Adapt and Thrive As a Small Clinic

Billing E/M with a Minor Procedure: 28
Bundle or separately bill services when appropriate

Streamline Your Revenue Cycle: 42
Efficiency begins with solid policies and procedures

End EHR Shortcut Misuse: 55
Know the risks and improve documentation
Learn Risk Adjustment Coding

New AAPC online training including HCC

Accurate selection of diagnosis codes plays a vital role in all risk adjustment models. Risk adjustment payment models are gaining momentum in the industry. This can be seen with the increase of Medicare Advantage plans and inclusion of a risk adjustment model for the health care exchanges through the Affordable Care Act. Whether you are an experienced coder in risk adjustment or seeking better understanding, this course will take you through the fundamental principles underlying risk adjustment coding and provide opportunity to practice the new coding skill.

Get Trained Today

- Study different risk adjustment models (HCC, CDPS)
- Identify diagnosis coding's impact on risk adjustment models
- Evaluate the elements of the medical record used for diagnosis code selection
- Review Official Guidelines for Coding and Reporting for ICD-9-CM and ICD-10-CM
- Evaluate the most common conditions included in most risk adjustment models
- Apply concepts by choosing ICD-9-CM codes for 50 notes

Online Course Includes:

- On-demand lectures, online reading materials, quizzes, and a 50 progress note coding assessment
- Seven modules to walk you through risk adjustment coding, including HCC
- 20 hours | 20 CEUs | 3 Months for Completion

800-626-2633
aapc.com/riskadjustment
Thrive as a Small Clinic
By Christopher Phillips

CODER’S VOICE
16 Speak Out About ICD-10
By Jeanne Yoder, RHIA, CPC, CPC-I, CCS-P

32 Face Change Head-On and Learn “To Be”
By Marilyn Holley, RHIT, CPC, CPC-I, CHISP

52 Professional Students Make Better Employees
By Leonta Julien-Williams, RHIT, CPC, CCS
Healthcare Business Monthly | July 2014 | contents

18 Coding/Billing
18 96372 Done Right
   Susan M. Edwards, CPC, CEDC
20 For Chiropractors: Know 97140 Billing Rules
   Heather M. Garcia, CMAA, CBCS, CMB
22 Optimize NPPs in Medicare Advantage Environments
   Holly Cassano, CPC
26 NCCI Version 20.1 Bundles Nurse Visit with Venipuncture
   Erica T. Cousin, CPC, CPC-I
28 Know When to Bill E/M with a Minor Procedure
   Karla Hurraw, CPC-A, CCS-P, and G.J. Verhovshek, MA, CPC

50 Practice Management
40 Open Up ICD-10 Payer and Vendor Communications
   Annie Boynton, BS, RHIT, CPC, CPCO, CPC-H, CPC-P, CPC-I, CCS, CCS-P
42 Streamline Your Revenue Cycle
   Linda Martien, CPC, CPC-H, CPMA
44 Employ Free Training Tools for Your Office
   Joe Ascensio
46 Payment Reform Brings Healthcare Change
   Lamon Willis, CPC, CPCO, CPC-I, CPC-H
50 Engage Patients and Improve Outcomes
   Vern Davenport

60 Auditing/Compliance
55 Watch Out for Misused EHR Documentation Shortcuts
   Ellen Risotti-Hinkle, CPC, CPC-I, CPMA, CEMC, CPC, CIMC
60 Pain Management for Compliance Concerns
   Barry Johnson, DDS, and Renée Dustman

COMING UP
• ICD-10 Positives
• Brain Waves
• Pediatric Cardiology
• HSA Scams
• High Deductibles

DEPARTMENTS
7 Letter from Member Leadership
8 Letters to the Editor
9 Healthcare Business News
10 AAPC Chapter Association
12 2013 Chapter of the Year
24 A&P Tip
24 Why I Code
27 Kudos

EDUCATION
31 A&P Quiz
64 Newly Credentialed Members
66 Minute with a Member
Online
   Test Yourself – Earn 1 CEU
   www.aapc.com/resources/publications/
   healthcare-business-monthly/archive.aspx
Auditors,
we have “THE” conference for you!

As a health care professional working in compliance, auditing and administration, concerns surrounding audits are everywhere — don’t panic, we have you covered!

- The ONLY auditor-specific conference
- ICD-10 training for auditors
- Effectively teach your provider ICD-10
- Multiple tracks with various breakout sessions to choose from
- Hands-on auditing during the main conference

Don’t miss this opportunity to be trained by the official ICD-10 trainers for the American Academy of Orthopaedic Executives and the Texas Medical Association!

Early Bird Special: Register Now!

Take advantage of our Early Bird Special and receive a FREE ticket to the Biltmore for the Christmas Candlelight Tour and Dinner (while supplies last). Register now before this offer runs out!

8th ANNUAL
Auditing Conference 2014
December 7-9, 2014 • Grove Park Inn in Asheville, NC

http://namas.co/events/namas-conference
Go Green!
Why should you sign up to receive Healthcare Business Monthly in digital format?
Here are some great reasons:
• You will save a few trees.
• You won’t have to wait for issues to come in the mail.
• You can read Healthcare Business Monthly on your computer, tablet, or other mobile device—anywhere, anytime.
• You will always know where your issues are.
• Digital issues take up a lot less room in your home or office than paper issues.

Go into your Profile on www.aapc.com and make the change!

Serving 135,000 Members – Including You!

HEALTHCARE BUSINESS MONTHLY
Coding | Billing | Auditing | Compliance | Practice Management
July 2014

Director of Publishing
Brad Ericson, MPC, CPC, COSC
brad.ericson@aapc.com

Managing Editor
John Verhovshek, MA, CPC
g.john.verhovshek@aapc.com

Editorial
Michelle A. Dick, BS
Renee Dustman, BS

Production
Tina M. Smith, AAS
Renee Dustman, BS

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

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

©2014 Healthcare Business Monthly. All rights reserved. Reproduction in whole or in part, in any form, without written permission from AAPC is prohibited. Contributions are welcome. Healthcare Business Monthly is a publication for members of AAPC. Statements of fact or opinion are the responsibility of the authors alone and do not represent an opinion of AAPC, or sponsoring organizations.

CPT® copyright 2013 American Medical Association. All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The responsibility for the content of any “National Correct Coding Policy” included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.

CPT® is a registered trademark of the American Medical Association. CPC®, CPC-H®, CPC-P®, CPC-O®, CPMA®, and CIRCC are registered trademarks of AAPC.

On the Cover:
Christopher Phillips explains how you can benefit from owning an independent medical practice by adapting to healthcare reform. Cover photo by istockphoto©Barcin. Cover design by Tina Smith.
ICD-10: Stop and Smell the Roses

For many months, the most reliable people throughout the industry told us the ICD-10 “go live” date of October 1, 2014 was set in stone. In March, an official announcement informed us that the ICD-10 deadline was being delayed, yet again, to no earlier than October 1, 2015.

A lot of people, including myself, were completely surprised. Months later, I still sense frustration from the majority of people in the healthcare industry. Many have invested heavily in time and money to reach a deadline that no longer exists.

The big question is: What now?

Do What You Do Best

For many providers, their first thought will be to stop where they are, even though the train has already left the station. Trains that stop on a dime, however, are called a “train wreck.”

The delayed “go live” date can either be an obstacle or an asset — the difference is in how you view it. To look at it rationally, there are a few basic realities about ICD-10 that you need to keep in mind.

The first is, regardless of when ICD-10 takes effect, at some point it will happen, so all the training and effort that has gone into readiness has not been in vain. Only the finish line has changed, giving you a little more time to breathe and to make sure critical pieces are in place. The more prepared you are for the inevitable, the fewer issues you will experience when it finally comes.

Secondly, putting off ICD-10 education until next year, or whenever, means you may lose the edge you now have in getting properly trained and certified. Creating and adhering to a “finish line” that incorporates all of your goals, including a more practical timeline to accomplish them, is perhaps a more logical finish line, instead of the previous hard and fast October 1 deadline.

When the training and certification are in place, investing in a maintenance strategy that keeps your training and preparedness fresh and ongoing will ensure changes in deadlines and the passage of time will not become future obstacles.

AAPC Keeps a Watchful Eye

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, vice president of ICD-10 training and education at AAPC, is monitoring this issue and participates at the national level. She recently attended a Workgroup for Electronic Data Interchange (WEDI) meeting, where she serves on the Clinical Documentation workgroup as co-chair. AAPC has also provided testimony on ICD-10 at multiple National Committee on Vital and Health Statistics (NCVHS) meetings. Rest assured, AAPC has its finger on the pulse and will keep us informed as the ICD-10 saga continues to unfold.

Manage Your Stress

Finally, it’s important to remember that no matter which way this pendulum swings, you need to remain calm and resolve in what you do. Containing your fear and reducing stress is a critical part of stepping back and dealing with situations that don’t go according to plan. If you find yourself stressed by ICD-10 and other issues in healthcare, please take a moment to consider the American Heart Association’s top 10 ways for fighting stress with healthy habits:

1. Talk with family and friends daily.
2. Engage in daily physical activity.
3. Accept the things you cannot change.
4. Remember to laugh.
5. Give up bad habits.
6. Slow down and “pace” instead of “race.”
7. Get enough sleep.
8. Get organized in your work and in your life.
9. Practice giving back to others.
10. Try not to worry.

Stress is the release of adrenaline, known as the “fight-or-flight” response. It’s a normal response, resulting in increased heart rate and blood pressure. But chronic stress, sometimes found in our modern lives, is not normal. It can lead to a myriad of psychological and physical ailments, including sleep deprivation, headaches, anger, depression, anxiety, irritability, body aches, etc.

So as we enjoy this summer, please try these healthy habits and, as Mac Davis said in his song, “You got to stop and smell the roses along the way.”

Take care,

David B. Dunn, MD, FACS, CIRCC, CCVTC, CCC, CPC-H, CCS, RCC
President, National Advisory Board
Supervising Physician Signature Requirements

The letter to the editor entitled “Mid-level Providers May Report Services” (May 2014, page 10) states, “…physician assistants must have their notes ‘signed’ by a supervising physician within three days, as do certified registered nurse practitioners at periodic intervals (by license, in Pennsylvania; the rules may differ from state-to-state).”

In fact, per Pennsylvania state regulations (§18.158.d.4), the physician has up to 10 days to review and sign the record:

18.158. Prescribing and dispensing drugs, pharmaceutical aids and devices.

(d) Recordkeeping requirements. Recordkeeping requirements are as follows:
(4) The supervising physician shall countersign the patient record within 10 days.

Authority
The provisions of this §18.158 issued under sections 8, 13, and 36 of the Medical Practice Act of 1985 (63 P.S. §§ 422.8, 422.13 and 422.36).

Source

Cross References
§18.159. Medical records.

95874 Confusion

Reader question: The article “Clinch Chemodenervation Coding” (June 2014, pages 26-27) states:

If the injection(s) is guided by needle electromyography (EMG) or muscle electrical stimulation, you may separately report +95873 Electrical stimulation for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure) or +95874 Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure), as appropriate. Report only a single unit of guidance, regardless of the number of injections performed.

Does this mean you may report +95874 only one time per session?

Response: Parenthetical instruction in the CPT® codebook states, “Do not report more than one guidance code for each corresponding chemodenervation code.” The January 2014 CPT® Assistant further advises:

A parenthetical note was added following code 64615 to direct users to report codes 95873 and 95874 for guidance, and to clarify that it is not appropriate to report more than one guidance code for 64615.... An additional instructional parenthetical note following code 64616 directs users to report codes 95873 and 95874 for chemodenervation guided by needle electromyography or performed by muscle electrical stimulation. This clarifies that it would not be appropriate to report more than one guidance code for any unit of code 64616.

In other words, as correctly stated in the “Clinch Chemodenervation Coding,” you may not report more than a single unit of +95874 per chemodenervation code billed; but you may report one unit of +95874 for each separate chemodenervation code billed during the session, when appropriate. This is supported further by an example in CPT® Assistant:

A patient with painful muscle spasms of upper extremities underwent chemodenervation bilaterally. Three muscles were injected on the left forearm and seven muscles were injected in the right arm and hand. Electromyography guidance was used for each. This service would be reported with one unit of code 64644 (5 or more muscles in an extremity), one unit of code 64643 (1-4 muscles in an additional extremity), and 2 units of code 95874 (2 units of service, one for each limb for electromyography guidance).

Bottom line: You may report a maximum of one unit of +95874 for each separate chemodenervation code reported on a claim.
Interrupted Stay for Long-term Hospital Care Vulnerable

The Office of Inspector General (OIG) conducted a study in 2010 and 2011, which showed Medicare paid $10.3 billion to 449 long-term care hospitals (LTCHs) for services of nearly 254,000 beneficiaries.

LTCHs are used to treat patients with complex medical conditions, and sometimes patients may leave treatment at an LTCH and return later. These services are costly; and to save money, Medicare counts them as another provider (co-located LTCHs) had inappropriate payments, financial incentives to delay readmissions, and potential overpayments.

There were concerns about whether financial incentives, rather than beneficiaries’ medical conditions, are influencing LTCHs’ readmission decisions.

The OIG wants CMS to analyze whether financial incentives influence LTCHs’ readmission decisions and to take action regarding LTCHs exhibiting certain readmission patterns and against identified overpayments.

Open Data Initiatives Announced for Health Datapoloza

Rumored to coincide with Health Data Consortium’s Health Datapoloza (June 1-3, 2014), the Centers for Medicare & Medicaid Services (CMS) and the U.S. Food and Drug Administration (FDA) released major announcements affecting open data.

CMS announcements elaborated on public healthcare utilization, including the first annual update to the hospital charge data that was released in the spring of 2013, and details for comparing patient and outpatient services against average payments for a service. CMS also announced adding analytic tools, such as Geographic Variation Dashboards (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_Dashboard.html), which show how charges differ between states and county comparisons. With raw data available for download, researchers can review healthcare billing data trends.

CMS released a research cohort tool (www.ccwdata.org/web/guest/pricing/estimate-study-size) for its Chronic Conditions Data Warehouse to help researchers with demographic profiles and health conditions data of Medicare beneficiaries.

FDA announcements included application programming interface (API) access through OpenFDA (http://open.fda.gov/) to its database of adverse drug reaction reports. OpenFDA provides API and raw download access to structured datasets and is being public beta tested. According to a June 2 FDA press release, OpenFDA will make:

… the FDA’s publicly available data accessible in a structured, computer readable format that will make it possible for technology specialists, such as mobile application creators, web developers, data visualization artists and researchers to quickly search, query, or pull massive amounts of public information instantaneously and directly from FDA datasets on as as needed basis.
How Does the ICD-10 Delay Affect You?

We randomly asked members about ICD-10’s delay at HEALTHCON. Here’s what they had to say.

Unless you have been hiding under a rock for the last few months, you have heard the news that ICD-10 has been delayed until October 1, 2015. The news of the delay came just two weeks before AAPC National Conference, HEALTHCON, in Nashville, Tenn., and it was one of the hottest topics at the venue. We asked conference attendees what they thought about the delay.

Let’s be clear: This was not a scientific survey. Members of the AAPC Chapter Association board of directors randomly asked conference attendees if they’d be willing to answer some questions about the ICD-10 delay. We heard from consultants, trainers, a physician, a nurse practitioner, and coders who work for small practices, large practices, and payers. We talked to 32 different people and, although there were some definite trends in their answers, it’s important to remember that this survey was conducted solely for the purpose of writing this article, and the results should not be interpreted to represent AAPC membership as a whole.

**Were you happy that ICD-10 was delayed? Why or why not?**

Of the people surveyed, 72 percent were unhappy with the delay, 22 percent were happy. Most of the unhappy respondents expressed frustration, disappointment, and even dismay at the amount of resources (both time and money) that had been spent by organizations and individuals to do what was necessary to prepare for October 1, 2014. There were concerns about retaining information that has been learned, both for coders and physicians. Some feared the prospect of job losses for those who were specifically hired to help with the predicted productivity losses inherent in ICD-10 implementation.

