGIONAL 2022 CONFERENCE AUG. 3-5. AS USUAL, THE CHAT WALL IN THE CONFERENCE APP WAS FILLED WITH ANTICIPATION AND ENTHUSIASM FROM THOSE ATTENDING IN PERSON, AS WELL AS LOTS OF PICTURES OF FOUR-LEGGED “HELPERS” FROM THOSE ATTENDING REMOTELY. WHETHER ATTENDING IN PERSON AT THE GAYLORD ROCKIES RESORT & CONVENTION CENTER IN DENVER, COLO., OR ONLINE, IT WAS CLEAR THAT EVERYONE WAS EAGER TO GET STARTED.
**Kicking Off the Morning**

AAPC CEO Bevan Erickson began the first official day of HEALTHCON Regional with his customary Conference Welcome and prize giveaways:

- **Myra Simmons** won the executive suite at the hotel. Erickson raffles off his hotel suite at every HEALTHCON.
- **Jarrod Dyck** and **Michelle Viale** won tickets to the ’70s-themed Colorful Colorado After-Hours Celebration.
- **Melinda Yargee** won a free registration for HEALTHCON 2023.

Erickson then launched into a review of the last year at AAPC. With a membership now topping 225,000 members, last year’s launch of AAPC Global, and the new business solutions website, there was plenty of ground to cover. Erickson also talked about what is coming for AAPC, including a hiring initiative to provide improved support, double the offered content, expanded exam locations, and job placement services for students.

Following Erickson, four industry experts representing the provider, facility, and payer perspectives led a telemedicine panel that discussed best practices for navigating the ongoing changes in telemedicine and telehealth regulations. **Colleen Gianatasio**, CPC, CPCO, CPC-P, CPMA, CRC, CPC-I, CCS, CCDS-O, AAPC Approved Instructor, **Lee Williams**, MBA, RHIA, CCS, CCDS, CPC, CPCO, CRC, CEMC, CHONC, **Marianne Durling**, MHA, RHIA, CCS, CDIP, CPC, CPCO, CDEI, CIC, AAPC Approved Instructor, and **Stephanie Sjogren**, CPC, COC, CDEO, CPMA, CPC-I, CCS, HCAFA, all lent their experience and knowledge to answer questions from the audience.

One thing was clear by the end of the session: There is still a lot of uncertainty around compliancy in telemedicine, and there will be more to come once the states and the federal government set an end date for the public health emergency.

**Lots to Learn**

Following lunch with vendors and a visit to the Virtual Café for some Tips for Successful Networking, the breakout sessions began. Attendees had a wide range of topics to choose from each day.
Day 1

Amy Pritchett, CPC, CDEO, CPMA, CRC, CPC-I, CANPC, CASCC,CEDC, AAPC Fellow, gave two presentations in the afternoon. In her session *Is Inpatient Cardiology Giving You Chest Pains?* attendees learned about assigning ICD-10-PCS codes for cardiology procedures in the inpatient facility from the operating room to discharge. And in the *ABCs of Ambulatory Surgery Centers*, Pritchett delved into the complicated world of ambulatory surgery center coding and billing, including an interactive coding simulation.

There was also an engaging and informative presentation on skin repairs and grafts in the session *Coding Wound Repairs*, a session on *Compliance Risks in the EMR*, and a session on *How to Negotiate Payer Contracts Like a Pro*.

Jaci Kipreos, CPC, COC, CDEO, CPMA, CRC, CPC-I, CEMC, took attendees through a comprehensive review of the office/outpatient evaluation and management (E/M) medical decision making table in her session *Climbing the Rocky Mountain to a Level 5 Encounter*. And Stephanie Thebarge, CPC, CPB, CPMA, CPPM, CEMC, CHONC, broke down the *Fundamentals of Credentialing*: What it is, why we do it, best practices, payer requirements, and how the role of the credentialing specialist has evolved.

For those interested in more about E/M, Jennifer McNamara, CPC, CPMA, CRC, CPC-I, CGSC, COPC, CCS, AAPC Approved Instructor, presented *E/M Documentation and Coding for Orthopedics* and Brenda Edwards, CPC, CDEO, CPB, CPMA, CPMS, CRC, CPC-I, CEMC, looked at clinical documentation and how it holds up under the new 2021 E/M guidelines in her session *E/M Auditing — What Does It Really Mean?*

Elizabeth Deak, CPC, CPMA, CEMA, wrapped up the afternoon sessions with her presentation on *Program Integrity Audits and the Special Investigation Unit*. The session delved into data analytics used to identify and trigger an audit request, how to respond to the request, and how to implement post-audit findings in the provider office.

Day 2

The second day of conference began with a discussion on how to create a work/life balance and went on to provide an awesome lineup of educational sessions presented by industry subject matter experts.

In the first general session of the day, moderator Gianatasio and panelists Samuel “Le” Church, MD, MPH, CPC, CRC, CPC-I (remote), AAPC Chief Product Officer Raemarie Jimenez, CPC, CIC, CPB, CPMA, CPPM, CPC-I, AAPC Approved Instructor, CCS, and Kipreos, fielded attendees’ questions about E/M service coding with expert advice.
In Diagnosis Coding Insights From the Experts, Gianatasio, Kipreos, Durling, and Williams gave their perspectives on the rules surrounding diagnosis coding for professional fee, risk adjustment, and facility. This was followed by a selection of breakout sessions that covered a wide variety of topics relating to medical coding, billing, auditing, risk adjustment, practice management, compliance, documentation, and more.

Attendees could learn about the Merit-Based Incentive Payment System (MIPS) in the session Physician Cost Efficiency in the MIPS Environment, by James S. Kennedy, MD, CCS, CCDS, CDIP; learn about the intricacies of billing services provided by nonphysician professionals in Compliance Issues with Billing for Nonphysician Practitioners, presented by Sandy Giangreco Brown, MHA, BS, RHIT, CHC, CCS, CCS-P, CPC, CPC-I, COBGC, COC, PCS; or attend a fun, informative, and entertaining session on Crucial Conversations (aka What Makes a Successful Medical Practice Manager), given by Rita Genovese, CPC, PCS.

There were also sessions on E/M guidelines, otolaryngology coding, wound healing and hyperbaric coding, anesthesia coding and billing, and documentation nuances.

Day 3
The final day of conference offered plenty more education, time for networking, and more opportunities to win prizes and vendor giveaways.

