Ovarian Cancer: Early Detection Is Key: 40
Recognizing the signs and symptoms can save lives

Beware PHI Phishing Attempts: 50
Don’t be fooled by masqueraders posing as a trusted client

Get the Facts on MIPS and APMs: 54
Dig deeper into the Quality Payment Program
You’ve studied for the CPC exam, but is it enough?
Increase your chances of success with an Online Exam Review.

Course students will:
- Learn testing strategies.
- Review frequently missed questions.
- Participate in a focused review of testing sections.
- Have Access to on-demand recorded classes for 12 months.

It’s no secret that the CPC exam can be challenging. This review was designed to focus on both the common and most challenging coding concepts of the CPC exam.

The CPC Online Exam Review (Self-Paced) is an on-demand learning system, where students can study and learn at their own pace.

Visit aapc.com/CPC-self-paced or call one of our Career Counselor at 877-524-5027.
Hike through Total Knee Arthroplasty

Pam Brooks, MHA, CPC, COC, PCS

Clubfoot Deformities: Get a Full Range of Understanding
Lori A. Cox, MBA, CPC, CPMA, CPG-I, CEMC

Is It Illegal for a Coder to Change a Provider’s Coding?
Michael D. Miscoe, Esq., CPC, CASCC, CUC, CCPC, CPCO, CPMA
Julie E. Chicoine, Esq., RN, CPC, CPCO

MIPS and APMs: Get the Facts
Renee Dustman

You’ve studied for the CPC exam, but is it enough?
Increase your chances of success with an Online Exam Review.
Course students will:
● Learn testing strategies.
● Review frequently missed questions.
● Participate in a focused review of testing sections.
● Have Access to on-demand recorded classes for 12 months.

It’s no secret that the CPC exam can be challenging. This review was designed to focus on both the common and most challenging coding concepts of the CPC exam.
The CPC Online Exam Review (Self-Paced) is an on-demand learning system, where students can study and learn at their own pace.

Visit aapc.com/CPC-self-paced or call one of our Career Counselors at 877-524-5027.
HEALTHCARE BUSINESS MONTHLY | SEPTEMBER 2016 | CONTENTS

DEPARTMENTS

7 Letter from Membership Leader
8 Letters to the Editor
9 Alphabet Soup
10 I Am AAPC
12 Healthcare Business News
14 AAPC Chapter Association
15 Chapter News

ADDED EDGE

10 Q&A: Why AAPC Is Passionate About Codebooks
Ana Saiz

CODER’S VOICE

16 Career Opportunities Open Up for a Proud Business Professional
Stacey Bunk, FABC

CODING/BILLING

22 Three Things E/M Documentation Usually Lacks
Brenda Edwards, CPC, CPB, CPMA, CPC-I, CEMC, CRC

26 Overcome Quirky NCCI Bundling Rules for Shoulder Arthroscopy
Margie Scalley Vaught, CPC, COC, CPC-I, CCS-P, MCS-P, ACS-EM, ACS-OR

28 RADV Reality
Tom Nasadoski, MBA

36 Get a Physician’s Perspective on Documentation Improvement
Marian J. Wymore, MD, CPC

40 Ovarian Cancer: Early Detection Is Vital to Survival
Bridget Toomey, CPC, CPB, CRCR

42 FAQ: 10 Things You Need to Know about Risk Adjustment
Brian Boyce, BSHS, CPC, CPC-I, CRC, CTTPR

46 The Secret to Proving Medical Necessity
Jennifer Comstock, CPC

58 “Same-day Wellness Exam and Problem-focused Visit” Saga Continues
John Verhovshek, MA, CPC

AUDITING/COMPLIANCE

50 Beware Phishing Attempts to Thwart Your IT Security
Brian Shrift, CISSP, and Kevin J. Slonka, Sc.D

COMING UP:
- Payments and Denials
- Audit Do’s and Don’ts
- Military Health System
- Unlisted Codes
- Speaker Ideas

On the Cover: Pam Brooks, MHA, CPC, COC, PCS, provides a personal perspective on total knee arthroplasty surgery and consumer-driven healthcare, technology, procedures, outcomes, and partnerships. Cover design by Kamal Sakar.

EDUCATION

62 Newly Credentialed Members

Online Test Yourself – Earn 1 CEU
Customize, manage, train and simplify your audit process. We streamlined your audit process by merging audit workflow, management, and reporting capabilities into one easy-to-use, web-based solution.

HEALTHICITY.COM/AUDITMANAGER
Serving 159,000 Members – Including You!

HEALTHCARE BUSINESS MONTHLY
Coding | Billing | Auditing | Compliance | Practice Management
September 2016

Publisher
Brad Ericson, MPC, CPC, COSC
brad.ericson@aapc.com

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

Editorial
Michelle A. Dick, BS
Renee Dustman, BS

Graphic Design
Mahfooz Alam

Advertising
Jon Valderama
jon.valderama@aapc.com

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

©2016 Healthcare Business Monthly. All rights reserved. Reproduction in whole or in part, in any form, without written permission from AAPC ® is prohibited. Contributions are welcome.

Medical Coding Legal Advisory Committee:
Timothy P. Blanchard, JD, MHA, FHFMA
Julie E. Chicoine, JD, RN, CPC
Michael D. Moscoe, JD, CPC, CPCO, CPMA, CASCC, CCPC, CUC
Christopher A. Parrella, JD, CPC, CHC
Robert A. Pelaia, Esq., CPC
Stacy Harper, JD, MHSA, CPC

CPT® is a registered trademark of the American Medical Association.
CPC®, COC™, CPC-P®, CPCO™, CPMA®, and CIRCC® are registered trademarks of AAPC.
Sometimes, I feel fortunate that I work in a bubble. I’m one of those people who works from home, shielded from the rest of the world. I rely on the internet to follow regulations and policies that apply to the audits I perform. Regulations like the Medicare Access and CHIP Reauthorization Act (MACRA), and the related Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs), don’t directly affect me. That doesn’t mean I can ignore what’s going on around me.

**MACRA Is Bigger than the Bubble**

AAPC members have a responsibility to stay informed and educated, as stated in the Member Bill of Rights, No. 1: Right to a Higher Standard (www.aapc.com/aboutus/member-bill-of-rights.aspx). That means we are accountable for understanding large scale changes, such as payment reform, even when not directly involved.

The new Quality Payment Program, and all of the acronyms that come along with it, will soon be a part of our jobs in one way or another. As proposed, the performance period for eligible clinicians begins January 2017.

The National Advisory Board (NAB) is here to represent AAPC membership, and to listen to your concerns. I hear from our membership that it will be a struggle to learn one more new system, educate providers, and have it implanted. Even if this is a change for the better, it will create additional work. The question on all our minds is: How can we stay informed and continue the pace needed to stay current in our day-to-day activities?

**You Have a Right to Know**

Also under the Member Bill of Rights, you’ll find that you have the right to quality information from AAPC and NAB — and we have a responsibility to you.

In the article “MIPS and APMs: Get the Facts,” (pages 54-56) in this issue of Healthcare Business Monthly, you’ll find specific details regarding MIPS and APMs. Read the article to better understand what these acronyms mean to you and the industry as a whole. Let’s expand our knowledge and burst the bubble together.

Take care,

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

The new Quality Payment Program, and all of the acronyms that come along with it, will soon be a part of our jobs in one way or another.
**ICD-10 Guidelines Don’t Direct Clinical Practice**

I would challenge the assertion made in the article “ICD-10 Restricts Same-day Sick and Well Visits” (July 2016, pages 44-46) that due to ICD-10 guidelines, “if the patient is symptomatic, the visit no longer qualifies as a preventive encounter,” and the patient should be rescheduled for their preventive services.

The stated purpose of ICD-10-CM is “to serve as a useful tool in the area of classification of morbidity data.” It is not within a code set’s scope or intent to direct clinical practice or to dictate what services may be provided to a patient at an encounter; nor does it govern the circumstances under which those services may be billed or paid. To state that a patient cannot receive a preventive service at the same encounter due to ICD-10 rules is like being told by a mechanic that you cannot have your oil changed and your brakes repaired on the same day because the shop’s bookkeeping rules don’t allow it.

Patients frequently present to providers for multiple reasons at one time, and the complexity and contradictions involved in applying ICD-10 rules to these varied situations do present challenges to coders. Ultimately, medical necessity, quality of care, and patients’ needs should drive the provision of healthcare — not coding rules. We should resist the urge to tell providers how they can practice simply because the coding grammar does not easily capture the situations we are reporting.

I believe our coding profession, also, must aim to be a “useful tool” in supporting healthcare, and to avoid imposing unnecessary administrative requirements and burdens on providers and patients. Otherwise, we risk taking our trade down the road to irrelevance.

*Thomas Field, CPC, CEMC*

**High Complexity Transitional Care Management Requirements**

The Transitional Care Management Timeline (Figure 1) in the article “Cut Costs with Quality Transitional Care Management” (July 2016, pages 28-31) suggests that a high complexity, face-to-face visit is due on day 2 after the patient is discharged from the hospital. As stated in the article, to report 99496 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge, you must have a face-to-face visit with the patient within seven days of the patient’s discharge from the hospital.

**Report Paravertebral Block Add-on Only Once, Per Day**

The coding example provided in “Soothe the Sting of 2016 Paravertebral Block Changes” (July 2016, page 42) erroneously reports three units of paravertebral block (PVB) add-on code +64462 Paravertebral block (PVB) (paraspinal block) thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure) in addition to a single unit of 64461 Paravertebral block (PVB) (paraspinal block) thoracic; single injection site (includes imaging guidance, when performed) for paravertebral block injections at T3-T6.

Per CPT® instructions, you may report only a single unit of +64462, per day. As the code descriptor indicates, +64462 applies to the “second and any additional injection sites.” Therefore, correct coding for paravertebral block injections at T3-T6 is 64461 (first level, T3) and +64462 (one unit) for the three additional levels (T4, T5, and T6).

**ALPHABET SOUP**

Make deciphering clinical documentation easier by recognizing common medical terms and acronyms.

- **ASC**: Ambulatory surgical center
- **DTR**: Disclusion time reduction
- **EGD**: Esophagogastroduodenoscopy
- **ETOH**: Ethyl alcohol
- **GI**: Gastrointestinal
- **HEENT**: Head, ears, eyes, nose, and throat
- **HTR**: Hormone replacement therapy
- **IOL**: Intraocular lens
- **LMA**: Laryngeal mask airway
- **LMP**: Last menstrual period
- **NABS**: Normal active bowel sounds
- **ORIF**: Open reduction and internal fixation
- **PERRL**: Pupils equal, round, reactive to light

**BECOME FAMILIAR with Clinical Lingo**
MARIA THERESA MIDDLETON, CPC, CPB

I grew up in the Philippines, and graduated with a bachelor’s degree in Business Administration with a major in banking and finance. When I came to the United States, I got a job as a medical records clerk for a small clinic in Detroit, Michigan. I left a year later when I became pregnant with my first child. When I was ready to return to work, I got a job in a department store while I continued to look for work in the healthcare field.

Overcoming Setbacks
I was interested in physical therapy, so I enrolled at Wayne State University and took the math and science classes I needed to qualify for the program. After finishing the classes, I found out the program was full and there was a two-year waiting period to get in.

Opening the Next Chapter
I researched other careers and thought of becoming a medical transcriptionist, but I was discouraged by my husband. He said it’s a monotonous job — listening to doctors’ dictation every day. By chance, I saw a short course for medical coding, read the description, and thought I could be good at it. When I finished the course, I was excited to find a job, but was quickly discouraged because all the companies were looking for an experienced coder.

Following the Light at the End of the Tunnel
Then, a temp agency sent me to work for a radiology office in Dearborn, Michigan. The company was willing to teach me, and I was eager to learn. After two weeks of being a temp, I was offered a full-time position in the company.

It took me 15 years before considering certification because I was told the exam was difficult. Experience is not enough anymore; however, nowadays practices want certified coders. With my family’s support and a brave heart, I took the first step: I paid for the exam fee, which sealed the deal. I studied and researched the test for months, and I passed!

I was so happy to receive my Certified Professional Coder (CPC®) credential, after a few months I took and passed the Certified Professional Biller (CPB™) exam, as well. It was a big accomplishment because I am the first to be certified in coding and billing in my office.

Learning and Looking Ahead
Earning my coding and billing credentials made me realize that I still have a lot to learn. The business of healthcare is a never-ending learning process, but I am now more confident and ready for the challenges. As they say, “Bring it on!”

The business of healthcare is a never-ending learning process, but I am now more confident and ready for the challenges.
**ADDED EDGE**

**WHY AAPC IS PASSIONATE ABOUT CODEBOOKS**

*Healthcare Business Monthly* (HBM) recently sat down with AAPC’s publisher, Brad Ericson, MPC, CPC, COSC, to talk about this year’s code changes and their impact on AAPC codebooks.

**HBM:** After last year’s implementation of ICD-10, what’s so important about the upcoming code season?

**Ericson:** There are a lot of changes in store for both ICD-10-CM and ICD-10-PCS, and they’re coming at the same time the one-year grace period offered by the Centers for Medicare & Medicaid Services (CMS) and other payers ends. Come Oct. 1, we’ll be required to report to the greatest specificity and accuracy, facing significantly less latitude, all the while implementing new, changed, and deleted codes. No more NOS [not otherwise specified] codes for us!

**HBM:** Where are the code changes to ICD-10? How about the other code sets?

**Ericson:** Changes are pretty impressive. We’re seeing nearly 2,000 new ICD-10-CM codes for 2017. There are 311 deletions and 425 revisions of existing codes. Many codes, such as the much-used diabetes codes, reflect a new focus on laterality.

There are new and clarified codes throughout the set. You’ll also find new codes for hypertension, hoarding, prediabetes, and paper cuts, to name just a few.

ICD-10-PCS reflects around 3,500 changes; and the Section X addition, released at the last minute, last year, is fully implemented. CPT® 2017 will have more than 700 changes, twice as many as usual. We won’t know about HCPCS Level II changes until around the end of October, when CMS releases the 2017 code set.

**HBM:** What other changes can we expect in AAPC’s codebooks this year?

**Ericson:** AAPC is lucky to be so connected to our members, and our books reflect the best of that relationship. We listen carefully to member suggestions and surveys, and adjust codebooks accordingly to make it easier for colleagues to learn and work.

For example, we heard our pages were too shiny, making them difficult and tiresome to read under fluorescent lights. We hand-picked less reflective, paper for 2017. We also put vertical lines in the Index to Diseases to make it easier to discern indentations.

Inpatient coding students and their instructors, along with Certified Inpatient Coder [CIC™] credential aspirants, asked for more inpatient information in our ICD-10-CM books. We listened and to save coders money, we added the requested information to our existing book, rather than developing a separate hospital ICD-10-CM codebook.

We also corrected minor problems, and added additional information in all the books, thanks to members’ feedback.

**HBM:** What additional information? Can you be more specific?

**Ericson:** For instance, we’ve added MS-DRG [Medicare severity diagnosis-related group] coding information to the ICD-10-CM book, so inpatient coders and those studying for their CIC™ exams can pair MCCs [major complications or comorbidities] and CCs with diagnosis codes.
Chief morbidity exclusion
Limited Coverage

members’ needs.

We’re also adding an appendix to identify Z codes with long-term use of drugs and an icon to denote a Z code as a first-listed diagnosis.

HBM: Tell us about the prices of this year’s AAPC codebooks.

Ericson: Our goal is to keep quality high and prices low. I know from my career that codebook users – be they coders, billers, auditors, or providers – are often low on cash, and any relief is wonderful. It’s a necessary evil that we need to update our resources when codes are revised. Fortunately, members get special discounts as part of their AAPC membership, which helps take the sting out of buying new books every year. It’s yet another reason membership is so worthwhile.

HBM: Are you sincere in your efforts to serve the AAPC community?

Ericson: You bet we are! Back when the 2016 edition was being developed, for example, we set out at the beginning of 2015 to pair the codebooks with our credentialing curriculum. This made it easier for both instructors and students to identify coding conventions in the codebooks. We also replaced CMS’ HCPCS Level II and AMA’s CPT® indexes with more comprehensive, applicable tools.

Our members aren’t afraid to tell us what they need to succeed, be it through surveys, focus groups, or member forums. We also invited members to review draft books and recommend changes.

We’re the only codebook publisher with books developed by AAPC coders, which means AAPC books directly reflect our members’ needs.

HBM: AAPC members develop the books?