**What should you do with the extra time?**

Now that we have until October 1, 2015 before ICD-10 is implemented, we have adequate time to prepare correctly if we keep moving forward. Testing is a key to success. Unprepared coders will put their practices at risk for revenue disruptions. Here are some ways you can help your practice to get on the right track.

- Make sure you thoroughly understand the pathophysiology of conditions your practice treats. This will allow for greater productivity and fewer queries to your physicians.
- Dual code often! Get your ICD-10-CM productivity rate up to what it is using ICD-9-CM.
- Work with your physician on clinical documentation to make sure there is enough documentation to assign the most specific ICD-10-CM code.
- Engage with vendors, clearinghouses, practice management systems, etc., and get on their radar for testing. If they can’t test with you, make sure they have good testing results when testing with others, and learn from that.
- Work with your health plans to determine what policy changes they are making, so your practice is prepared for changes coming your way.

It’s important to keep moving forward; if not, you’ll find yourself in the same boat next year, without learning from the past. Use this time wisely to make sure your physicians don’t suffer from revenue disruptions or lost productivity. Together, we can do it.

**Side note:** AAPC is offering free refresher webinars to anyone taking AAPC ICD-10 code set training by September 30, 2015.

Of the people surveyed, 72 percent were unhappy with the delay, 22 percent were happy, and one person expressed mixed feelings about it.
Stay on Top of Handbook Changes to Ensure Chapter Success

AAPC’s *Local Chapter Handbook* contains essential guidance and best practices for officers and members to follow to ensure the success of their local chapter. The handbook is updated twice per year (January and July) to reflect changed policies and share new insight.

- Some of the most important changes released this month will assist chapter secretaries. Officer meeting minutes no longer need to be uploaded to the AAPC national office; you’ll find this information in chapter 5, section 9. Secretaries do, however, need to keep a copy of the minutes in case the Local Chapter Department wants to review them. Please continue to upload a copy of your officer business meeting minutes.
- **Vice presidents** must hand in a list of all new officers accepting positions for the new year to the Local Chapter Department no later than January 1.
- To receive fourth quarter reimbursement, **treasurers** must submit requests with all financial statements (e.g., profit and loss statement, copies of all bank checking and savings account statements, etc.) no later than December 31.
- **Officers** can stay on top of the news from the Local Chapter Department by checking the Officer page on the AAPC website. They can also receive free continuing education units for reading the *Local Officer News* and answering a few questions.

To stay on top of semi-annual updates, consider downloading the latest version of the *Local Chapter Handbook* from AAPC’s website in January and July.

---

**Seven Reasons Why You Should Attend Webinars/Audio Conferences At [www.audioeducator.com](http://www.audioeducator.com)!**

1. **Save money on travel:** Our conferences are available from the comfort and convenience of your own office or meeting room.
2. **Meet your specific training needs:** Whether you attend a live event, load up one of our encore broadcasts, or purchase a DVD or PDF transcript - you’ll get the information you need on your schedule.
3. **Keep learning after the event:** Every conference purchase includes the speaker’s materials so you can keep learning long after the conference is over.
4. **Save time training your whole staff:** Gather around a speaker phone or computer and enlighten your entire team for one low price.
5. **Earn savings for virtual team or multiple locations:** If you work with a virtual team or multiple locations, ask our customer specialists about discounts for your whole staff.
6. **Get tips & strategies on coding and compliance topics:** Our nationally-known expert presenters bring you the best advice available to help you do your job and progress in your career.
7. **Meet your annual CEU requirement:** Most of our coding/billing conferences do provide AAPC or AHIMA approved CEUs.

Log on to [www.audioeducator.com](http://www.audioeducator.com) and check our upcoming and on-demand webinars for your specialty. You can also buy DVD recordings and PDF transcripts.

**DISCOUNT:** If you register for an event now, enter **AAPC10** at checkout for 10% discount!
Spartanburg, S.C.

Spartanburg’s game plan for 2013 was to win.

In 2013, Spartanburg, S.C., set out to become the AAPC Chapter of the Year, and they surely accomplished their goal. Allison Busbin, CPC, CPCD, 2013 president, said, “We won this award because of our determination to be a top-notch chapter, to provide education, and to be a support system to coders in our area.” Busbin said that she “presented this goal to the officers and chapter in January and each person played a part in receiving this award. Everyone rose to the challenge!” Brandi Downen, CPC, said, “All the chapter members became excited to make our chapter the chapter of the year. We all worked very well together as a team,” to achieve this goal.

Over the last five years Spartanburg has significantly grown in membership, events, and support. They now have 221 members and are growing strong. The officers who went above and beyond to make 2013 a successful year for Spartanburg were:

By Michelle A. Dick

2013 Chapter of the Year
Chapter of the Year

Spartanburg was off the charts in regards to holding meetings, proctoring exams, and bringing coding education to local colleges.

President: Allison Ray Busbin, CPC, CPCD
Vice president: Brandi Parham Downen, CPC
Secretary: Melissa Stanley, CPC
Treasurer: Courtney Clary, CPC
Education officer: Sheri C. Smith, CPC, CHONC
Member development: Tamela J. Walker, CPC
Special helper: Steven Scott Sisk, CPC

Head Coach and Cheerleader, Allison Busbin

An exceptional chapter needs a person to take the lead and inspire success. It’s clear that with Allison Busbin’s leadership and motivation — and with chapter teamwork — Spartanburg rose to the ranks as AAPC’s No. 1 chapter. With Busbin’s direction and enthusiasm, Spartanburg officers came together to make a fantastic year for their chapter.

2013 Education Officer Sheri Smith, CPC, CHONC, said, “I worked with some great people this past year as an officer and I give a huge part of the chapter’s success to our president, Allison Busbin. She went above and beyond and brought a lot of energy and motivation to Spartanburg.” Smith continued, “Allison kept all of the officers really motivated to give our members a great year of fellowship and education.”

Courtney Clary, CPC, 2014 president, agreed with Smith’s assessment of Busbin’s leadership and chapter members’ dedication, which brought pride to Spartanburg. “What really makes me proud of this past year has been all of the hard work and dedication of our officers and chapter members to be Chapter of the Year,” Clary said. “I would especially like to recognize last year’s president, Allison Busbin, because without her this would have never happened.” 2013 secretary Melissa Stanley, CPC, added that it was Busbin’s strong leadership and organizational skills, and a lot of time and hard work on her part, that made winning possible.

Exceeding Chapter Goals

Spartanburg was off the charts in regards to holding meetings, proctoring exams, and bringing coding education to local colleges, AAPC’s Director of Local Chapter Support, Marri Johnson, said this chapter had numerous accomplishments in 2013, among them:

- Minutes for all meetings were submitted
- Proctored eight exams (only four are required)
  - Four were to proctor students for colleges
- Their profit and loss information was submitted before the December 31 deadline
- All quarterly reimbursement information was submitted by each required deadline
- Each of the incoming officers met with the outgoing officers and reviewed responsibilities
- Outgoing officers committed to be mentors for those taking on new positions
- Chapter members represented AAPC professionally and with positive leadership attitudes
- Several members spoke at colleges

Teamwork was a key factor to Spartanburg’s success. Scott Sisk, CPC, said, “Everyone is always willing to help each other any way they can. Anytime there is something to be done, all you have to do is let everyone know and it gets taken care of.”
Feeding Hungry Children
Spartanburg’s charity work speaks volumes about their chapter, as well. Smith said, “Allison chose an organization called Backpack Buddies for our chapter to sponsor last year and it was such a great success.” The Spartanburg chapter donated huge amounts of snacks, drinks, and meals to the Backpack Buddies program, which ensures elementary students in Spartanburg County do not go hungry on weekends and holiday breaks. Children, selected by school administration, are each given a bag full of food on Friday to put into their backpacks and take home. Busbin hand delivered the chapter’s food donations to the charity.

Encouraging New Members to Join the Team
Networking with new or potential members is important to Spartanburg. Last year’s Member Development Officer Tamela J. Walker, CPC, said the chapter’s environment is always upbeat and happy, which makes new attendees want to come back for more. The chapter makes it known that they are excited about AAPC and coding, and it makes a point to welcome new members, mentor, and help students become successful.

“We do lots of things to welcome new members,” Walker said. “We have two community colleges [Spartanburg Community College and Virginia College] in our area that have programs for medical coding and billing. Several members in our chapter mentor some of these students each year. As part of their education, they spend time in medical offices to help them get hands-on experience with coding.

“When they join AAPC, many of these new members start coming to chapter meetings. We welcome them face to face when they attend a meeting and introduce ourselves so they can become familiar with chapter members. Many of them are new employees or are currently looking for jobs, so we ask about their progress and share information about possible jobs in the area. We actively engage these new members in conversation.

“In Spartanburg, we support each other. There is a wonderful feeling of working together. The hospital system, as well as physicians, are very supportive.”

2014 Chapter of the Year: Any Takers?
AAPC wants to recognize thriving local chapters that exceed requirements. If you think your chapter has what it takes to qualify for AAPC’s Chapter of the Year award, go to “Chapter 10 - Chapter of The Year Award” in your Local Chapter Handbook (http://cloud.aapc.com/localchapters/2014LC_handbook.pdf) and find out if you are eligible to win.
The Albany, N.Y., chapter accomplished so much through the hard work and dedication of 2013’s officers:

President: Lynn M. Nobes, CPC, CPC-I, CEMC
Vice president: Michelle M. Mesley-Netoskie, CPC
Secretary: Linda L. Ambrose, CPC
Treasurer: Deborah Bedard, CPC
Member development: Kathryn M. Glasser, CPC

Albany, N.Y. Takes Honorable Mention

Spartanburg, S.C., had tough competition in 2013. While there were many chapters that excelled in several ways, the Albany, N.Y., chapter merits an honorable mention for its many accomplishments last year.

In 2013, Albany:
- Held 13 meetings (only six are required)
- Minutes were uploaded for each meeting
- The officers all completed officer training
- Proctored 12 exams (only four are required)
  - A total of 250 exam-takers were accommodated through the year
- Donated $147 to Project AAPC for tornado victims
- Implemented a “Reward Points” system, where members could participate and win rewards
- Held a NYS Coders’ Day celebration, where the first “Denise Casso Scholarship” winner was presented with $300
- Hosted an AAPC ICD-10 Bootcamp

Members Are Active

The Albany chapter board members work hard as a team and have a very responsive membership, according to 2013 President Lynn M. Nobes, CPC, CPC-I, CEMC. In 2010, the Albany chapter was the “Grand Prize Winner – Most Guests” for May MAYnia. In 2013, they established a Rewards Program, and Nobes says that since its implementation, their 600 members have become more involved. Members receive a raffle ticket stub for every five reward points they earn. Points are allotted as follows:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteer to speak at a chapter meeting</td>
<td>50</td>
</tr>
<tr>
<td>Proctor an exam</td>
<td>30</td>
</tr>
<tr>
<td>Arrange for a speaker</td>
<td>25</td>
</tr>
<tr>
<td>Volunteer to serve on a committee</td>
<td>20</td>
</tr>
<tr>
<td>(e.g., May MAYnia, autopsy video, Coder’s Day celebration)</td>
<td></td>
</tr>
<tr>
<td>Assisting in the setup/cleanup at a monthly meeting</td>
<td>10</td>
</tr>
<tr>
<td>Post on AAPC in Albany N.Y. chapter forum</td>
<td>10</td>
</tr>
<tr>
<td>Chapter meeting attendance (per meeting)</td>
<td>5</td>
</tr>
</tbody>
</table>

Prizes are drawn, and the more points members earn, the more chances they have to win a prize.

An Officer’s Legacy Lives On

The Albany chapter reaches out and supports the local coding educational programs by offering the Denise Casso Scholarship. In 2012, Albany’s education officer, Denise Casso, passed away. She was a dedicated member of the Albany chapter and served on the executive board and as past secretary. Casso was friendly, helpful, and a positive role model to members. After her passing, the Denise Casso Scholarship was established to aid a student who is active in the chapter in the cost of his or her tuition or exam.

Autopsies! Yes, Please.

One thing that made the Albany chapter unique in 2013 was a showing of “Live Autopsy” by Dr. Gunther Von Hagens. It sold out for three sessions, and was limited to 50 members for each session. Members earned three CEUs and enjoyed a continental breakfast. In the future, the chapter plans a trip to New York City to see Von Hagens’ “Body Worlds.”

It’s Like Winning a Gold Medal

Albany was thrilled to be recognized with this honor. Nobes said, “It felt like we won a gold medal!” The chapter enthusiasm and excitement continues. Michelle M. Mesley-Netoskie, CPC, said, “I have been a chapter member for almost 10 years and I have never seen such excitement and networking among the chapter members, and the momentum has carried through to this year.”

The Albany, N.Y., chapter accomplished so much through the hard work and dedication of 2013’s officers:

President: Lynn M. Nobes, CPC, CPC-I, CEMC
Vice president: Michelle M. Mesley-Netoskie, CPC
Secretary: Linda L. Ambrose, CPC
Treasurer: Deborah Bedard, CPC
Member development: Kathryn M. Glasser, CPC

More Milestones Ahead

According to Busbin, Spartanburg’s future goal is to continue their progress. “We would love to hold more education sessions and even another seminar,” she said. “Our main goal is to continue to represent each member and AAPC as the best!” HBM

Michelle A. Dick is executive editor at AAPC.
Speak Out

About ICD-10

Do you want to do something that takes five minutes, and will make our country a better place? Write to your elective representative, and tell him or her that ICD-10-CM needs to be implemented—the sooner, the better!

Tell your elective representative that you care about the health of newborns, and that only ICD-10-CM provides the medical community with data to indicate the trimester when the mother was exposed to an infectious disease, took a drug, or fell. Tell him or her that we need a code set that (unlike ICD-9-CM) is being maintained, because new diseases, such as Middle East respiratory syndrome (MERS-CoV) and chikungunya (A92.0 Chikungunya virus disease), are entering the United States.

Tell your elective representative that, although ICD-10-CM may take us out of our comfort zone, we need to make the change. Tackling climate change is daunting, but ensuring we can code for epidemiology is within our grasp. The end of world hunger is hard to fathom, but an inpatient procedure system that accurately reflects hospital services is foreseeable. The United States already wastes millions annually because it does not use the (world standard) metric system; let’s not repeat this mistake by continuing to use an archaic medical data collection system.

We are up to the task of implementing ICD-10. Now we must make our elective representatives understand the importance of data, which will allow us to advance medicine into the future.

Tell your elective representative that this is a “jobs issue.” Tell him or her how you were scheduled to graduate, but now you will be delayed six months because you need to learn ICD-9-CM. Explain that you paid for your own courses to be ready for ICD-10-CM. Explain how your practice invested in training and had everything set to transition to a new billing system. Explain how the uncertainty affects you, the elective representative’s constituent.

Tell your elective representative, the longer we wait, the more expensive and difficult the transition will be. Tell him or her there needs to be a House rule, this session, that says, “The Secretary of U.S. Department of Health & Human Services will, on October 1, 2015, adopt ICD-10 as the standard code set under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.”

Expect to receive a canned response. That is the way it works. When an issue comes up, the elective representative asks his or her employees if there has been constituent input. That is when your email or
We need to make sure all of our letters explain in short, simple sentences why ICD-10 transition is important. The more feedback your elective representative has regarding the need for transition on October 1, 2015, the better chance we have of joining the rest of the world in using ICD-10-CM.

Jeanne Yoder, RHIA, CPC, CPC-I, CCS-P, is retired from the U.S. Air Force and is now a contractor working for the TRICARE Management Activity. She presented at the 2006-2009 AAPC national conferences. Her goal is to have quality data to help make quality decisions.

Tips for Contacting Your Elective Representatives

To contact your elective representatives, I recommend you start with the U.S. House of Representatives because that is where many bills start. If you don’t know your representatives, go to www.house.gov/representatives/find/ and enter your zip code to see the names, photos, and mailing addresses of your local representatives.

Snail mail is probably the most impressive way to contact your representatives, especially if your note is handwritten. You can also call (202) 225-3121 for the U.S. House switchboard operator. If you prefer email, enter your representative’s name and “congressman” in a search engine and look for email addresses ending in “house.gov.”

