

HEALTHCARE BUSINESS MONTHLY

Coding | Billing | Auditing | Compliance | Practice Management



AAPC

Advancing the Business of Healthcare

April 2015

www.aapc.com

NAB

Ready to Listen.
Prepared for Change.



2015 Pain Medicine Billing Changes: 36
Know code and epidural steroid injection updates

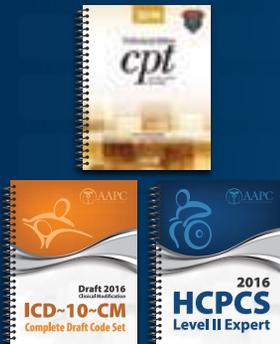
Therapy Setting Specialty Programs: 42
Mull over the benefits and drawbacks

Target Risky Billing Patterns: 46
Use benchmarking to compare your E/M levels

HEALTHCON AAPC National Conference Issue

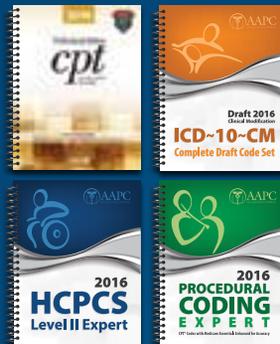
AAPC'S 2016 CODE BOOKS SAVE UP TO 65%

On our best Early Bird code book sale
by pre-ordering your 2016 books now



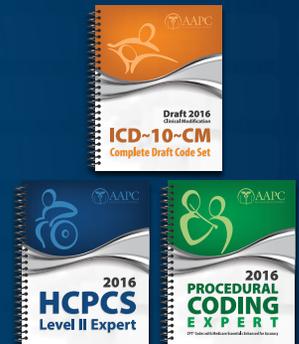
ICD-10 Physician Bundle 1

Retail: \$314.85
Member: **\$184.95**
thru June 30



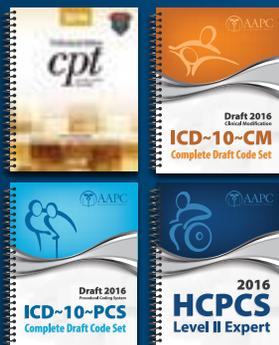
ICD-10 Physician Bundle 2

Retail: \$414.80
Member: **\$224.95**
thru June 30



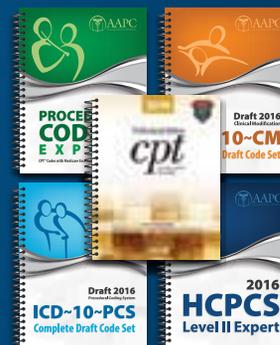
ICD-10 Physician Bundle 3

Retail: \$299.85
Member: **\$99.95**
thru June 30



ICD-10 Hospital Bundle 1

Retail: \$414.80
Member: **\$229.95**
thru June 30



ICD-10 Hospital Bundle 2

Retail: 514.75
Member: **\$274.95**
thru June 30

Highest Quality, Lowest Prices

CPT® is a registered trademark of the American Medical Association.



COVER | Member Feature | 12

Meet Your New NAB President

Michelle A. Dick



[contents]

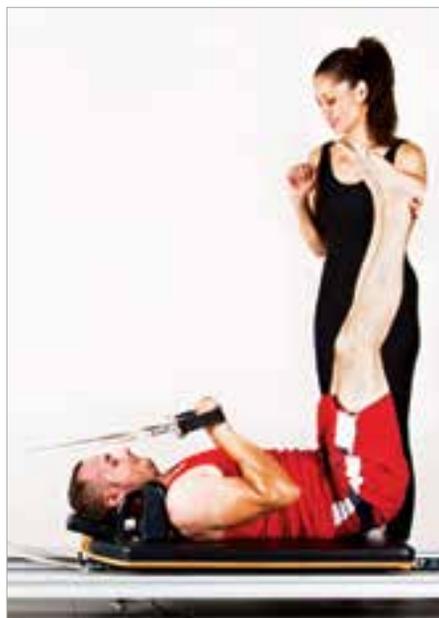
■ Coding/Billing



22 Gather Components for OB Ultrasound Codes 76805 and 76811

Pamela K. Kostantenaco, LPN, CPC, CMC

■ Practice Management



42 Mull Over Specialty Programs in the Therapy Setting

Kim Cohee, DPT, PT, MBA, OCS

■ Auditing/Compliance



51 Five Risk Areas Lurking within Your Pharmacy

Erica Lindsay, PharmD, MBA, JD

[continued on next page]



Coding/Billing

- 26 99211: Not So Simple
Karla M. Hurraw, CPC, CCS-P
- 28 How Medical Necessity Fits Into E/M Leveling
Ellen Risotti-Hinkle, BS, CPC, CPC-I, CPMA, CEMC, CIMC, CFPC
- 30 Use CMS' General Principles to Improve Documentation
Valerie Milot, BS, CPC, CCS
- 32 Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)
Chandra Stephenson, CPC, COC, CPB, CPCO, CPMA, CIC, CCS, CPC-I, CANPC, CEMC, CFPC, CGSC, CIMC, COSC

- 36 Pain Medicine Providers: Review 2015 Billing Changes
Joette Derricks, MPA, CMPE, CPC, CHC, CSSGB

Practice Management

- 42 Mull Over Specialty Programs in the Therapy Setting
Kim Cohee, DPT, PT, MBA, OCS

Auditing/Compliance

- 46 Target Risky Billing Patterns Using E/M Benchmarking
Judy MacWhinnie, RN, CPC, and Gene Clarke, MBA, CIA, CISA
- 55 Building a HIPAA Toolbox
Stacy Harper, JD, MHSA, CPC
- 58 HEALTHCON Hot Topic: Compliance Plan 101
Marcia L. Brauchler, MPH, FACMPE, CPC, COC, CPC-I, CPHQ

Special Feature

- 16 Welcome 2015-2018 NAB

COMING UP:

- 2014 Member of the Year
- 2015-2016 AAPC Chapter Association
- Medicare Teleconferences
- Informed Consent
- E/M vs. Eye Exams

On the Cover: NAB President Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC, welcomes AAPC's expansion into all areas of healthcare, and wants members to voice their needs. Cover photo by Rachel Minson.

DEPARTMENTS

- 7 Letter from the CEO
- 9 Healthcare Business News
- 10 AAPC Chapter Association
- 21 Quick Tip: DPS for ALS
- 33 A&P Tip
- 39 ICD-10 Quiz
- 40 Why I Am Certified

- 66 Added Edge: Conference Preview

EDUCATION

- 62 Newly Credentialed Members

Online

Test Yourself – Earn 1 CEU
www.aapc.com/resources/publications/healthcare-business-monthly/archive.aspx

Dr. Z presents an abundance of information in a clear, organized, and very entertaining way. The days fly by and I leave feeling excited about the knowledge I have learned. Thank you Dr. Z.

*--Laura Ross, Revenue Integrity Auditor
Dr. Z is an excellent teacher. I enjoy his style of teaching. He teaches anatomy, procedure details, devices and revenue cycle.
--Marsha McRorie, Clinical Specialist*

Join Us in

DOWNTOWN NASHVILLE

Tennessee

May 11th-15th at
the Omni Hotel

INTERVENTIONAL
RADIOLOGY
CARDIOLOGY &
VASCULAR SURGERY
CODING SEMINAR
WITH ICD-10

ICD-10 PCS COMPANION CODING REFERENCES COMING SOON.


PUBLISHING
WWW.ZHEALTHPUBLISHING.COM

HEALTHCARE BUSINESS MONTHLY

Coding | Billing | Auditing | Compliance | Practice Management

April 2015

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

Mahfooz Alam
 Renee Dustman, BS

Advertising

Jamie Zayach, BS
jamie.zayach@aapc.com

Jon Valderrama
jon.valderrama@aapc.com

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

Healthcare Business Monthly
PO Box 704004
Salt Lake City, UT 84170
(800) 626-2633

©2015 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 2014 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®, COC™, CPC-P®, CPCO™, CPMA®, and CIRCC® are registered trademarks of AAPC.

Volume 2 Number 4

April 1, 2015

Healthcare Business Monthly (ISSN: 23327499) is published monthly by AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208, for its paid members. Periodicals Postage Paid at Salt Lake City UT and at additional mailing office. POSTMASTER: Send address changes to: Healthcare Business Monthly c/o AAPC, 2480 South 3850 West, Suite B, Salt Lake City UT 84120-7208.

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!

vendor index

Coding Institute, LLC.....	25
www.SuperCoder.com	
CodingWebU.com	19
www.CodingWebU.com	
HealthcareBusinessOffice, LLC.....	39
www.HealthcareBusinessOffice.com	
Medical Group Management Association	61
www.mgma.org	
Optum360™ A leading health services business.....	54
www.optumcoding.com	
ProAssurance	41
www.proassurance.com	
ZHealth Publishing, LLC.....	5
www.zhealthpublishing.com	



Speak Up and Be Heard!

Do you have a question regarding information found in *Healthcare Business Monthly*? Or maybe you have a difference in opinion you would like to share with your peers?

Write us at: letterstotheeditor@aapc.com.

Leadership and Change Walk Hand in Hand

Change is the foundation of our field. Whether you code, bill, audit, maintain compliance, or manage, you know that each day brings changes from within and outside your workplace. I'm reminded of that every time I'm lucky enough to speak with you about the future we envision.

I'm excited that I'll have the opportunity to talk with many of you at AAPC's HEALTHCON National Conference, March 29-April 1, in Las Vegas, where we'll focus on change and leadership through workshops and networking. We'll embrace the new National Advisory Board (NAB) and AAPC Chapter Association board officers and members, and we'll honor those who have contributed so much during their tenure. All are models of leadership.

How a Great Leader Is Made

Our colleagues look to us for resolution when change blows in, whether it presents as a breeze or a thunderstorm. A great leader is committed to helping others and striving to improve the situation. It's executing on the day-to-day deliverables while making changes to help bring the future we want to create for tomorrow. It's lifting more than leaning. It's being part of the solution rather than being part of the problem — professionally and personally.

President Theodore Roosevelt described how change and leadership interact best: "It is not the critic who counts; not the [person] who points out how the strong [person] stumbles or where the doer of deeds could have done them better. The credit belongs to the [person] who is actually in the arena ... who strives valiantly ... who knows the great enthusiasms, the great devotions

... who spends [him- or her-]self in a worthy cause."

David Dunn, MD, FACS, CIRCC, CCVTC, CCC, COC, CCS, RCC, our outgoing NAB President, is a perfect example of that type of leader. During his years as a NAB officer, he has helped AAPC adapt to change — from our field's diversification of roles to ICD-10's on-again, off-again implementation. President-elect **Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC**, profiled in this issue of *Healthcare Business Monthly*, has already demonstrated her leadership abilities and will be introduced as new NAB president at National Conference. She, too, is a perfect example of get-it-done leadership. I'm excited and grateful to have her enthusiasm and experience as she represents AAPC's growing membership.

Leaders Advance the Business of Healthcare

Leaders prepare for change by learning and perfecting skills, never failing to take advantage of opportunities to understand what the changes are. That's why AAPC continues to develop new training for ICD-10 implementation, documentation, and coding, billing, and practice management, among other skills. New credentials for inpatient coding (CIC™) and risk adjustment (CRC™) are additional opportunities for you to manage change and demonstrate your leadership.

Thank you for continuing to be leaders in your professions. Please know your leadership contributions across your companies, local chapters, and communities are deeply appreciated. I am grateful for the oppor-



It's being part of the solution rather than being part of the problem — professionally and personally.

tunity to work with you and learn from you as we advance the business of healthcare together.

Sincerely,
Jason J. VandenAkker
CEO

How to Effectively Teach ICD-10 Documentation to Your Doctor

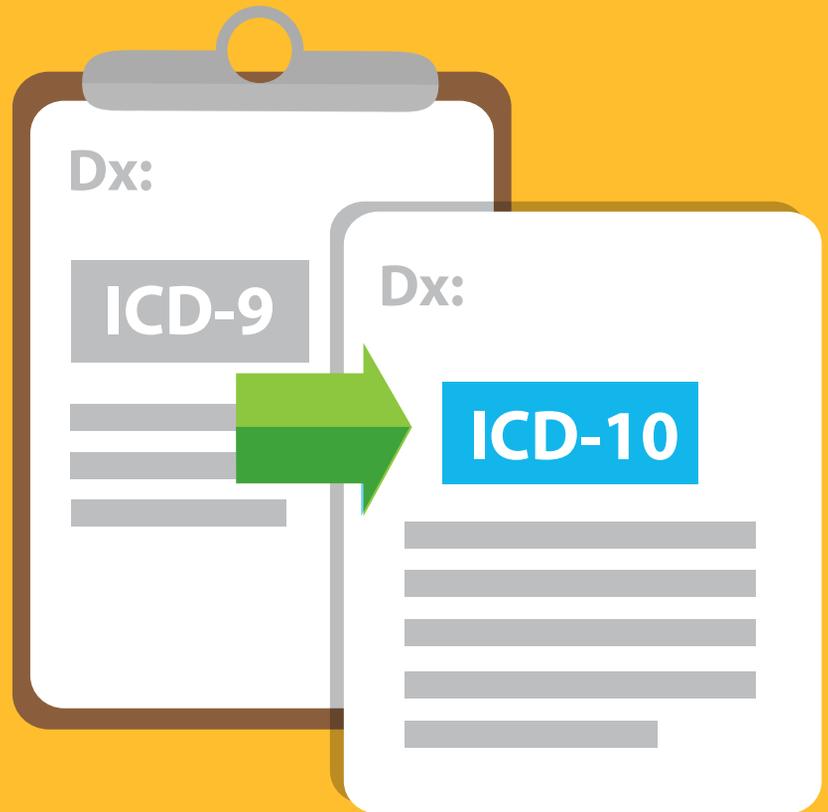
Author: Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

May Workshop Bundle: 4 Hours | 6 CEUs | \$199.00

includes Clinical Documentation Improvement Training (\$149 value)

In this workshop, you will learn:

- ✓ Results of nationwide studies detailing the preparedness of physicians across 25 specialties
- ✓ Why there is a gap between current documentation and ICD-10 specificity requirements
- ✓ 20 unique documentation concepts
- ✓ Top most effective ways to communicate documentation and code selection best practices to your doctor



Workshop Features:



Interactive and hands-on exercises with case studies



4 hours includes presentation and skill-building practice



Comprehensive workbook including presentation slides



Bonus: CDI Training access (\$149 value)



Find a location near you!
1-800-626-2633
aapc.com/MayWorkshop2015



By Susan Theuns PA-C, CPC, CHC

Medicare Updates Part B Coverage for Pneumococcal Vaccinations

Consistent with recent Advisory Committee on Immunization Practices (ACIP) recommendations, the Centers for Medicare & Medicaid Services (CMS) has updated its coverage for pneumococcal vaccinations. *MLN Matters*® Number: MM9051 (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9051.pdf) explains that Medicare will now cover:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

A Medicare beneficiary may receive the vaccine without a physician's order, and without physician supervision.

Previously, Medicare covered an initial revaccination for beneficiaries at high risk of serious pneumococcal disease, and revaccination for beneficiaries at highest risk of serious pneumococcal infection "and those likely to have a rapid decline in pneumococcal antibody levels, provided that at least five years had passed since the previous dose of pneumococcal vaccine."

When giving flu shots, consider the patient's prior vaccination history. "Receiving multiple vaccinations of the same vaccine type is not generally recommended," CMS instructs. For example:

... if a beneficiary who is 65 years or older received the 23-valent pneumococcal polysaccharide vaccine (PPSV23) a year or more ago, then the 13-valent pneumococcal conjugate vaccine (PCV13) should be administered next as the second in the series of the two recommended pneumococcal vaccinations.

MM9051 has been effective since February 2, and applies retroactively since September 19, 2014. Payers will not automatically adjust payment for claims filed from September 19, 2014-February 2, 2015; you must contact the payer to secure payment.

Low-cost Medicare Fraud Exposes Doctor to Prison and Hefty Fines

The *Denver Post* published an article about an Ohio podiatrist, Anthony Innocenzi, MD, who practiced medicine in Grand Junction, Colorado, and who pleaded guilty to Medicare fraud. The case is important, and should make providers pause and think because it demonstrates that even a small amount of inappropriately obtained money can serve as the basis for a fraud investigation and prosecution by the government.

Innocenzi practiced podiatric medicine at a nursing home, but

claimed he saw patients in an office. Use of the office place-of-service code qualified him for higher reimbursement levels than he should have received. Although the scheme only cost Medicare \$2,000, "the doctor could be sentenced to 10 years in a federal prison and to a three-year supervised release term and be fined up to \$250,000," according to Senior U.S. District Judge John Kane. A probationary term is also possible.

Because Innocenzi's guilty plea is a felony count of insurance fraud, he is now on Medicare's Exclusion List (<http://exclusions.oig.hhs.gov/>).

AAPC's National Advisory Board, Legal Advisory Board, and Ethics Committee member, **Michael Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO**, alerted *Healthcare Business Monthly* of this story, noting its significant to healthcare providers because "it demonstrates that even small overpayments can cause criminal trouble for physicians."

Resource: www.denverpost.com/news/ci_27513345/doctor-pleads-guilty-bilking-government-medicare-scheme

New Code for Reporting Group Obesity Counseling

In the Medicare Physician Fee Schedule for 2015, the Centers for Medicare & Medicaid Services created a HCPCS Level II code for face-to-face behavioral counseling for obesity in a group setting (G0473 *Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes*).

This code is payable under Medicare Part B for claims with dates of service on or after January 1, 2015.

To receive payment, G0473 (like its sister code G0477 *Face-to-face behavioral counseling for obesity, 15 minutes*) must be supported with a documented diagnosis of a body mass index (BMI) of 30.0 or more.

Usual diagnosis codes for reporting BMI include:

ICD-9: V.85.30 – V85.39, V85.41 – V85.45

ICD-10: Z68.30 – Z68.39, Z68.41 – Z68.45

Provider specialty types that qualify for payment of this service are: 01, 08, 11, 16, 37, 38, 50, 89, and 97. Allowable places of services are: 11, 22, 49, and 71.

This is a preventive service so Medicare beneficiary coinsurance and deductible do not apply.

Note: Coverage of group obesity counseling is at the carrier's discretion. Check your commercial payer contracts for coverage and reporting policies.

For complete guidance, see Medicare National Coverage Determinations Manual, Chapter 1, Section 210.

Source: *MLN Matters*® Article MM8874 Revised





Professionalism and Ethics Define Our Local Chapters



In keeping with the AAPC elevation statement of “Up-holding a Higher Standard,” your local chapter opens its doors (at least once a month) to provide you with networking and low cost educational opportunities. Set aside time this month to visit your chapter and network with your colleagues, enhance your career, and reinforce your professional ethics.

Professionalism and Ethics

Professionalism and adherence to ethical standards are essential for career success.

Being professional to some may mean dressing smartly, doing an excellent job, or arriving on time for work. For others, professionalism may mean earning advanced degrees and certifications. True professionalism encompasses all of that, and more. And it goes hand in hand with ethics.

Tip: View AAPC’s Code of Ethics at: www.aapc.com/aboutus/code-of-ethics.aspx.

As healthcare business professionals, we are known for our specialized knowledge. Our credentials show that we have made a deep, personal commitment to develop and improve our skills beyond any degrees and certifications we hold. We work hard to keep our knowledge up to date in an ongoing effort to deliver the best work possible.

Strive for Professionalism

Still not sure what being a “professional” means? As an AAPC professional, you exhibit:

Competency and reliability—You get the job done in a timely manner and do your best to meet expectations. Whenever you make a promise to your supervisor, colleagues, or team members, you keep it. If circumstances arise that make it difficult for you to meet a deadline, you let your supervisor, colleague, or team member know as soon as possible.



Let Kindness Lead You During May MAYnia

Spring is here and your local chapter is gearing up for its annual May MAYnia event. Be sure to attend your local chapter meetings to learn more about this exciting celebration.

Although every day is an opportunity to help someone, I encourage you to perform an act of kindness in May. Make a donation to Project AAPC, mentor someone at work or in your local chapter, buy someone a cup of coffee, or just smile and ask, "How are you?"

A little kindness goes a long way, and it's contagious.

No excuses – You always meet expectations to the best of your ability.

Honesty and integrity – You exhibit honesty and integrity. You keep your word and, in turn, your co-workers trust you implicitly. You never compromise your professional values and always choose to do the right thing, even when it's the least popular option.

Accountability – You hold yourself accountable for your words and actions, especially when you make a mistake.

Self-regulation – You exhibit a high degree of emotional intelligence by considering your co-workers' emotions and needs.

Exemplary image – You look the part and don't show up to work with unkempt hair, wrinkled clothes, or unprepared for the task at hand. You exude an air of confidence that gains you respect.

Preparedness – You are always prepared with the tools you need to complete the assignment at hand. This requires advance planning, timeliness, and attention. You focus on improving your time management and planning skills.

Politeness – You are kind, polite, and use good manners to everyone you come in contact with, no matter what their roles are or how you're feeling.

Humbleness – If a project or job falls outside your scope of expertise, you aren't afraid to admit it. You immediately seek help and are willing to learn from others.

Exhibit True Professionalism

Professionals are successful because they are the first to be considered for promotions and usually are awarded

valuable projects. As a professional, others will respect you and value you.