Ericson: Yes, an amazing team led by Mary Compton, PhD, CPC; Beth Martin, BS, COC; and Georgia Green, CPC-A, carefully craft the books every year. We also circulate advance copies of the books to members via local chapters for advice. This is significant. Most codebooks are developed and produced by companies more interested in general publishing or health insurance than coding or those who code. AAPC is made up of coders, billers, and other professionals who make the healthcare industry’s revenue stream effective and fair. We recognize the significant role they play in healthcare, and strive to facilitate their success with quality information.

HBM: AAPC started developing its own books just three years ago. What do you expect in the future?

Ericson: We’ll continue to listen and adapt our books to make them invaluable to AAPC members. As a result, the books will continue to evolve as our membership evolves. New codes, regulations, roles, and technologies demand constant change and improvement. Expect codebooks to be different three years down the road. That’s my goal.

Ana Saiz, a Thought Leadership coordinating editor at AAPC.
**Little Relief in 2017**

**IPPS/LTCH PPS Final Rule**

General acute hospitals paid under the Inpatient Prospective Payment System (IPPS) that successfully participate in the hospital Inpatient Quality Reporting Program and are meaningful electronic health record (EHR) users will see an estimated 0.95 percent increase in operating payment rates in 2017. Reflected in this payment update is a 1.5 percentage point reduction for Medicare severity diagnosis-related group (MS-DRG) documentation and coding. The Centers for Medicare & Medicaid Services (CMS) is required by law to recoup $11 billion over a four-year period (2014, 2015, 2016, and 2017). CMS made a -0.8 percent recoupment adjustment to the standardized amount in 2014, 2015, and 2016.

The update also includes an increase of approximately 0.8 percentage points to remove the 0.2 percent adjustment made to offset the estimated costs of the Two Midnight policy in 2014, 2015, 2016, and retrospectively in 2017.

Also factoring into the payment update is the projected hospital market basket update of 2.7 percent, adjusted by -0.3 percentage points for multi-factor productivity and -0.75 percentage points in accordance with the Affordable Care Act.

The final rule also includes provisional changes affecting:

- Medicare uncompensated care payments
- Medicare-dependent Hospital Program and low-volume hospital adjustment
- Notification procedures for outpatients receiving observation services
- Hospital-acquired Condition Reduction Program
- Hospital Readmission Reduction Program
- Medicare and Medicaid EHR Incentive Programs
- Hospital Inpatient Quality Reporting Program
- Hospital Value-based Purchasing Program
- PPS-exempt Cancer Hospital Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting Program
- Long-term Care Hospitals (LTCH)

CMS is updating the LTCH PPS standard payment rate by 1.75 percent for 2017 for LTCHs that successfully participate in the LTCH Quality Reporting Program (LTCH QRP).

This update is based on the most recent estimate of the revised and rebased LTCH PPS market basket of 2.8 percent, adjusted by -0.3 percentage points for multi-factor productivity and -0.75 percentage points in accordance with the Affordable Care Act.

CMS also continues to implement the changes required by The Pathway for SGR Reform Act of 2013. As a result of the continued phase-in of these changes, CMS projects LTCH PPS payments will decrease by 7.1 percent, or approximately $363 million in 2017. Cases qualifying for the higher standard LTCH PPS payment rate under the revised system will see an increase in payments of 0.7 percent in 2017.

In addition, CMS is streamlining its regulations regarding the 25 percent threshold policy, which is a payment adjustment made when the number of cases an LTCH admits from a single hospital exceeds a specified threshold (generally 25 percent).

The American Hospital Association (AHA) is "deeply disappointed that CMS is implementing the long-term care hospital 25% Rule," AHA Executive Vice President Tom Nickels said in a statement. “This arbitrary decision discounts the transformation that the LTCH field is undergoing and has the potential to negatively affect patient access to care.”

Sources:
- IPPS and LTCH PPS Final rule: https://federalregister.gov/a/2016-18476

**PCP Forgoes Insurance Payment for Flat Monthly Patient Fee**

For more than three years, Primary Care Physician Robert Lamberts, MD, has not taken insurance payment from government or private carriers. Instead, he runs a direct primary care (DPC) practice, which charges a flat monthly rate of $35-$65 from patients (rates depend on the patient’s age). The rate includes all care and the practice charges no co-pays.

You may ask how this can be a sustainable way to practice medicine; here’s how Lambert says it is paying off, according to an Aug. 3 Physicians Practice article:

> While this may seem an impossible business model, at 725 patients, we are profitable enough to pay me a “reasonable” salary (one that pays my bills and lets me save some) that is rapidly increasing. My collections this past month were more than $8,000 higher than a year ago, with minimal increase to office overhead.

> Other benefits according to Lambert are “I am happier, my patient satisfaction is very high (with very few patients leaving the practice), and my staff tells me they’d quit before they’d go back to the old type of practice.”

With the DPC model, “Instead of being rewarded for sickness, procedures, and brief office visits, I was rewarded for education, spending time with people, and keeping people healthy (all of which allow me to grow my panel), said Lambert.”

2017
ICD-10-CM & PCS
NOW SHIPPING!

Over 7000 Code Changes
ORDER TODAY!

AAPC
Advancing the Business of Healthcare

800-626-2633
www.aapc.com/medical-coding-books
ELECTIONS
Guarantee the Success of Your Local Chapter
Know the process for electing qualified officers for the coming year.

Each new year brings AAPC local chapters new officers, new goals, and new ideas. Last month we discussed the qualifications for officer nominees. Now comes the exciting part: nominating and electing new officers who will lead your local chapter in 2017. The best way to ensure your chapter is following the correct protocol for running a successful officer election is by consulting the Local Chapter Handbook, Chapter 6 — Elections. Here’s a synopsis.

Nominations and Eligibility
Nominations should be held for the offices of president, vice president, secretary, and treasurer (or secretary/treasurer). Education officer and member development officer are not required positions, but are strongly recommended and encouraged. Nominations must be made at least one month prior to the meeting when elections will take place — September, at the latest.

As we discussed last month, nominees must meet certain qualifications, depending on the office they are seeking. For instance:
- Members must be assigned to the chapter for which they are nominated, and hold the required credentials (if any) for that office.
- A member can only accept the nomination for one officer position (with the exception of the secretary/treasurer combined position).

The Election Process
The vice president facilitates the nomination, election, and balloting processes. This officer works with the president to plan a date for the election, which must be completed by Oct. 31. The vice president’s duties include:

- Ensuring all candidates are eligible to run for office.
- When the election date is set, making sure each chapter member is notified at least 30 days in advance as to when the election will be held. Acceptable means of notification include an AAPC forum posting or an email sent to all of the chapter’s members.
- Printing a list of the chapter members and making it available at the meeting (only current chapter members are eligible to vote in the election).
- Forming and governing an elections committee to organize and conduct the nominations. The committee should be comprised of at least two additional members who are not current officers or running for an office.

If the vice president is running for office, committee members must conduct the voting and ballot process.

Ballots/Voting
Voting must be conducted using a private ballot at a local chapter meeting. Ballots should be created with yes and no choices for members who run unopposed. Members may request an absentee ballot if they are unable to attend the chapter meeting. Absentee ballots must be returned to the officer running the nomination/election process no later than 24 hours in advance of the scheduled election.

On voting day, before the close of the chapter meeting, the elections committee counts all valid ballots (including absentee ballots), verifies the results, and announces the elected officers. Majority rules, and elected officers will fulfill the responsibility of that office for one year.

Unethical actions or mishandling of the election process by any officer or member of the elections committee will be reviewed by the AAPC Chapter Association board of directors and AAPC’s Local Chapter Department. Improprieties may result in the resignation and/or disqualification of all involved.

Election Verification Process
Within 10 days of the election, but no later than Nov. 30, the current vice president will complete the Election Verification Information form on AAPC’s website. When confirmed, the new officers must log in to AAPC’s website and accept the Chapter Officer Agreement.

Instill Confidence in Your New Officers
It can be a overwhelming for the new officers to jump into their new roles without any direction, so current officers should mentor the new officers for the remainder of the year. It’s important for the current officers to demonstrate leadership and provide resources and best practices to the new officers, as well as to help the new officers plan for the upcoming year and review chapter finances. Be there for each other and your chapter will flourish.

Resource

By Holly Brown, CPC, COC, CEMC, CPCO, CCS

Holly Brown, CPC, COC, CEMC, CPCO, CCS, is a coding quality analyst for Optum360, and has worked in medical billing and coding for over 10 years, starting out at the front desk of a multi-physician cardiology practice.

She quickly learned the billing/coding side and transferred to the billing office, where she scrubbed charges and helped to code office visits and procedures. Brown specializes in quality/training and auditing E/M and outpatient services for physicians and hospitals. She helped start the St. Augustine and Orange Park, Fla., local chapters. She is secretary of the AAPC Chapter Association and a Region 4 representative.
Clearwater, Florida, Hits It Out of the Ballpark
Submitted by President Sandi Webb, BA, CPC

The Gulf to Bay Clearwater local chapter scored a grand slam at their June symposium. The baseball-themed symposium was alive with decorations, a standing baseball player/cutout head board for photo opportunities, and the music of the old-time organ rendition of “Take Me Out to the Ball Game” as guests entered the large conference room. Attendee goody bag treats included Cracker Jacks®, an AAPC “Keep Calm and Code On” T-shirt, and other popular items. Sessions weren’t exempt from the baseball theme: “Staying Safe on Base” (compliance issues), “Fun in the Grandstands” (a rousing session of laughter yoga), “First Inning” (the 8 a.m. hierarchical condition category presentation), and more, were all big hits among attendees.

With 120 attendees (thanks to AAPC’s Monica Commins, who blasted the flyer to all Florida chapters) from all over the state and eight speakers, there were a lot of working parts to coordinate. Symposium co-chairs Christine Cornforth (secretary-treasurer) and Sandi Webb (president) said they couldn’t have pulled it off without some pre-game help from the rest of the committee:

- Virginia McKinney
- Education Officer Janet Kemp, CPC-A
- Carla Copp, CPC
- Terry Paulus, CPC, CPB, CEMC
- Rachel Paulus
- Deborah Hair, CPC

The Paulus mother-and-daughter team garnered tons of donated items for the goody bags and most of the raffle items. Clearwater is having a post-game review to start planning for next year, when they go on safari.

Toledo, Ohio, Gets a Workout
Submitted by President Robin Moore, CPC

Toledo’s July chapter meeting was a total change of pace for members. They had a chapter member present on what a sedentary job does to their bodies, and they talked about phone apps, recipes, and things that promote health and wellness. Everyone needs a little reminder, sometimes, on how to take care of themselves.

During the second half of the meeting, members participated in a modified version of cardio drumming. Wow! Stress relief and a great workout. Attendees were given sweat towels with the Toledo chapter logo on it.

Cardio drumming is a fun workout and stress reliever for Toledo.
Career Opportunities Open Up for a Proud Business Professional

One word carried this healthcare business professional through every job to help her continually reach her best.

“What do you want to be when you grow up?”
That was the question I heard at my first interview after I graduated with a bachelor’s degree in Business. I was sitting across from an Ivy-League-educated physician with beautifully hung plaques displaying his accomplishments, and I knew my response needed to come quick and be concise. I had no idea what I wanted to be; so instead of giving him my career goal, I said, “Proud.” He hired me on the spot.

Project Coordinator
My first job was as a departmental project coordinator at a world-class academic medical center. I worked for the vice chairman and he gave me every project that no one else wanted. I loved it. I learned so much from every assignment: how to navigate the system, what was important to successful people, who my friends were, and what I never wanted to do again. Over time, the projects were more visible and I had greater responsibility. It was the best training ground I could have been given.

Billing Manager
My next role was in the billing office at a different academic medical center. I had no idea what billing was or what my daily activities would be, but it was a management role with an actual job description and expectations, and I was excited. The day I walked in and started training I was astounded at the complexity of the revenue cycle. It was like working on a puzzle, every day. I was baffled by how advanced the medicine and patient care was, yet how undeveloped the revenue recovery seemed. That was when my passion to understand and manage a complex system of evolving rules and regulations began.

As a billing manager, I was expected to determine which claims could be adjudicated and which should be sent for bad debt write off; however, I had no idea what the codes on the claims actually meant or if the denial was fair. I sifted through operative reports and denied claims, trying to understand how words became codes. I asked my peers, and they told me about the “coders” who worked downstairs and remotely from home. I quickly became friends with the coder who worked with my accounts, and learned about her training and process. I decided to become a coder, as well.

Revenue Director
After I completed my Certified Professional Coder (CPC®) and Certified Cardiology Coder (CCC™) training, I felt well-qualified to talk with coding, claims, and clinical staff about how their pieces intersected to end in a paid or denied claim. We worked through common issues resulting in denials one by one, and eventually affected revenue enough to garner the attention of senior management in the hospital. Our diligence paid off, and the departments we supported were able to use the additional revenue we were securing to improve the care being delivered to our patients. It was incredibly rewarding.

Eventually, I became revenue director and managed the hospital, professional, and research revenue operations of more than...
$500,000,000. It was complex work that I loved. I would get excited at the end of the month when we posted record revenue on stagnant volume. Each year, costs would increase and the revenue team was expected to compensate. We did so, every time. The coding and billing staff worked hard. Their dedication was second to none, and I made lifelong friendships I cherish.

Field Reimbursement Specialist

Today, I work in the medical device industry. In all the years I worked in the hospital or served as the Boston, Massachusetts, local chapter president, I had never heard of a coder becoming a “field reimbursement specialist.” When I looked for jobs in the industry, I was intrigued to learn more about it.

In the medical device industry, field reimbursement specialists are generally coders who work directly with hospitals and physicians to help them secure reimbursement for their devices. The devices we manufacture are an investment for hospitals, and require a program approach to ensure a revenue return. Field reimbursement specialists reach out to hospital coders to talk through documentation, billing, and coding requirements. We can come to you and work alongside your team, or we can do webinars. Often, we offer continuing education units for coders who participate in our training.

Making the Business Side of Healthcare Better with Pride

Working in field reimbursement has combined all of the experience and skills throughout my career. I can help an administrator start a program for a medical device. I can talk a physician through documentation requirements, I can help coders assign codes based on documentation. And I can help a claims specialist understand a denial. But most of all, I can go home every single day knowing that my role helps physicians deliver world class care to patients in need.

When someone asks me how I ended up in this field known to few, I tell them I based all of my career choices on being proud of my work. 

Stacey Bunk, FABC, is senior manager of reimbursement and healthcare economics at Abiomed. Prior to joining Abiomed, she worked at multiple Partners Healthcare institutions in Boston. Bunk served as a service line director for Lahey Health, an academic medical center in Burlington, Mass. She served as the revenue director of the Corrigan Minehan Heart Center and consultant at The Advisory Board Company with the revenue cycle best practices team. Bunk is a member of the Boston, Mass., local chapter.

Make the Switch to HOSPITAL CODING

CIC & COC

aapc.com/hospital-coding
CLUBFOOT DEFORMITIES
Get a Full Range of Understanding

Clubfoot treatment and coding has come a long way since the ’70s.

Clubfoot (talipes equinovarus) is a common congenital disorder, and one that has affected me personally. To help you better understand clubfoot, I’d like to share my experience and research, and some educational information about the condition.

How Clubfoot Happens

According to the American Academy of Orthopaedic Surgeons (AAOS), approximately one infant in every 1,000 births will have clubfoot, making it one of the more common congenital foot deformities. Boys are twice as likely as girls to have this condition, which can be detected with prenatal ultrasound. Both my son and I were born with clubfoot, but when I was born in the 1970s, treatment was nowhere near as advanced as it is today. Clubfoot can be bilateral, as in my case, or unilateral, as was the case with my son.

Clubfoot occurs during fetus development, when the tendons that connect the leg muscles to the foot bones are shortened, causing the foot to twist inward. The affected leg is slightly shorter and the calf is thinner due to underdeveloped muscles. In my son’s case, his left foot was twisted so severely that his big toe was resting against the inside of his leg. If his clubfoot had not been corrected (as happens in many underdeveloped countries), he would be walking directly on his ankle instead of the sole of his foot.

Two Doctors Research for Advancements in Treatment

The cause of clubfoot is still unknown; however, advancements have been made to pinpoint genetic or environmental factors. Matthew Dobbs, MD, an orthopedic surgeon at St. Louis Children’s Hospital, has been researching and treating clubfoot for many years. Dobbs is convinced there is a genetic link for clubfoot: “Understanding the etiology is the first step toward the development of better...”
Clubfoot

Coding for clubfoot treatment following the Ponsetti and Dobbs methods are as complex as the procedures. The weekly casting procedures, the surgical treatments, and applicable supplies must be coded and billed accordingly.