Elective representatives’ websites are not uniform. You may need to look around the website to figure out how to send the email. In doing this, you may determine one of your representatives has greater influence based on his or her committee membership. With regard to ICD-10-CM, those representatives on the Energy and Commerce Committee (and especially those on the Health Subcommittee of the Energy and Commerce Committee) have the greatest influence.

When contacting an elective representative, explain your position in your own words. This shows “grass roots” involvement. Copying and pasting a national organization’s narrative is obvious, and significantly discounts the effect your correspondence will have on the elective representative.
96372 Done Right

Dodge denials and recoup proper reimbursement for injections.

Across the country, in offices and facilities, coders are having trouble with CPT® 96372 Therapeutic, prophylactic, or diagnostic injection, specify substance, or drug; subcutaneous or intramuscular. Providers are not being paid for this injection administration code because it is being applied incorrectly, insurance companies say. Here’s why.

The primary intent of an injection as described by 96372 is generally to deliver a small volume of medication in a single shot. The substance is given directly by subcutaneous (sub-Q), intramuscular (IM), or intra-arterial (IA) routes, as opposed to an intravenous (IV) injection/push that requires a commitment of time.

The injection codes (96372 and 96373 Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial) may be reported with any hydration therapy, IV drug administration, or chemotherapy administration during the same encounter.

Follow this guidance, as well:

- Code assignment for sub-Q, IM, or IA injection procedures does not affect the primary or secondary intent of the encounter.
- Each medically necessary injection can be billed separately, regardless of whether the injection is subsequent, or not for a new drug. The exception to this rule is the single preparation of the sub-Q or
To bill an E/M service with a minor office procedure (such as an injection), you must have documentation supporting the need for an additional assessment beyond that for the injection.

IM dose that exceeds the volume safely injected at a single site. When the volume of an injected dose requires it to be split into two or more syringes, you may bill only a single unit of service for 96372. For example, if you administer two separate drugs, but use three injections to administer them, you would report two injections (96372, 96372-59 Distinct procedural service, and the drug supply codes).

- Sub-Q infusions lasting 15 minutes or less are reported with the sub-Q/IM injection code for drug administration, 96372.

**Injection with Separate E/M**

All procedures are valued for reimbursement to include an assessment of the patient at the encounter (vital signs, appearance of the patient, etc.). If a procedure is scheduled in advance of the encounter, the medical necessity for that procedure has already been determined and the treatment has already been decided. This was the purpose of the previous evaluation and management (E/M) service, and you cannot charge again for an E/M service for the identical problem on the day of a pre-planned injection.

To bill an E/M service with a minor office procedure (such as an injection), you must have documentation supporting the need for an additional assessment beyond that for the injection. This is not possible with a scheduled injection performed by a nurse. The nurse is only following physician orders; if anything is out of the ordinary, the physician is called in, the injection is abandoned, and a higher level E/M is reported.

For example, in an obstetric/gynecology office setting, a Depo-Provera® (Depo) injection would be a scheduled visit reported with 96372 only. Reporting an additional E/M service code (e.g., 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional) for this visit would be inappropriate.

**Bottom Line:** Insurance payers are not paying 99211 when reported on the same date of service as 96372. If you report these codes in combination, the payer will deny the claim. But if you report any other E/M code on the same day of service, and properly append modifier 25 Significant, separately identifiable 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 indicate a significant, separately identifiable E/M service was provided, the claim may be paid.

For example, a patient presents for an office visit for pelvic pain. During the visit, the physician notices the patient is due for a Depo shot. The physician gives the patient her Depo injection at the end of the office visit. The office visit is billable as 99214-25 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity, along with the injection, 96372.

**Facility Reporting**

When reporting injections in the facility setting, consider the following:

- You may report 96372 in the facility without the physician present.
- Injections for allergen immunotherapy have their own administration codes, 95115-95117.
- Do not report 96365-96379 with any codes that describe a procedure of which IV push or infusion are a part.
- Hospitals may not report an E/M code in addition to 96372 or 96373 when the sole purpose of the visit is drug administration.

This guidance should resolve any problems you were having with 96372. The rules for IV push, infusions, and hydrations are more complex, however. Refer to the Medicine section of the CPT® codebook to find the “Hydration, Therapeutic, and Chemotherapy” section for the guidelines. There is a hierarchy for the injection and infusion therapy, with which you must be familiar.

Susan M. Edwards, CPC, CEDC, is a member of the 2013-2015 AAPC National Advisory Board, representing the Northeast Region. She has also served on the AAPC Chapter Association, Northeast Region, from 2010-2013, and the AAPC Ethics Committee. Edwards has held office as president, vice-president, education officer, and secretary of the Newport, Vt., local chapter. She works at Copley Hospital in Morrisville, Vt.
For Chiropractors: Know 97140 Billing Rules

Your options can mean the difference between getting paid and not getting paid.

Aetna has made a nationwide policy decision for chiropractic reimbursement, which states that when manual therapy (97140 Manual therapy techniques, one or more regions, each 15 minutes) is performed on the same date of service (DOS) as a chiropractic manipulative treatment (98940-98943), the manual therapy will be denied, automatically. There are two options to overcome this:

1. Perform the manual therapy service on a different DOS than the adjustment (if your state scope of services permits it); or
2. Submit the services together, anticipate the denial, and submit an appeal with your treatment records.

Keep in mind: Appeals will work if you are an out-of-network provider and will be less effective if you are an in-network provider. If you are in network, you have agreed to Aetna’s policies (through your contracts), and you’ll most likely need to write off reimbursement for 97140. In-network providers cannot bill the patient. Out-of-network providers can bill the patient, if necessary.

Aetna defends its policy of automatic denial. A review of services determined that 90 percent of audited patients receiving manual therapy on the same day as a chiropractic manipulative treatment had the services performed on the same region(s), although modifier 59 Distinct procedural service is supposed to be used only when the services are performed on different anatomic regions.

Apply 97410 Properly

Per CPT® guidelines, 97140 describes manual therapy techniques, such as mobilization and manipulation, manual lymphatic drainage, and manual traction. Chiropractic adjustments have their own set of codes (98940-98942, or 98943 for an extremity). If you report a subluxation diagnosis code, you must perform an adjustment — especially if you are in a state where you need a nexus to the spine to bill anything other than the adjustment.

National Correct Coding Initiative (NCCI) claim edits bundle manual therapy (97140) to chiropractic adjustment codes (98940-98942) when performed in the same anatomic region. If the procedures are performed in separate anatomic regions, you may report them separately by appending modifier 59 to the adjustment code (97410 is the “column 2” procedure). If the claim is properly filed and supported by documentation, the insurer should pay for both procedures.

Example 1: The chiropractor performs chiropractic adjustment (98940 Chiropractic manipulative treatment (CMT): spinal, 1-2 re-
National Correct Coding Initiative (NCCI) claim edits bundle manual therapy (97140) to chiropractic adjustment codes (98940-98942) when performed in the same anatomic region.

gions) on the cervical region. He then performs manual therapy (97140) to the same cervical region. The patient’s diagnosis codes reflect a cervical subluxation (739.1 Nonallopathic lesions, cervical region) and muscle spasms (728.85 Spasm of muscle). The manual therapy (97140) would not be reimbursable in this scenario.

**Example 2:** The chiropractor performs chiropractic adjustment (98941 Chiropractic manipulative treatment (CMT); spinal, 3-4 regions) on the cervical and lumbar regions. He or she then performs manual therapy (97140) on the patient’s shoulder. The patient’s diagnosis codes are cervical subluxation (739.1), lumbar degenerative disc disease (722.52 Degeneration of lumbar or lumbosacral intervertebral disc), adhesive capsulitis (726.0 Adhesive capsulitis of shoulder), and muscle spasms (728.85). The diagnosis pointers link the manual therapy (97140) to the diagnosis codes adhesive capsulitis (726.0) and muscle spasms (728.85). In this scenario, the manual therapy would be separately reimbursable if reported with modifier 59 appended.

To best support payment and minimize audit red flags, the provider’s notes should include:

1. Indications for treatment (manual therapy)
2. Treatment goals associated with manual therapy services
3. Objective measures used to ensure patient progresses in treatment goals
4. Progression towards treatment goals
5. Which regions, specifically, were treated with manual therapy and with your chiropractic adjustment; these areas should not coincide if you want to receive separate reimbursement.
6. Treatment plan (include frequency and duration)

**Handle Aetna Appeals**

Based on my experience billing to Aetna, you do not have to wait for Aetna to deny your claims for same-session manual therapy and chiropractic adjustment to file an appeal. You can send the notes with the original claim. This means you have to send the claims on paper. Paper claims have a longer processing time and this may hinder your cash flow.

If you do wait for a denial, you can get a partial payment at that time, and then wait for payment on the second code (through the appeal process). For smaller offices, it may be easier to track the appeals. For medium to larger offices, it may be easier to submit the original claims with the notes, so you do not have to track tons of appeals. Decide what works best for your practice.

**Billing Several Modalities**

Note that Aetna usually only allows payment for four modalities per visit. This raises a question: If you bill for five or six modalities, for instance, and Aetna only pays for four modalities, should you bother appealing 97140? I suggest you don’t have to appeal because you won’t receive additional compensation, in any case. But be aware some Aetna plans will reimburse for more than four modalities. Be sure, however, that your definition of a modality is the same as Aetna’s. For example, office visits are not part of the four-modality cap. This means that when supported by medical necessity, you can render an office visit in addition to four modalities. Just because Aetna paid on four codes, doesn’t mean they’ve paid on four modalities.

To help ensure your claims are processed correctly, in addition to sending your doctor’s notes with the original claim, use diagnosis pointers. Most billing programs default diagnosis pointers to 1, 2, 3, etc., or now A, B, C, etc., on the new claim forms, depending on how many diagnosis codes you input. Diagnosis pointing is under-utilized in billing, especially in the chiropractic world. Using diagnosis pointers can help differentiate the region(s) adjusted/manipulated from the region(s) on which the doctor performed manual therapy (97140).

**Additional resources:** Aetna Clinical Policy Bulletin: Chiropractic Services Number: 0107

---

**What Are Diagnosis Pointers?**

Diagnosis pointers are the numbers (now letters on the new claim form) in box 24E on the CMS 1500 form. Diagnosis pointers link the diagnosis to the applicable CPT® codes you are billing. For example, you can have three diagnosis on your claim forms but each of them go to only one of the CPT® codes you are billing for that day. It explains the reason you are performing the particular CPT® code.

---

Heather M. Garcia, CBCS, CMAA, CMB, has been in the medical billing and consulting business for over 13 years. She launched Smart Healthcare Solutions Corp. in 2005. Garcia has been an expert witness in New York litigation trials and has also participated in the Medical Assistant/Medical Coding and Billing Advisory Board for Lincoln Tech. She is a member of the Upper Saddle River, N.J., local chapter.

---

**National Correct Coding Initiative (NCCI) claim edits bundle manual therapy (97140) to chiropractic adjustment codes (98940-98942) when performed in the same anatomic region.**
Optimize NPPs
in Medicare Advantage Environments

2013 was a dismal year for Medicare Advantage (MA) plans. The Centers for Medicare & Medicaid Services (CMS) elected to retain a coding intensity adjustment of approximately 3.4 percent. And from January 1, 2013 to December 31, 2013 risk scores that included diagnosis/hierarchical condition categories (HCC) data experienced a reimbursement decline of nearly 2 percent, which had a significant, negative impact on MA plans. The Affordable Care Act mandated CMS to increase the adjustment to approximately 5 percent for 2014, and 2015 isn’t looking any better. The most recent federal budget calls for a coding intensity adjustment for MA plans equal to nearly $31 billion.

Plans that focus primarily on quality bonus payments will end up losing in the downward spiral of MA coding intensity adjustments. Medicare also uses information from member satisfaction surveys, plans, and healthcare providers to give overall performance star ratings to plans. Plans that earn fewer than four stars will not receive the highly-anticipated quality bonus payments.

Ways to Fight Back
MA plans and primary care providers can do several things to offset these cuts. Start by looking at who is providing care directly to MA plan members, and how chronic conditions are reported to the plans.

MA plans need to focus on provider groups whose risk scores fall below their peers’ scores (for both Medicare Parts C and D), and fine-tune those HCCs. First, identify the groups that have a low volume (or no volume) of reported Part C HCC codes. Next, review the Part D HCC codes. If medications are being prescribed, renewed, etc., but Part C HCCs are under-reported or not reported, there is a major disparity with that provider or provider group.

Several chronic disease conditions are consistently under-reported or not reported accurately by providers who participate in MA plans. These include:

Chronic Diseases
- Diabetes with manifestations
- Chronic kidney disease – stages 4 and 5
  440.0 Atherosclerosis of aorta
- Abdominal aortic aneurysm – 441.1 Thoracic aneurysm, ruptured (without repair)
- Amputations
  V49.75 Below knee amputation status
  V49.76 Above knee amputation status
  V49.71 Great toe amputation status
  V49.72 Other toe(s) amputation status
  V49.73 Foot amputation status
- Artificial openings
  V44.0 Tracheostomy status
  V44.1 Gastrostomy status

Tap this valuable resource to ensure HCCs are reported correctly and to offset reimbursement declines.
Several chronic disease conditions are consistently under-reported or not reported accurately by providers who participate in MA plans.

V44.2 Ileostomy status
V44.3 Colostomy status

Focusing on chronic disease reporting, by virtue of HCC codes, is critical to the mission of retrospective and prospective chart reviews, and is key to clinical documentation improvement and overall correct reimbursement from CMS.

Use NPPs to Assist with HCC Reporting

Non-physician practitioners (NPPs), such as nurse practitioners, are most often interacting with the patients directly on the “front lines.” They deliver care on the doctor’s behalf in the office, skilled nursing facility (SNF), assisted living facility (ALF), home health, and outpatient/inpatient facility settings. Who better than NPPs to assist MA plans and providers?

A study recently published in Preventing Chronic Disease states, “NPPs are much more likely to provide education and advice over a physician, as they have more time generally to spend with the patient.” The study, led by Tamara S. Ritsema at the University of Nebraska Medical Center, collected and reviewed four years of data on more than 130,000 patients’ outpatient office visits. The study focused on eight specific chronic conditions, including:

- Depression
- Obesity
- Diabetes
- Ischemic heart disease
- Hypertension
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Hyperlipidemia

Ritsema’s study results indicate that overall patient education is low for all provider types; however, NPPs achieve a significantly higher percentage in this area than physicians under the same study conditions. The problem isn’t necessarily that good care isn’t being rendered, but that good documentation isn’t taking place.

Another study by the National Association for Home Care and Hospice (NAHC) speaks to the disparity of reported chronic conditions, overall and within the risk adjustment community. The NAHC states in the report, “There remains substantial risk score improvement in medical records that is not being realized.” NAHC strongly encourages hospice and home health providers to ensure all related diagnoses are submitted on all claims, codes are sequenced properly, and all other correct coding guidelines for reporting ICD-9-CM codes are followed.

NAHC has made additional recommendations:

- Engage in clinical documentation improvement activities.
- Diseases must be documented in the medical record; they cannot be coded if they are not documented.
- Member-specific (risk adjustment data validation [RADV]-style) chart audits performed on larger scales will expose documentation issues for many providers.
- NAHC will continue to encourage prospective assessments and retrospective medical record reviews.
- Access to historical medical records will be part of the new landscape for MA.

Stop Under-utilizing Your Best Assets!

Nurses are often under-utilized in the risk adjustment marketplace, and Ritsema’s study speaks on that issue. Since CMS mandated the health risk assessment (HRA) two years ago, it has been a struggle for many providers to get them done — let alone have an annual wellness visit paired with the HRA.

MA plans need to look at and reach out to provider types employed in the offices of their primary care providers and to the local visiting nurse associations (VNAs) who visit members in SNF/ALF/home health settings. If the MA plans start to focus on the added value to risk adjustment documentation that NPPs and VNAs provide, MA plans and providers will understand that these NPPs can be a key resource for providing accurate and timely documentation on member’s chronic conditions, and will achieve better reporting of HCC codes.

Holly Cassano, CPC, is director of Coding Compliance and Education for Tactical Management Inc., (TMI) and CEO of ACCUCODE Consulting, LLC. She is a member of the Tampa, Fla., local chapter.

