HEALTHCARE BUSINESS MONTHLY

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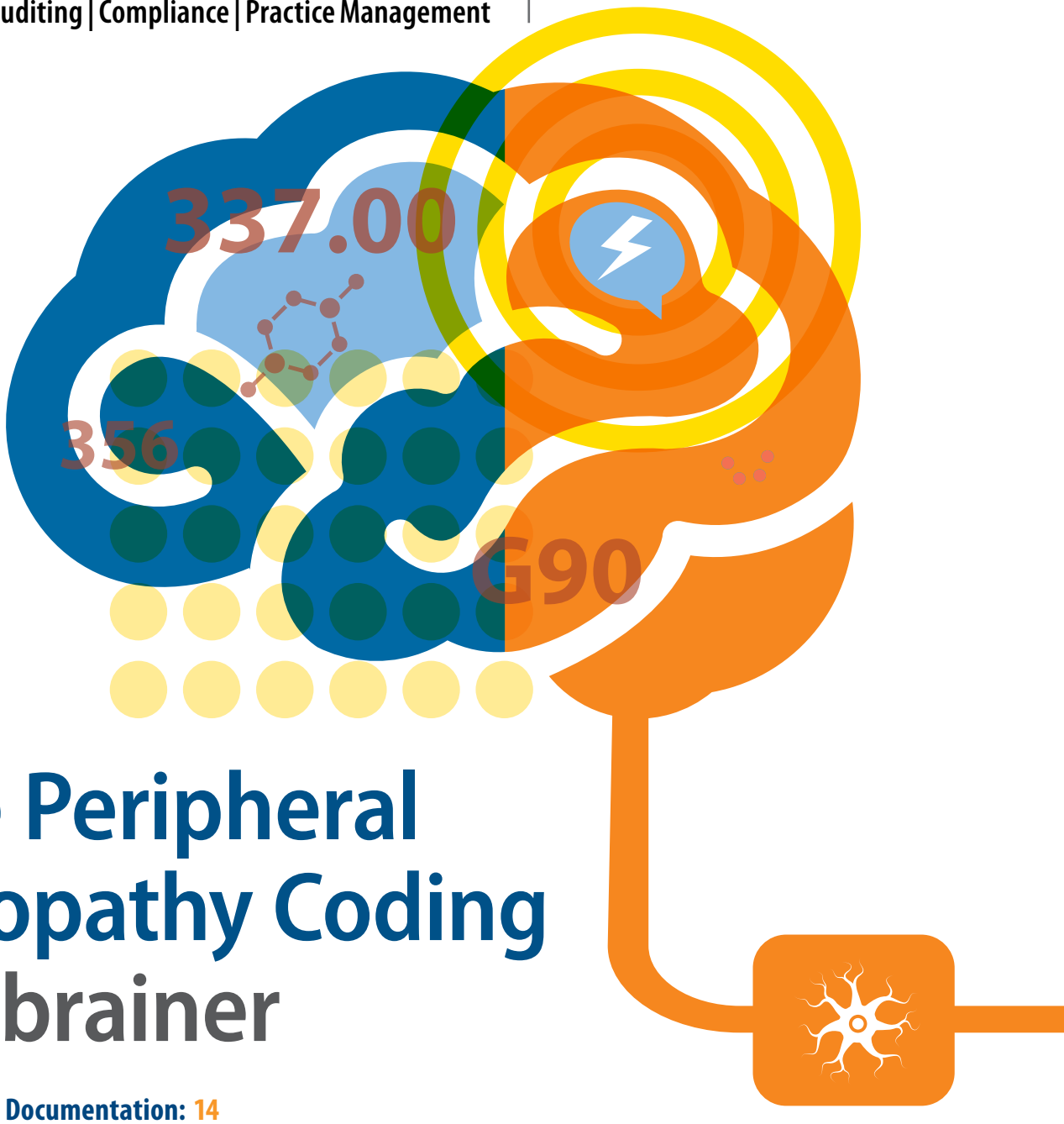

Make Peripheral Neuropathy Coding a No-brainer

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Coding/Billing

Make Peripheral Neuropathy Coding a No-brainer

By Denise Hull, JD, MHA, BSN, CPC

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On the Cover:
Diagnostic coding of peripheral neuropathy is a no-brainer when **Denise Hull, JD, MHA, BSN, CPC**, provides a thorough explanation of nervous system anatomy and conditions. Cover design by Tina M. Smith. *Illustations by iStock © kraphix and © Alex Belomlinsky.*

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Your Feedback Helps Us Support You

One of the most enjoyable parts of my role at AAPC is meeting members. You are the core of AAPC and I appreciate the feedback and suggestions you share. This feedback helps us make your membership experience better and provide tools that keep you current and competitive in a changing market.

Communications

You will see such suggestions reflected in this issue of *Health Business Monthly*. Many members asked if we could better indicate which articles focus primarily on coding/billing, auditing/compliance, and practice management. We hope new color-coded tabs and icons, more like those found in codebooks, will help you find articles important to you more quickly.

Another new effort to enhance communication with you is our blog on www.aapc.com. Industry experts who are members share insights to events, regulatory changes, coding updates, laws, and other areas several times a week. These interesting blogs allow you to get an inside look into the changes happening to our industry that might affect your work and career.

Careers

An issue always important to members is finding work. Whether you're looking for your first job or advancing your career, you will find AAPC's new service, Careerhealth.com, a valuable solution.

Careerhealth.com offers hundreds of thousands of healthcare job postings for all healthcare professions. The free Beta version enables you to more easily search jobs posted through AAPC members and gleaned from the Internet. Now you can search for jobs in a single place without having to surf the web. If you seek applicants, it means you can post the job in one place, rather than several.

We'll introduce new resources over time to help you in your job search or in your search for the perfect employee. Check out www.careerhealth.com.

Competencies

Another tool we introduced to help meet your needs is **Practicode**. Using redacted cases, Practicode modules offer opportunities for practice and training while helping to meet professional goals. You can improve skills using the cloud-based modules in general or specialty coding. If you're a Certified Professional Coder – Apprentice (CPC-A®), you can earn one year of experience through successful completion of the Practicode CPC-A® practicum. If you're an employer, you can evaluate coding proficiency of new employees or test existing employees' proficiency in new specialties. More information can be found at http://practicode.com/.

Our dynamic industry requires us to continue learning and changing. AAPC is dedicated to listening to you and changing with you. We enjoy developing resources and tools that help make your work easier and more fulfilling.

I appreciate the chance to participate in this, and I look forward to meeting you at conferences and while visiting local chapters. Keep letting AAPC know what you need and watch for new developments in the future.

Sincerely,

Jason VandenAkker
AAPC CEO

Please send your letters to the editor to:
letterstotheeditor@aapc.com

Avoid 728.85 for Back Spasms

My comment is regarding the article "For Chiropractors: Know 97140 Billing Rules" (July 2014, pages 20-21), and in particular the use of the ICD-9-CM code 728.85 *Spasm of muscle*. In the first example, the patient received treatment exclusively to the cervical spine. Among the diagnosis codes rendered to support this treatment is 728.85. The use of this code for muscle spasms of the cervical region, or any region of the back, is incorrect.

Per ICD-9-CM coding guidelines, codes 725-729 are for "rheumatism, excluding the back." Therefore, it is improper to use 728.85 for back spasms. In fact, the ICD-9-CM index highlights this distinction under "Spasms," "Muscle," "Back" and lists code 724.8 *Other symptoms referable to back*. It appears that example 2 describes muscle spasms to the patient's shoulder and, as such, 728.85 would be the appropriate muscle spasms code to report.

I see this coding mistake often, especially when it come to chiropractic care. Hopefully, AAPC can help spread the word as to the correct code for back spasms, as well as any other codes that are often confused.

Jeremy Reimer, CPC

Speak Up and Be Heard!

Do you have a question regarding information found in *Healthcare Business Monthly*? Or maybe you have a difference in opinion you would like to share with your peers? Write us at: letterstotheeditor@aapc.com.

For ACA Insured, 2015 Enrollment Is Automatic

If you signed up for health insurance coverage through a state or federal exchange in 2014, you'll automatically re-enroll next year. The U.S. Department of Health & Human Services (HHS) issued a proposal (www.modernhealthcare.com/assets/pdf/CH95314626.PDF) to help prevent disruptions in the marketplace and to troubleshoot and reduce major drop-offs in the 8 million individuals who are insured under private health plans through the exchanges.

Research shows the majority of people don't take action when coverage policy lapses, so HHS is taking the initiative by doing it for them. Managing Director at Manatt Health Solutions Joel Ario (former director of the Office of Health Insurance Exchanges at HHS) said, "I think it's critical that if somebody's already gone through the process and gotten enrolled that they can stay in coverage in as many cases as possible."

The benefits of automatic re-enrollment are:

- Reduces administrative burdens
- Makes it easier for insurance companies to hold on to customers
- Helps to bring stability into the program
- Solidifies market-share trends

Downside: Insurance plans wanting to join an exchange in 2015, or that are struggling to gain customers, will find it more difficult to gain customers during open enrollment if potential insurance customers automatically stay in the same plan.

You have 30 days to comment before HHS issues a final rule.

Source: ModernHealthcare.com, "HHS announces auto-enrollment for current ACA consumers," Paul Demko, June 26, 2014

Measles Makes a Comeback

The Centers for Disease Control and Prevention (CDC) recently reported 477 confirmed cases of the measles (rubeola) in the first six months of 2014. Although measles was deemed "eliminated" in the United States in 2000, the disease is still prevalent in many parts of the world, and travelers continue to bring it into the country. The Philippines, for example, is experiencing a large, ongoing measles outbreak, which has led the CDC to issue a Travelers' Health Notice.

Recognize the Signs

Providers should be on the lookout for measles, the CDC advises. Measles is an acute viral respiratory illness. Indications include:

- Malaise
- Cough
- Fever
- Coryza (rhinitis)
- Conjunctivitis (pink eye)
- Pathognomonic enanthema (Koplick's spots) – Little spots inside the mouth surrounded by a red ring.
- Maculopapular rash - A combination of both macules (flat, discolored areas) and papules (small, raised bumps).

Complications of measles may include:

- Otitis media (middle ear infection)
- Bronchopneumonia
- Laryngotracheobronchitis (croup)
- Diarrhea

Procedure Coding

There is no treatment for measles, but the provider may treat the symptoms and report an appropriate evaluation and management code.

The majority of reported cases occurred in unvaccinated people. The CDC recommends the Measles-Mumps-Rubella (MMR) and Varicella (VAR) vaccines, or the combination Measles-Mumps-Rubella-Varicella (MMRV) vaccine, for children 1-12 years of age, given in two separate doses: the first dose at 12-15 months of age and the second dose at 4-6 years of age.

For vaccination, report the appropriate CPT® vaccine product code:

90705 Measles virus vaccine, live, for subcutaneous use

90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use

90708 Measles and rubella virus vaccine, live, for subcutaneous use

90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use

Remember to also code the administration of the vaccine (90460-90474).

Diagnosis Coding

Measles is classified to ICD-9-CM category 055. The fourth digit depends on whether the patient experienced a complication, such as:

055.0 Postmeasles encephalitis

055.1 Postmeasles pneumonia

055.2 Postmeasles otitis media

055.71 Measles keratoconjunctivitis

055.79 Measles with other specified complications

055.8 Measles with unspecified complication

Assign 055.9 for measles without mention of complication.

ICD-10-CM coding is similar, but expands your options:

B05.0 Measles complicated by encephalitis

B05.1 Measles complicated by meningitis

B05.2 Measles complicated by pneumonia

B05.3 Measles complicated by otitis media

B05.4 Measles with intestinal complications

B05.81 Measles keratitis and keratoconjunctivitis

B05.89 Other measles complications

Assign B05.9 for measles without mention of complication.

By Peter Davidyock, CPC, CPMA

Take the Lead

One chapter officer opportunity stands out above them all: PRESIDENT

Opportunities to make a difference are abundant in your local chapter. Strong character, the ability to lead, professionalism, communication skills, and philanthropic tendencies are all qualities local chapter officers have in common. The president, at the helm, assumes the strongest of these traits. Members who are elected as president and agree to take on the role are investing in their chapter, as well as in themselves.

It Takes Determination and Direction

A strong desire to lead is necessary when grabbing hold of chapter reins. Presidential responsibilities take many forms, some of which include:

- Leading chapter meetings
- Appointing committees
- Mentoring new coders
- Developing study groups for students preparing to take credentialing exams
- Recruiting and developing new officers
- Providing oversight of chapter financial matters
- Engaging members and improving the chapter

The president is primarily responsible for the overall wellbeing of the chapter, including meetings and exams, and works with other officers to determine the needs and direction of the chapter for the coming year.

The president may have to assume multiple roles, as well. If the chapter doesn't have an education officer, for example, the president would work with the vice president to schedule educational resources for meetings.

Attention to Detail Is a Must

The president schedules exams and must serve as first proctor on at least one exam per year. Proctoring is a very rewarding experience, and a great way to give back to an organization that gives so much. The responsibility goes beyond simply scheduling and proctoring to ensure exams are administered properly. As a topic for an officers' meeting, presidents can offer to train other officers to proctor. Questions surrounding proctoring and AAPC expectations should be reviewed in advance, so that everyone understands his or her role and responsibility before exam day. This is a great bonding exercise for officers.

Presidents also play a role in the financial welfare of their chapters. They ensure the bank signature card is correct every January and update it during the year if there is an officer change. If the chapter uses a debit card, they provide a check-and-balance for the treasurer by regularly reviewing the card activity. The copy of the bank statement can be delivered via email to the president for review when it's mailed by the bank to the treasurer. It's really an efficient way to monitor all of the account activity. Electronic copies of bank statements can be maintained on a flash drive that can be given to the next president. Transferring electronic copies sure beats receiving bags and

The president works with other officers to determine the needs and direction of the chapter for the coming year.

Election time is drawing near. Be bold.
Put your leadership abilities front and center.

bags full of chapter paperwork from your predecessor.

Leave Your Mark

The effect presidents have on their chapters may go well beyond their terms. For example, a driving force for me when I accepted the role of chapter president was laying the ground work for things to come. By listening to other members my officers and I set the tone, which resulted in continued growth for our chapter to this day. We embraced technology and began using multimedia presentations to enhance speakers' lectures. We strived to create a comfortable, upbeat learning environment in which we could spread our enthusiasm. Every other month, we changed meeting locations to reach more members, which brought immense membership growth. This approach is ongoing and has retained members, which has truly been a blessing.

You Have What It Takes

Election time is drawing near. Be bold. Put your leadership abilities front and center. Get in the driver's seat of your local chapter. The bonds you create will last a lifetime, and the doors you open for your chapter may swing wide for years to come. HBM

Peter Davidyock, CPC, CPMA, works at Pawleys Island Pediatrics and Adult Medicine. He has been coding for four years and has experience in anesthesia, ear, nose, and throat, family medicine, pain management, cardiothoracic surgery and electrophysiology. Davidyock is a regular presenter at the Conway, S.C., local chapter and has held several offices. He has developed programs with local colleges in his area that allow students to be part of the chapter experience.

Resource: All of the exam guidelines are available in Chapter 8 of the Local Chapter Handbook (**http://cloud.aapc.com/localchapters/2014LC_handbook.pdf**). It's a good idea to read and review the handbook guidelines with all of your officers.

By Roxanne Thames, CPC, CEMC

Make Your Vote Count Using an Absentee Ballot

Local chapters are gearing up for the 2015 chapter officer elections. If you are unable to attend your chapter's upcoming election meeting, you can request an "absentee ballot."

Contact the officer at your chapter who is in charge of elections, typically the vice president, and let him or her know you are unable to attend the voting meeting. The officer in charge will send you an absentee ballot with a list of names for the candidates and the office for which they are running. If a nominee is running unopposed, there will be a "yes" or "no" option.

For your absentee ballot to be counted, you must return it to the officer in charge of the election no later than 24 hours before the scheduled election. It's best practice for officers to give plenty of advance notice of an election meeting's date and time, so members have ample time to request an absentee ballot and return it in the appropriate time frame.

For more information on absentee ballots and elections, see the Local Chapter Handbook, Chapter 6 – Elections, Section 5.

By Barbara Fontaine, CPC

Mentor Makes a Difference: Tribute to Marge Carney

Learn from this positive role model who thrived as a mentor.

AAPC members are lucky. This is one of the few professional organizations in which members consistently share knowledge — through local chapters, *Healthcare Business Monthly* magazine, e-blasts, forums, conferences, and educational programs — to help make each of us better at what we do. Another, perhaps less traveled, avenue we can take to support our fellow healthcare business professionals is mentoring.

A successful mentor/mentee relationship is a two-way street. Both parties must work on the relationship and be committed to a team effort, long term. Once you enter into a mentorship, you'll find it is incredibly rewarding. You might even gain a life-long friend, as I did with a mentor of mine, **Marge Carney, CPC, CGCS**.

Start with Good Communication

I first met Marge when the AAPC national conference came to St. Louis in 2007. She volunteered to chair the St. Louis local chapter's decorating committee, on which I also served. She had a vision of what our "Welcome to St. Louis" room should look like; and our committee, the "Decorating Divas," was determined to get the look she wanted. She gave us her expectations and offered support or suggestions if we asked, but she let everyone do his or her own job. The most beneficial thing she did was communicate via meetings, phone calls, and emails. Her communication was open and honest, not nagging. She had a plan, we caught her vision, and we triumphed together.

Provide Honest, Tactful, and Innovative Ideas

A mentor should be honest. If something wasn't up to par, she found a way to be truthful, but always kind. She would find something positive to say about any situation. For example, I'm reminded of the time we were decorating for a "Get to Know Your Local Chapter" event at the national conference in Orlando, a few years later. Our chapter had a "Meet Me in St.

Marge faced her treatment with a smile. She always saw the best in her friends and those she met along the way, and she gave the best of herself back to all of them.