In the general session E/M Lessons Learned, Jimenez started by polling the audience on how happy they would be to see the 1995 and 1997 Documentation Guidelines for E/M Services go away. It wasn’t too surprising that 100 percent said, “Good riddance!” to the cumbersome guidelines. She also polled the audience on their comfort level with the new 2021 E/M guidelines for office and other outpatient services. Surprisingly, 78 percent said they are proficient with using them. After her well-received general session, the breakout sessions commenced.

Christine Hall, CPC, CPB, CPMA, CRC, CPC-I, talked about the future of reimbursement in her session The Future of Reimbursement: Risk Adjustment; and Obi Egbunike, CPC, COC, CRC, CCS-P, AAPC Approved Instructor, took what appeared to be a daunting subject and offered a solid, easy-to-understand presentation on the basics of stereotactic procedures, why they are necessary, and how they work in her presentation Stereotactic Procedures for Diagnosis of Intracranial Lesions.

In the session OIG Enforcement Update and Emerging Trends (Fighting Fraud in the Time of COVID), attendees received insight into healthcare fraud and the actions of law enforcement with Department of Health and Human Services (HHS) Office of the Inspector General (OIG) special agents Tony Maffei and Kenny Barrett; and Dr. L. Renee Bradley, CPC, CPC-P, gave an enlightening presentation on the impact of Diversity, Equity, and Inclusion Awareness on healthcare organizations.

It’s hard to believe so much education could be packed into a morning but there were also sessions on networking, gastroenterology coding, inpatient risk coding, chart audits, auditing using 2021 E/M guidelines, and a few others.

An Evening Getting Funky With It
Following the educational part of Day 2, attendees could participate in a ’70s-themed dinner party hosted by AAPC, aptly named the Colorful Colorado After Hours Bash. Everyone boogied down to some groovy tunes and sang karaoke while enjoying a delicious meal.
Pet Pix Please!

A perk to attending conference virtually is being able to show off your pets! The Chat Wall in the AAPC Conference app is always filled with adorable photos of dogs and cats and … cows? Virtual attendees posted an interesting array of unusual pets at this conference.

Possibly a first for conference, we had a mascot. Oscar Watts is the cutest little Doxin we’ve ever seen!

A Fond Farewell, Until Next Time

Once the sessions were done, everyone had a great time at the Networking Lunch Farewell. A delicious meal was had (as well as some laughs!) and prizes were awarded for the passport scavenger hunt, the top conference networkers, and the top challenge winners. Codify and eNewsletter subscriptions, a Pro Fee Coder Bundle 2022, and free registrations for HEALTHCON 2023 were awarded to both in-person and virtual attendees. Congratulations to all who won!

Attendees also watched the video promo for HEALTHCON 2023. We hope to see you in Nashville!

Here’s what HEALTHCON Regional attendees were saying on the Chat Wall in the AAPC Conference app:

“Thank you to everyone for making such an amazing conference! This was my first and I’m now addicted. Absolutely loved the speakers, the panels, and especially the networking! Hope to see ya’ll again.”

—Jessie Beavers

“Thank you AAPC HEALTHCON for an amazing three days with GREAT people!”

—Ivelisse Tweedy

“Great conference, great presenters, great content, great networking, great connections. Thank you so much AAPC for this opportunity!”

—Vatsala M

“Had so much fun at our 70’s party last night!! I have thoroughly enjoyed the entire conference experience and LOVED meeting so many of you! Hope to see you all in Nashville!”

—Corella Lumpkins

“It’s been great meeting new people virtually and chatting with everyone. Thank you to those who have reached out and connected via the HEALTHCON app or LinkedIn. Looking forward to staying in touch! Thank you for all the great pics posted for those of us who are virtual. Last but not least, thank you AAPC for all the great information presented! Another great conference!”

—Annette Bush

“Thank you to all who won!”

—Milo the mini pig, submitted by Nicolette Reynolds.

“Dixie and her calf, submitted by Jill May.

“Mascot Oscar Watts (Oscar’s human is Albertina Watts).

“Frankie the hedgehog, submitted by Desiree Simpson.

“Pet Pix Please!”

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—Vatsala M
10 things I learned from attending HEALTHCON Regional 2022.

When I am asked, “Is attending conferences really worth it?” my short answer is an enthusiastic “Yes!” The educational, networking, and bonding experiences are well worth the trip; plus, you get to experience the delights of a new city. Read on for my conference tips and takeaways from this year’s HEALTHCON Denver Regional.

1. Arrive early.
Get to the hotel a couple of days early. This gives you time to relax before the conference starts. The conference is packed with activities, which can be exhausting. It also gives you time to get familiar with the hotel and explore the city in which the conference is being held.

2. Pre-conference sessions have great value.
The day before conference starts, AAPC approved instructors can obtain their continuing education units and offer feedback on courses through pre-conference sessions and workshops. There are sessions for chapter officers, as well.

3. Learn something new.
For me, the whole point of conference is to learn something new. I have experience in almost every aspect of revenue cycle management, but credentialing is not part of my background, so I sat in on a session on the fundamentals of credentialing.

4. The networking opportunities surpassed my expectations.
I was able to network with speakers and attendees from sessions I did not attend by sitting at different tables for each meal. This course of action caught some off guard, but learning about others’ journeys helps you grow. It’s also a great reminder that there is more than one way to be successful in this industry.

5. Talking with colleagues can help those who feel stuck or burned out.
I gave a presentation on the importance of networking and how to leverage it as a tool in your career. I got into discussions with wearied attendees on how vast the industry is, how to reignite their passion, and how AAPC can help.

6. The Conference App enhances the experience.
By utilizing the conference app as a networking and educational tool, I could see the attendees who signed up for specific sessions, reserve my seat to sessions, access handouts, and stay on top of conference updates.

7. The prizes are epic.
Everyone loves free stuff, but it’s that much better when the free stuff is worth winning! Prizes can be won by participating in daily challenges, posting on social media, and answering trivia questions. A HEALTHCON registration, AAPC courses, and newsletter subscriptions were just a few of the prizes awarded at this conference.

8. Going to the after-hours event is worth the extra money.
The after-hours event is a nice way to relax after all that learning. This year’s event was a 1970’s-themed party. There was karaoke, dancing, food, and so much fun!

9. There is a difference between attending in person versus virtually.
Attending conference in person has a different vibe than attending remotely. When you’re there, you’re submerged in the environment, and that is your sole focus. There is nothing wrong with attending online, and you will receive a great education, but if you are able to travel to conference, I encourage you to do so.

10. Attending conference is truly life changing.
With each conference comes a newfound energy. I have met some of the most incredible people through conferences, many of whom offered me career guidance, provided job leads, and became lifelong friends.