Take a moment to review your attributes and characteristics. Demonstrate professionalism every day and you'll soon earn a reputation as a positive and genuine contribution to your organization. **HBM**



Faith C.M. McNicholas, RHIT, CPC, CPCD, PCS, CDC, 2014 AMA Specialty Staff Liaison Excellence Award recipient, has experience in various solo and group practice medical specialties. She is the assistant editor for American Academy of Dermatology's (AAD) *Derm Coding Consult*, and a contributor for Association of Dermatology Managers/Administrators (ADA/M) Newsletter and *Journal of Dermatology Nurses Association (JDNA)*. McNicholas presents at AAD annual and summer meetings, AAPC regional conferences, ADA/M and JDNA annual meetings, and AAD monthly webinars and regional symposia. She is an ICD-10-CM/PCS expert and approved trainer and a past president, president-elect, and secretary of the Des Plaines, Illinois, local chapter.

Don't let your knowledge and skills get outdated. Make a commitment to build expertise and stay up to date with local chapter continuing education units.

Get to Know Your New NAB President

As AAPC grows its presence in our industry, strong, focused leadership is paramount.



Photography: Rachel Mason

An issue Kipreos wants to speak out about during her tenure is the importance of staying informed and connected as coders ...

Just a few short months ago, you knew the incoming AAPC National Advisory Board (NAB) President **Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC**, of San Diego, California, as Jaci Johnson of Richmond, Virginia. Since taking the helm from **David Dunn, MD, FACS, CIRCC, CCVTC, COC, CCC, CCS, RCC**, Kipreos has experienced major life-changing events simultaneously. Despite the flurry of excitement, Kipreos is calm, cool, collected, and focused on representing and leading AAPC membership during her 2015-2018 tenure as NAB president.

Let's take a moment to get to know Kipreos and learn what she brings to AAPC members as the organization grows into the business of healthcare. (See, also, the accompanying sidebar, "Up Close and Personal" for Kipreos' recent non-NAB-related life events.)

The Path to Presidency

To put into perspective the road Kipreos has traveled to get to NAB presidency, let's rewind 27 years to when she was in labor with her first child. As she entered the world of motherhood, the door to coding and auditing opened for her, as well. During labor at the hospital, her obstetrician/gynecologist offered her an assistant office manager position at her practice. It was a great opportunity for Kipreos, who has a degree in finance, and she gladly accepted. As soon as she began her new job, her career path all started to make sense.

"I found the coding books in the office and began reading them, and taught myself to code," Kipreos said.

She was hooked, and soon began attending coding conferences. Later, in the early '90s, she had the opportunity to work at the University of Virginia (UVA) at the pain management center. Although AAPC was new to the industry, her manager at UVA trained coders and encouraged them to get certified. She showed them just how far coding and billing knowledge could take coders in the healthcare industry.

Since then, Kipreos has earned several credentials and has been recognized for her professionalism. In 2006, she was honored with the state of Virginia's Coder of the Year award. She has served office as president of both the Richmond and Charlottesville, Virginia, local



chapters. She is a regular conference speaker and presenter. Kipreos also is president of Practice Integrity, LLC, where she manages a national client list and provides compliance monitoring for provider documentation. Kipreos has also been on the NAB since 2011.

Proud to be with AAPC

When asked what excites her about AAPC, Kipreos' response was, "What doesn't?" She is especially excited to have CEO **Jason VandenAkker** at the helm of AAPC as it expands into all business aspects of the medical office and hospital settings.

Up Close and Personal

National Advisory Board (NAB) president **Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC**, has been busy.

Last spring, Kipreos reconnected with her high school sweetheart, Harold Kipreos, and married him on December 26, 2014. Their families were home for the holidays in Richmond, Virginia, so they decided it was the perfect time to tie the knot.

Since then, Kipreos has been teetering back and forth from her home in Richmond, to San Diego, California, to be with her husband. She was born and raised in Richmond, loves it, and says she never had a reason to leave until now. She and her two cats plan to make San Diego their permanent residence this spring.

Kipreos is, and always will be, the proud mom of her sons, Christopher, 27, and Kenny, 21.

Kipreos is excited for AAPC's continued expansion, and likes that the organization remains loyal to the importance of the Certified Professional Coder (CPC®) credential.



VandenAkker's excitement to have Kipreos leading AAPC membership with him is mutual. "Jaci's passion for members, industry expertise, leadership experience, and commitment to excellence are a few of the many attributes which make her an exceptional fit for the NAB president role. I am grateful for the opportunity to serve with her as we work together to help AAPC members achieve their full potential and to advance the business of healthcare," VandenAkker said.

Jaci Johnson Kipreos' Hot Picks

Movies: Independent films. She wants to feel something when she watches a movie and prefers it to be edgy.

Music: Classical, classic country, bluegrass, blues.

Books: Stories based on true life, or a book written about ordinary people. Two favorite authors are Lisa Genova and Richard Russo.

Television: HBO® series and Showtime®. She does not like sitcoms or reality TV. Favorite shows are Six Feet Under, Shameless, and Top Gear.

Leisure: Free time is spent reading, gardening, and riding motorcycles with her husband.

Perfect Vacation: Paris or Tuscany, or anywhere on the bike with her husband.

Kipreos is excited for AAPC's continued expansion, and likes that the organization remains loyal to the importance of the Certified Professional Coder (CPC®) credential. "We are taking on inpatient and risk adjustment, but still remembering our roots with the CPC, while keeping up with what's new and exciting in coding," Kipreos said. "AAPC may be growing fast, but we have the strength to do that."

ICD-10 is a hot topic for enthusiasm, as well. "ICD-10! I mean, we are right there. We are such a big part of it," Kipreos said. "Management and people like **Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC**, have worked so hard to get our name out there to organizations like CMS and MGMA." Kipreos says she loves seeing our experts' names in publications and speaking as leaders in the industry. "It's all because AAPC has grown so much and has exploded in this exciting time," she said.

Speaks Out on Accountability

An issue Kipreos wants to speak out about during her tenure is the importance of staying informed and connected as coders, and keeping up with what is happening in healthcare by listening, reading, and asking questions. A concern of hers is that coders are turning to online articles, blogs, and forums for information.

"Coders aren't working as hard as they used to ... they are just grabbing stuff and relying on people to give them the information, instead of doing the work to research it," she said. "Blogs may be a resource, but they aren't *the* source."

It's OK to consult various media for information, Kipreos said, but it's imperative to always verify the information through credible sources.

Visibility Is Important

Kipreos' goals are to make sure members know that they are a priority to the NAB, that the NAB exists, and that the NAB is a vehicle to make members' voices heard.

"I want members to know we are here to be that liaison, not just for local chapter issues, but for anything and everything: all the different credentials, the expansion, etc.," Kipreos said. "We want feedback and are here to take that feedback."



Change Is Inevitable

When Kipreos looks to the future of healthcare, she acknowledges that there will be more changes on the horizon. “I think we must

use caution when attempting to predict the future of healthcare in any capacity,” Kipreos said. “I never would have anticipated the delay in ICD-10 last year.”

“I think we all know that change is on the way,” Kipreos said. “In what form, exactly, is hard to say. ... Perhaps, the basis for physician payment will move toward a risk model, or medical necessity will take on a more important role, or the physician payment schedules will look more like DRGs? We don’t know.”

“This is where it’s important to stay informed, ask questions, and read, read, read a lot,” Kipreos advised.

Colleagues Give Support

Kipreos’ enthusiasm for serving members and leading AAPC with strength and grace is evident to other dignitaries of our organization.

AAPC Chapter Association Chair **Barbara Fontaine, CPC**, said, “Jaci is one of the stars of AAPC. She sparkles with personality and enthusiasm as she meets members and carries on the vision of our organization.”

Dunn, 2013-2015 NAB president, has gotten to know Jaci over the years through AAPC, and has served alongside her for the past four years. He said, “I find Jaci to be

a wonderful person and feel she will be a stellar leader as the NAB helps AAPC navigate the healthcare industry over the next several years. AAPC is fortunate to have her in this role.”

And **Michael D. Miscoe, JD, CPC, CASCC, CUC, CCPC, CPCO**, member of AAPC National Advisory Board, Legal Advisory Board, and Ethics Committee, had this to say: “Jaci’s passion for coding is only exceeded by her passion for AAPC and its members. Her skills as a coder are exceptional and her quest to continuously improve her knowledge is unending. She embodies the concept of what it means to be a ‘professional’ coder and ‘pays it forward,’ every day. If there was a Mount Rushmore of coders, she would be on it.”

AAPC welcomes Kipreos in her new role, and looks forward to working with her in our shared goal of supporting members. **HBM**

Michelle A. Dick is executive editor at AAPC.



Welcome 2015-2018 NAB

AAPC's National Advisory Board (NAB) is a team of 20 professionals, representing eight regions of the United States. It's a diverse team, experienced in many areas of the health-care industry. They are a voice for AAPC membership. We are proud to present to you our 2015-2018 NAB.

PRESIDENT



Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC – San Diego, California
President, Practice Integrity, LLC

Jaci Johnson Kipreos has been working in the field of medical coding and auditing for over 22 years and has been a CPC® since 1994. She teaches PMCC and manages a national client list, providing compliance monitoring for provider documentation. Kipreos was recognized as Coder of the Year in 2006 for the state of Virginia. She has served office as president for the Richmond and Charlottesville, Virginia, local chapters. Kipreos received her Bachelor of Science in finance from Virginia Tech.

PRESIDENT-ELECT



Michael D. Miscoe, JD, CPC, CASCC, CUC, CPCO, CCPC, CHCC – Central City, Pennsylvania
*President, Practice Masters, Inc.,
Founding Partner, Miscoe Health Law, LLC*

Michael Miscoe has a Bachelor of Science degree from the U.S. Military Academy, a juris doctorate degree from Concord Law School, is president of Practice Masters, Inc., and founding partner of Miscoe Health Law, LLC. He has served on AAPC's NAB since 2013, is a member of the Legal Advisory Board, and is chair of the Legal Ethics Committee. Miscoe is admitted to the Bar in California and to practice law before the U.S. Supreme Court and the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. He has 22 years of experience in healthcare coding and over 18 years as a compliance expert, forensic coding expert, and consultant. Miscoe has provided expert analysis and testimony in civil and criminal cases, and represents healthcare providers in post-payment audits and HIPAA matters. He is a national speaker, a published author, and is a member of the Johnstown, Pennsylvania, local chapter.

MEMBER RELATIONS



Angela Clements, CPC, CEMC, COSC – Covington, Louisiana
Coding and Education Department Internal Consultant, Ochsner Health Systems

Angela Clements has worked for seven years at Ochsner Health Systems as senior associate analyst and abstractor, and now as an internal consultant for the Coding and Education Department. She has been in healthcare for 16 years, holds several certifications, and has an associate degree in Health Service Office Management. Clements helped to establish the Covington, Louisiana, local chapter and has held the offices of president, vice president, treasurer, educator, and new member officer.

SECRETARY



Ann M. Bina, CPC, COC, CPC-I – West Salem, Wisconsin
Manager of Coding and Revenue Integrity, Gundersen Lutheran

Ann Bina has over 22 years of experience in the healthcare field and has held various positions throughout the revenue cycle. She has been a CPC® since 1993 and serves as president of the La Crosse, Wisconsin, local chapter. Besides obtaining multiple AAPC coding credentials, Bina holds a master's degree in Business Administration from Viterbo University and is Certified in Healthcare Compliance (CHC®).

AAPC LIAISON



Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC – Seneca, Pennsylvania
Vice President, ICD-10 Training and Education, AAPC

Rhonda Buckholtz is vice president of ICD-10 Training and Education at AAPC and a member of the Oil City, Pennsylvania, local chapter.

15-2018 NAB

REGION 1



Colleen Gianatasio, CPC, CPC-P, CPMA, CPC-I – Albany, New York
Risk Coding and Education Specialist, Capital District Physician's Health Plan, Inc.

Colleen Gianatasio has 17 years of experience in the health insurance field, including customer service, claims, quality, and coding. As a risk coding and education specialist, Gianatasio's primary responsibilities are reviewing medical charts, auditing, and providing education to physicians and their staff. She is a certified AAPC instructor and enjoys teaching PMCC, auditing, and ICD-10 classes. Gianatasio serves as secretary of the Albany, New York, local chapter.



Ellen Maura Wood, CPC, CMPE – Dover, New Hampshire
Practice Manager, Seacoast General Surgery

Ellen Wood has been working in the medical field for over 20 years and has been a certified coder for over 13 years. Besides being the practice manager for Seacoast General Surgery, she is the adjunct professor at a local community college. Wood's experience includes mentoring employed coders, daily management of a busy surgical practice, and oversight of meaningful use policies and objectives, PQRS, and ePrescribing programs, etc. She helped to start the first New Hampshire local chapter, Seacoast-Dover, and served on its board.

REGION 2



Christina A. LaRosse, CPC – New Florence, Pennsylvania

Business Manager, Alleghenies Independent Physicians

Christina LaRosse has been working in healthcare for 25 years, of which 20 have been in the area of practice management. She holds a Bachelor of Science degree in Healthcare Management and obtained her CPC® credentials in 1996. LaRosse is employed as business manager for a multi-specialty physician group and is involved in implementing electronic health records (EHRs). She achieved recognition as a CGM Enterprise EHR Certified Professional. LaRosse has served as adjunct faculty for Pennsylvania Highlands Community College and Westmoreland County Community College. She was one of the founding members of the Johnstown, Pennsylvania, local chapter and serves as president.



Sharlene A. Scott, RHIT, CPC, COC, CPC-I, CPMA, CCS-P-P, CCP-P – Baltimore, Maryland
Senior Healthcare Consultant/Educator, Coding Academy of America, LLC, and American Coding Centers, LLC

Sharlene Scott is an ICD-10-CM trainer and has been working in the healthcare arena for more than 26 years. She provides coding and documentation education and training for physician-based specialties, as well as inpatient and outpatient hospital services. Scott has an extensive background training physicians and support staff in the government and private sector. She has been an AAPC member for 18 years and PMCC instructor for the last 10 years. Scott is a member of the Baltimore East, Maryland, local chapter.

REGION 3



Brian Boyce, BSHS, CPC, CPC-I – Richmond, Virginia
CEO, Proprietor, and Managing Consultant, ionHealthcare, LLC

Brian Boyce is an AAPC-approved PMCC medical coding instructor, and an approved ICD-10-CM trainer with a special interest in ethics, patient safety, disease management, and risk adjustment. He is a veteran of Desert Storm, where he served on active duty with the U.S. Air Force with a job specialty of Aeromedical Evacuation. Boyce went into physician practice management and medical coding after an honorable discharge. After working in the risk adjustment field for over six years, he started his own consulting firm, ionHealthcare, LLC (www.ionHealthcareLLC.com), which specializes in risk adjustment work and education. Boyce is a member of the Richmond, Virginia, local chapter.



Caren J. Swartz, CPC, COC, CPC-I, CPMA, CPB – Moseley, Virginia
Senior Consultant/Auditor, Practice Integrity, LLC

Caren Swartz has been working in the field of medicine for more than 20 years. Her career began as a U.S. Navy corpsman/surgical technician, where she was part of the surgical team at the sub base in Groton, Connecticut. Swartz has worked in office settings of orthopedics, oral surgery, oncology, general and vascular surgical, and large multi-specialty practices. She has been a CPC® since 1999, is a PMCC instructor, a past president of the Richmond, Virginia, local chapter, and works as a senior consultant/auditor for Practice Integrity, LLC.

Welcome 2012

REGION 4



Leonta (Lee) Williams, RHIT, CPCO, CPC, CCS, CCDS – Covington, Georgia

Coding Manager, Georgia Cancer Specialists Healthcare Consultant, Karna, LLC

Lee Williams has over 12 years of experience as a coding manager, auditor, educator, trainer, and practice manager. She holds a degree in Health Information Technology and provides leadership and oversight on Karna's NCHS Data Coding contract sponsored by the Centers for Disease Control and Prevention. Williams' specialties include ICD-9, ICD-10, CPT®, and HCPCS Level II coding, E/M auditing, ED coding/auditing, DRG assignment, CDI, CMS guidelines, OIG restructuring, MAC/RAC/ZPIC audits, HIPAA, physician/coder training, and pay for performance measures, including PQRS, meaningful use, risk adjustment, and HEDIS. She is founder and past president of the Covington, Georgia, local chapter.



Shelley Vandiver Garrett, CPC – Jacksonville, Florida

Corporate Coding Integrity Auditor, Nemours Children's Health System

Shelley Garrett has more than 24 years of healthcare experience. Her experience includes working for the Medicare program in single and multi-specialty physician offices and hospital settings, serving as a compliance officer, consultant, instructor, and auditor. Garrett has served as the director of socioeconomic and member advocacy for an international medical specialty society, has established and instructed a national certification program, and has written numerous articles and program manuals on coding, billing, compliance, and governmental regulation. She has served as the staff liaison to the American Medical Association CPT® Editorial and Relative Value Update committees. Garrett is former education officer for the Jacksonville, Florida, local chapter.

REGION 5



Angela Jordan, CPC – Blue Springs, Missouri

Managing Consultant, Medical Revenue Solutions, LLC

Angela Jordan has more than 25 years of experience in the healthcare field, and has been an AAPC member for 15 years. Her career path has taken her from a small family practice, radiology, large physician services group to a managing

consultant. Jordan recognizes that AAPC and her local chapter have played a major role in her career success and she promotes AAPC and local chapters. She has been a member of the Kansas City, Missouri, local chapter since 2003 and has held many offices including president. In 2009, Jordan served as a member of the AAPC Chapter Association board of directors and was chair in 2012.



Lori A. Cox, MBA, CPC, CPMA, CPC-I, CEMC – Hannibal, Missouri

Coding Team Leader, MedKoder

Lori Cox has over 15 years of experience in multiple areas of healthcare including auditing and compliance. She has been certified since 2002 and has held the offices of vice president and secretary of the Quincy, Illinois/Hannibal, Missouri, local chapter. Cox recently earned a master's degree in Business Management from Quincy University. She is the coding team leader for MedKoder, providing medical coding and auditing services for many healthcare facilities across the nation. Cox enjoys auditing and educating providers on proper documentation requirements for E/M services.

REGION 6



Angela (Annie) Boynton, RHIT, CPC, COC, CPCO, CPC-P, CPC-I, CCS, CCS-P – Shrewsbury, Massachusetts

Principal, Boynton Healthcare Management Solutions

Annie Boynton has served in the health information management field for 15 years across provider, payer, and educational capacities. She is principal of Boynton Healthcare Management Solutions, specializing in practice and payer consulting, compliance, and education. Boynton holds several certifications in coding and has degrees in health information technology and health care management. She is pursuing graduate work in health, hospital, and pharmaceutical law at Seton Hall University. She is a member of the Worcester, Massachusetts, local chapter.



Kimberly Reid, CPC, CPMA, CPC-I, CEMC – Burlington, Vermont

Manager of Professional Coding, University of Vermont Medical Center

Kim Reid has over 26 years of coding experience in healthcare and has worked in a variety of professional medical settings, including an academic medical group in Vermont with over 500 physicians. Her previous roles were director of ICD-10 Train-

15-2018 NAB

ing and Education at AAPC and senior coding educator at Fletcher Allen Health Care. Reid is a national speaker who presents regularly on coding topics across the country.

REGION 7



Glenda L. Hamilton, CPC, COC, CPC-P, CPMA, CEMC, MCS-P – Mount Laurel, New Jersey

Senior Billing and Compliance Auditor, Cooper University Hospital

Glenda Hamilton brings over 25 years of experience in practice management, insurance, coding, reimbursement, education, consulting, and expert witnessing to the board of medical examiners and federal criminal trials. In 2005, she joined Cooper University Hospital as clinical documentation educator, and today she is senior billing

and compliance auditor. She has been an active member of the Cherry Hill, New Jersey, local chapter, holding office as president-elect twice, president twice, and education and new member development officer in the past 10 years. Hamilton has started multiple charitable projects in the chapter, and believes in “paying it forward.”



Angelica M. Stephens, RHIT, COC, CPC, COSC, CCS-P – Albuquerque, New Mexico

CBO Manager, New Mexico Orthopaedics Association

Angelica Stephens has been in healthcare industry since 1996, and most recently works as manager of coding and charge entry for New Mexico Orthopaedics Association (NMOA). She serves as a member of the educational committee for Carrington College. Stephens is a member of the Albuquerque, New Mexico, local chapter, where she trains, proctors, and has served as secretary, president, and liaison between new and seasoned coders.



CodingWebU.com TM

Providing Quality Education at Affordable Prices

We are the only program that provides interactive training incorporating audio, text and graphics to ensure you comprehend the information being taught. You will receive live updates as codes change and content is added. You always have access to the most current information, even if you purchased the course five years ago.

NEW! 2015 Annual Coding Scenarios!