Resources:

- HHS risk adjustment methodology changes and updates:
- Medicare risk adjustment information:
  www.cms.gov/Medicare/Health-Plans/MedicareAdvantage/MedicareAdvantage-Special-Needs-Plan-Disadvantaged-Programs/HRA.html
- The Centers for Disease Control and Prevention, Differences in the Delivery of Health Education to Patients with Chronic Disease by Provider Type, 2005–2009: www.cdc.gov/pcd/issues/2014/pdf/13_0175.pdf
- The NAHC report: www.nahc.org/NAHCReport/nr130509_1/

STOP 

www.aapc.com July 2014 23
Why I Code

Denise A. Jones, CPPM

I think coding chose me. I didn’t plan to go into coding, but 25 years later, I still love it. I find medicine and coding so fascinating, and I’m proud to work as clinical coordinator at Ahrens Clinic.

To me, coding is like solving a mystery or a puzzle: You gather all of your clues, put the pieces together, and reach a conclusion.

I have a rule: If I stumble on a medical term, diagnosis, symptom, etc., I don’t skip over it. I research it using a medical dictionary to get a basic idea of what it is, and then I ask my provider to explain further.

I have been very fortunate through the years to work for providers who love to teach. I am so fascinated with the way medicine works and the thought process the doctor goes through to reach a diagnosis.

A&P Tip

Lymphatic System Functions

There are three functions of the lymphatic system. The first and most well known function is defense against disease and invading microorganisms. Lymph nodes and other lymphatic organs filter lymph (a colorless fluid containing white blood cells) to remove microorganisms and other foreign particles. Lymphatic organs contain lymphocytes, which work to destroy invading organisms.

A second function of the lymphatic system is returning excess interstitial fluid to the blood. Of the fluid that leaves the capillary, about 90 percent is returned. The 10 percent that does not return becomes part of the interstitial fluid that surrounds the tissue cells.

The third function of the lymphatic system is the absorption of fats and fat-soluble vitamins from the digestive system and the subsequent transport of these substances to venous circulation.

Pathology

Lymph capillaries pick up the excess interstitial fluid and proteins and return them to the venous blood. After the fluid enters the lymph capillaries, it’s called lymph.

Small protein molecules may “leak” through the capillary wall and increase the osmotic pressure of the interstitial fluid. This inhibits the return of fluid into the capillaries, and allows fluid to accumulate in the tissue spaces.

If this continues, blood volume and blood pressure decrease significantly and the volume of tissue fluid increases, resulting in edema (swelling).
informative and affordable

“I liked the courses especially since I was able to get CEUs for both my CIRCC™ & RHIT credentials. I really cannot think of anything I really disliked. They were informative and affordable.”

Debbie Smiley, Interventional/Cardiology Coder

CPT® Coding for Transvenous Cardiac Pacemakers
CPT Coding for Cervicocerebral Arteriography
CPT Coding for Diagnostic Cardiac Catheterization
CPT Coding for Diagnostic Venography
CPT Coding for Image-Guided Percutaneous Abscess Drainage & Management Procedures
CPT Coding for Implantable Cardioverter Defibrillators
CPT Coding for Lower Extremity Arterial Endovascular Revascularization
CPT Coding for Arteriovenous (AV) Dialysis Access Imaging and Interventions
CPT Coding for Non-Selective Catheter Placements
CPT Coding for Percutaneous Coronary Interventions
CPT Coding for Non-Coronary Vascular Stent Placement
CPT Coding for Transcatheter Embolization
CPT Coding for Transcatheter Mechanical Thrombectomy
CPT Coding for Selective Catheter Placement in the Arterial System

live Seminar,
Nashville, TN live Seminar September 8th - 12th at the Gaylord Opryland Resort
NCCI Version 20.1 Bundles
Nurse Visit with Venipuncture

Learn to correctly unbundle codes for proper payment of these services.

National Correct Coding Initiative (NCCI) version 20.1 includes code pair 36415 Collection of venous blood by venipuncture and 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services (a level 1 established patient evaluation and management (E/M), commonly called a “nurse visit”). The code pair includes modifier indicator 1 (see sidebar for description). What this means is that, when billing a nurse visit with venipuncture, you must ensure the provider documentation supports a medically necessary, significant E/M that was integral to the patient’s plan of care. You also must, when appropriate, append modifier 25 Significant, separately identifiable 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 all nurse visits billed with venipuncture to receive reimbursement.

Follow Clinical Examples
1. A patient presents for a prothrombin time/international normalized ratio (PT/INR) lab test. The patient takes 5 mg of Coumadin® Monday - Friday, and 2.5 mg on Saturday and Sunday. The patient reports no change in medication or diet. A non-physician practitioner (NPP) performs a finger stick for the PT, and results are documented as 1.8. The patient is aware to continue this same Coumadin dosage and recheck PT in four weeks.

Proper coding is:
- 85610 Prothrombin time for the PT/INR
- 36416 Collection of capillary blood specimen (eg, finger, heel, ear stick) for the finger stick
2. A patient presents for a PT/INR lab test. He complains of frequent hunger, which has resulted in unwanted weight gain. The patient takes 5 mg of Coumadin on Tuesdays and 2.5 mg all other days. The patient reports changes in diet, but no changes in medication. An NPP performs a finger stick for the PT, and results are documented as 2.4. The NPP discusses the option of taking moderate walks for exercise and incorporating more fruits and vegetables into the patient’s diet. The patient’s vitals are taken and documented. The patient is aware to continue his same Coumadin dosage and to recheck his PT in four weeks.

Proper coding is:
• 85610 for the PT/INR
• 36416 for the finger stick
• 99211-25 for the separately identifiable and significant nurse visit

As illustrated here, understanding when it is appropriate to use a modifier to override an NCCI code pair edit, and which modifier to use, is essential to appropriate reimbursement.

Erica T. Cousin, CPC, CPC-I, serves on the National Advisory Board for AAPC, Region 3. She manages the Central Charge Review department at Cornerstone Health Care in High Point, N.C. Cousin has worked in the healthcare industry for over 15 years in various capacities, including management, coding, accounts receivable follow up, and cash applications. She is a member of the Winston-Salem, N.C., local chapter.

When billing a nurse visit with venipuncture, you must ensure the provider documentation supports a medically necessary, significant E/M …

Deciphering Code Pairs

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) code pair edits to define coding practices that result in inappropriate Medicare Part B payments. The agency regularly updates NCCI edits using various resources, including the American Medical Association, and national and local coverage determinations. CMS and other payers load the NCCI code pairs into their prepayment edits to prevent improper reimbursements.

You may interpret the NCCI code pair tables by comparing columns 1 and 2 to the modifier indicator column. Indicators 0, 1, and 9 specify whether you may append a modifier, when appropriate, to bypass NCCI edits, and thereby gain payment for the column 1/column 2 code pair:
0 - Columns 1 and 2 are mutually exclusive and cannot be reimbursed together.
1 - Columns 1 and 2 may be reimbursed with a modifier, when billed together.
9 - You may bill column 1 and column 2 codes together and receive reimbursement, without a modifier (The code pair edits were retroactively deleted.).


Kudos

Please send your kudos to:
kudos@aapc.com

Conference Never Looked So Good

Healthcare Business Monthly would like to credit Rachel Minson for her fabulous photos of HEALTHCON in Nashville. The eye-catching images made the spread in June’s “A Good Old Time in the Heart of Nashville,” (pages 14-17) pop off the page.
Know When to Bill E/M with a Minor Procedure

Interpreting the Rules
A “minor procedure” is any procedure/CPT® code with a zero-day or 10-day global period, as defined by Medicare’s Physician Fee Schedule Relative Value File. Examples of minor procedures include many types of injections, minor integumentary repairs, and endoscopic procedures (e.g., diagnostic colonoscopy).

Per CMS rules, every procedure (whether major or minor) includes an “inherent” E/M component and, as such, you generally may not report a separate E/M service on the same date of service. This rule is repeated throughout CMS policy documents, but is succinctly explained in the Medicare Claims Processing Manual, Chapter 12, Section 40.1.C:

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed.

The “unless” clause is important. It allows you to report (and to receive payment for) an E/M service, along with a minor procedure, if the E/M service is “significant” and “separately identifiable.”

In practical terms, this means:

1. The medically necessary E/M service must “go beyond” the usual E/M component included as part of the minor procedure.
2. Documentation must support both the minor procedure and a separate, independent E/M service (e.g., the E/M documentation must “stand alone”). Although it’s not required, best practice is to separate the E/M note from the procedure note.
3. The appropriate E/M service code must be reported with modifier 25 Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service appended.

Determine when to bundle and when to separately bill services.

Many payers bundle an evaluation and management (E/M) service when reported on the same day as a minor surgical procedure. National Correct Coding Initiative (NCCI) edits routinely bundle E/M services with minor surgical procedures, and the Centers for Medicare & Medicaid Services (CMS) policy dictates, “The initial evaluation for minor surgical procedures and endoscopies is always included in the global surgery package” (Medicare Claims Processing Manual, Chapter 12, Section 40.1.B).

In spite of all of this, providers may (and should) report an E/M service performed on the same day as a minor surgical procedure, as long as medical necessity dictates the need for a separate, significant E/M, and the encounter is supported by documentation and reported with an appropriate modifier.
A “minor procedure” is any procedure/CPT® code with a zero-day or 10-day global period, as defined by Medicare’s Physician Fee Schedule Relative Value File.

Unrelated E/M Is Usually Separate
Generally, if the E/M service is unrelated to the minor procedure (i.e., the E/M is for a different concern/complaint), the E/M service may be reported separately.

Example 1
A patient presents to the office for scheduled lesion removal. When the patient arrives, she has a cough, sore throat, and fever, which are evaluated and treated in addition to the scheduled procedure. In this situation, it’s appropriate to bill the E/M service code (supported by documentation) with modifier 25 appended, in addition to the lesion removal.

Example 2
A patient presents to the office for a joint injection, which she receives every three months. During the visit, she mentions that she has been having chest pain and shortness of breath. The provider sends her for a chest X-ray and an electrocardiogram. In this situation, it’s appropriate to bill an E/M in addition to the joint injection. If the E/M service occurs due to exacerbation of an existing condition, or other change in the patient’s status, that service may be reported separately as long as it’s independently supported by documentation.

Example 3
A patient with known hypertension presents for a screening colonos-
Generally, if the E/M service is unrelated to the minor procedure (i.e., the E/M is for a different concern/complaint), the E/M service may be reported separately.

Example 5
The patient presents to receive a pre-scheduled procedure, such as a steroid injection. Whatever E/M service that led to the decision to perform the injection has already occurred, and any related E/M on the date of the injection would be included as part of that minor procedure. Because the minor procedure “drives” the visit, you would not report the E/M service separately.

Initial Consult for a Minor Procedure
Recall that minor procedures (including colonoscopies and endoscopies) have a zero-or 10-day global period and no pre-operative period (other than the day of the procedure). As such, the initial office consultation with the provider to determine the indications and need for the procedure, potential risks, type of sedation, preparation, etc., is a billable service, when medically necessary.

Example 6
A patient presenting to the office for a screening colonoscopy consult has chronic medical conditions and/or takes medication that may affect the risks, preparation method, or type of sedation for the procedure, all of which requires additional consideration and MDM. The patient meets with a provider to discuss these issues, decide whether to proceed, and what precautions will be taken if they proceed. Regardless of when this service is performed (e.g., one or more days before the screening or the day of the screening), you may report it separately, as supported by documentation. By the same logic, a patient presenting to the office for a colonoscopy or endoscopy consultation due to symptoms or a medical condition will require additional decision making, which will substantiate a billable service. HBM

Karla M. Hurraw, CPC-A, CCS-P, holds a degree in Medical Office Administration and is a professional coder with DeKalb Health, an independent community hospital in Auburn, Ind. She is a member of the Fort Wayne, Ind., local chapter.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.
Think You Know A&P? Let’s See …

There are three functions of the lymphatic system. One is to remove excess fluids from body tissues and another is to produce immune cells. What is the third?

A. Remove bile from the blood
B. Adjust blood pressure
C. Absorption of fats and fat-soluble vitamins from the digestive system and transporting them to venous circulation
D. Produce antibodies

Check your answer on page 65.

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC.

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

To learn more about AAPC’s ICD-10 training, go to www.aapc.com to download AAPC’s ICD-10 Service Offering Summary.
Learning is part of your everyday experience, even if there are some lessons you’d rather avoid. This is especially true when you must deal with change.

Humans seek stability and strive to maintain consistency. It’s little wonder that when change does occur — even though it may bring needed improvements — people are often skeptical, if not downright resistant. Much like a young child digging in his heels, kicking and screaming while his mother drags him to a much needed, long delayed bath, you may find yourselves pleading: Do I have to? I like things the way they are. Can’t it wait until tomorrow?

As adults and professionals, however, you should (like the mother in the scenario) recognize the need to take action. Ask yourself:

- Do I have a vision of where healthcare is going, and how can I assist in getting there?
- Do I adamantly resist necessary tasks that are unpleasant, uncomfortable, or difficult?
- Are my healthcare providers resistant to change?
- How can I get my providers “into the bathtub,” and help them to see the positive aspects of the change?

Meeting Change with Positive Action

Each of us has a “To Do” list that is continually changing, based on our personal and professional goals. While anticipating checking “ICD-10-CM coding implementation” off your “To Do” list in 2015, you might also consider creating a “To Be” list to motivate you to become a medical professional of the future, employing your skills to elevate the healthcare delivery system. Your “To Be” list might include:

- **To be a learner every day.** Whether it’s learning about a new medical procedure or advances in medicine, or what is happening in the healthcare delivery system at large or within your local healthcare community, develop the mindset that learning never ends. Embrace opportunities to stretch your mind and expand your capacity. Seek opportunities to learn from the physicians and healthcare workers within your organization.
... a medical coder who is willing to mentor providers in a thoughtful, professional manner will build trust and enforce the value of a skilled coder as the “go to” source ...

- **To be a teacher every day.** Look for opportunities to share your knowledge with your associates. Phil Collins may have said it best: “In teaching you will learn, in learning you will teach.” For example, a medical coder who is willing to mentor providers in a thoughtful, professional manner will build trust and enforce the value of a skilled coder as the “go to” source when providers and clinical staff have coding-related questions. This relationship also opens the door to coders who need answers to clarify and further understand clinical questions.

- **To be one who sees the value** of the role you play in your corner of the healthcare delivery system, and to look beyond. Look for areas of interest that will elevate your capabilities, and be willing to work towards achieving the skills that will take you there. Explore opportunities to gain further education in medical auditing and compliance, health information technology, and software skills.

- **To be optimistic when challenged,** and to be willing to offer thoughtful solutions. As Albert Einstein said, “We cannot solve our problems with the same level of thinking that created them.” You need to think creatively, and to be part of the solution when issues arise.

When made with thought and care, your To Be list will better equip you to coax your providers into the soapy waters of ICD-10-CM, and beyond. HBM

---

**The Power of One**

Each medical professional contributes to the healthcare delivery system in key ways. Although it may seem small compared to the role physicians and clinical staff play, the role of coders, billers, auditors, and other healthcare professionals is significant. You might even compare it to the role of a honeybee.

A honeybee is innately driven to pollinate, gather nectar, and turn the nectar into honey. During a honeybee’s short life of six to eight weeks, it will travel the equivalent of 1½ times the circumference of the earth to produce an average of 1/12 of a teaspoon of honey. That may seem small, but each bee’s contribution is vital to the life of the beehive.

Likewise, the daily task of correct code assignment is essential to healthcare. Coders contribute to the financial health of the places in which they work, as well as the accuracy of nation-wide health data collection, which ultimately enhances healthcare delivery.

The power of one well educated, well trained, and fully engaged medical business professional is truly far reaching.

---

Marilyn Holley, RHIT, CPC, CPC-I, CHISP, is director of education at AAPC.
ICD-10-CM
General Code Set Training

Updated training methods to prepare for ICD-10

Over the past year we’ve heard significant concern surrounding our requirement to complete a timed ICD-10-CM proficiency assessment as a condition of continued certification. As a result, we’ve made an At-Your-Own-Pace assessment option available with ALL of our ICD-10-CM General Code Set Training.