Hope to see you at HEALTHCON 2023 in Nashville! 🎉
So, you think you may want to be a medical auditor but you’re not sure if it’s right for you or if you’re on the correct path. The first thing to learn is that not all audits consist of merely confirming code selections; most delve much deeper into compliance, risk adjustment, or documentation integrity, and sometimes audits are performed on policies.

To show just how diverse auditing can be and how the path to becoming an auditor can be equally diverse, here are three different career paths from three members of AAPC’s Auditing Advisory Committee (myself included).

Let these tips and stories from AAPC’s Auditing Advisory Committee help you decide if medical auditing is for you.
Angie Clements, CPC, CPMA, CEMC, CGSC, COSC, AAPC Approved Instructor

I started in the healthcare industry with a part-time job while in college doing anything that was asked of me in a primary care office. I answered phones, I sat at the checkout desk and collected copays, I copied records, and I placed patients in the room, just to name a few things. Eventually, the opportunity came for me to code ICD-9-CM.

Another job then presented itself, and I became a receptionist and medical records clerk in an orthopedic office. Following that,

I took a revenue cycle position, where I performed charge entry, coding, billing, payment posting, denials, and accounts receivable follow-up. Basically, I performed the entire revenue cycle by myself. My career led me to various coding/revenue cycle positions in independent practices of various specialties, each growing my knowledge of multiple specialties and coding.

Then, I landed a position in a large healthcare system as an abstractor, coding for multiple specialties, both surgical and non-surgical. I educated my providers when there was either coding or documentation opportunities. At one point the coders where I worked were given the opportunity to learn how to audit. While some coders complained that they were performing an auditing job at a coder’s salary, I saw this as an opportunity and took advantage of it. I learned some very valuable skills from several different subject matter experts (SMEs) that I honed to become the best auditor I could be.

Today, I am a physician coding auditor, educator, and consultant at Medkoder. I continue to grow my skills to ensure I am performing my job at the highest level of expertise. I have worked hard to develop and fine-tune my skills and become a recognized SME in our industry.

I have also had the opportunity to serve as an expert witness for an attorney on behalf of a physician. I have served AAPC members at both local and national levels, and I serve as a SME and a certified instructor for AAPC.

My advice? Don’t look down your nose at any job. It may be the opportunity you were waiting for in disguise. It could be the steppingstone you need to grow your knowledge or advance your career. If you only take a job or take advantage of an opportunity based on financial gain, you will miss out on so much. Seize every opportunity and grow in it!

Take 5 Steps Before Taking the Path to Auditing

Before you decide to purchase the medical auditing curriculum and pick your exam date, I recommend that you first:

1. Read about the Certified Professional Medical Auditor (CPMA®) exam and review the exam breakdown on the AAPC website.
2. Consider if you have the time in your schedule/life to learn a new topic right now.
3. Network with current auditors at a local chapter meeting.
4. Participate in the AAPC Mentorship Program to meet auditors and learn what they do and how they got started.
5. Decide now if you will have the ability to maintain additional continuing education units (CEUs) for another credential.

If your employer has asked you to start auditing as a new job requirement, it would be well worth the effort for you to take steps 3 and 4.
Kathy Rowland, BSN, RN, CHC, CPC, CPC-I, CEMC

I had a great foundation for learning to audit as a manager and administrator for multiple large medical practices over a span of 17 years. This allowed me to understand the physician practice model, staffing, and documentation — kind of the soup to nuts process of a practice. I transitioned to consulting over 20 years ago and then got my coding and healthcare compliance certifications. Auditing was always my goal.

I started working as a consultant for practice management issues and it evolved into auditing. I transitioned to a full-time auditor at Vanderbilt Medical Center in the Corporate Integrity Office. There were five coders and we had to audit almost 3,000 providers annually. We audited all departments — even those for which I could not pronounce their specialty! I learned so much with that “boots on the ground” experience.

During that time, I developed a passion for educating providers, which blossomed into a consulting company of my own that I have run for over 18 years. Auditing and education certainly have their challenges, but they can also be very rewarding, especially when you are able to help a provider work more effectively and understand and apply the sometimes cumbersome guidelines.

Jaci Kipreos, CPC, COC, CDEO, CPMA, CRC, CPC-I, CEMC

I have been in the business of healthcare for over 30 years. Like Angie and Kathy, I started in a practice learning the ropes. My undergraduate degree is in finance, so I felt comfortable with the business side of the practice.

Like Angie, I just kept taking the next opportunity as it presented itself. I started attending conferences, which helped me to know I was on the right career path. At some point along the way the job I was in began to move from coding a record to reviewing documentation after the claim had been submitted; I found I liked looking at documentation at a slower pace and looking for opportunities and areas of risk and meeting with providers to explain my findings. I do not think I held the title of auditor; I was just performing the function.

Along my path, I was fortunate to land a job as an internal auditor for a large healthcare system. This was my first formal entry into auditing, and this is where I learned the skills that have and will stay with me forever. I was working with individuals every day who were basically doing what I was doing. The networking was amazing, and I knew I was heading in the right direction.

When AAPC created the Certified Professional Medical Auditor (CPMA®) exam, I offered to beta test the exam through my local chapter. Studying for that exam and reviewing the curriculum provided valuable information that helped me be more confident in my role as an auditor. It was at that point that I realized I wanted to start my own company and become an external auditor.

I truly enjoy all aspects of auditing. The audit process has many layers, and each is important and must be taken very seriously. It has been a fun ride and I have never looked back!

Take the Next Step

If you are considering a future in auditing, I highly recommend that you attend AAPC’s virtual AUDITCON, Nov. 3-4, 2022. Register now and take the next step toward a career in auditing!

“The audit process has many layers, and each is important and must be taken very seriously. It has been a fun ride and I have never looked back!”
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Healthcare policies and rules are continuously changing, and it’s important to stay on top of what all insurance carriers are doing and how their changes impact your practice’s revenue cycle. This, as well as managing your accounts receivable (A/R), is the best way to ensure your cash flow does not bottleneck and cause damage to your practice’s livelihood.

At AAPC’s HEALTHCON 2022 in Washington, D.C., Yvonne Dailey, CPC, CPB, CPC-I, owner of a medical billing agency, explained how to keep your revenue cycle’s cash flowing during her breakout session Best Practices for a Healthy Revenue Cycle. Here’s a synopsis of how she explained the process in 10 steps.

