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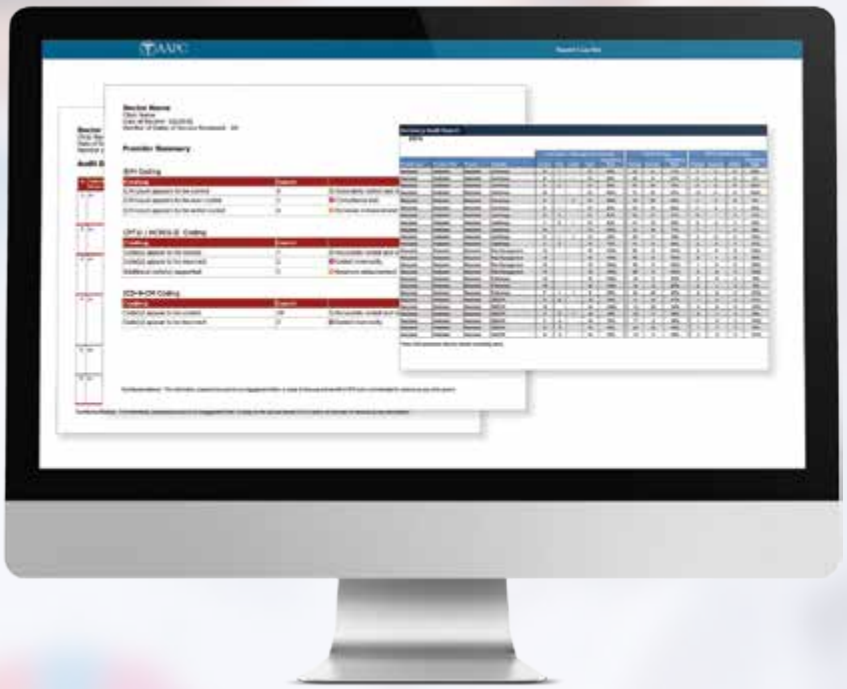

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Don't Leave Money on the Nebulizer Table

Ken Camilleis, CPC, CPC-I, CMRS, CCS-P

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AAPC Chapter Association

Member Feature

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Added Edge

COMING UP:

- Dx Burns
- Clock Games
- Coding Families
- STD Testing
- Outpatient Errors

On the Cover: Ken Camilleis, CPC, CPC-I, CMRS, CCS-P, will build your confidence in inhalation treatment billing, so you can breathe a sigh of relief when there is no money left on the nebulizer table. Cover design by Kamal Sarkar.

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"Dr. Z's conversational style makes the info more easily absorbable." Genie Vaughn, TN

"Very informative and everything went at the perfect pace." Debbi Stewart, TX

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Ask the Legal Advisory Board

From HIPAA's Privacy Rule and anti-kickback statute, to compliant coding, to fraud and abuse, there are a lot of legal ramifications to working in healthcare. You almost need a lawyer on call 24/7 just to help you make sense of all the new guidelines. As luck would have it, you do! AAPC's Legal Advisory Board (LAB) is ready, willing, and able to answer your legal questions. Simply send your health law questions to **LAB@aapc.com** and let the legal professionals hash out the answers. Select Q&As will be published in *Healthcare Business Monthly*.

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September 2015

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Strength in Numbers . . . and Letters

We are fortunate to be an active part of the transition to ICD-10. We are participating in healthcare history. Some individuals only have read about the transition, while AAPC has been living it, breathing it, and consuming it for the past few years.

We have seen highs and lows, anger and excitement. Through it all, the one constant has been one another. This community spirit has strengthened us as individuals and as a group. This change affects each of us, regardless of our job title or specialty. It does not matter what credential(s) we hold, we have all been feeling the affects of this transition.

Rhonda Rounded Up the ICD-10 Troops

The community spirit has been alive and well at AAPC, and our community cheerleader throughout this change has been **Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC.** She championed for AAPC to be heard, and the Centers for Medicare & Medicaid Services (CMS) listened. She rounded us up and informed us whenever anything ICD-10 was in the news. As a group, we are informed, educated, and ready. Thank you, Rhonda, for all you have done and continue to do. We are indebted for all of your hard work.

United We Stand

As a group, our strength continues to be in our growing membership numbers. We are a voice that's heard. I am still in awe when I conduct code set training; the enthusiasm of the participants is infectious. It's a pleasure to watch members learn something new, and who are anxious to get back to the office to share the knowledge they have gained. It makes me proud to be a part of this organization and this coding community.

It does not matter what credential(s) we hold, we have all been feeling the affects of this transition.

Now, the Real Fun Begins

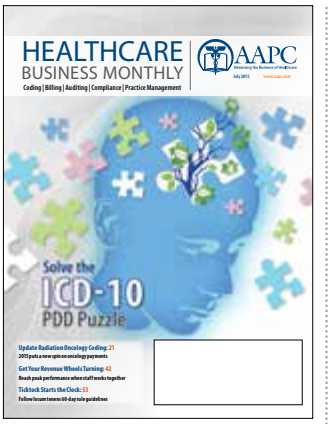
We've been preparing for years. On October 1, 2015, the real fun begins. We'll soon learn how ICD-10 will affect our day-to-day activities. As a group, we'll continue to grow and experience this history-making process.

As the next phase unravels, the one remaining constant is this organization — this incredible group of professionals who are committed to learning and growing, and helping each other. We have strength in numbers. And remember: In ICD-10, letters matter, too!

Good luck to each of you! Please let us know how you are managing.

Take care,

Jaci Johnson Kipreos, CPC, COC, CPMA, CPC-I, CEMC
President, National Advisory Board



Timed Therapy Services Require at Least 8 Minutes

The final example in "Common Chiropractic Procedures Aren't Always Straightforward" (July 2015, pages 26-27) reports seven minutes of manual therapy and 15 minutes of strengthening exercises using 97140-52 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes-Reduced services* and 97110-59 *Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility, only-Distinct procedural service*. I disagree with this because the total time is 22 minutes, which means you may bill only one unit of a timed therapeutic service. Because 15 minutes of exercise is documented, I would bill 97110, alone.

As a previous payer, I would only pay for the exercises based on the documentation. As a coder, I would have a conversation with the physical therapist about coding and guidelines.

Tina Hall, CPC

You are correct. Outdated coding resources may advise appending modifier 52 if the provider spends less than eight minutes performing a timed therapeutic service; however, the most recent Medicare Claims Processing Manual, chapter 5, section 20.2 states, "When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes."

Healthcare Business Monthly

N18.2 = CKD Stage 2 and N18.3 = CKD Stage 3

Code descriptions for N18.2 and N18.3 in the Covered Diagnosis Codes chart on page 28 (July issue) should be:

N18.2 Chronic kidney disease, stage 2 (mild)

N18.3 Chronic kidney disease, stage 3 (moderate)

Kidney Transplant Coding Correction

Two examples from "Kidney Transplant Coding in Brief" (July 2015, pages 28-29) require correction.

The first example describes a patient with bilateral kidney failure who is undergoing bilateral recipient transplantation. Because the patient is undergoing a nephrectomy at the same time as the transplantation, correct coding is 50365-50 *Renal allotransplantation, implantation of graft; with recipient nephrectomy-Bilateral procedure* rather than 50340-50 *Recipient nephrectomy (separate procedure)*, as stated.

In the second example, nephrolithotomy is reported using 50060-50075 *Nephrolithotomy* …, as appropriate, rather than 50340.

Patty Basa, CPC, CPMA, CCVTC

Unlisted Code Doesn't Describe Bicep Tenotomy

"Arthroscopic Shoulder Debridement Bundles Bicep Tenotomy" (July 2014, page 36) incorrectly states that when separately reported, the correct code choice to describe arthroscopic bicep tenotomy is 29999 *Unlisted procedure, arthroscopy*.

Arthroscopic bicep tenotomy is never reported with 29999. Rather, it is always inclusive of debridement and is described by either 29822 *Arthroscopy, shoulder, surgical; debridement, limited* or 29823 *Arthroscopy, shoulder, surgical; debridement, extensive, as appropriate to extent of the debridement.*

Healthcare Business Monthly

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.

SAMANTHA TURMAN, CPC-A, CRCST, CIS

I had worked as a Certified Registered Central Service Technician (CRCST) in the operating room for over 10 years when I received an email from the educational department about a medical coding program scholarship opportunity. I had no clue what medical coding was, but I was interested. I applied and was granted a scholarship. I started the course while I worked full time. The more I learned, the more I wanted to become a coder. The thought of telling a patient's story with numbers was intriguing.

Time to Get Certified

After graduation, I was fresh and excited and wanted to take AAPC's Certified Professional Coder (CPC®) exam. I took my first exam nervous and unprepared; I didn't know what to expect. I had never taken a test lasting 5 hours and 40 minutes. I did not complete the exam and failed the test. I remember thinking to myself, "I ran out of time, that's it."

If at First You Don't Succeed, Try, Try Again

I scheduled to take the test again. All I needed was to work on my timing, so I thought. I took the exam again, and my timing was better. I failed the exam again, however. I took the exam *three* more times. I was at my wits' end; I was so close to passing each time.

I knew that I was too close to give up. Besides, my children were watching and I wanted to set a good example. I knew that for me to pass, I had to do something I hadn't done on the other exams. I logged on to the AAPC website to reschedule and to browse. It never occurred to me that AAPC was there to help me succeed. All I had to do differently was ask for help.

The more I learned, the more I wanted to become a coder.

Help Me, AAPC!

I saw the names of my local chapter officers and I called the first name I saw, President-elect **Donielle Martin, MBA, CPC**. Martin was warm, empathetic, and listened with attention while encouraging me. I had no clue she was the local chapter president at the time; it wasn't important. Martin went right to work and introduced me to Member Development Chair **Rhonda Carney, CPC**. Carney, while in school herself, became my tutor. I was excited to be a part of such an organization. I took the exam again, and I failed, again. I called Carney and she didn't allow me even a moment of self pity.

Seventh Time Is a Charm

Carney told me, "We are going to meet and go over section by section. You can do this! Everything you need to know to pass is in the book." I took the exam for the *seventh time* on June 13, 2015, and *I passed!* I was ecstatic.

I remembered something my daughter told me, "You don't fail until you give up." For anyone who wants to give up I say, "Reach out." There are so many resources available for members through AAPC. **HBM**

#IamAAPC

Healthcare Business Monthly wants to know why you chose to be a healthcare business professional. Explain in less than 400 words why you chose your healthcare career, how you got to where you are, and your future career plans. Send your stories and a digital photo of yourself to Michelle Dick (michelle.dick@aapc.com) or Brad Ericson (brad.ericson@aapc.com).

By MariaRita Genovese, CPC, PCS

Inspire Through LEADERSHIP

Develop the skills necessary to advance your organization to greatness.

A successful organization can be attributed to its leaders. Through effective leadership, individuals are influenced, inspired, motivated, and aided in achieving personal goals that ultimately serve to elevate the entire team.

Some people are born leaders, but even they have a learning curve. Being an effective leader means always looking to improve inherent skills and learn new ones. Leaders must possess certain key skills, whether inherent or learned — namely, the ability to collaborate, communicate, and conceptualize.

Collaborate

Leadership may seem like a solitary endeavor, but it is far from it. Leaders who are disconnected from their team produce poor results. Leaders must be able to work cooperatively with everyone: physicians, staff, patients, vendors, etc. They must also be able to promote collaboration within the entire team.

As a leader, make a point to get to know your team — how they work and how they live. Embrace individual personalities and promote acceptance. This will create relationships built on respect, which will improve your ability to manage and motivate others.

Communicate

Communication is an essential skill for a leader. Not everyone possesses this skill, so it is the leader's responsibility to facilitate communication among the ranks. Leaders who have an open door policy and promote productive communication within the organization will see far better results.

Communicate expectations clearly and concisely, always be approachable, and listen to what your coworkers and colleagues have to say.

Conceptualize

Leaders are visionaries. Anyone who focuses on just his or her role is incapable of seeing the big picture. Tunnel vision puts restraints on everyone involved.

Share your vision and strategies so your team knows where you stand and understands how they fit into the big picture. Be open to new ideas, even if they're not your own. Take risks and accept the consequences of those risks.

Stretch Beyond Your Comfort Zone

If being a leader is out of your comfort zone, but you really want to advance in your career, start out slow. For example, volunteer in your chapter and run for a low-level officer position. When you're more confident, run for president. Our chapters need dynamic leadership, so think about volunteering today and help us grow great chapters. HBM

Maria (Rita) Genovese, CPC, PCS, is director of operations, Department of Medical Oncology and Jefferson Infusion Centers, Thomas Jefferson University. She manages a practice of over 50 physicians, two outpatient infusion centers, and a support staff of 200. Genovese has over 20 years of experience in billing and practice management, most recently in the areas of family medicine and medical oncology. She also educates physicians and staff in medical coding and compliance regulations. Genovese serves as president of the Greater Philadelphia Chapter, and served as either chapter president or vice president in 2008, 2010, and 2012. She is a Region 1 representative of the AAPC Chapter Association and a former member of AAPC's National Advisory Board.

Anyone who focuses on just his or her role is incapable of seeing the big picture.

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Focusing on Our Chapters

Successful May MAYnia reports continue to flood our mailbox.

More than 500 local chapters make up the backbone of AAPC. Every year these chapters celebrate May MAYnia as a fun way to provide quality education, draw in new members, and network with colleagues. Here are four more chapters who made May MAYnia a memorable event this year.

Madisonville Pennyrile, Kentucky

▲ Charlotte Lynn, president (aqua shirt); Mary Sims, vice president (multi-colored blouse); Linda Noel, secretary (pink jacket); Gwen Pruitt, speaker (tan sweater); Elizabeth Johnson, chapter member and photo "bomber" (tan shirt); Billie Ann Bevels, chapter member (gray shirt)

May MAYnia, for the Madisonville Pennyrile Kentucky chapter, was all about fun, facts, and food. The fun part was the prize drawings. "After our speaker finished, we drew from the wonderful prizes AAPC furnished for our chapter," said President **Charlotte Kay Lynn, COC, CPC, COBGC**. "I don't know which was the bigger hit: the books or the $50 gift certificates. The ladies love free items!"

◀ Speaker Gwendolyn Pruitt captivates the audience.

The theme of their event, "Fraud and Abuse: Behind the Scenes from a Compliance Perspective," was also a big hit. For this chapter, May MAYnia was a success with 22 people in attendance. "We even had two non-members sign up for the free membership," Lynn said. "A good time was had by all."

San Juan, Puerto Rico

AAPC's San Juan, Puerto Rico, local chapter hosted a May MAYnia event, featuring **Carmen Ibarrondo, CPC**, who spoke of the "Impact of Medical Documentation with ICD-10-CM." After the conference, temporary member certificates and AAPC May MAYnia certificates supplied by AAPC were awarded to participants through a drawing.

◀ (R-L) San Juan Puerto Rico chapter officers: President Addiss Maldonado, MD, CMC, CPMA, CEDC; Secretary Raquel Manzano, PCP; Treasurer Brenda Galvez, CPC

President **Addiss Maldonado Mendez, MD, CPC, CEDC, CPMA**, was thrilled with the turnout and told AAPC, "Thanks for your support and we would be honored if you ever visit our chapter."

Statesville, North Carolina

Statesville, North Carolina, local chapter also hosted a May MAYnia event, according to Education Officer **Juliana Kathman, CPC**. Their theme: The Garden of Eatin'. The event began with a smoothie demonstration and tasting. Then, they settled in for an insightful presentation about bariatric surgery and the gastrointestinal (GI) system; followed by a game of GI Jeopardy. In addition to the door prizes

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 high resolution and 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.

April Johnson was just one of the many lucky door prize winners.

provided by AAPC, the chapter also raffled off vegetable and fruit baskets, as well as a GNC gift, an Avon basket, and polo shirts. Naturally, there were plenty of good treats, too, which consisted of cut vegetables, corn chips, and varieties of dips and salsas. "We have a great officer team!" said Kathman.

Sumter, South Carolina

The Sumter, South Carolina, local chapter chose a Hawaiian luau theme for their annual May MAYnia. Each officer provided a luau-themed dish, which consisted of Hawaiian meatballs, sweet and sour Hawaiian chicken wings, Hawaiian fruit trays, BBQ pulled pork with Hawaiian rolls, and sparkling fruit punch. Officers greeted each attendee with a lei and a letter describing AAPC and the importance of local chapters.

The agenda for the event consisted of amazing presentations about the need for clinical documentation improvement (CDI), presented by **Courtney Gainey, RN**, CDI supervisor for Tuomey Healthcare System; physician queries and staying compliant, presented by **Christin Brodrick, CPC**, chapter president and coding supervisor for Tuomey Healthcare System; and ICD-10-CM practice coding using Disney characters, presented by **Lahoma Brasfield, CPC**.

Catina Tomlin was the grand prize winner.

President Christin Brodrick (left) and Crystal Junious-Green

Attendees team up to see who's the fastest ICD-10 coder in the south!

Throughout the evening, there were drawings for door prizes, including five codebooks, AAPC Bucks, calendars, pens, pencils, and more. The grand prize winner was **Catina Tomlin, CPC**, who won a personalized coding gift basket filled with an ICD-10-CM codebook, ICD-10-CM workbook, T-shirts, notepads, pens, pencils, highlighters, $50 in AAPC May MAYnia money, hand lotion, and of course, candy! At the end of the meeting, attendees were given a thank you card expressing gratitude for supporting their local chapter.

Tip: Use these ideas, and those of other chapters we've featured in the past few issues, to help plan for your chapter's May MAYnia event in 2016!

By Michelle A. Dick

With DEDICATION, Dreams Come True in AMERICA

Members immigrate to the United States and hurdle over career barriers in the healthcare industry.

If you think medical coding is hard, try learning it when English isn't your first language. Medical terminology is difficult, anatomy and pathophysiology are confusing, and doctors' notes can be challenging to decipher — throw into the mix all of the payer and government rules and regulations and it's a wonder anyone — let alone someone with a language barrier — can make sense of it all.

Meet four incredible women whose struggles and successes should serve as inspiration to us all.

JANYA GLADU

Janya Gladu, CPC, CPB, arrived in United States in December 1999, just before Christmas. She said, "I loved it all — festivities, decorations, and lights — coming from a country that hadn't celebrated religious holidays for over 70 years." Months later, she was married to a man to whom she was introduced during his missionary trip, giving aid to orphanages in Russia.

Gladu came from a math and computer technology background. She said, "I have a master's degree in mathematics and a secondary degree in computing technology. I also attended religious college with a degree in Director of Sunday School." In Russia, she had taught math to high school students and organized Sunday school, worked with teens at her local church, and taught Bible studies to boarding school students.