Courses Starting at \$30

Specialty Coding - Chart Auditing - Evaluation and Management - OB/GYN
Revenue Management - Medical Terminology - Anatomy - Physiology

(484) 433-0495

*We offer group discounts and reporting capabilities!
We can also create or host custom courses for your employees!*



Welcome 2015-2018 NAB

REGION 8



Boyd P. Murayama, CPC, CPC-I – Hilo, Hawaii
Assistant Hospital Administrator and Medical Group Practice Director, Hilo Medical Center

Boyd Murayama has more than 20 years healthcare experience, and over the past eight years he has served as assistant hospital administrator and medical group practice director on the executive management team for a community-based hospital system. Murayama is responsible for a wide variety of functions from healthcare administration, physician recruitment and retention, hospital/professional coding/billing, consulting, compliance, physician education and training, budget management, forecasting, contract negotiation, employee development, etc. He received CPC® designation in November 1997 and has since received the CPC-I® and ICD-10 Train the Trainer designations. Murayama is a member of the Honolulu, Hawaii, local chapter.



Jonnie Massey, CPC, CPC-P, CPMA, CPC-I,
 AHFI – El Dorado Hills, California
*Director, Special Investigations Unit,
 Blue Shield of California*

Jonnie Massey's specialties include healthcare fraud investigation, prevention, and resolution. She has extensive experience in health insurance plans and management. Massey trains on healthcare fraud, coding, and ICD-10. She has served on healthcare-related work groups for the Blue Cross Blue Shield Association, National Health Care Anti-Fraud Association, and AAPC's NAB (from 2007-2009 and current). Massey is a member of the Sacramento, California, local chapter. **HBM**

The Fastest Coder Search Engine On The Planet!



The premier online coding tool from the largest coding credentialing organization

"I find the CMS 1500 claim edit checker to be the most helpful tool ever created by coding-mankind. I also love the fact that everything is in one place: LCD, NCCI edits, Fee Schedule, etc."

- Vanessa M.



Earn up to 20 CEUs with your annual subscription

Start your FREE 30-day trial today



800-626-2633 | aapc.com/coder

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

NeuRx Diaphragm Pacing System™ for ALS



Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease, is a progressive neurodegenerative disease of nerve cells affecting the brain's ability to control muscle movement, and may lead to paralysis and death.

The term *amyotrophic* comes from the Greek language. *A-* means no or negative; *myo-* refers to muscle; and *trophic*

means nourishment. When a muscle has no nourishment, it atrophies or wastes away. Lateral identifies the area of the spinal cord where portions of the nerve cells that signal and control the muscles are located. As the area degenerates, scarring or hardening (sclerosis) occur in the region.

Respiratory Dysfunction in ALS

The diaphragm is the principal respiratory muscle in humans. A coordinated, downward movement of the diaphragm with simultaneous elevation of the ribcage produces the muscular work of breathing. With ALS, nerve control of the diaphragm and other respiratory muscles becomes impaired and respiratory dysfunction develops.

Typical symptoms of diminished respiratory work (hypoventilation) are a disturbance of sleep architecture, daytime drowsiness, cognitive disorders, and infections of the upper airways. Hypoventilation impairs quality of life and is the life-limiting element in ALS.

Accepted methods for treating hypoventilation are mask ventilation (intermittent non-invasive ventilation) and tracheotomy (an incision in the windpipe) with mechanical (invasive) ventilation. Paresis and atrophy of the diaphragm cannot be prevented or slowed by this conventional ventilation therapy.

ALS researchers have developed a technique utilizing a diaphragm pacer. The first approved product, the NeuRx Diaphragm Pacing System™ (DPS), provides electrical stimulation to the diaphragm (more specifically, the phrenic nerves), which leads to movement or "artificial breaths." The principal behind DPS is that when the diaphragm is repeatedly stimulated it provides a muscle "workout," which conditions the muscle and slows the progression of respiratory dysfunction.

During the procedure, several small incisions are made over the abdomen to allow the laparoscope to be introduced. Several trial stimulations are performed to identify the locations on the diaphragm that show the required stimulation effect. Four sites are selected, and two electrodes are implanted on each side of the diaphragm. The electrodes are connected to cables that exit the body and connect to an external stimulator device.

Procedural and Dx Coding

Most payers will consider this treatment medically necessary if the service is documented and coded correctly. Consider the possible coding scenario below for DPS.

CPT®:

- 64575** Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) (has a 90-day global period)
- 49329** Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
- 95970** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming

ICD-9-CM:

- 518.83** Chronic respiratory failure (primary diagnosis)
- 335.20** Amyotrophic lateral sclerosis (primary diagnosis)
- 519.4** Disorders of diaphragm
- 780.72** Functional quadriplegia (co-morbidity diagnosis)
- 507.0** Pneumonitis due to inhalation of food or vomitus (co-morbidity diagnosis)

The medical record must show supporting documentation of the patient's diagnosis of disuse atrophy. **HBM**



J.C. Cortese, MS, DC, CPC, has worked for the University of Iowa Hospital and Clinics since 2012, first as a psychiatry coder for the Department of Psychiatry, Coding Intelligence Division, and now as the coding integrity coordinator for the Psychiatry, Specialty Surgery, and Radiation Oncology Departments. She earned a Doctor of Chiropractic degree from Northwestern Health Sciences University and a Master of Science from Vanderbilt University.

After retiring from chiropractic practice, Cortese spent 12 years translating orthopedic research from Czechoslovakian to English at Motol Hospital, First Faculty of Orthopedics, Prague, Czech Republic. She is a member of the Iowa City, Iowa, local chapter.

QUICK TIP

Gather Components for OB Ultrasound Codes 76805 and 76811



Knowing the differences between these codes will clear up billing confusion.

There has been ongoing confusion among coders, auditors, ultrasonographers, and physicians regarding the difference between CPT® codes 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation*) and 76811 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation*.

The most common question is, “When can I report 76811?”

76811 Is a Specialty Code

The service described by 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it’s intended for a known or suspected fetal anatomic, genetic abnormality (e.g., previous anomalous fetus, abnormal scan this pregnancy, etc.), or increased risk for fetal abnormality (e.g., advanced maternal age, diabetes, fetus at risk due to teratogen or genetics, abnormal prenatal

Code 76811 is not intended to be the routine scan performed for all pregnancies.

screen). Performing this service is rare outside of referral practices with special expertise in fetal anomaly detection and counseling.

The American Institute of Ultrasound in Medicine (AIUM) and the Society for Maternal Fetal Medicine (SMFM) hosted a meeting to develop the appropriate indications for performing a detailed fetal anatomic ultrasound examination, the components of the examination, and the training required to interpret it (see Consensus Report on the Detailed Fetal Anatomic Ultrasound Examination: Indications, Components, and Qualifications at www.jultrasoundmed.org/content/33/2/189.full for more information). The participants included representatives from the AIUM, SMFM, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Obstetricians and Gynecologists, the American College of Radiology, the Society of Diagnostic Medical Sonography, and the Society of Radiologists in Ultrasound.

To answer fully our earlier question, let's address the required components for reporting 76805 and 76811, as well as common indications for 76811 based on the census report.

Required Components for 76805

The study described by 76805 is commonly performed as a “routine screening ultrasound” at approximately 16-20 weeks gestation on a low-risk pregnancy.

Head and neck:

- Lateral cerebral ventricles
- Choroid plexus
- Midline falx
- Cavum septi pellucidi
- Cerebellum
- Cisterna magna

Face:

- Upper lip

Chest:

- Cardiac activity
- Four chamber view
- Left ventricular outflow tract
- Right ventricular outflow tract

Abdomen:

- Stomach (presence, size, and situs)
- Kidneys
- Urinary bladder

- Cord insertion site into fetal abdomen
- Umbilical cord vessel number

Spine:

- Cervical
- Thoracic
- Lumbar
- Sacral spine

Extremities:

- Legs
- Arms

Placenta:

- Placenta location
- Relationship to internal os
- Appearance
- Placental cord insertion (when possible)

Standard evaluation:

- Fetal number
- Presentation
- Qualitative or semi-qualitative estimate of amniotic fluid

Biometry:

- BPD
- Head circumference
- Femur length
- Abdominal circumference
- Fetal weight estimate

Maternal anatomy:

- Cervix (transvaginal when indicated)
- Uterus
- Adnexa

Required Components for 76811

CPT® code 76811 requires all of the components of 76805, plus the following. Some components depend on the gestational age at the time the examination is performed. Components marked with an asterisk (*) are performed when medically indicated.

Head and neck:

- Third ventricle and fourth ventricle*
- Corpus callosum*
- Integrity and shape of cranial vault
- Brain parenchyma
- Neck

Face:

- Profile
- Coronal face (nose/lips/lens*)
- Palate* maxilla, mandible, and tongue*
- Ear position and size*
- Orbits*

Chest:

- Aortic arch
- Superior vena cava/Inferior vena cava
- Three vessel and trachea view
- Lungs
- Integrity of diaphragm
- Ribs*

**Abdomen:**

- Bowel - small and large*
- Adrenal glands*
- Gallbladder*
- Liver
- Renal arteries*
- Spleen*

Spine:

- Shape and curvature

Extremities:

- Number: Architecture and position
- Hands
- Feet
- Digits: Number and position*

Placenta:

- Masses
- Placental cord insertion
- Accessory/Succenturiate lobe with location of connecting vascular supply to primary placenta*

Biometry:

- Cerebellum*
- Inner and outer orbital diameters*
- Nuchal thickness (16-20 weeks)
- Nasal bone measurement (15-22 weeks)
- Humerus*
- Ulna/Radius*
- Tibia/Fibula*

Note: If any of the required fetal or maternal components are non-visualized due to fetal position, late gestational age, maternal habitus, etc., the circumstance must be clearly noted in the ultrasound report to meet the requirements for billing this service.

Common Indications for 76811

Indications for a detailed fetal anatomic examination include:

- Previous fetus or child with a congenital, genetic, or chromosomal abnormality
- Known or suspected fetal anomaly or known growth disorder in the current pregnancy
- Fetus at increased risk for congenital anomaly, such as:
 - Maternal pregestational diabetes or gestational diabetes diagnosed before 24 weeks gestation
 - Pregnancy conceived via assisted reproductive technology
 - Maternal BMI > or = 35 kg/m²
 - Multiple gestation
 - Abnormal maternal serum analytes including alpha fetoprotein level and unconjugated estriol
 - Teratogen exposure
 - First trimester nuchal translucency measurement > or = 3.0 mm
- Fetus at increased risk for genetic or chromosomal abnormality, such as:
 - Parental carrier of chromosomal or genetic abnormality
 - Maternal age > or = 35 years at delivery
 - Positive screening test for aneuploidy, including NIPT
 - Soft aneuploidy marker noted on ultrasound
 - First trimester nuchal translucency > or = 3.0mm
- Other conditions affecting the fetus, including:
 - Congenital infections
 - Maternal drug dependence
 - Isoimmunization
 - Oligohydramnios
 - Polyhydramnios

Example of 76805

The patient is 25-years-old, G2 P1, with a menstrual age of 18 weeks. An obstetrical ultrasound is ordered for routine anatomical evaluation and confirmation of dates. There is no family or personal history of a fetal or maternal condition. The patient's generalist obstetrician (OB) does not anticipate any problems because the pregnancy has been uneventful, thus far. A complete transabdominal ultrasound is performed. All required maternal and fetal components previous (as noted, above) are assessed and found to be normal.

The correct coding in this example is 76805 with V28.3 *Encounter for routine screening for malformation using ultrasonics.*

Example of 76811

A 41-year-old, pregnant patient is referred from the generalist OB to the maternal-fetal medicine specialists for an obstetrical ultrasound at 18 weeks gestation. Her obstetric history is significant for an intrauterine demise (IUD) at 25 weeks gestation, a fetus with a skeletal defect (short rib and polydactyly) who died shortly after birth, one full-term delivery (live, no complications), and two early miscarriages.

In addition to her poor obstetrical history, she has abnormal lab results that show an increased risk for Down syndrome of 1:30. She would like to avoid invasive testing (i.e., amniocentesis), and requests a comprehensive fetal anatomical survey to determine whether the fetus has a recurrence of a skeletal dysplasia or markers for Down syndrome. A detailed transabdominal ultrasound is performed. All required maternal and fetal components are assessed. Based on the limitations of the study, there does not appear to be any structural fetal anomalies.

The correct coding in this example is 76811 with:

- 659.63** Elderly multigravida, antepartum condition or complication
- 655.83** Other known or suspected fetal abnormality, not elsewhere classified, affecting management of mother, antepartum condition or complication
- 655.13** Chromosomal abnormality in fetus, affecting management of mother, antepartum condition or complication
- V89.03** Suspected fetal anomaly not found

These examples are provided to assist clinicians and coders, and are not intended to be all-inclusive. Payer requirements vary. Contact your local payers for specific listings of clinically indicated diagnoses that warrant a detailed ultrasound (76811). **HBM**



Pamela K. Kostatenaco, LPN, CPC, CMC, is president of PKK Consulting and was the lead coder for the Society for Maternal-Fetal Medicine (SMFM) Coding Committee since its inception in 2001 and continues to provide consultative services to the committee. She has been instrumental in developing coding resource materials for SMFM, and continues to be the keynote speaker for the SMFM coding courses. Kostatenaco has over 25 years of coding-related experience, and specializes in providing consultative services to clients in the obstetrics and maternal-fetal medicine fields. She is a member of the Lakeland, Florida, local chapter.



BoneCoder10

ICD-10 Coding Made Easy

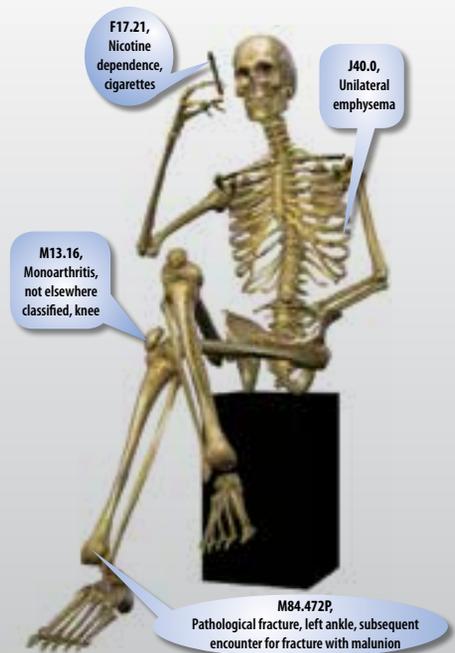
Requires no knowledge of ICD-10 CM codeset.

- » Try the only pictorial coding workflow tool
- » Developed by The Orthopaedic Center's spine surgeon Brian Scholl based on clinical residency coding training
- » Cuts code lookup time from 3-5 mins to 30 seconds!
- » Adds additional must codes to picklist as you select base code
- » Avoids reimbursement snaggles with coding workflow routed to most specific code
- » Export codes directly to any EHR, PMS, Coder

Available in: PC, Web-based, iOS, Android Phones and Tablets

Available for: Orthopedics, Neurosurgery, Physical Therapy, Chiropractic, Ophthalmology, Optometry, Emergency Medicine, Urgent Care, Family Practice

The tool doctors have been asking for!



Buy now: www.supercoder.com/BoneCoder10
For more information call 866-228-9252
 The Coding Institute LLC, 2222 Sedwick Drive, Durham, NC 27713

FROM THE CODING INSTITUTE
SuperCoder.com
 Inspired by Coders, Powered by Coding Experts

99211: Not So Simple

Check your nurse's credentials and payer incident-to rules before billing this E/M service.



CPT® 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* is sometimes referred to as a “nurse visit,” probably because the code description specifies that the service, “may not require the presence of a physician or other qualified health care professional.” Offices often use this code for any service that a nurse provides, but this is not always appropriate.

Consider Credentialing Clinical Staff

If your nurse is credentialed and is billing using his or her own National Provider Identifier (NPI), he or she may report 99211. If your nurse is not credentialed, however, and bills under the provider's NPI, the service must meet incident-to requirements. The nurse must follow an established, written care plan for that particular patient, to which there may not be any changes.

Note: Every payer I contacted when writing this article confirmed that a service provided solely by clinical staff must meet incident-to requirements to be billed under the provider. Payers differ, however, so it's best to check with your individual payers to confirm their policies.

Examples:

- A patient presents for a prothrombin time and international normalized ratio (PT/INR). A nurse performs the test, gives the results to the provider, and relays a medication change to the patient. The visit no longer meets incident-to requirements because there was a change in medication. You may not bill 99211; you may bill only the PT/INR. To bill for the evaluation and management (E/M), the provider must have seen the patient.

If your nurse is credentialed and is billing using his or her own National Provider Identifier (NPI), he or she may report 99211.

- A nurse performs a urinalysis (UA) for a patient with symptoms of urinary tract infection, relays the results to the provider, and gives the patient a prescription. Here again, incident-to requirements aren't met: There is likely no applicable, written plan of care, and a new medication was prescribed. You cannot report 99211; you may only charge for the UA.

Tip: The best solution to avoid such cases is to credential your nurses (if the payer allows it).

Medical Necessity Is a Necessity, Even for Low Level Visits

Don't forget the role of medical necessity when reporting 99211.

For example, a patient has an established diagnosis of hypertension. The provider documents that the patient should return for a blood pressure check with a nurse in one week, and the patient does so. The nurse measures the patient's blood pressure, which is normal, and sends him on his way.

Does this substantiate billing a 99211? Was an adequate E/M performed?

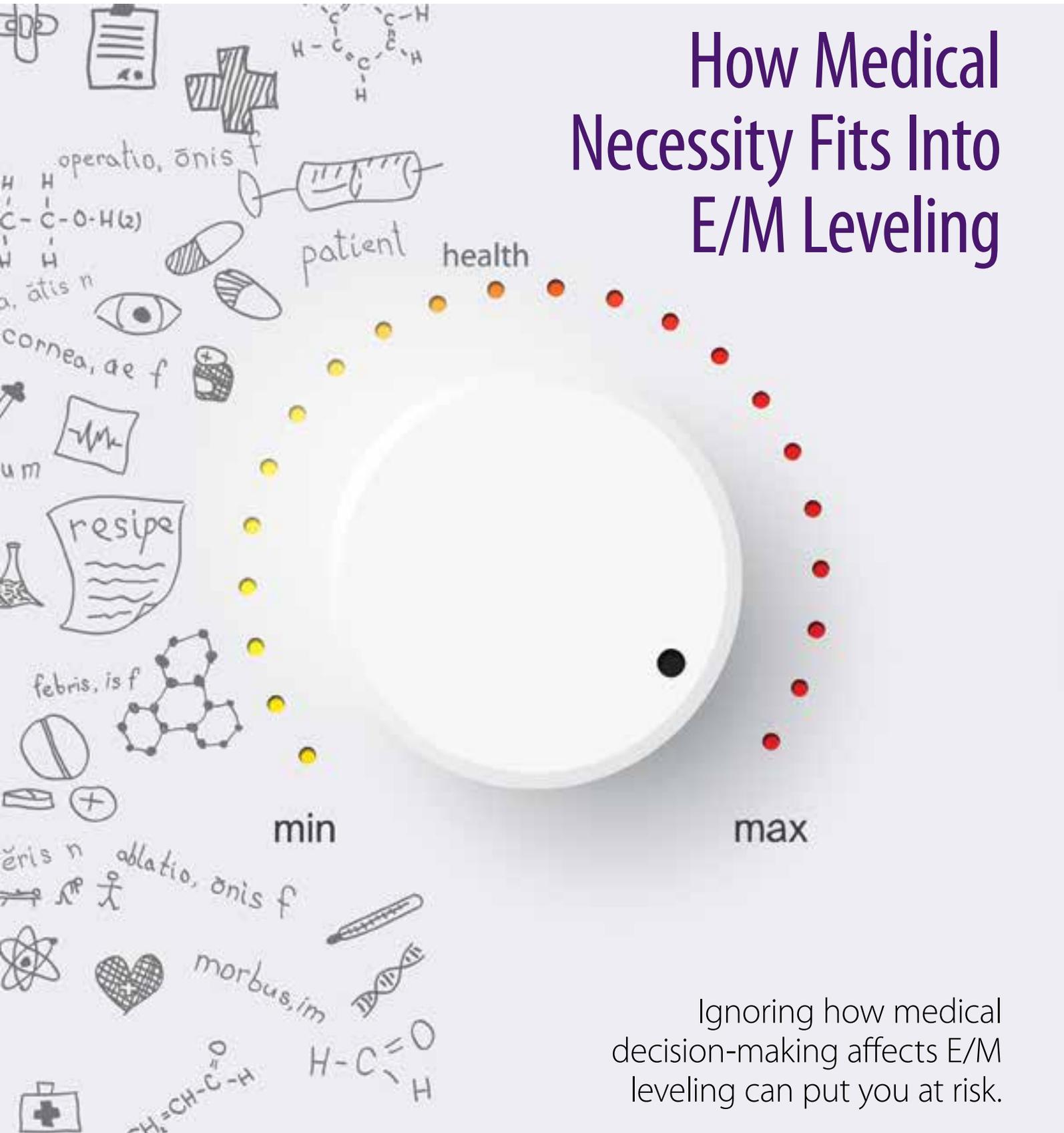
Most offices feel that charging for this service is not appropriate. You might even consider instituting an office policy stating that a credentialed provider will see all patients, and that only certain services (such as prearranged injections and quick blood pressure checks) are eligible for nurse visits. Injections are reimbursed through the injection fee, and an occasional quick blood pressure check could be considered a courtesy to the patient. **HBM**



Karla M. Hurraw, CPC, CCS-P, is lead coder at DeKalb Health Medical Group in Auburn, Indiana, and holds a degree in Medical Office Administration. She is a member of the Fort Wayne, Indiana, local chapter.