Procedure Coding

For the weekly casting, report 29450 Application of clubfoot cast with molding or manipulation, long or short leg with modifier RT Right side or modifier LT Left side to indicate laterality. Use modifier 50 Bilateral procedure — or modifiers RT and LT, as the payer desires — if bilateral. Bill this code for each weekly cast change visit. The code has 0 global days; therefore, a modifier shouldn’t be necessary for the subsequent visits. You may also be able to bill for the casting supplies, if applicable, based on your facility (clinic vs. facility) and durable medical equipment (DME) status. An evaluation and management (E/M) service is not usually billable with 29450, except on the first visit.

After the casting procedures, an Achilles tenotomy may be performed. CPT® 27606 Tenotomy, percutaneous, Achilles tendon (separate procedure); general anesthesia is often appropriate if the child is not able to hold still for local anesthetic (27605 Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia). A cast is placed on the foot during the tenotomy procedure, but this is not billable because it’s not a separately identifiable procedure.

More extensive procedures may be necessary if the deformity is severe. Some examples of these are hammertoe correction (28285 Correction, hammertoe (eg, interphalangeal fusion, partial or total phalanectomy)) and osteotomies (code range 28300-28309, depending on the affected bones in the foot).
DME Supply Coding

For the bracing, the following HCPCS Level II supply codes may be used, as prescribed by the physician:

- L1960 Ankle-foot orthosis, posterior solid ankle, plastic, custom fabricated
- L2280 Addition to lower extremity, molded inner boot
- L2300 Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable
- L2768 Orthotic side bar disconnect device, per bar

Billing these codes depends on your facility’s DME status, and if you are billing for the orthotic providers that create the boots and ankle-foot orthosis (AFOs), also known as foot-drop braces. As the child grows, new AFOs and bigger bars will be required and may be billed, accordingly.

Diagnosis Coding

ICD-10-CM coding for clubfoot is tricky. If you look for “clubfoot” in the ICD-10-CM Alphabetic Index, you’ll see Clubfoot (congenital) Q66.89. When you reference the Tabular List, however, Q66.89 describes other specified congenital deformities of the feet. Congenital clubfoot NOS is listed as a synonymous term. If the provider states talipes equinovarus, use Q66.0 Congenital talipes equinovarus. If your providers treat clubfoot regularly, educate them to document “talipes equinovarus” only if that is truly the case, or make sure they select the correct code in the electronic health record.

With proper treatment, many clubfoot cases are completely reversible. Today, the only motion I cannot perform is to squat with my feet on the ground (I must squat on my tiptoes). My son had to have several procedures to correct his foot; and at age 13, he must wear an insert in his shoe. He may need further corrective surgery, and will always have limited motion.

You can find more information about clubfoot by visiting www.miraclefeet.org or www.ponseti.info.

Resources


Lori A. Cox, MBA, CPC, CPMA, CPC-I, CEMC, is coding team leader at MedKoder in Hannibal, Mo. She has more than 15 years of experience in multiple areas of healthcare including auditing and compliance. Cox has been certified since 2002 and is treasurer of the Quincy, Ill./Hannibal, Mo., local chapter. She is the Region 5 AAPC National Advisory Board representative.
Crack specialty coding with the American Medical Association’s 2016 CPT® Coding Essentials series—the perfect companion to your CPT® Professional codebook

Strengthen your knowledge and simplify your research with the new 2016 CPT® Coding Essentials series. This six-book series includes illustrations and plain English descriptions for code selection in a CPT® code-driven format. Each book focuses on CSM reimbursement and medical necessity information.

This is the only specialty series that comes straight from the source of CPT code—the AMA—and exclusively provides the CPT Editorial Panel’s Guidelines instructions on ICD-10-CM documentation and coding.

Each CPT® Coding Essentials title includes CPT code for surgeries, medicine and ancillary services, paired with:

- Illustrations and plain English descriptions of the service represented by the code
- Official, code-specific instructions and parenthetical information from the AMA’s CPT Professional codebook
- ICD-10-CM codes mapped by coding experts
- RVUs, global periods and modifier payment rules
- References to CMS’s Pub 100 and the AMA’s CPT® Assistant newsletter

To learn more, visit amastore.com or call (800) 621.8335.

Series includes:

- CPT® Coding Essentials for Cardiology 2016
- CPT® Coding Essentials for General Surgery & Gastroenterology 2016
- CPT® Coding Essentials for Obstetrics and Gynecology 2016
- CPT® Coding Essentials for Ophthalmology 2016
- CPT® Coding Essentials for Orthopedics: Lower Extremities 2016
Three Things E/M Documentation Usually Lacks

Proper reimbursement hinges on providers telling the whole story of their encounters with patients.

Documentation is key to reimbursement. The more detailed it is, the more likely you’ll receive proper payment for the service it describes. When it comes to evaluation and management services (E/M), every encounter must have a beginning, middle, and end. Unfortunately, providers are not always the best storytellers. That’s where you, the coder, come in.

NO. 1 History of Present Illness (HPI)

The HPI is the beginning of the story: It sets the background for the patient’s presenting problem, from when it started until this encounter. Often, a provider will fail to document specific details to identify the severity, location, or presenting problem. For example, documentation may state “3 month f/u” or “doing well,” without indicating the condition being addressed.

Let’s look at an example note:

*The patient presents today for follow up. Patient seems to be improving and has no new complaints. We’ll plan to see him back in three months.*

This note is missing the specific details that aids in supporting medical necessity of this visit. The only element of HPI we could use is quality for the improvement of the patient.
Educating the provider does not have to be a lengthy process: Simply suggest the provider add a few buzzwords to enhance the note. This information is usually obtained, but often isn’t documented in the permanent record.

Let’s look at the same note with a few additional details:

The patient presents today for follow up on his type 2 diabetes. He has had type 2 diabetes for approx. the past 14 years, which was getting out of control. The patient now keeps a diet and exercise log, in addition to the changes in Lantis we made at the last visit. There is an improvement in his blood sugars that he has been recording at home.

By adding a few pieces of information, the provider has documented a complete HPI, including duration (14 years), severity (type 2 diabetes), modifying factor (Lantis), and quality (improvement in blood sugars).

Like any good story, the HPI must tell the:

- **Who** – the patient identifier;
- **What** – the chief complaint;
- **When** – the duration;
- **Where** – the specific location of the presenting problem;
- **Why** – the modifying factors, timing, or context; and
- **How** – the quality, severity, or signs/symptoms

The point is to find an aid your provider can use to recall and document information that is specific to the presenting problem, as well as supporting the medical necessity of the visit.

Payer rules regarding documentation also factor into the story. For example, here’s a Q&A posted on Wisconsin Physician Services’ (WPS) website:

**Q 20. Can the History of Present Illness (HPI) elements be counted for both the Chief Complaint (CC) and the associated signs/symptoms?** For instance, a patient presents with chest (location) pain (CC) that she has had for 3 days (duration). She also experiences shortness of breath (associated signs/symptoms) when walking up the stairs (context).

WPS responds, “The CC, ROS, and PFSH may be listed as separate elements of history or they may be included in the description of the history of present illness.”

---

**No. 2 Review of Symptoms (ROS)**

The ROS can be obtained from a form the patient completes prior to the visit or a conversation between the provider and patient during the encounter. This ROS often is either excessively documented on every encounter or missing in action.

For example, consider this less-than-ideal ROS:

HPI: The patient has complained of a cough for the past three days. She has tried over-the-counter sinus medication, without relief. There are no other complaints at this time.

ROS: As per HPI

The HPI portion of this documentation includes the duration (three days) and modifying factor (over-the-counter sinus medication), but there is not enough information to support the ROS.

Possible solutions: The provider could mention a review of a completed or updated patient history intake form, or document a more in-depth HPI that includes information to support some of the ROS elements.

Too much information can be just as problematic. A good indication a provider is over-documenting is the inclusion of a complete ROS at each visit, regardless of the time interval. Sometimes, providers mistakenly think an electronic health record (EHR) template that includes the entire ROS must be completed to move to the next field. It’s not appropriate for you to inform the provider that they cannot document a complete ROS. Instead, ask the provider to explain why it’s clinically relevant to obtain a complete ROS in every case. If the provider validates the need, encourage them to include the necessity in the documentation. More likely, the provider will agree that every patient does not warrant a complete ROS at every visit.

**No. 3 Assessment and Plan (A/P)**

The A/P is the “meat and potatoes” of the note. It should explain what was found; what labs, X-rays, or other services might be ordered or performed; and the expected outcome by the next encounter. Often, in an EHR, this field contains the least amount of information. It may be only a list of diagnosis codes without explanation of severity, medication management, or other important details.

If this part of a provider’s documentation is lacking, perhaps they don’t understand the functionality of the EHR. For example, the assessment area should only be used to list the conditions addressed at the current visit. However, a provider may prefer to see all of the
E/M Documentation

patient’s diagnoses or an ongoing problem list in this area when completing their note. As a result, you may see a list of all current and past chronic conditions in the printed version.

An example of the A/P being used inappropriately might look something like this:

Assessment and Plan:
1. Diabetes
2. Hypertension
3. Osteoporosis

This is a list of all diagnoses the patient currently has or has experienced. A problem ensues when there is no documented A/P for all of these conditions between this visit and the next encounter.

An accurate and complete A/P includes all conditions addressed at that encounter, or conditions that could affect the treatment of conditions currently being addressed. An example of an accurate A/P looks like this:

Assessment and Plan:
1. Type 1 Diabetes - no changes in medication at this time. Will check A1C in 3 months prior to next visit.
2. Hypertension - stable on Triamterene 37.5 mg, with no changes in dosage.
3. Osteoporosis
4. S/P CABG 2008
5. Migraines - followed by Dr. Smith; current medications are not affecting hypertension.
6. Gout

Conditions 3, 4, and 6 are removed because they are historical information and not currently addressed conditions. Condition 5 is elaborated on to indicate another provider is following it, and that the medication does not have an effect on chronic conditions being treated at this encounter.

The American Academy of Family Physicians offers guidance for when the diagnosis list does not match the order of the submitted diagnosis codes:

Q: Does the order in which diagnoses are listed on the claim matter? Must the order on the encounter form (documentation) match the order on the claim?

Yes, the order does matter. The physician should list on the encounter form the diagnosis (ICD-9) code that is associated with the main reason for the visit. This is the primary diagnosis, and in most cases it should be listed first on the claim form, followed by codes that describe any coexisting conditions that affect patient care, treatment or management. Each diagnosis code should be linked to the service (CPT®) code to which it relates; this helps to establish medical necessity. Any changes to codes or to the order in which they are listed on the claim should be approved by the physician. In some cases, the ICD-9 guidelines may require that certain codes be reordered. For example, the physician may list an ulcer of the ankle first, followed by a related condition such as diabetes. However, because ICD-9 instructs to “Code, if applicable, any causal condition first,” the code for diabetes with other specified manifestations, 250.8X, might need to be listed first, followed by 707.13 for the ulcer.

The same rules hold true for ICD-10: The reason for the visit should be the primary diagnosis, followed by codes for coexisting conditions affecting the care of the patient.

Communication

The way providers are paid for their services is gradually changing to a performance-based system, in which documentation is the lifeblood for accurate claims payment. You must inform your providers of any inadequacies in their documentation, but how you communicate this information to them is also important.

- **Respect their time; state information concisely.** Ask the provider when it would be a good time to talk, and use less time than scheduled. For example, schedule a 15-minute meeting and finish in 10 minutes. This allows the provider five minutes of down time before their next task.

- **Always use facts.** Refer to official source documents and final rules to support your request and methods for documentation improvement.

- **Explain both rewards and risks.** 2017 is the proposed start date for the performance period that will determine eligible clinicians’ Merit-based Incentive Payment (MIPS) adjustments in 2019. It will be too late to improve documentation after composite performance scores have been established.

Early education and consistent communication will help to ensure providers are meeting documentation requirements and, ultimately, fully compensated for the care they provide.

---

**Brenda Edwards, CPC, CPB, CPMA, CPC-I, CEMC, CRC** has over 25 years’ experience and is a senior managing consultant of risk adjustment at Medical Revenue Solutions. Her experience includes chart auditing, coding and compliance education, and writing articles for coding publications. Edwards is an AAPC ICD-10-CM/PCS training expert, and an AAPC workshop presenter. She is a frequent speaker for local chapters and AAPC conferences. She served on the AAPC Chapter Association board of directors from 2010-2014 and held office as chair.

---

**Resources**


NASHVILLE
Gaylord Opryland Resort
TENNESSEE

INTERVENTIONAL RADIOLGY
CARDIOLOGY
VASCULAR SURGERY
CODING SEMINAR WITH ICD-10

JOIN US IN
NASHVILLE, TN
SEPT. 19-23TH
GAYLORD OPRYLAND RESORT

“Great Seminar! Better than I even had thought it would be. Confirmed and clarified so much!” -- Lisa Entrekin, CCS, RCVT
“This is my first Dr. Z seminar -- I am very impressed and look forward to attending another!” -- Paula Thorpe, Clinical Data Specialist

ZHealth PUBLISHING
WWW.ZHEALTHPUBLISHING.COM
The American Academy of Orthopaedic Surgeons (AAOS) has campaigned to reverse National Correct Coding Initiative (NCCI) bundling edits affecting shoulder arthroscopy procedures. Their efforts have been successful — although, possibly with a catch.

Status Indicators Change, Guidelines Don’t

Effective July 1, 2016, NCCI no longer bundles CPT® code 29823 Arthroscopy, shoulder, surgical; debridement, extensive with 29828 Arthroscopy, shoulder, surgical; biceps tenodesis; 29827 Arthroscopy, shoulder, surgical; with rotator cuff repair; or 29824 Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure). That means a modifier is no longer needed when reporting these code pairs during the same operative session. Note, however, that this change affects only the modifier status indicator, not the guidelines in the 2016 NCCI Policy Manual for Medicare Services.

Chapter 4 guidelines continue to specify, “With the exception of the knee joint, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter.” By this logic, arthroscopic debridement of the shoulder (29823) is included in all other shoulder arthroscopy codes. Based on the Chapter 4 guidelines, you (still) should not report 29823 with 29828, 29827, or 29824 to Medicare. Many private payers also follow NCCI edits and guidelines. Reference your contracts for their stance. Until the NCCI guidelines are changed, your payer may not reimburse 29823 with a biceps tenodesis (29828), rotator cuff repair (29827), or Mumford procedure (29824). NCCI guidelines are not updated unless requested, and revisions normally take place by Dec. 1, effective the following year. Hopefully, AAOS will contact the Centers for Medicare & Medicaid Services (CMS) and request a change in the guidelines, prior to the deadline.

Even though the modifier status indicator has changed for these code pairs, keep an eye on your explanation of benefits (EOBs). If you find that payers continue to deny claims for 29823 with 29824, 29827, or 29828, you may want to appeal, citing the NCCI status indicator effective July 1, 2016. Be prepared for a rebuttal if the payer, in turn, cites the contradictory NCCI guidelines.

Capsulorrhaphy and More Still Subject to Bundling Edits

NCCI edits continue to bundle 29806 Arthroscopy, shoulder, surgical; capsulorrhaphy and 29827, which has caused difficulty when seeking legitimate reimbursement for these procedures when performed during the same operative session. NCCI also continues to bundle 23472 Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder)) and 23430 Tenodesis of long tendon of biceps, in spite of AAOS assertions that the two procedures are not bundled, as stated in Orthopaedic Code-X 2016 and the Complete Global Service Data for Orthopaedic Surgery – 2016.

For Medicare patients — and any other patients covered under federally-funded healthcare programs, such as Medicaid, federal
Shoulder Arthroscopy

Be prepared for a rebuttal if the payer, in turn, cites the contradictory NCCI guidelines.

BlueCross® BlueShield®, CHAMPVA, TRICARE®, and any other healthcare program provided to federal employees — code combinations 29806/29827 and 23472/23430 will be denied.

If the surgeon performs capsulorrhaphy (29806) and a Mumford (29824) with extensive debridement of the rotator cuff repair and chondroplasty (29823), remember that NCCI bundles 29823 with 29806. NCCI Chapter 4 guidelines state the shoulder is a single anatomic location, and instruct not to use a modifier to unbundle arthroscopic procedures performed on the same shoulder. The modifier status indicator changes pertain only to those cases when the surgeon performs 29827 with 29823; 29824 with 29823; or 29828 with 29823. Other code combinations involving 29823 may still trigger bundling edits.
RADV Reality
Coding expertise is a must for RADV audits, which are becoming a yearly part of most insurers’ workflows.