**STEP 1: Verify Insurance**

Verifying insurance is the most important and most ignored step in revenue management, according to Dailey. This should be done at the front desk during the first contact with the patient. With practice management (PM) systems now able to do insurance verification, there is no reason not to do it. Some tips when verifying insurance are:

- Schedule patients with credentialed doctors.
- Complete verification prior to the patient being seen.
- Set up a financial policy (e.g., automatically billing a patient’s credit card if no payment is received after 30 days).
- Collect copayments at initial visits.

Reading and analyzing insurance cards and identifying differences in key payers’ cards when billing is important for entering the correct info into your PM system. Things you should be looking for on the front and back of the cards are what the plan type is, the Payer ID, when the policy starts and ends, symbols, and whether there is a health savings account (HSA) linked to the plan. “Our practice management system is only as good as the information we put in it,” said Dailey.

Many insurance cards look similar with slight differences, such as payer IDs and rules, and many times the PM system will lump them all together, which can cause billing problems. After reviewing the insurance card, ask yourself, “Can all the cards with the same Payer ID be billed with one insurance carrier (for example, UHC Payer ID 87726) in your PM system?”

“The answer would be no,” according to Dailey, because they may have different fee schedules and different coding rules and requirements for claims submission. It’s critical to enter each carrier separately into your system.

**STEP 2: Collect Accurate Information During Patient Registration**

Be sure all information is correct when registering the patient. The name on the insurance card should match the name on the registration forms exactly, and you should get the patient’s complete
address; P.O. boxes should only be used for mailing purposes. Also
confirm the phone number, insurance information, and employer
are correct. If employment has changed, so may the insurance group
number or policy. Other important tasks at registration include:
• Make a copy of the patient’s ID, front and back.
• Have all forms signed and dated, including the financial
policy (signatures are only good for one year).
• Collect copay, deductible, and co-insurance, as applicable.
• Update intake forms annually.
• Require the start and end dates for insurance carriers.

Check the intake forms to ensure they are accurate, review them
at each visit to make sure nothing has changed since the last visit,
and look for discrepancies. “It is up to the person at the front desk to
ask those questions,” said Dailey.

STEP 3: Check for Deficiencies
in Provider Documentation
Deficiencies in provider documentation can cause all sorts of
problems. Insufficient documentation can cause claims to be
down-coded or denied, cause retraction of previous payment, or
flag practices for prepayment review, explained Dailey. Common
documentation deficiencies that cause billing hang-ups are:
• No patient signature for ABNs or financial policies
• No provider’s signature
• Missing pages in documentation
• Physician orders/scripts are missing, incomplete, outdated,
or illegible

Key Acronyms for Managing the Revenue Cycle
According to Yvonne Dailey, CPC, CPB, CPC-I, when talking about revenue
cycle management, you need to know the lingo and common acronyms:
A/R — Accounts receivable
CARC — Claims adjustment reason code
CO — Contractual obligation
EOB — Explanation of benefits
ERA — Electronic remittance advice (or RA — Remittance advice)
GCR — Gross collection rate
KPI — Key performance indicator
NCR — Net collection rate
OA — Other adjustments
PM — Practice management
PR — Patient responsibility
RARC — Remittance advice remark code
RCM — Revenue cycle management

• Wrong or missing date of service (DOS)
• Missing or improper CPT®/HCPCS Level II modifiers
• Missing clinical/medical necessity for lab orders
• Undocumented procedures
• Missing details from the patient encounter
• Cloned documentation

Dailey used the examples shown in Table A and Table B to
illustrate how improper coding can leave money on the table.

Table A Incomplete coding
• Patient was seen for stepping on a rusty nail, left foot no foreign body
provider gave Tdap vaccine. All documentation supported the level of care
and the provider selected the following on billing sheet:

<table>
<thead>
<tr>
<th>CPT® Code Billed</th>
<th>ICD-10-CM Codes Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>S91.332A</td>
</tr>
</tbody>
</table>

• Did the provider bill for all the services provided? What’s missing?

Table B Complete coding
• Patient was seen for stepping on a rusty nail, Left foot no foreign body
provider gave Tdap vaccine. All documentation supported the level of care
and the provider billed the following:

<table>
<thead>
<tr>
<th>CPT® Code Billed</th>
<th>ICD-10-CM Codes Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213, 90714, 90471</td>
<td>S91.332A, Z23, W45.0XXA</td>
</tr>
</tbody>
</table>

• Did we change what the provider did by adding these charges?

There is so much missing in Table A; for example, the vaccines
aren’t accounted for. “If you think about it, with the number of
times vaccines are done — that’s a lot of money that we are leaving
on the table,” said Dailey. Table B shows proper coding. Depending
on insurance, appending modifier 25 Significant, separately identifi-
cable evaluation and management service by the same physician or other
qualified health care professional on the same day of the procedure or
other service to the claim may be appropriate, Daily said.

Keep an eye on commonly missed charges, such as supplies,
devices, injections, infusions, vaccines (administrations), veni-
puncture, and whether the patient is new versus established, Daily
advised. Quickly identify when codes/charges are missing or there
is an error in code selection. Small charges often missed quickly add
up to thousands of dollars.

STEP 4: Be Sure Coding Is Compliant
Not linking CPT®, ICD-10-CM, and HCPCS Level II codes
correctly can have a negative effect on both compliance and reim-
bursement. Be sure you are following the coding guidelines for the
insurance you are billing. For example, do you need to use a CPT®
code, or, because it’s Medicare, do you need a G code?

STEP 5: Make Sure Charge Entry
Is Correct on the Claim Form
It’s important to know where the charge entry goes on the claim
form. To know if something is correct or incorrect, you need to
know where the information came from.
“Pay attention to whether your carriers are paying your contracted fee. ‘If they aren’t, you are going to have to appeal that,’ said Dailey.”

The order in which procedure codes are placed on a claim also can affect reimbursement, as shown in Table C. “Some insurance carriers will pick it up and adjust it for (you), but some won’t,” said Dailey. If this claim was sent to the carrier, you would want to send in a corrected claim for this, Daily said. But don’t delay because there is a limited time in which you can submit a corrected claim.