Louis" theme. We dressed as soda jerks in an ice cream parlor, handing out small ice cream cone candy. Someone brought a stuffed Clydesdale horse to put on the table, but it just didn't go with the ice cream theme. Clydesdales go with beer — at least in St. Louis! She took the lead and told the person that the horse was a lovely thought, but that she would like to use it as a door prize for our upcoming trivia night, instead. She then one-upped the prize by including tickets to a St. Louis Cardinals game, so the winner could see the real Clydesdales on the big screen at the ballpark! No one could deny that she was quick on her feet and innovative, too.

Instill Enthusiasm and Networking

One of the best things about my mentor was her willingness to participate in our chapter with every ounce of enthusiasm in her body. She served first as president-elect and then president. During her term, she asked several of the Decorating Divas to consider serving as officers with her. Because she was the one who asked, and I knew her level of commitment, I volunteered to run for education officer. I was elected and soon involved in a whirlwind of activity. I didn't realize it at the time, but Marge had big plans for our chapter, and she revolutionized it by becoming a mentor to us all.

She believed everyone deserved to be recognized, so together we developed a "Points for Education" system that is still in use today. We had committees for everything, from acquiring door prizes, to registering attendees at meetings, to handling refreshments at all of our activities. Everyone was welcomed, included, acknowledged, and felt as though he or she had a reason to attend our meetings. The first prize we awarded in our "Points for Education" program was a chapter name badge, to encourage people to meet others and to network.

Getting to know others in your chapter is the best way to build relationships, and a good mentor will introduce you to people who will be invaluable in your career and in your life.

Help Someone Excel

A mentor is reliable and consistent, and will teach you to become that way, too. Other professionals will begin to trust you and your work. Honesty, integrity, and a positive attitude are what make you excel in your career and in your life. Mentors show you how to do this, and lead you to excellence. Because of her belief in me, I became president of our chapter, and then a board member of the AAPC Chapter Association.

Marge's Mentoring Legacy Lives On

Marge was a great mentor and friend to many AAPC members. She served on the AAPC national advisory board (NAB) from 2009-2011. During those years, she discovered she had breast cancer. It didn't slow her down, and it didn't take away from her positive, caring nature. Marge faced her treatment with a smile. She always saw the best in her friends and those she met along the way, and she gave the best of herself back to all of them.

She died on May 17, in St. Louis. The breast cancer came back last fall and took her life. What it didn't take was her courage, her spirit, or her generous character, which is remembered by those who knew her and those she mentored. Because of her commitment and the investment of her time, the loss felt by those who she mentored and taught is too great for words. You, too, can make a difference in someone's life, as she did in mine. Please think about becoming a mentor. HBM

Barbara Fontaine, CPC, is 2014-2015 AAPC Chapter Association board of directors' chair and Region 5 representative. She is business office supervisor at Mid County Orthopaedic Surgery and Sports Medicine, a part of Signature Health Services. She served on several committees before becoming a St. Louis West, Mo., local chapter officer. In 2008, she earned AAPC's Local Chapter and Coder of the Year awards.

Find Out How to Support Mentoring

In 2012, the AAPC Chapter Association board of directors developed a mentoring program for local chapters. It's listed in the Officer Resources under Best Practices. Please consider using this program in your chapter to help our newer members find their career path. If your chapter needs help getting started, contact your AAPC Chapter Association regional representative. If you are unable to be a mentor right now, consider a donation to the AAPC Hardship Scholarship in honor or in memory of someone who mentored you. You can make a difference.

By Holly Cassano, CPC

Charge Up Your ECG Documentation

Be sure the medical record carries enough voltage to bypass reimbursement challenges.

Physicians often use computer-generated electrocardiogram (ECG) reports as the baseline for their own interpretation and report. Computer-generated ECG reports, alone, do not meet the requirements to code and bill for the professional component of an ECG. The Centers for Medicare & Medicaid Services (CMS) requires a "separate" interpretation report and signature from the ordering provider. Additionally, applying modifiers to ECG codes inappropriately may lead to reimbursement challenges.

Note: The CPT® codebook includes several types of tests within the Cardiography section. In this article, we will concentrate on "routine" ECG codes 93000-93010.

Routine ECG Reporting

Services described by 93000-93010 generally involve placement of six leads on the patient's chest, and another six leads placed between the patient's extremities. The heart's electrical activity generates a current that spreads to the skin; electrical activity sent from the sinoatrial node through the heart is traced/recorded and reviewed.

You should not apply modifiers 26 *Professional component* or TC *Technical component* to these ECG codes because CPT® has already broken down 93000-93010 into professional and technical components, as shown below.

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

This code reports the global professional and technical components of the service. Use 93000 if the equipment belongs to the ordering provider. Note that an ECG with interpretation must include the full graphic tracings with formal written interpretation

93005 Electrocardiogram, routine ECG with at least 12 leads, tracing only, without interpretation and report

Use this code for ECG without the interpretation and report (technical component). Documentation should include the serial tracing.

93010 Electrocardiogram, routine ECG with at least 12 leads, interpretation and report only

Report 93010 for the professional component of the ECG only. You should not apply modifier 26 when there is a specific code to describe only the physician component of a given service. For example, when a cardiologist provides an ECG interpretation at a hospital with a separate report, the correct code is 93010. Do not code 93000-26.

Meeting ECG Order Requirements

A valid ECG order will have the following attributes:

- A specific order for the diagnostic test
- Documentation in the medical record supporting the need for the diagnostic test
- A separate, signed, written, and retrievable report with an interpretation of the diagnostic test
- The order for the diagnostic test, triggered by an event
- The diagnostic test to help diagnose the presence or absence of an arrhythmia
- An electronic signature or some indication on the results for all tests
- An indication that the ordering provider reviewed the results (or the provider must indicate this in the note)

Warning: If there is no evidence that the ordering provider reviewed the results, or there is no mention of the ECG results in the note, you can't code for the ECG.

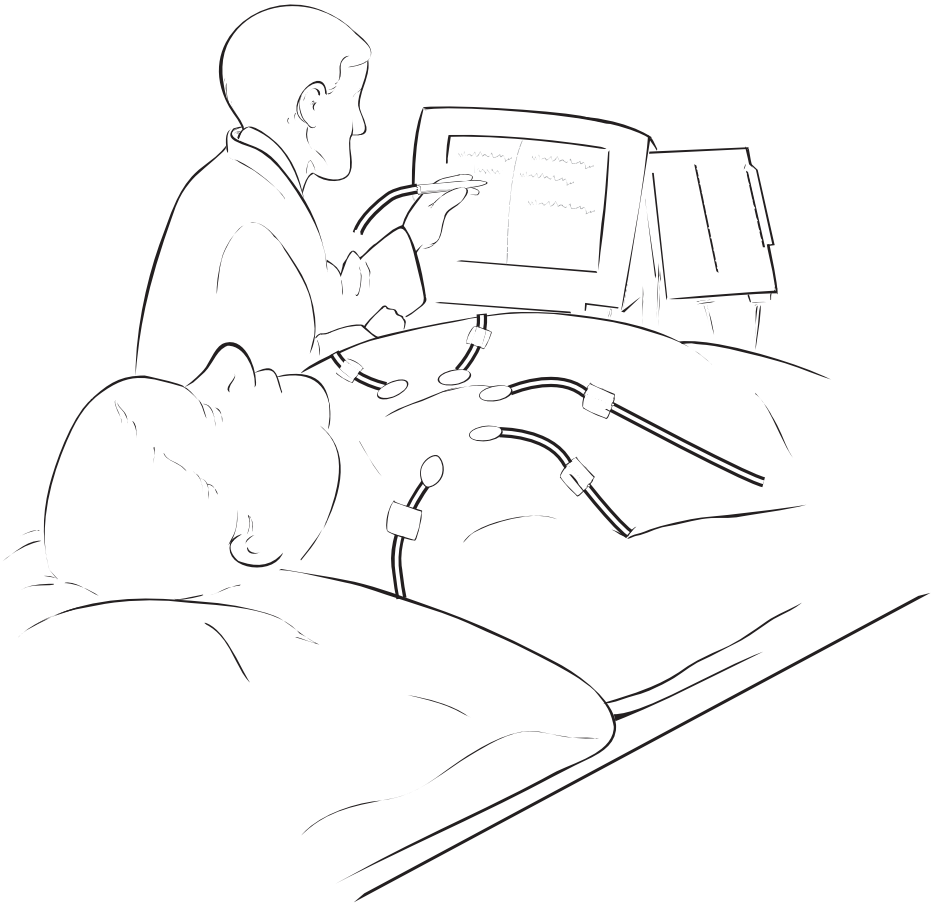
Best Practices to Document the Physician Report

As far back as 1992, the CPT® code book has included language stating, "a written report, signed by the interpreting physician, should be considered an integral part of a radiologic procedure or interpretation." Medicare law (42 CFR § 415.120(a)) likewise requires all interpretation services to be documented in "a written report prepared for inclusion in the patient's medical record maintained by the hospital."

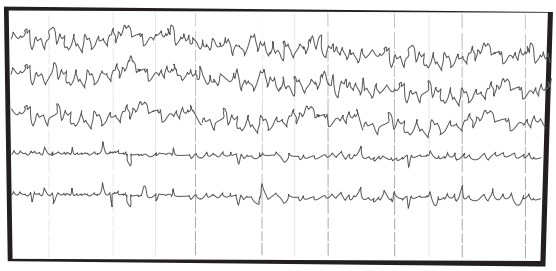
CMS does not require the provider to document an ECG interpretation on a separate piece of paper, but instead allows for a complete written interpretation to be recorded within the medical record (check with your local carrier for further guidance). CMS further requires a report to be complete, documented similarly to that of a specialist in the field (radiology), and consistent with the treatment rendered. CPT® states there must be a "separate, signed, written, and retrievable report."

Common ECG documentation errors:

- CMS differentiates between an interpretation with report and a simple review. An interpretation with report must include findings, relevant clinical issues, and comparative data (if available).
- Simply notating "ECG normal" would not suffice for separate payment consideration under an audit. This sort of documentation is a review of findings, only, which is inclusive to any E/M service reported.



A routine ECG is performed. At least 12 metal disks (electrodes) are applied to the patient's chest area with conductive gel. The weak waves are amplified and the data translated into readable graphs



ECG readout

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CMS does not require the provider to document an ECG interpretation on a separate piece of paper, but instead allows for a complete written interpretation to be recorded within the medical record ...

Documentation best practice of common ECG findings may resemble the following examples:

- Sinus tachycardia, rate 120, non-specific ST-T changes, no acute ischemia noted, no EKG available for comparison.
- Normal sinus rhythm with rate of 72, PR and QRS intervals within normal limits, QRS complexes in lead III and T-wave abnormalities in lead I, no acute changes noted from prior EKG.
- Right bundle branch block, no ischemic changes.

Compliance Coding Tip: Do not code for ECG or rhythm strip interpretation if the physician merely notes, "EKG normal or negative."

Problem Areas to Watch

For examples of where ECG claims can fail, consider that Novitas Solutions performed a 100 claim sample of ECG services in a post pay audit and found a 22 percent claim error rate and a 17 percent claims paid error rate. The majority of the errors were in the following areas:

- Missing order from the "ordering provider" and no supporting diagnosis for the ECG
- Missing ECG documentation – no signed review of the actual test, and/or no signed interpretation/report
- Incorrect billing of ECG – billing an ECG without a supporting diagnosis, wrong CPT® code

Clinical ECG Coding Example

A 65-year-old, obese female patient presents to ED via ambulance with an acute onset of chest pain. No prior cardiac history. Patient was walking her dog at the onset of event. EKG was performed or read by the ED physician. Separate notation of EKG results are in the chart. "Sinus tachycardia, rate 120, non-specific ST-T changes, no acute ischemia noted, no EKG available for comparison." The patient was discharged with orders to follow up with Dr. Cardiologist within three days. No medications prescribed at this time, other than OTC aspirin 85 mg bid, a.m. & p.m.

Lab work performed and patient admitted. Full H&P.

Code – E/M MDM management options = 4 points for additional work

Data reviewed = 3 points for order and read of EKG + 1 point for lab

Risk = High for acute chest pain and age of patient, obesity

CPT® codes:

99285 Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.

93010

ICD-9-CM:

427.89 Sinus tachycardia

278.00 Obesity NOS

Dx Can Make or Break Your Claim

The diagnosis code must establish the medical necessity of an ECG. If diagnosis coding is not precise, or if the medical record does not support a diagnosis code, some carriers will consider the ECG "routine" and will deny payment for ECG interpretation. HBM

Sources:

To learn more about ECG documentation, view the ACEP website: www.acep.org/Legislation-and-Advocacy/Practice-Management-Issues/Physician-Payment-Reform/X-Ray---EKG-FAQ/

For CMS guidelines on ECGs, go to: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf

Holly Cassano, CEO, CPC, is AAPC ICD-10-CM Certified, director of coding education and compliance for Tactical Management Inc., (TMI). She is a member of the Tampa, Florida, local chapter.

ECG or EKG? It Doesn't Matter

An electrocardiogram (ECG) measures the performance of the heart's electrical conduction system, which provides data that may be used to determine heart rate, the size and position of the heart chambers, the presence of any damage to the heart, etc. Dutch physician Willem Einthoven developed the ECG in 1903, and won the Nobel Prize for Medicine for his invention in 1924. The alternative spelling elektrokardiogram (EKG) comes from Einthoven's native language, Dutch.

To be clear: ECG and EKG describe the exact same test. There is no difference or distinction between them. You may use either spelling or acronym for coding and documentation purposes.

Understand Diabetes to Code It Right

Diabetes is a condition when the body does not use glucose normally. There are different types of diabetes. The ability to differentiate the types of diabetes by recognizing documented signs and symptoms in the medical record will ensure you code patient encounters correctly.

Type II

Type II diabetes does not respond normally to the insulin the body makes. Symptoms include frequent urination, excessive thirst and hunger, fatigue, blurred vision, and tingling, pain, or numbness in the hands/feet.

Type I

Type I diabetes is the result of the pancreas not making enough insulin. Symptoms include frequent urination, excessive thirst and hunger, fatigue, blurred vision, and weight loss.

Gestational

Gestational diabetes can occur in women during pregnancy. There are no symptoms: only a test can detect this type of diabetes.

Source: American Diabetes Association

photobyte/iStockphoto © aspenphoto

By Sheri Poe Bernard, CPC, CPC-H, CCS-P

Identify Causal Relationship Links in DIABETES

Small differences in documentation language play an important role in diagnostic coding.

A key concept for accurate diabetes coding is that of causal relationships. A causal relationship is a documented link between a disease (etiology) and a condition (manifestation) caused by that disease. For a coder to report a causal relationship between diabetes and a complication of diabetes, the provider must establish an unambiguous link in the documentation.

To illustrate causal relationships, consider these three assessments:

Assessment 1

- Diabetes
- Chronic kidney disease (CKD) stage 3
- Hyperglycemia

In this assessment, the provider does not document a causal link between the diabetes and the kidney disease. Correct code assignment is 250.00 *Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled* and 585.3 *Chronic kidney disease, Stage III (moderate)*. You may not assume a causal relationship where documentation has not established one.

Report the diabetes as type 2, although this is not documented. This instruction is from the *ICD-9-CM Official Guidelines for Coding and Reporting*, and is a guideline based on the demographic that more than 90 percent of diabetic patients have type 2 diabetes.

Assessment 2

- Diabetes and nephropathy
- CKD stage 3
- Hyperglycemia

In this second assessment, the provider does not successfully link the diabetes and the nephropathy, although it was likely the provider's intent was to make that link. Correct coding in this instance includes 250.00 (diabetes), 583.9 *Nephritis and nephropathy, not specified as acute or chronic, with unspecified pathological lesion in kidney* (nephropathy), and 585.3 (stage 3 CKD). You may be tempted to report 581.81 *Nephrotic syndrome in diseases classified elsewhere* for the nephropathy, but this is a manifestation code that may be used only when a causal relationship has been established. The correct nephropathy code is found in the index under:

Nephropathy (*see also* Nephritis) 583.9.

Examples of acceptable causal links in diabetes include when a manifestation is preceded by the word "diabetic," as in "diabetic retinopathy," or followed by the phrases "of diabetes" or "due to diabetes." "Diabetes and" does not establish a causal relationship, nor does the phrase "diabetes contributing to" because it only establishes a factor, not a cause.

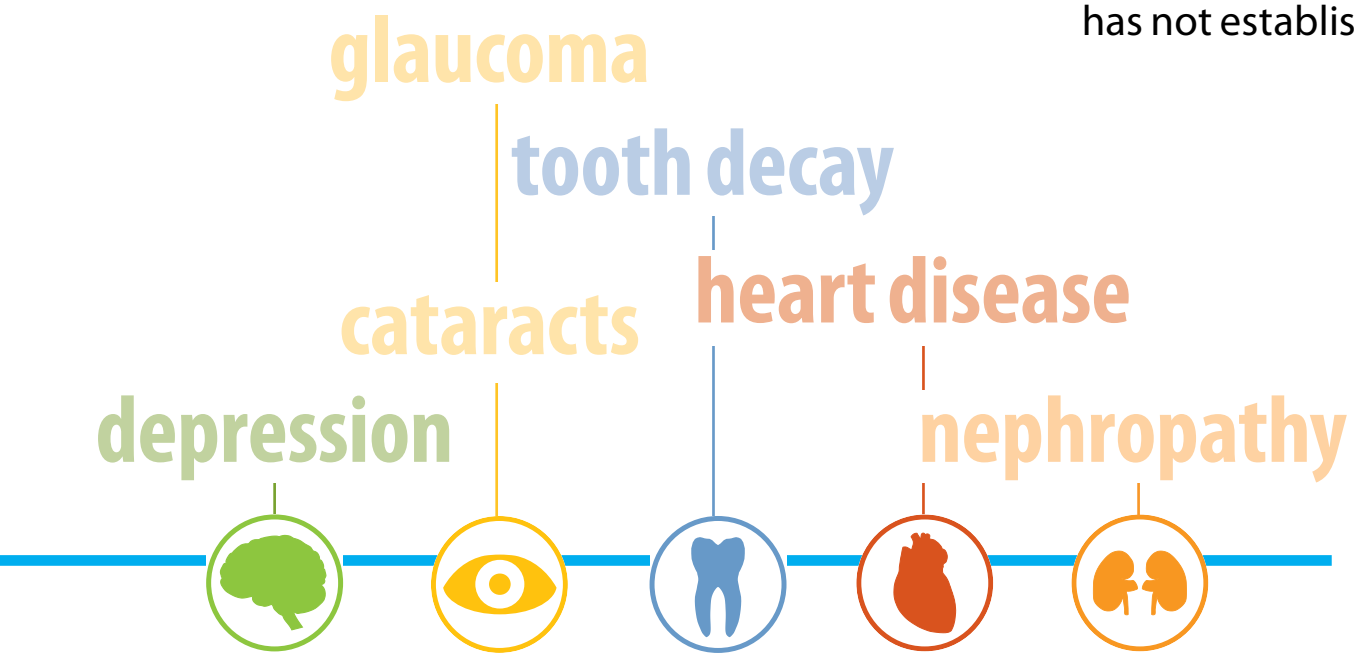
These small differences of language are critical in diagnostic coding audits. Correct documentation of causal relationships does not increase the provider's documentation burden; whenever possible, you should guide providers toward better documentation practices.