The Centers for Medicare & Medicaid Services (CMS) intends to significantly increase risk adjustment data validation (RADV) audits, including yearly audits for both Medicare and small group/individual commercial insurance, as required by the Affordable Care Act (ACA).

Risk Adjustment Primer
Risk adjustment is predictive modeling that assesses members’ risk for incurring medical expenses above or below the average during a defined time. Demographics and health status are used to determine health plan payments, which can also assist with care management needs. Diagnoses are collected and their specificity drives risk categorization, called hierarchical condition categories (HCCs). Sicker patients have higher risk scores than healthier patients, which assists with financial forecasting of medical expense and other financial implications. HCCs must be captured annually. Risk adjustment resets every Jan. 1.

CMS provides risk-adjusted premium revenue to Medicare Advantage (MA) insurers based on HCCs, which makes it critical to capture and report diagnoses at their highest specificity level. It’s even more critical for documentation to substantiate the diagnoses. This revenue is intended to cover costs to Medicare members: if it’s not accurately captured, the result is higher out-of-pocket expenses for the patient population.

Why RADV Audits?
The RADV audit is intended to verify the diagnosis codes submitted for payment through medical record documentation. This ensures risk-adjusted payment integrity and accuracy.

In RADV audits, CMS selects 30 plan contracts and audits 201 members each to validate the diagnosis-driven HCCs submitted during the year. MA plans must obtain the requested medical records and submit proof that supports the reported HCCs for which CMS provided a premium.

The records also must meet certain formatting criteria, including patient name and date of birth on each page, and specific provider signature guidelines. This can be a challenge because the 201 members could comprise more than 500 HCCs, which means retrieving and reviewing over 1,000 records in a 16-week period. The records that best represent the HCCs are submitted to CMS via the Centralized Data Abstraction Tool (CDAT). CMS then provides a pass/fail for each HCC. Insurers can appeal a disagreement.

The payment error calculation begins by dividing the MA plans’ members into three strata based on risk scores, sampling 67 members from each of the 201-member samples. After CMS reviews the records, failed HCCs result in an extrapolated recovery for all members in the relevant stratum. This can result in extraordinary penalties for the plan. The blame falls on the plan’s provider network’s coding practices. For example, a common coding error is active vs. history of cancer. If a patient had cancer, most clinicians will always view them as a cancer patient, even if they are in remission with no evidence of disease and no active treatment. This conflicts with the coding world, where this scenario would result in an appropriate history of cancer diagnosis. In a RADV, an insurer could have to repay several million dollars based on the extrapolation logic relative to the number of enrollees.

For example, prostate cancer has a high likelihood for a RADV failure. Below is a fictitious example of liability for a relatively small insurer:

- Incorrect diagnosis billed: C61 Malignant neoplasm of prostate
- Correct diagnosis: Z85.46 Personal history of malignant neoplasm of prostate

CMS payment based on HCC 12: Breast, prostate, colorectal, and other cancers
- Yearly payment per member: $1,100
Managing a RADV Audit

Managing a RADV audit takes preparation, resources, and coding knowledge to execute within the 16-week timeframe. This is particularly difficult for capacity planning because it’s unknown if a plan will be selected. If the plan is selected, mobilizing resources is a challenge due to the temporary duration of the project and competing priorities. The activities may be broken down into four phases: the preparation phase, the operational phase, the submission phase, and the post RADV activity phase.

The preparation phase includes:
- Organizing all written materials
- Ensuring internal resources are actively engaged
- Vetting and contracting third-party vendors

The operational phase includes:
- Claim analysis
- Provider network outreach
- Medical record retrieval and review
- Managing vendors
- Following up with any provider issues

The submission phase includes:
- Selecting the best medical records to support the diagnoses
- Converting all applicable records to the correct format
- Naming the records in accordance with CMS guidance
- Submitting the records through the CDAT application

The post RADV activity phase is important because the appeal process can potentially overturn any failures. An after-action review may benefit future audits, and the medical record review results may be used for provider education purposes.

Table A represents the high-level RADV activities, and recommendations for how they fit within the timeline of the project. CMS has only completed three RADV audits, so far, for a limited number of insurers. This process is moving to an annual process for all plans. In January 2016, CMS issued a Request for Information, advising of their intent to audit every MA plan yearly. This would be conducted in either a traditional RADV format, or using recovery auditors to audit targeted HCCs.

The ACA requires yearly RADV audits on commercial lines of business beginning in the summer of 2016. Insurers and providers must be diligent to ensure correct documentation and coding, focusing on common errors such as active versus history of cancer and acute condition billing in the office setting. The RADV reality is here, and audits will imminently be a yearly part of most insurers’ workflows. The good news for AAPC members is that this process has definitely created an increased demand for diagnosis coding talent.

Tom Nasadoski, MBA, is manager of risk adjustment at Capital District Physicians’ Health Plan.
Get a personal perspective on consumer-driven healthcare, technology, procedures, outcomes, and partnerships.
Many years of weekend athletics, hiking New Hampshire’s White Mountains, and three meniscus repairs left my right knee without cartilage. Standard conservative treatments — including nonsteroidal anti-inflammatory drugs (NSAIDS), hyaluronan injections, steroid injections, and physical therapy (PT) — proved ineffective, over time. I assumed I had to live with the pain and dysfunction because I was too young for a knee replacement. But as a good consumer of healthcare, I researched total knee arthroplasty (TKA) and learned that technology had advanced to the point of having developed custom joints. I spoke with my surgeon, David Thut, MD, about my research of ConforMIS, one of many manufacturers of custom joint prosthetics.

Custom Joint Replacements
Mean Better Options, Outcomes

One complaint about standard knee prosthetics, particularly for women, is that they are often unable to replicate the shape, size, and contours necessary for a comfortable fit. This is where advancing technology plays a role.

Two months prior to my surgery, I was sent for a computed tomography (CT) scan of both knees from mid-shin to thigh. ConforMIS used computer-aided design (CAD) to transform the CT image into a custom knee joint. Based on patient-specific measurements, including any underlying joint deformity, ConforMIS created both a custom prosthetic and, using 3-D printer technology, custom surgical tools to assist the surgeon with the implantation. The custom prosthesis was delivered to the hospital within days of the surgery.

Because this is a new technology, ConforMIS provides a great deal of surgeon support. According to Director of Provider Relations Amy Connors at ConforMIS, all surgeons who opt to perform TKAs using ConforMIS products can receive an intensive onboarding program including real-time training in a cadaver lab, video instruction, and peer-to-peer support. This research made me comfortable about my choice.

Patients also are provided education to help them understand the challenges they’ll encounter as they go through surgery, the post-operative course, and PT. I attended “Joint Camp,” where I met an operating room nurse, members of the recovery team, a physical therapist, an occupational therapist, and members of the integrative medicine group. I was introduced to pre-surgical planning ideas that included information on relaxation techniques and “pre-hab” PT, and listened to a presentation on what I could expect during my hospital stay. I was advised to visit my primary care physician (PCP) for a pre-operative examination. Following the guidelines of patient-centered care and cost-containment, there were no pre-disposing factors present that would warrant other tests. After a comprehensive physical exam, I was cleared for surgery.

Surgery and the Road to Recovery

During TKA surgery, diseased portions of the knee joint are removed, and the remainder of the joint is reshaped to fit the knee prosthesis. A 5- to 10-inch incision (depending on the patient’s body habitus) is made along the front of the knee, which allows access to the joint and permits the surgeon to move the patella away from the surgical area. Using the custom guides and instruments, the surgeon fits and cuts the distal femur to accommodate the femoral component of the prosthesis. The surgeon removes damaged bones and cartilage from the tibia, and again uses custom guides and instruments to fit the tibial component of the knee prosthesis to the bone. The anterior
cruciate ligament (ACL) and the medial and lateral meniscus are removed, as well. Both components are set in place with bone cement, and holes are drilled for pins according to the custom instrumentation to ensure accurate placement.

The patella is brought back into position and adjusted to fit over the prosthetic joint. Frequently, a plastic component is added to return the patella to its normal position. The surgeon bends and flexes the knee to make sure range of motion and patella balance are satisfactory, and may make adjustments prior to cementing the prosthetic components. The incision is closed with subcutaneous stitches and covered with a two-part skin closure system that provides a skin adhesive covered with a self-adhesive mesh for excellent skin approximation and healing, eliminating the use of staples.

Anesthesia includes a regional and spinal block, and post-operative pain medication.

My surgery took just over an hour, and recovery was uneventful. TKA patients are expected to get up within 12-18 hours following their surgery. I had to demonstrate to the physical therapist I was able to navigate stairs, get into and out of an automobile, and walk unassisted for several hundred feet before I was able to go home on the second day.

I used a walker the first day post-surgery, but by the second day I was more comfortable using crutches. Pain is managed by opiates, which may be a challenge for patients who have difficulty tolerating the side effects. Ibuprofen, naprosyn, and acetaminophen may also be used, and aspirin is used as a deep venous thrombosis (DVT) prophylaxis. Ice is encouraged, and PT continues at home for as long as the patient is homebound (which, for me, was one week).

I continued PT on an outpatient basis, and was able to walk independently on day four and drive after three weeks. To produce the best post-operative outcomes, physical therapists focus on three goals:

- Range of motion, including complete straightening of affected leg and eventual bending to at least 120 degrees or more;
- Quadriceps and hamstring strengthening to support proper body mechanics as patients relearn to walk; and
- Tissue massage to relieve muscle pain, scar adhesions, and neurological symptoms related to surgical nerve damage.

Each patient is different, and goals are set to ensure that the postsurgical results meet the pre-surgical expectations.

Capturing Reimbursement for TKA

The use of a custom prosthetic does not affect coding. The proper code for the surgery is 27447 Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty). Physician reimbursement for this procedure, per the Centers for Medicare & Medicaid Services (CMS), is approximately $1,400 (national average).

Diagnosis related group (DRG) 470 reports a major joint replacement of lower extremity without a major complication or co-morbidity. Reimbursement for northeast hospitals (per 2016 Inpatient Prospective Payment System (IPPS)) is approximately $30,000, based on the typical two-day length of stay with no post-operative complications.

ICD-10-PCS codes are based on root operation, approach, laterality, and whether cement was used. In my case 0SRC0J9 Replacement of right knee joint with synthetic substitute, cemented, open approach is the appropriate code.

Diagnosis coding in ICD-10-CM now reports laterality: M17.11 Unilateral primary osteoarthritis, right knee. Facility claims are submitted with additional diagnostic information: any chronic conditions that might affect surgery or the hospital stay, such as long-term use of certain medications, chronic conditions (as evidenced by current treatment), family history of coagulation defects, and any condition that is present on admission.

Healthcare Payments Are Evolving to Contain Costs

This is not an inexpensive surgery, and there are no guarantees that patients will recover to their best pre-surgical status; however, steps
are being taken to both reduce costs and improve outcomes in all areas of patient care.

An innovative CMS initiative called Bundled Payments for Care Improvement (BPCI) is changing the way hospitals look at patient care, from the acute phase to recovery and throughout the global period. Hospital payment, called the Net Payment Reconciliation Amount (NPRA), is calculated based on a particular target price that considers the DRG times the number of episodes of care, with further payment adjustments based on fee-for-service (FFS) payments, readmissions, and other factors. If providing the bundled services with expenses running over this NPRA amount, the hospital will owe CMS. If the hospital comes in under this amount, there is an additional chance for goal sharing, as well as the payment. The point of Bundled Payments for Care Improvement is not payment reform, but to improve care planning with the goal to achieve positive financial results without compromising patient outcomes. Commercial payers have not adopted this program and are reimbursing hospitals on either an FFS or a DRG basis.
Physicians continue to be reimbursed on an FFS model, and share no financial risk in this program. Because a patient’s surgical stay and post-operative results influence the ability for hospitals to take advantage of the bundled payment initiative, they are looking for ways to improve the patient’s pre-operative health status.

Both Wentworth-Douglass Hospital (WDH) in Dover, New Hampshire, and ConforMIS are concerned about patient outcomes, and they have identified that patient education and perception is linked to excellent recovery. Along those lines, Executive Director, Marketing Communications and Public Relations, Beth Best at ConforMIS is developing a Patient Advocacy Program to assist potential and current joint replacement patients by putting them in contact with successful post-surgical individuals. By sharing experiences, Best hopes that patients will be able to make informed decisions to assist their surgical experience and recovery.

**Patient Compliance Can Play a Larger Role**

Hospitals are increasingly experiencing pre-certification denials from commercial payers who do not want to take on the risk of approving procedures such as joint replacements for co-morbid patients, for which they have historical claims data.

Physicians are reimbursed on an FFS model, and share no financial risk in this program. Because a patient’s surgical stay and post-operative results influence the ability for hospitals to take advantage of the bundled payment initiative, they are looking for ways to improve the patient’s pre-operative health status.

Hospitals are increasingly experiencing pre-certification denials from commercial payers who do not want to take on the risk of approving procedures such as joint replacements for co-morbid patients, for which they have historical claims data.

Bundling the surgical package and pre-operative risk screening and mitigation are key to ensuring an optimal outcome. WDH has developed a comprehensive program that focuses on orthopedic patients and includes nutritional counseling, smoking cessation, and pre- and post-surgical rehabilitation. The program is designed to improve patient compliance and reduce surgical risk.

**Resources**

- National Center for Policy Analysis: [www.ncpa.org](http://www.ncpa.org)
- IPPS: [www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html)
AAPC VIRTUAL WORKSHOPS NOW AVAILABLE!

Any Time, Any Where

FEATURES

- Skill-building practice
- On-demand recordings
- Authored by experts

- Up to 6 CEUs
- Interactive exercises
- Case studies

800-626-2633
aapc.com/workshops
The importance of accurate, specific, detailed documentation in the medical record is essential, yet educating providers on how to achieve it is not always easy. To improve outcomes, it helps to see documenting and coding from a provider’s perspective. This requires understanding:

- The importance of physician documentation on accurate and precise ICD-10-CM coding
- Specific verbiage physicians need to use in documentation
- Why improved clinical documentation facilitates quality care and appropriate reimbursement
- The relationship between accurate and precise documentation, ICD-10 codes, risk adjustment, and the Five-Star Quality Rating System

Speak the Provider’s Language

As a Certified Professional Coder (CPC®) and a physician, I understand both points of view. I’ve found that approaching documentation from a clinical perspective is helpful in teaching doctors the kind of verbiage and detail necessary to support their diagnoses. Emphasizing key diagnostic terms for providers to integrate into their progress notes makes sense to them. And demonstrating how they can expand their thinking during a patient evaluation to include more specific terminology is helpful.

When you begin the documentation improvement educational process:

- Understand resistance to change (e.g., busy schedule, inadequate sleep, frustration with the electronic health record (EHR) etc.)
- Ask for providers’ input, and identify leadership who can support your efforts
- Establish a relationship of mutual respect
- Quantify potential financial and quality care incentives
- Be sure educational programs work with providers’ busy schedules
- Offer support, and make sure providers can access it

To cite an example, doctors may feel overwhelmed when first introduced to the increased number of rheumatoid arthritis codes in ICD-10-CM. But among the five pages of ICD-10-CM codes for “Rheumatoid arthritis with rheumatoid factor,” only four relevant points need to be documented to generate a very specific 5- to 6-character code. These are details a physician would likely be thinking about at the time of assessment. In other words, even though there are a lot more codes to choose from, providers simply must know which details they are already considering to document.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M05</td>
<td>Rheumatoid arthritis with rheumatoid factor</td>
</tr>
<tr>
<td>M05.0</td>
<td>Felty’s syndrome</td>
</tr>
<tr>
<td>M05.1</td>
<td>Rheumatoid lung disease with rheumatoid arthritis</td>
</tr>
<tr>
<td>M05.2</td>
<td>Rheumatoid vasculitis with rheumatoid arthritis</td>
</tr>
<tr>
<td>M05.3</td>
<td>Rheumatoid heart disease with rheumatoid arthritis</td>
</tr>
<tr>
<td>M05.4</td>
<td>Rheumatoid myopathy with rheumatoid arthritis</td>
</tr>
<tr>
<td>M05.5</td>
<td>Rheumatoid polyneuropathy with rheumatoid arthritis</td>
</tr>
<tr>
<td>M05.6</td>
<td>Rheumatoid arthritis with involvement of other organs and systems</td>
</tr>
<tr>
<td>M05.7</td>
<td>Rheumatoid arthritis with rheumatoid factor without other organ or systems involvement</td>
</tr>
<tr>
<td>M05.8</td>
<td>Other RA with RF</td>
</tr>
<tr>
<td>M05.9</td>
<td>RA with RF unspecified</td>
</tr>
</tbody>
</table>

The four key diagnostic terms required to generate a specific and accurate code are:

1. **With rheumatoid factor:** When diagnosing rheumatoid arthritis (RA), “with rheumatoid factor” (versus without) is the first distinguishing and relevant piece of information that needs to be documented.