How Medical Necessity Fits Into E/M Leveling



Ignoring how medical decision-making affects E/M leveling can put you at risk.

If it isn't medically necessary, the provider shouldn't bill for it, regardless of whether the work was done.

When coding evaluation and management (E/M) services, it's crucial to take into account medical necessity. Services billed at a level higher than what the medical necessity warrants will result in take-backs in the event of an audit, regardless of whether the work was performed and documented.

How Medical Necessity Fits

Documentation guidelines teach us that history, exam, and medical decision-making (MDM) are key components of an E/M service. How does medical necessity fit into these components? Knowing the answer to this question will help you to select E/M codes and reduce audit risk.

The American Medical Association (AMA) policy H-320.953^[3] defines medical necessity as:

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.

The Medicare Benefit Policy Manual, chapter 16, section 20, similarly defines medical necessity as, "services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and not excluded under another provision of the Medicare Program."

In other words: Medical necessity means the services provided were appropriate based on the reason the patient was seen.

According to the Medicare Claims Processing Manual, chapter 12, section 30.6.1:

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service

is billed. Documentation should support the level of service reported.

That is, a provider should not perform or order work (or bill a higher level of service) if it's not "necessary," based on the nature of the presenting problem.

For example: An established patient presents to the office with a splinter in his finger. The physician documents a comprehensive history and a comprehensive exam. Based on these two key components, the documentation supports a level five, established patient visit. Should the physician bill this visit as a 99215 *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 comprehensive history; A comprehensive examination; Medical decision making of high complexity?*

No. There isn't medical necessity to support such an extensive history and exam. If it isn't medically necessary, the provider shouldn't bill for it, regardless of whether the work was done.

A chief complaint of a splinter is a self-limiting problem. There are no (or very few) data elements to consider. You wouldn't likely need blood work or X-rays for a splinter, and the risk is minimal. The level of MDM is straightforward.

If a provider documents a high level history and exam, but the MDM is straightforward (as in our example), you should advise the provider to reevaluate the necessity of the history and exam (and to NOT bill 99215). In the case of the splinter, a straightforward MDM should lead a physician to bill 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making*, even if he or she performed a high-level history and exam.

The bottom line: When educating providers about E/M coding, teach them to consider the seriousness of the presenting problem, as well as the level of MDM, to judge the medical necessity of the services they provide. **HBM**



Ellen Risotti-Hinkle, BS, CPC, CPC-I, CPMA, CEMC, CIMC, CFPC, is a coding auditor with Visionary Health Group, Community Health Network, and is a member of the Indianapolis, Indiana, local chapter.

Use CMS' General Principles to Improve Documentation

Brevity is an effective approach to letting providers know documentation must support services.

Last November, the Centers for Medicare & Medicaid Services (CMS) released its revised Evaluation and Management Services Guide. In reviewing the document, I was reminded of how easy it is for any of us to get so caught up in our busy, day-to-day schedules that we overlook opportunities to help providers improve their documentation.

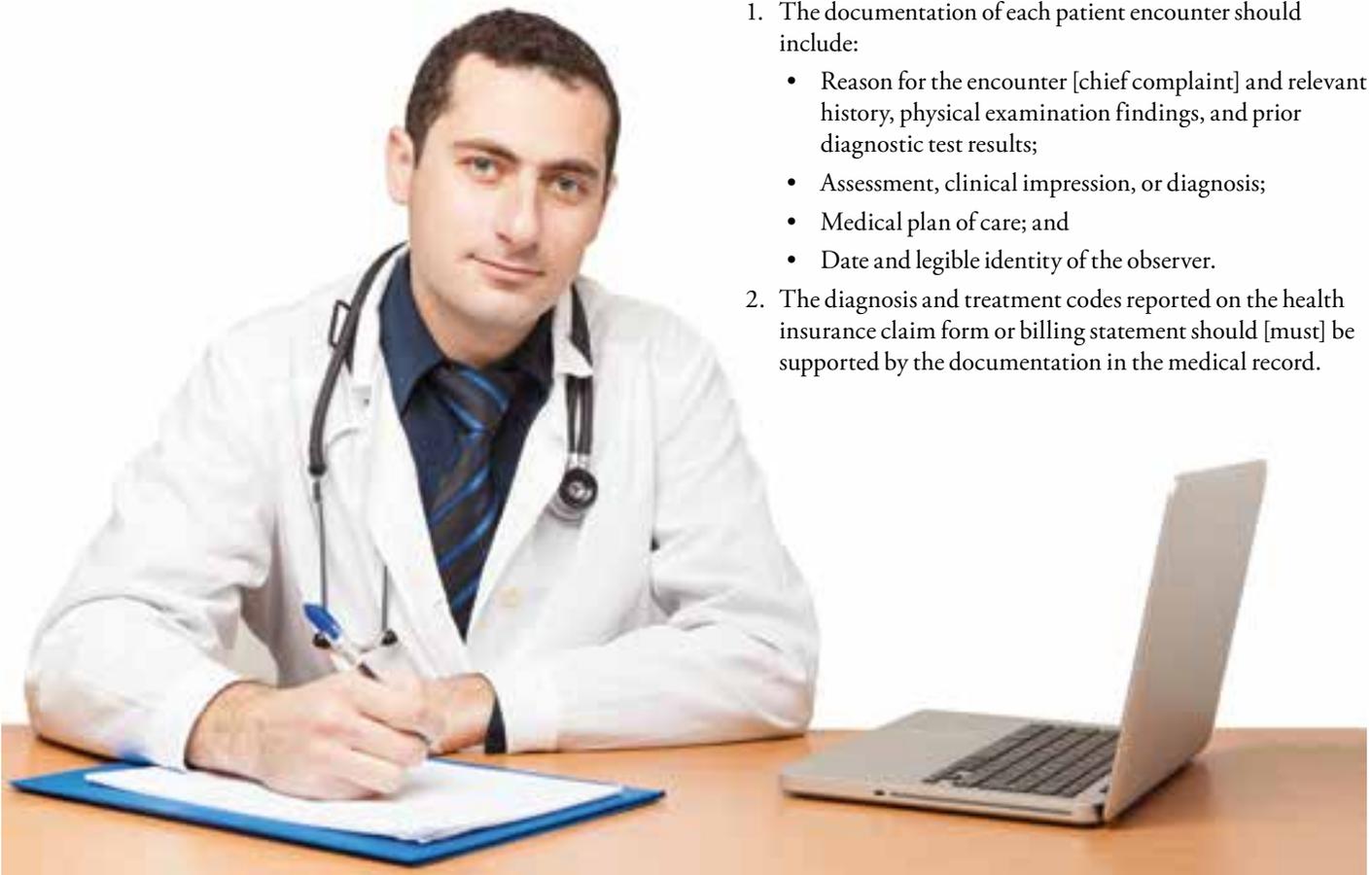
For example: How often do you see, "Patient is here for follow up?" Now begins a scavenger hunt for information: Follow up for what? What is the chief complaint?

Many of us "work around" these notes, instead of having a quick conversation with the provider to explain that the chief complaint must be clearly documented for each encounter. But that five-minute conversation can save a lot of time down the road.

Start with the Basics

CMS stipulates in the Evaluation and Management Services Guide for medical record documentation to have two general principles:

1. The documentation of each patient encounter should include:
 - Reason for the encounter [chief complaint] and relevant history, physical examination findings, and prior diagnostic test results;
 - Assessment, clinical impression, or diagnosis;
 - Medical plan of care; and
 - Date and legible identity of the observer.
2. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should [must] be supported by the documentation in the medical record.



A five-minute conversation can save a lot of time down the road.

The guide lists several other principles, but providers seem to overlook the above two most often. Use these guidelines when you need to have a conversation with a provider. Show the provider the document from CMS or reference the AMA's specific guidelines found in the CPT® codebook. The provider will see that you are asking him or her to follow legitimate regulatory guidelines and requirements to ensure the practice is paid appropriately for services rendered.

Keep Advice Brief

Researchers have repeatedly shown that people in general scan content rather than read it word for word. And the average attention span is only eight seconds, according to Statistic Brain (www.statistic-brain.com). To improve comprehension, keep your advice brief. For example, when training providers and new staff, I often refer to the “five Ws:”

- Why are you seeing the patient?
- Where is the problem located?
- What have you done?
- What tests are you going to order?
- What are you are going to do to help this patient?

Here's an example of how a catch phrase can aid comprehension:

A provider with whom I worked continued to under-bill his visits, to the point that the organization

chose to audit all of his charts. The provider's established patients routinely had a minimum of three chronic problems managed per visit. I explained to the provider that if he is treating three or more chronic conditions, and possibly ordering labs or other diagnostic tests and updating medications, the visit likely would qualify as a level four, established patient visit. The physician learned this as the “three for four” rule.

After a month of daily meetings, the physician would say to me as we passed in the hall, “Three for four, Valerie. Three for four!” As his results improved, the percentage of his claims audited was lowered. After 90 days without an audit, a follow-up audit showed his E/M leveling accuracy to be 92 percent — up from less than 50 percent prior to education.

The bottom line: If a provider's documentation isn't supporting the services he or she is billing, speak up! But remember to tailor your advice to be as efficient (and, therefore, effective) as possible. **HBM**

References:

Evaluation and Management Services Guide:
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf

Valerie Milot, BS, CPC, CCS, is an ICD-10-CM/PCS trainer, a coding consultant and auditor, and director of Physician Services at MRS. She is a member of the Manchester, New Hampshire, local chapter.



Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)

Refer to ICD-10 guidelines and sample cases to correctly report congenital anomalies.

An estimated one in 33 infants globally is born with a congenital anomaly. In 2010, congenital anomalies accounted for approximately 270,000 neonatal deaths in 193 countries. Congenital anomalies — commonly referred to as birth defects — include congenital malformations, deformations, and chromosomal abnormalities. Heart defects, neural tube defects, and Down syndrome are the most common congenital anomalies.

Source: Congenital Anomalies, World Health Organization (www.who.int/mediacentre/factsheets/fs370/en/)

Patients are most often diagnosed and treated for congenital anomalies during the neonatal period, but an individual may be diagnosed and treated at any age. Some congenital anomalies can produce long-term disabilities that require a lifetime of care.

To understand and correctly report congenital anomalies using ICD-10, refer to guidelines in ICD-10-CM Official Guidelines for Coding and Reporting, chapter 17, to code sample cases:

Congenital anomalies may be the principal or first-listed diagnosis during an encounter, or they may be reported as an additional diagnosis, depending on the circumstances of the encounter.

Example 1: Amanda returns to Dr. Adams' office with her parents to discuss her upcoming surgery to repair her left-sided cleft lip.

ICD-10-CM coding:

Q36.9 Cleft lip, unilateral

Example 2: John presents to Dr. Smith's office complaining of fatigue. John has non-mosaic Down syndrome.

ICD-10-CM coding:

R53.83 Other fatigue

Q90.0 Trisomy 21, nonmosaic

Manifestations that are not an inherent component of the congenital anomaly should be separately reported.

Example 1: Melissa is seen for difficulty swallowing associated with her cleft palate.

ICD-10-CM coding:

Q35.9 Cleft palate, unspecified

Example 2: Michael was diagnosed with a subglottic web of the larynx. During a follow-up evaluation for this condition, Dr. Jones noted a cardiac murmur upon examination and has ordered an EKG.

ICD-10-CM coding:

Q31.0 Web of larynx

R01.1 Cardiac murmur, unspecified

If the congenital anomaly has been corrected, a personal history code should be reported to identify the history of the anomaly, when applicable. NOTE: If a congenital anomaly requires multiple procedures before correction is complete, the anomaly is considered to still exist until all planned procedures are performed, and the provider feels the anomaly has been corrected. (This guideline is found in the excludes notes section of the applicable personal history codes.)

Example 1: Alex presents for her one-year, post-op visit following ventricular septal defect repair.

ICD-10-CM coding:

Z87.74 Personal history of (corrected) congenital malformations of heart and circulatory system

Example 2: Shannon is seeing Dr. Williams for follow-up on her tetralogy of Fallot. Shannon has undergone one surgery to begin

Some congenital anomalies can produce long-term disabilities that require a lifetime of care.

repair and Dr. Williams anticipates Shannon will need two additional surgeries before repair is complete.

ICD-10-CM coding:

Q21.3 Tetralogy of Fallot

When a congenital anomaly is identified at birth, the birth encounter should first list the appropriate Z38 code, followed by the appropriate codes from categories Q00-Q99 to identify the anomaly(s).

Example: Following vaginal delivery of a single liveborn infant in the hospital, Dr. Patel noted webbing between the toes of the neonate's left foot.

ICD-10-CM coding:

Z38.00 Single liveborn infant, born in hospital, delivered vaginally

Q70.32 Webbed toes, left foot

Although there are few specific guidelines for the reporting of congenital anomalies, understanding those guidelines is essential for proper coding of encounters. **HBM**



Chandra Stephenson, CPC, COC, CPB, CPCO, CPMA, CPC-I, CIC, CCS, CANPC, CEMC, CFPC, CGSC, CIMC, COSC, is a consultant who started out in healthcare 10 years ago. She has worked in a centralized billing office, a family practice office, a cardiology office, as a billing and coding instructor at a local technical college, and as a coding and compliance auditor. She enjoys conducting audits, researching coding and compliance issues, developing coding tools, and providing practitioner education. She is a member of the AAPC National Advisory Board and the Indianapolis, local chapter.

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

A&P Tip



Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is the most commonly diagnosed behavioral disorder of childhood. It affects about 3 - 5 percent of school-aged children, with an average age of onset at seven. ADHD is diagnosed much more often in boys than in girls.

For these problems to be diagnosed as ADHD, a child will:

- Have inattentive or hyperactive-impulsive signs and symptoms that cause impairment
- Have behaviors that aren't normal for children the same age who don't have ADHD

- Have symptoms for at least six months
- Have symptoms that affect school, home life, or relationships in more than one setting (such as at home and at school)

According to the National Institute of Mental Health, scientists are not sure what causes ADHD, although many studies suggest that genes play a large role. Like many other chronic conditions, ADHD probably results from a combination of factors. Researchers are studying genetics, possible environmental factors, and how brain injuries, nutrition, and social environment

may contribute to ADHD. It's normal for all children to be inattentive, hyperactive, or impulsive sometimes, but for children with ADHD, these behaviors are more severe and occur more often. To be diagnosed with the disorder, a child must have symptoms for six or more months and to a degree that is greater than other children of the same age.

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



ICD-10 Made Simple.

AAPC ICD-10 solutions and services help coders, physicians, and clinics prepare for the October 1, 2015 deadline. Simplify your ICD-10 implementation and training with the experts at AAPC.

**Visit AAPC Booth #1 at
HEALTHCON 2015
for a Demo and
Chance to Win a
MacBook Air.**





Solutions for Coders and Physicians



Coding
Solutions



Revenue
Solutions



Clinical
Documentation



Online Training &
Education

“The quality of AAPC’s ICD-10
services surpassed our expectations.”

Bill Gracey, President & COO
BlueCross BlueShield of Tennessee

Pain Medicine Providers: Review 2015 Billing Changes

Accurate claims payment hinges on your awareness of new CPT® codes and an epidural steroid injection reimbursement update.



Pain medicine coding experienced an overhaul for 2015. Of particular interest to pain medicine physicians are Medicare payment changes for epidural steroid injections (ESI). A multitude of revised CPT® codes also warrant your attention.

Epidural Steroid Injection Reimbursement

ESI reimbursement rates were significantly reduced in the 2014 Medicare Physician Fee Schedule (MPFS), which garnered angry responses from the pain medicine community. The Centers for Medicare & Medicaid Services (CMS) has raised payments for 2015, using prior resource inputs and pending further review and recommendations from the American Medical Association’s (AMA) Relative Value Scale Update Committee (RUC); however, CMS will not pay separately for image guidance in 2015. **Table 1** compares the MPFS national reimbursement for epidurals in 2013, 2014, and 2015.

Bundling of Ultrasound with Joint Injections

Bundling of ultrasounds into other procedures resulted in three new and three revised CPT® codes in 2015 (see **Table 2**).

ESI payments were significantly reduced in the 2014 Medicare Physician Fee Schedule (MPFS), which garnered angry responses from the pain medicine community.

Table 1: Medicare National Reimbursement for Epidurals in 2013, 2014, and 2015

Code	Short Descriptor	2013 ^a	2014 ^b	2015
62310	Injection(s) of diagnostic or therapeutic substance(s) spine cervical/thoracic	\$253.13 (\$349.07)	\$110.69 (\$201.68)	\$244.52
62311	Injection(s) of diagnostic or therapeutic substance(s) spine lumbar/sacral	\$213.32 (\$309.26)	\$108.90 (\$199.89)	\$225.19
62318	Injection(s), including indwelling catheter placement, of diagnostic or therapeutic substance(s) cervical/thoracic	\$244.63 (\$340.57)	\$111.41 (\$202.40)	\$233.42
62319	Injection(s), including indwelling catheter placement, of diagnostic or therapeutic substance(s) lumbar or sacral	\$175.90 (\$271.84)	\$114.99 (\$205.98)	\$170.41
All payments are national, participating, non-facility. a - The amount in parentheses shows the payment plus fluoroscopic guidance - \$95.94 b - The amount in parentheses shows the payment plus fluoroscopic guidance - \$90.99				

Table 2: Medicare Reimbursement for Joint Injections with Ultrasound Bundled in 2015

2014 Joint Injection Coding and Payment*		2015 Joint Injection Coding and Payment*	
20600 – Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes)	\$48.36	20600 - Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	\$48.33
20600+76942 – When ultrasound guidance was performed, report 76942 <i>Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation</i>	\$122.51	20604 - Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	\$72.32
20605 - Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow, ankle, olecranon bursa)	\$50.51	20605 - Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	\$50.84
20605+76942 – When ultrasound guidance was performed, report 76942	\$124.66	20606 - Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	\$79.84
20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	\$60.90	20610 - Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	\$60.86
20610+76942 - When ultrasound guidance was performed report 76942	\$135.05	20611 - Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	\$91.29
* Payment amounts reflect MPFS national reimbursement levels.			



New Codes for Transversus Abdominis Plane Blocks

In 2015, anesthesia providers will report transversus abdominis plane (TAP) blocks with one of four new codes, depending on whether the service is performed by injection or continuous infusion, and whether injected/infused unilaterally or bilaterally. The codes are outlined in **Table 3**.

Table 3: 2015 TAP Block Procedures

CPT® Code	Short Descriptor
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)
64487	by continuous infusion(s) (includes imaging guidance, when performed)
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
64489	by continuous infusions (includes imaging guidance, when performed)

For example:

- A 50-year-old, male patient undergoes an open cholecystectomy under general anesthesia. He is at risk for post-operative pain. At the request of the surgeon, bilateral TAP blocks are administered using ultrasound guidance for needle placement.

Correct coding is 64488 because the procedure was performed bilaterally by injections. The ultrasound guidance is included in the procedure and may not be separately reported.

- A 62-year-old, female patient undergoes a hysterectomy under general anesthesia for uterine cancer. At the request of the surgeon, bilateral TAP blocks with catheter placement for continuous infusion are placed to provide postoperative pain control.

The correct CPT® code is 64489. **HBM**



Joette Derricks, MPA, CMPE, CPC, CHC, CSSGB, has 35 years of healthcare finance, operations, and compliance experience. A national speaker and author, Derricks' unique style is to bridge the regulatory requirements with the practical realities of day-to-day operations. She has provided numerous expert reports and testimony regarding Medicare, Medicaid, and third-party payer regulations with an emphasis on coding, billing, and reimbursement rules. Derricks serves as the vice-president, regulatory affairs at Anesthesia Business Consultants and is a member of the Ann Arbor, Michigan, local chapter.

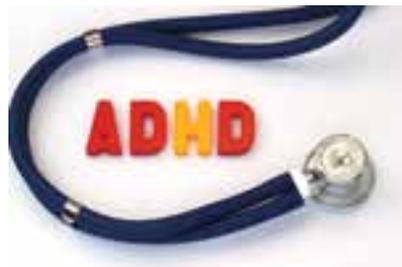


By Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC

Think You Know ICD-10? Let's See ...

There are three different types of attention deficit hyperactivity disorders (ADHDs), which are characterized by the strongest symptoms. What are they?

- A. Attentive, hyperactive, dissociative
- B. Hyperactive, attention deficit, combination
- C. Depressed, hyperactive, combined
- D. Hyperactive, attention deficit, depressed



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.

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

ICD-10 Quiz

Check your answer on page 65.



Our coding courses / AAPC CEUs:

- **Dive Into ICD-10** (18 CEUs)
- **E/M from A to Z** (18 CEUs)
- **Primary Care Primer** (18 CEUs)
- E/M Chart Auditing & Coding (16 CEUs)
- Demystifying the Modifiers (16 CEUs)
- Medical Coding Strategies: CPT O'view (15 C's)
- Walking Through the ASC Codes (15 CEUs)
- **Coding with Heart — Cardiology** (12 CEUs)
- Elements of ED Coding (11 CEUs)



HealthcareBusinessOffice LLC: Toll free **800-515-3235**
 Email: info@HealthcareBusinessOffice.com
Web site: www.HealthcareBusinessOffice.com

(All courses with AAPC CEUs also earn CEUs with AHIMA. See our Web site.)