Assessment 3

- Diabetic nephropathy
- CKD Stage 3
- Hyperglycemia

In this assessment, the provider clear-

You may not assume a causal relationship where documentation has not established one.



ly links the diabetes to the kidney disease, by stating "diabetic" nephropathy. Report codes 250.40 *Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled*, 581.81 *Nephrotic syndrome in diseases classified elsewhere*, and 585.3 (Stage 3 CKD).

Hyperglycemia, as documented in all three assessments, is a symptom of diabetes and would not be separately reported. You cannot assume that high blood glucose means the patient has uncontrolled diabetes. This coding decision is supported in the index:

Diabetes

with

hyperglycemia - code to Diabetes, by type, with 5th digit for not stated as uncontrolled.

There are a few exceptions to the documentation rule for causal relationships in diabetes. Loss of protective sensation (LOPS), gangrene, and osteomyelitis may be reported as complications of diabetes even when no link is established in the documentation, according to *Coding Clinic* entries (LOPS, 4th Quarter 2009; gangrene, March 1986; osteomyelitis, 1st quarter 2004). Also, 2nd Quarter 2009 *Coding Clinic* states that diabetes "with" neuropathy establishes a causal link between the diabetes and the neuropathy. It would be unwise to extrapolate that rule across all diabetic complications, however.

New Rules on the Horizon

Don't get too comfortable abstracting undocumented links between diabetes and neuropathy, osteomyelitis, gangrene, or LOPS because ICD-10-CM will start the rule-making all over again. An ICD-10-CM *Coding Clinic* entry from 4th Quarter 2013 is evidence that changes are already happening. It reads:

> *ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.*

Diagnosis coding is gaining more importance among professional coders as the number of risk-adjusted claims increases, year over year. Payment under risk adjustment is affected by these causal relationships, making it important for everyone to understand the causal relationship rules and code accurately for ICD-9-CM and ICD-10-CM. Following the guidelines, as well as the rules within *Coding Clinic*, will ensure accurate coding as you move from one code set to the other. HBM

Sheri Poe Bernard, CPC, CPC-H, CCS-P, is an independent consultant specializing in risk adjustment coding quality and training, and author of *Netter's Atlas of Human Anatomy for CPT Surgery*, to be published by the American Medical Association in early 2015. She is a member of the Salt Lake City, Utah, local chapter.

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By Cristy Donaldson, CPC, CPB, CPMA

CODING/BILLING

Are "Get-acquainted" Visits Billable?

Let medical necessity point you to the correct answer.

A few years ago, I presented to a family practice office as a new patient for a preventive medicine visit. I filled out all the necessary new patient forms, gave the receptionist my insurance card, and was promptly asked for a co-pay. I explained that my insurance policy covered an annual preventive medicine visit at 100 percent, with no co-pay required. The polite receptionist told me it was office policy to perform a "get-acquainted" visit first, to determine my medical history, and that I could schedule a preventive visit for another day.

My initial reaction was to sigh and sit down. But, after thinking about it, for a few minutes, I returned to the receptionist and explained that preventive medicine visits include two categories: new patient and established patient. The new patient category allows healthcare providers to obtain a history and perform an examination relevant to a new patient. As a certified coder and auditor, I tried to be as kind as possible while educating the staff that it was neither appropriate nor necessary to demand that a new patient submit to a get-acquainted visit. I also offered to explain this to the provider.

As you might have guessed, I received my new patient preventive medicine visit from a very nice physician, that same day. And, hopefully, everyone in the office learned something, too.

Educate Providers and Staff

Providers must remember that CPT® codes 99201–99205 are problem oriented in nature, and should be reported only when the services rendered uphold evaluation and management (E/M) of a condition, problem, or symptom of a new patient. Each level of service has specific requirements for the history, examination, and medical decision-making, based on the chief complaint.

CPT® codes 99381–99387, by contrast, are preventive in nature, and should be reported only when the rendered services uphold preventive evaluation, largely based on the age and gender of the patient. Both the problem-oriented and preventive medicine E/M codes allow the clinician a sufficient degree of history to get acquainted with the patient, and to establish a doctor-patient relationship.

There is no CPT® code for merely getting acquainted with a patient. A visit performed solely for taking a patient's history is neither medically necessary, nor appropriate to report to insurance using CPT® 99201–99205. It's not appropriate to bill the patient for this type of visit, or to require this type of visit when the patient has no complaints. HBM

Cristy Donaldson, CPC, CPB, CPMA, is a coding manager with University Physicians' Association in Knoxville, Tenn. She has over 20 years of experience in the healthcare industry. Donaldson previously worked as a coding and compliance specialist in Florida and is now at the UPA Central Billing Office in Knoxville, where she educates fellow team members and supervises appeals. She is a member of the Knoxville, Tenn., local chapter.

As a certified coder and auditor, I tried to be as kind as possible while educating the staff that it was neither appropriate nor necessary to demand that a new patient submit to a get-acquainted visit.

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By Roxanne Thames, CPC, CEMC

Billing Rules Change when the Patient Isn't Present

Know the best coding approach when a family member or caretaker is present on a patient's behalf.

Typically, insurers (including Medicare) will not cover an evaluation and management (E/M) service with a patient's family or caretaker(s) if the patient is not present. In such a case, the best approach to ensure reimbursement is to not file a claim with insurance, but rather to bill the family member(s) who are present for the visit.

You should inform the family member(s) that the service is not billable to the insurance company, and therefore will be provided at his or her expense. Explain this prior to scheduling the appointment, so there are no surprises when the bill arrives. If the family member/caretaker isn't a patient, obtain his or her demographic information so you may enter it into your practice management system.

Select E/M Codes Based on Time

You may report visits with family members and caretakers using typical E/M service codes, based on time. Per CPT® instructions:

> When counseling and/or coordination of care dominates (more than 50 percent) the encounter with the patient and/or family (face-to-face time in the office or other outpatient setting on floor/unit time in the hospital or nursing facility) then time shall be considered a key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision-making whether or not they are family members (e.g., foster parents, person acting in

Because the patient is the focus of the visit, you should bill an established level of E/M visit (e.g., 99211–99215).

loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the patient's medical record.

Counseling is a discussion with a patient and/or family concerning one or more of the following:

- Diagnostic results, impression, and/or recommended diagnostic studies
- Prognosis
- Risk and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

The provider should document in the medical record, all pertinent information discussed during the session. For example, "30 minutes of counseling" isn't sufficient. Instead, the provider should summarize the discussion that comprises the counseling or coordination of care. In a best-case scenario, the provider also will document the beginning and ending time of the counseling and/or coordination of care, and the beginning and ending time for the overall face-to-face visit.

Because the patient is the focus of the visit, you should bill an established level of E/M visit (e.g., 99211–99215). When reporting E/M services by time (rather than the key components of history, exam, and medical decision-making), use CPT® "reference times" to determine an appropriate E/M service level.

99211 = 5 minutes

99212 = 10 minutes

99213 = 15 minutes

99214 = 25 minutes

99215 = 40 minutes

CPT® states, "When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used." For example, a level III established patient outpatient visit (99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity*) has a reference time of 15 minutes, while a level IV service (99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity*) has a reference time of 25 minutes. When reporting a time-based E/M lasting 19 minutes, you would report 99213.

As an example of how such a visit might be documented and coded, consider the following sample note:

> Family discussion on 5/10/2014 with Jane Doe (daughter) and Joe Doe (son) regarding their mother Mary Doe, MRN # 12345, DOB 2/2/45. Mary is a current patient of mine who was recently diagnosed with CA of the left breast that is very aggressive. I discussed prognosis and treatment options for Mary's aggressive breast CA, including surgery, recovery time, and chemotherapy; and the side effects of chemotherapy. I gave them literature from the American Cancer Society, and the name of local support groups that they could contact. I spent a total of 42 minutes with Jane and Joe. Both parties verbalized understanding. I answered all their questions, and they are in agreement with my plan, as outlined above.

Proper code selection is 99215 (with a reference time of 40 minutes). HBM

Roxanne Thames, CPC, CEMC, has worked in the medical billing and coding field for 20 years. She began her career as a billing office clerk for a nursing home, and later worked as a physician biller/coder for a large internal medicine practice in Lemoyne, Pa. She has taught ICD-9-CM at Harrisburg Area Community College, and now works as an auditor/educator for a practice management group. She is an active member in the York, Pa., local chapter, and enjoys mentoring, networking, and visiting with other local chapters.

By Jackie Stack, CPC, CPC-I, CPB, CEMC, CFPC, CIMC, CPEDC

There Is a Bright Side to ICD-10-CM

Counteract the negative hype of ICD-10-CM with well-informed benefits.

Many people focus on the differences between ICD-9-CM and ICD-10-CM, and the problems that implementing a new diagnosis code set may cause. I prefer to focus on the positive aspects of moving to ICD-10-CM.

Providers Benefit in Many Ways

The best thing about ICD-10-CM is that it allows you to code to a higher level of specificity. The more precise the documentation, the more excactly you can code. This puts pressure on providers to make sure their documentation is up to snuff. And that is a really good thing.

Decreased Denials - More specific documentation will improve medical decision-making. The medical decision will be supported by a clear picture of the encounter with the patient. This will help to reduce denials, and will save time and money for the payer, provider, and patient.

For example, think about what happens when there is a denial for medical necessity. It takes time and money to process a denied claim. The claim needs to be reviewed to determine why it was denied. The documentation needs to be reviewed to see if it supports the codes that were selected. Then, the documentation needs to be sent in with the claim. Phone calls to the payer may be necessary, and the patient may call you with questions regarding the denial.

When documentation paints a clear picture and services are coded to the utmost specificity, claims are less likely to be denied, and providers are more likely to be reimbursed in an appropriate, timely manner.

Consolidation through Combination Codes - ICD-10-CM has many combination codes. A combination code is a single code used to classify two diagnoses: a diagnosis with an associated sign or symptom, or a diagnosis with an associated complication. Assigning a combination code reduces the time it takes to find and apply multiple codes.

"If the provider could've easily spelled out that a patient fell on ice in the parking lot of a hotel while traveling for work using a code … Think about how much time could've been saved …"

For example, when coding for pressure ulcers in ICD-9-CM, two codes are required: one for the ulcer and one for the stage. In ICD-10-CM, we have one combination code that includes the site of the ulcer and the stage.

Severity Shows Necessity - In ICD-9-CM, the codes for otitis media do not have an option for recurrent. ICD-10-CM has codes for acute, chronic, and recurrent, in addition to type and laterality. Using the recurrent code helps to show medical necessity, which assists in getting approval for surgery.

External Cause for Efficiency - External cause codes enable the payer to receive specific information regarding the injury. This can help the payer determine quickly if it is responsible for paying the service, and mitigate problems between the payer, provider, and patient.

A Big Benefit to Patients

How can ICD-10 benefit a patient? To provide a better understanding of how ICD-10-CM can save time and hassles for patients, let's look at an example of what happened to **Rhonda Buckholtz, CPC, CPMA, CPC-I, CENTC, CGSC, COBGC, CPEDC**, vice president of ICD-10 Training and Education at AAPC:

"Keep in mind, I am a seasoned healthcare professional. I know what to expect and how to handle things. When I explain the timeframes, you need to imagine the impact this case would have on an 'average' patient.

"While traveling for work several years ago, I slipped and fell in an icy hotel parking lot. I broke both my ankle and wrist. I was out of state, out of network, and needed surgery urgently.

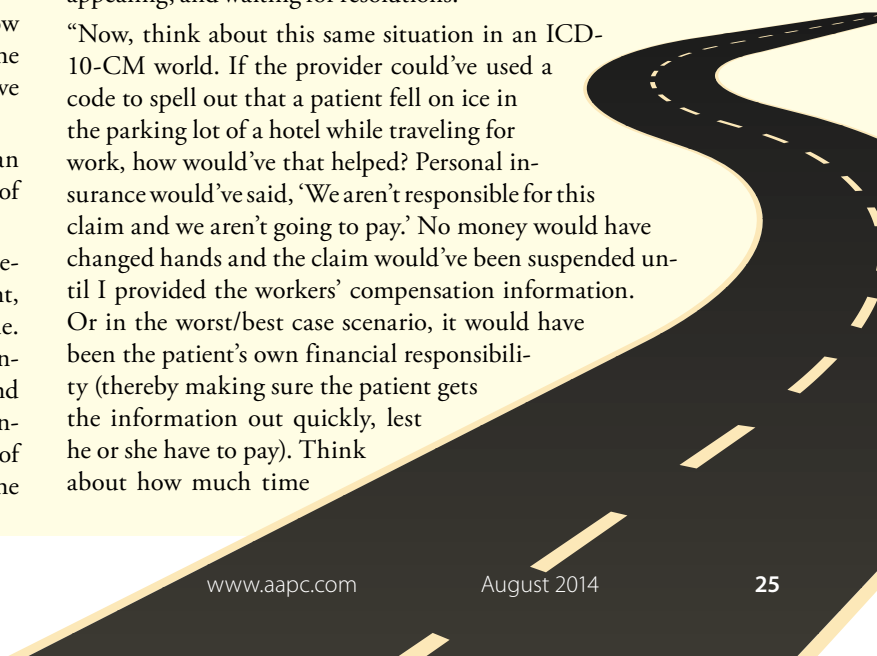
"As I handed over my primary insurance card, I apologized because I knew what was going to happen. At the time of treatment, it was not known who would end up financially responsible. Would it be the hotel, workers' compensation, or my personal insurance? Because we are sometimes impatient in healthcare and we want our doctors to get paid, everyone billed my personal insurance. Six weeks later, the hotel declared the fall to be an 'act of God,' and workers' compensation accepted responsibility for the claims. By this time, a lot of money had changed hands for services such as emergency room treatment, DME, prescriptions, surgery, and physical therapy, to name a few.

"It took me more than two years to get it completely straightened out. That was after too many phone calls to treating providers, hospital systems, health plans, and others. Remember, I know the industry. As soon as I got the information from my workers' compensation plan, I personally called everyone."

The problem? According to Buckholtz:

"My personal insurance paid and no one wanted to rock the boat and do all the work required to go back and fix it. It was not until my personal plan started taking money back that I got action. I was steered toward collections services twice by companies not understanding the problem was no longer a balance billing issue, but a workers' compensation issue. Two long years of working to correct it not only consumed plenty of my time, but that of countless others, as well. Correcting the situation required many administrative tasks, including rebilling, refunding, researching, appealing, and waiting for resolutions.

"Now, think about this same situation in an ICD-10-CM world. If the provider could've used a code to spell out that a patient fell on ice in the parking lot of a hotel while traveling for work, how would've that helped? Personal insurance would've said, 'We aren't responsible for this claim and we aren't going to pay.' No money would have changed hands and the claim would've been suspended until I provided the workers' compensation information. Or in the worst/best case scenario, it would have been the patient's own financial responsibility (thereby making sure the patient gets the information out quickly, lest he or she have to pay). Think about how much time



There are many other examples on how the use of ICD-10 codes can benefit a patient, such as quicker, more efficient approval of services and procedures.

could have been saved by the providers' offices, the health plans, the pharmacy, the physical therapists, and, of course, the patient."

Other Benefits to Patients

There are many other examples on how the use of ICD-10 codes can benefit a patient, such as quicker, more efficient approval of services and procedures.

Preventive vs. Sick – The preventive codes in ICD-10-CM include the specificity of "with" and "without" abnormal findings. Preventive services vs. acute visits can be clearly defined with the use of the new preventive codes in ICD-10-CM.

For example, a patient comes in for a well-child check-up. During the exam, the provider discovers the patient has an ear infection, which is addressed. The provider would code the abnormal findings and the otitis media. The provider would also report the preventice medicine service, as well as an evaluation and management (E/M) visit with modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service.*

Non-compliance Codes – Non-compliance codes have been expanded in ICD-10-CM. The use of the non-compliance codes protects the provider legally by documenting when patients are not taking their medication as prescribed or are non-compliant with their treatment. Reporting non-compliance codes aides in the tracking and trending of how many people do not take their

A&P Quiz

By Peggy A. Stilley, CPC, CPB, CPMA, CPC-I, COBGC

Think You Know A&P? Let's See . . .

For proper coding of a diabetes diagnosis, you must know what type of diabetes the patient has. If the physician doesn't specify the type, look for clues in the documentation. There is one type of diabetes that:

- May be controlled by oral medication or insulin;
- Generally is the result of obesity and sedentary lifestyle;
- Usually develops in adults; and
- Is the most predominant type of diabetes.

What type of diabetes is described above?

A. Type I diabetes

B. Type II diabetes

C. Gestational diabetes

D. None of the above

Check your answer on page 65.

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

To learn more about AAPC's ICD-10 training, go to www.aapc.com to download AAPC's ICD-10 Service Offering Summary.

Peggy A. Stilley, CPC, CPB, CPMA, CPC-I, COBGC, is an ICD-10 trainer and educator at AAPC.

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medication correctly, or forgo treatment recommendations, and the reasons why.