In America, Gladu wanted to find part-time work in a field related to math. She said, "I saw advertising for a coding school in a magazine." Gladu thought, "What a perfect start! It could lead anywhere in the medical field." She took the advice of a friend to find a school or courses locally, not online.

> "I saw advertising for a coding school in a magazine." Gladu thought, "What a perfect start!"
>
> Janya Gladu, CPC, CPB

Getting in the Trenches to Overcome Challenges

Gladu finished Seacoast Career School in Sanford, Maine, as a health claim student, and in 2013 she completed her Certified Professional Biller (CPB™) medical billing course. She said, "I scored an 'A' in both!" Gladu proudly passed her exams to obtain Certified Professional Coder (CPC®) and CPB™ certifications.

Gladu loved learning anatomy and medical terminology, but spelling and pronunciation were difficult. She said, "The majority of all that knowledge was new for me, as English was my second language."

The language barrier was evident for Gladu while she worked at the hospital. She said, "I am not talking about discrimination, but immigrants who arrive in this country as adults have an accent to deal with."

Getting Involved and Volunteering

Gladu worked at Huggins Hospital in Wolfeboro as a Medicaid biller, but isn't currently working in the medical field. This year, she is secretary of the Seacoast-Dover, New Hampshire, local chapter, with the encouragement of **Pam Brooks, CPC, COC, PCS**.

Gladu's advice to members who are facing challenges: Volunteer! She said, "If you love what you are doing, go for it! Volunteer to let people get to know who you are and your abilities … This way they will be more comfortable to make a decision to hire you."

MARIA CASTANEDA

Maria Castaneda was born in Cuba. She came to the United States in 2013, petitioned by her mother who lived in the states already. Castaneda said, "I have always wanted to come to this country — well, as a matter of fact, all Cubans dream about is getting off of our island." The day she received her visa is etched in her mind as one of the happiest days of her life.

"Finally, I could join my family. I knew better changes and opportunities were ready for me here," Castaneda said.

Castaneda has been living in Miami, Florida, for more than six months and has reunited with her family. She became certified in the Medical Front Desk and Billing Specialized program from Florida Career College, Miami Campus, and is studying to get certified through AAPC.

Prior to coming to the United States, Castaneda has worked various administration jobs for 20 years in Cuba. She said, "The past nine years have been very pleasant and enriched my professional life." Castaneda was the executive secretary of The French Alliance of Havana, which is a cultural institution headquartered in Paris, France, with the goal of taking French culture and language to every corner of the world.

Breaking the Language Barrier

Castaneda said, "I came to this country to follow a dream and to be part of this great nation." She has a long road ahead of her, but is paving a solid path behind her. Castaneda recalls the challenges she has faced getting into the medical field as an immigrant:

> As all immigrants, I didn't have any references from here, nor a diploma. Since my English knowledge wasn't so bad, I decided to go back to school, thanks to my family and their support. … I enrolled in a 10 month program at Florida Career College, Miami Campus, without knowing it was exactly what I needed. I was fascinated at how medical coding because it was the first time I saw medical services becoming codes. Medical coding seems very well organized, and there is nothing like it in Cuba.

When asked what Castaneda's biggest challenge has been, she said, "The English language."

"Even when I spoke some English, it was difficult for me to find a job, since I had no references, nor diploma or studies in this country. That's why I decided to study in order to find a better job," Castaneda said.

> "This is a country of opportunities, but they're not going to come easily and knock at your door."
>
> Maria Castaneda

Spanish is Castaneda's native language, but her classes were all in medical English, as well as her codebooks, notebooks, and medical dictionary. Castaneda said, "I thought I knew enough English, but I had to work twice as hard as the rest of my classmates."

Advice to Members Entering the Coding Field

Castaneda follows her teacher's advice, "Study, study, and study, and do your homework!" She sits down for hours until she better understands her books, terminology, and rules. For anyone who comes to this great country, Castaneda advised, "Learn English and be perseverant, because there will always be obstacles. This is a country of opportunities, but they're not going to come easily and knock at your door. Work hard, study hard, and prepare yourself, so when the opportunity comes, you'll be ready for it."

NAMRATA MEHTA

Namrata Mehta, BS, ADSE, CPC, CPB, is secretary of the San Jose, California, local chapter. She moved to the United States several years ago, after she was married. Mehta had been working for more than 15 years when, four years ago, she made a career change from finance to medical coding. While in finance, she worked for J.P. Morgan and Citibank, but due to the housing market crash in California, she changed to medical coding.

Mehta says that while she was growing up, she always wanted to be a part of the medical world, but had no desire for direct patient care. She said, "My aunt and father-in-law suggested the field of coding, as it still involved numbers. With the help of my family, I pursued it further. Every day I would study for my medical billing and coding course while my mother-in-law took care of my newborn." Mehta received her first coding break at Civic Medical Center when her primary care physician, Bala Annadurai, MD, hired her.

A mentor from AAPC, **Bertina Nunes**, helped Mehta pursue the Certified Professional Coder (CPC®) credential. She gained a lot of education and exposure while attending the San Jose, California, local chapter meetings and trainings. Mehta said, "I was able to imple-

> "A lot of times I have felt out of place, but that has not stopped me."
>
> Namrata Mehta, BS, ADSE, CPC, CPB

ment what I learned from AAPC in my day-to-day work. Soon, I was promoted from biller to office manager."

Mehta now works at the Indian Health Center of Santa Clara Valley, California, a non-profit, community-based American Indian/Alaska Native urban health center that provides medical and wellness services to diverse patients, and she loves it.

Challenges Abound

Mehta found anatomy challenging. She said, "I still remember the day I was almost in tears: When I found out about oxygenated blood and the deoxygenated blood (blue blood)." Despite not understanding and the tears, she was determined and committed to coding. "Nothing stopped me and I studied by myself and proceeded," she said. Mehta would get dropped off at her local library and study all day.

We can all learn from Mehta's determination. She said:

> I can understand and speak English very well; however, the slang and metaphors of America are very different. A lot of times I have felt out of place, but that has not stopped me. Do not hesitate to ask questions. This is the way I learned about the CPC®, and how to pursue it. I made contacts through AAPC chapter meetings and learned at the meetings about different areas of medical coding.

Now that Mehta is settled into the medical coding field, she said her biggest challenge is to get providers to understand the importance of medical necessity versus documenting to qualify for a level of service. As any evaluation and management coder knows, this is an ongoing struggle.

Being Grateful and Giving Back

Mehta promotes local chapters and said, "AAPC also has a very big platform for networking and an effective support group." Mehta will be proctoring upcoming CPC® exams, to which she looks forward. She volunteers by mentoring and helping charities and committees. Her next goal is to become a Certified Professional Medical Auditor (CPMA®).

SARAH W. SEBIKARI

When **Sarah Sebikari, MHA, CPC**, came to the United States, her first shock was the weather, which is much different than Uganda's. It was a "very cold" November day in 1999. "Although it was still fall, it felt like winter to me," Sebikari said.

In New Jersey, Sebikari worked in several capacities, none of which were satisfying. While working at Staples, a co-worker who was taking a phlebotomy course at the Manhattan Institute in New York City told Sebikari about the school and courses offered, and even recommended coding and billing. Sebikari worked two jobs to pay for school, traveled to New York City, and attended class for four hours a day for about six weeks.

> "Today I do not have to search for a job; the jobs come to me."
>
> Sarah Sebikari, MHA, CPC

The first coding-related job she landed was at McKesson in Somerset, New Jersey, as a reimbursement fee analyst. Larni Banez, her supervisor encouraged Sebikari to obtain AAPC certification. Banez not only provided the books, but asked one of the experienced coders, Marie Timbol, to walk Sebikari through the books and train her. Every day Sebikari was assigned charts to code, which Timbol would later review with her.

Sebikari worked her way up the ranks to educating on ICD-10, coding, and compliance as the lead coding compliance educator for Summit Health Management (SHM), which provides physician practice management to Summit Medical Group (SMG) in New Jersey.

Language Was the Least of Her Problems

Aside from an accent, language wasn't a barrier for Sebikari because she attained early formal education in Uganda, where English is the official language. She had other challenges, though. "Having to keep up and adjust to the American system and way of life — harsh winters and no close family support — was a challenge," she said. Sebikari pulled through and did what she had to do to succeed. "I worked two jobs to keep up with the bills, made new friends, learned how to get around, and the list goes on," she said.

Keep Your Chin Up and Code

To get ahead, "Never look down at any job or duty you're given as that may be your chance to shine and move on up," Sebikari said. "I have done everything from charge entry, payment posting, customer service, and A/R follow-up to basic diagnosis coding, complex coding of neurosurgery, and interventional radiology procedures. All these experiences are immeasurable and have helped me to become a well-rounded coder." Although Sebikari has favorite specialties, she now can code for any specialty.

"Today I do not have to search for a job; the jobs come to me," she said.

Michelle A. Dick is executive editor at AAPC.

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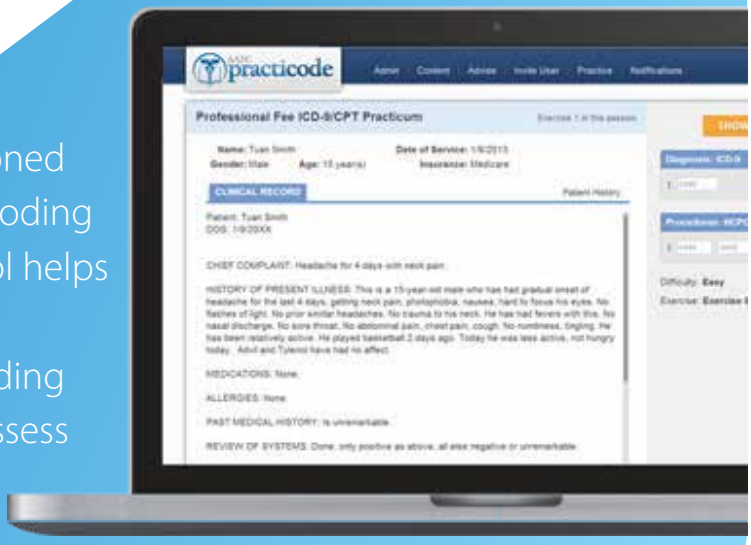
Practicode by AAPC helps new and seasoned medical coders get real-world experience coding actual medical charts. This new practice tool helps to improve coding skills across multiple specialties, allowing new coders to gain coding experience or employers to evaluate and assess the skills of potential medical coding employees.



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93015 Applies Only to Global Cardiovascular Stress Test

Q When we report 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report* and 93018 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only*, the health plan has been paying only for 93016, stating there is a better way to bill for the service using a single code. This seems wrong to me. Can you offer insight?

A There is a single code to report a complete cardiovascular stress test. *CPT® Assistant* (January 2010) explains:

> The CPT coding for the stress test consists of three components:
>
> - Physician supervision of the test (code 93016),
> - ECG Tracing, the technical component (code 93017 [*Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report*]), and
> - Physician interpretation and report (code 93018).
>
> Code 93015 [*Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report*] is used to report the complete cardiac stress test procedure, which includes all three components. Because code 93015 includes the technical component, supervision, and interpretation, this code is rightfully reportable only by a physician in a nonfacility setting (eg, office, clinic, or diagnostic testing center).

CPT® Assistant further explains that a physician may properly report 93016 and 93018 individually, in the facility setting.

> When a complete procedure (code 93015) is not performed, codes 93016-93018 are reported by the various providers according to the specific procedures that are actually performed…. In a facility setting (eg, hospital), the facility reports the technical component of the service and the physician(s) report the applicable component codes (eg, codes 93016 and 93018). Each physician should take care to report only those components of the stress test that he or she has actually provided ….

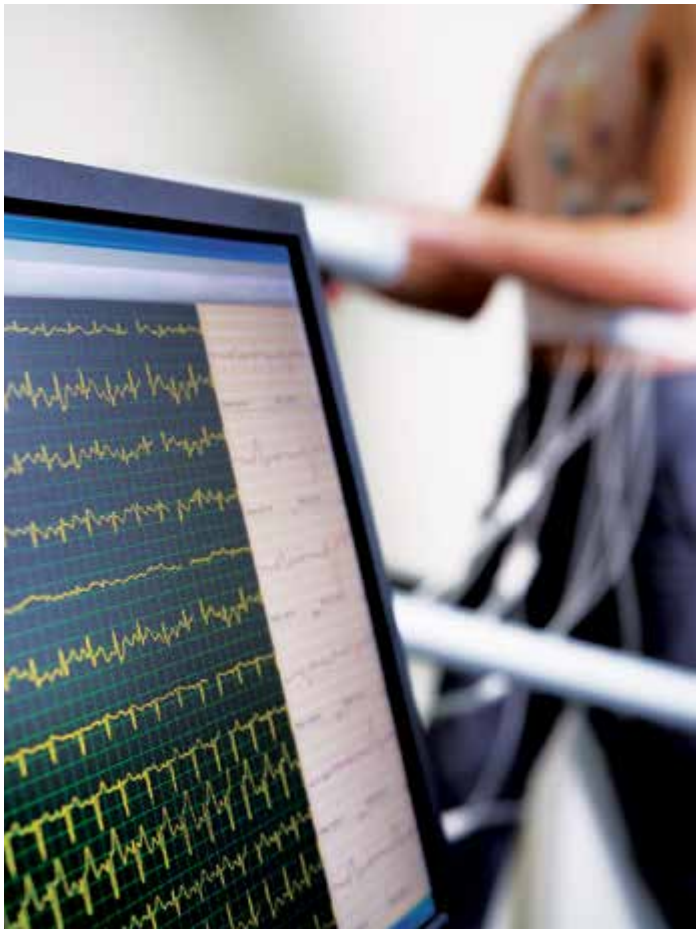


image by iStockPhoto ©Lunaert

To restate: Code 93015 is appropriate only if *all three* components of the service are provided (e.g., the physician performs the test in a nonfacility setting, using his or her own equipment). In a facility setting — where the facility reports the technical portion of the service — you are correct to report 93016, 93018. **HBM**

In a Coding Quandary? Ask John

If you have a coding-related question for AAPC's *Healthcare Business Monthly*, please contact John Verhovshek, managing editor, at g.john.verhovshek@aapc.com.

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

Ovarian Cancer

Ovaries are female gonads, the primary reproductive organs of the female reproductive system. Located in the pelvis, one on each side of the uterus, their main purpose is to produce ova, or eggs. Ovaries are also endocrine glands and produce sex hormones (progesterone, estrogen, etc.) that govern the early development of the female reproductive system and contribute to the menstrual cycle. Ovaries are nodular bodies and each is approximately 4 cm long by 2 cm wide. A suspensory ligament attaches the ovary to the pelvic wall, and a rounded cord called the ovarian ligament (which lies within the broad ligament) attaches it to the uterus. An ovary consists of numerous ovarian follicles embedded in a layer called the cortex, which is immediately below the ovary's surface, and is abundantly supplied with blood vessels.

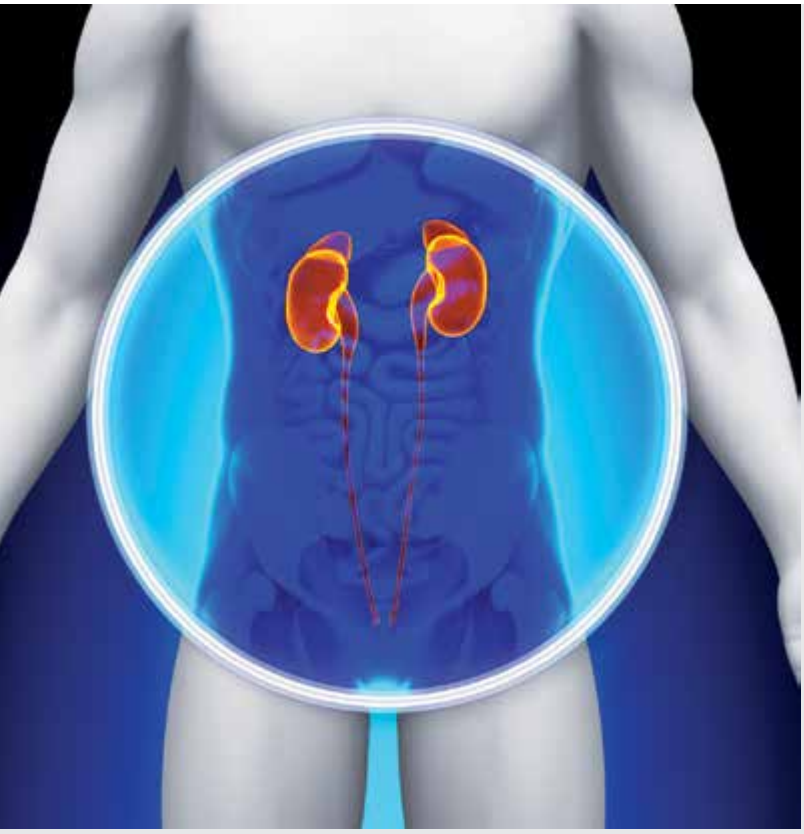
It's estimated that in 2015, 21,290 women will be diagnosed with ovarian cancer, and that approximately 14,180 of those women will die from the disease (http://seer.cancer.gov/statfacts/html/ovary.html). Death rates increase with age, and ovarian cancer is the 12th leading cause of cancer deaths in the United States.

Ovarian cancer may cause one or more of the following signs and symptoms:

- Vaginal bleeding or abnormal discharge
- Pain in the pelvic or abdominal area
- Back pain
- Bloating
- Feeling full quickly while eating
- Change in bathroom habits

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

By Nancy Reading, RN, BS, CPC, CPC-P, CPC-I



RENAL FAILURE

Physiology is the key to better diagnosis coding.

The renal system consists of two kidneys (each of which usually has an adrenal gland perched on top), two ureters, a bladder, and a urethra. This article focuses on renal failure and the physiology behind code selection.

image by iStockphoto/© decade3d

The Renal System's Role

The kidneys maintain a stable metabolic environment in the body. They provide regulation of acid and base balance, excretion of metabolic wastes, and conservation of nutrients. Balance between water and ions such as potassium, sodium, chloride, magnesium, phosphate, and calcium are maintained through conservation and excretion.

The kidneys also play a role in the endocrine system. Secretion of renin regulates blood pressure; secretion of erythropoietin regulates production of erythrocytes; and secretion of 1,25-dihydroxyvitamin D3 regulates calcium metabolism.