Be with the family and earn CEUs!

Need CEUs to renew your CPC®? Stay in town. At home. Use our CD courses anywhere, any time, any place. You won't have to travel, and you can even work at home.

- From the leading provider of interactive computer-based CD courses with **preapproved CEUs**
- Take it at your own speed, quickly or leisurely
- Just 1 course can earn as many as 18.0 CEUs
- **Apple® Mac** support with our **Cloud-CD™** option
- **Windows®** support with **CD-ROM** or **Cloud-CD™**
- **Cloud-CD™** — lower cost, immediate Web access

Finish a CD in a couple of sittings, or take it a chapter a day — you choose. So visit our Web site to learn more about CEUs, the convenient way!

*Easily affordable with **EasyPayments!***
<http://bit.ly/hbollc-ezpay>



Continuing education. Any time. Any place. SM



AAPC Certification Matters to Me

I've never been more confident in the work I do.



My career in the healthcare office began many years ago, working for an orthopedist while I was in high school. I liked working there; and to this day, it's my home away from home. I now work for a growing multi-specialty practice in a supervisory position. I'm accountable for reviewing claims before they are submitted, checking documentation against billed charges, and collecting on aging delayed or denied claims.

Education Is Key

Times are changing and it's becoming more difficult to obtain reimbursement from insurance carriers that deny claims for so many different reasons. A few years ago, I wanted to know if an insurance carrier was correct in down-coding an evaluation and management (E/M) visit. I was told by a supervisor to just use my judgment. Well, "my judgment" told me to get educated on the matter so I would have confidence in making such determinations. Lucky for me, an AAPC-certified coworker pointed me in the right direction.

AAPC has been an extremely helpful resource for my coding, compliance, auditing, and revenue management needs. My AAPC certifications have put me in a much better position to help other billers and supervisors review claims that need a little more attention.

Learn Proper Billing for Success and Confidence

I earned two certifications over the past two years: Certified Professional Medical Auditor (CPMA) and Certified Evaluation and Management Coder (CEMC).

I had to take the CEMC exam twice, but it was worth it. My appeals on improper payments and denied claims are successful because I learned what I needed to know about modifiers and E/M levels. I have a better understanding of the system in place for proper E/M coding, which seems like a gray area at times. Earning my CPMA taught me rules, regulations, and knowing exactly what to look for when auditing a medical record.

Now, when others turn to me with billing or auditing questions, I can readily provide an answer with confidence.

Next Step Is ICD-10

I'm preparing for the ICD-10 proficiency exam. I have no doubt AAPC's materials, webinars, and resources will help me to better understand ICD-10 and pass the exam. **HBM**

Julie Pisacane, CPMA, CEMC, is employed as the collections team leader of the No Fault Department at Orlin & Cohen Orthopedic Group, and is a member of the Nassau County, New York, local Chapter.

Because of my certifications with AAPC, I am in a much better position to help other billers and supervisors review claims that need a little more attention.

Healthcare Business Monthly is spotlighting local chapters with photos and stories. If your chapter would like to be featured, please contact your AAPC Chapter Association regional representative or send your information to kudos@aapc.com. In sharing what your chapter is doing, others will benefit.

We ask for your stories to be short and your photos to be clear. Send us highlights of what happened in your chapter recently. Spotlight your special events, coding training, special speakers, fundraising results, or honors bestowed on chapter members.

When you need it.



*Medical professional liability insurance specialists
providing a single-source solution* | ProAssurance.com

Mull Over Specialty Programs in the Therapy Setting

Before you decide, consider the benefits and drawbacks.



Your clinic will gain new clientele who would otherwise go elsewhere for the specialty.

Specialty programs in the rehabilitation setting have become increasingly popular in the past decade. Offerings vary and include clinics and programs specific to running injuries, cycling injuries, Pilates, women's health, throwing injuries, dancing injuries, and so on. If you can secure staff engagement, access to specialty equipment, physician support, marketing resources, and administrative backing (all of which should be carefully vetted prior to initiation), the programs your facility offers are limited only by the developer's imagination for establishing the specialty and growing the program.

Pros and Cons

There are pros and cons to incorporating specialty services into clinics that emphasize generalized care, such as orthopedic physical therapy (PT). Some of these issues do not become apparent until later in the process of program development, and require patience and communication to work through. Other issues are obvious from the start, and can be addressed early on. Here are some of the benefits and drawbacks you can experience while incorporating specialty clinics and programs into a general orthopedic PT setting.

Pros:

Increased volume - Your clinic will gain new clientele who would otherwise go elsewhere for the specialty. For example, runners can be very particular regarding medical care and often want to see professionals who understand their commitment (addiction) to the sport. While many providers in the general orthopedic PT setting are capable of treating run-

ners, not all have the experience necessary to connect with this population, let alone fulfill their expectations. Having a provider who is passionate about the science of running, and who practices what he or she preaches, can go a long way in developing a successful and long-term patient/client relationship.

New specialty clientele can increase general orthopedic volume, as well. For example, runners have family members who may need care for their own orthopedic issues. When one family member is familiar with a clinic, he or she often refers the rest of the family there for non-specialty care.

Improved staff morale - An unexpected side effect is how exciting it is for everyone in the clinic to watch another staff member learn new information that benefits the practice clinically and financially. Not surprising, staff members who feel their career is stagnant may be inspired to learn new skills or start a different specialty practice.

Enhanced general practice recognition - Society is attuned to the "bells and whistles" specialty practices offer. New equipment, technology, training techniques, and injury prevention knowledge are expected from these types of practices. The ability to separate your clinic from the crowd can draw the attention of an institution's marketing department, the local media, and your own professional organization.

Higher treatment success - One of the biggest pros to a specialty program is giving patients with complicated, previously non-treatable injuries, new hope. Many specialty clinic clients come in saying they've "tried everything" without success, until they saw your





One of the biggest pros to a specialty program is giving patients with complicated, previously non-treatable injuries, new hope.

more experienced and knowledgeable specialty provider.

Cons:

Staffing challenges - Staffing a specialty clinic may be a challenge for a variety of reasons. Initially, the volume may not warrant a full-time staff member, which is problematic for professionals looking for full-time, benefitted positions. Finding motivated staff who are willing to be hourly employees without full-time benefits is one strategy — you pay only for the time they put into the development of the program. You also may be able to negotiate the number of hours to pay a provider for initially setting up the program, requiring him or her to invest some personal time into the venture. As an incentive, suggest that when referrals warrant a full-time position, the specialist may be hired with benefits.

Waiting for appointments - When the program is established and demand has grown, patients may have to wait days, or even weeks, for an appointment. The high demand for a specialized provider's time requires you to plan ahead for absences.

Staff morale may suffer - Rather than boosting morale, resentment may result if staff feels there is administrative favoritism towards the specialty provider (procurement of new equipment, scheduling flexibility, etc.). You can curb some of these issues by commending staff for their own initiative and willingness to help start a unique practice, and offering them appropriate perks such as flex time.

Setup Strategies

Besides setting up initial staffing, marketing and equipment procurement are important to a successful launch of a specialty clinic. You must be able to trust the specialty provider to advise you regarding necessary equipment, starting with the basics. Marketing departments prefer that specialty programs are first vetted to determine how much they are needed in the community. This creates confidence in the program's potential for success. Be sure to discuss content of marketing materials (collateral) because clinicians and marketing professionals often have different views on how to present a product to the public. Patience and compromise are useful during these discussions.

Do Your Homework and Keep It Going

Evidence-based practice is becoming commonplace for the majority of healthcare settings, including therapy services. This is a critical piece of the puzzle for successful specialty programs.

Consumers of specialty services are often highly educated, perceptive, and have done a great deal of homework (mostly on the Internet) regarding their specific problems. Programs that don't use current research and fail to incorporate their patients' values into their treatments will not grow and thrive in an increasingly competitive environment. To keep everyone on the same page, hold regular meetings and "journal



clubs” for those involved in the program. Designate a program leader if more than one person is involved in the specialty practice.

Other Lessons Learned

Referring providers like to know about your specialty programs. Provide them with any science, data, and peer reviewed literature related to your specialty. Consider a slideshow presentation early on to get referring providers’ input. You might even ask a physician, physician assistant, or nurse practitioner if he or she would like to be involved with your program in some capacity. Billing should not be an issue unless you provide ser-

vices not related to an actual clinical problem. For instance, if you set up a cycling specialty clinic, and you provide bike fitting for clients who just bought a new bike, you can’t bill a therapy-related CPT® code. You can, however, provide this as a cash-based service.

Be sure to consult with your local payers if you have questions regarding which services may be billed. **HBM**



Kim Cohee, DPT, PT, MBA, OCS, is the clinical operations director of the University of Utah Orthopaedic Center Therapy Services. She graduated from the University of Utah with undergraduate and doctorate degrees in PT and a Master of Science in Exercise Physiology. Cohee received a Master of Business Administration from Western Governors University in 2009, and achieved Orthopedic Clinical Specialist designation in 2006.





Target Risky Billing Patterns Using E/M Benchmarking

Compare your levels with other providers in the same specialty.

Increasingly, government and commercial payers are using claims data mining and advanced statistical techniques to identify potential billing risks and direct their audit resources. As you review your billing compliance procedures, assess and benchmark the frequency distributions of your evaluation and management (E/M) billing codes. Determine and clearly understand if the billing lev-

els you report for new and established E/M services are dramatically different compared to national and state statistics and other providers in the same specialty within your practice area.

Comparing your E/M services data with other providers in your specialty is an easy way to identify risky billing patterns, which may mark you as a potential outlier and a target for a payer audit.

Distribution variances like these are what payers look for to determine which practices require a billing audit.

Benchmarking and billing variance analysis can also help in selecting sample services for coding and documentation reviews, and assists you with ongoing provider education.

E/M Billing Variance Analysis Is the First Step

National and state E/M service utilization data by specialty (i.e., E/M bell curves) can be calculated from the data on the Centers for Medicare & Medicaid Services (CMS) website, or may be purchased from published sources. The example in **Chart A** uses 2012 CMS data to calculate the national utilization percentages for the internal medicine specialty.

Using these percentages, the example in **Chart B** shows how to quickly benchmark E/M established patient services against CMS' utilization percentages to identify potential risks. In this example, several providers (Dr 2, Dr 3, and Dr 4) appear to have a variance in level five visits (99215 *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 comprehensive history; A comprehensive examination; Medical decision making of high complexity*); mid-level providers (PA 2, NP 1, and NP 2) appear to be variant in level three (99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history;*

An expanded problem focused examination; Medical decision making of low complexity) billing patterns. This provides a good high-level overview of the practices' billing patterns and identifies potential billing risks.

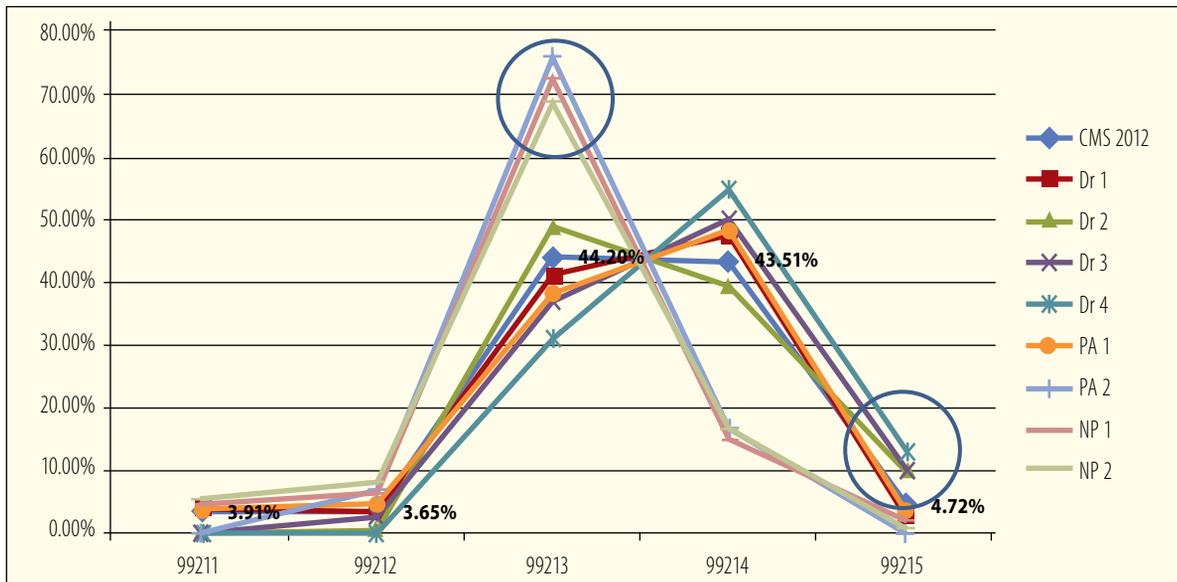
Distribution variances like these are what payers look for to determine which practices require a billing audit. This is supported by the Office of Inspector General (OIG) May 2012 report "Coding Trends of Medicare Evaluation and Management Services" (OEI-04-10-00180), which concluded that, from 2001 to 2010, physicians increased their billing of higher-level E/M codes in all types of E/M services. The key finding was that physicians who consistently billed higher-level E/M codes treated beneficiaries of similar ages, and with similar diagnoses, as physicians with more typical E/M billing

Chart A: 2012 CMS Part B E/M Distribution: Internal Medicine

CPT	CMS Utilization	Percent
99201	10,045	0.58%
99202	97,584	5.66%
99203	504,209	29.27%
99204	793,766	46.07%
99205	317,278	18.42%
Total	1,722,882	100.00%
99211	1,889,982	3.91%
99212	1,762,485	3.65%
99213	21,353,091	44.20%
99214	21,018,890	43.51%
99215	2,281,969	4.72%
Total	48,306,417	100.00%

Source: CY 2012 Evaluation and Management (E&M) Codes by Specialty (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/MedicareUtilizationforPartB.html)

Chart B: Internal Medicine Practice Established Patient E/M Medicare Utilization vs CMS 2012 National Distribution



CPT	CMS 2012	Dr 1	Dr 2	Dr 3	Dr 4	PA 1	PA 2	NP 1	NP 2
99211	3.91%	3.50%	0.10%	0.00%	0.00%	4.30%	0.30%	4.40%	5.60%
99212	3.65%	4.80%	1.10%	2.10%	0.20%	4.80%	6.80%	6.40%	7.80%
99213	44.20%	41.20%	48.90%	36.70%	31.00%	38.20%	76.10%	72.10%	68.40%
99214	43.51%	47.50%	39.60%	49.80%	54.80%	48.30%	16.80%	15.10%	17.20%
99215	4.72%	3.00%	10.30%	11.40%	14.00%	4.40%	0.00%	2.00%	1.00%
Billed Service Units		2,252	2,615	3,545	1,733	1,981	3,201	2,256	2,434
Medicare Units		1,112	1,818	2,103	886	1,131	1,701	1,415	1,312
Subspecialty		General	Geriatrics	General	Oncology	Oncology	General	General	General

patterns. In payers' eyes, this naturally raises questions of the medical necessity for the higher-level services billed by the variant providers, leading to greater claims scrutiny.

Ask the Right Questions

The distribution variances provide a good starting point to identify risk, but let's put the value of the E/M bell curve in its proper perspective. When a provider is within the range of the benchmark (e.g., within 10 percent), you may have greater confidence in his or her overall billing patterns.

Even if a provider's usage falls significantly outside the bell curve (e.g., beyond 10 percent), you should not assume he or she is engaged in fraudulent coding. A number of factors must be considered in addition to billing variance, including the provider's subspecialties, practice demographics, patient acuity statistics, administrative adjustments and denied claims analysis, and even local public health data.

For providers who vary, the next step is to generate a report reflecting the diagnosis codes that have been billed for all high-level E/M codes. If these diagnoses are for chronic conditions, inju-

ries, and severe acute conditions, the services likely are medically necessary, and if well documented, are coded correctly. If a portion of these high-level office visits are linked to diagnosis codes that you would not usually expect to require a high level of service, audit these records for medical necessity and adequate medical records documentation.

Also consider under-coding, which is selecting a code that does not capture the true intensity or amount of work actually performed. Under-coding of services represents a direct loss of revenue to the practice. Providers may purposely under-code, believing this is a way to avoid denied claims or audits. Or they mistakenly believe their practice must mirror the E/M bell curve to be compliant (i.e., coding to the averages).

Although there is no fixed formula for how many medical records you should review, a sufficient size sample from the service level(s) at risk, per provider, must be taken to fully explain the billing patterns. Does the documentation support the procedure and diagnosis codes submitted? If not, carefully review the discrepancy and take note of trends. For example, did the provider code all ICD-9-CM 401.9 *Unspecified essential hypertension* as 99214 *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*? Billing all services in any category at a single level significantly increases your audit risk, and is a good indicator the provider needs additional coding education.

Use Results to Educate

In most cases, your review will lead to a discussion with the providers to walk through the distributions and results from the medical records review, with the goal of reaching an understanding of the composition of the provider's billing patterns.

If the results of the review and provider discussions indicate that coding levels aren't selected properly, or documentation is not compliant, schedule your providers for E/M education using the distributions and review findings as the basis for hands-on coding review and training. Continually monitor at-risk providers for a representative shift in their billing patterns and improvement in supporting documentation.

For 2015, make it your practice's goal to add E/M benchmarking to your compliance and provider training plans. Review your E/M coding patterns and documentation at least annually. You and your providers will gain a better awareness of your practice's coding risks and gain confidence that your documentation will support the level of codes billed in the event of a third-party audit. **HBM**

Judy MacWhinnie, RN, CPC, is a billing compliance audit coordinator, with a focus on coding risks and reimbursement issues (judyn152@cs.com). She is a member of the Sayre, Pennsylvania, local chapter.

Gene Clarke, MBA, CIA, CISA, is an internal auditor focused on risk assessments and risk management (gclarke@binghamton.edu).

Even if a provider's usage falls significantly outside the bell curve (e.g., beyond 10 percent), you should not assume he or she is engaged in fraudulent coding.



Affordable, Achievable Compliance

7Atlis helps providers create and maintain a comprehensive compliance program that fulfills all seven OIG requirements. Have total confidence that your practice is compliant, trained, and fully protected, even when audited.



Total Compliance Management



Simple, Step-by-Step Guidance



Affordable Plans and Pricing



Training and Education by AAPC



Visit AAPC Booth #1 at HEALTHCON 2015 for a Demo and Chance to Win a MacBook Air.

By Erica Lindsay, PharmD, MBA, JD

Five Risk Areas Lurking within Your Pharmacy

Identify, address, and reduce common compliance issues in your facility's pharmacy department.



An effective compliance program identifies risks and operational deficiencies, while ensuring the entity conforms to the law. Compliance departments are responsible for many areas within the healthcare facility, including billing, lab, patient care, and pharmacy. Pharmacy has many risks because the department provides medication support to patients and staff daily. Effective communication between pharmacy and compliance departments to identify noncompliance issues can avoid financial, safety, operational, and clinical downfalls.

Pharmacy departments are regulated through accrediting bodies, as well as federal and state laws. Pharmacy directors, managers, and staff have the primary responsibility of adhering to current pharmacy rules and regulations. When there is turnover or regulatory changes, and the policies and procedures are not updated, the entire organization is at risk. Many deficiencies may be hidden un-

til an outside auditor (e.g., The Joint Commission or a state board of pharmacy) identifies them.

Let's address five of the most common compliance issues that pharmacies face.

1. HIPAA

HIPAA Privacy and Security Rules provide federal protections for individually identifiable health information held by covered entities (CE) and their business associates, and give patients an array of rights with respect to that information.

For example, a CE's employee may access without consent a patient's protected health information (PHI) for treatment, payment, or other healthcare operations, but he or she may not access PHI of a spouse, child, or family member without consensual cause.

Stolen drugs often are sourced from the pharmacy's drug inventory.

I have seen many cases where healthcare workers have inappropriately accessed PHI belonging to celebrities, publicized victims, or family members. Your organization must emphasize that this conduct is inappropriate, and may lead to direct termination. Create or update policies surrounding internal HIPAA breaches. Conduct regular audits of employee access to patient records to ensure compliance. And encourage all staff to report misuse of PHI to the compliance department.

2. Pharmacy Drug Billing/Auditing

Noncompliance risks have heightened for pharmacies since the inception of the Health Care Fraud and Abuse Control program (HCFAC). Under the joint direction of the U.S. attorney general and the secretary of the U.S. Department of Health & Human Services (HHS), the HCFAC program is designed to coordinate federal, state, and local law enforcement activities with respect to healthcare fraud and abuse (see: Health Care Fraud and Abuse Control Program Report. <https://oig.hhs.gov/reports-and-publications/hcfac/>).

Medicare and Medicaid programs are fertile ground where federal insurers can audit and identify serious discrepancies. Noncompliance can lead to state and federal false claims, holding the facility liable for each civil penalty of not less than \$5,000 and not more than \$10,000; plus, three times the amount of damages that the government sustains (see: Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410) and the federal False Claims Act, 31 U.S.C. § 3729 (1986)). In 2013, the federal government captured over \$2.6 billion in healthcare fraud judgments and settlements. Over \$25.9 billion has been recaptured to the Medicare trust fund since the inception of the HCFAC program in 1997. To evaluate your pharmacy's risk of improper billing, coding, and drug pricing, the compliance and finance departments should work together to perform an audit of the pharmacy department's chargemaster. This audit should

identify discrepancies surrounding national drug codes, HCPCS Level II codes, billable units, and drug acquisition costs.

