Auto-population Gone Wild

Consultant Mary LeGrand, RN, MA, CPC, CCS-P
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The membership of AAPC, and subsequently the readership of Coding Edge, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

- **APPRENTICE**: Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
- **PROFESSIONAL**: More sophisticated issues including code sequencing, modifier use, and new technologies.
- **EXPERT**: Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

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Payers: Thorn in Side or Needed Service?

Those of us who code and submit medical claims sometimes view payers as our adversaries. So-called “payer bashing” is a familiar conversational topic among attendees at AAPC coding conferences and seminars. I'd like to step out on the proverbial limb and suggest that we think more critically about the role payers play.

What Do Payers Do?
First and foremost, payers sell insurance. That is, payers cover short-term risk and provide a measure of relief against possible catastrophe. This may not be profitable in the near term, and insurers must charge sufficient premiums to make a profit over the long haul. As is health care, insurers are a business, and they must consider the bottom line if they are to survive.

Second, payers pay claims. Many years ago, my medical bills came directly to me. I would pay the provider, and then collect from the payer. That’s rare now. As health care has become increasingly sophisticated, even informed patients find medical bills difficult to decipher. And when a common office visit bill can bewilder a patient, a list of hospital charges will overwhelm him. In this environment, payers must:

- Figure out the charges.
- Determine if the charges are accurate and supported.
- Decide if the diagnosis, procedure, or drug is covered under the patient's plan contract.
- Pay the correct amount of the claim.

Payers usually have a pre-negotiated rate with the provider for the services he or she provides so both know how much to bill. This is a payer administrative task that most patients could not do.

Without payers to act as intermediaries, your practice or facility either would be a cash-only business or accept receivables directly from patients. Cash only sounds great, but it’s not very viable—or I suspect all providers would do just that. Plus, if you think collecting from payers is a pain, imagine following-up to collect receivables from each individual patient.

How Much Do Payers Make?
As I write this (just after Christmas), the health care reform debate in Washington, D.C., rages on. I’ve heard many politicians suggest that payer profits contribute unreasonably to high health care costs.

We looked up five publicly traded payers (Aetna, Humana, Cigna, UHC, and WellPoint) to see just what they are pulling in these days. Over the past three years, on average, they made less than 5 percent revenue (Aetna’s margin was the highest; Humana’s the lowest). Five percent of revenue is less than most industries make.

Like any industry, payers do seek to reduce their costs. But these very same payer efforts—along with the Centers for Medicare & Medicaid Services (CMS) pay schedules—more than anything are working to hold down overall health care costs.

Mistakes Happen—On All Sides
Payers sometimes make mistakes. Correct claims are denied, and deserved payments are delayed. This frustrates providers and coders because such mistakes usually demand extra time and effort to correct.

My answer here is simple: Providers and their coders and billers make mistakes, as well. Education and coding certification go a long way, but payers still must deal daily with problem claims—incomplete documentation, missing signatures, truncated diagnosis codes, unsupported E/M coding, the list goes on—and even outright fraud.

My point is: Payers make a reasonable profit while providing valuable services to everyone. The outrageous salaries collected by payer CEOs in past years may have hurt the industry’s credibility, but payers share with providers and coders the common goals of cost-effective health care, accurate claims reporting, and legitimate payment. In other words, “We're all in this together.”

Sincerely,
Reed E. Pew
CEO and President
Consults, Continued …

I read Suzan Berman’s article, “Brace Yourself for Change: CMS Says No More Consults” (Coding Edge, January 2010, pages 46-48) with interest. Not since the Health Insurance Portability and Accountability Act (HIPAA) has there been so much confusion regarding changes in our health care delivery system. Luckily, more information has been published since press time—particularly in terms of Medicare as a secondary payer (MSP) guidelines.

Our physician coding department did take the time to contact each of our contracted payers to weigh in on this issue; and as of right now, all of the commercial payers with whom we participate (including Cigna, Anthem, and Harvard Pilgrim) will continue to accept the consultation codes in 2010.

Although good news, this did raise a question when considering MSP. Do we bill the consult code to the commercial primary, and submit to the Centers for Medicare & Medicaid Services (CMS) using an evaluation and management (E/M) code secondary? Do we bill an E/M code anytime Medicare was a payer of record? MedLearn Matters number 6740 Revised (www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf) advises:

Medicare will also no longer recognize the consultation codes for purposes of determining Medicare secondary payments (MSP). In MSP cases, physicians and others must bill an appropriate E/M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

1. Bill the primary payer an E/M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E/M code, to Medicare for determination of whether a payment is due; or

2. Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E/M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Note: The first option may be easier from a billing and claims processing perspective.

Although our facility is still sorting through the financial and work-flow implications of CMS’s decision, what absolutely is not appropriate is to write off the MSP co-insurance following the CMS denial of the consultation code, or to fail to submit secondarily to CMS, just to save time and effort.