Each kidney contains approximately 1.2 million nephrons, the functional unit of the kidney. A nephron is comprised of five distinct units:

1. Glomerulus
2. Proximal convoluted tubule
3. Loop of Henle
4. Distal convoluted tubule
5. Collecting duct

The glomerulus is a cluster of capillaries that loop together to form Bowman's capsule. The capillaries are held together with Mesangial cells, creating a wall of glomerular capillaries. This wall serves as the glomerular filtration membrane.

The membrane separates the blood in the capillary bed from the fluid filtering out into Bowman's space (the space inside Bowman's capsule). The glomerular filtrate passes through three layers of the glomerular membrane to form urine.

The rate of ultrafiltration through the glomerulus depends on many variables. The glomerular filtration rate (GFR) is often used as a measure of renal health. It's normally greater than (>) 60.

Etiology

Renal disease usually results from damage to one of four major structures of the kidney: the tubules, the glomeruli, the interstitium, or the intrarenal blood vessels. Renal disease is classified as acute or chronic.

Today, the term acute kidney injury (AKI) replaces the term acute renal failure (ARF). AKI equates to an abrupt decline in renal function, associated with a 50-80 percent mortality rate.

The etiologies for AKI are often described as pre-, intra-, or post-renal.

Pre-renal problems occur before the kidney, and usually cause a drop in perfusion of the kidneys without compromising the integrity of the parenchyma. Causes of intra-renal AKI are usually due to diseases of the renal vessels, diseases of the renal microcirculation and glomeruli, effects of ischemia or nephrotoxic drugs, and/or tubo-interstitial inflammation. An obstruction further downstream (e.g., in the ureter) can put backward pressure on, and cause damage to, the nephron as a post-renal etiology.

Manifestations of renal failure can be found in simple blood chemistry studies that measure serum creatinine, blood urea nitrogen (BUN), and glomerular filtration rate (GFR). A decrease in GFR with an elevation of serum creatinine and BUN are hallmarks of renal disease. The severity of the problem is based on how far from normal these parameters have changed.

Rating Renal Function Severity

There are a variety of ranking systems for rating acute renal failure. Three systems that classify acute kidney injury (AKI) are:

1. Risk, Injury, Failure, Loss of Kidney Function, and End-stage Kidney Disease (RIFLE);
2. Acute Kidney Injury Network (AKIN); and
3. Kidney Disease Improving Global Outcomes (KDIGO).

Chronic kidney disease (CKD) is a mixed bag of conditions characterized by changes in kidney structure and function.

Measuring Renal Function

Serum creatinine is a waste by product from skeletal muscle metabolism of creatine phosphate. Creatinine is taken up in the blood stream and 100 percent of it is excreted by the kidneys. Creatinine levels can vary based on size and muscle mass. Normal serum levels in men range from 0.7-1.3 mg/dL and for women, 0.6-1.1 mg/dL. These numbers can vary slightly between laboratories based on equipment and calibration of that equipment.

Blood urea nitrogen (BUN) measures the amount of urea nitrogen in the blood serum. Urea is a byproduct of protein metabolism that takes place in the liver. It's released from the liver into the blood stream and then cleared from the body in the kidneys. Many factors can influence BUN levels in the blood serum such as liver failure and dehydration. BUN measurement is not as reliable as serum creatinine measurement for testing renal function. The reference range for BUN is 8-20 mg/dL.

There is only one diagnosis code for AKI, regardless of how severe it is. *AHA Coding Clinic* (4th quarter 2008, pages 192-193) tells us to use ICD-9-CM 584.9 (*Acute kidney failure, unspecified*) for non-traumatic acute kidney injury. The index in ICD-9-CM supports coding AKI to 584.9.

Note that different physicians may have different interpretations of the meaning of acute renal insufficiency versus acute renal failure (ARF). It's generally accepted that renal insufficiency (593.9 *Unspecified disorder of the kidney and ureter*) refers to the early stages of renal impairment, determined by mildly abnormal elevated values of serum creatinine or BUN, or diminished creatinine clearance. Clinical symptoms or other abnormal laboratory parameters may be present, but are usually minimal.

If the physician is not specifically documenting ARF or AKI, do not code 584.9; however, if clinical indicators are present for ARF or AKI and only acute renal insufficiency is documented, a query is needed.

Chronic kidney disease (CKD) is a mixed bag of conditions characterized by changes in kidney structure and function. The manifestation of these conditions is based on the underlying cause and severity of the disease.

According to the National Kidney Foundation, Kidney Disease Outcomes Quality Initiative (NKF KDOQI) for renal diseases, the list of clinical parameters shown in the table below is provided for staging CKD. The provider must document the stage and be queried in the absence of documentation.

Stages of Chronic Kidney Disease

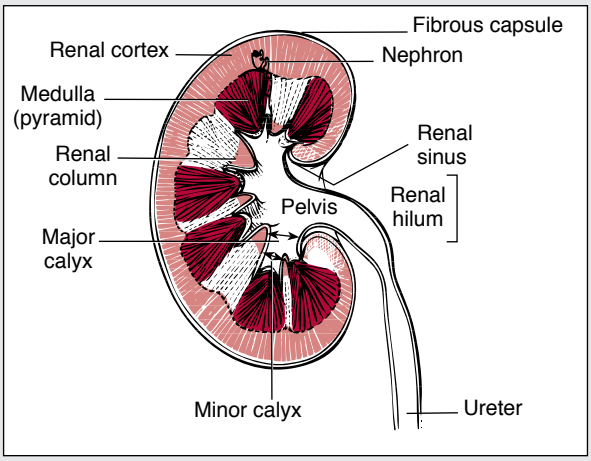
Stage	Description	GFR (mL/min/1.73 m^2)
1	Kidney damage with normal or ↑ GFR	≥ 90
2	Kidney damage with mild ↓ GFR	60 - 89
3	Moderate ↓ GFR	30 - 59
4	Severe ↓ GFR	15 - 29
5	Kidney failure	< 15 (or dialysis)
Chronic kidney disease is defined as either kidney damage or < 60 mL/min/1.73 m^2 for ≥ 3 months. Kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies.		

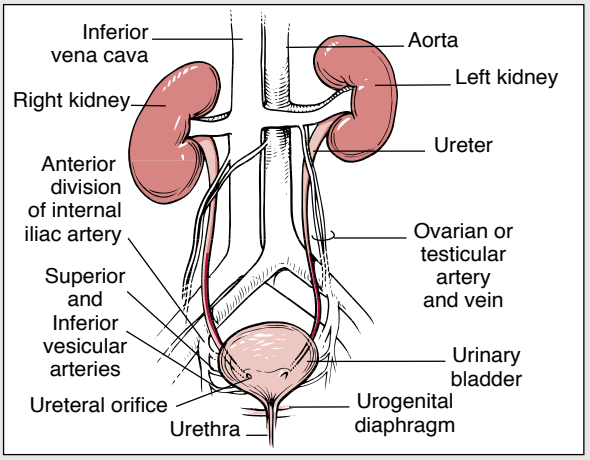
Source: **www2.kidney.org/professionals/KDOQI/guidelines_ckd/p4_class_g1.htm**

Coding the Stages of CKD

The appropriate code for stages 1-5 is assigned to depict the documented severity of CKD:

- Stage 1 codes to N18.1 *Chronic kidney disease, stage 1* (ICD-9-CM, 585.1 *Chronic kidney disease, Stage I*).
- Stage 2 codes to N18.2 *Chronic kidney disease, stage 2 (mild)* (ICD-9-CM, 585.2 *Chronic kidney disease, Stage II (mild)*).
- Stage 3 codes to N18.3 *Chronic kidney disease, stage 3 (moderate)*, (ICD-9-CM 585.3 *Chronic kidney disease, Stage III (moderate)*).
- Stage 4 codes to N18.4 *Chronic kidney disease, stage 4 (severe)*, (ICD-9-CM, 585.4 *Chronic kidney disease, Stage IV (severe)*).
- Stage 5 codes to N18.5 *Chronic kidney disease, stage 5*, (ICD-9-CM, 585.5 *Chronic kidney disease, Stage V*).





Code N18.6 *End stage renal disease* is assigned only when the provider has documented end-stage renal disease (ESRD). Encounters where both a stage of CKD and ESRD are documented, report N18.6, only. The same holds true in ICD-9-CM when assigning 585.6 *End stage renal disease, stage V requiring chronic dialysis* when both CKD and ESRD are addressed in a single encounter.

Kidney Transplants with CKD

Patients who have had a renal transplant can still suffer some form of CKD. This does not equate to a transplant complication, according to *AHA Coding Clinic*. The coder would assign transplant status V42.0 *Kidney replaced by transplant* and the documented level of CKD for ICD-9-CM.

When attaching an ICD-10-CM code, assign the appropriate N18 *Chronic kidney disease (CKD)* code for the patient's stage of CKD and Z94.0 *Kidney transplant status*.

Coders are directed to only use the complication of transplant code when the complication affects the function of the transplanted organ, followed by ICD-9-CM code 996.81 *Complications of transplanted kidney* or ICD-10-CM code T86.10-T86.19 (complications of kidney transplant), as appropriate. For either of the complication code set, ICD-9-CM or ICD-10-CM, use an additional code for the transplant complication, such as graft versus host disease (D89.81_ or 279.5_).

Both ICD-10-CM and ICD-9-CM presume a cause-and-effect relationship between hypertension and CKD.

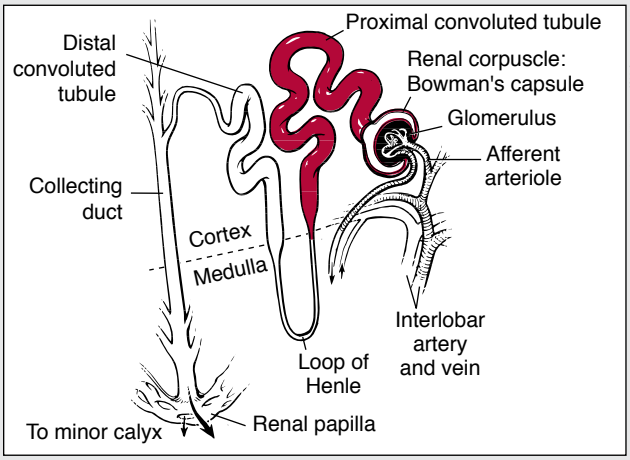
Factors Leading to CKD

CKD is often due to nephrotic syndrome. Nephrotic syndrome is associated with overexcretion of protein in the urine (proteinuria); edema of lower extremities, face, and abdomen; and damage to the blood vessels of the nephron. Only assign the code for nephrotic syndrome when the physician specifically states the patient has it. See N04.1-N04.9 in ICD-10-CM or 581.81-581.9 in ICD-9-CM for the appropriate code assignment.

Hypertension is one of the leading causes of CKD. Both ICD-10-CM and ICD-9-CM presume a cause-and-effect relationship between hypertension and CKD. You are directed to combine the two when the chart indicates the patient has both hypertension and CKD. The exception to this rule is when the provider specifically states the two are not related.

ICD-9-CM Official Guidelines for Coding and Reporting guidance for assigning hypertensive CKD codes directs you to assign codes from category 403 *Hypertensive chronic kidney disease*, when conditions classified to category 585 *Chronic kidney disease* are present with hypertension. Accurate reporting for a diagnosis of hypertensive CKD (403) requires selection of the appropriate fourth digit to indicate whether the hypertension is classified as malignant (0), benign (1), or unspecified (9). Report the appropriate code from category 585 to identify the stage of CKD.

ICD-10-CM is identical in the requirement to provide two codes for hypertensive renal disease, as well as in the presumption that if they



occur together there is a cause-and-effect relationship. There is no longer a distinction between benign, malignant, and unspecified hypertension in ICD-10-CM. Code I12.0 *Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease* or I12.9 *Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease* is assigned with the appropriate N18._ code. **HBM**

Resources

www2.kidney.org/professionals/KDOQI/guidelines_ckd/p4_class_g1.htm

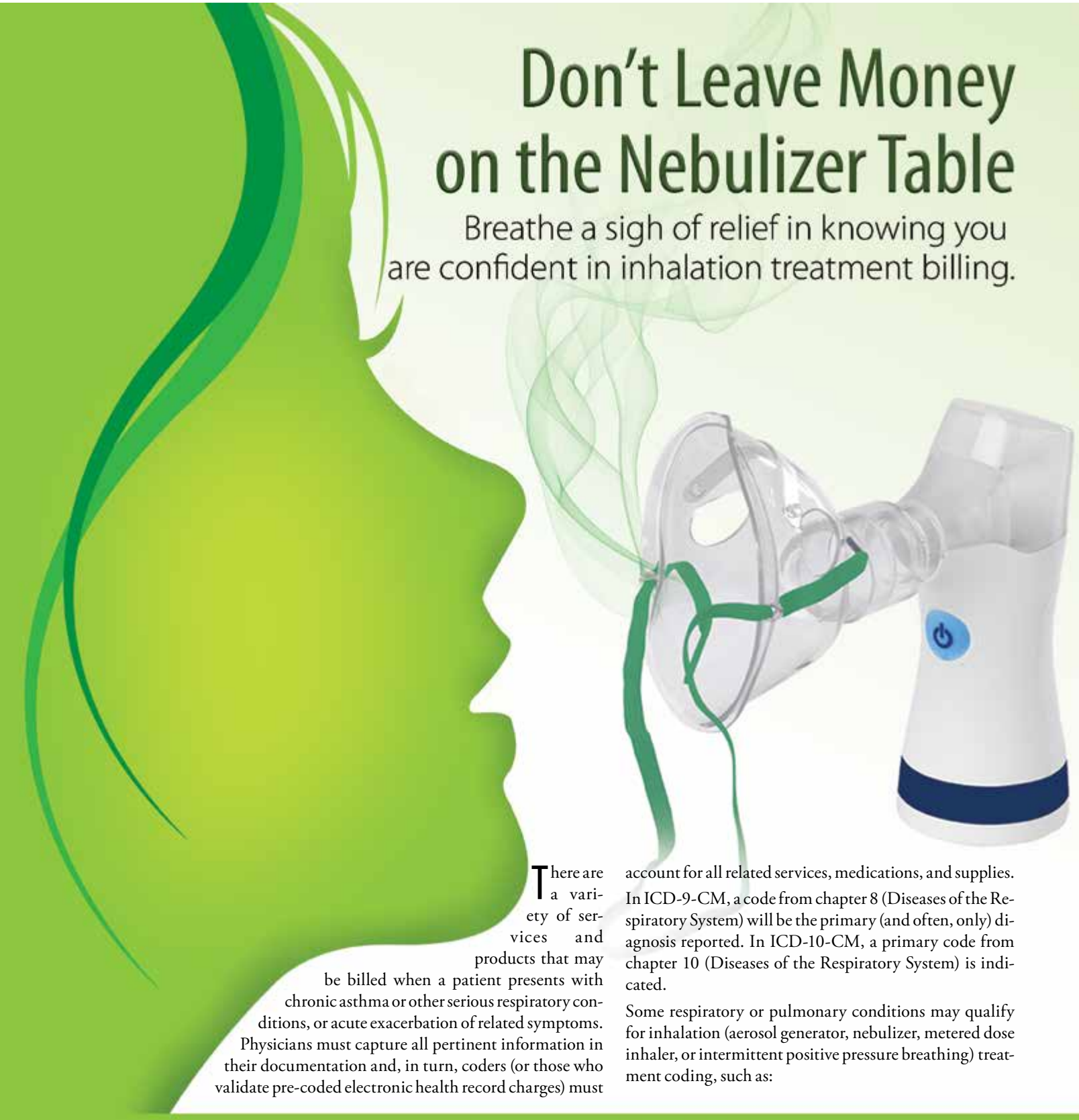
www.uptodate.com/contents/definition-and-staging-of-chronic-kidney-disease-in-adults

Nancy Reading, RN, BS, CPC, CPC-P, CPC-I, has held a Registered Nurse license for 36 years, earned a Bachelor of Science in Biology/Chemistry, and has 26 years of coding experience. She has worked the gamut of the industry, from a large university practice with over 1,000 providers to Medicaid. Reading is a member of the Salt Lake South Valley, Utah, local chapter.

By Ken Camilleis, CPC, CPC-I, CMRS, CCS-P

Don't Leave Money on the Nebulizer Table

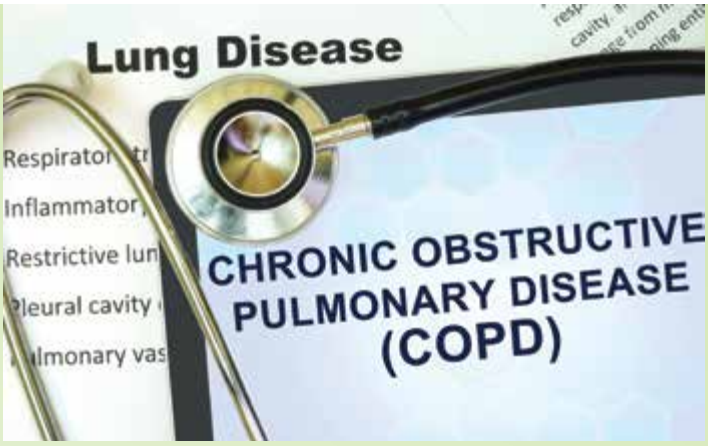
Breathe a sigh of relief in knowing you are confident in inhalation treatment billing.



There are a variety of services and products that may be billed when a patient presents with chronic asthma or other serious respiratory conditions, or acute exacerbation of related symptoms. Physicians must capture all pertinent information in their documentation and, in turn, coders (or those who validate pre-coded electronic health record charges) must account for all related services, medications, and supplies.

In ICD-9-CM, a code from chapter 8 (Diseases of the Respiratory System) will be the primary (and often, only) diagnosis reported. In ICD-10-CM, a primary code from chapter 10 (Diseases of the Respiratory System) is indicated.

Some respiratory or pulmonary conditions may qualify for inhalation (aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing) treatment coding, such as:



- Asthma (ICD-9-CM 493.90, ICD-10-CM J45.-)
  - unspecified, with status asthmaticus (493.91, J45.902)
- Acute bronchitis (466.0, J20.-)
- Other chronic obstructive pulmonary disease (COPD) (496, J44.9)
- COPD with (acute) exacerbation (491.21, J44.1)
- COPD with acute lower respiratory infection (491.22, J44.0)
- Pneumonia (486, J18.-)
- Bronchopneumonia (485, J18.0)
- Acute bronchospasm (519.11, J98.01)
- Cough (786.2, R05)
- Wheezing (786.07, R06.2)
- Shortness of breath (786.05, R06.02)

As we convert to ICD-10, physicians must capture all relevant information regarding the patient's respiratory condition, and coders must be adept at picking up details to properly report the expanded inhalation treatment diagnostic codes.