2. **With rheumatoid complications or without:** The ICD-10-CM requests a 4th character. The second key point that needs to be documented is whether there are associated rheumatoid complications (i.e., **Felty’s syndrome**, rheumatoid **lung disease** with RA, rheumatoid vasculitis with RA, etc.), or the 4th character 7 may be used for “RF **without other organ or systems involvement.”**
3. **Joint involvement:** A 5th character is required to specify which joints are involved. Involvement of the shoulder, elbow, wrist, hand, etc., must be documented, although the 5th character 9 can be used for “multiple sites.” (This is not the same as using 9 in the 4th character for “unspecified.”) Advise providers to avoid unspecified codes whenever possible.

4. **Laterality:** The affected side should be documented, if relevant, with a 6th character for right and/or left (but no code for bilateral, in this instance).

Invite physicians to look in an ICD-10 codebook for the 50 most common diagnoses they treat. Becoming acquainted with the necessary verbiage — rather than relying exclusively on lengthy and potentially truncated drop-down menus in an EHR — will yield more coding and diagnostic accuracy.

### Teach the Basics

When educating providers, don’t assume they understand coding, risk adjustment, hierarchical category conditions (HCCs), or the Five-Star Quality Rating System. Explain what a “family” of codes means; that codes may vary from three to seven characters; and that the length of a code may vary, even within the same family.

For example, within the E11 **Type 2 diabetes mellitus code family,** E11.3 **Type 2 diabetes mellitus with ophthalmic complications** requires either five characters (for diabetic cataract or with “other diabetic ophthalmic complication” — use an additional code to identify complication) or six characters (for retinopathies with or without macular edema). Encourage providers to refer to specialists’ consultation reports for specific diagnoses, and to update medical records accordingly.

Providers appreciate consolidated training: Consider educating them to expand their clinical thinking at the time of evaluation to include improved documentation and any necessary actions for ICD-10, risk adjustment, and Five-Star Quality Rating measures.

### Document Type of Diabetes (HCC) - first three characters

- **Type 1** – E10._ _ _
- **Type 2** – E11._ _ _

Use additional code to identify insulin use (long term) (current) Z79.4

**Due to underlying condition** – E08._ _ _
  
  e.g., Cushing’s; pancreatitis (chronic is HCC)

**Drug or chemical induced** – E09._ _ _
  
  e.g., Steroids

**Other specified diabetes mellitus** – E13._ _ _
  
  e.g., Due to genetic defects; status (post) pancreatectomy

### Document Complications and Specifics – 4th - 6th characters

**Type of DM: E08 to E13**

**Complications** of each type of DM: E08._ to E13._ (4th digit)

**Specifics of each complication** of each type of DM:

E08._ _ to E13._ _ (to 5th digit)

More detail about specifics of each complication:

E08._ _ _ to E13._ _ _ (to 6th digit)

### Tip: Target Problem Diagnoses

Make a list of diagnoses that would benefit from documentation improvement in your practice. Typical conditions might include:

- Diabetes type 2
- Major depression
- Cancer
- Alcohol and substance abuse
- Morbid obesity
- Malnutrition
- Chronic obstructive pulmonary disease
- Rheumatoid arthritis

Code to the 7th character for:
- Episode/encounter – for injuries, fractures
- Fetal number, for obstetrics
- A-initial encounter/active treatment, D-subsequent, and S- sequela (“late effects” in ICD-9-CM)

Orthopedics uses more letters for encounters: e.g., G-complication (delayed healing of fracture), if using Gustilo classification, may use A-H, J, K, M, N, P-S.
ICD-10 Documentation, HCCs, and Star Ratings Measures

When providers document diagnoses to the highest level of specificity and capture all appropriate HCCs, there will be more Star Ratings measures to fulfill (e.g., type 2 diabetes mellitus, rheumatoid arthritis).

For example, testing HgbA1C (screen for control of blood sugar) is a Star Ratings measure. If diabetes is diagnosed, there is additional testing necessary to comply with quality guidelines.

• **ABI/Flochec** (screen for diabetic peripheral angiopathies)
• **NCV/monofilament screening** for diabetic peripheral neuropathy
• **Ophthalmologic exam** every two years (One year if there is an abnormal finding. Update the medical record to include the diagnosed ophthalmic complication.)
• **Urine microalbumin/Cr ratio** (screen for nephropathy/chronic kidney disease (CKD))
• **eGFR and serum Cr** (screen for CKD)
• **PTH if eGFR <60** (screen for hyperparathyroidism)
• **Check Vit. D if PTH abnormal** (screen for Vitamin D deficiency)

Screening tests may reveal diabetic complications. Updating physician documentation accordingly will result in an accurate ICD-10 combination code assignment and risk adjustment. This is an opportunity to educate physicians about the use of relevant combination codes and “use additional code.”

**An Example of Combination Codes and HCCs:**

- E11.21 **Type 2 diabetes mellitus with diabetic nephropathy**
- E11.22 **Type 2 diabetes mellitus with diabetic chronic kidney disease and use addition code to identify stage of chronic kidney disease (N18.1-N18.6)**

Stage 4, stage 5, and end-stage renal disease (N18.4-N18.6) also risk adjusts (HCC)

- Use additional code to identify dialysis status (Z99.2)
- E11.29 **Type 2 DM with other diabetic kidney complication e.g., Type 2 DM with renal tubular degeneration**

---

**SADSS: Provider Documentation Essentials**

When improving your documentation of the patient encounter, ask yourself:

**S:** Can I be more specific?

**A:** Acuity/Chronicity

Document if the problem is:

- Acute? Chronic? Acute on chronic?
- Past medical history (PMH) vs. active and under treatment?
- Affecting the care of current condition?
- Why is the patient on medications?

**D:** Is the diagnosis due to a coexisting/comorbid condition?

- Document the cause and effect/combination codes in ICD-10.

**S:** Does the medical record support the diagnosis?

- History
- Physical findings
- Assessment
- Treatment plan
- Medication
- Current year? HCC-risk adjustment
- Update the EHR

It’s not sufficient to code a more specific diagnosis without chart documentation to back it up.

**S:** Are there quality measures to address for the Star Ratings?

**Weighted x 1:**
- Breast/colorectal screening
- Annual flu shot

Assess:

- Physical activity
- Body mass index (BMI)

**Weighted x 1.5:**
- Patient reported outcomes
- Patient satisfaction

**Currently weighted x 3:**

- Review high risk meds:
  - Consider adjustment? Elimination? Substitution?
  - Document diagnosis, treatment plan, and justification
  - Document drug or alcohol dependency – HCCs
  - e.g., opiates, sedative, hypnotics
  - Beers criteria for potentially inappropriate medication use (Reference: American Geriatrics Society)

**Weighted x 3:**

- Medication compliance - diabetes/HTN/statins
- Control - blood sugar/blood pressure
- Improving or maintaining - mental and physical health
- Plan - for all readmission causes

- Educate providers on actionable measures and support their efforts in helping patients realize these goals.
- Explain to providers the importance of their maintaining a four- or, optimally, 5-star rating.
- Prepare providers for the Centers for Medicare & Medicaid Services (CMS) continually raising the bar.
- Help providers understand that inadequate ratings will jeopardize contracts and their standing within the community.
When educating providers, don’t assume they understand coding, risk adjustment, hierarchical category conditions (HCCs), or the Five-Star Quality Rating System.

Support Your Physicians
To help promote positive reinforcement for providers:
1. Respect and acknowledge the actions they take and the results they receive.
2. Share data with them often.
3. Competition: Compare your physician with self, peers, and ratings.
4. Let them know the financial incentives of quality documentation.
5. Emphasize quality because providers want to do a good job.
6. Support them.

Be Sure the EHR Supports the Diagnosis
Here are some things to look out for in the EHR:
• The patient problem list and PMH are often extensive and automatically regenerated in a new progress note
• Many listed diagnoses are not addressed on the date of service, and may appear to be PMH
• Providers should document any active conditions assessed at the time of service, at least once per year for HCCs
• Medical record should be updated with additional or more-specific diagnoses from the emergency room, inpatient, specialist, test results, or other provider visits since the last date of service

Providers should document the associated diagnoses or conditions that exist at time of the visit that require or affect patient care or treatment, decision-making, or management. Consider:
• All acute and chronic medical conditions
• Complications
• Manifestations
• Mental, behavioral, neurologic, or congenital disorders
• Obstetric, dermatologic, musculoskeletal diagnoses
• Injuries or poisonings
• Substance abuse
• Infections
• Signs and symptoms (if the primary diagnosis is not known)

Familiarize providers with the following ICD-10 verbiage:
• Additional characters required
• Code first underlying disease
• Includes/excludes
• With/Without (e.g., gangrene)
• Mild, moderate, severe (e.g., malnutrition)
• Single episode, recurrent (e.g., major depression)
• Temporality (e.g., old myocardial infarction, now > four weeks)
• Placeholder X use
• Anatomic location
• Accurate and detailed descriptions include location, size, depth, right/left (e.g., L97.412 Non-pressure chronic ulcer of right heel with fat layer exposed (If due to type 2 diabetes mellitus, code first E11.621 Type 2 diabetes mellitus with foot ulcer, for example.)

Using a clinical approach for documentation improvement education will help doctors understand and accept the necessity for increased specificity. Physician-to-provider education is optimal, but if this is unavailable, recruit physician leaders to support your educational efforts. Share information often and be accessible to offer support. Reward actions and positive outcomes.

Marian J. Wymore, MD, CPC, is a board certified family physician with 20 years clinical experience in outpatient and inpatient medicine for patients of all ages. She has been involved in medical group and hospital leadership, utilization management, quality assurance, and managed care program development. Wymore educates providers on how to improve clinical documentation, including ICD-10-CM, HCCs, and the Star Ratings Program. Wymore is a member of the Culver City, Calif., local chapter. She can be reached at marianwymore@gmail.com.
S


 Oxford is National Ovarian Cancer Awareness month — a perfect time to learn more about this devastating disease.

Ovarian cancer ranks fifth in cancer deaths among women, and is the deadliest of the gynecologic cancers, with a five-year survival rate of 46 percent. Because of the location of the ovaries in the body, most ovarian cancers are not diagnosed until the late stages. When diagnosed in the early stages, the percentage of survival is much higher, at 91.2 percent. A woman's lifetime risk for developing ovarian cancer is 1 in 75, and approximately 22,000 new cases will be diagnosed, this year. It's important to understand the signs and symptoms of this silent killer.

Ovarian cancer can be hard to detect in the early stages, which is when only approximately 19 percent of diagnoses happen. Most signs and symptoms do not happen until the disease has progressed and tumors have begun to push on the bladder and/or fluid has begun to accumulate in the abdomen. Symptoms of ovarian cancer that may help to detect early stages of the disease include:

- Bloating
- Pelvic or abdominal pain
- Trouble eating or feeling full quickly
- Feeling the need to urinate urgently or often
- Fatigue
- Upset stomach or heartburn
- Back pain
- Painful sexual intercourse
- Constipation or menstrual changes

Individually these symptoms may not stand out as a problem, but if any of them persist for more than two weeks, see a doctor immediately.

Pap smears do not test for ovarian cancer. The best way to diagnose the disease when there are no symptoms is to undergo annual rectal and vaginal pelvic examinations. If an irregularity is suspected, a transvaginal ultrasound (76830 Ultrasound, transvaginal) can be performed to view the ovaries. If there is a family history of ovarian cancer, some doctors may decide to take a tumor marker. The most common tumor marker is the blood test CA-125 (86304 Immunoassay for tumor antigen, quantitative; CA 125). Genetic testing may also be done to detect if a woman has Lynch Syndrome or a BRCA1 or BRCA2 mutation (the same mutation seen by some
Women who test positive may be advised by their doctor to undergo a transvaginal ultrasound and a CA-125 test, yearly.

**Diagnosis and Procedural Coding**

**ICD-10 codes:**

- C56: Malignant neoplasm of ovary
  - C56.1: Malignant neoplasm of right ovary
  - C56.2: Malignant neoplasm of left ovary
  - C56.9: Malignant neoplasm of unspecified ovary

- Z80.41: Family history of malignant neoplasm of ovary
- Z84.81: Family history of carrier of genetic disease (BRCA1 or BRCA2 gene mutation) (Lynch syndrome)

**Genetic testing CPT® codes:**

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Test Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>81211, 81213</td>
<td>BRCA1/2: Comprehensive BRCA analysis by gene sequencing with deletion/duplication analysis</td>
</tr>
<tr>
<td>81212</td>
<td>BRCA1/2: Ashkenazi Jewish 3-site mutation analysis</td>
</tr>
<tr>
<td>81215, 81217</td>
<td>BRCA1 or BRCA2 specific site analysis</td>
</tr>
<tr>
<td>81211, 81213</td>
<td>BRCA1, BRCA2 (eg, hereditary breast and ovarian cancer) gene analysis common and uncommon duplication/deletion variants</td>
</tr>
<tr>
<td>81288</td>
<td>MLH1 (mutl homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis</td>
</tr>
<tr>
<td>81292-81294</td>
<td>MLH1 genetic testing code range</td>
</tr>
<tr>
<td>81295-81297</td>
<td>MSH2 genetic testing code range</td>
</tr>
</tbody>
</table>

**Resources**

- Norma Leah Ovarian Cancer Foundation®, Detection page: [www.normaleahfoundation.org/detection.html](http://www.normaleahfoundation.org/detection.html)
- Stand Up to Cancer: [www.standup2cancer.org/press_release/view/new_ovarian_cancer_dream_team_announced_6m_grant_over_3_years_will_focus_on](http://www.standup2cancer.org/press_release/view/new_ovarian_cancer_dream_team_announced_6m_grant_over_3_years_will_focus_on)
Providers who hire Certified Risk Adjustment Coders (CRCs™) have nothing to fear.

The risk adjustment methodology is a relatively new payment model that is prospective in nature — meaning that healthcare costs in future years are based on what is known to be true of healthcare costs in recent years. Providers that hire CRCs™ have the advantage in this new culture, as these professionals understand risk adjustment and its inherent challenges. The following 10 frequently asked questions (FAQs) shed more light on the subject.

FAQ No. 1

Isn’t risk adjustment just like fee-for-service (FFS), except it focuses on diagnosis codes instead of CPT® codes?

A: Risk adjustment cannot be compared to FFS rules for several reasons, one being that the qualifications for diagnosis submission are not the same. In the FFS world, diagnoses are typically submitted when they have “MEAT” (monitor, evaluate, assess, or treat) — a concept that only applies when choosing an evaluation and management (E/M) level of service. You cannot bump up a level of service with additional diagnoses unless those diagnoses are addressed at that visit. ICD guidelines, however, have always instructed us to code for all coexisting comorbidities, and especially those that are a part of medical decision-making (MDM). There is no rule in ICD that says a diagnosis has to be treated to be coded, but you cannot allow diagnoses not addressed or treated to influence selection of E/M service codes.

FAQ No. 2

What spurred AAPC to create the CRC™ credential?

A: Years ago, I spoke with AAPC about the need for a credential or platform for risk adjustment coders. I was not alone: Others had even
pitched a curriculum or program. Many of these were education ideas centered on hierarchical condition categories (HCC), but there has never been a credential based on a singular payment methodology. What should have been pitched was a curriculum that includes all forms of risk adjustment (including population health management), instead of focusing on payments. The CRC™ credential was eventually created out of demand from coders and risk adjustment professionals.

**FAQ No. 3**

**What is the difference between AAPC’s CRC™ curriculum developed in 2015 and the new curriculum?**

**A:** The curriculum developed in 2015 was created for coders who already had a core coding credential. The curriculum focused on risk adjustment, only, and did not cover basics, such as the business of medicine, anatomy and physiology, complete ICD coding guidelines, etc. Risk adjustment was in full swing for Medicaid and Medicare plans, but the risk adjustment model for the U.S Department of Health & Human Services (HHS) was still being developed. The 2016 CRC™ curriculum is designed as a standalone credential. In addition to the fundamentals, the curriculum includes current information for the HHS model, as well as annual updates.