Conduct regular audits to ensure proper reporting to all federal and state health insurance providers. If discrepancies are discovered, the facility, with the assistance of the legal department, should self-report to the respective entity within 60 days of discovery.

3. Drug Diversion

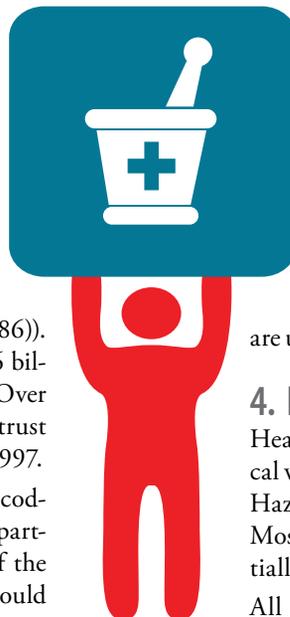
Drug diversion occurs when healthcare workers use drugs for purposes not intended by the prescriber. A diverter might take prescription drugs for personal abuse or distribute them illegally. Diverters who pilfer for their own use can harm patients by delivering care in an impaired state, failing to administer adequate pain relief to patients, and endangering themselves, coworkers, and visitors — all of which can place direct liability on the healthcare facility. Diversion can occur within pharmacy, nursing, physician, and auxiliary staffs.

Stolen drugs often are sourced from the pharmacy's drug inventory. Facilities that have pharmacy compliance officers can conduct random drug audits of their narcotic and high-cost drugs to ensure purchases and drug utilization are being accounted for. If your facility does not have a pharmacy compliance officer, you might hire an outside auditor to perform drug purchase/utilization reviews periodically. Some facilities also use random drug screenings to identify employees who are using illicit drugs.

4. Disposal of Drugs/Waste/PHI

Healthcare facilities generate substantial pharmaceutical waste, classified as either hazardous or nonhazardous. Hazardous waste includes cancer and radiology agents. Most nonhazardous pharmaceutical waste includes partially dispensed drugs.

All waste — including drugs, documents, and labels



— requires proper disposal. Facilities must dispose pharmacy waste in accordance to regulations enforced by the Environmental Protection Agency, Department of Transportation, state regulations, and accrediting bodies, including The Joint Commission or Healthcare Facilities Accreditation Program, while also reducing the risk associated with handling dangerous compounds. The Joint Commission has approximately 20 standards that apply to pharmaceutical waste alone.

Improper disposal of PHI can also lead to a violation. Personal and medical information printed on bottles and records must be disposed to prevent others from accessing patients' PHI. Identity theft can result when staff mishandles PHI. Be sure your staff understands waste regulations and its impact on healthcare operations including patient and employee security protections.

5. 340B Services

The 340B drug program is regulated by the Office of Pharmacy Affairs and allows certain covered entities (e.g., disproportionate share hospitals, children hospitals, community hospitals, etc.) to acquire outpatient medications at a discount. Program requirements include maintaining auditable records documenting compliance, refraining from participating in group purchasing organizations for covered outpatient drugs, and accurately reporting Medicaid billing of drugs on the Medicaid Exclusion File, as mandated by 42 USC 256b(a)(5)(A)(i) (see: 340B Program Requirements, Health Resources and Services Administration. www.hrsa.gov/opa/programrequirements/).



Some facilities participating in the 340B program have been audited by the manufacturer or federal government and were found liable to refund manufacturers for obtained discounts and/or loss of 340B status. If your facility participates in 340B purchasing, seek an external audit regularly to ensure program integrity. **HBM**



Erica Lindsay, PharmD, MBA, JD, is an ethics and compliance professional practicing in the greater Chicago area. She has worked in pharmacy compliance for over 15 years and has developed, evaluated, and implemented corporate compliance plans for hospitals and clinics. Lindsay consults clients through complex pharmacy regulations and guidelines, including 340B, Medicare and Medicaid billing, and HIPAA compliance.



Optum360™

FIFTEENTH ANNUAL

ESSENTIALS

CODING, BILLING & COMPLIANCE CONFERENCE

NAVIGATING THE **NEW FRONTIER**

Destination: Coding, billing and compliance excellence

Mark your calendars now for the 15th annual Optum360™ Essentials Conference. Whether you're looking to focus on your continuing education, network with experts in your field, or ensure your skills stay current and relevant in this ever-changing world of coding, billing and compliance, Optum360 Essentials is truly, well, essential.

 **Nov. 30–Dec. 3, 2015**
The Cosmopolitan™ Hotel
Las Vegas

**REGISTER
NOW**

Optum360 Essentials Coding, Billing & Compliance Conference

Earn up to 16 CEUs and learn from nationally recognized experts to help you navigate the new frontier of coding, billing and compliance.

- 40+ educational sessions
- ICD-10 boot camps
- Network with industry experts
- CPT Code updates directly from the AMA
- We're back in Vegas, baby!

► **Early bird registration: \$625**

Conference registration after July 31, 2015: \$725

To learn more and register visit
optumcoding.com/essentials.



By Stacy Harper, JD, MHSA, CPC

Building a HIPAA Toolbox

Part 5: The core of an effective compliance program is managing risk assessment.



The purpose of Office of Inspector General (OIG) compliance guidance is to encourage use of internal controls to efficiently monitor adherence to applicable statutes, regulations, and program requirements (65 FR 59434, October 5, 2000). HIPAA implements regulations that similarly encourage internal controls for organizations to maintain the privacy and security of protected health information (PHI) (45 C.F.R. §§ 164.530, 164.306). While both OIG guidance and HIPAA regulations provide the basic structure for implementation of compliance programs, HIPAA provides additional details regarding specific safeguards. Although clearly appropriate for PHI confidentiality and security, some of these safeguards are beneficial in developing an effective corporate compliance program.

Risk Assessment and Management Take Focus

Compliance risk assessment and management is a focal point for Office for Civil Rights (OCR) HIPAA investigations, and is a frequently cited deficiency in HIPAA settlement agreements and enforcement actions. Although not as clearly labeled as in the HIPAA regulations, OIG compliance guidance similarly recommends consideration of fraud and abuse topics that need to be addressed, based on your organization's specific needs (65 FR 59434, 59438, October 5, 2000). Ultimately, whether for fraud and abuse or privacy and security, your organization's compliance program will not be fully effective without a risk assessment and management process. Risk assessment is the process of identifying, estimating, and prioritizing information related to organizational risks (NIST Special Publication 800-30, Revision 1, Guide for Conducting Risk As-

essments, section 2.3, September 2012, http://csrc.nist.gov/publications/nistpubs/800-30-rev1/sp800_30_r1.pdf). There is no one method that is endorsed by regulators for performing a risk assessment. Every organization may vary in the process to reflect its structure or particular documentation methods; however, an effective risk assessment and management process should include, at least, the following steps:

1. Inventory
2. Flow
3. Scope
4. Threats/vulnerabilities
5. Likelihood
6. Impact
7. Risk
8. Response

Take Inventory

The first step in the risk assessment process is to take an inventory of your organization. For HIPAA compliance, the inventory should focus on identifying all of the locations where PHI is stored or transmitted. This usually begins with the servers storing store electronic health records (EHRs) or practice management software. It should expand to include all other ancillary storage of PHI,

Risk assessment is the process of identifying, estimating, and prioritizing information related to organizational risks



such as email systems, Microsoft Office®, backup drives, and laptop computers.

For a corporate compliance program, inventory begins with identifying service lines. Within each service line, inventory should include CPT®, HCPCS Level II codes, ICD-9-CM codes, and modifiers used on claims. Inventory should also include the volumes of each code for each provider.

Diagram Information Flow

The risk assessment should next diagram the flow of information through your organization. For HIPAA compliance, this flow should track the movement of PHI in and out of your organization. For a corporate compliance program, it should track the information relevant for billing from the patient visit through the entire collections process.

Define the Scope

The first two steps assume a comprehensive risk assessment is being performed. Not every risk assessment must be comprehensive. A risk assessment may focus on HIPAA implications related to EHR implementation or other sections of your organization's information systems. A compliance risk assessment may focus on a specific department or service line. Where the risk assessment is narrower in scope, it should be clearly defined and communicated in the documentation.

Identify Threats/Vulnerabilities

A threat is the potential for a person or thing to exercise (accidentally trigger or intentionally exploit) a specific vulnerability. A vulnerability is a flaw or weakness in system procedures, design, implementation, or internal controls that could be exercised and result in a breach or a violation (NIST Special Publication 800-30, Revision 1, Guide for Conducting Risk Assessments, section 2.3.1, September 2012). This step creates the greatest variance between organizational risk assessments. To determine potential threats and vulnerabilities, your organization might consider information such as:

- Transmittals, alerts, or relevant guidance from regulatory agencies or payers
- Recent audit results or compliance investigations
- Coding or regulatory changes
- Other industry guidance

The more specific your organization is in identifying threats and vulnerabilities, the more specific the risk assessment will be.

Assess Risk

The end product of any risk assessment is determining the risk level associated with each threat and vulnerability and the overall risk for your organization. A risk is the extent to which your organization is threatened by a particular event considering:

1. The probability that a particular threat will exercise a particular vulnerability; and
2. The resulting impact, if this occurs.

There are a number of different methodologies for calculating risk level. As part of the process, your organization should document the methodology used. What factors were considered in determining the likelihood and probability? What matrix was used to convert the likelihood and probability combination into a risk?

Respond

Much of the industry guidance available focuses on performing and documenting the risk assessment. For the process to be complete, your organization must also respond to identified risks and document the responses.

For the process to be complete, your organization must also respond to identified risks and document the responses.

For each identified risk, document the potential options evaluated for response, the option selected, the reason that option was determined to be appropriate, and the plan for implementation. You can then integrate the risk management plan into future assessments to evaluate the effectiveness of each response.

Make It a Driving Force

The risk assessment and management process is the driving force behind an effective compliance program, regardless of whether it's protecting confidentiality and security of information, or reducing fraud and abuse. If implemented as a continual process

within your organization, it can provide the structure necessary for your compliance program to evolve and respond to industry changes. **HBM**



Stacy Harper, JD, MHSA, CPC, is healthcare attorney with Lathrop & Gage, LLP. She serves on the National Advisory Board and Legal Advisory Board for AAPC. Harper works with healthcare providers around the country to navigate regulatory requirements such as HIPAA, data privacy and security, Stark, Anti-kickback, state licensure, and Medicare conditions of payment and participation. She is a member of the Kansas City, Missouri, local chapter.

Announcing Certified Risk Adjustment Coder

CRC™ Certification

With the increase of Medicare Advantage plans and inclusion of risk adjustment models in the ACA, proficient risk adjustment coders are in demand.

The CRC™ exam will test competency in:

- ✓ Risk adjustment models (including HCC, CDPS, and HHS-ACA)
- ✓ Compliance
- ✓ Diagnosis coding
- ✓ Documentation improvement
- ✓ Pathophysiology
- ✓ Medical terminology
- ✓ Anatomy
- ✓ Quality care



Learn more at aapc.com/CRC



HEALTHCON Hot Topic: Compliance Plan 101

Six takeaways illustrate the importance for providers to have a working compliance plan.

Compliance is the hot topic in healthcare right now — and with good reason. Government payers, especially, are aggressively targeting compliance vulnerabilities, including improper coding and billing (intentional or otherwise), HIPAA lapses, self-referral and Stark violations, etc. In preparing to speak at AAPC’s HEALTHCON 2015 (March 29-April 1 in Las Vegas, Nevada), my firm confirmed, in spite of all the buzz, that many provider practices and organizations are both unformed about compliance and unprepared to enact a comprehensive compliance plan.

This article provides important takeaways from my HEALTHCON presentation. In the coming months, I’ll delve into specific compliance concerns and provide you with hands-on, how-to steps you can use to improve compliance in your organization.

TAKEAWAY 1 Compliance Is an Obligation

The core of my consulting business is negotiating insurance contracts on behalf of physicians. When physicians sign contracts with a commercial payer, they are obligating themselves to all

kinds of requirements, from collecting co-pays to following the payer’s coverage requirements, and on and on. Compliance, broadly defined, is a legal condition of your contract. Participation in federally funded health plans, including Medicare and Medicaid, requires similar compliance.

HIPAA, Stark law, Occupational Health and Safety Administration (OSHA) requirements, etc., are federal laws with which healthcare entities have no choice but to comply.

The cost of ignoring or underestimating compliance obligations can be ruinous to a practice (as later discussed), but many continue to turn a deaf ear. My firm recently surveyed approximately 100 physician practices in the Denver area, asking, “In what year was compliance last addressed in your practice?” More than a third of respondents said they hadn’t addressed compliance for six or more years.

TAKEAWAY 2 Compliance Is Cost Effective

Compliance isn’t free. It requires you to dedicate resources often in short supply: time, money, manpower, and the attention of management, providers, and staff. These costs are the number one reason providers fail to prioritize compliance.

In my firm’s survey, we asked how much money should be allotted in a practice’s annual budget for compliance. Again, more than a third (38 percent) of respondents replied, “zero” or “no budget.” One respondent said, “It’s not budgeted, and we can’t afford it.”

The truth is, compliance is now considered a cost of doing business. Whether you think of it as a form of insurance or as “preventive medicine” for your practice, compliance is a worthwhile investment to protect the financial viability of your practice.

By enacting an active compliance program (see Takeaways 4 and 5), you’ll reduce exposure to civil damages, criminal sanctions, and administrative remedies, such as program exclusion. If your compliance program is robust, you should be able to identify and prevent employee actions that endanger your bottom line (e.g., embezzlement).



Compliance doesn't just happen. It's a big undertaking, and you need written policies and procedures to guide your efforts.

Did you know? Under the False Claims Act (FCA), a healthcare facility or entity may be held liable for the conduct of its employees, or the conduct of other entities with whom the healthcare organization contracts or associates, even if the organization has no knowledge that its employee or associate was engaged in the preparation or submission of false claims.

Compliance programs demonstrate commitment to good corporate conduct. Just having a compliance plan may reduce or mitigate fines or penalties. It also provides a centralized source of information on healthcare regulations, and a methodology encouraging employees to report areas of concern to the practice. Theoretically, a good compliance program should improve quality of patient care.

There are also intangible benefits of a compliance program. Practice leaders and staff can sleep better at night knowing the rules are being followed. Communicating clear and consistent messages to employees that the practice takes compliance seriously creates a positive work environment. If you've ever worked where it's clear no one cares about the rules, and the leadership doesn't care about cutting corners, you understand how uncomfortable such an environment can be. This sort of malaise encourages whistleblowers.

TAKEAWAY 3

Even if You Aren't Paying Attention to Compliance, Someone Else Is

If the benefits of compliance aren't enough to convince you, consider the costs of doing without. Under the FCA, penalties for improper billing can total three times the amount of the claim, plus fines of \$11,000 per claim. As modified by the HITECH Act, HIPAA may result in fines of up to \$1.5 million per year. And these are just two of the many applicable rules!

Payers are keen to contain costs, curb fraud, waste, and abuse, and protect consumers. Government entities and private insurers monitor providers for potential noncompliance, and favorable return on investment has encouraged them to increase their efforts. According to the Office of Inspector General (OIG), the federal government recovered over \$8 for every dollar it spent on healthcare-related fraud and abuse investigations from 2011-2014. The OIG

expects to return \$4.9 billion to the government from investigations in 2014, bypassing previous record recoveries in 2012 (\$4.2 billion) and 2013 (\$4.3 billion).

TAKEAWAY 4

OIG's Compliance Guidance Is a Great Place to Start

Compliance doesn't just happen. It's a big undertaking, and you need written policies and procedures to guide your efforts.

Since 2000, the OIG has made available voluntary compliance program guidance(s) for individual and small group physician practices, third-party medical billing companies, hospitals, and nursing homes. These downloadable guidance documents are available at: <http://oig.hhs.gov/compliance/compliance-guidance/index.asp>. In my firm's informal survey, we asked practices if they were aware of OIG's voluntary guidance, Compliance Program for Individual and Small Group Physician Practices (<https://oig.hhs.gov/authorities/docs/physician.pdf>). Almost half of respondents didn't know the voluntary compliance program existed, even though that particular guidance has been around for nearly 15 years.

The Patient Protection and Affordable Care Act (ACA) §6401 directs the Secretary of the HHS to implement requirements that providers and suppliers establish compliance programs as a condition of Medicare enrollment. The core elements have not yet been defined, but they will most likely be based on the seven components outlined in OIG's Compliance Program for Individual and Small Group Physician Practices:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing corrective action;
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.

Communicating clear and consistent messages to employees that the practice takes compliance seriously creates a positive work environment.



TAKEAWAY 5

A Compliance Program Must Be Active to Be Effective

In my firm's survey, slightly more than half of respondents answered yes to the question, "Do you have written policies and procedures?" Of those, however, fewer than half could affirm that everyone in the practice knew where the written policies and procedures were located.

We also asked, "Does your practice have a compliance officer?" We were thrilled that 79 percent of the practices said yes. But because of our experiences working with physicians, we knew to ask a follow-up question: "Does your compliance officer have a position description?" As we suspected, only one third of the practices said they have a written position description for their compliance officer.

Implementing a compliance program is "not just a paper exercise," the Centers for Medicare & Medicaid Services reminds providers. A practice must be able to demonstrate that they have a "sys-

temic process for proactively and promptly fixing noncompliance issues." In other words, your compliance program must be effective. This requires an ongoing commitment, not a one-time effort. A compliance plan in name only is no better than no plan at all.

The best example I can think of that drives this point home involves Caremark™. This organization had a complete compliance plan on paper, but they didn't follow their own rules. A shareholder sued the board of directors for breach of fiduciary duty of care. The lawsuit followed a multi-million dollar civil settlement and criminal plea relating to the payment of kickbacks to physicians, and improper billing to federal healthcare programs. A whistleblower turned them in for not following their own billing guidelines, and the organization was found liable.

TAKEAWAY 6

It's OK to Seek Help

The OIG acknowledges that there is no "one size fits all" compliance program, especially for physician practices. Whatever the compliance needs of your practice or organization, you may need help tackling such a major and important undertaking. In addition to the model OIG plans, there are a number of compliance programs from which you can draw inspiration, or copy. There are also additional resources available to help you with individual components of a program, such as monitoring, education, or recruiting compliance professionals. Don't be afraid to seek advice and guidance from outside your organization. Often, it may be the more cost-effective solution. **HBM**



Marcia L. Brauchler, MPH, CMPE, CPC, COC, CPC-I, CPHQ, is the president and founder of Physicians' Ally, Inc., a full service healthcare company, where her and diverse staff provide advice and counsel to physicians and practice administrators, and education and assistance on how best to negotiate managed care contracts, increase reimbursements to the practice, and stay in compliance with healthcare laws. Brauchler's firm sells updated HIPAA policies and procedures at www.physicians-ally.com. She is a member of the South Denver, Colorado, local chapter.

Build your **compliance** plan in minutes

Invest in your
current peace of mind
and your practice's
long-term future



With the MGMA Compliance Plan Toolkit, a web-based “wizard,” and a few simple pieces of your practice’s information, you can create a customized compliance plan in minutes.

This compliance toolkit covers the seven elements of a small group or third-party billing company’s voluntary compliance plan, as outlined by the U.S. Department of Health and Human Services Office of the Inspector General in 2000.