Capture All Relevant Procedures, Services, and Supplies

Five services and products are reported in a typical inhalation treatment encounter:

1. Separately identifiable office visit
2. Inhalation treatment
3. Pulse oximetry (oxygen saturation)
4. Medication dispensed
5. Nebulizer mask/administration set

Although reimbursement for these items is based on specific payer guidelines (not all payers will reimburse for all services), failure to account for any of the above services and products, when covered, will result in lost revenue.

Take a Closer Look at the Five Items

Office visit (99201-99215) – The patient is examined to achieve a diagnosis and to conduct or prescribe a treatment plan. The doctor needs to listen to lung sounds and observe a variety of findings. When the provider performs other, separately coded procedures or services during the same encounter, you must append modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service* to the visit code. If the patient is scheduled solely for inhalation treatment, no office visit is reported.

Inhalation treatment (94640 *Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (eg, with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing [IPPB] device)*) – This is the component of treatment that potentially improves the patient's condition, or even eliminates ongoing symptoms.

Oxygen saturation (O2Sat) (94760 *Noninvasive ear or pulse oximetry for oxygen saturation; single determination*) – An O2Sat is routinely performed as a preliminary step to assess a patient's condition. Even a persistent cough with no definitive diagnosis may justify a separately billable O2Sat. Based on the results of the O2Sat, the physician may decide the patient warrants further (possibly immediate) services, such as inhalation treatment. Although this code does not create a Column 2 National Correct Coding Initiative edit, some payers may want modifier 59 *Distinct procedural service* appended to the secondary procedure.

Medication provided (e.g., J7613 *Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg*, or J7620 *Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME*) – When nebulizer treatment is provided, a medication is expended. Because the medication is dispensed in the doctor's office (place of service code 11), the practice is allowed to bill for the drug separately.

Documentation must indicate:

1. The type and concentration of the agent; and
2. The specific dosage of each constituent.

For instance, J7620 describes albuterol and ipratropium, with unit dosages of 2.5 mg and 0.5 mg, respectively. Code J7620 is often

Because a nebulizer mask is used only once by one patient, report only one unit.

called a "DuoNeb" because the nebulizing product is a combination of two medication agents. For higher doses, if supported by medical necessity, you may report J7620 x 2 (or more).

Nebulizer mask (A7003 *Administration set, with small volume non-filtered pneumatic nebulizer, disposable*) – Because a nebulizer mask is used only once by one patient, report only one unit. The payer may want modifier NU *New equipment* appended for a new purchase. Documentation must support that the item was provided to the patient at the time of treatment. When the medication and mask are provided in the doctor's office, there is no charge for the use of the nebulizing machinery (e.g., E0570 *Nebulizer, with compressor*) because this is rolled into the visit.

For example, a patient with coughing, wheezing, and shortness of breath arrives at the emergency room (ER). She is tested and discharged without a definitive diagnosis. Several weeks later, her primary care physician refers her to a pulmonologist. The pulmonologist performs a detailed history and exam with moderately complex medical decision-making, including an O2Sat, and diagnosis the patient with COPD. He administers a dose of 1 mg albuterol in concentrated form, non-compounded. The O2Sat was instrumental in confirming the patient's diagnosis. The O2Sat (94760) and inhalation treatment (94640) are separately billable, as is the nebulizer mask (A7003). The proper HCPCS Level II code for the medication is J7611 *Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg.*

Other Services and Conditions

Additional billable services may be provided. For example, a maximum breathing capacity/maximum voluntary ventilation study (94200 *Maximum breathing capacity, maximal voluntary ventilation*) may be performed at the same session. Some payers may require billing the technical and professional components separately with modifiers TC *Technical component* and 26 *Professional component*.

For example, a patient who has suffered asthma attacks over the past six months is diagnosed with acute exacerbation of asthma, confirmed by an O2Sat. A maximal voluntary ventilation (94200) and nebulizing treatment (94640), consisting of Duoneb 2.5 mg albuterol/0.5 mg ipratropium (J7620) ensues, with a peak flow meter (A4614 *Peak expiratory flow rate meter, hand held*) and nebulizer mask provided.

Continuous positive airway pressure (CPAP), 94660 *Continuous positive airway pressure ventilation (CPAP), initiation and management*), spirometry (e.g., 94010, 94060, or 94070), and other pulmonary procedures may be conducted with a nebulizing treatment. A handheld or provider-assisted peak expiratory flow meter (A4614), or (depending on the payer) a peak expiratory flow rate study (S8110 *Peak expiratory flow rate (physician services)*) may be provided.

Other drugs represented by HCPCS Level II codes J7604-J7685, popularly known as Accuneb®, Xopenex®, Proventil®, Brethine®, Azmacort®, and other brands or market labels, may be administered.

If there are comorbid conditions such as laryngitis or pharyngitis, a throat culture (87880 *Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A*) may be performed at the same session.

Treatment During Non-traditional Hours

When an inhalation treatment is done outside of regular business hours, some payers may allow additional reporting of 99050 *Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, weekends), in addition to basic service* or 99051 *Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service* for services provided when the office is open during "non-traditional" hours. Check with each payer in your state or locality; some will accept 99050 on a Sunday or holiday, but won't accept 99051 under any circumstances.

Repeated Treatment

Both the inhalation treatment (94640) and the medication code may be reported in multiple units. Sometimes, an initial treatment fails to provide the desired nebulizing effect and must be repeated. If a treatment is performed twice on the same date, add modifier 76 *Repeat procedure or service by same physician or other qualified health care professional* (as directed by an instructional note beneath the descriptor for this code) to the second occurrence, so the payer doesn't think you made a duplication error. Some payers may allow or request 94640 x 2, or other variations of multiple treatments.

Code 94644 *Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour*, with add-on code 94645 *Continuous inhalation treatment with aerosol medication for acute*

airway obstruction; each additional hour (List separately in addition to code for primary procedure), represents a less common method of inhalation treatment administration.

For example: A 76-year-old man with chronic bronchitis was diagnosed two years ago with COPD. He arrives at the ER with sudden shortness of breath and dizziness. He is admitted to the hospital, and the next day he is administered level 2 care along with continuous aerosol treatment for acute airway obstruction (COPD with acute exacerbation) for one hour and 45 minutes. Coding for the level 2 subsequent care is 99232 *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity*. Because the aerosol treatment spanned more than one hour but less than two, report 94644 and 94645 x 1. The diagnosis is 491.21 *Obstructive chronic bronchitis with (acute) exacerbation* (ICD-10 J44.1 *Chronic obstructive pulmonary disease with (acute) exacerbation*). The facility will bill for the medication (aerosol) and supply (aerosol mask). **HBM**

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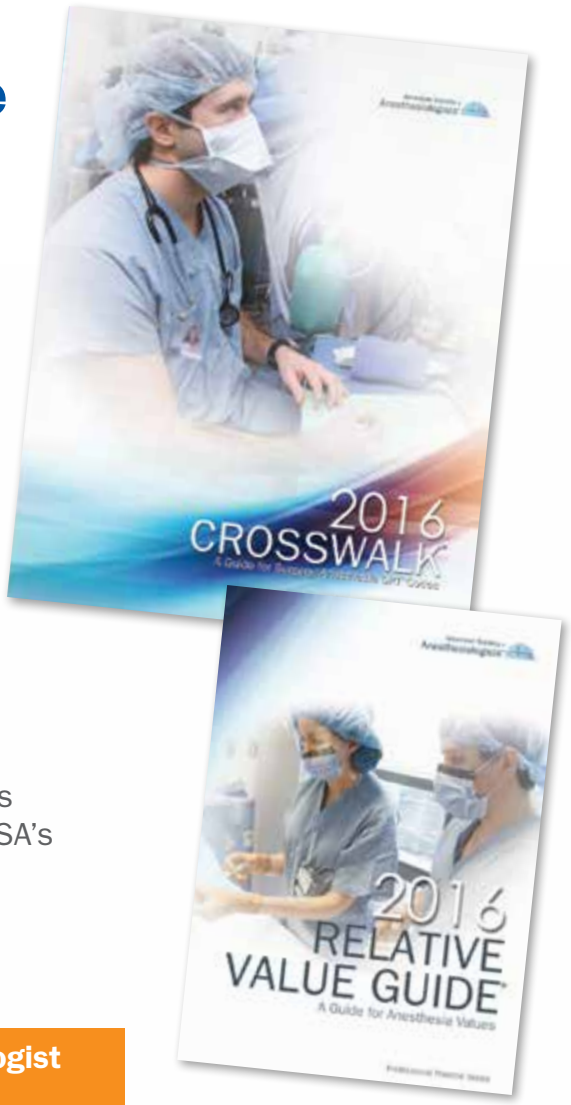

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By Edie Hamilton, CPC, CPC-I

Decipher Multiple Procedures Payment Reduction Rules

Reducing indicator, modifier, and calculation confusion will safeguard reimbursement.

The Medicare Physician Fee Schedule (MPFS) was introduced in 1992 to replace the "reasonable and customary" payment methodology standard for physician services. Under the MPFS, payment has been based on Relative Value Units (RVUs), which represent the value of work or expense each service entails. Multiple Procedure Payment Reduction (MPPR) was introduced concurrently with the MPFS, with the rationale that there are savings associated with multiple procedures performed during a single encounter.

The Harvard School of Public Health conducted a study for the Health Care Finance Administration (now the Centers for Medicare & Medicaid Services (CMS)) in the early 1980s, which found that actual physician work was reduced by approximately 50 percent when subsequent procedures were performed during the same session (as opposed to separate encounters). Originally, the multiple procedure reduction was applied to bilateral procedures and surgical services (e.g., surgery, endoscopy, and dermatology).

Calculate and Apply Reductions

To understand how these reductions are applied, you must first understand how payments are calculated. Per the CMS website, "Medicare is statutorily required to adjust payments for physician fee schedule services to account for differences in costs due to geographic location." To meet this mandate, CMS applies a Geographic Price Cost Index (GPCI) value to the RVUs for each code to calculate reimbursement. The formula for pricing calculations is:

	Work RVU x Work GPCI
+	PE RVU x PE GPCI
+	MP RVU x MP GPCI
=	New Total RVU
x	Conversion Factor
=	Price

Predicted reimbursement can be manually calculated using this formula. CMS' Physician Fee Schedule Look-up Tool can be configured to provide pricing information, payment policy indicators, RVUs, and the GPCI for each CPT®/HCPCS Level II code, based on the location where services are provided.

To maximize legitimate reimbursement, be sure to append modifier 51 to the lower-valued codes.

Another important factor determining reimbursement is the setting in which services are provided. When services are provided in a non-facility setting, payment rates for non-facility are applied, and when services are performed in a facility setting, facility rates are applied. Publication 100-04, Medicare Claims Processing Manual, chapter 26, section 10.5 contains the place of service information you need to determine when to use the facility versus non-facility amounts.

Identify Multiple Procedure Indicators

CMS has added different types of multiple procedure reductions over the years. There is a column in the Relative Value File labeled "Mult Proc," and in the Physician Fee Schedule Look-up Tool labeled "Mult Surg," that has an indicator identifying which type of MPPR applies to each CPT®/HCPCS Level II code. The multiple procedure indicators are:

Mult Proc 0 = no reduction applies

Mult Proc 1 = does not apply to any current codes (was used pre-1995)

Mult Proc 2 = standard payment adjustments

Mult Proc 3 = endoscopic reductions

Mult Proc 4 = diagnostic imaging reduction

Mult Proc 5 = therapy reductions

Mult Proc 6 = diagnostic cardiovascular services

Mult Proc 7 = diagnostic ophthalmology services

Mult Proc 9 = concept does not apply

Image by iStockphoto ©michaeljung

The full multiple procedure descriptions for all the RVU indicators are available in the RVUPUF file, located in the zip file in the "Downloads" section of the RVU file (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html). Every CPT®/HCPCS Level II code in the RVU file has a Mult Proc indicator. The RVU file also contains other columns with indicators relevant for MPPR: the Endoscopic Base Code and the Diagnostic Imaging Family Indicator. Each version of MPPR applies reductions differently.

Let's take a look at the Mult Proc indicators with payment reductions.

Mult Proc 2 Standard Multiple Procedure Reductions

Mult Proc 2 Standard Multiple Procedure Reductions apply to approximately one third of the codes on the MPFS. This category applies to more CPT®/HCPCS Level II codes than all of the other multiple procedure reduction categories combined. It's comprised mostly of surgical codes and other invasive services, along with a few nuclear medicine codes. When a claim presents with multiple procedures with Mult Proc indicator 2, the code with the highest value is priced at the full fee schedule payment amount (or charge amount, whichever is lower), the second through fifth codes on the claim are priced at 50 percent of the fee schedule amount, and any additional codes with Mult Proc 2 are paid by report. CMS reviews these claims and pays any additional allowed procedures at a minimum of 50 percent of the fee schedule amount. CMS ranks procedures according to value, from highest to lowest, to make these payment reductions.

Although coding rules require appending modifier 51 *Multiple procedures* to multiple procedures, CMS does not rely on this modifier and makes the appropriate reductions. Other payers may base the reductions on the presence of a modifier. To maximize legitimate reimbursement, be sure to append modifier 51 to the lower-valued codes.

Mult Proc 3 Endoscopy Reductions

Mult Proc 3 Endoscopy Reductions contain the next largest group of codes. It applies to just over 300 CPT®/HCPCS Level II codes. It's unique because it may result in two separate reductions: the endoscopic reduction and the standard reduction.

Endoscopic reductions are applied when multiple codes in the same endoscopic family are submitted for the same encounter. For example, 31623 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings* and 31628 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe* are in the same endoscopic family, with a shared base code of 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)*. All codes in the same endoscopic family, found in the Physician Fee Schedule Look-up Tool or the RVU file, are grouped together and ranked highest to lowest value. The code with the highest value is paid the lower of the full fee schedule amount or the charge amount. All other codes in that family are paid by subtracting the value of the endoscopic base code from the value of the code submitted. If there are additional endoscopic codes in other families on the same claim, or if there are codes with Mult Proc 2 on the claim, the endoscopic codes are also eligible for the standard multiple procedure reduction.

The total value of the endoscopic family is ranked against the other families or codes eligible for the standard reduction. The code (or code family) ranked highest is priced at the full fee schedule amount, minus any previous endoscopic reductions, if applicable. The other codes or code families are subject to the 50 percent reduction, as shown here:

CPT®/ HCPCS	National Price	Endoscopy Reduction	Standard Reduction	Final Price
11420	$123.71		123.71 x .5 = 61.86	$61.86
31623	$337.17	337.17 - 318.93 (value of base code 31622) = 18.24	18.24 x .5 = 9.12	$9.12
31628	$379.00		379.00 x .5 = 189.50	$189.50
43202	$371.85	371.85 - 277.10 (value of base code 43200) = 94.75		$94.75
43217	$458.73			$458.73

Mult Proc 4 Diagnostic Imaging Reductions

Mult Proc 4 Diagnostic Imaging Reductions apply to more than 100 codes. This reduction is separately applied to the professional and technical components of each code. For example, when multiple diagnostic imaging procedures are submitted, such as 70450 *Computed tomography, head or brain; without contrast material* with modifier 26 *Professional component*, indicating the physician is reporting only the professional component, only that reduction will be applied. The full fee schedule professional component value is allowed for the highest valued procedure, with subsequent procedures reduced by 25 percent when there are multiple diagnostic imaging procedures performed in the same session.

Similarly, when multiple diagnostic imaging procedures are submitted with modifier TC *Technical component*, indicating the technical component only, the highest valued code is allowed at the full fee schedule amount and the technical components of subsequent diagnostic imaging services in the same session are reduced by 50 percent.

When multiple diagnostic imaging codes are submitted globally, without modifier 26 or TC, the professional components are ranked and reduced separately from the technical components. It's theoretically possible that no code on a diagnostic imaging claim would be priced at the full fee schedule value. That's why it's critical to identify the professional and technical components with the appropriate modifier to ensure appropriate reimbursement.

Mult Proc 5 Therapy Reductions

Mult Proc 5 Therapy Reductions consist of approximately 50 codes (CMS' "always therapy" codes). This reduction has been controversial since its 2011 introduction because the reductions apply to the same provider or all providers in the same practice, and are applied regardless of whether the services are performed in one or multiple therapy disciplines. In other words, if providers in the same practice perform speech therapy, occupational therapy, and physical therapy on the same date of service, the reduction considers all of their services together. The therapy code with the highest value is priced at the full fee schedule amount. Subsequent services have a 50 percent reduction taken on the non-facility technical component.

Mult Proc 6 Cardiovascular and Mult Proc 7 Ophthalmology

Mult Proc 6 Diagnostic Cardiovascular Procedures and *Mult Proc 7 Ophthalmology Procedure Reductions* were introduced in 2013. The Affordable Care Act directed CMS to review codes frequently billed in combination to identify potentially misvalued codes. As a result of that review, policies were implemented that reduce the technical component of certain diagnostic cardiovascular and ophthalmology procedures. As always, the highest valued service is priced at the full fee schedule amount. Subsequent cardiovascular services are subject to a 25 percent reduction of the technical component, while subsequent ophthalmology services are subject to a 20 percent reduction.

Know the Rules and Their Impact

Since the implementation of the MPFS introduced the first MPPR, CMS has implemented several rules for saving money by reducing payment for these multiple procedures, as mandated by various congressional actions. MPPR rules do not replace any correct coding or editing rules; they are payment rules only. It's especially important for coders, reimbursement analysts, and practice managers to understand exactly how these rules apply because they can have a significant impact on an individual or group practice. **HBM**

Resources:

Physician Fee Schedule Look-up Tool: **www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx**

PFS Relative Value Files: **www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html**

Pub. 100-04, Medicare Claims Processing Manual, chapter 26, section 10.5: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf**

Edie Hamilton, CPC, CPC-I, has more than 20 years practical experience in clinical and surgical coding, professional and outpatient facility billing, physician education, compliance, reimbursement, edits, and denials management at large academic institutions. She is on the content team at Verisk Health, Payment Accuracy Division and is an adjunct instructor in Medical Office Administration. Hamilton is a member of the Chapel Hill, N.C., local chapter.

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

Your LAST ICD-10 Pep Talk

After years of ICD-10 prep, it's time to put some pep in your ICD-10 step.

As we draw closer to the October 1, 2015, ICD-10 implementation date, I think we've all experienced moments of either panic or relief. For many AAPC members, embracing this change to the coding system came easily and the learning opportunity was welcome. But for others, the thought of change has been difficult.

Those of you who jumped in to meet the ICD-10-CM proficiency requirements for certification have excelled. I continue to have faith that AAPC members are the *best* in our industry, as ICD-10 proficiency results demonstrate. If you haven't yet fulfilled the ICD-10 proficiency requirements, it's time.