**FAQ No. 4**

**How can I best prepare for the CRC™ exam, and who made this exam?**

**A:** The CRC™ exam committee is comprised of risk adjustment professionals from across the country. The exam questions are based on what you should know to properly code for risk adjustment. This includes the basics of risk adjustment, proper ICD code selection, how to handle documentation challenges, as well as predictive modeling, quality, and basic financial ties of risk adjustment in healthcare. To best way to prepare for an AAPC exam is to take the related AAPC course. Be wary of generic and “homegrown” courses. While some may offer good information, the AAPC exam will include information conveyed only in an AAPC course. Professional Medical Coding Instructors often teach courses for which they carry a credential, so seek an instructor who is approved by AAPC.

**FAQ No. 5**

**Why are there differing instructions for risk adjustment coding, and which instructions are correct?**

**A:** There are differing instructions for many reasons: Some organizations feel more comfortable only allowing diagnoses that were managed or addressed in the encounter. Although there have been Risk Adjustment Data Validation (RADV) audits by the Centers for Medicare & Medicaid Services (CMS) that have approved all current diagnoses, there have also been Office of Inspector General audits conducted by auditors who are not trained in risk adjustment and who applied FFS rules to risk adjustment audits. The correct methodology for risk adjustment coding is to code for all current diagnoses. The diagnosis does not need to be treated, managed, or addressed; it merely has to be an ongoing chronic condition noted by the treating provider or part of MDM. For example: “I had to consider the patient has diabetes when treating this other condition,” or “I had to consider this patient has cancer, even though I am not personally treating the cancer myself,” etc. The purpose of collecting all current diagnoses for each year is to account for the correct financial needs of patients in the following year. Leaving out factual diagnoses harms the health plans and, ultimately, the patients. The idea is that if a patient really has a condition, then it will be addressed at some point in the year in a face-to-face visit. (This is not necessarily true for “status of” codes and other conditions that are persistent and known, but not regularly treated.)

**FAQ No. 6**

**How do I handle lists found in documentation such as a past medical history (PMH) only list?**

**A:** The problem with lists in medical record documentation is that there can be so many variations from one provider to another. CMS knows that providers make mistakes — such as mixing both old and current diagnoses in a list titled PMH, or listing old conditions under the “Active” or “Current” header. Errors like these make clinical documentation challenging to code properly.
The purpose of TAMPER™ is not to be a competitor for the MEAT concept; this acronym was made for coders evaluating various lists, such as PMH, Active, Current, Ongoing, etc.

I created a new acronym, TAMPER™ (T reatment, Assessment, Monitor or Medicate, Plan, Evaluate, or Referral) for lists. This acronym is officially trademarked through the U.S. Patent and Trademark Office by ionHealthcare®. The purpose of TAMPER™ is not to be a competitor for the MEAT concept; this acronym was made for coders evaluating various lists, such as PMH, Active, Current, Ongoing, etc.

Note that when medications are used to support a current diagnosis, it’s important for the medication list to be current and for the medication to be used to treat only that condition. If you feel uncertain about a diagnosis presented in a list, you can easily apply the TAMPER™ concept by asking yourself, “Did the provider TAMPER™ with the diagnosis?” If the answer is yes, then you can code it from the list as a current diagnosis.

TAMPER™ Decision Flow:

| Look for Evidence of Treatment: Did they “TAMPER™” with the condition? |
|--------------------------|--------------------------|
| Treatment                | Assessment               |
| Monitoring or Medicare   | Plan                     |
| Evaluate                 | Referral                 |

Code Condition

- Look for diagnosis with evidence of treatment documented in another DOS. If no other DOS is found clearly, enter condition as “PMH only.”

FAQ No. 8

What exactly is RADV and what are the differences of CMS RADV and HHS RADV?

A: There are two main types of RADV for CMS:

- Random CMS RADV uses a selection process in which a Medicare Advantage (MA) plan is randomly selected for an audit.
- Targeted CMS RADV is applied to MA plans who have raised red flags, such as a large increase in risk scores, etc.

Both random and targeted CMS RADVs use a “stratified sample;” a random sample of 1/3 of patients with high risk scores, 1/3 of patients with medium risk scores, and 1/3 of low risk scores. The focus is not proving the ICD code, but rather proving the validity of the HCC value that was paid to the health plan by CMS for the reported ICD code. Any ICD code supporting the HCC (or higher HCC value) is acceptable.

HHS RADV is similar to CMS RADV, but stratifies its sampling among adult, child, and infant patients, and by metal levels (silver, gold, platinum) offered through the commercial health plans. CMS RADV allows any face-to-face encounter that supports the HCC value for a date of service within the calendar year. HHS RADV requires the face-to-face encounter to be reported through the claims EDGE server. CMS recently stated it also allows for non-EDGE claims, as long as the encounter meets all of the same criteria of a face-to-face encounter.

CMS RADV allows any face-to-face encounter that supports the HCC value for a date of service within the calendar year. HHS RADV requires the face-to-face encounter to be reported through the claims EDGE server. CMS recently stated it also allows for non-EDGE claims, as long as the encounter meets all of the same criteria of a face-to-face encounter.

CMS RADV is typically performed on data from three years prior, whereas HHS RADV is performed on the prior year's data.

CMS RADV affects payments made to a health plan and may require reimbursement to CMS. HHS RADV affects allowable funding for...
When assigning codes, remember that there may be new codes issued in October that are not yet added to risk adjustment models.

FAQ No. 9
Why do some companies code offshore in risk adjustment?
A: Some organizations will not offshore coding work because it is derived from U.S. government-based programs. Organizations who do offshore usually do so because coding services are less costly than in the United States. HIPAA does not apply overseas. Anyone considering offshoring risk adjustment work should include all requirements of HIPAA in their contractual agreements, and perform a mock breach process to ensure the ability to track disclosures and medical record security.

Some organizations market themselves as “approved by HIPAA,” but there is no such designation. They may have had a third party assess their security, but the covered entity is ultimately responsible for the security of their records.

Some U.S.-based companies have only administrative offices onshore, while the actual work is offshore. Several coding companies based in other countries focus on marketing risk adjustment coding services. U.S.-based companies can vary, as well: Some specialize in medical record retrieval, some in analytics, and others in population health management. Very few specialize primarily in coding.

FAQ No. 10
What are some of the important changes to risk adjustment with ICD-10-CM?
A: Risk adjustment models change each year (January-December); while ICD codes change each Oct. 1. When assigning codes, remember that there may be new codes issued in October that are not yet added to risk adjustment models.

Most conditions that risk adjust are chronic, life-long illnesses.

ICD-10-CM includes many new combination codes that may best describe two or more conditions when concurrently present on a date of service. There was a CMS HCC model change in preparation for ICD-10, and this newer model took into account these combination codes and their respective values. HHS based its model on the CMS model, but also includes diagnoses commonly found in young people. The HHS model does not have a Part D portion, as CMS does, but there are plans to move in this direction on the commercial risk adjustment side.

Brian Boyce, BSHS, CPC, CPC-I, CRC, CTPRP, is an AAPC-approved PMCC instructor and ICD-10-CM trainer, and the author of the AAPC CRC™ curriculum. He has specialized in risk adjustment from the very beginning of model utilization, and has assisted large and small clients nationally. Boyce’s special interests are ethics, patient safety, disease management, and managing people and leadership. He is a Desert Storm veteran, where he served on active duty with the U.S. Air Force, with a job specialty of Aeromedical Evacuation. Boyce began physician practice management and medical coding after an honorable discharge. He is CEO of ionHealthcare®, a company that specializes in risk adjustment coding and support services (email inquiries to info@ionHealthcare.com). Boyce is on the AAPC National Advisory Board and a member of the Richmond, Va., local chapter.
The SECRET to Proving Medical Necessity

Two Medicare cases illustrate the importance of NCDs and LCDs.

Proving medical necessity is really no secret at all: Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs) dictate which diagnosis codes must be documented by clinicians to support the medical necessity of most services or supplies they provide to patients. Coders who are informed of these policies play an essential role in garnering uninterrupted cash flow for their clinicians.

NCDs vs. LCDs

NCDs are issued by the Centers for Medicare & Medicaid Services (CMS) at the national level — meaning the policies apply to all Medicare providers. LCDs are issued by Medicare administrative contractors (MACs) or other payers at the local level. As such, LCDs may vary by state and carrier, even if they are for the same service or supply. Carriers other than Medicare may adopt these national/local policies and payment guidelines, as well.

When an NCD or LCD exists for a CPT® code being reported on a claim, one of the ICD-10 codes listed in that policy must be reported on the claim, too. Otherwise, the claim will be denied.

A provider or supplier cannot bill a Medicare patient for an uncovered service or supply unless they inform the patient prior to rendering the service or supply, and the patient signs an advanced beneficiary notice (ABN). Without a signed ABN on file, the patient is not liable for the charges, and the provider or supplier has no other choice but to write off the charges as lost revenue.

To illustrate, let’s review the encounters for two different Medicare patients.

Example 1

Novitas Solutions, Part A and B MAC for jurisdictions L and H, has an LCD for hydration therapy (L34960). The LCD addresses CPT® codes:

96360  Intravenous infusion, hydration; initial, 31 minutes to 1 hour
+96361  each additional hour (List separately in addition to code for primary procedure)

Some covered indications for hydration (among others) on this policy are:

E86.0  Dehydration
R11.2  Nausea with vomiting, unspecified
R42   Dizziness and giddiness

The patient’s emergency room note reads:

Chief Complaint
Patient presents with dizziness

Patient had episode of dizziness, lightheaded earlier today with a HR of approx 105. Patient’s brother-in-law had patient do some vagal maneuvers and ice to the face, which made him feel better. Patient has history of SVT ablation.

ED Course
12:13 a.m.
29 y/o male with PMH of SVT with ablation in 2005 p/w dizziness that began earlier this evening. While at dinner, patient felt sudden onset palpitations and dizziness. His brother-in-law tried some vagal maneuvers, which brought his pulse down and his dizziness resolved. Patient states that it happened to him again later this evening. He has not followed with a cardiologist recently but states this is the same way he felt back in 2005 when he was having episodes of SVT. Patient reports nausea, but no chest pain/SOB/syncpe. On exam, VSS, heart RRR, lungs CTA, abd soft/nt/nd, no LE edema, neuro exam intact. Will order labs and IVFs.

EKG Interpretation:
Rhythm: Normal sinus rhythm at 69 beats per minute.
Axis: Normal axis.
Intervals: Normal PR interval.
QRS complex: Left bundle branch block.
ST segment: Normal ST-T segments.
QT interval: Normal.
Compared with prior: Unchanged.

2:01 a.m.
Labs are all stable. Patient’s symptoms have all resolved. Patient’s heart rhythm has remained NSR on the monitor. Will d/c patient home in stable condition with f/u with his PCP. Also given referral to cardiology. Advised patient to return if he develops worsening/return of symptoms: dizziness/lightheadedness, palpitations, SOB, cp. Patient and family verbalize understanding and are in agreement with the plan.
MDM
Number of diagnoses or management options.
Dizziness: New and requires workup.
Amount and/or complexity of data reviewed.
Clinical lab tests: Ordered and reviewed.
Review and summarize past medical records: Yes.
Discuss the patient with other providers: Yes.
Final diagnoses: Dizziness

Based on this report, the encounter was coded ICD-10 R00.2 Palpitations and R42. The hydration will be paid.

Example 2
Novitas’ LCD for multigated acquisition (MUGA) scans (L35083) addresses the following CPT® and diagnosis codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78472</td>
<td>Cardiac blood pool imaging, gated equilibrium, planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing</td>
</tr>
<tr>
<td>78473</td>
<td>Cardiac blood pool imaging, gated equilibrium; multiple studies, wall motion study plus ejection fraction, at rest and stress (exercise and/or pharmacologic), with or without additional quantification</td>
</tr>
</tbody>
</table>


Group 2 Paragraph: Medicare is establishing the following limited coverage for Cardiac Blood Pool Studies through CPT® codes 78472, 78473, 78481, 78483, 78494, and 78496

Covered for:

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISO.21 - ISO.23</td>
<td>Acute systolic (congestive) heart failure - Acute on chronic systolic (congestive) heart failure</td>
</tr>
<tr>
<td>ISO.41 - ISO.43</td>
<td>Acute combined systolic (congestive) and diastolic (congestive) heart failure - Acute on combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>Z01.30*</td>
<td>Encounter for examination of blood pressure without abnormal findings</td>
</tr>
<tr>
<td>Z01.31*</td>
<td>Encounter for examination of blood pressure with abnormal findings</td>
</tr>
<tr>
<td>Z08*</td>
<td>Encounter for follow-up examination after completed treatment for malignant neoplasm</td>
</tr>
<tr>
<td>Z09*</td>
<td>Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm</td>
</tr>
<tr>
<td>Z51.11</td>
<td>Encounter for antineoplastic chemotherapy</td>
</tr>
<tr>
<td>Z51.12</td>
<td>Encounter for antineoplastic immunotherapy</td>
</tr>
<tr>
<td>Z51.81*</td>
<td>Encounter for therapeutic drug level monitoring</td>
</tr>
</tbody>
</table>

Group 2 Medical Necessity ICD-10 Codes Asterisk Explanation: *CHEMOTHERAPY: Report Z01.30 – Z01.31 when the testing is performed as a BASELINE STUDY before chemotherapy, Report Z51.81 for SUBSEQUENT MONITORING while the patient is receiving chemotherapy, and report Z08 and Z09 for testing when CHEMOTHERAPY IS COMPLETED.

DEVICE PLACEMENT: Report CPT-10 codes ISO.21 - ISO.23 and ISO.42 - ISO.43 when using to support medical necessity only performed to calculate ejection fraction in those patients being actively considered for defibrillator or biventricular pacemaker placement, where ejection fraction is the determining factor in the decision.

The report for the patient’s study reads:

**Resulting lab:** Radiology

**Narrative:**

**History:** 53-year-old female with malignant neoplasm of left breast.

Radiopharmaceutical and technique: Multigated cardiac scan was performed following the intravenous administration of 1.5 mg of cold stannous pyrophosphate and 18.3 mCi of Tc-99m labeled red blood cells.

**Findings:**

Comparison is made to prior study from 7/15/15. There is normal biventricular wall motion and chamber size. The calculated left ventricular ejection fraction is 60% which is above the normal lower limit of 50%. Right ventricular contractility is normal. The findings are unchanged compared to prior study from 7/15/15.

Incidental note is made of small round photopenia related to left breast tissue expander port.

**Impression:**

Normal left ventricular wall motion and left ventricular ejection fraction at 60 percent, unchanged compared to prior study from 7/15/15.

Based on this report, the encounter was coded C50.912 Malignant neoplasm of unspecified site of left female breast. This claim will be denied. Very likely the physician was ordering this as a pre-, peri-, or post-chemotherapy study (which are covered in this policy), but a lack of documentation prohibits reporting those codes.

**Knowledge is Power**

Familiarizing yourself with the NCDs and LCDs relevant to the services your practice or facility commonly offers, presents a great opportunity for you to offer feedback and education to your clinicians relative to their documentation. For instance, in the MUGA example, educating the oncology physicians on documenting their orders — whether the test is being done as a baseline before chemotherapy or as monitoring during/after chemotherapy — would ensure future tests were covered.

Jennifer Comstock, CPC, is a coding and billing analyst for Lehigh Valley Health Network. She has been in the billing and coding industry for 20 years, working all parts of the revenue cycle. Comstock works on claim edits, denials, appeals, and assists with audits. She is a member of the Allentown, Pa., local chapter.

**Resources**

www.cms.gov/medicare-coverage-database
Ask the Legal Advisory Board

Is It Illegal for a Coder to Change a Provider’s Coding?

Know your role as a coder, and develop policies promoting communication and documentation education.

Question

In my practice, the physician chooses the evaluation and management (E/M) level and diagnosis codes. Our coders review the notes to ensure documentation supports the physician’s billed service. For example, if the physician says her E/M is a level 4, but documentation does not support a level 4, the coders will change the E/M code to the level that documentation supports. Our coders also provide feedback and education to providers when their documentation doesn’t support the selected level.

Recently, someone told us that it’s illegal for a coder to change a diagnosis code based on documentation, and that coders cannot change the provider’s E/M code selection. Can you clarify?
If a coder has a validation role, as it appears to be the case in the question, the coder is responsible for identifying potential errors and reviewing them with the physician.

**Answer 1 - by Michael D. Miscoe**

There is no statutory direction in this situation (that I am aware of). Whether a coder is authorized to change a physician’s coding is an issue that must be worked out between the physician and coding staff. If a physician is adamant about a coder not changing their codes, the coder should not do so. Regardless, the coding staff should continue to alert the physician to potential errors and request approval for appropriate changes.