Policies in the toolkit include:

- Code of conduct
- Compliance officer position description
- Antitrust laws
- DEA certification
- Food and Drug Administration
- Sunshine Act
- Professional courtesy
- Dismissing a patient
- Non-retaliation
- Nondiscrimination
- Sexual harassment
- Use of nonphysician providers
- And dozens more

Authors:

Marcia Brauchler, MPH, FACMPE, CPC, CPC-H, CPC-I, CPHQ
Erika Riethmiller Bol, CHC, CIPP/US, CPHRM
Amy Powers, JD
Christopher Varani, MSF, MBA, CPC
Daryl T. Smith, FACMPE

Purchase your toolkit today.
mgma.org/store-compliance



Magna Cum Laude

Bethany Olson, **CPC**
 Jennifer Freeman, **CPC-A**
 Jennifer L Beaudry, **CPC, CCC, CCVTC**
 Sarah Ann Jennings, **CPC-A**
 Susan Richards, **CPC, CPMA**
 Therese Christ, **COC-A**

CPC®

Adita S Bheecham, **CPC, COC**
 Ahni Diomarie Richardson-Brown, **CPC**
 Allison Wakeland, **CPC**
 Alma Chavez, **CPC**
 Alyssa Black, **CPC**
 Amanda Allen, **CPC**
 Amanda Hustler, **CPC**
 Anandhi Thangaraj, **CPC**
 Andrew Gorby, **CPC**
 Anna Marie Seville Monteza, **CPC**
 April Edwards, **CPC**
 April James, **CPC**
 Barb Rogers, **CPC**
 Barbara Eby, **CPC**
 Bettie F Phillips, **CPC**
 Bonnie Thomas, **CPC**
 Brande Watson, **CPC**
 Brenda Cox, **CPC**
 Brooke Ashley, **CPC**
 Carla J Orr, **CPC**
 Carol Pedigo, **CPC**
 Cassandra Mae Smith, **COC**
 Cassy Keerthika Kusuma, **CPC**
 Cherise Belton, **CPC**
 Cheryl Robair, **CPC**
 Chetan Gund, **CPC**
 Cindy J Nichols, **COC, CPC**
 Claire B Cartwright, **CPC**
 Cody Dayton, **CPC**
 Constance Coppo, **COC, CPC**
 Dawn Bouldrey, **CPC**
 Deborah Ann Santos, **CPC, COC, CPMA**
 Deepthi Keerthika Korati, **CPC**
 Deidrea K Bostic, **COC, CPC**
 Denise Schow, **CPC**
 Dolores M Guy, **CPC**
 Fern Wood-Mosley, **COC**
 Gwendolyn Pruitt, **CPC**
 Gyongyi Ertl Harsanyi, **COC, CPC**
 Hynissah Williams, **CPC**
 Jamie Summers, **CPC**
 Janelle Anderson, **COC, CPC**
 Jeanne Carol Tinari, **CPC**
 Jennifer N Siron, **COC, CPC, CEDC**
 Jennifer Page, **CPC**
 Jerri Eidson, **COC, CPC**
 Joshua Tinelli, **CPC**
 Kana Kim, **COC**
 Kara M Gonzalez, **CPC**

Karen A Raymond, **CPC**
 Kathleen Taras, **COC, CPC**
 Katie Easton, **COC, CPC, CIRCC**
 Katie Gibbings, **CPC**
 Kimberly Schwantner, **CPC**
 Kirsten Zimmerman, **CPC**
 Kylene King, **CPC**
 Lara Applegate, **COC, CPC**
 Laura Caroots, **CPC**
 Laura Darnell Caroots, **CPC**
 Laura Katz, **COC, CPC**
 Lauren Abrantes, **CPC**
 Leslie Blalock, **CPC**
 Linda S Gombac, **COC, CPC, CPMA**
 Linda T Thomas, **COC, CPC**
 Lindsey Solis, **CPC**
 Lisa Johnson, **CPC**
 Lisa Paley, **CPC**
 Loretta Joan Reifsteck, **CPC**
 Lucinda Overbee, **CPC**
 Lynette Kuualoa Beechler, **COC, CPC**
 Madelen Fuller, **CPC**
 Mallory Pittman, **CPC**
 Margaret Badgley, **CPC**
 Margie Jones, **COC**
 Marie Hansborough, **CPC**
 Marti Brettler, **CPC**
 Martina Marie Pain, **CPC**
 Mary Loretta Santoyo, **CPC**
 Mary Wakely, **CPC**
 Maureen Purcell, **CPC**
 Melanie Holmquist, **COC, CPC**
 Melinda Lindsey, **CPC**
 Melissa De La Rosa, **CPC**
 Melissa Oertle, **CPC**
 Michelle Kalinowski, **CPC**
 Monika Kindziarski, **CPC**
 Muthuraja Balakrishnan, **CPC**
 Nancy Harris, **CPC**
 Natalie A Figliomeni, **CPC**
 Norma Rios, **CPC**
 Nykula Ellison, **CPC**
 On Wong, **CPC**
 Pamela Jager, **CPC**
 Patricia Crump, **CPC-P**
 Peggy Odoro, **CPC**
 Rana McSpadden, **CPC**
 Rebecca P McCann, **CPC**
 Richelle Pritchard, **COC, CPC**
 Ronalyn Recustodio, **CPC**
 Rosalind D Moss, **CPC**
 Sara Stevens, **CPC**
 Saramma Varughese, **CPC**
 Sathiya Rathinam, **CPC**
 Seena Mathew, **CPC**
 Senobia Yvette Veney, **CPC**
 Shantel Jenkins, **COC, CPC**
 Sharon A St Lawrence, **CPC**
 Sharon Madera, **CPC**
 Shauna Kazee, **CPC**
 Sheila Cabell, **CPC, CPPM**
 Shwetha Mahendra, **CPC**
 Stasi R Spriggle, **CPC**

Susan Goodrow, **CPC**
 Takeda McTear, **CPC**
 Tami S Penick, **COC, CPC**
 Teresa Scott, **CPC**
 Tiffany N Moore, **CPC**
 Tomeka McGinnis, **CPC**
 Tonya Hawkins, **CPC**
 Tonya Schnepf, **CPC**
 Torey Riley, **CPC**
 Tracey Williams, **CPC**
 Tracy Johnson, **COC, CPC**
 Veronica Melgar, **CPC**
 Victoria Duffel, **CPC**

Apprentice

Aaron Paul Bantolino, **CPC-A**
 Adithya Varala, **CPC-A**
 Ajay Kumar Silari, **COC-A**
 Alexa Rackett, **CPC-A**
 Alicia Fahlsing, **CPC-A**
 Alisa Bonham, **CPC-A**
 AlJanofer Fouzia, **CPC-A**
 Alyssa Cousins, **CPC-A**
 Alyssa Mueller, **CPC-A**
 Alyssa Sutton, **CPC-A**
 Amanda Goff, **CPC-A, CPB**
 Amanda Hodson, **CPC-A**
 Amanda L. Garcia, **CPC-A**
 Amanda Lamb, **CPC-A**
 Amanda Presley, **CPC-A**
 Amber Kharkwal, **CPC-A**
 Amber White, **CPC-A**
 Ambreen Polani, **CPC-A**
 Amy Moats, **CPC-A**
 Amy Baird, **CPC-A**
 Amy Beach, **CPC-A**
 Amy Jones, **CPC-A**
 Amy Trammell, **CPC-A**
 Ancy Kunnumpurath, **CPC-A**
 Andrea Gerstenecker, **CPC-A**
 Andrea Pinzon-Marquardt, **CPC-A**
 Angel Musgrave, **CPC-A**
 Angela Eva Bowe, **CPC-A**
 Angela Moses, **CPC-A**
 Angela Rebeck, **CPC-A**
 Angela Thomas, **CPC-A**
 Angela Wylie, **CPC-A**
 Anita VanAlstyne, **CPC-A**
 Anjana Ghimire, **CPC-A**
 Ann Austin, **CPC-A**
 Anna Trom, **CPC-A**
 Anna Urban, **CPC-A**
 Anumula Praveena, **CPC-A**
 Anupam Singh, **CPC-A**
 Anushia Reghukumar Kamala, **CPC-A**
 Anushia Vellaishamni Devi Ballasingam, **CPC-A**
 AnwarBasha Shaik, **CPC-A**
 Aparna Pramod, **CPC-A**
 April Feldman, **CPC-A**
 Ariane Petty, **CPC-A**
 Armando Sumano, **CPC-A**
 Arpita Banerjee, **CPC-A**
 Arun Sharma, **COC-A**
 Ashley Harris, **CPC-A**
 Asqari Jahan, **CPC-A**
 Atsuko Rockwell, **CPC-A**
 Ayesha Siddiqha, **CPC-A**
 B. Lavanya, **CPC-A**
 Balaji Chinnaswamy, **COC-A**
 Barb Townsend, **CPC-A**
 Barbara Votruba, **CPC-A**
 Bency Pramila Anthony Doss, **CPC-A**
 Bernadette Mongillo, **CPC-A**
 Beth Amy Counts, **CPC-A**
 Beth Brummond, **CPC-A**
 Beth Gagnon, **CPC-A**
 Beth Rice, **CPC-A**
 Beth Stever, **CPC-A**
 Bharathi Reddypalli, **CPC-A**
 Bhawna Khokhar, **CPC-A**
 Binoy Luke, **CPC-A**
 Boyapati Sreeram, **CPC-A**
 Brandon Coleman, **CPC-A**
 Brandy Mauldin, **CPC-A**
 Brandy R Brown, **CPC-A**
 Brenda Jensen, **CPC-A**
 Briana Salaverria, **CPC-A**
 Bridget Heath, **CPC-A**
 Brittany Dee, **CPC-A**
 Brittany Irene Hickey, **CPC-A**
 Brittany Leake, **CPC-A**
 Brittney Franklin, **CPC-A**
 Caitlin Garippa, **CPC-A**
 Caressa Mills, **CPC-A**
 Carol K Weber, **CPC-A**
 Carol Cross, **CPC-A**
 Carol Madonna, **CPC-A**
 Carole J McMillen, **CPC-A**
 Caroline John, **CPC-A**
 Caroline Rebecca Mifflin, **CPC-A**
 Carolyn Lammle, **CPC-A**
 Casey Meyer, **CPC-A**
 Catherine Sheryl, **CPC-A**
 Catina Ridler, **CPC-A**
 Chandraj Reghunathan, **CPC-A**
 Chandralekha Yadav, **CPC-A**
 Charlie Haukeness, **COC-A**
 Chelsea LeBlanc, **CPC-A**
 Cherie Parson, **CPC-A**
 Cheryl Allen, **CPC-A**
 Cheryl Ben-David, **CPC-A**
 Chisie G Klinglesmith, **CPC-A**
 Chitranjan Tyagi, **COC-A**
 Christina Capporelli, **CPC-A**
 Christy Denenberg, **CPC-A**
 Cindy Nevarez, **COC-A**
 Cindy Wolf, **CPC-A**
 Claudia Howard, **COC-A**
 Claudia Howard, **COC-A**
 Clemons Poindexter, **CPC-A**
 Colin Smith, **CPC-A**
 Colleen Sawyer, **CPC-A**
 Connie Croft, **CPC-A**

Courtney Ann Corwin, **CPC-A**
 Cynthia A James, **CPC-A, CRHC**
 Cynthia JoAnn Sanchez, **CPC-A**
 Damon Hamilton, **CPC-A**
 Daniel R Cohen, **CPC-A**
 Danielle Albano, **CPC-A**
 Darick Conley, **CPC-A**
 Dasa Simova, **CPC-A**
 Dawn Galentine, **CPC-A**
 Dawn Michelle Menser, **CPC-A**
 Dawn Reeves, **CPC-A**
 Dayanand Sodadasi, **CPC-A**
 Dean M Davis, **CPC-A**
 Deanna Grella, **CPC-A**
 Debira Haque, **CPC-A**
 Deborah A Marshall-Kern, **CPC-A**
 Deborah Schin, **CPC-A**
 Deborah Torres, **CPC-A**
 Debra Byble, **CPC-A**
 Debra Iedema, **CPC-A**
 Debra Windle, **CPC-A**
 Deepak Kumar, **CPC-A**
 Deepika Chirvee, **CPC-A**
 Deidre Dowling, **CPC-A**
 Deko Farah, **CPC-A**
 Della Paknik, **CPC-A**
 Demetra White, **CPC-A**
 Denise Gamby, **CPC-A**
 Derrek Rogers, **CPC-A**
 Dhaarna Mehrotra, **CPC-A**
 Dhivyaa Ganesh, **COC-A**
 Diana Barron, **CPC-A**
 Diana Brandt, **CPC-A**
 Diana C O'Connor, **CPC-A**
 Diem Thi Nguyen, **CPC-A**
 Donna Harvey, **CPC-A**
 Doris Jones, **CPC-A**
 Dorothy Lee Harrington, **CPC-A**
 Elena Najor, **CPC-A**
 Elizabeth Abraham, **CPC-A**
 Elizabeth Gilliam Williams, **CPC-A**
 Elizabeth McCormick, **CPC-A**
 Elizabeth Jann Briones, **CPC-A**
 Elsie Burton, **CPC-A**
 Emily Beshears, **CPC-A**
 Emily Gentry, **CPC-A**
 Emily King, **CPC-A**
 Erica Costantino, **CPC-A**
 Erica DeLong, **CPC-A**
 Erica Jewett, **CPC-A**
 Eva Salas Darby, **CPC-A**
 Evelyn McCulloch-Owens, **CPC-A**
 Ezhilarasi Saarangam, **CPC-A**
 Farsina Anvar, **CPC-A**
 Fazila Azher, **CPC-A**
 Gajalakshmi Nandakumaran, **CPC-A**
 Geethalakshmi Arul, **CPC-A**
 Graciela Quintero, **CPC-A**
 Griselda Perez, **CPC-A**
 Gundla Ramulu Gopi, **CPC-A**
 Habeebulla Buganpalli, **CPC-A**
 Harsha Patel, **CPC-A**
 Harshita Bhola, **CPC-A**

AAPC's 23rd National Conference
HEALTHCON
 LAS VEGAS 2015

Thank you to our exhibitors and sponsors

7Atlis
 AE & Associates, LLC
 AHA Central Office/AHA Coding Clinic
 Allzone Management Solutions, Inc
 Alpha II
 Altegra Health
 American Health Information
 Management Association (AHIMA)
 American Medical Association (AMA)
 American Society of Anesthesiologists
 Audicy
 Aviacode
 BC Advantage
 Bristol Healthcare Services
 Caban Resources
 Cardiovascular Systems
 Career Step
 Cengage Learning, Inc
 Coding Network, LLC (The)
 Coding Strategies
 CodingAID
 Columbia Southern University
 Cross Country Education
 CSI Healthcare IT
 DecisionHealth
 Elsevier
 Excite Health Partners
 F. A. Davis Company
 Feel Good, Inc
 Find-A-Code
 Gebbs Healthcare Solutions
 GLOBO-SA, Inc
 HCA Physician Services Group
 HCPro, a division of BLR
 Health Information Associates
 Healthcare Systems Management Group,
 A Western Integrated Systems Company

IMO - Intelligent Medical Objects
 Infinite Trading, Inc
 Infix, Inc
 Inspira Financial
 Kelly Services
 Langley Provider Group
 Libman Education
 Matrix Medical Network
 Maxim Health Information Services
 McGraw-Hill Education
 Medical Business Systems
 MedLearn Publishing/Panacea
 MedSave USA
 myTRICARE.com
 NAMAS, a division of Doctors Management
 NextGen Healthcare
 Ohana Healthcare LLC
 Optum360
 Otto Trading, Inc
 Oxford HIM
 Perry Johnson & Associates, Inc
 Peterson's
 Phoenix Children's Hospital
 PopHealthcare
 ProMED Healthcare Financing
 Quintessence Business Solutions & Services
 ReimbursementCodes.Com
 (Powered by RJ Health Systems)
 Security Metrics
 Society For Vascular Ultrasound
 SuperCoder.com
 Surgical Notes, MDP, LLC
 Vee Technologies
 Vitality
 Wolters Kluwer Law & Business
 ZHealth Publishing, LLC



800-626-2633
HEALTHCON.com

Hasan Mohiuddin, CPC-A	KaleshaVali Shaik, CPC-A	Lisa R Smith, CPC-A	Mohammed Zaki Ahmed Shaik, CPC-A
Heather Fjeld, CPC-A	Karen Ann Hunt, CPC-A	Lisa Weston, CPC-A	Monica Veluz, CPC-A
Heather Hines, CPC-A	Karen Iverson, CPC-A	Lois Patterson-Fluker, CPC-A	Monika Karam, COC-A
Hebe Sacasa, CPC-A	Katelyn Poppe, CPC-A	Ludivina Rivera, CPC-A	Monika Yadav, CPC-A
Heda David, CPC-A	Katherine Muse, CPC-A	Ludmila Anna Barcic, CPC-A	Mrinmoy Ghosh, CPC-A
Heena Usman, CPC-A	Kathleen Hegyi, CPC-A	Lynn Westlake, CPC-A	Mugeswari Pakrisamy, COC-A
Heidi Gilman, CPC-A	Kathryn Bartle, CPC-A	Lynne Miron, CPC-A	Muhilan Thangasamy, CPC-A
Hilda Ledford, CPC-A	Kathryn Walker, CPC-A	Ma Clarette Sambile, CPC-A	Mukesh Thakur, COC-A
Holly Barney, CPC-A	Kathy A Passerelle, CPC-A	Maiko Nova Espinosa, CPC-A	Mukesh Yadav, CPC-A
Imran Khaleeque, CPC-A	Kathy J D'Agostino, CPC-A	Mamta Singh, COC-A	Muni Divya Veluru, CPC-A
Isha Chhabra, CPC-A	Kathy Reyes, CPC-A	Mandy Hall, CPC-A	Murali Muthulingam, CPC-A
Ishtiyaq Ahmad, CPC-A	Katie Greene, CPC-A	Maninder Manda, COC-A, CPC-A	Nadar Ajimol Sundaran, CPC-A
Jack Allen Sweeney, CPC-A	Katie Hicks, CPC-A	Manivannan Kuppuswamy, CPC-A	Nadine L Monge, CPC-A
Jackelyn Lopez, CPC-A	Katie Kitchen, CPC-A	Manohar Konkati, CPC-A	Nagalakshmi Muthireddi, CPC-A
Jackie Cawood, CPC-A	Katka Havic, CPC-A	Manuel Haynes, CPC-A	Nageswara Rao Gollamandala, CPC-A
Jacqlyn Davis, CPC-A	Katrina D Martinez, CPC-A	Marci Huntsinger, CPC-A	Nanette Neil, CPC-A
Jacqueline Montes, CPC-A	Kavya Maheshwari, CPC-A	Margaret Leyden, CPC-A	Naomi A. Tyler, CPC-A
Jake Paulo Llamas, CPC-A	Kayla Merryman, CPC-A	Mari Ward, CPC-A, CENTC	Natasha Fabor, CPC-P-A
Jane Annette Webb, CPC-A	Kelli Schmeling, COC-A	Maria Cecille Limon Carandang, CPC-A	Naveen Manubothu, COC-A
Janette Hundey, CPC-A	Kelly Finn, CPC-A	Maria Concepcion Agbulos, CPC-A	Neethu Balakrishnan, CPC-A
Janice Rose Christen, CPC-A	Kelly Finn, COC-A	Marian Fidelis Agapito, CPC-A	Neha Bhutani, CPC-A
Jayalakshmi Francis, CPC-A	Kelly Merillat, CPC-A	Marianne Wertzler, CPC-A	Nelson Afanador, CPC-A
Jayasree Madhavamoorthy, CPC-A	Kenny Sotomayor, COC-A	Marie Joy Feliciano, CPC-A	Nicole Anne Davis, CPC-A
Jayasudha V., CPC-A	Kenya Gastelum, CPC-A	Marie Pyram, CPC-A	Nicole Gaffney, CPC-A
Jeanne Dixon, COC-A	Kenzi Brooks, CPC-A	Marielys Cruz, CPC-A	Nicole Kauffman, CPC-A
Jeanne Smith, CPC-A	Kimberly Calavetta, CPC-A	Marilyn Kucharik, CPC-A	Nicole Lambert, CPC-A
Jennifer Bone, CPC-A	Kimberly Courtemanche, CPC-A	Marjohn Villanueva Abulencia, CPC-A	Nicole Treber, CPC-A
Jennifer Freeman, CPC-A	Kimberly Gausi, CPC-A	Marla Hocker, CPC-A	Niko Kim Timothy Regla, CPC-A
Jennifer Isebrands Caldwell, CPC-A	Kimberly Layugan Guasi, CPC-A	Mary Ann Paborada, CPC-A	Nina Watters, CPC-A
Jennifer Nahulu, CPC-A	Kimberly Mills, CPC-A	Mary Elizabeth Mick, CPC-A	Nishanthi Gajendira kumar, CPC-A
Jennifer Starry, COC-A	Kiran Kumar Petha, CPC-A	Mary Jane Villar, CPC-A	Nitish Shukla, CPC-A
Jennifer Walker, CPC-A	Kokila Dharmalingam, CPC-A	Mary Louise Percival, CPC-A	Niveditha Srinivasan, CPC-A
Jenny Choi, CPC-A	Komal Sharma, CPC-A	Mary Perdue, CPC-A	Nofa Rahim, CPC-A
Jessica Erin Harris, CPC-A	Krishna Kumar, CPC-A	Mary Sergeant, COC-A	Noorudeen Sahul Hameed, CPC-A
Jessica Muszynski, CPC-A	Krishnan Soundarapandian, CPC-A	Mary Walker, CPC-A	Padma Narayani, CPC-A
Jessica Purdy, CPC-A	Kristin Cramer, CPC-A	Mary Wignall, CPC-A	Pamela K Patterson, CPC-A
Jessica Weaver, CPC-A	Kristin Tipton, CPC-A	Marybeth Smith, CPC-A	Pandiselvi Karuppaiah, CPC-A
Jeyandra Saravanan, CPC-A	Kristine Gammer, CPC-A	Maureen Dobos, CPC-A	Patty Meza, CPC-A
Jill Cisneros, CPC-A	Kristine Smith, CPC-A	Meena Rajendran, CPC-A	Pauline Preethi Abraham, CPC-A
Jill M. White, CPC-A	Kristy Johnston, CPC-A	Meera Raju, CPC-A	Pavanselvi Jayaprakasam, CPC-A
Jillian Carico, CPC-A	Kumar Budda, COC-A	Meetika Khurana, CPC-A	Philip Smith, COC-A
Jino Aswin Masillamani, CPC-A	Lakisha Ross Mitchell, CPC-A	Megan Lamboy, COC-A	Prabha Amalraj, CPC-A
Jitender Kumar, CPC-A, COC-A	Lakshmanudu Bommana Boina, CPC-A	Megan O'Brien, CPC-A	Prabhakar Aillapuram, COC-A
Jo A Lumley, COC-A	Lakshminanth Kolthuri, COC-A	Meilan Xie, CPC-A	Prabhakar Coulampet, COC-A
Joan Winters, CPC-A	Larshuwn Chanel Simpson, CPC-A	Melissa Crislip, CPC-A	Prachi Joshi, CPC-A
Joann Lind, CPC-A	Latisha Belafonte, CPC-A	Melody Dela Torre, CPC-A	Prachi Umrao Gajbhiye, COC-A
Joanna Mlot, CPC-A	Laura Evans, CPC-A	Melody Dimaano, CPC-A	Prafulla Shankar Jha, CPC-A
John Banfield, COC-A	Laura Wile, CPC-A	Melody E. Roth, CPC-A	Pramod Marri, COC-A
Johnson Paul, CPC-A	Lauren Lowe, CPC-A	Michele Forman, CPC-A	Prasad Nangunoor, COC-A
Johny Das, COC-A	Lauren Lucas, CPC-A	Michele Martineau, CPC-A	prasath.K Krishnamoorthy, CPC-A
Jorynell Sibal, COC-A	Lavanya Bagari, COC-A	Michelle Ashbock, CPC-A	Praveen Kumar, CPC-A
Joseph Ian Cruz Dimaano, CPC-A	Lavette Headen, CPC-A	Michelle Assalita, CPC-A	Praveen Kumar Kancharla, COC-A
Joseph Tayco, CPC-A	LeeAnn Nicole Dove, CPC-A	Michelle Fioto, CPC-A	Precious Grace Maypa, CPC-A
Juanita K Gill, CPC-A	Lettie Siu, CPC-A	Michelle Murray, CPC-A	Preeti Gupta, CPC-A
Judith "Brooke" Moores, CPC-A	Lillian White, CPC-A	Michelle Ryan, CPC-A	Preeti S, CPC-A
Judy Gay, CPC-A	Lilly Devasahayam, CPC-A	Mike Pasternak, CPC-A	Premteja Duvva, CPC-A
Julen Weigle, CPC-A	Lily Chiang, CPC-A	Mindell Siegel, CPC-A	Priscilla Martinek, CPC-A
Julie Wilson, CPC-A	Lindsay Della Vella, COC-A	Miquela Smith, COC-A	Pulikonda Veena, CPC-A
Justin Harrison, CPC-A	Lindsay M Stephens, CPC-A	Miranda Walker, CPC-A	Purification Lomibao, CPC-A
Jyoti Rawat, COC-A	Lisa Hayes, CPC-A	Mohamed Shahin, CPC-A	Quintalia T Glover, COC-A
K. Karuna, CPC-A	Lisa Morrow, CPC-A	Mohammed Abdullah, COC-A	Rachel Houston, CPC-A
Kaitlin R Murray, CPC-A	Lisa Paley, CPC-A	Mohammed Ahmed Khan, CPC-A	Rachel Maltese, CPC-A
			Rachel Medina, CPC-A
			Rachelle Ballotti, COC-A
			Radha Lakkumanan, CPC-A
			Rahul Bhaskarrao Patil, CPC-A
			Rajeev Babu Dasari, COC-A
			Rajesh Palla, COC-A
			Rajyalakshmi Cr, CPC-A
			Rakesh Chhetri, CPC-A
			Rakesh kumar Vudiyana, CPC-A
			Ralph lerardi, CPC-A
			Ram Prakash Reddy Bhumireddy, CPC-A
			Ramakanth Peramduri, CPC-A
			Rambabu Nayak Gugulothu, COC-A
			Ramesh Chandra Pulula, COC-A
			Ramesh Edunoori, CPC-A
			Ramesh Thanabal, CPC-A
			Ramprasad Jajula, CPC-A
			Rani Samantha Saggam, CPC-A
			Ranjith Raja, CPC-A
			Rashawne Turner, CPC-A
			Rashmi Mal, CPC-A
			Rebecca Gilmer Miles, CPC-A
			Rebecca Hartman-Wagner, CPC-A
			Rebecca Hutchens, CPC-A
			Rekha Devi S, CPC-A
			Renganayaki Perumal, COC-A
			Renuka Rajpet, CPC-A
			Reynosa Cline, CPC-A
			Rinki Sharma, CPC-A
			Rita Beames, CPC-A
			Riya Scaria, CPC-A
			Robert Manrique, CPC-A
			Robin Egging, CPC-A
			Robin Watrous, CPC-A
			Rohit Pandey, CPC-A
			Rosa Hobbs, CPC-A
			Roseann Joule, CPC-A
			Roshan Lal, CPC-A
			Ruhidas Sarkar, CPC-A
			Ryan Permelona, CPC-A
			Ryan Posey, CPC-A
			Sadhana Basavaraj Sonnad, COC-A
			Sadie Richardson, CPC-A
			Sahar Banu Abusalih, CPC-A
			Sailaja Thekkepat, COC-A
			Samantha Barnes, CPC-A
			Samantha Green, COC-A
			Samantha Rowe, CPC-A
			Sander Padrones Poblete, CPC-A
			Sandra Smith, CPC-A
			Sandra Wilt, COC-A
			Sandy Miller, CPC-A
			Sangeetha Ragupathy, CPC-A
			Sanjana Rana, CPC-A
			Sanjay Kumar Ray, CPC-A
			Sanjay Kumar Singh, CPC-A
			Santhalakshmi Shanmugasundharam, CPC-A
			Sara Gaulrapp, CPC-A
			Sara Nofziger-Drew, CPC-A
			Sarah Ann Jennings, CPC-A