Members Give a Shout Out to ICD-10

As Franklin D. Roosevelt said in his 1933 inaugural address, "The only thing we have to fear is fear itself." After all, it isn't the first time you've had to learn and use a new code set, **Suzan Berman, CPC, CEDC, CEMC**, reminds us.

"Were you born knowing ICD-9?" asks Berman. "No, you learned it and you can learn this set, too. You have been coding and have obtained your certification; learning a new set of codes is what you do best!"

If it's the number of codes in ICD-10 that has you worried, fear not. According to **Pam Brooks, CPC, COC, PCS,** "It's easier than you think, and so much more interesting to code."

ICD-10 Will Ensure Our Livelihood

Multiple chronic conditions continue to dominate healthcare dollars and will force payment structure changes as we move forward with healthcare reform. Physicians will be reimbursed less under the new payment models unless we code to the highest level of specificity. To do that, however, we must understand documentation requirements and we must relay that information to our physicians.

Continued education is essential. Learn about the conditions your physician treats. Develop an understanding of disease processes and how they affect coding. And embrace ICD-10.

Proficiency Is the Key

The AAPC deadline for demonstrating ICD-10 proficiency is December 31, 2015. You still have some time, but the industry needs you to be ready, now. Coders who know ICD-10 are in high demand. Don't miss out on this golden opportunity!

To those of you who have demonstrated ICD-10 proficiency, thank you for proving that AAPC has the best coders, who are prepared for this massive change. The value of a coder cannot be emphasized enough during this crucial time. Stand up and be counted. You've got this! HBM

Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC, is vice president of ICD-10 Training and Education at AAPC and a member of the Oil City, Pa., local chapter.

Were you born knowing ICD-9? No, you learned it and you can learn this set, too.

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

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

In ICD-10-CM, coding for malignant neoplasms has expanded to include what documentation concepts?

A. Complications

B. Laterality

C. Both A and B

D. Neither A nor B

Check your answer on page 65.

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

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ICD-10 Quiz

By Erin Andersen, CPC, CHC

Test Your Knowledge of Teaching Physician Guidelines

Take our quiz to find out if you need to be re-schooled.

Teaching hospitals receive federal money to train residents. When teaching physicians are involved in a patient's care and meet certain criteria, their documentation (combined with the resident's) may be used to bill a professional fee to Medicare Part B, Medicaid, and insurance companies. Teaching physician rules are Medicare rules, but most insurance companies follow them, as well.

Let's go through both common and unusual scenarios to test your knowledge of Medicare's teaching physician rules, which may be found in the Medicare Claims Processing Manual, chapter 12, section 100, and in *MLN Matters*® "Guidelines for Teaching Physicians, Interns, and Residents."

Disclaimer: This test is a fun exercise for those who are in love with the craft of medical coding. No continuing education units (CEUs) will be awarded for correct responses.

Evaluation and Management (E/M)

1. Which statement(s) meet Medicare's teaching physician rules?

A. I saw and evaluated the patient. I agree with the resident's documentation.

B. The patient was evaluated. Please see resident's note.

C. My exam shows the patient to be alert and oriented, RR, and no hepatosplenomegaly. Encourage aggressive albuterol use with beginning of colds, coughing, and wheezing. Start 2-3 times per day and increase to every four hours with worsening symptoms.

The answer is A. In the list of acceptable statements in the guidelines, there are four common traits among them:

1. A personal pronoun;
2. The teaching physician saw the patient;
3. The teaching physician reviewed the resident's documentation; and
4. The teaching physician either agrees with the resident's documentation or notes exceptions.

Statement "A" meets all of these. "B" does not have a pronoun to indicate the teaching physician personally saw the patient, nor is there evidence the teaching physician reviewed or agrees with the resident's note. "C" shows evidence the teaching physician saw the patient, but there is no documentation to show the teaching physician reviewed or agrees with the resident's note. For "C," the teaching physician's minimal documentation could be used by itself to bill a low level E/M code.

It would also be appropriate for the oncologist to bill an established outpatient code.

2. A patient is admitted to the hospital at 9 p.m. on May 1, 2015. The on-call resident examines the patient, initiates treatment, and then writes an admit note. The next morning, the attending physician sees the patient on rounds and writes, "I saw and examined the patient. No changes. I agree with the resident's note."

What can be billed?

A. An initial inpatient code for the May 1 date of service

B. An initial inpatient code for the May 2 date of service

C. Nothing, the physician cannot use the resident's note from the previous day.

The answer is B. Because the attending physician did not see the patient on May 1, the initial inpatient code cannot be billed for that day, but the resident's documentation to can be used to bill for May 2. The guidelines describe a similar situation in which it's allowed for an attending physician to use the resident's note from the previous calendar day.

3. An oncologist sees an established patient for a scheduled outpatient hospital visit. The patient's condition has worsened to the point that the patient must be admitted. The oncologist places the admit order, as well as other orders for tests and treatment initiation. The oncologist does not see the patient in the hospital later the same day.

What can be billed?

A. An initial inpatient code using the outpatient visit note

B. An established outpatient code

C. Either one, but not both

The answer is C. All clinical documentation from the same provider group on the same day of service may be used to support the initial inpatient level of service, even if the billing provider did not see the patient after admission on the same day. It would also be appropriate for the oncologist to bill an established outpatient code (but not both codes for the same day).

4. Building off the scenario above: Another resident sees the patient on rounds with the attending physician on May 2 and writes a brief, subsequent inpatient note. The same attestation from above is documented on the resident's note from May 2.

What can be billed?

A. An initial inpatient code using both residents' notes

B. An initial inpatient code using the May 1 resident's note

C. A subsequent inpatient code using the May 2 resident's note

The answer is C. The attending physician's note does not specify that she read and agrees with the May 1 resident's note. Without documentation of this action, the May 1 resident's note cannot be used. Although it's possible to bill an initial inpatient code using the May 2 resident's note, it likely does not contain enough elements of history, and perhaps exam, to meet the requirements of 99221. In that case, you could bill an unlisted E/M code or a subsequent inpatient code.

5. Interventional radiologist Dr. Jones sees a patient for an inpatient subsequent visit and writes a note. An attending interventional radiologist and a vascular surgeon both see the patient. Each writes, "I saw and evaluated the patient. I agree with Dr. Jones' note."

Can both attending physicians use the same resident's note to support their level of service?

A. Yes.

B. No, only one can.

C. No, only the interventional radiology attending can.

The answer is B. It would be double-dipping to use the work of the resident twice. The guidelines do not specify that an attending cannot use a resident's note from another specialty; however, it's implied that the attending physician is acting in a teaching capacity towards the resident and not merely using the resident's note to avoid having to personally document the encounter. In this scenario, only one attending may use the resident's note. Typically, that would be the interventional radiologist attending, since he or she would likely be acting as the teaching physician, in this case.

6. For an established outpatient visit, an internal medicine attending physician documents, "I was present the entire time with the medical student. I repeated portions of the history and exam. I agree with the student's excellent note."

Can the attending physician use any portion of the medical student's note to support his level of service?

A. Yes, he was there the entire time and performed the critical aspects of the E/M service.

B. No, Medicare does not pay for any services performed by a medical student even if the attending was present.

C. Yes, the past medical, family, social history, and review of systems may be used to support the attending physician's level of service, but the attending physician did not document enough of the other elements to support billing an E/M.

The answer is C. It's arguable whether it would be appropriate to bill 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*. Even if the attending physician was present the entire time with

a medical student, he or she needs to personally document the history of present illness, exam, and medical decision-making (MDM).

It would be risky for a medical student to use the same template as a resident or attending physician. It may appear the resident or attending physician copied the medical student's documentation to claim it as his or her own.

Time-based Billing

7. A resident writes an excellent note about a newly admitted, critically ill patient. The attending physician documents:

CC time: 35 min. I saw and examined the critically ill patient. I agree with the resident's note.

What can be billed?

A. An initial inpatient code

B. 99291

C. Either code, but not both

The answer is A. The guidelines state that the attending physician must document the critical nature of the patient's illness and the care that he or she specifically provided. Merely stating the patient is critically ill does not describe the condition, nor does the statement demonstrate the attending physician's level of involvement in providing critical care.

The time statement should indicate that it was the attending physician's time only by using a personal pronoun. Without the pronoun, you might assume the time was both the resident's and the attending physician's time, combined. When billing based on time, only the attending physician's time may be used to support the billed code.

8. Both a resident and an attending physician see an established patient in the clinic. The resident documents the encounter and includes the following time statement, "We spent 45 minutes face-to-face with the patient. Over 50 percent was spent counseling the patient about her diabetes and weight management." The attending physician documents, "I examined the patient with the resident. I agree with her note."

Can 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* be billed based on time?

A. Yes

B. No

C. Maybe

The answer is C. Query the resident and/or the attending physician to see if the attending physician was present the entire time (all 45 minutes). If so, one of them (ideally the attending physician) should clarify the time statement to clarify that the attending physician was present for all 45 minutes. If the time documented included time when the attending physician was not present, the note should be billed based on the elements of history, exam, and MDM.

Procedures

9. A dermatology resident uses liquid nitrogen to burn off two warts on the patient's hand and documents the service. Her attending physician adds his teaching statement, "I was present for the critical portions."

Is this sufficient to bill for the wart destruction?

A. Yes

B. Unlikely

C. No

The answer is B. The guidelines say the teaching physician must be present the entire time for procedures taking less than five minutes. For procedures taking longer than five minutes, the teaching physician need only be present for the critical portions of the procedure. It's unlikely the wart destruction took more than five minutes; therefore, the teaching physician's level of involvement is not sufficient to bill for the service.

10. The general surgery resident documents the hernia repair and states the attending physician was present for the entire surgery and co-signs the note.

Is this acceptable to bill the hernia repair?

A. Yes

B. No

The answer is A. The guidelines state that if the teaching physician is present the entire time, a resident or operating room nurse can document the entire encounter, including the teaching physician's presence.

11. The resident documents a blepharoplasty and the following: "Dr. Smith was present for the critical portions." The ophthalmologist documents, "I was present the entire time."

Is this acceptable?

A. Yes

B. No

The answer is B. The statements are contradictory. The documentation needs to be corrected to reflect what actually happened.

12. The neurosurgeon was present for the critical portions of three surgeries this morning. Surgery 1 occurred in building A from 8:00 – 10:00 a.m. Surgery 2 occurred in the room next to surgery 1, from 9:30 – 11:30 a.m. Surgery 3 occurred across campus in building C, from 10:00 a.m. – 12:00 p.m. The residents documented the encounters and the neurosurgeon added the following presence statement to each, "I was present and/or performed the critical portions."

Has the surgeon met the presence requirements to bill each surgery?

A. Yes, there were only two overlapping surgeries, as per the guidelines.

B. No, the surgeon was not immediately available for surgery 3.

C. Yes, the surgeon can teleport.

The answer is B. Surgery 1 and Surgery 3 did not overlap. The guidelines allow for a maximum of two overlapping surgeries; but the surgeon must be immediately available to attend the other surgery. Check to see how your Medicare carrier defines "immediately available;" it's commonly understood to mean "without delay." By that definition, the surgeon was not immediately available if he was across campus in another building.

Secondly, the surgeon's presence statement, "present and/or performed," is unclear. Although this will not prevent any of the surgeries from being billed, the surgeon should state clearly whether he performed a given surgery, or merely present for it.

Lastly, if the surgeon was performing the critical aspects of one of the overlapping surgeries, there is a question of whether the surgeon could be immediately available for the other surgery. Would the surgeon be able to disengage himself from the act of performing surgery 1 and get to surgery 2 without delay, even if it was in the next room?

13. A family medicine resident sees an established patient for follow-up of his hypertension, and to receive an injection in his knee to relieve the pain caused by osteoarthritis. The resident documents the encounter, which includes giving the patient the injection. The attending physician documents, "I saw and examined the patient. I agree with the resident's note."

Is this sufficient to bill both an established outpatient visit code and the injection?

A. Yes

B. No, the injection was scheduled so you can't bill the visit.

C. No, we do not know if the teaching physician was present for the injection.

The answer is C. The injection was scheduled, but the E/M portion of the visit was for hypertension and not for knee pain.

14. A cardiothoracic surgeon documents a coronary artery bypass graft (CABG) and states he was present for the critical portions.

Is this acceptable?

A. Technically, yes; philosophically, no

B. Yes

C. No

The answer is A. According to the guidelines, this meets the letter of the law. But how can the surgeon document steps for which he wasn't present? It either means he is assuming the normal course of events occurred, documenting what the resident told him happened, or his presence statement is incorrect.

Non-surgical Endoscopies

15. The otolaryngologist documents she was present for the critical portions of the laryngoscope performed by the resident.

Is this acceptable?

A. Yes, the scope can be billed.

B. No, the otolaryngologist must be present the entire time for the scope or perform it again herself.

It would be risky for a medical student to use the same template as a resident or attending physician.

The answer is B. The attending otolaryngologist must be present from the insertion to the removal of the scope or re-scope of the patient.

16. The pulmonology resident documents the bronchoscopy and states the pulmonologist was present the entire time. Is this acceptable?

A. Yes

B. Maybe

C. No

The answer is B. The guidelines allow for a resident or operating room nurse to document a surgery when the attending physician is present the entire time. Because this is a nonsurgical scope, it does not fall under the same guidelines — but your Medicare carrier may find this acceptable.

Diagnostic Tests

17. The radiologist reviews the resident's interpretation of an X-ray and documents that he agrees with the resident's note. Is this sufficient to bill for the interpretation?

A. Yes

B. No

C. Maybe

The answer is B. The attending radiologist must review the film himself to know whether he agrees with the resident's interpretation.

How Did You Do?

Did you get all 17 questions correct? Reading the guidelines carefully, paying attention to the verbiage used in the medical records, and educating teaching physicians about the rules are key to billing appropriately for services involving residents and students. HBM

Resources:

Medicare Claims Processing Manual, chapter 12, section 100: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

MLN Matters®, "Guidelines for Teaching Physicians, Interns, and Residents," www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf

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By Linda R. Farrington, CPC, CPMA, CPC-I

CMS Releases ICD-10-CM to HCC Mappings

Look at your common clinical conditions, ICD-10-CM requirements, and note changes.

On April 6, 2015, the Centers for Medicare & Medicaid Services (CMS) released the 2016 Rate Announcement and Final Call Letter, outlining the details of the CMS Hierarchical Condition Category (CMS-HCC) model for payment year 2016. In that announcement, CMS commented that they would be releasing the ICD-10-CM to HCC mappings "in the near future." CMS released the much-anticipated mappings in July.

Here are highlights of the mappings for just one common chronic condition: diabetes.

Diabetes ICD-10-CM to HCC Mappings

The diabetes two-code pairs in ICD-9-CM have been consolidated into single codes in ICD-10-CM, with a few exceptions still requiring two codes to fully report.

We started to see similar consolidation in the CMS-HCC model as we moved from the 2013 model to the 2014 model. In the 2013 model there were five hierarchical categories for diabetes; in the 2014 model we now have just three: Diabetes with Acute Complications (HCC 17); Diabetes with Chronic Complications (HCC 18); and Diabetes without Complication (HCC 19).

In the 2014 CMS-HCC model, we also saw consolidation of ICD-9-CM codes where more diabetic manifestations are grouped into the diabetes categories. An example of this is diabetic neuropathy. In the 2013 model, code 250.6x *Diabetes with neurological manifestations* and neuropathy code 357.2 *Polyneuropathy in diabetes* mapped to separate categories with separate risk scores. In the 2014 model, they both map to HCC 18, with a single risk score. This appeared to be in preparation of ICD-10-CM, where we now have single codes for the previous two-code pairs. More than ever, it's important for providers to report all of the diabetic manifestations that a patient has.

As indicated above, there are still some diabetes with manifestation codes that map separately with separate scoring (e.g., diabetic chronic kidney disease (CKD), diabetic ulcer, and some of the diabetic manifestations where the descriptor ends with "other specified manifestations"), and require more than one code to fully report. Let your providers know about these remaining two-code pair requirements in ICD-10-CM so they correctly report both codes. Providers need to report an additional code for:

- The stage of the CKD;
- The type, site, laterality (e.g., right, left, bilateral) and depth of the ulcer; and

As a coder, it's your responsibility to know the guidelines and the code set, … and to help educate providers on the guidelines they are required to uphold.

- The exact nature of the "other specified manifestation."

This is just an example of the changes for one clinical condition. Look carefully at the mappings for all of your most prevalent clinical conditions; look at the instructional notes in the Tabular for each of those sections, categories, and subcategories; identify additional reporting requirements in ICD-10-CM; and inform providers of these changes.

What This Means for Providers

As with ICD-9-CM, providers need to document to the greatest degree of certainty based on their clinical judgment and code to that same level of specificity *for each encounter*. If you understand the statement in the *ICD-9-CM Official Guidelines for Coding and Reporting*, "Rather, code the condition(s) to the highest degree of certainty *for that encounter/visit* …," [emphasis added] you know this has always been the case. This requirement has been enhanced in the *ICD-10-CM Official Guidelines for Coding and Reporting*:

> Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.
>
> If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of *that particular encounter*. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code. [emphasis added]

As a coder, it's your responsibility to know the guidelines and the code set, including the instructional notes, so you're able to identify errors and omissions in coding, to query authoritatively using the guidelines, and to help educate providers on the guidelines they are required to uphold. This has implications not only in risk adjustment, but in the portrayal of medical necessity on the claim form. CMS states in the Medicare Claims Processing Manual, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of the CPT code." The only way we can portray medical necessity on a claim form is in accurate and complete diagnostic coding. Failure to do so can result in claims denials, claims delays, and records requests, as well as affect risk scoring. HBM

Resources:

CMS ICD-10-CM to HCC mappings: **www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html**

Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, page 74, Table 5: **www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2014.pdf**

Medicare Claims Processing Manual, chapter 12: **www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf**

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By Tina Hill, CPC, MHA

Shrink Revenue Leakage with Strategic Communication

Analyze root cause and resolve issues by encouraging communication across departments.

Poor communication throughout a revenue cycle is common, and often results in revenue leaks. After a review of revenue cycle management and common communication gaps, we'll consider solutions for closing any gaps within your organization, so you can quickly realize a more efficient revenue cycle.