In many cases, physicians hire a coder to prevent such errors and give the coder (formally or informally) blanket authorization to review the records and make corrections to coding, when appropriate. If this is the case, then it’s appropriate for a coder to make those changes. Even when this is the case, the physician should review any changes because, ultimately, the physician is responsible for the accuracy of the codes submitted. The review also provides an opportunity to educate the physician.

The practice should develop a procedure for how to handle a situation when the physician and coder do not agree. In such cases, an independent review by the compliance department (if one exists) or an outside compliance contact may be necessary to resolve the dispute.

This situation gets more complicated when the physician and coder are both employed by an entity or a group. In such a case, it’s the entity or group that is financially liable for any mistakes leading to overpayments. As a result, there should be a compliance policy and procedure detailing whether coders are responsible to validate physicians’ code selections, or may only bill the codes the physicians select. In the first case, the policy/procedure should also address how to handle coding disputes between the coding staff and the physician. In the latter, physicians must be appropriately trained and there should be some sort of internal auditing to ensure coding is accurate.

Coders need to know their role — specifically, whether they have been hired to code from the records, validate the codes selected by the physician, or simply bill the codes selected by the physician.

In the end, the physician is liable for the accuracy of the codes submitted. When the physician’s payments are assigned to a group, the group is financially liable for any errors resulting in overpayments. If a coder has a validation role, as it appears to be the case in the question, the coder is responsible for identifying potential errors and reviewing them with the physician. If the physician does not agree with the change, the coder should not overrule the physician, but instead turn to the practice’s policy for resolving such disputes. If the physician authorizes the change, there is no issue.

**Answer 2 - by Julie E. Chicoine**

Legally, providers are responsible for all claims submitted under their National Provider Identifier. I’m aware of no laws that expressly forbid coding professionals from changing a physician’s coding on claims. Nor is there a legal requirement that physicians code their services. If a diagnosis code is not consistent with documentation, then the coding professional should circle back with the provider and clarify. The above scenario reinforces the important role that coding professionals play in the physician revenue cycle. It’s unrealistic to expect physicians to possess the skills and experience to code claims. Managing the revenue cycle should not be part of their job. Practices wishing to minimize financial risk should hire credentialed coding professionals.

Documentation must support the level of service billed. If it doesn’t, the coding professional needs to work with the physician to ensure the documentation accurately reflects the services billed. If coders change code levels (up or down), they should inform the provider of the change, in the context of education.
Beware Phishing Attempts to Thwart Your IT Security

Help prevent the damage that a criminal data attack can have on a healthcare organization.

Often, when talking about information technology (IT) security, you hear responses such as, “It’ll never happen to us,” or “I’m too small to be a target.” The truth is, viruses, spyware, malware, phishing, hacking, phreaking, social engineering, data loss, improper access, etc., are equal opportunity offenders. Any individual or organization is a potential target.

Phishing Clients
To demonstrate that small and medium businesses are not immune from security threats, I spoke with Kevin Slonka, Sc.D., senior systems engineer at Precision Business Solutions and professor of Computer Science, about conducting a case study in which we “phish” our clients.

Phishing is an email attack in which the attacker masquerades as a trusted source sending fraudulent emails to elicit personal information from the recipients and gain access of their digital life. There are many examples of phishing emails, which include:

- An infected UPS shipment notification with attached PDF (often during the Christmas season);
- A PayPal or bank “account security concern” that requests you to click a link, which takes you to an infected webpage or site to further illicit login credentials;
- A Nigerian prince wishing to send you money by asking you for banking information; or
- A relative who is stuck in another country and needs you to wire money for airfare to return home.

The goal of our project with Slonka was to attack our clients in a way that anyone could attack them: using readily available information found on the internet.

Step 1: Trusted Source
Although we could have used a local financial institution as our trusted source, we decided to phish as ourselves (after all, we didn’t want FBI knocking on the door). Slonka and I built a legitimate digital presence using the domain precisionbs.tech. This domain was purchased from GoDaddy, a reputable domain registrar. We set up website hosting, an SSL Security Certificate, and Office 365 email hosting, which provides a fully legitimate domain, secure website, and trusted email hosting. Upon checkout, we also selected private registration, so no one was able to look up the true owner of the domain.

Although my credit card could have been traced back to me during an investigation, if I was a criminal phisher, a stolen credit card would have been used for these transactions.

Step 2: The Ask (Email)
Our case study involved tracking two primary actions: the number of clients who clicked on the infected link, and the number of clients who provided their account credentials.

The email was sent using a variation of a widely known email address that clients frequently see and use, support@precisionbs.com, and it appeared to be sent from myself. As shown in Figure 1, it’s very hard to tell this was a fraudulent email.

We included a call to action in bolded red, further enticing the recipient to click the link and provide their account credentials in hopes of winning the $100 gift card.
Often, anti-spam software and systems are in place to block phishing and spam. The difficulty in preventing emails such as the one in Figure 1 is that they are technically legitimate. Precisionbstech is a valid domain, using a valid email provider. Our emails were timed to be sent every few seconds (randomized between five and 10) to further prevent detection by anti-spam systems.

Step 3: Fraudulent Website

The precisionbs.com website was mirrored and a fraudulent precisionbstech webpage was created: www.precisionbstech/reg.php. As shown in Figure 2, the webpage looks identical to a page you’d see on precisionbs.com.

Results Reveal Security Weaknesses

The objective was to study the results and use them to enhance security awareness and training materials for our clients. The website was developed so that no account credentials were transmitted to the website or collected (even though they technically would have been encrypted). The goal of this study was only to locate security weaknesses.

Of the 1,198 targets (individuals emailed), the phishing website — which could have contained malware or other infectious code — had 493 interactions (clicks on the email link, clicks on website links, and form submissions). Of those 493 interactions, 152 completed the form, in which sensitive account credentials were requested.

Healthcare clients accounted for 385 of the target emails, of which 164 individuals clicked the phishing link and 49 individuals submitted their account credentials.

Discussion and Thoughts

Some may argue the results are high due to Precision Business Solutions being an IT provider, but I feel I could obtain equally high results if I were criminally phishing for information. Not all phishing attempts are as easily spotted as the email from the Nigerian prince.

IT providers are excellent examples of organizations to impersonate because, unlike banks, individuals seem to drop their guard when it’s IT. We’ve had a technician walk into the wrong office building and ask the receptionist where the firewall was because he had a new firewall to install to fix the company’s internet issues (who doesn’t want faster internet?)! He was allowed in and sat down at a computer, only to figure out after a few minutes he was at the wrong location.

Healthcare Hazards

Imagine the damage that could have been done with those 49 individuals’ account credentials. Aside from the financial gains that could have been realized by downloading and selling patients’ account, billing, and insurance information, what if the attacker decided to do harm?
If a physician’s credentials were compromised, and patients’ medications altered, an attacker could literally kill a patient.

If your credentials allow remote connectivity, the attacker now has access to your network, which most likely has a number of networked medical devices connected to it that care for patients. Unfortunately, a challenge in healthcare is to keep those computer systems updated and patched, leaving them vulnerable to attacks that could compromise patient safety.

If you’re a small practitioner who works closely with a local hospital, you’re a prime target, as your credentials grant you access into the larger healthcare system.

**Security Awareness and Training**

Security awareness and training is the process of educating employees on computer security and proper computing practices. Example topics include:

- **Guarding against, detecting, and reporting malicious software;**
- **Monitoring log-in attempts and reporting discrepancies;**
- **Creating, changing, and safeguarding passwords;**
- **Using safe browsing practices; and**
- **Email security.**

Although employee security awareness and training is important for all businesses, it’s a requirement for healthcare.

Here are a few tips to help you identify phishing emails:

- **Domain names** – Pay particular attention to non-standard domain names. Most organizations are still using .com and .org (or .edu and .gov). Pay close attention to email using an alternate domain (e.g., .net, .co, .tech, .info, etc.).
- **Attachments** – Any email you receive with an attachment should warrant additional review, especially when it comes unexpectedly or from someone unfamiliar to you. If you’re not sure if an email is legitimate or from a trusted sender, you can always confirm it by replying to the sender before opening it. My rule of thumb is typically to delete suspicious emails.
- **Holiday or fundraising scams** – You’ll notice an uptick of phishing attempts around the holidays, often with infected attachments (e.g., UPS/FedEx shipment notifications or fake receipts). Be wary of emails you receive supporting a cause, such as the mass shootings in Orlando this past summer, which triggered fraudulent donation requests. Thieves have no moral issues in how they exploit people.
- **Personal information or passwords** – Take caution when you receive an email requesting personal information or anything to do with your password. If a service you use asks you to change your password, don’t click the link; manually go to the website and login to change your password.
- **Change passwords regularly** – When you’re required to change your password at work, use that as a reminder to change your password on personal accounts, such as online banking, personal email accounts, etc. Often when passwords are compromised, it takes time to use that information, and by changing your password regularly, that compromised information becomes useless.

**Consider Cyber Insurance**

Did you know that cyber insurance is not always included in a general liability policy, and often is an exclusion? Check with your insurance provider to ensure you have adequate cyber insurance coverage. Cyber insurance is recommended for anyone who accesses, stores, or maintains any personally identifiable information or protected healthcare information.

Brian Shrift, CISSP, HCISPP is president of Precision Business Solutions.

Kevin Slonka, Sc.D. is a senior systems engineer at Precision Business Solutions and head of the Computer Science program at Pennsylvania Highlands Community College. His primary research area is information security, with recent studies on social networking scams and phishing.

**Resources**

For more information, please visit the following sites:

- **www.PhishingOurClients.com** – Additional information on this study, including the official case study.
- **https://precisionbs.com/security-awareness/** – Publicly available security awareness and training videos, which may be used to further educate staff on relevant IT security information.
Keeping the **game fair**...

...so you’re not **fair game**.

Your medicine is getting hit from all angles.

You need to stay focused and on point—confident in your coverage.

Get help protecting your practice, with resources that make important decisions easier.

---

**ProAssurance.**

Healthcare Liability Insurance & Risk Resource Services

ProAssurance Group is rated **A+ (Superior)** by A.M. Best.

Want to reduce risk? >> ProAssurance.com/Seminars

*800.282.6242 • ProAssurance.com*
Ever since the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) proposed rule appeared in the May 9 Federal Register, stakeholders have been consumed with questions: Does this apply to me? How do I avoid a downward payment adjustment? How can I find more information? Anticipating these questions, the Centers for Medicare & Medicaid Services (CMS) scheduled an MLN Connects National Provider Call the day after the proposed rule was published. Questions and answers stemming from that call offer deeper insight into what CMS proposes to finalize in November.

Note: The following Q&A has been modified from the original transcript to omit unnecessary verbiage.

**Part B Services in Skilled Nursing Facilities**

**Q:** Does MIPS apply to physicians who treat patients in nursing facilities?

**A:** Yes, although MIPS does not apply to facilities directly, it does apply to eligible clinicians who provide services to patients covered under Medicare Part B in nursing facilities.

**FACT:** For the first two years (2019-2020), MIPS eligible clinicians are physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) who bill for Medicare Part B services. Exemptions apply for:

- Eligible clinicians in their first year of Medicare Part B participation;
- Eligible clinicians who bill Medicare less than or equal to $10,000 and provide care for 100 or fewer Medicare patients in one year; and
- Certain participants in Advanced APMs.

MIPS does not apply to hospitals or facilities.
Although physician and occupational therapists are not eligible for MIPS for the first few years, they can volunteer to participate in MIPS.

**Part B Services in Other Facilities**

**Q:** If facilities are not eligible for MIPS, how will eligible clinicians who provide therapy services to patients with Part B coverage participate in MIPS when their services are billed on an institutional claim through the facility?

**A:** [The caller was told to submit a comment for consideration in the final rule.]

**FACT:** CMS touches on this scenario in the proposed rule at Section II.E.1.d – MIPS Eligible Clinicians Who Practice in Rural Health Clinics (RHCs) and/or Federally Qualified Health Centers (FQHCs): “Some eligible clinicians may not receive MIPS adjustments due to their billing methodologies. If a MIPS eligible clinician furnishes items and services in an RHC and/or FQHC and the RHC and/or FQHC bills for those items and services under the RHC’s or FQHC’s all-inclusive payment methodology, the MIPS adjustment would not apply to the facility payment … However, these eligible clinicians have the option to voluntarily report on applicable measures and activities for MIPS and the data received would not be used to assess their performance for the purpose of the MIPS adjustment.”

**Advice for Ineligible Clinicians**

**Q:** In regards to physical and occupational therapy, I understand that we will not be included in MIPS initially. What are we supposed to do in the meantime? Do we continue to submit Physician Quality Reporting System (PQRS) data? Do we continue to submit functional limitation reporting as we have been?

**A:** Although physician and occupational therapists are not eligible for MIPS for the first few years, they can volunteer to participate in MIPS. If you have been participating in the PQRS program, and would like to know how the performance requirements would apply to you prior to actually being scored under the MIPS program, you can still submit data for quality measures. You could select applicable clinical practice improvement activities and CMS would issue you a feedback report. There is more specific information on this in the proposed rule.

**FACT:** CMS states in the proposed rule (Section II.E.5.a), “For individual clinicians and groups that are not MIPS eligible clinicians, such as physical therapists, but elect to report to MIPS, we would calculate administrative claims resource use measures and quality measures, if data is available.” You need at least two categories with non-missing scores to receive a composite performance score (CPS) on which CMS can base a payment adjustment.

**MIPS and Medicare Advantage**

**Q:** How does MIPS play out if you’re a physician or physician group that’s contracted with a Medicare Advantage (MA) plan?

**A:** The Advanced APM side for the first two years of MIPS focuses on Medicare Part B. Payments under MA would not be considered for qualified professional (QP) status, and the incentive payments would not be based on those payments either. Starting in the third year, MA arrangements can be considered Other Payer Advanced APMs, based on similar criteria for Advanced APMs; however, that APM incentive payment will always be based on Part B professional services.

**FACT:** CMS states in the proposed rule, “With respect to the APM Incentive Payment, section 1833(s)(1)(A) of the Act clearly states that the APM Incentive Payment is based on payments for Part B for covered professional services (which are made under the Medicare Physician Fee Schedule) and which do not include payments for services furnished to Medicare Advantage enrollees.”

**Advancing Care Information Weighs Heavy on Some**

**Q:** Regarding the MIPS program in years 1 and 2, physician assistants are eligible clinicians, but they’re not eligible for the advancing care information performance category. Does that mean they end up taking a zero point for that, and then get 0 times 30 percent?

**A:** The composite performance score will always be based off of a 100-point threshold. We’re proposing to take those 25 points and redistribute them to the quality resource use and clinical practice improvement activities categories.

**FACT:** A single MIPS CPS will factor in performance in four weighted performance categories on a 0-100 point scale. The four performance categories are: Resource Use; Clinical Practice Improvement Activities; Quality; and Advancing Care Information. In year 1, Advancing Care Information accounts for...
25 out of the 100 points; however, participation in this category is optional in 2017 for NPs, PAs, CNSs, and CRNAs.

CMS states in the proposed rule, “The low numbers of NPs and PAs who have attested for the Medicaid incentive payments may indicate that EHR Incentive Program measures required to earn the incentive are not applicable or available … For these reasons, we propose to … assign a weight of zero to the advancing care information performance category if there are not sufficient measures applicable and available to NPs, PAs, CRNAs, and CNSs. We would assign a weight of zero only in the event that an NP, PA, CRNA, or CNS does not submit any data for any of the measures specified for the advancing care information performance category.” CMS provides an example of how this will work, shown in Figure 1.

To receive the base score, eligible clinicians must provide the numerator/denominator or yes/no for each objective and measure. There are six objectives and their measures that require reporting for the base score:
1. Protect Patient Health Information (yes required)
2. Electronic Prescribing
3. Patient Electronic Access
4. Coordination of Care Through Patient Engagement
5. Health Information Exchange
6. Public Health and Clinical Data Registry Reporting (yes required)

The performance score accounts for up to 80 points towards the total Advancing Care Information category score. Eligible clinicians select the measures that best fit their practice from the following objectives:
1. Patient Electronic Access
2. Coordination of Care Through Patient Engagement
3. Health Information Exchange

Lastly, you can earn up to one bonus point for Public Health and Clinical Data Registry reporting, for a total of 131 possible points, of which you only need 100 points to receive the full 25 points CPS.

**Advanced APM Criteria**

**Q:** Is there a cap on the number of participants who are eligible to be in a certified or patient-centered medical home?

**A:** There is no proposed cap on the number of clinicians who are part of a medical home. The cap we mention is for the Medical Home Model to have a unique financial risk criterion when we’re determining whether or not it’s an Advanced APM. So the only time we’ll look at the overall number of people is to see whether the medical home qualifies for advanced status.