For example, there is a code for non-compliance of medication regimen due to financial hardship. If the code is widely used, it will show how many people do not have the money to pay for their prescriptions. This will show a need to decrease the cost of prescriptions, and that more programs are necessary to help patients receive the medications they need.

Being a positive force and seeing the benefits of ICD-10-CM can provide a different perspective than the confusion and the media hype that seem to speak so loudly. HBM

Jackie Stack, BSHA, CPC, CPC-I, CPB, CEMC, CFPC, CIMC, CPEDC, is an ICD-10 specialist at AAPC.

Send your coding questions to: g.john.verhovshek@aapc.com.

Dear John

Have a Coding Quandary? Ask John

36000 vs. 36410

Q: Can you explain the difference among venipuncture codes 36000 and 36400-36415?

A: For routine collection of blood samples by venipuncture, use 36415 *Collection of venous blood by venipuncture*. Codes 36400-36410 differ from 36415 in that they describe venipuncture that requires a physician's (or other qualified provider's) skill to perform. The codes distinguish patients by age and, if the patient is younger than 3 years old, by the vein accessed:

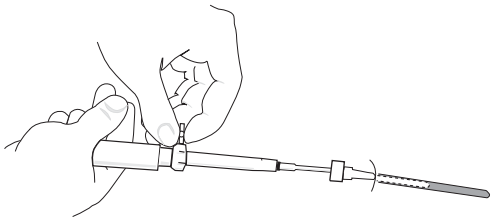
36400 Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein

36405 scalp vein

36406 other vein

36410 Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)

As the code descriptors specify, you should not report 36400-36410 for routine venipuncture or, for instance, if the physician draws blood simply because an assistant is not available. Claim 36400-36410 only if documentation supports medical necessity (including any special circumstances) for the physician or other qualified provider to perform the non-routine venipuncture.



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Whereas 36415 describes routine venipuncture (to withdraw blood), 36000 *Introduction of needle or intracatheter, vein* describes routine venous access for introduction of fluids. If the physician or other qualified healthcare provider's skill is necessary to place a needle for catheter insertion, you may turn to 36400-36410.

Note that National Correct Coding Initiative edits, as well as CPT® guidelines and many payer policies, commonly bundle venous access into surgical, anesthesia, and infusion/injection services because performance of the service requires such access. When intravenous access is a routine component of another procedure, and/or is necessary to accomplish the procedure (e.g., infusion therapy, chemotherapy), do not separately report the venous access.

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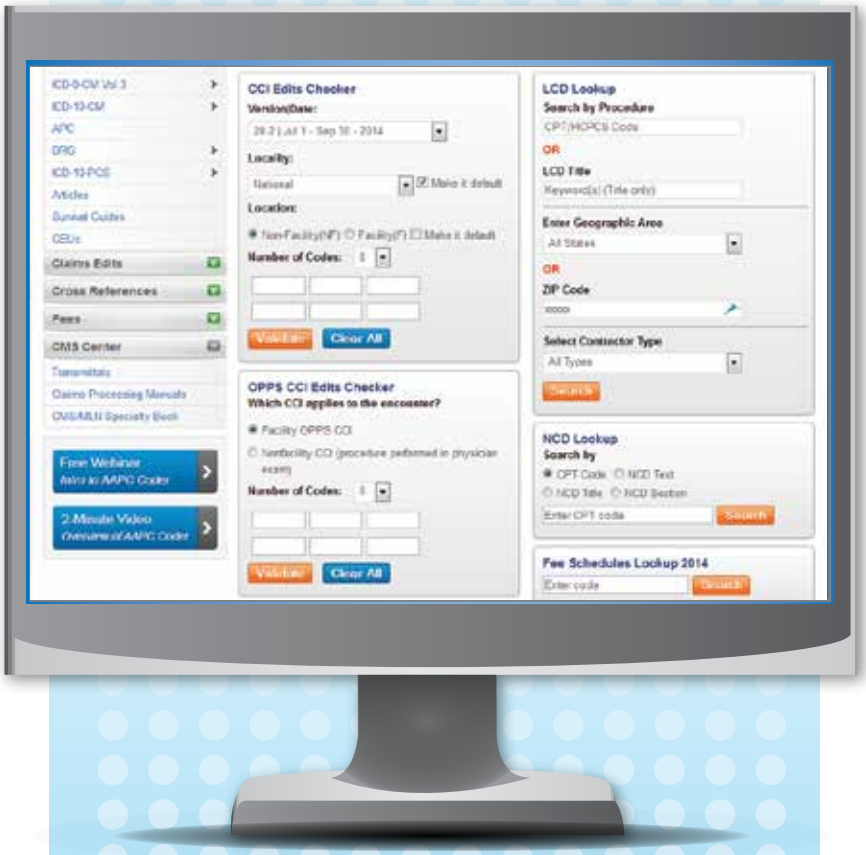

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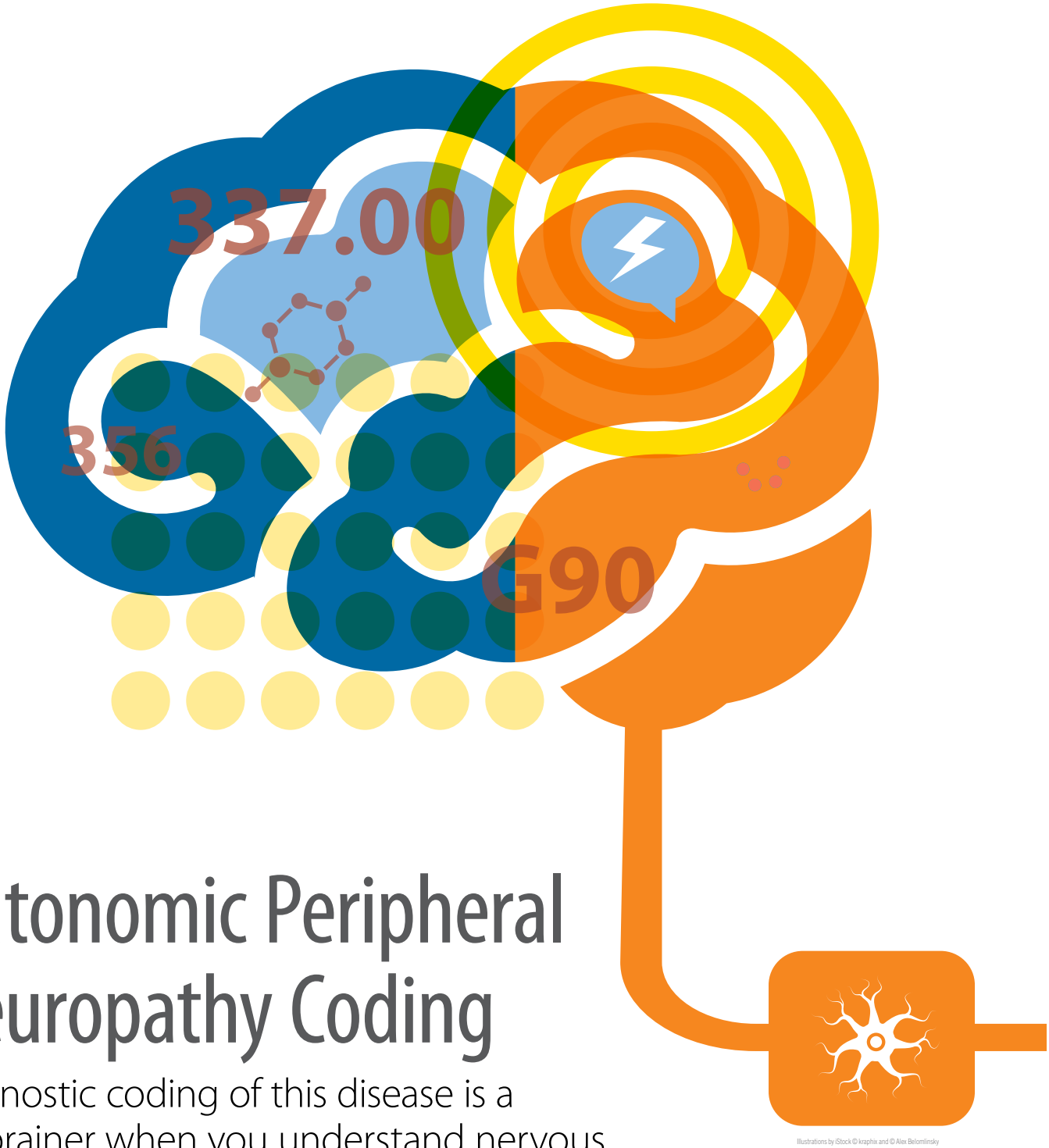
By Denise Hull, JD, MHA, BSN, CPC



Autonomic Peripheral Neuropathy Coding

Diagnostic coding of this disease is a no-brainer when you understand nervous system anatomy and conditions.

Illustrations by iStock © kraphix and © Alex Belomlinsky

Peripheral neuropathy is a common nervous system disruption that can cause numbness, pain, weakness, and alterations in body functions. A basic understanding of the nervous system and peripheral neuropathies, chart findings to support a neuropathy, and ICD-9-CM and ICD-10-CM categorization of peripheral neuropathies will allow you to:

- Ask physicians the right questions for clarification
- Assure appropriate coding to establish procedural medical necessity
- Assist providers in their documentation practices
- Code more consistently

Basic Structure of the Nervous System

The nervous system is comprised of the *central nervous system* and the *peripheral nervous system*. The central nervous system is divided into the brain and the spinal column. The brain is where the decision-making takes place, based on the sensory nervous input from other areas of the body. Nervous tissue or pathways outside of the central nervous system are part of the peripheral nervous system.

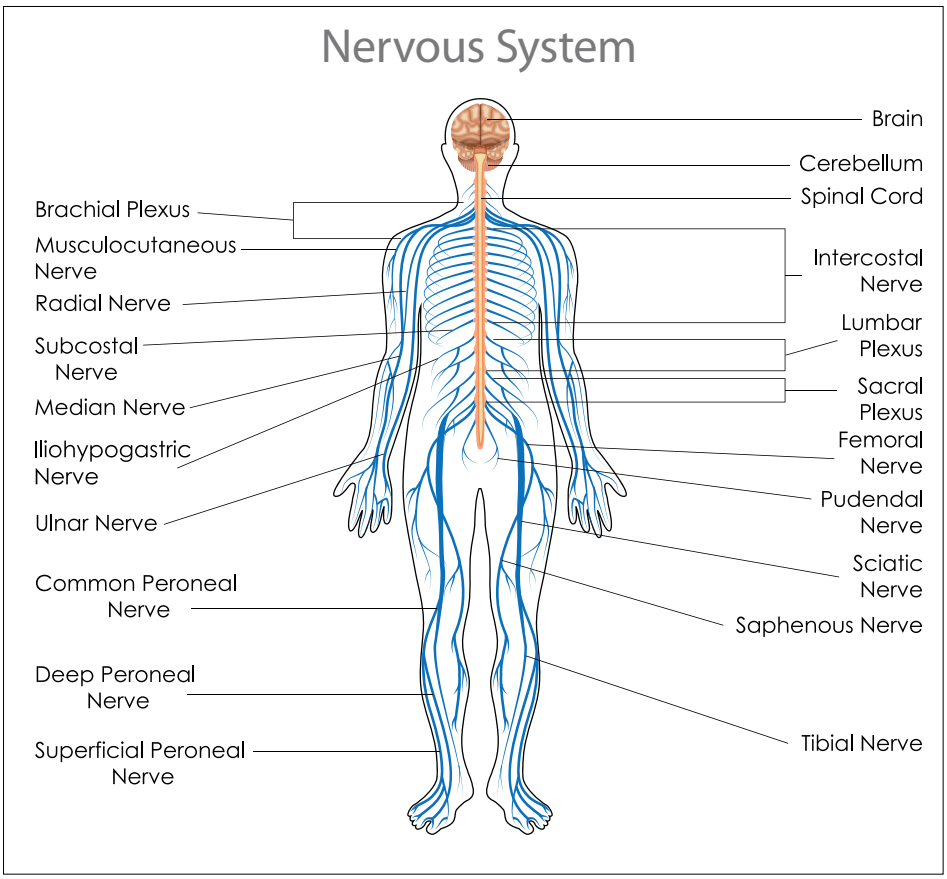
The peripheral nervous system is also divided into two parts: the *autonomic* and *somatic* systems. The *autonomic nervous system* is controlled "automatically" by the brain's outgoing messages, in response to incoming sensory information. For example, the viscera (heart, lungs, stomach, and intestines) and other organs, such as the eyes and bladder, are not within the complete, conscious control of the individual. These organs are primarily controlled by the brain's parasympathetic (relaxing) or sympathetic (excitation) messages.

The organs of the *somatic nervous system*, or musculoskeletal system, allow for a high level of conscious control. For example, if your hand were to touch a hot stove, the sensory input to your brain would send the action message to your hand to pull away; however, you would have some control over whether you moved your hand.

Regardless of whether you are discussing the central or peripheral nervous system, the basic cell remains the same. The nerve cell consists of a cell body, where sensory information is translated into a motor command. Numerous dendrites carry the sensory information to the cell body. A single axon moves the motor impulse from the cell body to the axon terminals, which end at an internal organ, skeletal muscle(s), or another group of nerve dendrites. The axon is covered in myelin sheaths, which help to protect it against damage. Destruction of the myelin sheath leaves the longer axon vulnerable to injury, resulting in the neuropathies.

The Origin of Neuropathy

Many situations can cause a neuropathic condition. The most common medical condition to cause peripheral neuropathy is diabetes mellitus. The hyperglycemic state can cause direct injury to parts of the nerve cell, as well as indirect injury caused by lack of circulation (and subsequent nutrient deprivation) to the cells. Other medical conditions, such as HIV, kidney disorders, hormonal imbalances, and cancers, also can damage nerve cells. Heredity can play a role, as can traumatic situations such as a crush injury or fractured bone, which can result in compression, stretching, or severing of the nerve cell, leading to a neuropathic condition.



Interpreting Neuropathy Documentation

When reviewing your practice's medical records for support of a peripheral neuropathy diagnosis, look for indications of the cause of nerve damage, such as diseases or traumas, to help determine if peripheral neuropathy exists, and which type. Symptoms reported by the patient, or signs the provider finds during the exam, can support a diagnosis of peripheral neuropathy and assist in determining if the correct type of neuropathy is documented as the final diagnosis.

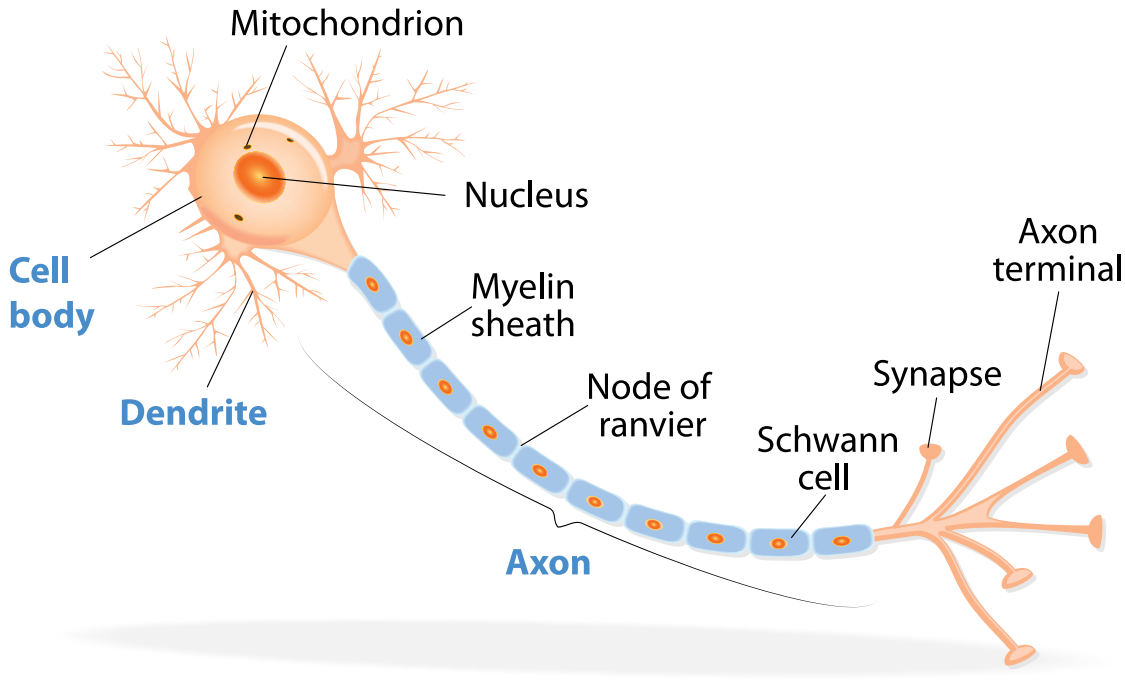
Autonomic nerve damage will manifest in several ways, such as an inability to sweat, loss of bowel or bladder control, dizziness, and digestive problems. Somatic peripheral nerve damage (either sensory or motor) could result in complaints of numbness, loss of position, painful cramps, muscle weakness or loss, and changes in skin, hair, and nails.

Although you would not choose the correct diagnosis code from the documented signs and symptoms, you should query the provider if the final diagnosis is not supported by the remainder of the medical record documentation. For example, if the provider were to document peripheral autonomic neuropathy, but the symptomatology lists numbness and tingling of the hands and feet, be sure to clarify whether there truly is an autonomic problem, or if the problem lies with the somatic nervous system.

Diagnosis Code Assignment

The codes for peripheral neuropathy diagnoses can be found in Chapter 6: Diseases of Nervous System and Sense Organs (320-389) of the ICD-9-CM code book. You may find the terminology for the peripheral neuropathies does not mirror the true clinical conditions, which can make it difficult to assign codes.

If your hand were to touch a hot stove, the sensory input to your brain would send the action message to your hand to pull away; however, you would have some control over whether you moved your hand.