Medicare’s Fraud and Abuse Guide’s “Examples of Improper Waiver of Deductible and Copayments,” outlines, “marketing practices that may be suspect to charge-based providers” includes “(Non-) Collection of copayments and deductibles only where the beneficiary has Medicare supplemental insurance (“Medigap”) coverage i.e., the items or services are “free” to the beneficiary,” and “Failure to collect copayments or deductibles for a specific group of Medicare patients for reasons unrelated to indigence.”

As certified coders, it is up to us to research, verify, and clarify what the legal and acceptable processes are to perform our coding duties in a compliant manner, and protect our providers, as well as ourselves from fraudulent practice.

Pam Brooks, PCS, CPC
Physician Services Coding Supervisor
Wentworth-Douglass Hospital
Dover, N.H.

Many thanks for the additional guidelines, as well as the reference to MedLearn Matters 6740 Revised, which provides important information regarding coding and billing of consultation services for CMS. Look for a complete discussion of Medicare’s Revisions to Consultation Services Payment Policy (Transmittal 1875, Change Request 6740) in an upcoming Coding Edge.

Due to publication production schedules, Coding Edge articles are written one to three months before an issue can publish. While we are committed to providing the most complete and timely information each month, we encourage readers and AAPC members to read our bi-weekly e-mail newsletter, Edge-Blast, and to visit the AAPC Web site often for up-to-the-minute information.

Planning for Chapter Success Pays Off

I just wanted to say the article “Plan Now for 2010 Local Chapter Success” in the December 2009 issue of Coding Edge couldn’t have come out at a better time. I will be serving as an officer this upcoming year and plan on using some of the ideas given in this article. What a great networking opportunity for all of our chapter members. Thanks for the wealth of information the AAPC has to offer.

Respectfully,
Kim Hogback, CPC
2010 AAPC Tacoma Chapter Secretary
2010 is well under way, which means you should be using the new CPT® book. Some codes you previously had memorized are gone, with new ones added. Descriptions have been updated and now there are out-of-numeric sequence codes. Hospitals and offices should have made the New Year computer changes effective Jan. 1 or they won't be getting paid. If your employer hasn't made the changes yet, now is the time to become an integral part of the team by providing input to your physicians and staff.

**Speak Up Now**

While speaking at meetings, I frequently ask “How many of you coders meet regularly with your billing and IT staff?” The response from the audience usually shocks me. Generally, less than 5 percent of those in attendance have ever done so. Because of this low percentage, these questions haunt me:

- How can you, as a coder, implement new CPT® codes without a discussion with billing and IT staff?
- How do you know whether claims are getting paid?
- Are some claims being denied for medical necessity, incorrect modifiers, or no authorizations in place?
- Are you confident you have coded the reports to the best of your ability utilizing correct coding initiatives (CCI) knowledge? Unless you are familiar with the specific payer rules or are able to see denials, do you really have any idea if claims are being paid?
- Are your physicians documenting correctly and thoroughly?
- Do you speak regularly to physicians and feel confident enough to have an open dialogue with them concerning their documentation?

If not, you have work to do.

**Prevent Tomorrow’s Failures**

You should be auditing your physicians now for thorough documentation. If they aren’t documenting well enough to meet ICD-9-CM requirements, they surely will fail to meet ICD-10-CM requirements in 2013.

It is not your job to get claims paid; it is your job to meet medical necessity for the service(s) you are coding utilizing CCI. If your claims are not being paid and the denials are not being corrected, you probably won’t have a job for very long due to lack of revenue.

It is a coder’s job to work with physicians, billers, and IT staffs to make sure all are openly communicating, monitoring physicians for thorough documentation, and meeting regularly with the billing staff to review denials, payer rules, and additional documentation requested by payers.

**Decrease Denials Now**

As a coder, have you looked at your payer rules? If not, now is the time you should become familiar with them and code using them. Billers should not be correcting coding questions; you should. Coders should know what billers need to get the claims paid correctly and timely. Start a chart audit committee and meet regularly to review denials, coding questions, payer requests for additional documentation, etc.

You will be shocked at what a biller deals with on a daily basis trying to get claims paid correctly and they would be shocked at what coders have to know to code correctly. The physicians, coders, billers, and IT staffs are all major pieces of the overall team.

Start working together as a team, monitor the number of denials on an ongoing basis, review the denials with your physicians—they really need your expertise and input. If you can cross these hurdles now, your transition to ICD-10-CM and electronic medical records (EMRs) will be much, much easier.