Now, the most comprehensive and affordable methods to prepare for ICD-10 will also allow coders to demonstrate their proficiency at their own pace and with unlimited attempts.

- Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, CPEDC, CENTC
  Vice President, ICD-10 Training and Education

Features:

- ICD-10 format and structure
- Complete, in-depth ICD-10 guidelines
- Nuances of the new coding system
- Hands-on ICD-10 coding exercises
- Course manual for ICD-10-CM Code Set
- At-Your-Own-Pace Proficiency Assessment (included or optional)

Choose from the five options
Available September 2012

Learn more at: www.aapc.com/icd10 | 800-626-2633

Over the past year we’ve heard significant concern surrounding our requirement to complete a timed ICD-10-CM proficiency assessment as a condition of continued certification. As a result, we’ve made an At-Your-Own-Pace assessment option available with ALL of our ICD-10-CM General Code Set Training.

Now, the most comprehensive and affordable methods to prepare for ICD-10 will also allow coders to demonstrate their proficiency at their own pace and with unlimited attempts.

- Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, CPEDC, CENTC
  Vice President, ICD-10 Training and Education

Updated training methods to prepare for ICD-10

Features:
- ICD-10 format and structure
- Complete, in-depth ICD-10 guidelines
- Nuances of the new coding system
- Hands-on ICD-10 coding exercises

Course manual for ICD-10-CM Code Set

At-Your-Own-Pace Proficiency Assessment (included or optional)

<table>
<thead>
<tr>
<th>Training Options</th>
<th>Cost</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online</td>
<td>$395</td>
<td>Online training at your own pace.</td>
</tr>
<tr>
<td>Conference</td>
<td>$495</td>
<td>3-day live, in-person training with added educational (CEU) sessions.</td>
</tr>
<tr>
<td>Boot Camps</td>
<td>$595</td>
<td>2-day live training and interactive group environment in a city near you.</td>
</tr>
</tbody>
</table>

These training options include access to AAPC’s Online ICD-10-CM Proficiency Assessment Course. Successful completion of the hands-on exercises and questions found at the end of the course will satisfy AAPC’s certification maintenance requirements for ICD-10-CM.

Local Chapter and Onsite training include the option to add-on AAPC’s online ICD-10-CM proficiency assessment course at a reduced cost. Successful completion of the hands-on exercises and questions found at the end of the course will satisfy AAPC’s certification maintenance requirements for ICD-10-CM.

Local Chapter: Only available with participating chapters. Registration available through local chapter.

Onsite: Only available for groups of 10 or more.

Learn more at: www.aapc.com/icd10 | 800-626-2633
Thrive as a Small Clinic

Benefit from owning an independent medical practice by adapting to healthcare reform.
Changes already underway in the healthcare industry will require practices to dedicate substantial time and attention to adaptation. New challenges, from value-driven reimbursement to vertical integration, make it more complicated to maintain a small, physician-owned medical practice while competing with hospital systems and large, multispecialty clinics. Here are some tips on how to adapt a small clinic to an evolving healthcare industry and thrive.

**Value and Outcome-driven Reimbursement**

The Affordable Care Act (ACA) initiated a shift in the way healthcare providers are paid. Historically, most treatments have been billed and paid on a fee-for-service basis; providers were paid for a service regardless of whether it improved a patient’s condition. According to ideology behind the ACA, such “volume-based medicine” contributes to disproportionately high healthcare expenses in the United States, as compared to other nations. The hope is that shifting from a volume-based model to a “value-based” model will reduce the total expense to treat a patient. You might argue that this is an unfair transfer of risk from patients and payers to providers, but — for better or for worse — this change is underway, and practices need to prepare to thrive with outcome-based reimbursement.

In the fee-for-service world, the best opportunity many practices have to influence their profitability is to perform more services and to exert as much control as possible over their payer mix. In a value-based model, services with little benefit to a patient’s outcome provide little, if any, revenue for a practice.

Adapting economic ideology, such as providing the minimum number of services necessary to improve a patient’s condition, is essential to a practice’s sustainability.

**Value from Treating the Chronically Ill**

Controlling a practice’s risk is more important than controlling payer mix. When reviewing your contracts, look for each payer’s definition of an “episode of care.” Understand what triggers the start of an episode and what services are excluded or considered part of a different episode.

When insurance companies pay a capped amount for an episode of care, they shift the risk for patient improvement to providers. To anticipate and balance that risk, clinics should use billing and health record data to track and understand the most common problems among their patient population. For example, treating chronically ill patients may generate less revenue and net loss for your practice because those patients require more time and resources than other patients. In a value-based model, you must give the same attention to controlling chronically ill care as you do your payer mix. You don’t want to turn away patients, but you may need to schedule specific times for certain illnesses to prevent chronic diseases from taking up an unsustainable percentage of your treatment time.

Many factors that determine the success of treatment are outside of a physician’s control. What a patient does when he or she leaves your office matters more to the success of your treatment than what you do when the patient is in your office. That’s why now, more than ever before, it’s essential for you to determine the percentage of your patients who are non-compliant. Studies on non-compliance have shown that 20-30 percent of prescriptions are never filled, and 50 percent of medications for chronic diseases are not taken as prescribed. You can’t make patients compliant, but you can control the extent to which you continue treating non-compliant patients. It’s a hard call, but a necessary one to remain financially viable under new payment models.

**Review Contracts for Shared Savings**

Pay close attention to the shared savings and shared risk sections of your insurance contracts. Consider negotiating a 50/50 split of shared savings with each insurance company. Providers are shouldering at least half of the burden for keeping treatment costs low; it’s only fair they receive half of the reward. But don’t force a 50/50 split of shared savings if it means you also must accept a 50/50 split of shared risk. For the first few years of risk sharing, try to keep your...
share of the risk at approximately 25 percent. In the past, insurance companies absorbed nearly 100 percent of the risk, and they have revenue from healthy patients to offset some of their risk (a luxury most medical specialties don’t have); therefore, a 25 percent share of risk to the provider is more than fair for the first few years.

**Compete for Market Share**

Even without incentives from the ACA, the industry significantly motivates practices to merge and hospital systems to purchase autonomous practices. This rise of vertically integrated super clinics and multi-specialty practices is putting additional strain on independent practices to stay competitive.

Big clinics have a variety of advantages, from large scale name recognition to controlling many of their own referral sources. Hospitals, however, actually lose money — $189,910 per full-time equivalent physician, according to the 2011 MGMA Cost Survey — subsidizing physician compensation and benefits competitive with those of physician-owned practices. That means small practices must bring on substantial resources to compete with larger clinics and hospital systems.

Right now, it’s necessary to give attention to the business aspects of your practice, with a focus on patient statistics. In new payment models, the number of patients treated will be a key factor in reimbursement, and you’ll need to find creative ways to better manage providers’ and ancillary staff’s time. Even a slight increase in visits per day will result in additional revenue. Study trends in your patient demographics to find ways for your practice to see more patients. Compare the ZIP codes of patients seen in your practice to see if you would benefit from opening a satellite office in an underserved area.

It may be worth your effort to engage a data aggregation service to analyze the demographics of your patient population and to help you identify good-fit patients and attract them to your practice. If you don’t already do so, use your existing infrastructure and staff to be proactive about getting patients to make appointments when follow-up care is due. Reach out to patients through recalls and follow-up calls from providers, rather than waiting for the patients to contact you. And cultivate ongoing personal and public relations with other providers to assure the integration you currently enjoy will be ongoing.

**Create Happy Patients**

Customer satisfaction is important to any business, but much more so to medical practices. Not only does it drive a patient’s decision to choose your practice over another, but it factors into reimbursement in new payment models.

In a value-based model, payers weigh the results of patient satisfaction surveys into their performance measures for your practice, which influences how much they pay. You, too, can use patient satisfaction surveys to gain an understanding of, and control over, the aspects of the patient experience in your practice that influence happiness. Consider filling out a survey yourself, as a patient. Track the patient experience from start to finish. Figure out what would make the visit more pleasant and satisfying from a patient’s perspective.

Two common complaints patients have with their providers are availability for appointments and the amount of time they’re in the waiting room before they’re seen. It’s very com-
Common for patients to be frustrated about efficiency and access to care.

You can improve accessibility and efficiency by including patient portals, telemedicine, house calls, and physician follow-up calls. Many practices have had good results from having a nurse or physician assistant available to answer patient questions by phone for a few hours each day.

Customizing care to fulfill patient needs is essential in the new healthcare climate. Time constraints and technological changes in medicine have instilled a sense in patients that care is impersonal. Becoming sensitive to patients’ personal needs may increase patient satisfaction scores. For example, in addition to noting chief complaints for patient visits, a provider might inquire about the patient’s fears and how illness affects his or her life. That’s the framework in which they understand their illness, and you can gain insight by understanding it.

Ask questions to find out what patients aren’t telling you. Patients almost always come in with additional concerns that weren’t mentioned when scheduling an appointment; some of those concerns may result in treatment that leads to improved outcomes and satisfaction. Digging deeper will allow you to provide more complete treatment, improve patient education, and reduce recidivism.

**Improve Communication Skills**

According to the Centers for Disease Control and Prevention, nine out of 10 patients (90 percent) struggle with routine medical advice because it isn’t understandable in the format being presented. The *Journal of the Royal Society of Medicine* reports that between 40 and 80 percent of medical information provided during a visit is forgotten immediately. Those statistics suggest there is significant room for improvement in the way providers communicate with patients. Improving communication with patients will distinguish your outcomes and patient satisfaction from other clinics.

There are several things you can do to improve treatment retention statistics. For example:

- Send pre-visit information packets to new patients well before their visit, which will help them to plan ahead and to be adequately prepared.
- Talk with patients to find out how they prefer to receive information, and what they respond best to.
- Make sure after-visit instructions, education forms, prescriptions, and follow-up plans are clear and understood.
- Contact patients after their visit to confirm their understanding of and adherence to their prescribed treatment plan.

**Benefit Now**

There are many benefits to running a small, physician-owned medical practice, and many physicians would choose to remain autonomous business owners, if they could. Adopting the aforementioned tips will help your practice thrive in the changing healthcare industry. **HBM**

Christopher Phillips is president of MBA Medical Billing in Vancouver, Wash. He earned his CPC® in 2005 and has been working in the medical billing industry for 17 years. In addition to billing services, his company provides consultation services to help smaller clinics compete, adapt, and thrive (www.mbamedical.com).

Improving communication with patients will distinguish your outcomes and patient satisfaction from other clinics.
Open Up Payer and Vendor ICD-10 Communications

It’s not too early to reach out and ask questions.

Although ICD-10 implementation has been pushed back a year, providers cannot afford to overlook the importance of establishing open lines of communication with vendors and payers. Vendors and payers are on the cutting (and bleeding) edge of ICD-10 implementation. Understanding how the changes will affect them is a critical step in successfully achieving ICD-10 compliance in the practice setting.

Ask the Right Questions

There are a few key questions that providers and facilities should ask vendors and payers as they begin ICD-10 outreach.

Vendor-specific questions include:

• Will your organization be compliant with ICD-10 by October 1, 2015?
• Who are the ICD-10 contact people, and what is their contact information?
• Will there be additional fees charged as a result of the ICD-10 upgrade?
• When will our organization be able to test ICD-10 transactions?
• Will there be additional training needed as a result of the ICD-10 upgrade?
• What payer organizations are you testing with?
• Can we test with you? If we cannot, will you make your testing results public?
• When will we be able to “dual code,” using both ICD-9 and ICD-10?
• Will you offer customization for our specialty within your products (i.e., clickable templates/matrixes to help with documentation improvement)?

Payer-specific questions include:

• Will your organization be compliant with ICD-10 by October 1, 2015?
• Who are the ICD-10 contact people, and what is their contact information?
• What is your ICD-10 implementation approach? (e.g., will you use General Equivalence Mappings (GEM) files, proprietary crosswalks, or a hybrid approach?)
Diligence Will Pay Off

It’s not enough to ask these questions a single time. ICD-10 implementation will require constant updates and continued outreach to your vendors and payers. Providers and facilities should plan monthly communications with both vendors and payers throughout 2014 and 2015. Be persistent and willing to share your organization’s ICD-10 plans, as well. ICD-10 will require communication and cooperation on all sides.

Many payers and vendors are developing free training materials and other types of assistance for practices. You won’t know if your payers are doing these things unless you ask. Developing a rapport with vendors and payers today will secure further collaboration as the implementation deadline approaches.

Providers and facilities should plan monthly communications with both vendors and payers throughout 2014 and 2015.

• What (if any) are the contractual impacts to the practice as a result ICD-10?
• Will payers be able to offer any sort of contract-based financial protections as a result of ICD-10?
• When will medical policies/payment policies specific to ICD-10 be available for review?
• Are you offering no-cost training assistance to the provider/facility community?
• When will you begin testing? What types of organizations are you testing with?
• If we are unable to test with you, will you share the results of ongoing test processes?

Annie Boynton, BS, RHIT, CPC, CPCO, CPC-H, CPC-P, CCS, CCS-P, is director, Communications, Adoption & Training, Regulatory Implementation Office, at UnitedHealth Group. She has been in the healthcare information management field for nearly 15 years, serving in provider, payer, and educational capacities. She is embarking on the next phase of her career as the principal of Boynton Healthcare Management Solutions, focusing on practice management, compliance, technology, and regulatory preparedness for evolution of healthcare. Boynton frequently speaks and writes on healthcare management. She is president of the Worcester, Mass, local chapter, and has served on the AAPC National Advisory Board.
Streamline Your Revenue Cycle

Part 1: Begin with solid policies and procedures.

Being a practice manager means you must know where the buck stops in your facility or office: Who is accountable for what? Can you measure staff performance? What is your policy for conflict resolution, collections, appointment no shows, absenteeism, etc.? These questions beg for clearly written, specific policies and procedures that will serve as roadmaps for your organization. When staff know the expectations, consequences, and boundaries, confusion and conflict are minimized. A well-defined, streamlined workflow will naturally improve employee productivity, as well.

Start with the Operations Manual

One of the best ways to increase the efficiency of your entire practice is to create an operations manual. Although you may think operations manuals are only for large corporations, even small medical practices benefit from their use.

Operations manuals set standards for all practice employees to follow. This negates some excuses employees may have for not performing their duties properly. Manuals may also help cut the costs of employee absenteeism. According to Forbes Magazine, unscheduled absenteeism costs employers $3,600 per employee, per year. You can deflect this loss by incorporating a policy in your operations manual that allows employees to fill in for other employees in the event of an absence. Manuals also are handy in the training process. Instead of guiding new employees personally through each operation, there is a guide to consult.

Creating an operations manual is a low-cost way to improve your practice from within. Here’s how to create a medical office operations manual:

1. Take note of day-to-day operations. You may want to jump right into creating your operations manual, but it’s best to observe the daily operations of your practice for one to two weeks. This will give you a better idea of what your manual needs to cover.

2. Pay special attention to the table of contents. Make sure it’s detailed. Use headings and subheadings to make specific tasks easier to find.

3. Create job descriptions. Although you may have kept your staff for years, turnover is inevitable. Create detailed job descriptions in the manual to help ease the transition for new employees and to resolve conflicts between employees in regards to responsibilities.

4. Enlist office experts to create certain sections. If any employee is especially adept at a particular task, have that person write an explanation and “how to” steps for the manual. This will ensure the task is explained thoroughly and will help others to perform it properly.
5. **Be concise.** An operations manual isn’t meant to be an exceptional piece of literature, but it needs to be useful and understandable. Keep it simple.

6. **Operationalize common situations.** Certain things aren’t part of your operations, but still occur at times. For instance, include a section in your manual for dealing with dissatisfied patients.

7. **Keep it open to revision.** A key to an effective operations manual is that it needs to change with the times. Technologies and procedures change, so make sure to review and, if necessary, update your manual every six months.

Create Policies Geared Towards Better Workflow

Next, consider these miscellaneous workflow questions:

- Have tasks been clearly defined by job responsibility?
- How will you make the transition from paper records to electronic health records (if you haven’t already)?
- Do you have an ongoing training and development plan for all employees?
- Have all job areas been identified to improving workflow success?
- Have you evaluated the layout of the office and patient areas?
- Do you have the most current and up-to-date health information technology?