**FACT:** CMS proposes to expand its list of APMs to include: Advanced APMs and Other Payer Advanced APMs.

An Advanced APM must meet three requirements:
1. Require participants to use certified electronic health record technology;
2. Provide payment for covered professional services based on quality measures comparable to those used in the quality performance category of MIPS; and
3. Be either a Medical Home Model expanded under Section 1115A of the Act or bear more than a nominal amount of risk for monetary losses.

The Medical Home Model nominal amount standard is subject to size, and standards only apply to APM entities with 50 or more eligible clinicians. Amount of risk under the Medical Home Model...
There is no proposed cap on the number of clinicians who are part of a medical home.

must be at least 2.5 percent in 2017; 3 percent in 2018; 4 percent in 2019; and 5 percent in 2020.

There were several other questions that the panel wasn’t able to answer. These questioners were asked to submit their questions for consideration in the final rule.

The MIPS program and APMs are intended to streamline quality reporting so clinicians are more easily rewarded for providing quality care. There’s nothing easy about creating and implementing a new payment system, though. AAPC will continue to keep you apprised of new developments so you are armed with the information you’ll need to succeed in a value-based healthcare system.

Renee Dustman is executive editor at AAPC, and a member of the Flower City Coders, Rochester, N.Y., local chapter.

Resources

You Wanted Low Priced CEUs?
How about $2.50 per Webinar!

- 12 Months of Access to 40+ Live Events & Entire Library of 100+ On-Demand Webinars
- Receive 2 CEUs per Webinar (Live & On-Demand)
- Topics Cover 21+ Specialties
- 12-Month Subscription Starting at $295 (Volume Discounting Available for Your Office)

800-626-2633
aapc.com/webinars
Same-day Wellness Exam and Problem-focused Visit Saga Continues

AHA Coding Clinic clarifies ICD-10 guidelines.

During a wellness exam, a patient may mention a new complaint or worsening of a known condition, or the provider may uncover a new or worsening problem. Traditionally, providers have been able to collect reimbursement for a wellness exam and a problem-focused evaluation and management (E/M) service during the same visit, as long as medical necessity (per the provider’s documentation) supports a significant, separately identifiable E/M service in addition to the wellness exam.

“ICD-10 Restricts Same-day Sick and Well Visits” (July 2016, pages 44-46) reasoned that ICD-10-CM code descriptors, by definition, disallow reporting a well-patient exam encounter if the patient has a “complaint, suspected or reported diagnosis.” In addition, ICD-10-CM Excludes1 notes prevent reporting code categories Z00 Encounter for general examination without complaint, suspected or reported diagnosis and Z01 Encounter for other special examination without complaint, suspected or reported diagnosis with signs and symptoms. The article concluded that ICD-10 instructions restrict when a provider may report a well exam encounter and a problem-focused E/M at the same visit.

Since the July article was conceived, the American Hospital Association (AHA) Coding Clinic® has provided additional guidance about how to code wellness exam encounters with abnormal findings, and about what counts as an “abnormal finding.”

Worsening, Known Conditions Qualify as Abnormal Findings

AHA Coding Clinic® (first quarter, 2016) clarifies that a worsening, known condition is an abnormal finding that may be reported in addition to a wellness exam:

Question: A 59-year-old patient presents for his yearly physical exam. The patient has pre-existing chronic obstructive pulmonary
Since the July article was conceived, the American Hospital Association (AHA) Coding Clinic® has provided additional guidance about how to code wellness exam encounters with abnormal findings …

disease (COPD). During the examination, the patient has complaints of shortness of breath on exertion, mucus production, and chest discomfort. The provider documented acute exacerbation of COPD. Should the COPD be considered an abnormal finding? How is this encounter coded?

Answer: Assign code Z00.01, Encounter for general adult medical examination with abnormal findings, as the first-listed diagnosis. Assign code J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation, as an additional diagnosis since the patient had an exacerbation of a chronic problem.

In this case, the patient complains of new and worsening signs and symptoms that signal exacerbation of a known condition. Critically, the provider reports the definitive diagnosis of COPD with acute exacerbation, but does not report the signs and symptoms (e.g., shortness of breath, chest discomfort).

In a second AHA Coding Clinic® example, the patient has no complaints, but during examination the provider finds the patient’s previously diagnosed hypertension is no longer under control. The uncontrolled hypertension qualifies as an abnormal finding, which is reported secondary to the wellness exam encounter.

Question: An adult patient diagnosed with hypertension presents for an annual physical examination. During the visit the patient’s blood pressure is noted to be elevated, and the physician adjusts the antihypertensive meds for better control. Should this visit be coded as an exam with abnormal finding?

Answer: Yes, this is considered an examination with abnormal findings. Assign code Z00.01, Encounter for general adult medical examination with abnormal findings, as the first-listed diagnosis. Assign an additional code for the hypertension to describe the abnormal finding (uncontrolled hypertension). An abnormal finding refers to something new (in this case, the fact that the blood pressure is elevated and uncontrolled), which the physician discovered during the visit. For the purpose of assigning codes from this category, an “abnormal finding” is a newly discovered condition, or a known/chronic condition that has increased in severity (e.g., uncontrolled, and/or acutely exacerbated).

Newly-discovered Conditions May Also Qualify as Abnormal Findings

In the second answer above, AHA Coding Clinic® defines an abnormal finding as “… something new … which the physician discovered during the visit” and “a newly discovered condition.” Elsewhere in the same issue, AHA Coding Clinic® states, “An examination with abnormal findings refers to a condition/diagnosis that is newly found, or a change in severity of a chronic condition … during a routine physical exam.”

This means that even when a patient who presents for a wellness exam is found to have, or complains of, a problem unrelated to an existing diagnosis, you may report the well exam encounter as well as the new problem as a secondary diagnosis. AHA Coding Clinic® provides an example for which a newly discovered condition is reported in addition to a wellness exam encounter.

Question: A four-month-old female infant is seen for a well exam. The mother reports that the baby has had a runny nose for one week. The baby has been fussy, but without fever, cough, vomiting or diarrhea. On examination, the tympanic membrane was noted to be red and bulging. The patient is diagnosed with acute right suppurative otitis media. How would this encounter be coded?

Answer: In this case, it would be appropriate to assign code Z00.121, Encounter for routine child health examination with abnormal findings, as the first-listed diagnosis. Assign code H66.001, Acute suppurative otitis media, without spontaneous rupture of ear drum, right ear, as an additional diagnosis. The abnormal diagnostic finding is acute suppurative otitis media. During a routine exam, when a diagnosis or condition is found, it is coded as an additional diagnosis.
Although the instruction, “During a routine exam, when a diagnosis or condition is found, it is coded as an additional diagnosis,” seems straightforward, there remains a contradiction between AHA Coding Clinic® and ICD-10-CM descriptors that define wellness exam encounters as “without complaint, suspected or reported diagnosis.”

Lack of Definitive Diagnosis Remains a Problem

If the provider is unable to establish a definitive diagnosis based either on findings or the patient’s complaints, ICD-10-CM excludes reporting signs and symptoms in addition to the wellness exam Z codes. This leaves the provider with two options:

1. When the signs and symptoms need further work-up, the provider may code the signs and symptoms with a problem-focused visit and reschedule the well visit encounter for another day; or

2. If the payer allows payment for both the wellness exam and problem-focused visit on the same day, you may have another option. “I would suggest coding the preventive exam with the Z code, and linking the signs and symptoms to the problem-focused service,” says Raemarie Jimenez, CPC, CPB, CPMA, CPPM, CPC-I, CANPC, CRHC, AAPC vice president of member and certification development. “I would not recommend to have the patient return for the preventive visit unless the problem was so complex that a well visit could not be performed. This is an example where coding rules and payer rules vary.”

Follow Your Payer’s Lead

Ultimately, follow your payer’s guidelines regarding same-day wellness and problem-focused visits. Many payers are on record as allowing this coding combination. For example:

Sick visits – When a sick patient comes in and is due for a well-child visit, document all the components of a well-child visit. They can be reported in addition to the problem-oriented visit. Documentation must support that both services were provided in their entirety as significant and separately identifiable services. Then report the problem-oriented E&M service with the 25 modifier. This allows us to capture data for the well-child visit and will reimburse for both services.

— Priority Health, Well-child visit billing

When providers perform a separately identifiable medically necessary E/M service in addition to the IPPE [Medicare initial preventive physical exam], CPT codes 99201-99215 reported with modifier -25 may also be billed. When medically indicated, this additional E/M service would be subject to the applicable copayment for office visits. See CMS NCCI policy under CMS Resources.

— United Healthcare, Medicare Advantage Annual Wellness, Welcome to Medicare and Preventive Screening Guidelines

Blue Cross and Blue Shield of North Carolina (BCBSNC) understands there are times during a preventive visit when a patient is identified as having a condition or symptom that requires “significant” additional effort to address and treat. When a problem-oriented evaluation and management (E&M) service is performed on the same day by the same physician as a preventive visit, the modifier “-25” can be reported on the claim form. Report the appropriate E&M code with modifier -25 along with the preventive medicine services code.

— Blue Cross Blue Shield of North Carolina, Reminder: Preventive Visits and Use of Modifier -25
Note the importance of appending 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 appropriate E/M service code to describe the problem-focused history, exam, and medical decision-making, which is reported in addition to well visit exam.

John Verhovshek, MA, CPC, is managing editor at AAPC and a member of the Hendersonville-Asheville, N.C., local chapter.

When the signs and symptoms need further work-up, the provider may code the signs and symptoms with a problem-focused visit and reschedule the well visit encounter for another day.

Resources
United Healthcare, Medicare Advantage Annual Wellness, Welcome to Medicare and Preventive Screening Guidelines: www.unitedhealthcareonline.com
Blue Cross Blue Shield of North Carolina, Reminder: Preventive Visits and Use of Modifier -25: www.bcbsnc.com/content/providers/news-and-information/news/Preventive_Visits_Library.html

UPCOMING INTERVIEW?
Looking to land your dream job?
Winning Answers to the Top 100 Coding and Billing Interview Questions Revealed!

You’ll stay one step ahead with these interview essentials from Master the Interview and Land the Job!

• 100 top coding & billing interview questions, answers, & rationale
• Answers for tough “Gotcha!” questions
• How to answer interview questions when you don’t have experience
• Priceless salary negotiation tips
• Sample resumes for coders and billers
• Behavioral-based Q&A
• How to avoid common interview mistakes
• Checklists to streamline your job search strategy — interview preparation, employer research, and more!

3 Easy Ways to Pre-Order

800-508-2582 service@codinginstitute.com
www.codinginstitute.com/books/job.html
Join the growing field of Clinical Documentation

CDEO

Become a Certified Outpatient Documentation Expert Today!

For a limited time
Save 50% on CDEO Exams

Visit aapc.com/CDEO to learn more about this new certification.
NEWLY CREDENTIALED MEMBERS

NEWLY CREDENTIALED MEMBERS

Tiffany Sherrill, CPC-A
Tiffany Eason, CPC-A
Theresa Crawford, CPC-A
Theegalapally Praveen Kumar, CPC-A
Thangadurai Sekar, CPC-A
Tevin McCray, CPC-A
Terry Joseph Olson, CPC-A
Teri Lee Gardner, CPC-A
Teresa Tarte Duncan, CPC-A
Tequilla Bethea, CPC-A
Tara Kuebrich, CPC-A
Tammy Beck, CPC-A
Tabitha Brown, CPC-A
T  Akmal, CPC-A
Swathimutyam Chidapana, CPC-A
Susan Barnes, CPC-A
Sunil Bann, CPC-A
Sumit Kumar, CPC-A
Sue Dellabella, CPC-A
Subhash Shankar, CPC-A
Stephen Shugh, CPC-A
Stephanie Nelson, CPC-A
Stephanie Lyons, CPC-A
Stephanie Casebier, CPC-A
Stacy Christensen, CPC-A
Stacey Duncan, CPC-A
Soniya Devi Mongjam, CPC-A
Sima Sosnowik, CPC-A
Shobana Cadambi, CPC-A
Shirin Iranfar, CPC-A
Shikha Bhanwer, CPC-A
Sheryl A Baynes, CPC-A
Sherry Benton, CPC-A
Shaniqua Bland, CPC-A
Shayla McGinley, CPC-A
Sharayah Chamberlain, CPC-O
Shannon Crase, CPC-A
Shelly Clausen, CPC-A
Sheila Harris, CPC-A
Sheila McAllen, CPC-A
Sheila Zappala, CPC-A
Shelby Davis, CPC-A
Shel Martens, CPC-A
Shdarra Smullen, CPC-A
Sherry A. Steines, CPC-A
Shawn Killingbeck, CPC-A
Sherry A. Steines, CPC-A
Shawna Kibbey, CPC-A
Shenima Patel, CPC-A
Shelby Rene Sweetland, CPC-A
Sheniqua Matsumura, CPC-A
Sherry A. Steines, CPC-A
Shawna Kibbey, CPC-A
Shalyn Daniel, CPC-A
Shane M. Murphy, CPC-A
Sharmila Murali, CPC-A
Sharon A. White, CPC-A
Shaniqua Bellamy, CPC-A
Shaila Malik, CPC-A
Shakeria Lewis, CPC-A
Shakiria Taylor, CPC-A
Shalae Martin, CPC-A
Sharon A. White, CPC-A
Shaniqua Bellamy, CPC-A
Shakiria Lewis, CPC-A
Shalae Martin, CPC-A
Sharon A. White, CPC-A
Shaniqua Bellamy, CPC-A
Shakiria Lewis, CPC-A
Shalae Martin, CPC-A

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

I started my journey in the medical field at Westmoreland County Community College in Youngwood, Pennsylvania. I studied anatomy & physiology and biology alongside nursing students. I also learned typing, shorthand, and how to run a ditto machine (no joke!). By the time I earned an associate degree in Medical Secretarial Sciences in 1984, I was equipped to do almost any position in a medical office.

My first job was transcriptionist for a chiropractor. It lasted a month because I was offered a receptionist/billing position in an obstetrics/gynecology (ob/gyn) office. I seized the opportunity and relocated to Ohio. We used ledger cards and day sheets, filled out claim forms by hand with ditto paper, and copied the ledger cards to send monthly bills to the patients. I’ll never forget when the doctor purchased a “new machine,” called a sonogram, and I saw a 4-week-old baby’s heart beat for the first time, right in the exam room! I worked for that ob/gyn for nine years, during which time we saw technology improvements such as computers and impact printers (with a continuous, perforated paper feed).

Everything was changing: Doctors were asked to sign a contract with an insurance company to be in their Preferred Provider Network. It was the first concept of a limited fee schedule and managed care. After I met my husband, I moved to Mansfield, Ohio, where I worked for a family practitioner and a pediatrician who had separate businesses, but shared office space and staff. What a trip that was! I stayed in the trenches of family practice for the next 20 years. I added staff and credentialed more physicians as the group became a corporation. I learned multiple new computer programs, transitioned to sending claims and billing electronically, and learned about EFTs, HCFA, HIPAA, CMS, CAQH, etc.

When I learned of an organization offering coding credentials, at first I thought, “Why would I want to get credentialed in coding?” I had already been doing it for years. I considered the prospect more closely, however, and decided it would benefit me in the future. I joined AAPC in 2005, sat for the Certified Professional Coder (CPC®) exam, and passed.

Four years ago, my husband and I moved back to my hometown of Grantsville, Maryland, and I now work as an office manager for a single-doctor, family practice.

What is your involvement with your local AAPC chapter?

I became active in my local chapter when I joined AAPC, and have served in officer positions over the years. I am the vice president of the Johnstown, Pennsylvania, local chapter, and help out any way I can. I look forward to continuing education and self-improvement.

What AAPC benefits do you like the most?

Being an AAPC member has helped me to keep up with and understand changes in the industry, so I can do my job better.

What has been your biggest challenge as a coder?

Now that I am office manager for a small practice, I wear many hats: Sometimes I am the receptionist; sometimes I room patients; and sometimes I clean the restrooms—all while I teach my 68-year-old co-worker how to code ICD-10 and bill through yet another new clearing house. Keeping up with all of the industry changes is the biggest challenge.

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

My interests include church and being a Christian, family time, playing my fiddle, and playing with our three horses, two dogs, and two cats.
We reinvented compliance management through a complete, flexible solution that complies with all seven OIG recommendations to ensure you’re compliant, even when audited.

HEALTHICITY.COM/COMPLIANCEMANAGER
Where will YOU be next spring?

AAPC HEALTHCON 2017
LAS VEGAS

www.HEALTHCON.com