Table C  Example of how billing can affect revenue

<table>
<thead>
<tr>
<th>Billed Out in the Correct Order</th>
<th>Billed Out in the Reverse Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure 1</td>
<td>Procedure 2</td>
</tr>
<tr>
<td>$2,000 (100%)</td>
<td>$150 (100%)</td>
</tr>
<tr>
<td>Procedure 2</td>
<td>Procedure 1</td>
</tr>
<tr>
<td>$150 (50%)</td>
<td>$2,000 (50%)</td>
</tr>
<tr>
<td>Total paid out</td>
<td>Total paid out</td>
</tr>
<tr>
<td>$2,150</td>
<td>$1,150</td>
</tr>
<tr>
<td>Difference in revenue</td>
<td>$925</td>
</tr>
</tbody>
</table>

Dailey’s eight tips for charge entry review:
1. Make sure all billable charges are entered.
2. Properly link the charges.
3. Review for lost revenue (administration codes, supplies, etc.).
4. Determine if code modifications are necessary for reimbursement such as applying modifiers, multiple procedure rules, or rules for different providers (advanced practice nurse vs. provider).
5. Make sure the referring doctor and ordering doctor are in the correct places (sometimes the ordering doctor is the same as the referring doctor).
6. Check for the correct DOS and correct date of onset.
7. Check the National Provider Identifier (NPI) or Provider ID number.
8. Make sure the charges are entered in accordance with payer policy.

**STEP 6: Submit the Claim**

Before you click the claim submission button, prepare the claim and determine if any modifications are needed. Daily gave an example of how three claims submitted for the same services for United Healthcare (UHC) all needed different reimbursement modifications because insurance card No. 1 followed UHC rules and guidelines, insurance card No. 2 followed Medicare rules and guidelines, and insurance card No. 3 followed Medicaid rules and guidelines for chiropractic services.

Daily said another important thing to remember is “some insurances will not allow or won’t even look at more than four diagnoses, so … try to make sure that (your) first four diagnoses are being pointed wherever (you) need them to be. … Most of them are going to pick up that primary one.” Be sure you are pointing the diagnosis correctly to justify the procedure that was done.

**STEP 7: Evaluate Your Payment Posting Process**

When posting payments, you need to know your gross collection rates (GCR) and net collection rates (NCR). Pay attention to whether your carriers are paying your contracted fee. “If they aren’t, you are going to have to appeal that,” said Dailey. You also need to know if you are bulk posting or line item posting, and know when a contractual obligation (CO) is not a write-off. Understanding the difference between a denial and rejection is of importance as well.

To evaluate the payment posting process:
1. Reconcile remits. Make sure payments correctly match in your PM system.
2. Audit CO write-offs. There are times when a CO is not a true write-off.
3. Send timely statements. Move patient balances over right away.
4. Generate reports through the PM system for write-offs and adjustments to make sure they are correct.
5. Handle and resolve denials.

It’s important to understand why a claim didn’t get paid and use that information to educate other staff and providers. Then, implement quality measures to catch errors.

“Payment posting is what is going to give you a true picture on how your practice is doing financially,” Dailey said.

**STEP 8: Work on A/R**

The most important aspect of managing A/R is follow-up, Daily said. You must be able to research and know where to search. Decide...
“Get patients involved early if there is an issue,’ said Dailey, ‘and identify the reason for delays, such as job loss/reduced income, emergency, loss of coverage, or change of coverage.’”

whether your A/R should be worked on weekly, monthly, quarterly, or yearly.

Your goal should be to keep insurance A/R aging under 90 days. When working on A/R, start with time-restricted carriers, then go to the largest outstanding balance. Next, run a report by carriers and divide the follow-up work between your team members. Sometimes the best way to resolve payment hiccups is by picking up the phone, Daily said. When following up, document all your payment attempts via notes, letters, phone calls, email, etc. This information will help if you need to appeal.

To keep patient A/R from aging, offer automated alerts and several payment options, such as:
• Payment portals that are tied to your PM system
• Credit cards and debit cards
• Checks and cash
• Merchant accounts through your website
• Money transfer apps set up for business (e.g., Venmo, PayPal, Zelle)

“Get patients involved early if there is an issue,” said Dailey, “and identify the reason for delays, such as job loss/reduced income, emergency, loss of coverage, or change of coverage.”

Daily said working the A/R is the most time-consuming aspect of billing, but she finds it to also be the most rewarding when done correctly.

STEP 9: Analyze the Causes of Billing Denials and Delays

Know the difference between a rejected claim and a denied claim. A rejected claim means you did not have the necessary information to determine coverage, such as a billing error, “and the claim does not afford appeal rights, nor can it be reopened,” according to Dailey. A denied claim does not meet the coverage criteria.

It’s estimated that denials and rejected claims cost the healthcare industry over 1 million dollars annually. But approximately 93 percent of rejections are due to data entry and are preventable, while 70 percent of denials can be overturned, Daily said. Causes of rejections, delays, and denials include:
• Not performing insurance verification
• Missing or misuse of modifiers
• Not understanding the differences between rejected and denied claims and how to correct them
• Not appealing when you should

STEP 10: Run Adjustment Reports and Use them as Learning Tools

Finally, effectively monitor your organization’s A/R by running reports on:
• Practice analysis
• Insurance analysis
• Charge and payment analysis
• Patient aging
• Secondary claims status
• Denials
• Adjustments
• Statement cycles

Run these reports by the DOS rather than the date of post, Daily said. Use the reports as staff learning tools, set up goals, and make staff accountable to fix errors hurting your practice’s revenue cycle.
Outsourcing Challenges Create Domestic Opportunities

Certification and diversification will keep U.S. medical coders in demand.

Many large U.S. health systems have found it advantageous to outsource their medical coding and billing processes. This concept strikes a nerve with many U.S. workers who think the business model will put them out of a job. This isn’t the case according to industry leaders, however — quite the opposite.

In the last session at AAPC’s HEALTHCON International, held virtually May 14-15, industry leaders from four business process outsourcing (BPO) companies joined AAPC International Vice President Gregg Hatch for a panel discussion. Hatch asked the panelists how their companies fared during the pandemic, what challenges exist for this sector, and how medical coders and billers can prepare for the future of healthcare.

Hatch started the conversation by asking the panelists how the COVID-19 pandemic affected their organizations.

The COVID Effect on BPO

“COVID has caused significant disruption around the world. How has it impacted your company and outsourced coding in general?” Hatch asked the panelists.

The biggest hurdle, panelists agreed, was transitioning employees to work from home. Infrastructure was the first issue, followed by HIPAA security, and then social dynamics. For the most part, though, these companies were able to continue operations with very little interruption.

Session panelists were:

- **Andrea Faber, RHIA, CCS**, vice president and global head of coding operations, Sutherland Healthcare Solutions
- **Anurag Mehta**, chief executive officer, Omega Healthcare
- **Neda Ryan**, president, MiraMed
- **Roger Salazar**, country manager, R1
According to Faber, “There were a few bumps in the road — getting connectivity, getting people set up and used to working from home.” But eventually employees adjusted and started seeing the advantages to working remotely. “I think that it has brought about some good changes, and we plan to keep that work-at-home in place about 70 percent or more,” she said.