The success of your medical office largely depends on how well the front-end staff performs. When creating policies and procedures, you must consider:

- **Registration Accuracy:** The cycle of a patient account originates with the initial entry of patient demographic and insurance information. Invalid information will delay payment.

- **Scheduling Efficiency:** Does your medical office have a high “no show” rate? One way to reduce no shows is to use online patient scheduling. Patients can manage, schedule, or reschedule their own appointments, which makes “no shows” less likely.

- **Patient Satisfaction:** Providing high quality care and excellent customer service will prevent loss of revenue for the medical office due to a high level of patient satisfaction.

Periodic surveys, both oral and written, will target problem areas and help you to reward superior staff performance.

Additional policies related to the front desk should include:

- **Greeting patients and answering phones:** A smile and a personal greeting will make your patients feel welcome at your office. Remember that seeing a doctor can be a stressful situation, and a friendly face may help to alleviate some anxiety.

- **Providers who are running far behind:** Notify patients and allow them the option to reschedule.

- **Confirming and updating patient demographics:** Do this every visit.

- **Patient check out and co-pay/co-insurance collection:** When a patient checks out, have the patient pay his or her co-insurance or co-pay in full. This also can be done on the front end during check in, especially for co-pays, when the exact amount due is known.

- **Scheduling the next appointment:** Always try to have a patient schedule his or her next appointment before leaving the office. When a new patient schedules an appointment, have him or her bring completed new patient information forms, medical history, insurance cards, etc. Make these necessary forms available on your website for patients to print and fill out before coming in (even if the appointment is the next day). This will accelerate the intake process and shorten patient waiting times.

- **“No shows” and cancellations:** Develop a policy to address missed or cancelled appointments within a certain time frame. You can assess a penalty or charge a fee, but you must have this policy in writing, and patients must be informed.

Consider these and other policies and procedures for your operations manual to make your front office run efficiently and cost effectively. In Part 2 of this revenue cycle management series, we’ll address the patient contract. 

Linda Martien, CPC, CPC-H, CPMA, brings her 30+ years of experience in coding, billing, auditing, management, and consulting to healthcare. She is employed as Director of Reimbursement at Cytomedix. Martien is a member of the AAPC Chapter Association board of directors for the 2014-2017 term and has served as a past member and officer of the AAPC National Advisory Board. She has served in officer positions for the Columbia and Jefferson City, Mo., local chapters.
Employ Free Training Tools

Take advantage of five resources to help educate your healthcare organization staff.

Looking for low-priced training for your employees can be like finding a needle in a haystack. More often than not, the training is either too expensive or too generic. An alternative is to create your own training solutions. It may sound scary, but there are hundreds of tools out there to help, and some are even free! Here are five free tools that offer practical solutions for your various training needs, such as cross training, new hires, standard operating procedures, etc.

1. Jing by Techsmith (www.techsmith.com/jing.html)

Jing is a screen capture and screen recording program. Anything you can put on your screen can be captured and recorded with narration. Just think of the possibilities: Show a new employee how to make an appointment for a patient; make a series of videos to show nursing staff how to update online charts; or record stepped out guidance for ICD-10 code selection. You can even create videos for your website that instruct patients on how to fill out necessary health forms, or how to prepare for a procedure.

Jing is easy to use, and the Techsmith website has several demo and training videos. Videos can be saved to your computer or uploaded to a free site so you can send the hyperlink in an email. This video recording tool does come with a limit: Recordings cannot exceed five minutes.

To create clearer-sounding training videos, you can record using a headset with a microphone (a headset costs approximately $25, and can be purchased from an electronics or big box store).

2. Quizlet (http://quizlet.com/)

Quizlet makes learning fun using flashcards and study and game modes. The free website contains over 30 million study sets, all of which are user-generated.

To create your own study set, simply type in or upload a file that contains terms and definitions (images work, too) of the study material. You can customize the flashcards to show the phrase and the definition, or you can show only the phrase and require the user to “flip” the card to see the definition. You can even use audio to have Quizlet read the cards to you — in 18 different languages!

Games, such as “Scatter,” and a race, allow employees to participate in friendly, interoffice competition.

3. Vyew (http://vyew.com/)

Vyew offers interactive visual web conferencing. It provides a shared whiteboard, chat, and audio, and is particularly useful for training sessions. The free version allows up to five participants. The platform can make training more engaging by allowing you to share your screen with your employees and collaborate in real-time.
Vyew is an online collaboration tool that is particularly helpful if you have employees at multiple locations. There is no software to install, and Vyew works on any browser. Use it to collaborate across the world or just across town.

You can create one or more meeting rooms, which you can access at any time. While in a meeting, you can upload documents that can be seen by everyone in attendance. Easily mark up documents in real time with the white-boarding and drawing tools. Other means of communication include text chatting, talking using voice over Internet protocol or a standard phone system (within the USA), and voice notes. There’s also a built-in webcam video option, so you can put a face to the voice. A moderator can create poll questions and participants can raise a “hand” if they have a question. You can even embed comments (typed or recorded) for everyone to see the next time they enter the meeting room. The content of your meetings is continuously auto-saved.

4. **LibreOffice**  
(www.libreoffice.org/)

The Internet has transformed the world into a global marketplace; and as such, our co-workers and clients are often from parts unknown. This creates diversity in more ways than one: Beyond the language barrier, employees often deal with incompatible electronic files. LibreOffice is an open protocol suite of programs, including a word processor, spreadsheet, presentation software, drawing program, and database tool. Use it to open and edit various document formats, including Microsoft Office and Publisher, and to create various types of documents, including slideshow presentations, in OpenDocument Format (ODF). LibreOffice is easy to download, and you can start to use it right away.

5. **myicourse**  
(http://myicourse.com/)

After you create all of your great training solutions, where will you keep them to easily share with your peers or employees? That’s where iCourse comes into play.

iCourse is a learning management system that provides a public or private place to build an online classroom. You simply create an account, give your “school” a name, and start to create courses. The courses can contain typed content, audio, video, and even hyperlinks to other online content. iCourse allows you to create surveys and provide a certificate of completion when the “student” has finished the course. This is a great solution for bringing new employees on board or administering mandatory routine courses, such as sexual harassment training or updates about regulation changes. iCourse is free up to 100 students and 100 courses. If you have more of either or charge for your courses, there are fees.

They say nothing in life is free, but I beg to differ. Try these free training tools and you’ll soon learn that the knowledge you share, collaborative meetings you hold, and training materials and online courses you create are priceless. Your employees will be so inspired, they may even teach you a thing or two.

---

**Jose “Joe” Ascensio** lives in Kansas City, Mo., where he is system director of academics at Pinnacle Career Institute. He has a master’s degree in education, with an emphasis in adult education, and bachelor’s degrees in computer information systems. His passions in life are family, technology, and training.
Payment Reform Brings Healthcare Change

Become familiar with new initiatives and payment models, and be willing to adapt.

Among 191 countries, the World Health Organization ranks the United States as 37th for quality of healthcare, yet we spend a higher portion of our gross domestic product on healthcare than all other countries (The World Health Report 2000—Health Systems: Improving Performance). As a result, payment reform and new payment models and initiatives are the norm for both state and federal government payers. Let’s look at several such initiatives, as well as advice on what they might mean for coders, auditors, managers, and other healthcare business professionals.

**Healthcare Innovation Awards**

Under the Healthcare Innovation Awards, the Centers for Medicare & Medicaid Services (CMS) has provided $1 billion to organizations implementing the most compelling new ideas to deliver better healthcare, ensure improved outcomes, and lower costs to people (particularly individuals with the highest healthcare needs) enrolled in Medicare, Medicaid, and the Children’s Health Insurance Program. There are eight participants operating in multiple states.

Awards range from approximately $1 million to $30 million for a three-year period. Providers, payers, local government, public-private partnerships, and multi-payer collaboratives accepted applications. Each grantee project is monitored for measurable improvements in quality of care and generated savings.

**Bundled Payments for Care Improvement (BPCI) Initiative**

Medicare makes separate payments to providers for services furnished to beneficiaries for a single illness or course of treatment. This leads to fragmented care with minimal coordination across providers and healthcare settings. Payment is based on how much a provider does, rather than how well the provider treats the patient.

Research shows that bundled payments can align incentives for providers — hospitals, post-acute care providers, doctors, and other practitioners — to partner closely across all specialties and settings a patient may encounter to improve the patient’s experience of care in an acute care hospital and during post-discharge recovery.

The Bundled Payments for Care Improvement (BPCI) initiative includes two phases for Models 2, 3, and 4. Phase 1, also referred to as the “preparation” period, is the initial period of the initiative, during which CMS and participants prepare for implementation and assumption of financial risk. Participants in Phase 1 of Models 2, 3, and 4 may enter into a BPCI Model agreement with CMS, as awardees, and begin Phase 2, also referred to as the “risk-bearing” period.

On January 31, 2013, the first set of BPCI Phase 1 participants were announced. Awardees began Phase 2 of Model 2 either on October 1, 2013 or January 1, 2014. The complete transition of all episodes (for all episode initiators) to Phase 2 is expected to occur January 2015. During the transition period, awardees may transition episodes and/or episode initiators from Phase 1 to Phase 2 on a quarterly basis.

This initiative allows organizations to enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. There are currently four models, as illustrated in the “Features of BPCI Initiative” chart.
This initiative allows organizations to enter into payment arrangements that include financial and performance accountability for episodes of care.

### Features of BPCI Initiative

<table>
<thead>
<tr>
<th>MODEL</th>
<th>FEATURE</th>
<th>MODEL 1: Inpatient Stay Only</th>
<th>MODEL 2: Inpatient Stay plus Post-discharge Services</th>
<th>MODEL 3: Post-discharge Services Only</th>
<th>MODEL 4: Inpatient Stay Only</th>
</tr>
</thead>
</table>
| Eligible Awardees | • Physician group practices  
• Acute care hospitals paid under the IPPS  
• Health systems  
• Physician-hospital organizations  
• Conveners of participating health-care provider | • Physician group practices  
• Acute care hospitals paid under the IPPS  
• Health systems  
• Physician-hospital organizations  
• Conveners of participating health-care provider | • Physician group practices  
• Acute care hospitals paid under the IPPS  
• Health systems  
• Long-term care hospitals  
• Inpatient rehabilitation facilities  
• Skilled nursing facilities  
• Home health agency  
• Physician-hospital organizations  
• Conveners of participating health-care provider | • Physician group practices  
• Acute care hospitals paid under the IPPS  
• Health systems  
• Long-term care hospitals  
• Inpatient rehabilitation facilities  
• Skilled nursing facilities  
• Home health agency  
• Physician-hospital organizations  
• Conveners of participating health-care providers |
| Payment of Bundle and Target Price | Discounted IPPS payment; no separate target price | Retrospective comparison of target price and actual FFS payments | Retrospective comparison of target price and actual FFS payments | Prospectively set payment |
| Clinical Conditions Targeted | All MS-DRGs | Applicants to propose based on MS-DRG for inpatient hospital stay | Applicants to propose based on MS-DRG for inpatient hospital stay | Applicants to propose based on MS-DRG for inpatient hospital stay |
| Types of Services Included in Bundle | Inpatient hospital services | • Inpatient hospital and physician services  
• Related post-acute care services  
• Related re-admissions  
• Other services defined in the bundle | • Post-acute services  
• Related re-admissions  
• Other services defined in the bundle | • Inpatient hospital and physician services  
• Related re-admissions |
| Expected Discount Provided to Medicare | To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in year 3 | To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode | To be proposed by applicant | To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration |
| Payment from CMS to Providers | • Acute care hospital: IPPS payment less pre-determined discount  
• Physician: Traditional fee schedule payment (not included in episode or subject to discount) | Traditional FFS payment to all providers and suppliers, subject to reconciliation with predetermined target price | Traditional FFS payment to all providers and suppliers, subject to reconciliation with predetermined target price | Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment |
| Quality Measures | All hospital IQR measures and additional measures to be proposed by applicants | To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs | | |
Coding doesn’t change under these new payment models because the process of assigning ICD-9-CM/PCS, ICD-10-CM/PCS, or CPT® codes is the same as with traditional payment models.

Pioneer Accountable Care Organizations
The Pioneer Accountable Care Organizations (ACO) model is designed for healthcare organizations and providers already experienced in coordinating care for patients across care settings. It allows these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a separate track consistent with the Medicare Shared Services Program. It’s designed to work in coordination with private payers by aligning provider incentives. The goal is to improve quality and health outcomes for patients across the ACO and achieve cost savings for Medicare, employers, and patients. There are 23 ACOs participating in the Pioneer ACO Model.

The payment models tested in the first two years of the Pioneer ACO model are a shared savings payment policy, with generally higher levels of shared savings and risk for Pioneer ACOs than levels proposed in the Medicare Shared Savings Program. In year three of the program, participating ACOs that have shown a specified level of savings over the first two years are eligible to move a substantial portion of their payments to a population-based model. These payment models are flexible to accommodate the specific organizational and market conditions in which Pioneer ACOs work.

Advance Payment ACO Model
The Advance Payment ACO model is designed for physician-based and rural providers who have come together voluntarily to give coordinated, high-quality care to the Medicare patients they serve. Through the Advance Payment ACO model, selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. There are 35 ACOs participating in the Advance Payment ACO model.

Through the Advance Payment ACO model, selected organizations receive an advance on the shared savings they are expected to earn. Participating ACOs receive three types of payments:

- An upfront, fixed payment: Each ACO receives a fixed payment.
- An upfront, variable payment: Each ACO receives a payment based on the number of its historically assigned beneficiaries.
- A monthly payment that varies depending on the ACO size: Each ACO receives a monthly payment based on the number of its historically assigned beneficiaries.

Advance payments are structured in this manner to acknowledge that new ACOs will have both fixed and variable start-up costs.

CMS recoups advance payments through offset of an ACO’s earned, shared savings. ACOs selected to receive advance payments enter into an agreement with CMS that details the obligation to repay advance payments.

If the ACO does not generate sufficient savings to repay the advance payments as of the first settlement for the Shared Savings Program, CMS will offset shared savings in subsequent performance years and future agreement periods, or will pursue recoupment, where appropriate.

The Advance Payment ACO model targets two types of organizations participating in the Shared Savings Program:

- ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue; and
- ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals that have less than $80 million in total annual revenue.

Impact on Revenue Cycle and Coders
Coding doesn’t change under these new payment models because the process of assigning ICD-9-CM, ICD-10-CM/PCS, or CPT® codes is the same as with traditional payment models. The main responsibility of hospital and physician revenue cycle personnel and coders is to ensure documentation of any performance measures, quality standards, and acuity and severity indicators are not only complete and thorough, but the measurement of trends and patterns are identified early so future payment does not decrease, regardless of the payment model you find yourself using.

Change can be slow at times. Delayed guidelines, competing rules and regulations, and legislation reversing previous initiatives all affect the implementation and outcomes of these payment models. But whatever the outcome, the business of healthcare is sure to be different in the future.

One thing will remain the same, however: Healthcare professionals and support staff who are able to adapt to evolving, increasing demands of payment models, documentation requirements, and workloads will always be in great demand. HBM
Practicode is a powerful tool for medical coders to strengthen their coding skills, demonstrate their proficiency, and earn continuing education units. This web-based tool can be accessed anywhere providing user friendly practice and training while helping to meet professional goals.

Practicode Practice Modules:
- Multiple Specialties
- 100 coding Exercises
- Earn 15 CEUs

Practicode CPC-A Practicum:
- 600 coding Exercises
- Earn 1 Year coding experience toward removal of apprentice designation
- Assess proficiency

Practicode Employee Assessments:
- 20 Exercise Assessments
- Evaluation tool for potential employees
- Cross-training tool for new employees learning new specialties

Key features for Practicode include:
- Web-based
- Actual Records
- Instant Feedback
- Coding Rationale

www.aapc.com
Engage Patients and Improve Outcomes

Implement three practices to achieve success with patient portals.

The “meaningful use” of electronic health records (EHRs) and other federal regulations are pushing for more online communication between providers, patients, and payers to bring about a more transparent exchange of financial and clinical information. In response, many providers are implementing patient portals, which have improved patient engagement and outcomes as a positive side effect.