Somatic (the peripheral system that innervates the muscular skeletal system) is not found within the alphabetical index of neuropathies. Luckily, clinicians do not often use the term "somatic" when describing neuropathies. Rather, a somatic neuropathy affecting the muscular skeletal system is termed simply in medical records as "peripheral neuropathy." The alphabetical index of the ICD-9-CM code book will direct you to use codes from Chapter 6, under the category Disorders of the Peripheral Nervous System (350-359), for these muscular skeletal system neuropathies.

You also may be faced with the decision of a mono (one) or a poly (more than one) peripheral nerve issue. Unless the provider clearly states this in the record, you may have difficulty determining which category of neuropathies to use. The alphabetical index of the ICD-9-CM code book refers you to "polyneuropathy," and the default code of 356.9 *Unspecified hereditary or idiopathic peripheral neuropathy,* when the term "neuropathy" is used. If the provider does not further clarify, or the documentation does not raise further issues, you may use a peripheral polyneuropathy code.

Peripheral autonomic neuropathies can be found in the alphabetical index and have a category in the tabular list; however, the category for the peripheral autonomic neuropathies is found within the central nervous system section, rather than the peripheral nervous system. Specifically, the peripheral autonomic nerve disorders are found within category 337 *Disorders of the autonomic nervous system,* which are located in ICD-9-CM, Chapter 6, under Hereditary and Degenerative Diseases of the Central Nervous System (330-337). For example, a diagnosis of peripheral autonomic neuropathy would be coded with 337.00 *Idiopathic peripheral autonomic neuropathy, unspecified*.

Logically, this may seem appropriate because the functions of the autonomic nervous system are largely outside of the control of the individual, as are the functions of the central nervous system. But clinically, it's not a clear match of the system's anatomy and physiology.

ICD-10-CM coding of peripheral neuropathies follows a similar pattern as ICD-9-CM, with a few changes.

Determine Underlying Cause

After the correct part of the nervous system is identified, you must also determine from the documentation if there is an underlying cause for the neuropathy. For the autonomic nervous system, the idiopathic and hereditary neuropathies are found in category 337, along with those caused by underlying conditions (such as diabetes). For example, if a patient is diagnosed with diabetic peripheral autonomic neuropathy, along with the appropriate code from category 250 *Diabetes mellitus*, you would also report 337.1 *Peripheral autonomic neuropathy in disorders classified elsewhere*. In the case of the somatic nervous system, the hereditary and idiopathic peripheral neuropathies are found in category 356 *Hereditary and idiopathic peripheral neuropathy*, while those caused by underlying conditions (e.g., diabetes) can be found in category 357 *Inflammatory and toxic neuropathy*. Diabetic peripheral neuropathy is coded with the appropriate code from category 250 and 357.2 *Polyneuropathy in diabetes*.

Code It Using ICD-10-CM

ICD-10-CM coding of peripheral neuropathies follows a similar pattern as ICD-9-CM, with a few changes. Many neuropathies caused by other conditions will be listed with the other conditions as combination codes. For example, diabetic neuropathies are now combination codes within the diabetic code categories (I8 through I13), rather than within the nervous system chapter. Coding these conditions requires one code, rather than separate diabetes and neuropathy codes. The aforementioned diabetic peripheral autonomic neuropathy would now only require one code, E11.43 *Type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy*. Likewise, the aforementioned diabetic peripheral neuropathy would also only require one code, E11.42 *Type 2 diabetes mellitus with diabetic polyneuropathy*. (Note: The category of diabetes in ICD-10-CM depends on the documented type of diabetes. In this example, we default to E11 *Type 2 diabetes mellitus*, as directed by ICD-10-CM, because the type of diabetes is not documented as type 1, type 2, or secondary.)

In ICD-10-CM, peripheral autonomic neuropathies codes are found within category G90 *Disorders of autonomic nervous system*, in the section titled "Other disorders of the nervous system." And our earlier diagnosis of peripheral autonomic neuropathy would be coded G90.09 *Other idiopathic peripheral autonomic neuropathy*.

Understanding the Basics Is Key

The nervous system can be fascinating, and a basic understanding of it is an important factor in determining which codes represent the documented conditions. You can use clues from several documentation areas to choose the right code, or to determine whether you should query the provider. Having a clear understanding of anatomy and conditions will help you to achieve consistent coding and set a standard of professionalism for medical coders. HBM

Denise M. Hull, JD, MHA, BSN, CPC, is a provider performance improvement consultant with Excellus BCBS in Rochester, N.Y. She works with hospitals on pay-for-performance quality programs to assist in improving the safety of medical care and driving improvements in quality healthcare. Hull also has worked as a Medicare Risk Advantage coder with the organization. Her previous professional experiences included 25 years of clinical nursing experience, primarily in the emergency department setting. She is a member of the Rochester, N.Y., local chapter.

By G.J. Verhovshek, MA, CPC

Breast Excision vs. Mastectomy: Margins Matter

It can mean the difference between reporting 19120 and 19301.

If the surgeon removes only the mass, with little or no margin, look first to 19120.

When deciding between 19120 *Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, 1 or more lesions* and 19301 Mastectomy, partial (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy), search the documentation to determine whether a margin of healthy tissue was removed, along with the breast mass.

If the surgeon removes only the mass, with little or no margin, look first to 19120. Report one unit of 19120, per incision (*not* per mass removed). *CPT® Assistant* (March 2005) instructs:

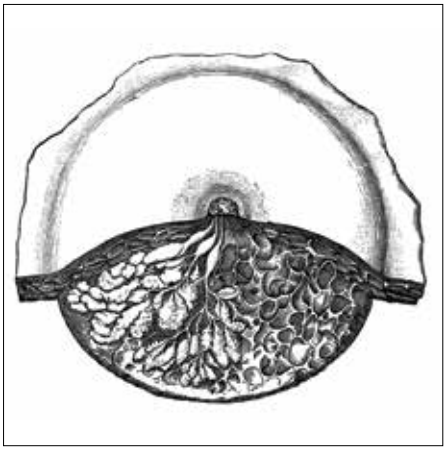
> …code 19120 should be reported for each of the separate excised areas since it includes one or more lesions through the same incision. However, if excisions are performed on different areas of the breast through separate incision sites, code 19120 should be reported for each incised area. Modifier 59 [*Distinct Procedural Service*] should be appended to the second procedure code.

You may report 19120 for breast excision performed on either male or female patients. Note, however, "19120 does not include more extensive resections of breast tissue. More extensive resection performed for gynecomastia [benign enlargement of breast tissue] should be reported with code 19300 [*Mastectomy for gynecomastia*]" (*CPT® Assistant*, March 2014). You should claim 19300 only for male patients, "as gynecomastia is a male condition" (*CPT® Assistant*, February 2007).

When the surgeon removes a breast lesion with a margin of healthy tissue, look instead to 19301. *CPT® Assistant* (February 2007) instructs:

> Partial mastectomy procedures describe open excisions of breast tissue and include specific attention to adequate surgical margins surrounding the breast mass or lesion. In a partial mastectomy, a larger amount of breast tissue and some skin are removed with the tumor. This also includes removal of the lining over chest muscles below the tumor. This surgery is usually performed for stage 1 and 2 tumors. This code is reported also for the performance of a lumpectomy where the tumor and a small amount of surrounding tissue are removed.

In these cases, the mass is suspected or known to be malignant, and the margin of healthy tissue is removed to ensure that the entire malignancy has been excised.



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Sometimes, the surgeon may excise a breast mass (19120), but pathology reveals malignancy and the surgeon must return the patient to the operating room and remove additional tissue. When this occurs, the Centers for Medicare & Medicaid Services rules (National Correct Coding Initiative Policy Manual for Medicare Services, Chapter III, Section J.1) allow you to report the follow-up excision using the partial mastectomy code, 19301, with modifier 58 *Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period* appended.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

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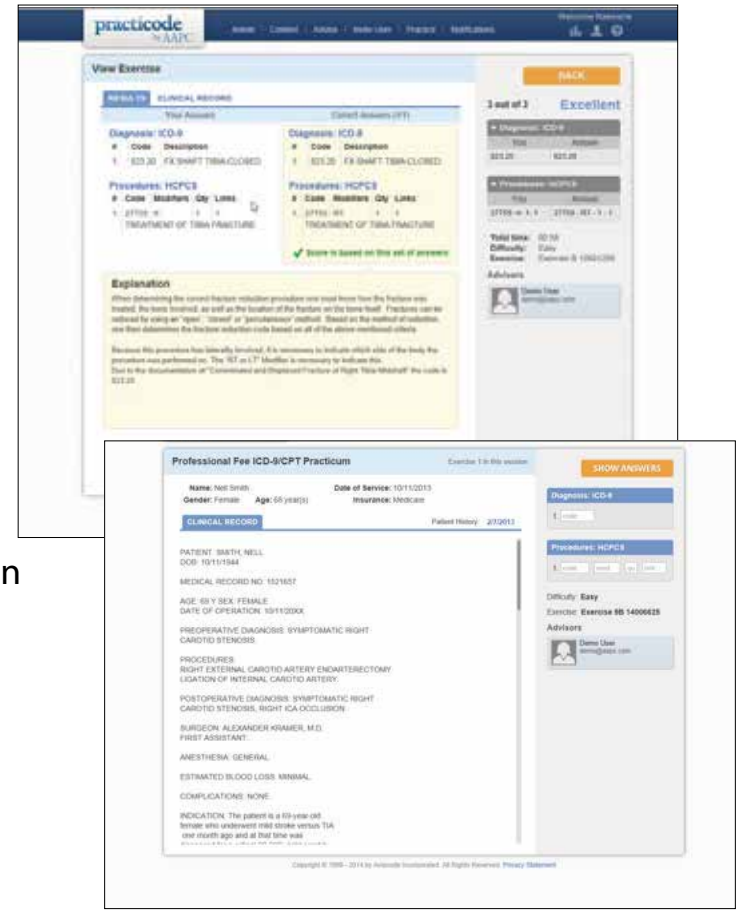

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By John S. Aaron, Jr., CPC

Informed Patients Are More Likely to Meet Financial Obligations

H.R. 1767, better known as the Medical Debt Responsibility Act of 2013, was supposed to amend the Fair Credit Reporting Act to require credit reporting agencies to delete medical debt within 45 days of payment or settlement; however, like similar bills introduced in 2010, 2011, and 2012, it failed to become law. Rather than waiting for Congress to act, perceptive providers have learned there is value in acting as a steward of patients' financial health.

For example, your healthcare organization should actively inform medical consumers about the cost of healthcare services. In fact, under the Affordable Care Act (ACA), consumers are now entitled to receive cost estimates before receiving healthcare services. Healthcare providers can assist by sharing with patients the following cost estimation resources:

- Healthcare Blue Book (www.healthcarebluebook.com)
- Fair Health (www.fairhealth.org/Toolsforconsumers)

These websites offer a wealth of information about usual and customary costs for various procedures by region and other search-defined options. Arming your patients with tools such as these allows patients to plan better and to make payment arrangements with the practice, ahead of time. Informed patients will likely stay with your practice, even if faced with costly procedures, and they are likely to spread the word on how well your practice takes care of them, both financially and physically.

You may wish to offer a patient advocacy discount for some individuals, but be wary of offering discounted rates simply because a patient is uninsured. For example, a patient with no insurance recently demanded that I allow him to pay the insurance discounted rate. But is it appropriate to charge the same rate to an uninsured patient as to a patient who has dutifully paid his or her premiums, year after year? Consider informing patients of the financial protections offered under the ACA. With a maximum per year out-of-pocket expense of $6,350 for individuals and $12,700 for families, and premium payment assistance, coverage may be more affordable than the patient realizes.

John S. Aaron Jr., CPC, is a member of the Northbrook, Ill., local chapter. He served as president in 2013 and has 15 years of billing and coding experience. Aaron is in the process of establishing a billing service with a focus on patient advocacy. You can follow him on Twitter at: @ClaimChek.

Anne M. Noel, CPC, CPC-H, CCS, CCS-P

I didn't really know what a coder did until one fateful day … I was carrying the day's charts to be filed when I encountered an acquaintance in the hallway. In those days, I was a medical transcriptionist and she was a coder. We talked, mostly about work, and I found myself intrigued by her job. Soon after, I registered for a coding program offered at a local adult education center. I became a Certified Professional Coder (CPC®) in 2001 — right around the time when the facility where I worked was expanding their coding department. Talk about perfect timing!

Code What You Know

Coding turned out to be a great fit for me, partly because of my past work and life experiences. The skills I developed as a medical transcriptionist, a secretary, and a parent advocate for special education have been very helpful in my work as a coder. Ironically, the many health issues my family has endured over the years, such as avulsion fractures, epiphyseal plate fractures, Wegener's granulomatosis, Osgood-Schlatter's disease, dyspraxia, etc., gave me a lot of insight into coding. And I think it helps that I understand the whole revenue cycle process from both sides of the spectrum: patient and provider.

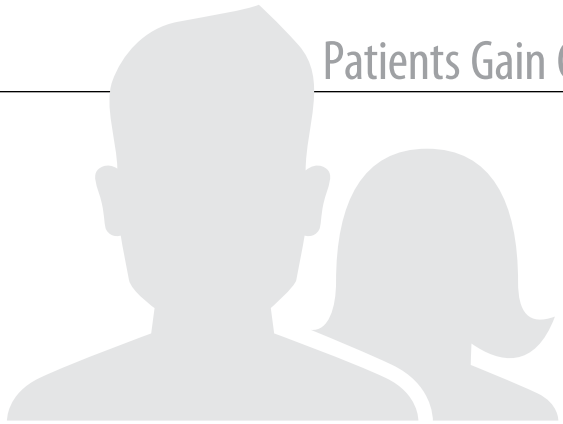
Next Step, ICD-10

I love my job because I learn something new every day. I face the challenges realistically and look forward to them. ICD-10 is the next area for me to conquer. I'm confident that I will!

By Vernessa Fountain, RHIA

Patients Gain Control of Their Health Data

Data provenance and EHRs: The significance of patient-generated health data (PGHD).



Electronic health records (EHRs) Meaningful Use requirements, Stages 1 and 2, empower patients to become more involved in their own care. For example, per Meaningful Use requirements, patients must be able to view online, download, and transmit their health information under HIPAA standards 170.210(f) and 170.204(a). Such patient engagement is meant to improve healthcare outcomes. To give patients further control, consider using Patient Generated Health Data (PGHD).

PGHD are defined as "health-related data that includes health history, symptoms, biometric data, treatment history, lifestyle choices, and other information created, recorded, gathered, or inferred by or from patient or their designees to assist them with their health concerns." Examples might include blood glucose monitoring or blood pressure readings using home health equipment, or exercise and diet tracking using mobile apps. Patients, rather than healthcare providers, are primarily responsible for capturing or recording their data and for deciding how to share or distribute it.

Types of PGHD include:

PGHD Types	Description
Patient Proxy	Measures vital signs by means of a device and recorded by the patient (e.g., temperature, blood pressure, blood glucose, and weight)
Self–reported	Recorded by the patient or family member about the patient's lifestyle data (e.g., caloric intake, diet, exercise, hydration, medication adherence, ability to perform activities of daily living)
Self-reported Quality of Life Data	Recorded by the patient's family or a patient proxy

To incorporate PGHD with your practice management, develop a strategy and educate staff, patients, and patients' families about the ways they can provide health information, as well as the benefits of doing so. Specifically, greater granularity and specificity of documentation can improve patient safety, quality of care, and clinical quality measures.

Patients may gather supplemental data and record changes in their health condition using smart phones, tablets, and online patient portals. PGHD helps to provide a comprehensive picture of the patient's signs and symptoms, and changes in his or her conditions occurring outside of the traditional clinical environment. PGHD also provides relevant information for preventive and chronic care management, and allows a provider to be more prepared for a patient's visit because the patient's health information is available before the encounter.

When the patient transmits or shares data with the healthcare provider, and when the provider reviews the PGHD to assist in formulating the patient's care plan and documents the information in the patient's electronic record, the PGHD become part of the practice management EHR, and are HIPAA compliant.

Electronic document management is a part of every EHR. Everything from email, financial records, legal records, website content, PGHD, and traditional provider-generated information are included. All data is considered an asset that can be managed and leveraged to improve patient outcomes and quality of care.

Possible Challenges for PGHD

PGHD involves health information technology standards, which include RxNorm for medication terminologies and LOINC terminologies for laboratory results. These clinical terminologies are required for PGHD data integrity. The standard requires the data to be tagged and the source of the PGHD to be provided in such a way that it's consistent across systems (i.e., data provenance semantic or semantic interoperability). Data provenance (the process of tracing and recording the origin and movement of data) is critical for providers to trust the data that is received from patients, and patients' devices and applications.

Another concern for EHRs that capture PGHD is the ability to store the status of the information, such as "not reviewed" or "reviewed." PGHD status and workflow may not be consistent across different systems. For instance, how are providers notified when their patients' PGHD arrives for review? Are you able to determine the data priority to alert the providers whether the data has a low,

Specifically, greater granularity and specificity of documentation can improve patient safety, quality of care, and clinical quality measures.

All data is considered an asset that can be managed and leveraged to improve patient outcomes and quality of care.

medium, or high priority? It's also critical that when PGHD arrives, it cannot be altered or modified.

There are barriers related to data provenance of the EHR. Some EHRs cannot capture the origin with sufficient granularity to meet a provider's expectation related to PGHD. There is no uniformity among data provenance systems to determine the origin of the information (e.g., who created, received, and shared the data, whether the data were integrated into another system, and whether shared data were reconciled). HBM

Vernessa Fountain, RHIA, CTR, is the health information management consultant presenter at Caban Resources, LLC, and director, health information management/travel consultant at Healthcare Resource Group; former health information operation manager at Methodist Hospital of Arcadia, former adjunct instructor at East Los Angeles Colleges; and a former interim director, health information management, medical records director, and coder manager at Los Angeles County University of Southern California. Fountain was also a former cancer registrar at Los Angeles County University of Southern California and a former bone marrow transplant cancer registrar, Hoag Presbyterian Hospital of Newport Beach, Calif. She is a member of the Chino Hills, Calif., local chapter. She can be reached at: vernessa.fountain@cabanresources.com.

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By Douglas J. Jorgensen, DO, CPC, FAAO, FACOFP, CAQ Pain Medicine

Manage Cash Flow: No Margin, No Mission!