Revenue Cycle Management (RCM)

FRONT Patient Access	MIDDLE Revenue, Charge and Payer Integrity	BACK Billing & Collections Services
Scheduling	Charge Capture/Fee Schedules/Pricing	Customer Service
Pre-Registration	Coding & Billing Compliance	Claims Processing
Eligibility/Authorization	Government Applications	Remittance
Registration	Payer Credentialing	Payment Posting
Benefit Verification	Payer Strategy & Negotiations	A/R Follow-up
Medical Necessity (ABN)	Payer Operations	Denial Management
Financial Counseling	Payer Contract Modeling & Support	Revenue Systems, A/R Reporting & Revenue Data Analytics
Upfront Collections		

Each person providing patient contact (including corporate support) should understand his or her effect on the revenue cycle and the overall net reimbursement for services rendered. Relevant areas include:

- Front office (scheduling, intake, pre-registration, registration, eligibility, benefits, etc.)
- Clinical operations (physicians, nurses, ancillary staff, etc.)
- Coding, charge entry, charge description master (CDM), contracting
- Back end (payment posting, accounts receivable (A/R), customer service, denials)
- Finance and accounting

Patient access, also known as the "front end" of the revenue cycle, is responsible to collect all patient demographic information, including insurance and accurate contact information. They also drive the process to gather all pre-authorization and eligibility information from the insurance companies.

It's imperative that front-end staff understand which information they must collect to submit a clean claim and to receive timely payment. Many pieces of information, if transposed or inaccurate, may cause claim denial.

The best strategy to reduce patient A/R, speed cash acceleration, and decrease bad debt is to collect as much as possible prior to, or at the time of, services.

Often, "back end" staff working denials do not effectively communicate with the front end to share denials they see. In the absence of that communication, front end staff are not aware they are creating denials, and do not understand what is required to prevent them.

Scheduling

The healthcare revenue cycle begins at scheduling. Any physician orders should be available prior to test scheduling, must meet physician signature requirements, and should include the diagnosis code to indicate the reason for the test. The referring physician information is also captured and validated for Medicare patients at this time.

Many exams and tests are not supported without a physician order and should not be billed. Coders often validate that the physician orders are in the medical record, especially for government payers. Develop a communication process for coders and front-end staff when physician orders are not found in the supporting documentation. Missing orders could allow for recoupment in an audit.

Medicare denials commonly occur when the referring provider is not enrolled in the Medicare program. Providers cannot refer Medicare patients for services if they are not enrolled. To help eliminate this denial type, build an indicator into the front-end system to identify when the referring physician is not enrolled. Without something built into the system, staff must manually refer to a spreadsheet on the Medicare website that indicates which providers are enrolled. System-built enhancements to assist front-end staff with checking Medicare enrollments will help; however, in the absence of a system indicator, front-end staff should receive training on how to validate provider enrollment through the Medicare website.

The scheduling department affects all subsequent steps in the revenue cycle. Depending on the structure of front office departments, pre-registration, registration, and eligibility may be affected by workflows of scheduling staff.

Make the scheduling department aware of issues discovered downstream. Communication may include a report or reoccurring meeting. Common findings include: outdated patient demographic information, inaccurate insurance information, and unsupported medical necessity.

Scheduling errors slow communication with the patient and collecting patient liabilities. If demographic data is inaccurate, staff may not be able to validate the information until the patient presents, which slows down the patient check-in process. Inefficient and/or incorrect scheduling workflows and processes can only be improved if deficiencies are well communicated.

Upfront Collections

Collecting upfront is not necessarily a new concept in revenue cycle management, but continues to draw even more attention with rising patient liability. The best strategy to reduce patient A/R, speed cash acceleration, and decrease bad debt is to collect as much as possible prior to, or at the time of, services. You may want to purchase tools permitting eligibility checks to be completed prior to the patient's appointment to verify eligibility and estimate the total out-of-pocket expenses due from the patient. Contracted allowed amounts are built into the up-front tools to provide the most accurate estimate.

Allow front desk staff to view patient balances and collect payments. How disappointing would it be for a patient to inquire about his or her balance and want to pay, only to find out the person at the front desk does not have access to view the balance?

Staff who collect up-front should understand who their contact is for questions about technology: This could include information technology (IT), operations support, or the vendor providing the technology.

If contract information is loaded into tools, it's important for contract management staff to communicate significant changes. Payment posters may look for front-end staff notes or documentation when posting payments after claim adjudication; therefore, those staff should document consistently when giving benefit and/or estimates.

Provide staff training to communicate to the patient the purpose of the estimate, and to reiterate that it is only an estimate. Patients can become very frustrated when they pay an estimated amount up front, thinking it's paid in full, only to find out the insurance paid differently and now they owe more. Make an effort to maintain patient satisfaction while increasing upfront collections.

Charge Capture and Reconciliation

Develop a charge capture and reconciliation policy to prevent revenue leakage. Clinical staff is the most knowledgeable of services rendered during the patient visit, and are the best resources to validate all charges were captured. Coders or revenue integrity specialists should train clinical staff how to run reports to validate all charges properly crossed over to the billing system for each encounter, and should ensure everything was billed correctly. Reconciliation training should also include how to delete, edit, or add charges, as necessary.

Reconcile the billed charge report with the day's schedule to make sure each patient was charged appropriately for provided services. The

process is not easy to implement for high volume services such as lab and pharmacy, but can be reviewed at a high level to look for inconsistencies. Reports should be as simple as possible for busy clinicians.

Ensure a solid communication process between coding and the clinical staff entering the charges. Some examples may include: Epic In-basket messaging, other notes options in the front-end system, or reports with coding notes assigned to encounters or accounts. Coders should communicate trends of inappropriate charges to eliminate constant re-work and/or removal of charges.

Annual coding updates should be a separate, deliberate communication that share how the inappropriate charges affect a particular specialty.

It's helpful to develop a process to understand the impact of coding changes for each specialty or department. Steps within the process may include:

1. Complete an interview with the clinical departmental to understand if they will provide services represented by the new codes.
2. Run a revenue and usage report to understand the impact of code changes (not new, but changed and deleted codes).
3. Communicate new codes and complete necessary revisions to charge capture vehicles (preference lists, smartsets, superbills, etc.).
4. Provide contact information for questions and/or concerns as new codes become available.

Creating a coding review position or team is imperative to consistently provide training and education to clinical departments. A coding review team allows a proactive versus reactive approach, and helps to eliminate the need to "put out fires" constantly. Over time, consistent review and provider education will negate the need for 100 percent review by the coding department. For successful implementation, get support from senior leadership to help engage the clinical departments. If your organization uses an electronic health record (EHR) system, it's helpful to involve IT/EHR resources to assist in documentation enhancements as you uncover areas requiring improvement.

Share audit findings with the entire clinical department; healthy competition can jumpstart improvements. Develop an escalation process for the largest and/or most consistent offenders who don't want to get on board.

Denial Management

Denial management is arguably the largest back-end function, which requires the most communication across operations. Denials are a key indicator of performance and success throughout the organization, both operationally and financially. Although A/R management or collectors often resolve denials, the information must be shared across all departments. Denials should prompt root cause analysis and result in process improvement projects. Create and share scorecards with contributing departments, indicating their denial percentage and what denial types are included. Cross functional workgroups may be required for full improvement related to the denials.

Optimally, the individuals creating the errors should be responsible for fixing them. Common reasons for denials include inaccurate demographic information, inaccurate or missing authorizations, unbundling codes, and lack of medical necessity.

A coding or documentation expert should meet with providers or the operational leader to share the top denials and to explain clearly what caused them, with recommendations for improvement. Include IT resources, when necessary, to assist in provider documentation/EHR workflow enhancements. It can be influential to include relative value unit (RVU) information with denial dollars, if providers are paid on RVUs. Share denial information, by provider, with the entire department to generate healthy competition and engagement. Include dollars written off, versus dollars still in appeal.

Share write-offs and adjustments with operational leadership teams. Leaders do not appreciate seeing this information for the first time

Denial management is arguably the largest back-end function, which requires the most communication across operations.

on financial/operational scorecards, as it affects their overall budget and bad debt reserves when not managed appropriately. Operational leaders need to be aware of recurring patients who are resulting in bad debt, especially if care is not emergent, as they may choose to not schedule those patients going forward.

Key Takeaways

Do your best to encourage communication across departments, and never make the assumption, "They must know that!" Process improvement and issue resolution allow for cross-functional root cause analysis and resolution development to strengthen communications across teams. An easy way to improve communications is to document: Always include agendas and meeting minutes that can be distributed to staff who cannot (or should not) attend all meetings. Make sure key project initiatives are shared early on among all departments to keep everyone in the loop. Provide frequent learning and education so revenue cycle management staff understands the complete revenue cycle and their individual roles in it. Finally, always encourage opportunities for knowledge transfer among staff. HBM

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By John Verhovshek, MA, CPC

Take a Stand for Better Health

Too much sitting is dangerous, so get off your tush!

Image by iStockphoto ©Katarzyna Białasiewicz

Many of us sit for hours, every day — during our commute, behind our desk, in front of the television — and it's killing us, researchers say. The negative health effects of sitting are well-established. For example:

- A peer-reviewed study involving approximately 800,000 people, carried out by British researchers from Loughborough University and the University of Leicester, found that people who sat the longest (compared with those who sat the least) have a more than 100 percent increased risk of diabetes, a nearly 150 percent increase in cardiovascular events, an almost 100 percent increase in death caused by cardiovascular events, and a 49 percent increase in death from any cause.
- A recent study in the *Annals of Internal Medicine* concludes, "Prolonged sedentary time was independently associated with deleterious health outcomes regardless of physical activity." In other words, even a brisk run or other strenuous physical activity every day can't undo the damage done by hours of uninterrupted chair time.

Excessive sitting affects mental health and productivity, too. Researchers led by psychological scientist Michelle Kilpatrick of the University of Tasmania surveyed more than 3,300 government workers and found a significant relationship between rates of psychological distress and sitting. Employees who sat for longer than six hours per day had increased prevalence of moderate symptoms of anxiety and depression relative to those who reported sitting for less than three hours a day.

Learn more: Google "dangers of sitting" for more scientific data.

Adopt Work Solutions to Sit Less

Breaking free of your chair can be tough, especially at work. Here are a few ideas to adapt your office routine to sit less.

Set an Alarm

We often sit for long stretches without thinking about it. Set an alarm or other reminder to stand up and take a few steps at least every 30 minutes. Even a little movement does your body and mind good.

Drink More Water

Many of us don't drink enough water: The Centers for Disease Control and Prevention says nearly half of Americans drink four or fewer glasses of water per day. The Institute of Medicine recommends that women drink approximately 2.7 liters (nearly a dozen 8-oz. glasses) of total water (from all beverages and foods) each day. For men, the recommendation is approximately 3.7 liters (125 ounces) daily. Water (as opposed to soft drinks, coffee, etc.) costs nothing and is calorie free. And drinking more water does more than just prevent dehydration and improve overall body function; it also forces us out of our seats to refill our cups and to use the bathroom.

Talking Tall

Any time your phone rings, stand to talk. Pace, if you can. Even if you must remain near your workstation, at least you're getting out of your chair.

Deliver Your Message in Person

If you need to send a message to a colleague down the hall or on the next floor, walk to see him or her instead of emailing or calling. "In person" interruptions aren't always welcome, but often you can resolve an issue quicker face to face than by exchanging multiple messages.

Lunch and Go

Whether you take your lunch at your desk, or consider lunch to be a sacred time to get out of the office, give yourself at least 15 minutes to walk after eating. Almost all of us could use more exercise, but

Any time your phone rings, stand to talk. Pace, if you can.

moving your body after meals is especially helpful. Researchers have found that a postprandial walk can aid digestion and improve blood sugar levels (blood sugar typically spikes immediately after a meal).

When eating out or in the break room, choose a high table and stool rather than a chair. Sit on the "edge of your seat" and keep weight on your feet.

If you choose to drive-through for lunch, park and take a walk while you eat. It's no more awkward — and a lot safer — than eating while navigating traffic.

Meet on Your Feet

"Standing meetings" (a favorite of AAPC **CEO Jason VandenAkker**) accomplish two tasks at once: They get you out of your chair; and they make the meetings shorter!

According to a 1999 study, published by University of Missouri researchers in the *Journal of Applied Psychology*, standing meetings last on average only two-thirds as long as sit-down meetings. That's good news for those of us who dread never-ending meetings. Plus, researchers at Washington University in St. Louis report that groups working together on a project while standing are more engaged than while seated.

Note: Taking meeting minutes can suffer during standing meetings. Equip your conference/meeting room with a few tall tables to make this easier, or consider recording your meeting with a cell phone or laptop.

Take it to the next level: If you're meeting with only one or two others, consider the "walk and talk." Walking can help you to focus, and you'll get some exercise in the bargain. You might also find that walking together improves your relationships with coworkers.

Try a Standing Workstation

Perhaps the ultimate "get out of your seat" solution is a standing workstation. For added flexibility, many standing workstations can be converted quickly to seated stations (for when you must sit down).

You can also create your own standing workstation for relatively little money ($25 or less). Use your favorite search engine to seek "DIY standing desk" or "how to build a standing workstation." You'll find plenty of ideas.

Resources:

NHS Choices, "Having Desk Job 'Doubles Risk' of Heart Attack," (www.nhs.uk/news/2012/100ctober/Pages/Having-desk-job-doubles-risk-of-heart-attack.aspx)

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Anahad O'Conner, New York Times blog, "Really? The Claim: Taking a Walk After a Meal Aids Digestion," (http://well.blogs.nytimes.com/2013/06/24/really-the-claim-taking-a-walk-after-a-meal-aids-digestion/?_r=0)

Chris Gardner, BobVila.com, "6 DIY Standing Desk Projects to Keep You Healthy While You Work," (www.bobvila.com/articles/diy-standing-desks/#.VYCRBFwYeDo)

Take it to the next level: If you have the space and the ambition (plus the financial means), you can step up to a treadmill desk.

Be the Change

Often, changing our own habits is easier than overcoming the objections of others. Your co-workers or supervisors may balk at the idea of a standing meeting, for instance, or you may have to endure some good-natured ribbing if you use (or even ask for) a standing desk. Choosing to stand when others sit may be interpreted as rude or distracting. You may be able to defuse objections by stating cheerfully, "I spend so much of my day sitting, it feels good to stand every once in a while." Stress the benefits of standing (chief among them, healthier, more energized, and more productive employees) to help you gain acceptance — and maybe even convert a few other employees. HBM

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By Joe Ascensio

Need Space or Technology? Go Back to School!

With so much classroom equipment and training resources, it's like your office hit the technology jackpot.

When it comes to managing a practice, you may find yourself in need of space for a quarterly meeting or recording equipment for new-hire or procedure training.

You could buy or rent more office space or spend thousands of dollars on recording equipment and the software and training to use it. Or you could reach out to a nearby college and ask to rent everything you need. Yes, you could go back to school!

Colleges and universities have meeting rooms and classrooms in all shapes and sizes. They are filled with state-of-the-art technology, used to train students on the latest and greatest equipment. And here's a secret: Those rooms and that technology are not in use 100 percent of the time. Schools look for ways to increase revenue, and many are actively seeking individuals and businesses (like you) to rent underused resources. Businesses and entrepreneurs can rent space for a monthly staff meeting or a quarterly seminar, as well as the school's technology to record that event, or to live stream it to a satellite office or to an employee who works offsite.

Pick a Venue

Conference Rooms: A conference room could be equipped with a large, boardroom-style table with chairs. Seating capacity might be from six to 20 people.

Flat Classrooms: A flat classroom has a flat floor, and may have individual desks or could be equipped with tables. These rooms usually can be rearranged into "pod-like" work areas for small groups (the school's janitorial staff generally will arrange it for you). Capacity may be 20 to 60 people.

Tiered Classrooms: The presenter may have a desk or podium on the first level with seating on successively higher levels, like an amphitheater. Seating for a tiered classroom may be 30 to 100 (or more) people.

Lecture Hall: A lecture hall is like a tiered classroom, but larger to accommodate hundreds of individuals. It may include small, folding worktops that tuck in between the seats.

Conference Hall: A conference hall is used for large events. Some include movable divider walls that may be used to change the room size. These rooms are perfect for conferences, vendor displays, and large audience events. Various seating arrangements and tables may be available.

Auditorium: Theatre seating, multiple lighting options, and a stage could be just what the doctor ordered when you are selecting a venue for an annual employee recognition event.

Rent the Equipment You Need

College and university spaces are usually equipped with computers, wired and wireless Internet, projectors, and screens. Ask to speak with the school computer technician (he or she usually is referred to as an educational technologist). The technologist specializes in "teaching the teachers" how to use the school's technology, but can also be a wealth of information to you, and can serve as consultation advisor for your event. Be sure to let the technologist know what you want to do; he or she may be able to enhance your meeting with ideas for using the technology.

Be sure to let the technologist know what you want to do; he or she may be able to enhance your meeting with ideas for using the technology.

Technology you may want to rent for your staff includes:

Computer Labs: Many computer labs are equipped with 20-30 computers, each loaded with typical office programs. Schools can usually load your specific software, as long as the license information is provided.

Classroom Recording: Schools often record lectures so students can watch the recordings at a later date. Imagine a camera mounted on the back wall, focused forward, and rotated or zoomed to the instructor's preference. You can use that technology to record a message to new employees, etc.

Video Conferencing: Combine a conference room with a videoconference system and you are instantly able to conduct meetings from anywhere around the world. If you don't need advanced videoconference capability, many schools are equipped with free or inexpensive software such as Skype or Zoom.

Special Needs Compatibility: Colleges and universities usually have specialized technology for special needs. For example, the auditorium may have special listening devices for hearing impaired patrons. Translators could also use the devices to translate information into another language for the listener.

Colleges and universities provide affordable space, technology, and other resources that can help you maintain and grow your business without investing in a lot of expensive overhead. The next time you need a special venue and/or cutting edge technology for a meeting, consider reaching out to a college or university near you. **HBM**

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By Tod Ferran

Prioritize HIPAA Compliance Efforts

Image by iStockphoto ©lazoo_n

Find your risks, and then implement security measures to remedy them.

Having a successful HIPAA risk analysis and risk management plan will help you to maintain compliance within your organization. Unfortunately, many organizations are unprepared to tackle the project, and either give up or lose focus on what's important. Don't let your organization become a statistic! By prioritizing HIPAA compliance, you'll soon be on your way to accurately assessing your organization's security posture and developing a successful plan for managing risk.

Start with a Risk Analysis

A risk analysis is a prerequisite to your organization's HIPAA Security Rule compliance efforts. Its purpose is to assess potential vulnerabilities, threats, and risks to protected health information (PHI) your organization is privy to. Let's dive into the methodology for conducting a risk analysis the U.S. Department of Health & Human Services (HHS) would be proud of.