That number surprised Mehta. “As far as allowing people to keep working at home, I think for us it will be north of 50 percent on the coder front but less in other areas,” he said.

Ryan agreed that some functions are better done in the office. At MiraMed, she said, “Voice processes are going to be in the office but most of our coders are staying home; they have expressed that desire and I think there’s been a global shift to be more employee friendly and we have really been able to take advantage of that on behalf of our staff, and clients are being understanding.”

But there are negative aspects to remote work, too, such as disassociation and miscommunication. “There have been issues such as people who work from home don’t feel like part of the company, so engaging them is important,” Mehta said.

And then there are the security and privacy issues. Ryan said, “From a security standpoint, from a checks and balances standpoint, it is requiring a lot more from our leadership to make sure that staff are meeting their quality and production metrics and requirements.”

**BPO Challenges Post Pandemic**

Hatch asked next, “As we adjust to this new reality, what are one or two other challenges that your organization is dealing with?”

Everyone agreed that getting and keeping employees is a concern, as is meeting clients’ demands. “The quality is probably the biggest challenge because now we’re starting to see audits happening; [clients] are looking to see what the impact of the last couple of years has been,” Faber said.

More work and less time, “that’s always a challenge,” Mehta said, especially when your coders work in a different time zone than your clients. On top of that, not everyone has broadband connectivity in India. “It’s not like the U.S.; you have pretty good internet connection most of the time,” Mehta said.

Unreliable and slow connectivity, HIPAA security concerns, and transient workers are challenges international BPO organizations admit they must overcome to secure future growth. “If there’s one thing that could derail this industry,” Mehta said, “it would be a significant data breach from a major hospital system.”

**The Future of Outsourcing**

“Do you agree that the industry will continue to grow and expand, and what do you think the drivers will be over the next several years?” Hatch asked the panelists.

Despite the challenges, there has been growth in the healthcare BPO sector, according to Salazar. “In just the healthcare subsegment of the business process outsourcing industry, we’re looking at the growth somewhere more than 10 percent,” he said.

Mehta has also seen growth in international outsourcing at his company. “We saw 30 percent organic growth last year,” he said. And he expects to see similar growth this year, and for a very concerning reason: “It’s hard to find people in the U.S. and, in fact, we are looking,” Mehta said. “We have hundreds of open positions for coders in the U.S.”

Ryan agreed that domestic employment challenges are driving much of the growth in the international BPO industry. And she expects continued growth as baby boomers retire and create a shortage of experienced workers in the United States.
The increasing complexity of coding guidelines and government regulations also makes outsourcing attractive to health systems. “It’s just so much easier to outsource the work and let healthcare providers focus their energies on their core,” Mehta said. Mergers and acquisitions among U.S. health systems will likely drive future growth for these companies; and with that growth comes employment opportunities for medical coders and billers both domestically and internationally.

**Domestic Outsourcing Opportunities Exist**

Hatch asked next, “What are your thoughts on things that could be done in either your organization or organizations like AAPC to improve the way we’re training individuals getting into the industry?”

All four leaders stressed the need for training and certification. “More and more clients are demanding certification,” Mehta said.

In the Philippines, Salazar said, AAPC Approved Instructors (formerly Certified Professional Coder-Instructor or CPC-I) are in high demand. “I think we need to build that pool of CPC-Is in the Philippines and in the other countries, as well,” he said. There is also a need for Certified Inpatient Coders (CIC™). “I can count on one hand the number of certified inpatient coders in the Philippines,” Salazar said.

Faber agreed with Salazar about the need for more well-rounded training. Team leaders are needed who are prepared to deal with situations caused by extreme and uncontrollable circumstances. “We need more of the middle management to have those skills. … even people who are coders managing these processes need to have different skills in order to manage those things,” she said.

In addition to certification, communication skills and familiarity with the latest technology are highly sought-after attributes.

**AI and The Future of Coding**

“In what ways are you seeing AI being used, and where do you see it going in the future?” Hatch asked the panelists.

The consensus among the BPO leaders is that artificial intelligence (AI), such as computer-assisted coding (CAC) and electronic health records (EHRs), serves to supplement job processes, not replace physical employees. In fact, Ryan said, “I think we’re also going to see AI directly on the provider side at the point of care or documentation, where it’s going to help improve documentation, which will then hopefully reduce the need for queries or just have better quality data that the coders are using to prepare the charts … and improve that entire process.”

Faber also sees AI expanding the role of coders. “There are a lot of places that a coder can set in the revenue cycle,” she said. “You can go into a lot of the things that surround it. A lot of the things we’re doing today involve clinical documentation improvement. The coder is already there. Why not get the feedback from the coder at the time of coding? This is an exciting concept that would expand the role of coders who are ready to embrace it.

As with outsourcing, however, many fear what they don’t understand. “I remember the day when we had paper records and we changed to electronic,” Faber said. “Everyone was fearful that something was going to change with jobs, and in fact it increased jobs. My best advice is to educate yourself. Embrace the technology. Don’t be afraid of change because there are opportunities hidden within all of these things that are coming and it’s pretty exciting.”

**Position Yourself for Success**

Hatch asked next, “What advice would you give to professionals currently working in these areas for how they can best position themselves to take advantage of these opportunities and some of the changes that you’ve described?” and “What advice would you give to someone who is not in the industry but thinking about getting into RCM or coding?”

Faber recommends education and staying on top of the rules; embrace the changes and invest in yourself so you understand and grow with the industry. “Those things will come back and pay dividends at the end of the day,” she said.

Ryan concurred. “Look at how … you can really use it to push yourself forward and improve upon your own skills,” she said.

Diversification is also key to getting ahead in this business. Revenue cycle management (RCM) is no longer just coding charts and billing claims; there are appeals, audits, complex clinical reviews,
quality data capture, clinical documentation improvement, risk coding, etc. Another area Mehta thinks will be big is registry work that goes beyond national registries to include areas such as the Oncology Care Model, pharma, data abstraction, etc. “There’s a limited number [of people who can do this work] in the U.S. and there’s a giant need,” he said.

So, there you have it. The healthcare industry is an enormous, complex business producing enough work to go around. As the U.S. health system reinvents itself and other countries follow its lead, the world is your oyster. The only limitations are those you put on yourself. 

Renee Dustman, BS, is managing editor of content and editorial for AAPC and is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

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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 a lot of information gathering and careful planning.