According to an AARP study, engaged patients tend to be healthier and more likely to follow their provider’s advice. Engaged patients are also typically more confident and knowledgeable about healthcare, and take more responsibility for their health. These benefits can mean improved quality, optimal utilization, and lower healthcare costs, overall. Investing in patient engagement can make good business sense for providers — allowing them to leverage incentives, build patient loyalty, and improve outcomes.


Patient portals help establish a framework for patient engagement by:

1. Offering access to their health information;
2. Facilitating provider-patient messaging; and
3. Providing convenient scheduling and billing resources.

These three features enable patients to actively participate in the process of managing their health and healthcare needs by partnering and communicating with their physicians, which is how The Center for Advancing Health defines “engagement”:

Employers, government payers, politicians, health plan administrators, technology developers, labor leaders and patient advocates have noted the need for the public’s involvement in health care and have labeled the phenomenon patient or consumer “engagement.”


Let’s expand on the three ways practices might establish the framework for patient engagement through patient portals.

1. Access to Health Information
Historically, if patients wanted to review information in their chart, they would ask their practice to photocopy documents, or to print them from the EHR system. This was an inconvenience for both the practice and patient, and could take several days to complete.

With portals, providers can document office visits and notes and send these summaries to patients within minutes. They can also offer patients direct access to documentation in the electronic chart. As a result, patients have timely and accurate information about their treatment plan and care options, reinforcing the notion that they share the responsibility for their care and for making informed health decisions.
Secure messaging features in patient portals allow providers and office staff to communicate with patients for non-urgent matters, while avoiding the time-consuming “phone tag” process.

3. Scheduling and Billing Resources

As with the sprained ankle example, many patient portals offer administrative support elements — such as scheduling — that can transform and simplify every interaction a patient has with his or her practice.

Patient health status and history paperwork, for instance, is often not filled out correctly or completely in the waiting room on the day of an appointment, adding to the burden on staff members and delaying office visits. This, in turn, affects scheduling and the provider’s workflow, leading to longer wait times and care decisions due to limited information.

A portal gives patients the ability to fill out and submit paperwork online and to access to all of their medical information. They can also make appointments, pay their bills, request prescription refills, and receive reminders. These features are especially effective if delivered as a smartphone notification because these devices are usually with patients and frequently accessed throughout the day. Patients can take immediate action with smartphones, confirming appointments or requesting prescription refills, with a tap on their screen. Conversely, reminders delivered by postal mail are easily lost or forgotten.

To measure patient engagement, practices must consider actions that illustrate connection and collaboration with their providers. A few good patient engagement indicators are patient portal utilization and transactions, such as scheduling preventive care appointments through the portal, sending medication refills, or communicating with their provider through secure messaging.

Establishing reporting and analytics around these measures early on allows practices over time to more accurately set achievable goals, analyze engagement, and identify opportunities to improve performance. These metrics will not only help providers align with value-based care and meaningful use objectives, but they will also position practices for a sustainable future. 

Vern Davenport is president and equity partner of Medfusion Inc., a leading provider of patient engagement and practice efficiency software for more than 9 million patients. He brings a lifetime of healthcare and healthcare technology experience to his role.

Portals also allow practices to leverage advanced functionalities that will help them to achieve the Centers for Medicare & Medicaid Services’ (CMS’) Stage 2 Meaningful Use core objective, which requires providers to offer patients “the ability to view online, download and transmit their health information within four business days of the information being available to the eligible professional.”

2. Communication with Providers

In addition to satisfying core objective 17 (“Use secure electronic messaging to communicate with patients on relevant health information.” (CMS, October 2012)) for Stage 2 Meaningful Use through health information access, patient portals also facilitate patient engagement.

Secure messaging features in patient portals allow providers and office staff to communicate with patients for non-urgent matters, without wasting time playing “phone tag.” Despite fewer interactions over the phone, patient engagement actually increases through the portal because it serves as a direct connection to the practice through a computer or mobile device. Most importantly, all transactions and interactions can be tracked and monitored through monthly reporting that gives the practice a view of patient engagement trends and progress over time. Practices can analyze that data to determine when patients most often send secure messages and how quickly providers are able to respond. This will help to ensure a prompt response rate and increase the chances a patient’s health concern or question will be addressed appropriately, which will likely improve his or her outcome.

Smartphone applications are an important part of this value proposition. Consumers want support wherever and whenever they want to take action. For example, if a patient sprains an ankle during his or her lunch hour, the patient may head to a costly emergency room or urgent care center if he or she cannot immediately determine whether an appointment is available at his or her primary care physician’s office.
Professional Students Make Better Employees

If you are enrolled in an educational institution and pursuing a degree in health information or healthcare business certification, remember that a professional student should have the same work ethic and perform in the same manner as does a professional employee. The expectations for prospective employees are not unlike those for professional students. Ask yourself:

- **Am I dependable and responsible?**
  Being on time and prepared for class is a strong indicator that you will be on time and prepared for work, when employed.

- **Do I complete class and homework assignments on time?** If your answer is yes, you should easily transition to completing assigned tasks and meeting project deadlines as an employee.

- **Do I dress appropriately and adhere to institution policy?**
  Adherence to your school’s policies will prepare you for prospective employers’ dress code requirements and other company rules and regulations.

**Qualities of a Professional Student**

Whether you take online courses or physically sit in a classroom setting, it’s important for you to consider this learning time the same way as you would a new job. A professional student is well-organized, always prepared, and dedicates additional time outside of class to studying instructional material. The U.S. Department of Labor (2014) has identified the qualities below as those required for health information professionals. As an instructor, I’ve found the same qualities very important in successful, professional students.

- **Analytical skills:** Your ability to follow educational instruction and comprehend course material will help you to understand and comply with internal guidelines of a prospective employer.

- **Detail oriented:** Accuracy is essential in abstracting data from the medical record and assigning diagnoses and procedural codes. Through your curriculum, you will learn how to become more detail oriented.

- **Integrity:** Taking pride in your schoolwork by completing your own assignments and following ethical practices will prepare you for compliance and legal obligations.
you’ll face as an industry professional and AAPC member.

- **Interpersonal skills**: Good communication with your instructors and classmates is a strong attribute of a professional student; these skills will strengthen your networking abilities and help you to work well with others.

- **Technical skills**: A job requirement for this industry is to use and navigate through medical software systems and coding software. As a student, use your time efficiently to learn about these systems and their functionalities.

**Time Management**

You are fortunate if you are able to focus solely on school without having to work. For many, attending school and working is a balancing act. Even if you are not balancing work and school, you may have family, friends, and church or other organizational obligations that require your time. As a professional (whether student or employee), you must learn to manage your time resourcefully. Remember: When you gain employment, those other responsibilities are still going to be present. Here are some timesaving tips to help you be a more professional student:

- Dedicate 30 minutes to an hour for study time per week, per class.
- Identify a quiet zone for independent study or online coursework to avoid distractions.
- Alert family members and friends to not disturb you during study and coursework time.

- Take heed to the old cliché: Don’t bite off more than you can chew. You may have to learn how to say no to certain people, activities, or invitations that may keep you from being a professional student.

**Being Professional Helps Land a Job**

Gather your portfolio items, including a well-written, action-oriented resume, cover letter, grade point average, awards, letter(s) of recommendation, and certifications. Include a list of professional references (past employers, instructors, chapter officers, etc.), as well as personal references. Make sure your personal references are as professional as you. If you use social media (Facebook, Twitter, etc.), make sure your online actions don’t appear unprofessional. Clean it up, if you must. Listen to your voicemail to be sure it sounds acceptable in the business world (no music, clear language). Ensure your email address is professional, as well. For example, lwilliams@yahoo.com sounds more professional than classydiva@yahoo.com.

The goal is to increase your chances of landing that dream job. Carrying yourself as a professional is the first step towards getting an interview. Take time to evaluate your current level of professionalism. Make necessary changes or improvements to your behavior. And treat each day as a day on the job, rather than a day in the classroom.

**Leonta Julien-Williams, RHIT, CPC, CCS**, has worked a coder, auditor, and educator in the healthcare industry for the past 10 years. Julien-Williams is founder and president of the Covington, Ga., local chapter.

**Jobs in the Business Side of Healthcare Are Opening**

There are more opportunities for newly credentialed coders today than there were 10 years ago. Hospitals and facilities across the United States have implemented training programs for newly certified coders with no work experience. Many well-known industry consulting firms also offer similar training programs with remote opportunities and flexible work hours. The pending implementation of ICD-10-CM brought about many programs to meet the needs of the healthcare industry.

The U.S. Bureau of Labor Statistics (2014) projects a 22 percent increase in job growth through 2022 for health information professionals. This projected growth is much higher than the average for all other occupations.
CPT® AND RBRVS 2015 ANNUAL SYMPOSIUM
MARRIOTT CHICAGO MAGNIFICENT MILE
NOV. 19–21, 2014

Join a thousand of your colleagues for the only three-day event where you learn from, and network with, the experts on CPT®, RBRVS and Medicare payment policy.

The Symposium faculty includes members of:
• CPT Advisory Committee
• CPT Editorial Panel
• AMA/Specialty Society Relative Value Scale Update Committee (RUC)
• Centers for Medicare & Medicaid Services (CMS)
• Contractor medical directors (CMDs)

Special discounts and group rates available by calling (800) 882-3000.
The use of electronic health records (EHRs) is steadily increasing, and so are the number of high-level evaluation and management (E/M) services being billed. These claims may very well be substantiated by documentation contained in the EHR, but is the documentation valid? That’s what government and private payers are questioning, and that’s what practices have to prove if audited.

**The Best EHRs Are Also the Worst EHRs**

The crux of the problem is that the same time-saving features that attract physicians to use EHRs, such as copying and pasting or pulling forward documentation and templates, can also put practices at risk for failing an audit. Used inappropriately, these features can create “cloned” documentation (e.g., the documentation is the same from visit to visit, or from patient to patient) or other errors in the EHR that are easily detected by an auditor. The key is to be ever vigilant, scrutinizing your physicians’ documentation from the perspective of an auditor.

**Confirm the Chief Complaint and HPI**

The way audits are conducted varies. Sometimes, an auditor may have access to the EHR. Other times, the records are printed and sent to the auditor. In either circumstance, the system compiles all of the information entered during a visit into a neat progress note format. This is typically how the auditor will view the information.
HPI should not be counted toward the level of E/M service when there is valid reason to believe someone else documented it.

The first thing an auditor looks for is a documented chief complaint. Documentation guidelines require the chief complaint to establish medical necessity. They also require the chief complaint to be documented by the physician; however, some payers will allow documentation from the medical assistant (MA) or nurse. Most EHRs provide a field to enter a chief complaint or the reason for the visit, but it can be inferred from the history of present illness (HPI).

**Check if the Physician Entered the HPI**

HPI may be entered through a list of drop down menus, via point and click options, or using “free text.” Documentation guidelines explain that recording the HPI is physician’s work; auditors need to ensure the physician documents this portion of the record. This poses a huge challenge for auditors because there may be no indication in the EHR when someone other than the physician completed the HPI.

For example, I performed an audit for an office wanting additional education. In shadowing the providers, I learned that the Medical Assistant was fully documenting the HPI for every patient. I quickly informed the physicians that they should be doing this work. Had I not been there in person, however, I would not have known this, and I would have mistakenly given credit to the physicians for completing the HPI.

Payers are catching on to this issue. EHRs often have an internal log that tracks who is entering what within the record. Payers are beginning to ask for audit trail logs to see who documented the HPI. As an internal auditor for a practice, you should ask for this, as well. If you cannot get the log, look for clues within the documentation. Paper charts were easy to track because the handwriting was different. Clues are more subtle in the EHR. For example, documentation may state, “You told her to take her meds twice a day,” or “Dr. XYZ told the patient to take Tylenol.” Phrases like this raise the question, “Who documented that HPI?” HPI should not be counted toward the level of E/M service when there is valid reason to believe someone else documented it.

**ROS and PFSH Must Be Updated at Each Visit**

The review of systems (ROS) and past, family, and social history (PFSH) may be documented by ancillary staff, gathered from a form completed by the patient, or updated from an earlier visit. The visit documentation should note the source of this information.

If the ROS and PFSH are gathered from a form, the physician needs to document that he or she reviewed the form, and sign and date it. The form also should be scanned into the EHR. If the ROS and PFSH are copied and pasted, or pulled forward from an earlier visit, the note should indicate the original date of service and confirm that the ROS and PFSH were reviewed and updated at the current visit.

Many EHRs automatically populate PFSH information from other areas into the visit note documentation, without a clear indication that the physician reviewed the information during the visit. If there is a concern that PFSH was pulled into the visit documentation automatically, the auditor must verify who accessed the information and when it was accessed using audit trail logs.

**When Using Templates, Verify the Exam**

The issues with templates also carry over into exam elements. EHRs often have exam templates geared to a specific complaint or that are pre-populated with findings. The physician scrolls through the template, pointing and clicking on items to select as positive or negative.

Some systems are able to carry forward or copy and paste a previous exam. This can be a time-saver for patients who are seen at regular intervals for chronic condition follow up. But templates may also result in documentation errors if exam items are pulled forward that aren’t actually performed, or if the physician doesn’t change a result that may have been
positive at a previous visit, but is negative for the current visit.

**Example 1**
When a patient presents for diabetes (DM) follow up (F/U), a DM F/U template is used. The template is pre-populated with ROS negatives, exam negatives, etc. It’s up to the physician to change any of the findings to positives. It’s also up to the physician to remove elements that he or she didn’t examine. If the physician fails to do these things, the template will create nearly identical notes, and create flawed documentation.

**Example 2**
I worked with an OB/GYN office that created a template for their GYN exams. The template pre-populated all the exam elements as negative. Numerous times during their audits, I would find exam elements that indicated a negative finding when the HPI or the ROS would indicate the opposite. This makes the validity of the documentation questionable and renders the level of service unsupported. Credit cannot be given for elements where discrepancies occur.

**Don’t Overlook Dx Selection**
EHRs can make documenting the assessment and plan of an E/M service easier by providing diagnosis codes and including check boxes for the status of problems (improved, worsening, etc.), and by linking the plans to each diagnosis. Some systems provide a “favorites list” that keeps the diagnoses the physician uses most right at his or her fingertips. These tools — helpful as they may be — can also result in incorrect documentation. Auditors must look out for assessments populated from problem lists. The history and exam must support each diagnosis, showing that it truly was assessed at that particular visit. Often, the level of service is coded higher because chronic conditions are pulled into the assessment from a problem list, but there is no evidence in the history or exam that the condition was addressed during the visit, or that it affected the patient’s treatment.

Integrated diagnosis codes also can create problems if physicians do not take the time to find the most specific code.

**Example 3**
The patient has diabetes, type II, uncontrolled, with renal complications. The physician types in “diabetes,” and so many codes come up that he or she just picks the first on the list: diabetes, type II, controlled, without complications. Or the physician pulls a diagnosis for DM, type II, uncontrolled, but the documentation does not support the uncontrolled designation.

Favorites lists can really cause havoc if physicians are able to rename the diagnosis associated with a given code. For instance, I once audited a physician who had saved the code for an abnormal Pap smear into her favorites list, shortening and renaming it “pap.” She then mistakenly used this code for any patient who came in for a routine Pap smear.

When scoring out the medical decision-making (MDM), you must verify the selected codes are supported in documentation and that each scored item was truly addressed at the visit. Using an EHR can often result in a physician not providing a detailed enough plan to support the level of MDM. The physician’s thought process — used to complete the picture of that visit and to ensure an accurate selection of MDM — gets lost in the mix.
Favorites lists can really cause havoc if physicians are able to rename the diagnosis associated with a given code.

Customize EHRs to Overcome Shortcomings

Internal audits are tremendously important to any organization’s compliance processes. Through the audit process, you can uncover and address documentation concerns with EHRs. Customize your EHR to:

- Assist physicians in the documentation process so they have more time to provide quality care to patients;
- Reduce compliance risk to your physicians and your organizations; and
- Ensure documentation guidelines are met and that services billed are supported.