Step 1: Set Your Scope by Identifying PHI Flow

To set your scope on the areas within your organization that must be secure, you have to understand how patient data flows within your organization. If you know all of the places PHI is housed, transmitted, and stored, you can better safeguard those vulnerable places.

There are four main locations to consider when defining your scope:

Where does PHI enter your environment?

Identify all PHI inputs to determine exactly where security should begin at your organization.

When considering the origins of PHI, think of both new and existing patient records. For example, PHI can begin with patients filling out their own information on your paper forms or with business associates requesting information about a current or former patient.

What happens to your PHI, and where is it stored?

It's not enough to know where PHI begins. You must know exactly what happens to it once it enters your environment:

- Does it go directly to accounting?
- Is it automatically stored in your electronic health record?
- If it is emailed, is it encrypted?

To understand what happens to PHI in your environment, note all hardware, software, devices, systems, and data storage locations touching PHI in any way. Also note all human contact with PHI.

Where does PHI leave your environment?

Many workforce members forget they must protect PHI throughout its entire lifecycle. That includes when it leaves your hands. If

Every vulnerability and associated threat should be given a risk level, typically assigned as high, medium, or low.

PHI leaves your organization, it's your job to ensure it's transmitted or destroyed in the most secure way possible.

Where does PHI leak?

Once you've identified your organization's PHI lifecycle, look for any gaps in security. In particular, environment weaknesses provide gaps for unsecured PHI to leak in or out of your organization.

The best way to find all possible leaks is by creating a PHI flow diagram. Essentially, a PHI flow diagram documents all the information you found above, and lays it out in a graphical format. A PHI flow diagram isn't a requirement, but it's a lot easier to understand PHI trails when looking at a diagram, such as the one at http://blog.securitymetrics.com/2014/11/diagrams-help-hipaa-audits.html.

Step 2: Identify Vulnerability, Threats, and Risks to PHI

Once you know where PHI is stored and how it flows within your organization, the next step is to identify any problems within that scope.

Problems to look for:

- What *vulnerabilities* exist in the system, applications, processes, or people?
- What *threats* — internal, external, environmental, and physical — exist for each of the vulnerabilities you identified?
- What is the probability of each threat triggering a specific vulnerability? This is risk.

What are your vulnerabilities?

Something that is vulnerable is flawed in some way, be it a component, procedure, design, an implementation, or an internal control. Vulnerabilities must be fixed.

Examples of vulnerabilities seen while conducting a HIPAA risk analysis:

- Unpatched operating system software
- Website coded incorrectly
- Lack of office security policies, or failure to follow established policies
- Misconfigured Internet security or no firewall
- Computer screens in view of public patient waiting areas

What are your threats?

A threat is the potential for a person or thing to trigger an existing vulnerability. Generally, it's difficult for threats to be controlled. Although most threats remain out of your control to change, they must be identified and assessed for risk. Location, organization size, and systems are all potential threats.

Examples of threats I've seen while conducting a HIPAA risk analysis include:

- Geological threats, such as landslides, earthquakes, and floods
- Hackers downloading malware onto a system
- Inadvertent data entry or deletion of data
- Power failures
- Chemical leakage
- Workforce members
- Business associates

What are your risks?

Risks are the probability a particular threat will exercise a particular vulnerability, and the resulting impact on your organization.

In a system that allows weak passwords, for example, the vulnerability is the password because it is susceptible to attack. The threat is a hacker could crack the password and break into the system. The risk is the probability of a hacker exploiting this weakness.

Other examples of risks seen during a HIPAA risk analysis include:

- **Unencrypted laptop ePHI.** There is an extremely high probability (high risk) that an external hacker can access unencrypted electronic PHI (ePHI) on a lost or stolen laptop.
- **Windows XP machine with access to the Internet.** There is an extremely high probability (high risk) that an external hacker will exploit security flaws (in outdated software) using malicious software to gain access to PHI.

Analyze HIPAA Risk Level and Potential Impact

After identifying any possible security problems in your organization, it's time to decide what risks could and will impact your organization. To analyze your risk level, first consider:

- **Likelihood of occurrence:** Just because you're threatened by something, doesn't necessarily mean it will affect you. For example, an organization in Texas or Vermont could be struck by a tornado; however, the likelihood of a tornado striking Texas is much higher. So the Texas-based organization's tornado risk level is higher than the Vermont-based organization's risk.

… if your risk is employees throwing PHI in the trash, your security measures could be quarterly employee security training and replacing trashcans with shredders.

Here's another example: Two organizations — one a large hospital group in New York City and the other, a single provider office in Wyoming — have remote access through the Internet without two-factor authentication and are set up with a weak password. The risk is the same for both: Extremely high!

- **Potential impact:** What is the effect the risk you're analyzing will have on your organization? For example, although a computer screen might accidentally show ePHI to a patient in the waiting room, it probably won't have as big of an impact as a hacker attacking your unsecured Wi-Fi and stealing all your patient data.

Every vulnerability and associated threat should be given a risk level, typically assigned as high, medium, or low. By documenting this information, you'll have a prioritized list of all security problems at your organization.

Create Your Risk Management Plan

The risk management plan is the compliance step that works through issues discovered in the risk analysis, and provides a documented instance proving your acknowledgement (and correction) of PHI risks and HIPAA requirements.

Although the risk analysis outcome should directly feed into a risk management plan, your plan should also include all HIPAA security, privacy, and breach notification requirements. For example, identifying and documenting job roles are HIPAA requirements, but this information doesn't necessarily come from a risk analysis.

Although specific items included in a risk management plan vary, here are a few industry best practices to include:

- Each HIPAA rule and its corresponding resolution
- Risk level assigned in your risk analysis
- Date completed (for both HHS documentation and your own records)
- Completed by section (great for practices where two or more people are completing a risk management plan together)
- Notes section (in case you want to jot a reminder for later)

Consider defining a timeline for HIPAA goals in your plan, like so:

- When do you want to complete your risk analysis?
- When do you want to complete your risk management plan?
- When do you want to train employees?

Identify Top Security Measures

The most important part of your risk management plan is what you do about the risks identified in the risk analysis. Start with the top-ranked risks and identify the security measures that fix those problems. For example, if your risk is employees throwing PHI in the trash, your security measures could be quarterly employee security training and replacing trashcans with shredders.

Implement, Rinse, Repeat

Once your risk management plan is complete, it's time to implement it. A prioritized HIPAA compliance plan is a rinse and repeat process. One of the most important parts of HIPAA is documentation. If you don't document, you can't prove to HHS that you've performed a complete and thorough risk analysis. They will want to see documentation, your risk management plan, and monthly progress on addressing the items identified in that risk management plan. **HBM**

Resources:

PHI flow diagram: **http://blog.securitymetrics.com/2014/11/diagrams-help-hipaa-audits.html**

HIPAA Security Series 6: Basics of Risk Analysis and Risk Management: **http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/riskassessment.pdf**

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By Robert Pelaia, Esq., CPC, CPCO, and Jamie Ewing

COMPLYING WITH COMPLIANCE

Although compliance is your entire organization's responsibility, it's your board's responsibility to manage it.

The Office of Inspector General (OIG) and the American Health Lawyers Association (AHLA) have collaborated on three occasions (2003, 2004, and 2007) to provide guidance for boards of directors' oversight of compliance issues. This oversight is so important that OIG and AHLA recently collaborated again, this time incorporating the Association of Healthcare Internal Auditors (AHIA) and the Health Care Compliance Association (HCCA) to help develop and publish an updated guidance tool: Practical Guidance for Health Care Governing Boards on Compliance Oversight (the guidance).

Why Is Board Oversight Important?

Compliance with applicable state and federal laws should be of the utmost importance for any organization, especially in healthcare. The industry-wide shift to increased transparency in public reporting has led to greater board involvement. Board oversight helps to ensure your organization's compliance program is working efficiently and effectively. The guidance was developed to provide "practical tips for Boards as they work to effectuate their oversight role of their organizations' compliance."

Current Expectations for Board Oversight

Boards must consistently act in good faith to safeguard an organization against violations of applicable state and federal regulations. To accomplish this, your board must guarantee a reporting system is in place, and that the reporting system is sufficient to maintain

Did You Know?

AAPC addresses compliance requirements for practices (**www.7atlis.net**) and offers Certified Professional Compliance Officer (CPCO™) credentials. (**www.aapc.com/certification/cpco.aspx**)

AHLA is the country's largest educational organization devoted to legal issues in the healthcare field.

AHIA is an international organization of professional auditors working to assess and evaluate risk in the healthcare arena.

HCCA is a nonprofit organization serving compliance professionals in the healthcare industry.

OIG is the largest inspector general's office in the federal government, dedicated to improving the efficiency of the U.S. Department of Health & Human Services (HHS) through combating fraud, waste, and abuse in HHS programs.

Board Oversight in Healthcare Organizations

Image by iStockphoto © Steve Debenport

timely action. The new compliance oversight guidance notes that boards are expected to use all available resources to optimize the organization's compliance program. Available resources include Federal Sentencing Guidelines, OIG's guidance documents, and OIG Corporate Integrity Agreements (CIAs).

The sentencing guidelines "offer incentives to organizations to reduce and ultimately eliminate criminal conduct by providing a structural foundation from which an organization may self-police its own conduct through an effective compliance and ethics program." The OIG guidance documents highlight the importance of implementing internal controls to monitor adherence to applicable regulations. CIAs outline key structural and reporting requirements for compliance. These resources work to function as a baseline for developing internal controls to promote and monitor compliance.

Balance the Program's Scope with Your Organization's Size

Compliance programs vary by organization. No single standard applies to all organizations. Ideally, your board should strive to make compliance programs as comprehensive as possible, but must balance the scope of the compliance program with the size (and available resources) of an organization. The sentencing guidelines recognized this area of concern, and allow compliance programs to vary according to the size of the organization. The sentencing guidelines also recommend that boards of smaller organizations "may need to become more involved in the organizations' compliance and ethics efforts" than might be required in larger organizations.

Stay Informed of Regulatory Changes in the Industry

Regulatory changes in the healthcare industry are common, and it's important for boards to stay informed. The new compliance oversight guidance suggests that your board develop a "formal plan to stay abreast of the ever-changing regulatory landscape and operating environment." Periodic updates from staff members will allow your board to make informed decisions.

The guidance also notes that outside educational programs are a way for boards to expand their knowledge of industry risks and regulatory requirements. The most effective way to ensure your board is up to date with regulatory changes is by consulting with a compliance professional or, if possible, adding a compliance professional to your board.

Compliance Program Functions

The guidance suggests that you should "define the interrelationship of the audit, compliance, and legal functions" within your organization. Every organization balances myriad functions; when clear

Although independence is crucial, collaboration between each function promotes your organization's overall interests.

boundaries exist between each function, an organization is more likely to maintain a solid structure. According to the guidance, the five significant functions include compliance, legal, internal audit, human resources, and quality improvement. More specifically:

- The compliance function includes prevention, detection, and resolution of any actions that do not comply with the applicable state and federal standards.
- The legal function entails providing advice concerning the legal and regulatory risks of your organization's business strategies.
- The internal audit function involves an objective evaluation of internal control systems and framework within your organization.
- The human resources function includes the recruitment, screening, hiring, and training of employees.
- The quality improvement function focuses on providing high quality practices and improving efficiency.

Your board must evaluate each area independently and consistently to ensure each function is met.

The OIG believes your organization's compliance officer should be independent from your legal counsel because the professional obligations for each function differ. Although independence is crucial, collaboration between each function promotes your organization's overall interests.

The guidance notes that boards should develop a process to "ensure appropriate access to information," perhaps through a "formal charter document approved by the Audit Committee of the Board or in other appropriate documents." Organizations that cannot separate each function are particularly prone to risks due to the significant possibility of sharing privileged information within the organization (intentionally or otherwise). The guidance suggests that to monitor risks your board should closely evaluate how management:

1. Identifies and investigates compliance risks;
2. Identifies and implements appropriate corrective actions and decision-making; and
3. Communicates between various functions.

Issue Reporting Mechanisms

Your board should receive risk mitigation and compliance effort reports on a consistent, timely basis. Your board must enact a system to encourage open and honest communication, and must make its expectations clear. Expectations may include the use of objective scorecards, internal and external investigation reports, hotline call activity, and reports of allegations of material fraud or senior management misconduct. Per the guidance, your board needs to exhaust all efforts to hold management accountable to meet those expectations.

Formats to receive reports vary by organization. Dashboards are a popular tool that contain key financial, operational, and compliance indicators to assess risk, strategic plans, policies, and procedures. The guidance suggests that your board and management work together to tailor the dashboards to meet your specific needs.

Your board can also establish a risk-based reporting system when certain risk-based criteria are met. This is an effective way to ensure timely reporting of suspected violations.

The guidance also suggests your board conduct systematic "executive sessions" to achieve greater compliance results. These executive sessions should not include senior management, but should include leadership from the compliance, legal, internal audit, and quality functions. Systematic executive sessions act as a way to encourage dialogue by keeping the lines of communication continuously open.

The guidance additionally recommends regularly scheduled sessions as a way to maintain continuity (vs. holding sessions only when problems arise).

Risk Identification Procedures

Per the recent guidance, a variety of activities in the healthcare field are prone to violations, including patient referrals, billing problems, privacy breaches, and quality-related events. Your board must first be able to identify high-risk areas. Identification can be accomplished through internal sources, such as employees reporting to an internal compliance hotline or internal audits, and through external sources, such as professional organization publications, OIG-issued guidance, consultants, or news media outlets. Your board can also monitor competitor's violations to verify that your departments are in compliance.

The sentencing guidelines highlight your board's responsibility as, "ensuring the organization's compliance and ethics program is followed, including monitoring and auditing to detect criminal behavior." Your board should also develop, implement, and monitor corrective action plans.

New reimbursement forms are now in place, such as value-based purchasing and service bundling, which have led to increased in-

An effective board must remain well informed of regulatory risk, have a comprehensive understanding of your organization's compliance program, and continually encourage open communication across the organization.

centives to monitor compliance. Pay-for-performance policies have placed an increased burden on organizations to focus attention on quality guidelines and outcomes. Statutes addressing the provider-physician relationships are broad in nature; therefore, the guidance notes that it is up to your board to continue reviewing these arrangements to ensure compliance is being met — particularly with self-referral (Stark) and anti-kickback laws.

Another industry trend is increased transparency. The recent guidance states that although increased transparency provides significant opportunities to improve care quality, it also carries substantial risk. Information is continually provided to the public concerning health outcomes and quality measures through the Centers for Medicare & Medicaid Services (CMS) quality compare measures. The Open Payments System also provides data to the public on pharmaceutical and device industries' payments to physicians.

Accountability Methods

The guidance notes that compliance is an "enterprise-wide responsibility" and suggests that organization needs "to support the concept that compliance is a way of life," as opposed to simply one requirement in a long list of requirements. To encourage compliance, your board should conduct frequent performance assessments and possibly use the results to withhold incentives or provide bonuses. One method for promoting accountability is through annual incentive programs. Per the guidance, you may implement employee and executive compensation claw-back/recoupment provisions to be implemented when compliance metrics are not satisfied. The OIG has set this example by requiring compliance certifications from managers of all departments (not just the compliance department). This acts as a clear demonstration to your organization that everyone is responsible for compliance.

According to the guidance, self-disclosure compliance programs offer significant benefits. Self-disclosure of violations — particularly of overpayments for providers enrolled in Medicare or Medicaid — allows your organization to remedy the violation promptly, resulting in a faster resolution. The average resolution for OIG self-disclosure is less than one year. The OIG's self-disclosure cases settle for 1.5 times the damages, as opposed to double the damages under the False Claims Act. Self-disclosure cases also include exclusion releases as part of the settlement; therefore, your board can help your organization avoid significant penalties when violations occur by implementing self-disclosure programs.

Effective Board Oversight

An effective board must remain well informed of regulatory risk, have a comprehensive understanding of your organization's compliance program, and continually encourage open communication across the organization. Although it's your entire organization's responsibility to remain compliant with state and federal regulations, the guidance emphasizes that it's your board's responsibility to ensure it provides comprehensive methods for identifying and investigating risk areas, and providing corrective action to remedy any violations.

Why Is this Important to Coders?

Board oversight is important to coders because of the noteworthy shift in expectations. The healthcare industry has placed significant value on transparency in public reporting. Fraud and abuse laws are focused on quality improvement. This drive toward transparency in public reporting of quality data is a clear recognition that quality care is more of a system problem than a competence problem. Medical coders are responsible for ensuring the requirements for medical billing are properly followed, and are aligned with your organization's compliance program. HBM

Resources:

Practical Guidance for Health Care Governing Boards on Compliance Oversight: **http://oig.hhs.gov/compliance/compliance-guidance/docs/Practical-Guidance-for-Health-Care-Boards-on-Compliance-Oversight.pdf**

2014 Federal Sentencing Guidelines Manual (§8, Intro. Comment): **www.ussc.gov/sites/default/files/pdf/guidelines-manual/2014/GLMFull.pdf**

CMS Physician Compare and Hospital Compare websites: **www.medicare.gov/physiciancompare/search.html and www.medicare.gov/hospitalcompare/search.html**

CMS Open Payment System: **www.cms.gov/openpayments/**

OIG Self-Disclosure Information is available at **http://oig.hhs.gov/compliance/self-disclosure-info**

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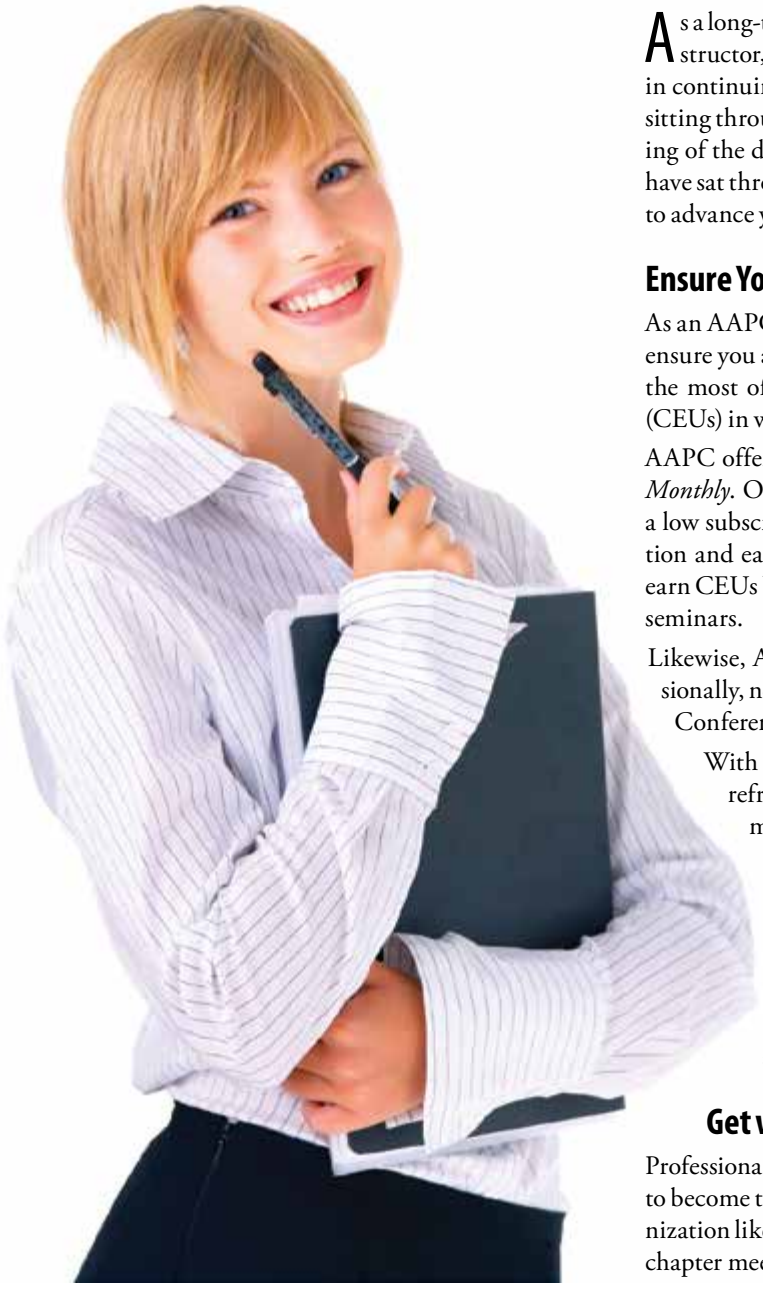
By Dawn Moreno, PhD, CPC, CBCS, CMAA, MTC, CPL, CLT

Develop Professionally for Success

Think outside the box when it comes to advancing your professional skillset.