Take action to bolster revenue and give your practice financial breathing room.

There are several reasons why cash flow may be impeded in medical practice, and there are several strategies to mitigate that risk and keep your practice running smoothly and efficiently. Ultimately, you must know your needs and your market, and be ready to adjust your management, the services you offer, and, potentially, with whom you are willing to contract.

First, Know Your Needs

The first order of business is to determine your monthly cash flow needs. Hire a medical business consultant to perform and analyze a *pro forma* (a statement of your practice's financial activities). This crucial step is too often overlooked. Given today's managed care market, however, you are well advised to analyze the "musts" in your practice and determine the financial outcome you want to achieve.

Put your goals in writing and check back periodically to see if priorities have changed. The questions below are a good place to start, but do not comprise an exhaustive list:

How much money does the business/practice want to make?

- Is this realistic based on specialty, region, and current offerings?
- Does the practice know how to analyze potential, medically necessary offerings not currently being done (or who to ask if it does not?)
- Does the practice want to expand?
- Is the practice space adequate?
- Is owning vs. renting possible to create equity and save cash?
- Could marketing in the "right" areas bring better paying patients/insurance to the practice?
- Does the practice continue to see patients with bad debt, racking up more unpaid claims/bills?

What personnel are key to your mission? Can the practice thrive without them?

- Staffing ratios have changed, but a 3-4:1 staff-to-provider ratio should be the rule. Busy is not the same as efficient.
- Are there clear productivity guidelines to determine if staff is achieving goals? Are the goals being revisited weekly? Monthly? Quarterly?

Outline achievable goals and make people accountable.

- This includes administration and providers.

- Use data, not feelings, to make business decisions.
- What is the return on investment (ROI) to add new staff/services?

What are the losses to the practice (monetarily and in morale) to keep inefficient or problematic staff members?

- Is the practice over-insured or paying too much? Get second (and even third) opinions to avoid redundancies.
- Are consumables being purchased in bulk to improve margins/profit? Has the practice looked into alternative suppliers or contract revisions?
- Are immunizations, injectables, or medication expiring before use?
- Is the practice billing for all supplies not inclusive to the service or procedural definition? Does this vary by payer in your region?

Is accounts receivable (A/R) managed so payments are posting within 2-3 weeks?

- Is A/R being worked by the billing company?
- How successful are they?
- Is the A/R growing or improving?
- Should A/R be brought back in-house because nobody watches out for your money like you do?
- Should A/R be sold to a third party to improve immediate cash flow, and to remove it from the books?

Remember: Business as usual is not good business. Constantly reanalyzing and moving toward collective business and practice goals will keep your practice nimble and mitigate cash flow losses.

Next, Take Advantage of Immediate Opportunities

There are many ways you can increase your cash flow, right now. Consider the following ways you can manage and cut back on wasted revenue.

Time-of-service Discounts

Give a discount to patients who pay using cash, check, or credit card at the time the service is rendered. The practice is not obligated to offer the insurer this discount unless it is willing to pay for services rendered on the same date the patient is seen (I've never seen this happen).

Contractually, a time-of-service discount may not be feasible for some services. Check with a respected healthcare attorney in your state if you have any question about what is appropriate. When allowed, such discounts can save the patient money and get cash in the door, immediately.

Some opponents argue that discounted services make it harder for patients to reach their deductible; however, patients unlikely to reach their deductible due to low utilization still benefit. In some instances, the discounted rate (e.g., 40-50 percent reduction) may even save the patient money, compared to the amount the insurer has contracted with the practice.

Be proactive when negotiating contracts. Joining a good physician-hospital organization (PHO) or provider organization can improve gross income by 10-15 percent, or more.

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Renegotiation, Policy Adherence, and Payer Relationships

Be proactive when negotiating contracts. Joining a good physician-hospital organization (PHO) or provider organization can improve gross income by 10-15 percent, or more.

Contracts for workers' compensation, federal insurers, or federal contractors are usually "take it or leave it." The provider cannot amend the contract, and it can literally take an act of congress to change the contracted fee schedule.

For private payers, scrutinize the time in which the insurer must pay the practice, the time the practice has to appeal, and the fee schedule. Some contracts are in violation of state prompt payment laws, but if you agree to the contract you may need to hire an attorney to re-assert your rights. Most contracts allow appeals within 90 days, but you should negotiate for six to 12 months. You can also negotiate to change the fee schedule. I have seen contracts where a 40 percent increase in the fee schedule occurred due to a challenge by the practice. Many practices do not challenge payer contracts — too bad for them.

Guard Against Embezzlement

Medical Group Management Association (MGMA) data suggests the majority (>70 percent) of individuals who embezzle money have done so previously. Here are a few tips to avoid and protect against embezzlement:

- Get bonded. Bonding your company takes personal bias out of the investigation process because it financially protects your organization. And the bonding company — not the doctor or practice — seeks prosecution. Bonding is cost effective (typically hundreds of dollars, to a few thousand dollars), and the insurer will often risk-stratify the practice because it has a stake in doing so. Theft insurance also reimburses you for any stolen cash.
- Perform daily front desk reconciliation: Have two people verify the balance sheet at the end of every day for all cash, credit card, and check transactions. Each person must sign off on the total; nobody leaves until both independent counts are done. Checks and cash are most vulnerable. Using an electronic deposit for checks prevents a thief from cashing the checks.
- Account for outgoing monies. Have an accountant, administrator, or the owner verify checks written to payroll, vendors, charity, etc., every month (or at least once per quarter). Checks for "petty cash" can result in hundreds of thousands of dollars stolen over several years, even in a small practice. The owners of many small practices review every check that goes out the door. This is not feasible in a larger practice, but the point is clear: Checks and balances are necessary.
- Reconcile all billing department checks, daily. Electronic funds transfers (EFTs) are becoming common, but checks are not likely to go away, any time soon. Cell phones or other electronic scanning systems now allow money to be deposited immediately —perhaps into someone else's account. Daily reconciliation and verification of payment against services rendered will identify the money going into A/R, and will allow your billing team to track deposits.

Most billing companies and electronic health record administrative panels can provide a report linking paid and unpaid claims. These are usually based on human postings, so a two-person verification system is best to protect the practice and billing personnel.

Personal Injury

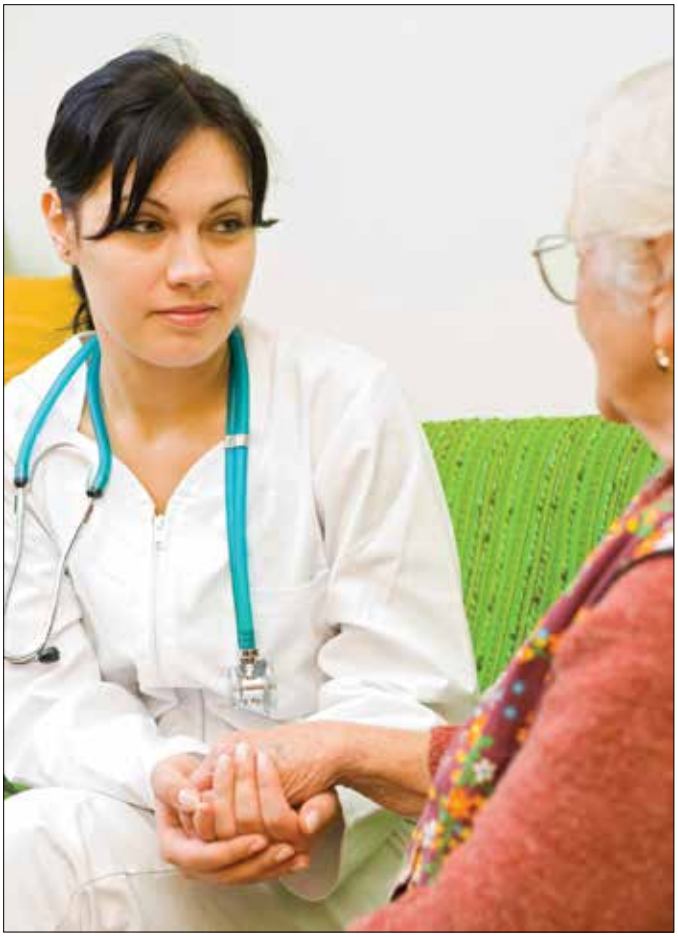
Many practices are reluctant to work with personal injury cases due to the perceived hassles of attorney work, workers' compensation M1 forms, letters, etc. But in most states, motor vehicle insurance, homeowners, and other personal injury insurers pay the practice/provider directly for whatever fees are charged. Some states impose limits or a fee schedule, but payments are typically better than those from Medicare or private insurance.

You also may receive payment for attorney phone calls, letters, depositions, and court appearances. The latter can be worth thousands of dollars, per case, and you may request payment before services are rendered.

Workers' compensation claims require the most onerous paperwork; however, when you learn the rules, payment typically exceeds the private payer arena.

If the insurer is still litigating, or if responsibility for costs is still being debated, payment may be delayed for months (or years) while treatment is being rendered. The end payout is usually very good; in the meantime, the practice can charge the patient's commercial insurance (or even Medicare). When the case settles and the practice is paid, the practice refunds the commercial program or Medicare. If you fail to charge the insurer, or the patient has no insur-

Many practices do not challenge payer contracts — too bad for them.



ance and no means to pay, the practice may be stuck with the outstanding bills. Most patients and practices do not want this risk, which the above methodology helps to avoid.

Diagnostics

Diagnostic medicine is crucial in identifying pathology, but can also aid in disease prevention. Perceptive practices provide both excellent customer service and a great revenue source by providing these services under their own roofs. Under the Affordable Care Act, you can anticipate a push to more outpatient services in settings that are not hospital affiliated. Patients don't want to pay inflated costs at the hospital for lab or other diagnostic services, and they like the convenience of one-stop shopping.

By analyzing the ICD-9-CM codes for various diseases (e.g., diabetes, hypertension, allergy, smokers, chronic obstructive pulmonary disease, asthma, etc.), you can develop a diagnostic menu relative to available testing. For example, in-house serologic allergy testing can generate as much as $2,000 to $5,000 per month, for an initial cost of $7,000 to $10,000.

When deciding whether to offer such services, determine the potential volume and recurrence based on medical necessity and payer policy. Research what the billable CPT® codes pay, and determine if the volume of patients tested will support the cost of equipment, etc. The return on investment may be excellent, and you can mitigate risk by running a pro forma on the anticipated expenses and income.

Philanthropy and medicine go hand in hand, but free care should be intentional, not accidental.

I have seen several internal medicine practices bring in $5-10 million per year doing everything from nuclear stress tests and mammography, to diagnostic ultrasound, bone density, and pulmonary function testing. This additional revenue comes from medically necessary testing that typically is sent out of the practice.

Unintended Free Care

Philanthropy and medicine go hand in hand, but free care should be intentional, not accidental. Medicolegal risk aside (and these are very real), not charging for a last-minute medication adjustment as the patient is leaving the office, or for a quick question in the emergency department or doctor's parking lot, results in lost revenue.

Practices lose an estimated 10 percent of gross revenue from unintended free care. If a consult is requested informally, ask that it be made formal. If a patient medication tweak occurs for a prescribed medicine, be sure to note it in the patient file. As a result, the service might qualify as a level IV visit, rather than a level III. Over time, the revenue adds up.

There are many ways to protect cash flow. Some involve limiting spending and optimizing the practice, while others require more in-depth analysis of practice policy and procedures, as well as the clinical offerings the practice might offer. Being proactive, not reactive, is key. Most experts recommend a six-month war chest for ICD-10 implementation. That means six months of expenses for the practice should be in the bank (in cash, or a combination of cash and line of credit). The above strategies, along with excellent accounting and banking relationships, make this daunting task achievable and give the practice financial breathing room. HBM

Dr. Jorgensen is the owner and board chair of Patient360, practicing pain management and osteopathic manipulation in central Maine. He is triple-boarded in family practice and osteopathic manipulative treatment, as well as neuromusculoskeletal medicine and osteopathic manipulative medicine, and has a Certificate of Added Qualification in Pain Medicine. As a consultant and speaker, Jorgensen lectures nationally on billing and coding issues, and provides expertise for the FBI, OIG, and DEA. He has published a second edition of *A Physician's Guide to Billing and Coding* with his brother, Raymond T. Jorgensen, CPC. A third edition is scheduled to publish summer 2014. Jorgensen is a member of the Lewiston, Maine, local chapter.

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By Joe Ascensio, MEd

Realize the Benefits of a Patient Portal

Use this online vehicle to improve patient outcomes and office productivity.

Exchanging confidential healthcare information with patients typically requires an in-person encounter. This is often an inconvenience for the patient and — with today's increased patient populations and physician shortages — a scheduling challenge for the provider. One solution may be found in a secure communication tool called a patient portal.

Send Confidential Information Efficiently

Technology enables secure, HIPAA-compliant online communications without extraordinary expense. Established patients can enroll in the patient portal by providing an email address to a staff member who creates a login and initial password. When the patient logs in and establishes an original password, both patient and provider can use this online vehicle to send private and confidential information, such as:

- Current insurance information
- Online return on investment requests
- Test results
- Appointment confirmation
- Pre-procedural instructions
- Reminders for monthly or annual encounters (e.g., monthly blood pressure check for patients with hypertension, or an annual physical)

Protocols may vary, but typically an email is sent to inform the patient that new information is waiting in the portal. The patient can log in to the portal 24/7. The information is secure and can only be seen by the patient. The patient can send a private email back to the provider, as well. Following a disclaimer warning patients not to use this method of communication in an emergency, a patient can ask a question about medication, a recurrent condition, or clarification about instructions.

The benefits of a patient portal to the practice have been proven. Research has shown that providers using patient portals experience a decrease in phone calls, while patient compliance increases. As a result, staff members are able to use their time in the office more effectively and efficiently.

A Smart Way to Handle Payment

Because the system allows the patient to send a secured email anytime, portals can allow patients to provide insurance information, confirm payment methods, and even make payments with a credit card, debit card, or check. The office can respond during business hours. No more phone tag! Plus, typed data coming through the portal is much clearer than handwritten data.

Embrace and Support Patient Use

Not all patients will embrace this new technology. Be careful not to stereotype, however; patients of every age and income level are technologically savvy. You should also get buy-in from your staff. You will want to designate at least one individual to be the point person, to answer and dispatch communications, and to be responsible to provide patient support with log-in difficulties.

Using telehealth and m-health (mobile health) to manage health communications between providers has proven to increase efficacy and proficiency. It's time to bring your patients into the zone. HBM

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

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By G.J. Verhovshek, MA, CPC

Two Coding Tidbits for Better Abscess Coding

When coding for procedures involving an abscess, you'll need two pieces of information:

1. The location of the abscess
2. The treatment method (e.g., incision and drainage, excision) for the abscess

In some cases, you also may need to know the approach (open, percutaneous) the provider uses in treating the abscess.

Know Your Abscess ABCs

An abscess is a collection of pus, a thick fluid that generally contains white blood cells, dead tissue, and foreign bacteria (e.g., Staphylococcus aureus) or other infection. Think of an abscess as a miniature battlefield, where the body's immune system is fighting against an infection. Both sides take casualties and inflict damage on the surrounding area.

An abscess may occur nearly anywhere on or in the body. For incision and drainage (I&D) of superficial abscess or abscess of the skin at any location, turn to 10060 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle or paronychia); simple or single* or 10061 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle or paronychia); complicated or multiple.*

As specified in the code descriptors, use 10060 for single abscess, or for a small collection of purulent material (e.g., paronychia, or a small cyst around a hair follicle). In such a case, the infection is limited to the superficial subcutaneous tissues. For I&D of multiple abscesses, or for a single large or "complicated" abscess, report 10061. The physician determines whether the abscess is simple/single vs. complex/multiple, and this determination must be supported by documentation. If the medical record is not clear, ask the documenting physician for detail.

Below the Skin Calls for More Precise Code Selection

For abscesses *below the fascia, or skin*, coding is much more specific. To select an appropriate code to describe an "internal" abscess, check the CPT® index under the main term "abscess." You'll find nearly a full page of entries, categorized primarily by location (e.g., bone, tissue-abdomen, tissue-nasal, etc.). Be sure to explore the index entries to select the most appropriate treatment method (I&D is most common) and approach (if applicable).

For example, if the provider treats an abscess of the kidney, look up the subterm "kidney" under the main term "abscess." This will lead you to codes 50020 *Drainage of perirenal or renal abscess; open* and 50021 *Drainage of perirenal or renal abscess; percutaneous.*

Caution: Do not code directly from the index. Confirm your code selection by referencing the full code descriptor in the tabular portion of the CPT® codebook.

Note also that within the musculoskeletal section of CPT®, there is a general incision code (20005 *Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)*, as well as codes specific to: neck, shoulder, upper arm and elbow, forearm and wrist, hand and fingers, pelvis and hip joint, femur and knee joint, leg and ankle joint, and foot and toes. For example, for I&D of an abscess below the fascia of the foot, any of the following may apply:

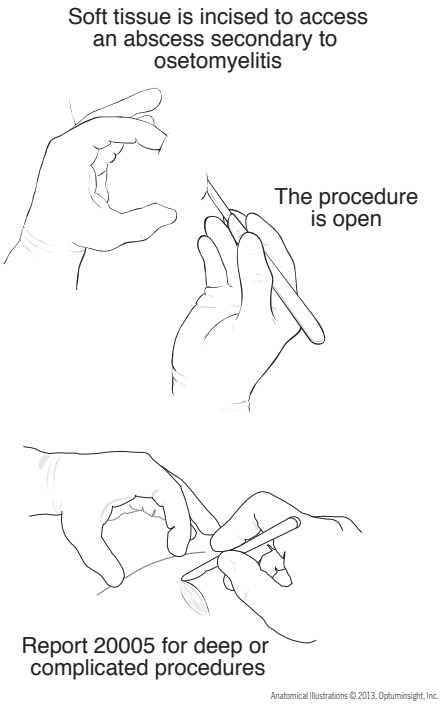
28001 Incision and drainage, bursa, foot

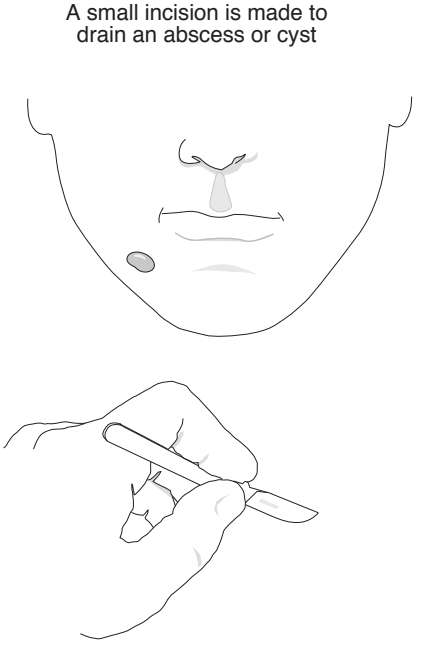
28002 Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space

28003 multiple areas

28005 Incision, bone cortex (eg, osteomyelitis or bone abscess), foot

Proper code selection depends heavily on the provider's documentation. For example, the procedure note may specify a "deep" abscess, but you should still check with the performing provider to determine if the incision was below the fascia, as this could mean the difference between reporting 10060–10061, or a code describing a more extensive procedure.