Whether you are shopping for an EHR or looking to restructure the way your existing EHR works, look at areas of concern uncovered in internal audits and ask your vendor to add features to correct these areas (for example, adding a feature to display who documented the HPI and exam). Ask the vendor if they can add dates from which a previous ROS was pulled forward, etc. Be sure you choose an EHR that is customizable to meet your organization’s needs and don’t hesitate to put that vendor to work to ensure you get the system that works best for your organization.

A final note: Ensure your physicians and staff are thoroughly trained on the EHR, and the training is provided by individuals knowledgeable in both clinical and billing guidelines. 

Ellen Risotti-Hinkle, CPC, CPC-I, CPMA, CEMC, CFPC, CIMC, is an AAPC national ICD-10 trainer, an online adjunct instructor for Ultimate Medical Academy, and president and CEO of Rizhink Medical Consulting, LLC. She is a member of the Indianapolis, Ind., local chapter.
Earn up to 42 CEUs with timely education from expert presenters— all from the comfort of your home or office. Purchase your AAPC Half-Year Coding/Billing Webinar Subscription for an unbeatable member price of just $395 (that’s less than $19 per webinar) including:

- Earn up to 42 CEUs
- Access to more than 40 one-hour webinars (July - December 2014 schedule*)
- Access to live event + on-demand version
- Access to the presenter for online chat during the live event
- 2014 CPT® coding updates
- Access for the entire office*


**Just some of the informative webinars:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 09</td>
<td>ICD-10 Specialty - Cardiology</td>
<td>Oct 01</td>
<td>Medical Necessity in the Cardiology Office</td>
</tr>
<tr>
<td>July 16</td>
<td>Audit Challenges with E/M Services</td>
<td>Oct 08</td>
<td>Implementing Lean Strategies to Create Wow Moments for Patients</td>
</tr>
<tr>
<td>July 23</td>
<td>Avoiding Rejections, Delays, and Denials</td>
<td>Oct 15</td>
<td>E Codes, V Codes, W Codes, X Codes, and Y Codes, Oh My!</td>
</tr>
<tr>
<td>July 30</td>
<td>Fine Needle Aspirations</td>
<td>Oct 22</td>
<td>The Billing Office DIET</td>
</tr>
<tr>
<td>Aug 06</td>
<td>The HHS OIG Workplan - What’s in it for You?</td>
<td>Oct 29</td>
<td>Tricks for OB/GYN Coding - Don’t Be Scared!</td>
</tr>
<tr>
<td>Aug 13</td>
<td>How to Audit an Audit</td>
<td>Nov 05</td>
<td>Defending an Adverse E/M Audit: What the E/M Guidelines Really Say</td>
</tr>
<tr>
<td>Aug 20</td>
<td>Vital Building Blocks for a Successful Medical Practice</td>
<td>Nov 12</td>
<td>Common E/M Coding Conundrums</td>
</tr>
<tr>
<td>Sept 09</td>
<td>How to Effectively Analyze and Manage the Denial Process</td>
<td>Nov 19</td>
<td>ASC: Avoid Common Errors</td>
</tr>
<tr>
<td>Sept 10</td>
<td>CMS Value-Based Payment Modifier</td>
<td>Nov 25</td>
<td>2015 CPT Updates</td>
</tr>
<tr>
<td>Sept 24</td>
<td>Pain Management E/M Coding for Pain Injections, EMG/NVC Studies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Visit aapc.com/webinars | 800-626-2633 (CODE)
Pain Management for Compliance Concerns

With compliance programs now mandatory for providers who treat Medicare and Medicaid patients, compliance officers are feeling the pressure. The job of a compliance officer is an important one, but it shouldn’t be overwhelming. Let’s look at the challenges many compliance officers face and, with the help of a couple of compliance experts, lighten the load a bit.

Know What You’re Up Against

A compliance officer’s primary responsibility is to develop a corrective action plan for compliance risks identified in periodic audits, and to oversee the practice’s adherence to that plan.

A compliance officer may also be responsible for:

- Overseeing and monitoring the implementation of the practice’s compliance program;
- Establishing methods, such as periodic audits, to assess risk and reduce the practice’s vulnerability to fraud and abuse of government programs, as well as improve the practice’s efficiency and quality of services;
- Periodically revising the compliance program in light of changes in the needs of the practice or changes in the law and in the standards and procedures of government and private payer health plans;
- Developing, coordinating, and participating in a training program that focuses on the components of the compliance program;
- Ensuring the Office of Inspector General’s (OIG) List of Excluded Individuals and Entities, and the General Services Administration’s Excluded Parties List System have been checked with respect to all employees, medical staff, and independent contractors; and
- Investigating reports or allegations concerning possible unethical or improper business practices, and monitoring subsequent corrective action and/or compliance.

Write Your Job Description

That’s a lot of responsibility for one person to take on! If you’re a compliance officer, and you are feeling overwhelmed in your day-to-day responsibilities, it’s time to do something about it. A good place to start is by making a list of everything you do. Categorize your duties by how often you do them (e.g., daily, weekly, monthly, annually, etc.).
Review your list and determine which of these tasks are the most challenging. In speaking with several compliance officers, their most challenging duties include:

- Keeping up with regulatory changes
- Training staff on compliance
- Communicating compliance issues with staff
- Creating and maintaining an audit trail

Once you’ve identified your pain points, you’re ready to conduct a little pain management. For example, if communication is your worst nightmare, Marcella Bucknam, CPC, CPC-H, CPC-P, CPC-I, CCC, COBGC, CCS-P, CCS, compliance manager at University of Washington Physicians, recommends using multiple ways of communicating critical information.

“Send emails to everyone to update them on changes or problems that affect the whole group. You can also create flyers or newsletters that include reminders about errors that happen frequently. Add a little time to talk about compliance at staff meetings or lunchtime meetings. Providing reminders in many different formats will allow staff to review the information when they have the time to really think about compliance,” Bucknam explains.

Whereas, if you find staying current with regulatory changes is keeping you awake at night, remote healthcare consultant and ICD-10 trainer Lamon Willis, CPCO, CPC-I, CPC-H, CPC, suggests signing up for multiple Medicare fiscal intermediary, Medicare administrative contractor, and carrier listservs. “This will allow you to receive emails concerning government regulatory changes by state, region, and also any national guidance that occurs. There will be overlap of issues, which will confirm that you have done your due diligence for review of regulatory changes,” Willis says.

Remember: You’re not alone! You have access to a vast network of compliance professionals who can help you.

The 7 Components to Compliance

The Office of Inspector General (OIG) outlines in a September 11, 2000 notice, OIG Compliance Program for Individual and Small Group Physician Practices, the seven components that provide a solid basis upon which a physician practice can create a compliance program:

1. Conduct internal monitoring and auditing through the performance of periodic audits.
2. Implement compliance and practice standards through the development of written standards and procedures.
3. Designate a compliance officer or contact to monitor compliance efforts and enforce practice standards.
4. Conduct appropriate training and education on practice standards and procedures.
5. Respond appropriately to detected offenses through the investigation of allegations and the disclosure of incidents to appropriate government entities.
6. Develop open lines of communication with employees, such as discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and community bulletin boards to keep practice employees updated regarding compliance activities.
7. Enforce disciplinary standards through well-publicized guidelines.

“Writing and maintaining policies and procedures is one of the seven elements of an effective compliance program that I find often gets missed or delayed,” said Marcella Bucknam, CPC, CPC-H, CPC-P, CPC-I, CCC, COBGC, CCS-P, CCS. “It is critical that all policies are current and that they reflect the actual practices of the group. For example, if you have a policy that says all notes must be signed within 14 days, that policy should be followed, and any audits or reviews should include monitoring for timely signatures. Medicare requires ‘timely’ signatures but has not defined what they consider to be timely. However, if your group has defined timely as 14 days, you can use that guideline to reprimand those who are holding up the works by not signing their records.”
Utilizing a compliance management system is another viable solution for practices.

Arm Yourself with Essential Knowledge

Naturally, the more you come to understand about compliance, the better equipped you will be to handle the job. AAPC’s Certified Professional Compliance Officer (CPCO™) credential prepares individuals for the responsibilities of this demanding position, and reassures employers that they’ve hired the best person for the job.

In earning your CPCO™ credential, you will come to understand the key requirements to developing, implementing, and monitoring a healthcare compliance program, and be able to demonstrate knowledge of:

- OIG Compliance Program for individual and small group physician practices, clinical laboratories, and third-party billing companies
- Compliance program effectiveness
- Key healthcare fraud and abuse laws including the False Claims Act, Stark Laws, and Anti-kickback Statute, including the associated penalties
- How the Affordable Care Act will affect medical practices
- Other laws and regulations including HIPAA, EMTALA, and CLIA
- Handling investigations, including self-disclosure protocols
- Requirements under Corporate Integrity Agreements and Certificate of Compliance Agreements
- Current investigative activities (RACs, ZPICs, MFCUs, etc.)
- Risk areas such as accepting gifts/gratuities, conflicts of interest, use of Advance Beneficiary Notices, teaching physicians guidelines, and incident-to services

Learn more about earning your CPCO™ credential on AAPC’s website, www.AAPC.com.

Consider Compliance Management Software

Utilizing a compliance management system is another viable solution for practices. An affordable solution to complete compliance is AAPC’s 7Atlis.

7Atlis offers everything a practice needs for the creation and management of all seven elements of a comprehensive compliance program, including:

- Automated risk assessment tools
- Audit management
- Compliance category checklists
- Training courses
- Incident management
- Documentation control
- Reporting and dashboard capabilities
- External audit services and support
- Comprehensive Reports and Dashboards
- Non-Compliance Management
- Incident management
- Reporting and dashboard capabilities
- External audit services and support
- Compliance Category Checklists
- Train, Test and Review Dashboards on Mobile Devices
- Automated Risk Assessment
- Audit Management and Tracking
- Total Compliance Management
- Affordable for All Practices
- 7Atlis systematically enables users to design and maintain their own custom compliance programs.
- From drafting policies to incident management, 7Atlis to compliment the feature-rich essentials, 7Atlis features include:
- Total Compliance Management
- Simple Step-by-Step Guidance
- Feature Rich + Bonus Resources
- Affordable for All Practices
- 7Atlis

Register for a free demo today at www.7atlis.com to see what it’s like to have total confidence that your practice is compliant, trained, and fully protected, even when audited.

Barry L. Johnson, DDS, is president of AAPC’s Compliance Division. His 44 years in healthcare include a wide range of experience in a variety of roles. Prior to coming to AAPC, he was a founding partner and CEO of HealthCare Insight (HCI), acquired in 2007 by Verisk Analytics. He continued as president of the HCI division of Verisk Health, the leader in fraud and abuse prevention solutions for payers, until his retirement in December 2011. His first fictional work, Untried Greed, a thriller about healthcare fraud, was published in 2012.

Renee Dustman is an executive editor of Healthcare Business Monthly.
Announcing 7Atlis by AAPC

Total Compliance Management
The complete solution for the creation and management of all 7 elements of a comprehensive compliance program.

Simple Step-by-Step Guidance
From drafting policies to incident management, 7Atlis systematically enables users to design and maintain their own custom compliance programs.

Affordable for All Practices
Full compliance plus extra features provided at three pricing tiers designed to address the needs and budgets of all practice sizes.

Feature Rich + Bonus Resources
To complement the feature-rich essentials, 7Atlis users receive discounts on a host of optional AAPC products and services.

Among Other Things:
Automated Risk Assessment / Audit Management and Tracking / Comprehensive Reports and Dashboards / Non-Compliance Management / Compliance Category Checklists / Train, Test and Review Dashboards on Mobile Devices

7Atlis – Complete Compliance Management for a Surprisingly Affordable Fee
NEWLY CREDENTIALED MEMBERS

www.aapc.com July 2014

A&P Quiz Answer (from page 31)

The correct answer is C. There are three functions of the lymphatic system: to remove excess fluids from body tissues; to produce immune cells; and to absorb fats and fat-soluble vitamins from the digestive system and transport them to the venous circulation.
Tell us a little bit about your career — how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.

I have been with CoxHealth — a not-for-profit health system — for more than 20 years. Thirteen of those years have been with Ferrell-Duncan Clinic (FDC) — one of CoxHealth’s 80 physician clinics in Missouri.

I became interested in medical coding when I was hired as a Medicare claims follow-up representative for FDC. I was curious as to why a certain ICD-9-CM code should be primary on a claim or why a CPT® code had to be filed with a specific ICD-9-CM code. I had a very patient teacher who answered all of the questions I asked. I was hooked after that. I became certified in 2009 and an AAPC member shortly before that. I now code for urology and general surgery, which includes surgical oncology, bariatric, and trauma. I tell everyone who asks where I work, “I work for the best physicians in Southwest Missouri!”

What is your involvement with your local AAPC chapter?

I have been involved with my Springfield, Mo., local chapter for many years and have met some wonderful people. I jumped in at my first meeting by volunteering for the registration table for an upcoming seminar. Since then, I have served as member development officer, which was a new officer role when I volunteered for the position. Being a member officer allowed me to meet new people, mentor, and become friends with a lot of people. I also served as education officer, which has been my favorite role. I love to learn through teaching. I have helped with review classes and served on committees for seminars and May MAYnia. When a person says, “Thank you for spending an extra 10 minutes with me,” as they prepare for a Certified Professional Coder (CPC®) exam or “Thanks for all you have done for our chapter,” it makes all of my hard work worth my time.

What AAPC benefits do you like the most?

There are so many great things AAPC offers; the list is too long to name everything, but I’ll name a few. I love the forums. I have always been able to find additional information to help me with daily coding. The discounts we receive on coding resources and books are also nice. I was fortunate to attend the Chicago regional conference a few years ago. Not only was it a great educational experience, but a wonderful opportunity to meet new people.

What has been your biggest challenge as a coder?

It has been a challenge to keep up with the many changes in healthcare over the last several years, and to keep my providers in the loop without overwhelming them. Some people think medical coders don’t deal with patient care, but that is simply not true. It truly breaks my heart when a patient cannot afford a much needed test or procedure because of financial strains. It’s hard to code a surgery or send a claim out the door to a patient knowing he or she may not be able to afford it.

How is your organization preparing for ICD-10?

Our clinic has monthly ICD-10 meetings. We have a coding round table where we code documentation that is selected by a coder prior to the meeting. We then meet to discuss and share our findings. When appropriate, we take information gathered from a meeting and share it with our providers to help improve their documentation. We study and discuss ICD-10 guidelines and how they will affect our business. The training and education has not stopped for us, even with ICD-10’s delay.

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

I love what I do. I would expand on my job and become a trainer/educator for medical coding. I’d make sure those interested in medical coding understood everything about the career, not just how to code. I also love to write, so maybe I’ll become an author, as well.

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

I love to read. A lot of my time lately is spent reading and learning anything related to ICD-10. I am a self-professed coding geek. My husband and I like to do what we call “free-style junking.” We buy what others have deemed “junk,” and refurbish it. We also love spending time with our grandchildren.
AAPC REGIONAL CONFERENCES
Starting at $495 | 12+ CEUs | Featuring ICD-10 & Practice Management

CHICAGO
August 28-30, 2014
Hyatt Regency Chicago

ANAHEIM
September 18-20, 2014
Disneyland® Hotel

Save $50 with coupon code: 50HBMV14
www.aapc.com/2014regionals
800-626-2633
Stay the course - continue your training and preparation for the transition to ICD-10.

With Optum360 tools and resources at your fingertips, you can open a world of opportunities and help build the foundation for greater efficiencies, financial gains, and competitive advantages. For nearly 30 years, our print resources have remained trusted tools for coding professionals, and our 2015 editions offer the same quality and reliability you have come to expect from us.

Eliminate roadblocks with web-based coding solutions. ICD-10 will have 668 percent more codes than ICD-9. Web-based coding solutions can help you experience a smooth, successful transition with fast access to ICD-10 codes, data and mapping tools, and can easily be used in conjunction with our ICD-10 training book. Learn more about EncoderPro.com and RevenueCyclePro.com today.

Save up to 25% on the ICD-10 resources you need.

Visit OptumCoding.com and enter promo code GETICD10 to save 25%

Call 1.800.464.3649, option 1 and mention promo code GETICD10 to save 20%