NEWLY CREDENTIALLED MEMBERS



Sarah Cox, **CPC-A**
Sarah Denise Coman, **CPC-A**
Sarah Johnson, **CPC-A**
Sarah Padi-Stephens, **CPC-A**
Sarah Turner, **CPC-A**
Saravanan Subramaniam, **CPC-A**
Sathiyamoorthy Dhasarathan, **CPC-A**
Sathya Vengatesan, **CPC-A**
Saurabh Gupta, **CPC-A**
Senthil Kumar Thudhukuchi, **CPC-A**
Shanthi Sreenivasan, **CPC-A**
Shayne Manito, **CPC-A**
Sheila Shook, **CPC-A**
Shellie Cross, **CPC-A**
Shelly Shimizu, **CPC-A**
Sheri Tesaline Meadows, **CPC-A**
Sheris Legrone, **CPC-A**
Sherry Struemke, **CPC-A**
Shimab Shahin, **CPC-A**
Shimla Rejul, **CPC-A**
Shiva Shankar Edam, **CPC-A**
Shondrell Mitchell, **CPC-A**
Shubham Chauhan, **CPC-A**
Siena Sacchi, **CPC-A**
Simhachalam Naidu Lekkala, **CPC-A**
Simy Jose, **CPC-A**
Smitha Joshy, **CPC-A**
Snufa Sadick, **CPC-A**
Sofija Hadjijski, **CPC-A**
Soumya Pattanaik, **CPC-A**
Soundararajan Ramasamy, **CPC-A**
Sravan Thati, **COC-A**
Stacie Shaffer, **COC-A**
Stephanie Anne McCann, **CPC-A**
Stephanie Doughty, **COC-A**
Stephanie Pomo, **CPC-A**
Steven Walker, **CPC-A**
Subethar Sarthar, **CPC-A**
Subodh Awana, **CPC-A**
Sudarshan Reddy, **CPC-A**
Sudha Manikandan, **CPC-A**
Sudhanshu Singh Pal, **CPC-A**
Sue Koski, **CPC-A**
Sukanya Palanikumar, **CPC-A**
Sumeet Sharma, **CPC-A**
Sumera Ansari, **CPC-A**
Sumit Kumar Biswas, **CPC-A**
Sundarapandian Sivaprakasam, **CPC-A**
Sundararajan Mani, **COC-A**
Sunil Thomas, **CPC-A**
Surajit Banerjee, **CPC-A**
Suri Babu Gunda, **COC-A**
Susan Biggs, **CPC-A**
Susan Brown, **CPC-A**
Susan King, **COC-A**
Susan Lynch, **CPC-A**
Susan Sammarco, **CPC-A**
Suzanne Tingley, **COC-A**
Swetha Silpa Pasumarthi, **COC-A**
Sylvia White, **CPC-A**
Talha Bin Ali, **CPC-A**
Tamara O'Dell, **COC-A**
Tami Rai Simmons, **CPC-A**

Tamilarasi Rathinam, **CPC-A**
Tammy Jean Hill, **CPC-A**
Tanya Getchell, **COC-A**
Taylor Lane Gregory, **CPC-A**
Terry Lynn Hill, **CPC-A**
Terry Mazdra, **CPC-A**
Terry Rice, **CPC-A**
Terry Thompson-Bullock, **CPC-A**
Theresa Bonar, **CPC-A**
Therese Christ, **COC-A**
Tia Marie Allen, **CPC-A**
Tiffaney Green, **CPC-A**
Timothy Foye, **COC-A**
Tina Loeb, **CPC-A**
Tony Premu, **CPC-A**
Tracey Ravo, **CPC-A**
Traci Blue, **COC-A**
Tracy Dugas, **CPC-A**
Travis Chaney, **CPC-A**
Tricia Kolb, **CPC-A**
Trisha Lynn Smith, **CPC-A**
V. L. Harika, **CPC-A**
Vaibhav Ramchandra Nikam, **COC-A**
Valerie DeWeese, **CPC-A**
Valinda Meyer, **CPC-A**
Vamsi Pichikala, **CPC-A**
Vanaja Akula, **COC-A**
Vareena Gray, **CPC-A**
Varsha Goyal, **CPC-A**
Veeralakshmi Raja, **CPC-A**
Veerendra Kurapati, **CPC-A**
Velusamy S, **CPC-A**
Venkata Ravi, **CPC-A**
Venkateswara Rao Achana, **COC-A**
Veronica M Whalen, **CPC-A**
Veronica Morales, **CPC-A**
Vicki Barilla, **CPC-A**
Vickie Nava, **CPC-A**
Victoria Wheeler, **CPC-A**
Vidhya G, **COC-A**
Vijayakumar Karuppapillai, **CPC-A**
Vinayaka Prabhu, **CPC-A**
Vishnuvu Pasula, **COC-A**
Wanda Hughes-Bush, **CPC-A**
Wendy Hager, **CPC-A**
Wilson II Agpalo, **CPC-A**
Y Deepthi, **CPC-A**
Yelemy Shobha, **CPC-A**
Yogesh Aggarwal, **CPC-A**

Specialties

Adriel Go, **CPB**
AmyBeth Durant, **CPC, CIRCC**
Angela Dubose, **CPC, CPPM**
Ankit Patel, **CPB**
Annie Nesakumar Nisha, **CPC, CPMA**
April Purifoy, **CPC-A, CPB**
Arun Manickam Sivanandan, **CPC-A, CPMA**
Barbara L Knox, **CPC, COC, CPC-P, CPMA, CPPM**

Beverly Collison, **CIC**
Beverly Grisham, **CPC, CPMA, CUC**
Bradley Hart, **CPC, CPMA, COBGC**
Brian Quattlebaum, **CPCO, CPMA, CCPC, CEMC**
Brittany Adams, **CPB**
Cailin Spencer, **CPB**
Carolyn Ede, **CPC, CPCO, CPMA**
Carolyn S Shankle, **CPC, CPMA, CPC-I, CEMC**
Charlotte A Marz, **COC, CPC, CPMA**
Chris Lam, **CASCC**
Christine Hall, **CPB**
Christy Wood, **CFPC**
Cindy McRoberts, **CPC, CPMA, CEMC, CUC**
Courtney Erin Birnbaum, **CPC, CPMA**
Courtney Lantz, **CPC, CPMA**
Cynthia Briggs, **CPC, CPMA**
Cynthia DeClerk, **CPC, CPMA**
Danielle Dowell, **CPB**
Dawn Michelle Johnson, **CPC, CPMA**
Dayla Gentry, **CEDC**
Deanna R Cornish, **CPC, CENTC**
Deborah Damon, **CENTC, CGSC, COBGC**
Deitra Dee Payne, **CPC, CPMA**
Denene Conahan, **CPC, CPPM**
Denise Williams, **CPMA**
Diana Grossbohlhlin, **CPC, CPPM**
Diana Nichols, **CPC, CPMA**
Diane L Hartwig, **CPC, CPMA**
Donna Cranford, **CPC, CIRCC**
Donna M Stahlecker, **COC, CPC, CPMA, CANPC**
Eileen Perry, **CPC, CPMA**
Erika Hupp, **CPB**
Erin Anderson, **CPC, CEDC**
Ernest Sari, **CPB**
Freda Beyah, **CPC, CPMA**
Garrett Sutter, **CEDC**
Ginger James, **CPB**
Gloria Espinoza, **CPB**
Heather Hays, **CPB**
Heather Vick, **CPC, CPMA, CGSC, CHONC**
Hema Dharshini, **CPC, CIC**
Holly L Hadley, **CPC, CEMC**
Imelda P Luft, **CPC-A, CPB**
Ioana Ruiz, **CPB**
Jaclyn D Cronch, **CPC, CPMA**
Jacqueline Ruiz, **CPC, CPCD**
Jade Nee, **CPB**
Jane E Suellflow, **CPC, CPB**
Jason Sandoval, **CPB**
Jeanette Grasso, **CPC, CPCO**
Jen Beth Flohr, **COC, CPCO, CPMA**
Jennifer Parker, **CPC-A, CPCO, CPPM**
Jennifer Roberts, **CPC, CPMA**
Jenny Berkshire, **CPC, CPMA, CEMC, CGIC**
Jessica Miller, **CPC-P-A, CGIC**
Jihyang Pardillo, **CPC-A, CPB**

Joann Holbrook, **CPC, CPMA**
Jodi DiBiasi, **CPC, CPCO, CPB, CPMA**
John Muthersbaugh, **CPB**
Johnny Duff, **CPCO**
Joyce Dodd, **CPC, COBGC**
Judith Joanne McKee, **CPC, CEDC**
Judy Dejong, **CIMC**
Kassy D Hodge, **CPC, CPMA, CCC**
Kathryn Willson, **CPC, CPCO, CPPM**
Kathy Kuhns, **CHONC, CPCD, CUC**
Kawana N. Scott, **CPC, CEDC**
Kelly E Wallace, **CPC, CPMA, CPC-I**
Kim A Wells, **CPC, CPMA**
Kimberly A Henke, **CPC, CPEDC**
Kimberly Brown, **CPB**
Kshama Narendra, **CPC, CEMC**
Laura Marie Natoli, **CPC, COBGC**
Lindsey Smith, **CPB**
Lino John, **COC-A, CIC**
Lisa Hyde, **CPMA**
Lisa Jarvis, **CPC, CPMA**
Lular Jackson, **CASCC**
Mandy Bayles, **CPB**
MaraLynn Arbogast, **CPC, CIC**
Marcy Blitch, **CIC**
Mari Ward, **CPC-A, CENTC**
Maria Guerrero, **CPC, CPMA**
Mary Ann Curry, **CPC, CPMA**
Mary Ann Timlin, **CPPM**
Mary P Spivey, **CPB**
Mary-Jo Griffith, **CPC, CEMC**
Maryum McCurdy, **CPCD**
Melinda Russell, **COBGC**
Melissa Oaks, **CPMA**
Melissa Windham, **CPMA**
Meridith McNeal, **CPC-A, CPMA**
Michele Hendrix, **CPC-A, CEMC**
Michelle Diane Griggs, **CPC, CPMA, CPC-I**
Michelle Stibs, **CPC-A, CPMA**
Mohit Kumar Gorski, **CIC**
Nancy Alterman, **CPC, CPMA**
Natalie Wilson, **CPC-A, CPB**
Pamela A Gamble-Thompson, **CIRCC**
Pamela Wheeler, **CPC, CPB, CPPM**
Paul Chandler, **COC, CPC, CPCO, CPC-P, CPB, CPMA, CPPM, CPC-I, CANPC, CASCC, CCC, CCVTC, CEDC, CEMC, CFPC, CGIC, CGSC, CHONC, CIMC, COBGC, COC, CPCD, CPEDC, CPRC, CRHC, CUC**
Paula Hanson, **CPC-A, CPB**
Paula Sauder, **CPC, CPMA**
Prabhu Kumar Singh, **CIC**
Rachel Leos, **CPPM**
Rajarajeshwari Lional, **CPC-A, CPMA**
Rajesh Kurikkanthara Ramakrishnan CCA, **CPC-A, CPMA**
Ramasubbu Subburayalu, **COC, CPC, CPCO, CPC-P, CIRCC, CPB, CPMA, CASCC, CCC, CCVTC, CGIC, CGSC, COBGC, COC, CPCD, CPEDC, CPRC, CRHC, CUC**
Rebecca Peterson, **CPC, CIMC**

Renu Gupta, **CPC, COC, CIRCC**
Renu Kumar Watwani, **CPC, CEMC**
Rhonda Hendricks, **COC, CPC, COBGC**
Robyn Kelley, **CPMA**
Roma Danielle Valentine, **CPC, CPMA**
Rose Tiffin, **CPB**
S S N V P R Kumar N, **CIC**
Sanjay Namdev Patil, **CPC, CPMA**
Saraswathi Sundaram, **COC, CPC, CIRCC, CPMA**
Shari Lynn Smith, **CPC, CRHC**
Sharon Lindauer, **CPC, COSC**
Sharon Spinuzza, **CHONC**
Shelley Andrews, **CPC, CPB**
Simoukda Boutmahanimith, **CPPM**
Stacey Puchalla, **CASCC**
Stavon Williams, **CPC, CCC**
Stella Kendall, **CPC, CPB**
Stephany Best, **CPB**
Sujith Balaparambil, **CPMA**
Tamara Calcutt, **CPC, COSC**
Tamera Lynn Guy, **COC, CPC, CEMC**
Tami Jane Lock, **CPC, CEMC**
Tammy Looney, **CPB**
Terrena Copeland, **CPB**
Terry Paulus, **CPC, CPB, CEMC**
Tina Steffens, **CPC, CPMA**
Tina Robinson, **CEMC**
Toni Osborne Carson, **CPC, CPC-P, CPMA**
Tori Hunt, **CPC, CUC**
Veronica J Lombardo, **CPC, CRHC**
Vicci Nails, **CSFAC**
Virginia Dorazio-Marchese, **CPC, CPMA, CPPM**



ICD-10 Quiz Answer (from page 39)

The correct answer is B.

Conference Preview

Gather in Vegas and Grow at HEALTHCON

Where optimism flourishes, healthcare business professionals learn.

Las Vegas has always been a gathering place. Long before Celine Dion and Caesar's, before Howard Hughes and the Desert Inn, and before Mormon settlers built a fort there, the spring-fed meadow in the Mojave Desert was a welcome oasis for tired, parched travelers. Spanish explorers learned of it from the indigenous people, and it became a favorite stop for immigrants and traders on the Old Spanish Trail.

Brush aside the showgirls and gambling, and Las Vegas is still a place where people meet on the way to success. Regardless of what you do for a living, Las Vegas is a spring of knowledge.

Optimism Abounds in Vegas

It's the optimism of Las Vegas that makes it a perfect place for HEALTHCON, AAPC's National Conference, March 29-April 1, at the Paris and Bally's hotels. Visitors looking to the future hope to strike it rich on the slot machines, get married, honeymoon, and forget daily travails. Residents hope for the same.

You'll meet them during your visit — hospitality workers, university students, professionals, retirees, and others who have made Las Vegas home. They exude the energy of this modern oasis, and hold the key to the American Dream, a dream that comes from a willingness to take risks and forge a new future. I remember once meeting an English family stopping over on their tour of America. They told me that, while they knew Las Vegas doesn't define America, it represents the optimism of America.

It's that optimism that makes Las Vegas a place where you can accomplish so much and have a whole lot of fun doing it.

AAPC and the Future

We do what we do because we love the challenge of finding answers to tough questions, helping patients who need care, providing for our families, and improving our healthcare system through our expertise.

It's that optimism that makes Las Vegas a place where you can accomplish so much and have a whole lot of fun doing it.



This month's HEALTHCON is a chance to gather with others like us to share mysteries and solutions, find common ground and experience with our peers, and learn the latest information and techniques. New professional tracks and more presentations will help both those who attend HEALTHCON and those with whom they network.

We get to choose from more than 90 educational sessions, attend expos on business and anatomy, and be with like-minded friends (at least, they will be by the end of the conference). Faced with the challenges of electronic health record implementation, ICD-10, and new payment methodologies, we can gather around the camp fire, drink the water, and strike a new trail toward making healthcare business better for us and for our patients. Optimism and opportunity live at HEALTHCON, and we're the ones to seize it, just like the desert travelers who made Las Vegas the place it is. **HBM**

Brad Ericson, MPC CPC, COSC, is director of publishing at AAPC. He is a member of the Salt Lake City local chapter.



Meet Audicy. Audit Intelligently.

Introducing Audicy, the best way to manage medical record audits. Put the only smart, all-in-one audit management system in your hands today.



Improve Audit Accuracy



Simplify Audit Processes



Reduce At-Risk Revenue



Enhance Post-Audit Training

Visit AAPC Booth #1 at
HEALTHCON 2015 for
a Demo and Chance
to Win a MacBook Air.



HEALTHCON
ORLANDO 2016

Save the Date!



Disney's Coronado Springs Resort | April 10-13, 2016



HEALTHCON.com | 800-626-2633