As a long-time medical coding, billing, and medical office management instructor, I often speak to coworkers, peers, and students who are interested in continuing professional development. To get there, some people envision sitting through long, boring seminars, struggling to stay awake while dreaming of the delicious lunch waiting for them. Although many of us probably have sat through mind-numbing meetings such as these, it's not the only way to advance yourself professionally.

Ensure Your Skills Are Current

As an AAPC certified professional, you need continuing education hours to ensure you are up to date on the changes in your chosen field. You can make the most of the requirement by earning your continuing education units (CEUs) in ways most interesting to you.

AAPC offers members 12 free CEUs per year through *Healthcare Business Monthly*. Other professional publications also offer 12 CEUs per year with a low subscription price. The advantage is that you learn valuable information and earn many of your CEUs to maintain membership. You can also earn CEUs by attending AAPC (or AAPC-approved) courses, webinars, and seminars.

Likewise, AAPC conferences provide an avenue for you to develop professionally, network with other professionals, and take classes that interest you. Conference is like a mini-vacation, but you come home with many CEUs.

With the advent of ICD-10, we can all use an anatomy or terminology refresher class. AAPC offers these, as well. Even if you already know medical terminology and anatomy, you can always learn something new. As you know, nothing stays the same in this industry!

Another way to accelerate your professional growth is to expand your knowledgebase. For example, if you're a medical coding professional, why not venture into the medical billing field? You'll not only expand your knowledge about reimbursement but also earn CEUs. (Look for an entity that will give you a good amount of CEUs for taking their program.)

Get with Other Professionals

Professional development isn't just about earning CEUs. The ultimate goal is to become the best professional you can be. Get plugged into a national organization like AAPC and become active on the local level, as well. Attend local chapter meetings. Take on a leadership role in your local chapter. Volunteer

Asking to observe in a department that you don't know anything about is a great way to develop professionally.

to proctor exams. Teach a review class. This involvement will make you feel connected to other professionals and you will quickly become an essential part of your AAPC local chapter.

Explore Free Educational Apps

If you're big on ideas but short on time, smartphone apps make it possible to learn anywhere, anytime. There are apps for medical terminology, anatomy, ICD-10 — you name it — and many are free.

Gain a Competitive Edge

Part of growing as a professional involves improving your basic job skills and expanding your horizons. Through your local community college or adult education center, you can explore topics such as professional resume writing or how to interview more effectively. Classes in business management might help you to land a more lucrative management role. Even if you've been in the business for 20 or more years, you'd be surprised what you can learn to help yourself become more competitive.

Take Advantage of Resources

Asking to observe in a department that you don't know anything about is a great way to develop professionally. For example, if you don't know anything about oncology coding, ask to observe the oncology department for a few days as they code records. You'll probably need to sign confidentiality agreements, but this shouldn't be a problem if you already work for a multispecialty practice or hospital.

Put Yourself Out There

Embrace constructive feedback. Ask your boss what your strengths and weaknesses are, and then do something to strengthen your weak areas. Participate in AAPC forums; and when people post questions, try to answer them. We can always learn something from each other. **HBM**

Dawn Moreno, PhD, CPC, CBCS, CMAA, MTC, CPL, CLT, teaches adults medical coding, medical billing, and medical office management for MT Advantage. She writes for professional journals and blogs within the medical and legal industries. Moreno's motto is that one is never too old to learn something new. She is a member of the Albuquerque, N.M., local chapter.

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Martha Plascencia, **CPC**
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Wendy Creed, **CPC**

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Abby Spinks, **CPC-A**
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Adrian Carlo Parungao, **CPC-A**
Afsar Vadapalle, **CPC-A**
Ahmed Khan, **COC-A**
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Aira Veronica San Pedro, **CPC-A**
Ajayreddy Kasireddy, **COC-A**
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Aldona Swihart, **CPC-A**
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Amanda T Zomerdyke, **CPC-A**
Amanda Whalen, **CPC-A**
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Amber Lander, **CPC-A**
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Brenda Beyer, **CPC-A,** CPB
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Carol Shoemake, **CPC-A**
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Christina Pollreis, **CPC-A**
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Leslie Edwards, **CPC-A**
Leslie Jones, **CPC-A**
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Lindsey Davis, **COC-A**
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Lisa Dunn, **CPC-A**
Lisa Gibson, **CPC-A**
Lisa Houg, **CPC-A**
Lisa Ryle, **CPC-A**
Lisa Somerville, **CPC-A**
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Lisa White, **CPC-A**
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Maddi Vijay Kumar, **CPC-A**
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Madhu sudhan reddy P, **COC-A**
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Mahendra Singh, **CPC-A**
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Manisha Kothari, **CPC-A**
Manjusha Nair, **CPC-A**
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Mansi Barchha, **CPC-A**
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Melinda Wolfe, **CPC-P-A**
Melissa Mancha, **CPC-A**
Melissa B Sullivan, **CPC-A**
Melissa Baker, **CPC-A**
Melissa Krumsiek, **CPC-A**
Melissa Loughry, **CPC-A**
Melissa MacDonald, **CPC-A**
Melissa Miller, **CPC-A**
Meredith Kulago, **CPC-A**
Mia Herrera, **CPC-A**
Michael Boyle, **COC-A**
Michael Mendoza, **CPC-A**
Michael Rodbell, **CPC-A**
Michael Shema, **CPC-A**
Michelle Brown, **CPC-A**
Michelle Buxenstein, **CPC-A**
Michelle Hoffie, **CPC-A**
Michelle Reece, **CPC-A**
Michelle Rugino, **CPC-A**

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Mickie Hoffert, **CPC-A**
Mikayla Weeks, **CPC-A**
Mike Demi, **CPC-A**
Mikki Bruegeman, **CPC-A**
Miluska Dias Martinez, **CPC-A**
Misha Mohan, **CPC-A**
Misty Clark, **CPC-A**
Misty Cuevas, **CPC-A**
Mohamed Faheem, **COC-A**
Mohammed Haquani, **CPC-A**
Mokanapally Sai Krupa, **CPC-A**
Mollie Kreps, **CPC-A**
Monica Einsel, **CPC-A**
Monica Juno, **COC-A**
Mudhiganti Mounika, **CPC-A**
Mukkamalla Rama Devi, **CPC-A**
Mulla Khadar Navaz Shareef, **CPC-A**
Muralidhar Karike, **COC-A**
Muthireddy Venkatareddy, **COC-A**
Nabanita Roy, **CPC-A**
Najeeb Navab, **CPC-A**
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Naomi Tokuda, **CPC-A**
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Nayeem Pasha, **CPC-A**
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Ngan Tran, **CPC-A**
Nicholas Limerick, **CPC-A**
Nichole Tavaly, **CPC-A**
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Nisha Nadeer, **CPC-A**
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Toni Ann Panepinto, **CPC-A**
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Tracy Hardy, **CPC-A**
Travis J Eberhardy, **CPC-A**
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Tyler Jordan, **CPC-A**
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Usha Kumari, **CPC-A**
Usha Pandiyan, **CPC-A**
Vainala Lavanya, **CPC-A**
Valarmathi Annadurai, **CPC-A**
Valerie Fehlman, **CPC-A**
Valerie Smith, **CPC-A**
Valerie Wysocki, **CPC-A**
Vanessa A Blood, **CPC-A**
Vanessa Smith, **CPC-A**
Veerabathini Divya, **CPC-A**
Venkat C, **CPC-A**
Venkataramana Behara, **COC-A**
Venkateswarlu Kancharla, **COC-A**
Venu Gopala Krishna Sathya Narayana, **CPC-A**
Verenice Santizo, **CPC-A**
Veronica Anderson, **CPC-A**
Vicki Reed, **CPC-A**
Vickrala Sravanthi, **CPC-A**
Victor de la Torre, **CPC-A**
Victoria Gnell Barrett, **CPC-A**
Victoria Skarzynski, **CPC-A**
Vijayakumar Kannaraj, **COC-A**
Vijayalakshmi Baburao, **CPC-A**
Vijayalakshmi Krishnan, **CPC-A**
Vikki Rawson, **COC-A**
Vimbai Tsodzo, **CPC-A**
Viola Burns, **COC-A**
Virginia Dunn, **COC-A**
Vishnupriya Malla, **CPC-A**
Vishnupriya Malla, **CPC-A**
Vishwanadhula Ramya, **CPC-A**
Viswanadham V, **CPC-A**
Viswanadham Vemala, **CPC-A**
Vivek Khirwar, **CPC-A**
Vivek Shukla, **CPC-A**
Vivek Sivaraman, **CPC-A**
Vodapalli Keerthi, **CPC-A**
Wendy Bingham, **CPC-A**
Wendy Cutler, **CPC-A**
Wendy Thompson, **CPC-A**
Wendy Tippett, **CPC-A**
William Campbell, **CPC-A**
William Gillis, **CPC-A**
William kier Matias, **CPC-A**
XianJing Zhou, **CPC-A**
Yessenia Alvarez, **CPC-A**
Yoshida Cooley, **CPC-A**
Yvonne Laulainen, **CPC-A**
Yvonne Marie Boyd, **CPC-A**
Zandile Dube, **CPC-A**

Specialties

Adair Chesley PhD, CPC, **CPMA**
Aide Barajas, CPC, **COSC**
Alayne Day Haller, CPC, **CPMA**
Allison W Chase, CPC, **CGSC**
Amanda Nicole Riley, CPC, **CPMA**
Amanda Powell, CPC, CPMA, **CRC**
Amanda Price, **CPB**
Amanda Sunnycalb, CPC, **CPMA**
Amelia Davis, CPC, CEMC, **CIC**
Amory Tolbert, CPC, **CANPC**
Amy Fisher, **CEMC**
Amy Jones, CPC, **COSC**
Amy Moore, COC, **CIC**
Ana Restrepo, **CPMA**
Anabell Diaz, CPC, **CPMA**
Andrea Hunemuller, **CEMC**
Andrea Marie Ward, COC, CPC, **CPMA**
Angel L Luciano-Cruz, CPC, **CRC**
Angela Ryce, CPB, **CPPM,** CHONC
Angelia Puckett, CPC-A, **CEMC**
Angelica M Stephens, COC, CPC, **CPMA,** COSC
Anita Kumari, COC-A, CPC-A, **CPMA**
Ann Margaret Kaiser, CPC, **CPMA,** CEMC
Anne K Hoge, CPC, **CEMC**
Anthony Drozd, CPC, **CCVTC,** CGSC
Antonio Garfield Fraser, CPC, CPMA, CEDC, **CEMC**
Aravind Chikile, **CRC**
Ashley Marie Bullock, CPC, **CEMC**
Aswini Rajeev, **CRC**
Audrey Dickens, CPC, **CPEDC**
Aviette Marie Bueno, **CIC**
Bambii Ulrich, CPC, **CPMA**
Barbara Buckley, COC-A, **CPB**
Barbara E Wigglesworth, CPC, **CPMA**
Barbara Elaine Kaumeier, CPC, **CRC**
Barbara Kineavy, CPC-A, **CRC**
Beth Ann VanAllsburg, CPC, **CPCO**
Beverly Kujawinski, COC, CPC, **CPB**
Bhagyalakshmi Shetty, **CRC**
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Brandy Lisbon, CPC, **CEMC**
Brenda Braxton, **CPB**
Brenda Israel, CPC, **CPMA**
Brian Matthew Cogdill, **CRC**
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Candice B Jacobs, CPC, **CPB**
Carissa Morgan Foster, CPC, **CCC,** CEMC
Carlos Velasquez, **CRC**
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Carolyn Blecker, **CIC**
Carrie Lynn Mirando, CPC, **CPMA**
Catherine A Phipps, CPC, CPMA, **COBGC**
Cecelia Helen Hall, CPC, **CPMA**
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Cherrie H Broekhoven, CPC, **CEMC**
Cheryl Johnson, CPC, **CRC**

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Christine M Schaefer, CPC, **CCC,** CEMC, COBGC
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Detrica Sims, **CIRCC**
Devika Arjune, **CPMA**
Diana Durcan, CPC, CPMA, COSC, **CRC**
Diana Durcan, CPC, CPMA, **COSC,** CRC
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Donna Kirby, **CPPM**
Donna Powell, CPC, **CIC**
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Elizabeth Anglin, **CPPM**
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Elizabeth Leanne Stevens, CPC, **CRC**
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Emma Lee Johnson, CPC, **CPMA**
Esther Ruvalcaba-Olmedo, CPC, **CPB**
Evangelina Salazar, CPC, **COBGC**
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Felicia Ann Miles-Collier, CPC, **CPMA**
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Karen Gonyeau, **CPB**
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Karen L Astafan, CPC, **CPMA,** CPC-I
Karen Savage, CPC, **CPMA**
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Kasey J Grove, CPC, **CPMA**
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Katharina Ross, **CRC**
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Kathleen Hall, CPC, **CPPM**
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Kathleen Taras, COC, CPC, **CHONC**
Kathryn DeJesus, COC, CPC, **CPMA**
Kathryn Gabel, CPC, **CPMA**
Kathryn Lindsley, **CEMC**
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ICD-10 Quiz Answer (from page 37)

The correct answer is B. In ICD-10-CM, it's important to indicate laterality. "Unspecified" should not be used unless no further query is possible.

Rob J. Pachciarz, CPC, COC, CIRCC, CASCC

Senior Manager, Outpatient Coding Ethics and Compliance, LifePoint Health, ICD-10-CM/PCS Trainer

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

I was introduced to the business side of healthcare in 2000 when I began posting insurance and private payer payments for skilled nursing facilities across the United States. I then moved down the street to another large hospital ownership group, where I posted payments and issued refunds for overpayments. After four years, I transitioned to accounts receivables, which is where my love and appreciation for good coding took shape.

To better serve the facilities that rely on me for resolving denial issues, I obtained my Certified Professional Coder (CPC®) credential in 2004. After that, my coding instructor recruited me to participate in a new coding program that provided outsourced coding services to ambulatory surgery centers (ASCs). There were three ASCs that I served in the Nashville area. My love for outpatient surgical/facility coding grew and it showed with excellent audit results. During that time, I also became an adjunct coding instructor for a medical vocational school.

In 2010, I was asked to work in the Outpatient Coding, Ethics and Compliance Department at LifePoint Health. When I was first hired, I was challenged to obtain the Certified Outpatient Coding (COC™) credential, and then I earned Certified ASC Coder (CASCC™) designation. I most recently obtained the Certified Interventional Radiology Cardiovascular Coder (CIRCC®) credential. Besides my CPC, I'm most proud of the CIRCC® due to the difficulty of the exam. My current job title is senior manager and I'm overjoyed to work with the some of the best coders and educators in the country.

What is your involvement with your local AAPC chapter?

I've served as member development officer for the Nashville, Tennessee, local chapter.

I attend as many local chapter meetings as I can; however, I've won so many raffles and giveaways that I think I may have been unofficially banned from any future events! I'm proud to say that the current vice president of the chapter, **Stephen Cannon, CPC**, is a former student of mine.

How has your certification helped you?

Early in my career, my CPC® helped me open a lot of doors. At this stage of my career, though, it's all about how I can use my credentials to best serve others who need help, whether it's helping a catheterization laboratory that's having difficulty selecting the appropriate charge for an abdominal aortogram or a relative deciphering an Explanation of Benefits.

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

Don't give up hope. Be a source of inspiration to those who depend on you when times are tough. Let your actions during your job search — especially in moments of frustration — teach perseverance and faith to those who are watching you with impressionable eyes.

My other advice is to draw a 50 mile wide circle around where you live and attend any local chapter meeting in that circle. Network like crazy; put yourself out there to meet hiring managers and other coders who know about unadvertised openings.

What has been your biggest challenge as a coder?

I create educational content concerning proper coding and documentation for some of the ancillary services our hospitals provide on an outpatient basis. I love it, but tailoring it to meet the needs of hospitals in different states is complicated.

How is your organization preparing for ICD-10?

LifePoint Health owns 60-plus hospitals in more than 30 states, so our preparation for ICD-10 has been extensive and ongoing. We are finalizing curricula for employees and continue to roll out dual coding and productivity tracking methodologies. We are testing with top payers to ward off potential problems down the road. We developed a 60-day out awareness campaign, with emphasis on clinical documentation expectations for physicians.

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

I would feel privileged to serve my country again in the United States Air Force. I served from 1987-1991, and I would gladly do it all over again.

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

I have been married for 19 years to Angela, and we have three kids: Julia, 12, Yuli, 8, and Lucy, 4. Our two youngest children are adopted: Yuli is from Bulgaria and Lucy is from Albania. I enjoy vacationing at the beach and exploring new places with my family. I like to write poetry and lyrics, dance, and live life to the fullest.

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