The Odds Aren’t Even
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
Job Expenses

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 within 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, eight states (California, Iowa, Illinois, Massachusetts, Montana, New Hampshire, North Dakota, and South Dakota) and the District of Columbia 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 are 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?
• What will you need to do to get approval?
• Is there a formal process/form you 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

Ask yourself the following questions prior to approaching your employer:

• 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. Gather the following information:
• 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 (e.g., competing facilitators and costs)?

4. Anticipate Concerns
While 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 at 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, has 15 years of experience in healthcare marketing and operations, and he currently oversees all the marketing at CenExel, a leading clinical research site network. He has published and collaborated on dozens of industry articles and is a frequent speaker at healthcare, marketing, and tech conferences around the country. Blackmer earned a master’s degree in strategic communication from Westminster College.

Resources
Lexology, “Illinois Now Mandates That Employers Reimburse Employees’ Business Expenses,” Vorys Sater Seymour and Pease LLP: www.lexology.com/library/detail.asp?g=0bbeebc5-9e0a-42d0-b70e-379fc1fe648
DOL, Fact Sheet #47: www.dol.gov/whd/regs/compliance/whdfs47.htm
100% Effective Ltd, “How to convince your employer to pay for your training”: www.100percenteffective.com/blog/convince-employer-pay-training
LendKey Technologies, Inc., “10 Tips to Get Your Employer to Pay for Continuing Education”: www.lendkey.com/blog/paying-for-school/10-tips-to-get-your-employer-to-pay-for-continuing-your-education

“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.”
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I truly think this is the best conference I have ever attended. I have attended many conferences in my 20 years of coding including Society-specific conferences with doctors speaking. I do believe that Dr. Zielske and Dr. Dunn are excellent at teaching you correct coding!
-- Sharon Greene, CPC, CPRC

Thank you Char and Dr. Z for putting this together as a virtual conference for those of us who could not travel. It is always a pleasure to see you both even if it is virtual. . . Dr. Z gives the best seminar and I have attended many from others.
-- Candiss Grannis-Hamilton, OH

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Two of the most difficult tasks administrators and managers have are hiring and retaining staff. Recruiting and keeping staff have always been challenging, but since the pandemic, most practices have found it even more difficult. Here are some ways to recruit qualified staff members and keep them for the long term.

Have a Recruiting Plan
What is the best way to recruit staff? There are several routes you can take. Try one or all of the following:

- Network with other managers and share resumes with each other (if the job candidate does not mind).
- Use your AAPC local chapter to advertise for open job positions.
- Post job openings on AAPC’s website at www.aapc.com/medical-coding-jobs/employers.
- Advertise at local colleges for medical assistant, nursing, and administrative positions.
- Encourage current staff members to help recruit someone and offer them an incentive if you hire the individual.

When hiring staff, it’s imperative that they understand your organization’s culture, mission, vision, and values. From the moment they walk through your door as an employee, they should feel welcomed and valued.

As leaders of our organizations, we must show our staff that we are a team. Look at yourself as the leader and not the boss. Our work should reflect a cohesive unit whose goal is to take care of patients in a way that we would want to be taken care of ourselves. I tell my staff that, as a team, if we have one staff member out, our circle is broken, and we need to pull together to tend to patients and complete all necessary jobs. Ensuring that our office culture is one that will not only attract but retain qualified employees is essential.
“When onboarding new staff, it’s imperative that training be comprehensive and specific to their role in the practice.”

Offer Good Benefits
Benefits are always important to those considering a new employer. When establishing the benefits to offer your staff, check what the other medical practices in your area are offering. Most practices are willing to share this information, as they too want to be competitive in attaining quality staff. Review the health, dental, vision, short-term and long-term disability, and any other health coverages you offer. Do you share the cost of premiums with employees and is the cost-sharing ratio competitive? Look at adding other items, if possible, including a 401(k) or similar retirement plan, a Christmas club account with employee match, or scrub reimbursement to sweeten the overall compensation package.

Vacation, sick, and paid time off (PTO) benefits are important to employees, as well. Typically, practices offer a set number of hours for the first five years and then increase that number every five years. Long-term employees generally max out their PTO after 11-15 years. Again, be competitive, when possible. It’s important for employees to take time away from work when they are sick or need to relax, and they need a robust time-off plan to do so.

Approach Onboarding With Care
Utilize AAPC’s or MGMA’s data to benchmark the number of staff you have employed. The number of staff should correlate to the volume of patients you see, the number of providers you have, and other metrics. If you are understaffed, this can lead to disgruntled employees who feel their work is never done or that they do not have time to complete tasks.

When onboarding new staff, it’s imperative that training be comprehensive and specific to their role in the practice. The best thing you can do is arm the new employee with as much information as possible to do their job. For example, all front office employees should have specific training on checking patients in and out, answering phones, scheduling appointments, and scanning medical records.

If you can arrange for an outside speaker to present to your new staff on vital training protocols, try to do so as employees come on board. This will solidify with your staff the importance of what you have already trained them on.

Provide Comprehensive Training
Once you train new employees on the mandatory items (OSHA, HIPAA, compliance plan, etc.), ensure that you have training protocols set up for each department. Give each new employee the tools necessary to do their job and set expectations for them. People work better when they know what’s expected of them and flourish when proper training protocols are in place.

Here are six tips for training your staff:
1. Streamline tasks: Streamlining tasks in your front office will give staff more time to focus on other important things. For instance, have an eligibility program that will verify patients’ insurance and gather vital information so correct copays, co-insurance, and deductibles are collected. Provide your staff with fee schedules for all payers to ensure they know the correct amount to collect when patients are seen.
2. **Manage referrals:** Proper training on how to manage referrals from other physicians is important. Have a list of the medical records, including labs and imaging, that you may need to see a new patient. If you have these protocols in place, patients can be seen in a timelier manner and providers will have the vital information they need at the time of service.

3. **Get specific:** Ensure clinical staff members understand your specialty or practice and are properly trained in their specific job duties. Have protocols on routine duties such as test or biopsy results, refilling prescriptions, and how patients should be roomed. Create protocols for all other routine tasks to help limit the number of questions staff have and give them the tools necessary to complete their jobs more efficiently.

4. **Offer reference materials:** Provide updated CPT®, ICD-10-CM, and other needed code books for your billing staff and certified coders to use. Create or purchase “cheat sheets” for staff to make it easier for them to look up codes for your specialty.