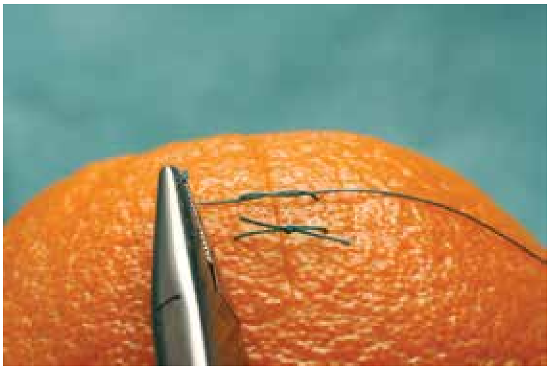




E/M Services

Sometimes getting paid for additional work takes ingenuity.

Q: In our family practice, I occasionally see documentation stating that one of our physicians removed sutures that were placed by another provider outside the practice, such as an emergency department physician. Should we code separately for the suture removal?



A: Both CPT® and the Centers for Medicare & Medicaid Services consider suture removal to be part of a minor surgical procedure's global package. If the same physician who placed the sutures removes them during the original procedure's global period, you cannot report the removal separately. If a different physician removes the sutures (as in your case), the removal becomes part of any evaluation and management (E/M) service reported.

Exceptions to this rule:

- If the patient must be placed under general anesthesia to remove the sutures, you may report 15850 *Removal of sutures under anesthesia (other than local), same surgeon* or 15851 *Removal of sutures under anesthesia (other than local), other surgeon.* Circumstances under which general anesthesia would be medically necessary or appropriate for suture removal are rare, however.
- Some private payers might allow you to report S0630 *Removal of sutures by a physician* other than the physician who originally closed the wound, as long as the physician who removed the sutures isn't the one who closed the wound. Check with the payer before submitting this code.

If suture removal is the primary reason for the patient encounter, claim V58.3 *Encounter for other and unspecified procedures and aftercare; attention to surgical dressings and sutures* as the primary diagnosis.

Both CPT® and the Centers for Medicare & Medicaid Services consider suture removal to be part of a minor surgical procedure's global package.

Q: Can our physicians code separately for reading X-rays and other images taken somewhere else? For instance, may we report the appropriate X-ray CPT® code with modifier 26 *Professional component* attached?

A: If another provider (e.g., hospital radiologist) previously read/interpreted the image, and has submitted a claim, your physician cannot separately code or be paid for the same work. For example, if the patient brings an X-ray report with him to his appointment, the provider does not earn payment simply for examining the films to determine the nature of the problem.

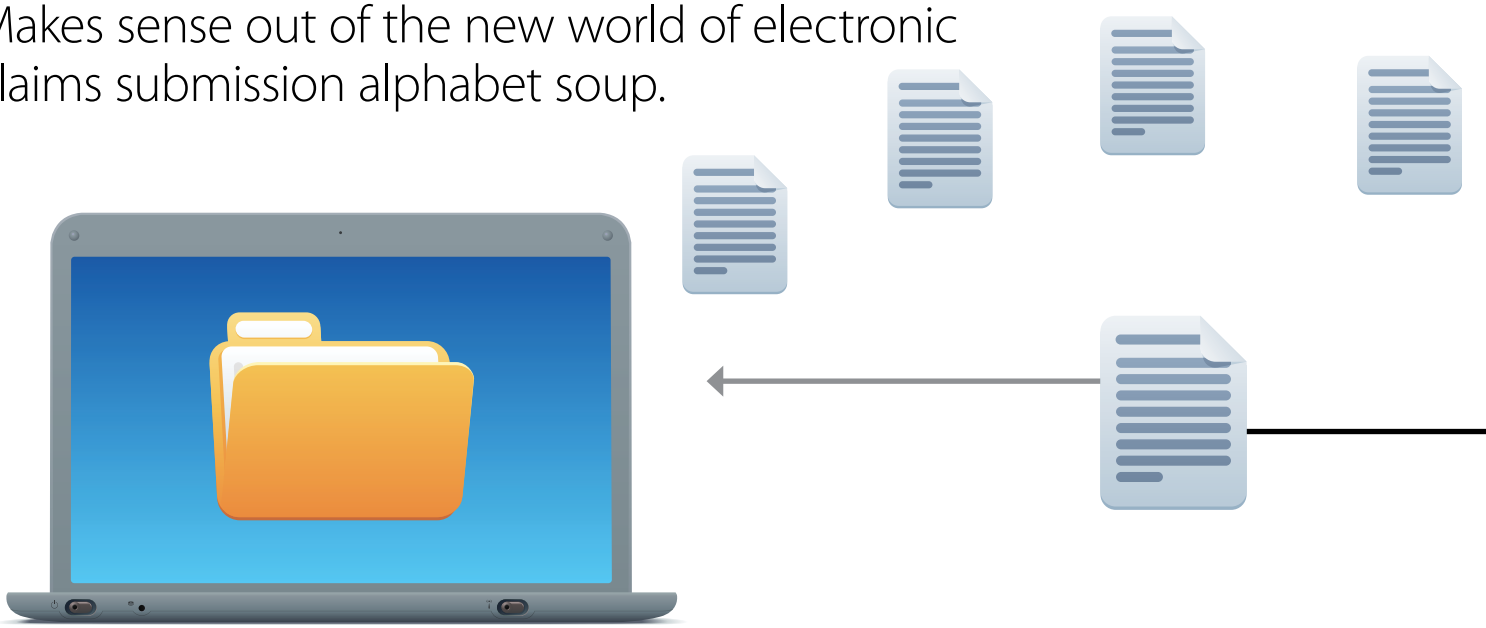
If the X-ray is relevant to the patient's complaint, and the provider documents the relevance of this "data to be reviewed," however, the effort of reviewing the images counts toward the complexity of medical decision-making when determining the appropriate E/M service level.

G.J. Verhovshek, MA, CPC, is managing editor at AAPC.

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

EDI, EHR, and esMD

Makes sense out of the new world of electronic claims submission alphabet soup.



For coders, billers, and other healthcare business professionals, a crash course on electronic data interchange (EDI) is necessary due to HIPAA requirements that cover all entities involved in transmitting electronic healthcare information (e.g., health plans, healthcare clearinghouses, and certain healthcare providers). The rules pertain to certain healthcare administrative transactions, such as claims, remittances, eligibility, and claims status requests/responses, when sent electronically.

Resource: See www.wedi.org/docs/resources/hipaa-glossary-download.pdf?sfvrsn=0 for a complete list of HIPAA terms and definitions.

Content *and* Format Matter for Data Transfer

There are two distinct issues relevant to electronically transferred claims data: *data content* and the *file format* used to transmit data from one system to another. If the systems can't recognize and store the information in a meaningful way, they can't work properly. This is where the standardized HIPAA code set (data content) and ANSI X12 (file format) come in.

The HIPAA Transactions and Code Sets final rule, published August 17, 2000, identifies CPT®, ICD-9-CM, and HCPCS Level II as the approved code sets for claims submissions. ICD-10-CM and ICD-10-PCS were added as approved code sets under the HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS final rule.

The movement towards electronic claims submission began with the Administrative Simplification Compliance Act (ASCA) of 2001, which required the use of electronic claims for providers to receive Medicare reimbursement after October 16, 2003. Following that, a uniform format was developed to ensure the meaningfulness of data to an enormous number of provider and payer systems.

Resource: For more on the ASCA, go to: www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/TheHIPAALawandRelated-Information.html.

There have been several iterations in these standard formats to accommodate changing code set requirements. For example, modifications to the HIPAA Electronic Transaction Standards final rule, published January 16, 2009, replaced the current versions of standards with Accredited Standards Committee X12 Version 5010 (ASC 5010).

The HIPAA Electronic Transaction Standards final rule also addresses the National Council for Prescription Drug Programs (NCPDP) Version D.0, adopting a new standard for Medicaid subrogation for pharmacy claims, known as NCPDP 3.0. Previously, no standard existed to allow state Medicaid agencies to recoup funds for payments made for pharmacy services to Medicaid recipients when a third-party payer had primary financial responsibility.

Within Version 5010 for Medicare, the file formats listed below are mandated per HIPAA for claims submission, remittance advice, claims status reporting, and patient/provider eligibility. These file formats have replaced the CMS 1500 form and UB 04 forms for Medicare initial claims submissions, unless the provider is eligible for a waiver.

Claims

There are four kinds of HIPAA claims or encounters: 837P, 837I, 837D, and NCPDP.

- 837-I (inpatient claims)
- 837-P (professional claims)
- 837-I COB (inpatient coordination of benefits)
- 837-P COB (professional coordination of benefits)
- NCPDP
- 837 – D (dental claims)

Remittance Advice

- 835

Claim Status Inquiry/Response

- 276/277

Eligibility Inquiry/Response

- 270/271

Source: "Coordination of Benefits Agreement (COBA) Companion Guide for Health Insurance Portability and Accountability Act (HIPAA) 837 Institutional and Professional Medicare Coordination of Benefits Version 5010 (COB)/Crossover Claim Transactions" (**www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Downloads/HIPAACompanionGuide101211.pdf**)

If you are scratching your head, wondering how this applies to your practice, carefully consider the following two issues when working with your vendors to complete systems upgrades in advance of the (now delayed) ICD-10-CM start date.

1. Provider Taxonomies

Under HIPAA 5010, restrictions have been removed for using provider taxonomies. The provider's taxonomy code may be reported at any level without restriction for both 837 institutional and professional claims.

Both the current ASC X12 837 institutional and professional Technical Report Type 3 (TR3s) require the National Uniform Claim Committee's (NUCC) Healthcare Provider Taxonomy Codes (HPTC) set to be used to identify provider specialty information on a healthcare claim; however, they do not mandate the reporting of provider specialty information. Neither do they mandate HPTC to be on every claim, or for every provider to be identified by specialty. Per *MLN Matters*® MM8211, this information is "Required when the payer's adjudication is known to be impacted by the provider taxonomy code." Individual Medicare carriers may use this information for identifying subspecialties in the future, and this information may be useful in appealing denied claims where treatments across providers was medically necessary as performed by the sub specialist, such as in cardiology. The two-character system of identifying a cardiologist using 06, which maps to 201RC0000X, will not provide this level of granularity:

207RC0000X	Allopathic & Osteopathic Physicians	Internal Medicine	Cardiovascular Disease
207RC0001X	Allopathic & Osteopathic Physicians	Internal Medicine	Clinical Cardiac Electrophysiology

Medicare, in general, does not currently use HPTCs to adjudicate its claims; however, Medicare systems will validate any HPTC that a provider supplies against the NUCC HPTC code set. If the code on the claim is not valid or current, the claim will deny. The 10-digit taxonomy code associated with the provider's National Provider Identifier (NPI) number is referenced in the claims adjudication system. If the taxonomy associated with the provider NPI is not set up in the provider file, the claim will fail. To date, two-digit specialty indicator codes are still in use.

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If the systems can't recognize and store the information in a meaningful way, they can't work properly.

2. Electronic Submission of Medical Documentation (esMD)

On September 15, 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the Electronic Submission of Medical Documentation (esMD) system, which enables providers to send medical documentation to review contractors, electronically. The system is Exchange compatible, based on standards developed by the Office of the National Coordinator for Health Information Technology (ONC).

Using esMD is not mandatory for providers. Review contractors are prohibited from targeting providers for medical review because they use esMD. Transactions are safe and secure because the esMD system uses ONC's Exchange gateway standards.

As of September 2011, providers are able to respond to these requests for medical documentation electronically using esMD via Medicare's esMD gateway. Since September 2011, CMS enhanced the esMD gateway to support several new use cases, for example:

- **September 2012:** CMS implemented a prior authorization (PA) process via the esMD gateway for power mobility devices (PMDs) for fee for service Medicare beneficiaries who reside in seven states with high populations of error prone providers (Cali., Ill., Mich., N.Y., N.C., Fla., and Texas). Phase 2 will allow for expansion to additional carriers.
- **January 2013:** CMS expanded their esMD gateway to allow durable medical equipment suppliers and providers to send electronic PA Requests to Medicare review contractors.
- **June 2013:** CMS enabled automated Prior Authorization Review Results Responses from Medicare review contractors to health information handlers via the esMD gateway.

There are also future enhancements planned for the esMD system that will allow:

- **Providers to submit first level appeal requests:** CMS plans to expand the esMD system to enable providers to submit first level appeal requests electronically, starting in 2014. Review contractors participating in the initial release for this functionality are volunteers.
- **Providers to submit recovery auditor discussion requests:** Currently, providers who want to request a discussion of the results of a recovery auditor review must do so via mail or fax. CMS plans to expand the esMD system to allow providers to submit discussion requests, in .pdf format, to recovery auditors starting in 2014.

Medicare's esMD system provides an alternative mechanism for submitting medical documentation, PMD PA requests, and PMD result code responses to review contractors. A list of review contractors accepting esMD transactions, as well as receiving PMD PA requests and sending PMD PA review results can be found at: www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Which_HIHs_Plan_to_Offer_Gateway_Services_to_Providers.html.

For a list of contractors who can handle esMD transactions see: www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Review-Contractors.html

You can find the latest CMS white paper on esMD progress at: www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Downloads/ESMD-Semi-Annual-Report_Final_508_Oct012013-Mar312014.pdf.

A final note: Regional carriers are in different stages of implementing the electronic tools described in this article. If you have any question about your carrier's progress, check with both the local carrier and your claims clearinghouse. HBM

Maintenance of the HPTC Set

The HPTC set is maintained by the NUCC, for standardized classification of health care providers. The NUCC updates the code set twice per year, with changes effective April 1 and October 1. The HPTC set is available for view or for download from the Washington Publishing Company (WPC) at www.wpc-edi.com/reference/.

The HPTC set online revisions made since the last release can be identified by the color code:

- New items are green;
- Modified items are orange; and
- Inactive items are red.

Nancy Reading, RN, BS, CPC, CPC-P, CPC-I, comes equipped with a Registered Nurse license, a Bachelor of Science in Biology/Chemistry and 25 years of coding experience. She has worked gamut from a large university practice with over 1000 providers to Medicaid. As a past employee of AAPC, Reading had a hand in just about everything. She is a member of the Salt Lake South Valley, Utah, local chapter.

By Olga Khabinskay, COO

Tips for Successful Medical Billing

Medical billers and providers nationwide face difficulty when establishing best medical billing practices for improving practice revenue cycles. With a goal to submit clean claims that support appropriate reimbursement levels, the following tips may help you to establish successful medical billing in your practice:

- ✓ Verify appropriate eligibility and benefits before rendering services. Incorrect insurance information and non-covered services are the leading cause of easily avoided denials.
- ✓ Submit claims on appropriate and updated claim forms: CMS 1500 and UB04 forms, or the electronic equivalents 837P and 837I. The type of form submitted significantly affects claims processing.
- ✓ File claims in accordance with insurance-specific medical policies and state and federal billing regulations and guidelines. A biller should have a concrete understanding of HIPAA regulation and compliance policies.
- ✓ Know your provider type, revenue codes, covered ICD-9 codes, and up-to-date CPT®/HCPCS Level II codes to appropriately report services rendered.
- ✓ Understand and use National Correct Coding Initiative (NCCI) edits, and medically unlikely edits (MUEs). You must identify bundled CPT® codes when services are rendered by the same provider on the same date of service. Understanding NCCI edits helps you to submit claims with appropriate modifiers.
- ✓ Submit claims in a timely manner. Timely filling limits vary by insurance company and provider status (in network vs. out of network). Know the guidelines to avoid timely filling denial.
- ✓ Keep current with industry trends, state and federal legislation, and insurance policy updates and changes. Often, you can sign up with insurance vendors on their websites (e.g., www.cigna.com, www.aetna.com, etc.) to receive monthly updates. Likewise, you can sign up on state and federal carriers' websites (e.g., www.cms.gov) to receive regular bulletins and newsletters as they are released.
- ✓ Put in place quality assurance measures to ensure the accuracy of claims submitted. For example, select a random sample of submitted claims and verify the medical necessity, coding, and billing based on patient charts. Internal audits protect the practice and help prevent future insurance disputes, refunds, or audits.

Successful medical billing is a direct link to a healthy revenue cycle. Today's healthcare environment leaves no room for mistakes in the medical billing process.

Olga Khabinskay is chief operating officer of WCH Service Bureau, Inc. (www.wchsb.com). With 13 years of medical billing experience, WCH Certified Medical Billing Professionals provide insight to practices in medical billing.

By Michelle Ann Richards, CPC, CPMA, CPPM, CPCO

Make Training and Education Mandatory

Set your practice's compliance program up for success, not failure.

Training is an essential part of any compliance program. If employees don't know about compliance issues and the applicable laws and regulations specific to their job descriptions, your compliance program will fail. Conversely, if employees understand how the rules affect them personally, they will be more willing to embrace necessary protocols.