5. **Make training mandatory:** Mandatory attendance of payers’ training and coding-specific training for your practice is essential. As we know, the information and policies from payers often change, and it’s imperative for practices and staff to stay current. Encourage your certified coding staff to attend monthly AAPC local chapter meetings, as well. The more information your staff has, the better equipped they are to manage issues and work with patients.

6. **Cross-train positions:** Consider which roles and responsibilities cross over and cross-train employees. For example, have a floater in your practice who can cover the front office as well as the clinical department.

Thorough, quality training will encourage new employees to excel and help them integrate easier with veteran employees, making day-to-day operations run smoothly.

### Boost Morale

It’s important to provide your employees with a happy, engaging place to work. There are many things you can do to boost morale and foster a team spirit amongst your staff. Celebrate holidays and birthdays, for example. Provide candy or chocolate-covered strawberries on Valentine’s Day or organize an Easter egg hunt that includes prize eggs with money. (It’s so much fun to watch adults fight over eggs!)

At Christmas time, we create employee teams to decorate wreaths. The practice provides the money to cover the cost of the wreaths and decorations. We hang the finished wreaths on exam room doors and let patients vote for the best wreath. The winners receive a gift such as a gift card or personalized company merchandise. It’s amazing how creative your staff can be. And patients love to join in the fun. Building teams with staff members from different departments helps build camaraderie.

When you’re short-staffed, and it will be difficult for employees to take a lunch break, have lunch delivered at the practice’s expense. In the summer, arrange for a food vendor to come to the office.

In my practice, we held a cornhole tournament to raise funds for Relay for Life. Employees paid $5 to enter. The first-place...
winners received a day off with pay and second-place winners received a half day off with pay. This was an inexpensive way to both reward employees and collect donations for the American Cancer Society.

It’s the little things that go a long way in fostering happiness in the workplace. Create a culture where employees want to come to work and feel as though they have some ownership in the practice and you will find that you have a more committed, happier staff.

Show Staff You Appreciate Them
Creating a budget for staff appreciation is a great way to let employees know that you care and appreciate the fantastic job they’re doing. You don’t need a large budget, just one that will give you dedicated funds that can be allotted for your staff.

With this fund, consider purchasing a selection of gift cards to keep on hand ($10, $15, and $25) to surprise deserving employees with. Put the gift card in the mail with a thank you note for whatever it is they did. This kind of gesture is appreciated more than you can imagine.

Another, less expensive, idea is to create coupons that allow staff to come in to work 30 minutes late or leave 30 minutes early with pay. Give these coupons to staff members who go above and beyond, are always eager to help other staff members, are great team players, or are helpful and kind to patients.

Holding a staff appreciation day is also a nice gesture and a great way to build comradery amongst co-workers. If possible, take everyone out to lunch and do an activity such as bowling, an escape room, or a painting class.

Giving each employee their birthday off with pay is another nice way to show employees they are valued and a perk they will likely boast about to others.

Assemble Your Dream Team
You now understand how much goes into attracting and retaining quality employees. From a well thought out recruiting plan to comprehensive training to employee appreciation and engagement, each aspect leads to happier employees and a better work team and workplace. It may be challenging, but the rewards are worth it. All you need is some hard work and dedication to create a culture in which employees will want to be (and stay). HBM

Karen Bowman, FACMPE, CPC, CPMA, has been the practice administrator with Gastrointestinal Associates of Cleveland for 18 years and is a Fellow with the American College of Medical Practice Executives. Bowman is an adjunct faculty member with South College, teaching medical insurance and coding, and serves on the college’s Medical Assisting Advisory Board. She is a past president of Tennessee’s Medical Group Management Association (TMGMA) and currently serves as the American College of Medical Practice Executives (ACMPE) Forum Rep. and on the ACMPE Certification Commission with MGMA. Bowman is president-elect with Cleveland MGMA and has volunteered in several capacities with MGMA and ACMPE. She has served as an officer for local chapters of AAPC and MGMA and has presented to multiple professional organizations. Bowman is married and has two children, one special grandson, and three yorkies.

“Give each new employee the tools necessary to do their job and set expectations for them. People work better when they know what’s expected of them and flourish when proper training protocols are in place.”
AAPC member Kate Tierney, CPC, CPC-P, CDEO, CMPA, CRC, CPC-I, CEDC, CEMC, CGSC, COBGC, has worked in the business side of healthcare for more than 30 years as a coder and administrator. She has spent the last five years employed as a national coding educator for Optum Risk – Quality and Provider Enablement.

AAPC asked Tierney about her experience with earning the Certified Obstetrics Gynecology Coder (COBGC™) credential, how it has helped her career, and what sort of advice she has for anyone considering the specialty certification.

What led you to obtain the COBGC™ credential?
I started my coding career in an ob-gyn office answering phones and placing patients in exam rooms and then began helping with insurance claims when we got a computer and a modem. (Yes, this was a long time ago!) The COBGC™ credential was the logical first specialty certification for me based on my previous experience. When I started teaching coding classes, I knew if I obtained specialty certifications it would help my students and also prove that I had that higher level of knowledge for the rest of my career.

Do you have any tips for individuals preparing for the COBGC™ exam?
Even if you have some ob-gyn coding experience, take the AAPC course, get the study guides and practice exams, and make sure you are REALLY familiar with the CPT® guidelines for billing obstetrics. Many payers have their own rules and exceptions for billing obstetrics, and they can be confusing when taking the exam. Stick to the guidelines in the CPT® book.

How has the COBGC™ credential helped you in your job/career?
I passed the COBGC™ exam in 2006, and that experience helped me develop the material and questions for the ob-gyn chapter of the 2011 AAPC Official CPC® Certification Study Guide. As a coding instructor, I have been able to pass on an extra level of knowledge to my medical coding students, as well as enhance the information I share while teaching the Certified Professional Coder (CPC®) and Certified Risk Adjustment Coder (CRC®) exam review classes for my company and for local chapters.

Who do you think would most benefit from the COBGC™ credential?
Coding instructors, ob-gyn coders, and anyone who would like to expand their knowledge into the area of obstetrics to make themselves more attractive to recruiters and employers. I know that each and every one of my credentials has enhanced my knowledge and credibility while teaching and speaking to providers and students.

What resources do you use most to earn your continuing education units (CEUs)?
Regional and national conferences, local chapter meetings, AAPC webinars, the Centers for Medicare & Medicaid Services (CMS) webinars, and Healthcare Business Monthly magazine. I almost always learn something new from these resources since our codes and guidelines are always changing.

Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.

“When I started teaching coding classes, I knew if I obtained specialty certifications it would help my students and also prove that I had that higher level of knowledge for the rest of my career.”
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