Put Your Policy in Writing

To begin, create a written policy mandating training and education. Next, determine who should be trained, the duration of the training, and who should conduct it. Essentially all employees, independent contractors, and agents of your practice or medical organization should be educated in the significance of the compliance program and its operation, including the audit and reporting functions and features.

All employees should know there are consequences for not attending any required training sessions. A policy titled "Training and Education" should clearly explain what these consequences might be. Examples may include a performance improvement plan, corrective action, suspension, etc. The expectations of training cannot be stressed enough. Employees must clearly understand that their employer expects them to attend training throughout the year.

Employees should be provided with a timeline of when the

Require internal and external education and training updates for all staff members at least annually.

training is expected to be completed. A few days prior to the deadline it's best practice to send the employee a reminder. At that point, if the timeline has expired and the employee still has not completed his or her mandated training, the next step per the Training and Education policy must be followed.

Make Training Mandatory

Training should consist of overviews of federal and state fraud and abuse laws and regulations, employment laws and regulations, and health and welfare laws and regulations. Everyone must understand his or her role in adhering to the compliance program, including a duty to report misconduct. Be sure to explain the procedures and methods to report suspected misconduct, as well as the conditions of confidentiality (and when/where confidentiality ends). Assure employees they will not be retaliated against for good faith reporting.

Each person should be educated and trained in the specific areas applicable to their department. As soon as possible after their date of hire, all new employees should receive initial training regarding your practice or organization's compliance program, as well as specific, job-related compliance training.

Look for More on Compliance Plans

Over the next few months, we will discuss compliance to kick off AAPC's recently created compliance-solution software, 7Atlis. Next month, *Health Business Monthly* will feature compliance-risk assessments.

Compliance does not have to be a difficult process. For more information on 7Atlis or to view a demo, please log onto **http://www.7atlis.com/**.

Require internal and external education and training updates for all staff members at least annually. These updates should include a refresher of HIPAA rules and regulations and your compliance program (with an explanation of how these updates specifically relate to employees' roles and responsibilities).

Document Training and Continue Maintenance

Document all training. Best practice is to document the date and time of training, provide a brief summary of what was covered, and ask both trainer and trainee to verify their participation with a signature. Employees should understand the expectations of your practice or organization with regard to additional training required to perform their job in compliance.

Your practice or medical organization will need a written directive regarding maintenance and retention of training and education records. Each individual's attendance at all training and education seminars should be documented and retained in his or her human resource file, as well. During an annual review of employee records, your practice or organization will need to audit these records to ensure the training requirements have been met. HBM

Michelle Ann Richards, CPC, CPMA, CPPM, has 21 years of practice management experience. She has been an auditing and compliance consultant for AAPC since 2009, and was promoted earlier this year to manager, Compliance division. Richards teaches the CPPM boot camp and holds a Bachelor of Science in Health Care Administration. She is a member of the Elyria, Ohio, local chapter.

By Marcia L. Brauchler, MPH, CMPE, CPC, CPC-H, CPC-I, CPHQ

Answer Common HIPAA Questions

How can our practice use social media under HIPAA?

Social media can be an exciting and valuable tool when used wisely; however, it can also put a practice at risk. If you haven't done so already, create a social media policy for your practice, and seek to understand how employees and providers are using social media, both during and outside of work hours.

A "Social Media Policy" Provides Direction (and Cover)

To ensure you're protecting your practice from the perils of social media, while still maximizing its potential, designate a social media policy to guide you and your employees' use of this tool. How you plan to use social media sites for marketing your practice should be clearly defined. Make sure your employees understand what they can post on social media websites from their personal accounts. For instance, what if a patient sends a friend request to one of your employees or providers on Facebook or another online site? Practices can have a policy that restricts "friending" of patients or family members. This allows the provider or employee to politely decline the request, stating that it would be against practice policy.

Resource: See **Form A** (on the next page) for a Social Media Policy from the Physicians' Ally, Inc. HIPAA Policy and Procedure binder to use as a guide in creating your own policy.

Patient Privacy Is Paramount

Perhaps the most worrisome concern relative to social media is violating patient privacy protections under HIPAA. Patient privacy should always be a concern when putting information online, even when a practice believes that all patient identifiers have been removed and the information is "de-identified" (i.e., not subject to HIPAA because the information can't be attributed to any one individual). Often, seemingly de-identified patient case studies or stories can be linked to the specific individual by using commonly available information. One example is a news agency that wanted to cover a story on a teenager who had died from taking a certain medicine. The news agency was able to match details provided by the medical provider in a blog with obituary information to identify the patient and contact her family for a story.

There are countless examples of providers taking seemingly harmless photos of patients' tattoos, skin piercings, or other seemingly unidentifiable body parts and posting them online, only to learn later that the patient filed a complaint. Medical boards have also disciplined providers for unprofessional behavior related to social media blogs, posts, communications, and images. Disciplinary actions range from a letter of reprimand to revocation of a provider's license to practice medicine.

Tips to Protect Privacy and More

1. *Patient privacy and confidentiality must be protected at all times*, especially on social media and social networking websites. When using the Internet for social networking, employees and providers should use privacy settings to safeguard patient information to the highest extent possible. They should also realize that privacy settings are not absolute and that

The news agency was able to match details provided by the medical provider in a blog with obituary information to identify the patient and contact her family for a story.

photo by iStockphoto/© MacroWave

Form A
(**Source:** Physician's Ally, Inc. HIPAA Policies & Procedures binder)

The Practice of _____

HIPAA Policies & Procedures

Social Media

The Practice recognizes that participating in social networking and other similar Internet opportunities can support workforce members' personal expression, enable Providers to have a professional presence online, foster collegiality and camaraderie within the profession, and provide an opportunity to widely disseminate public health messages and other health communication. However, social networks, blogs, and other forms of communication online also create new challenges to the privacy and confidentiality of Patient PHI.

1. The Practice encourages all workforce members and Providers to be cognizant of standards of Patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable Patient information online.
2. Social media websites may only be visited for work-related or supervisor-approved purposes.
3. When using the Internet for social networking, workforce members and Providers should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently.
4. Physicians who interact with Patients on the Internet must maintain Patient/Physician relationship boundaries in accordance with professional ethical guidelines.

when information exists online, it will likely be there for a long time (if not permanently). Most importantly, your social media policy should be very clear that providers and employees are prohibited from posting any identifiable patient information online.

2. *Have patients authorize the use of their personal information online*, including for use in testimonials, success stories, photos, videos, etc. If a practice wants to use pictures or videos for promotions or other reasons, make sure the patients sign a valid HIPAA authorization form. These forms are required before a patient's image can be used in any medium for educational, promotional, advertising, or other purposes.

Resource: Use **Form B** (on the next page) as a guide for you to create your own "Authorization Form for Media Events," provided by Physicians' Ally, Inc.

3. *Train providers to apply the same ethical and professional conduct online as they use in their daily actions offline.* The American Medical Association published a policy to guide providers in the use of social media entitled "Professionalism in the Use of Social Media." Recommendations include:

- Providers who interact with patients on the Internet must maintain appropriate boundaries of the patient/physician relationship in accordance with professional ethical guidelines, just as they would in any other context;
- Providers should consider separating personal and professional content online;
- Providers should recognize that actions online and content posted can negatively affect their reputations among patients and colleagues, and may have consequences for their medical careers.

4. *Social media can enter into what HIPAA regulates as marketing to patients.* HIPAA has new rules on what is considered "marketing," and what practices can do to market to patients. HIPAA requires patients to sign a valid authorization form declaring their permission before a practice can market to that patient. This authorization form must be kept by the practice for six years. (See June 2014 *Healthcare Business Monthly*, "Answer Common HIPAA Questions" pages 62 -63, for more information on marketing under HIPAA).

5. *Ensure that vendors who assist you in social media activities sign a business associate agreement.* HIPAA has new rules on what types of vendors are considered business associates under HIPAA. Practices must sign business associate agreements with these vendors that obligate the vendor to safeguard the patient information it maintains or has access to. Software vendors, such as "Constant Contact" and others who have access to your patient list, are considered to be business associates and must sign agreements with a practice to maintain compliance with HIPAA. (See May 2014 *Healthcare Business Monthly*, "Answer Common HIPAA Questions," pages 46-47, for more information on business associates under HIPAA).

Form B (**Source:** Physician's Ally, Inc. HIPAA Policies & Procedures binder)

Authorization Form for Media Events

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are giving us permission to share your PHI as you indicate below.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether I sign this authorization or not. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if the Practice is soliciting my signature.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time by submitting my desire to revoke this Authorization in writing to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

In consideration of my participation in an interview, testimonial, photograph or video for the Practice, I hereby consent to the publication, reproduction, distribution or other use by the Practice, their successors and assigns, of my name, photograph, likeness, words, voice and/or personal data for broadcasting, commercial, advertising, public service announcement, trade, fundraising or any other purpose.

I am the age of majority or greater, or if a minor, I have read this release and had it signed and ratified by my legal guardian.

Patient Name: _____

Persons/Organization(s) to receive the information: _____

_____

Specific description of information to be disclosed or used (include applicable dates) and what format the media : _____

_____

What is the purpose of the requested use or disclosure?

_____

This Authorization will expire when the Practice is no longer using the interview, testimonial, photograph or video, or earlier if revoked in writing by the Patient.

_____

Patient Signature _____ Date _____

Never defend the practice or respond to a patient's negative comments online.

A Few "Never" Reminders

- Never defend the practice or respond to a patient's negative comments online. Take this conversation offline. Seemingly innocent comments such as, "We dismissed this patient from our practice," can get the practice in big trouble with the federal government under HIPAA.
- Never post photos of patients — or any part of patients, no matter how unidentifiable they seem — online. There have been many cases where individuals were sanctioned or sued by patients, friends, and family members who recognized the patient from the online post. (Source: Office of Civil Rights website)
- Never text patient information without ensuring a secure (i.e., encrypted) method for doing so. The practice, not the patient, is responsible for ensuring the safe transmission of patient information over open networks. HBM

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

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Avinash Kumar, **CPC-A**
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Ayeshwarya Lakshmi Sivasankaran, **CPC-A**
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Banu Priya Sathiyamoorthy, **CPC-A**
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Barbara Urbielewicz, **CPC-A**
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Bekki Deepthi, **CPC-H-A**
Belen Ortiz, **CPC-A**
Beth Anne Maney, **CPC-A**
Beth Leonard, **CPC-A**
Bethanie Clausen, **CPC-H-A**
Bethany Casey, **CPC-A**
Bethany Davis, **CPC-A**
Betty Evans, **CPC-A**
Beula Devi, **CPC-A**
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Beverly Kopac, **CPC-A**
Bhagya Rajagopal, **CPC-A**
Bharathi Elia, **CPC-A**
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Bhuvaneswari Sivakumaran, **CPC-A**
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Brittany Crafts, **CPC-A**
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Chelsea Ramsey, **CPC-A**
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Diana Bruns, **CPC-H-A**
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Diane Davis, **CPC-H-A**
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Divya Rajendran, **CPC-A**
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Donna Buan, **CPC-A**
Donna Whitledge, **CPC-H-A**
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Eric Thomas Berg, **CPC-A**
Eric Vermeulen, **CPC-A**
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Erika Rohde, **CPC-A**
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Erin Mangus, **CPC-A**
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Erin Pettit, **CPC-A**
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Heather Stoffers, **CPC-A**
Heather Varney, **CPC-A**
Heidi Evans, **CPC-A**
Heidi Snyder, **CPC-A**
Helen Good, **CPC-H-A**
Helen Lawless, **CPC-A**
Helen Patrick, **CPC-A**
Hemalatha Vijayan, **CPC-A**
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Jennifer Cruz, **CPC-A**
Jennifer Curtis, **CPC-A**
Jennifer Day, **CPC-A**
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Jennifer Phillips, **CPC-H-A**
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Kristen Jacks, **CPC-A**
Kristen Kijowski, **CPC-A**
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Lakshmi Pushadapu, **CPC-A**
Lakshmikala Velusamy, **CPC-A**
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Laquan Martin, **CPC-A**
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Lavanya Mettukuru, **CPC-A**
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Virginia Masters, **CPEDC**
Wendolyn Leigh Reed, CPC, **CPPM**
Yaneiry Lora, CPC, **CPMA**
Yutonya Horton, **CPCO**

Magna Cum Laude

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Bindya Viswambharan, **CPC-A**
Cara S Geary, CPC, CPC-H, **CEDC**
Charity Rathbun, **CPC-A**
Elisha Chenault, **CPC-A**
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Gloria Noriega, **CIRCC**
Holly Elliott, **CPC-A**
Jaclyn Bolinger, **CPC-A**
Jayashree Durai, **CPC-A**
Katrina White, **CPC-A**
Kawaldeep Inderjeet, **CPC-A**
Kristen Wiggins, **CPC-A**
Leah Straube, **CPC-A**
Lindsay MacKnight, **CPC-A**
Lisa Johnson, **CPC-A**
Lorie Slawsky, **CPC-A**
Pratibha Asireddy, **CPC-H-A**
Qiana Flowers, **CPC**
Rebecca Hardy-Bakalik, **CPC**
Sarah Collinson, **CPC-A**
Sherry Morgan, **CPC**
Sherry Peck, CPC, CPC-H, **CEMC**
Traci Lynn Hayes, **CPC-A**
Wendy Willes, CEA, **CPC-A**, CPC-H-A, CPB, CPC-I

A&P Quiz Answer

(from page 26)

The correct answer is B, type II diabetes.

Cynthia Scott, CPC-P, CEHRS

Medical Office Manager, Medical Billing and Coding, and EHR Instructor, Holyoke Community College, Holyoke, Mass.

"I really enjoy my present position and can't imagine doing anything else. "

GOT A MINUTE?

If you, or someone you know, is an AAPC member who strives to "Uphold a Higher Standard," we want to know about it! Please contact Michelle Dick (michelle.dick@aapc.com) to learn how to be featured.

Tell us a little about your career — how you got into coding, what you've done during your coding career, and what you're doing now.

I always knew I would work in the medical field. After high school, I went to school to be a medical secretary. When my husband was in the military, we moved around a lot, and I took a job through a temp agency as a data entry specialist for a medical billing service. From there, I moved up to a medical biller position. When we moved home to Massachusetts, I continued in the medical field by working as an account manager. I've had the opportunity to work from home for a billing service and to bill and code for an orthopedic surgeon and podiatrist, as well. I enjoy medical billing and coding so much that I decided in 2002 to teach my trade at a career school, Branford Hall Career Institute. Today, I manage a urology practice and teach coding procedures and electronic health records (EHRs) at Holyoke Community College in the Medical Billing program.

As for my own education, I went on to attend Holyoke Community College in the Health Office Supervision program and then Ashworth College, where I majored in Health Care Management.

What is your involvement with your local AAPC chapter?

I drive an hour and a half to Albany, N.Y., to be part of the Albany local chapter. I enjoy this chapter because they are very active and provide a lot of education to their members. I even bring my students to meetings. I look up to chapter President **Lynn Nobes, CPC, CPC-I, CEMC**, as she is also a teacher. I am on the list to proctor exams and on the volunteer list.

What AAPC benefits do you like most?

I enjoy the webinars that AAPC offers, as well as the continuing education, regulatory updates, AAPC Coder, and the discounts on coding books.

What is your biggest challenge as a coder?

To make sure my students get the most education during the time allotted in the class schedule and keeping up with coding updates.

How is your organization preparing for ICD-10?

In November 2013, I was attended a two-day boot camp hosted by my local chapter. The live autopsy video really helped me to better understand anatomy. I obtained my AAPC ICD-10 proficiency in February 2014.

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

I really enjoy my present position and can't imagine doing anything else. I have job flexibility in my daytime position and I enjoy mentoring students and teaching at night.

How do you spend your spare time?

I travel with my husband and three sons. I like going to the gym, attending boot camp classes, and tap dancing. I also enjoy watching my middle child at his tap dancing competitions. HBM

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Pam B, Coding Manager

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Lisa U, Coding Manager

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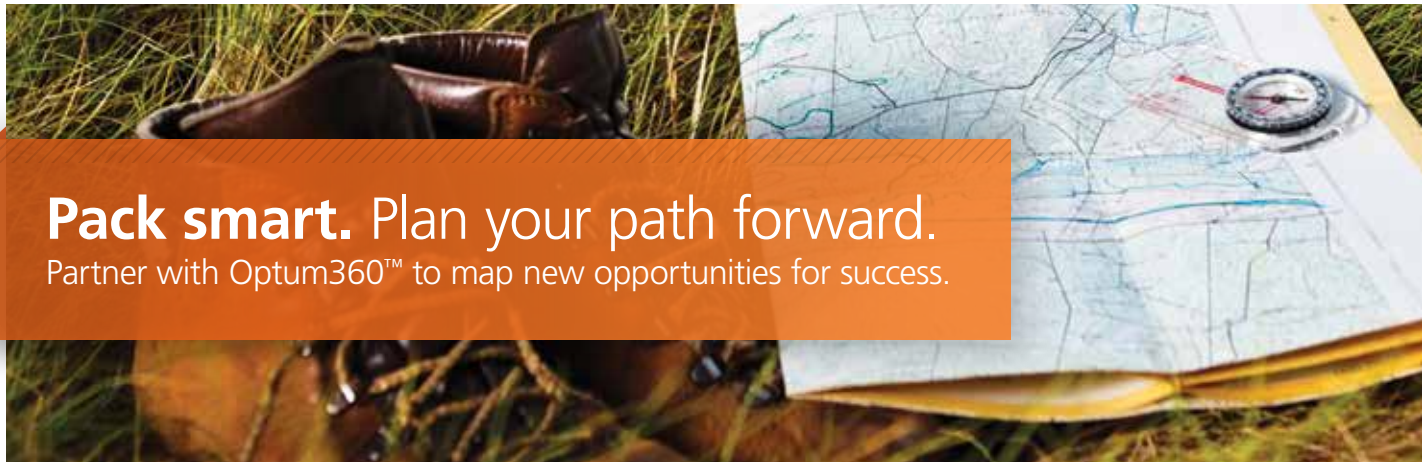

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