Sincerely,

Terrance C. Leone, CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board
Providers: Are YOU Satisfied?
As you read this, approximately 30,000 physicians, health care practitioners, suppliers, and institutional facilities serving Medicare beneficiaries across the country have been asked to participate in the fifth annual Medicare Contractor Provider Satisfaction Survey (MCPSS). This survey offers Medicare fee-for-service (FFS) providers the opportunity to tell the Centers for Medicare & Medicaid Services (CMS) exactly what they think of their contractor.
Survey questions focus on seven key business functions of the provider-contractor relationship:
- Provider inquiries
- Provider outreach and education
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

The MCPSS is a provision of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, which mandated CMS develop contract performance requirements. The purpose of the MCPSS is to allow CMS to:
- Hear provider concerns;
- Monitor trends;
- Improve contractor oversight; and
- Increase efficiency of the Medicare program.

2010 MCPSS data will be released as a summary report in the summer of 2010. Visit www.cms.hhs.gov/MCPSS for more information about MCPSS.

Medicare Sets Aside HIV Stigma to Screen Seniors
CMS recently changed its National Coverage Determination (NCD) for human immunodeficiency virus (HIV) screening to expand coverage for Medicare beneficiaries who are at increased risk for HIV, who are pregnant, or who request it—including seniors.

The Hartford Courant reported Jan. 4 that “testing for the virus among those 65 and older lags far behind testing of other Americans, and experts say they worry that HIV cases in older adults go undiagnosed—some because of the stigma that the disease still carries, some because patients might dismiss the symptoms of the virus as signs of other conditions more frequently associated with aging and some because doctors can be hesitant to talk to older patients about sex or link their symptoms with HIV.”

HIV is crossing barriers into the older population. “HIV was very much a disease of young individuals, particularly those who are homosexual or intravenous drug abusers, and as a geriatrician, it was a problem that we very, very rarely saw,” said Dr. George Kuchel, director of the UConn Center on Aging. “But that has changed a great deal.

“In some ways, it’s often misdiagnosed because people don’t think about it,” Kuchel said. “Clinicians will often think, ‘Well, it’s not a disease of older adults, we don’t see it.’ And it does happen.”

CMS’ decision to cover HIV screening sprang from cited research suggesting 53 percent of people aged 65 to 74 were sexually active, as were 26 percent of those aged 75 to 85.

It may not be long before private payers decide to cover senior screenings, as well. “When Medicare covers something, it’s also not just a signal to the population that this is something that’s important and needs to be done, but it often becomes a standard that private insurance follows,” said Judith Stein, executive director of the Center for Medicare Advocacy.

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Each October, the Office of Inspector General (OIG) reveals to us in their annual Work Plan what they will be working on with respect to Department of Health and Human Services (DHHS) programs and operations in the upcoming year. This plan can give you an idea of what the federal government’s areas of concern are in the public health care sector. You can then use this information to create or update your own compliance work plan.

Last month, we looked at the 2010 OIG Work Plan in regards to physician practices. This month, we’ll look at the items relating to hospitals, and consider how providers can use this information to prepare for the upcoming year.

**New Work Plan Items for Hospitals**

**Hospital Payments for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System (IPPS)**—In the hospital setting, all outpatient diagnostic services and admission-related nondiagnostic services provided within three days prior to an inpatient admission date are not paid separately, but payment is considered as included in the Medicare Severity Diagnosis-related Group (MS-DRG) payment provided to the hospital for the inpatient admission. This is commonly known as the three-day window, or somewhat inappropriately, the 72-hour rule. Prior OIG work had shown significant issues in these areas in the past, when it was previously included in the plan. They’ve included it again this year, specifically looking at payments made for these services within that three-day time period.

To prepare yourself for this review, look at your current controls, to be sure you have appropriate edits in place to prevent billing for these services to the program outside of MS-DRG payment. If you do not have automatic controls in place to protect your facility, does your current compliance program monitor this issue? If not, now is definitely a great time to look at the program and include these in reviews for the upcoming year.

**Hospital Admissions with Conditions Coded Present-on-Admission**—The rules and regulations regarding hospital acquired conditions (HACs), serious adverse events, and present-on-admission (POA) indicators have not been in place for very long. It is, however, an area of significant concern to the OIG, as it’s an area with potential error, fraud, and abuse issues. The OIG will look at claims to determine the number of inpatient admissions for which certain diagnoses are indicated as POA and specifically which diagnoses were most frequently coded as POA. Under the new rules, a facility receives a lower payment for services if certain conditions were acquired in the hospital. This provides a facility incentive to show that a condition was not acquired in the hospital setting, but was present upon the patient’s admission to the facility. OIG also plans to look at transfer activity between facilities, especially those transferring a large number of patients with conditions present upon admission and those receiving transfers of patients with conditions present upon admission.

This is a new area to be concerned with in your compliance programs. Hopefully, you are already auditing and monitoring with regard to these types of indicators. If not, it’s important to review your POA and HAC coding, as with any new process, there is the potential for errors. It is also a good idea to review your transfer rates, to find if there are any concerning or alarming statistics that might be red flags to the OIG.

**Hospital Readmissions**—If you discharge a patient from an inpatient admission, and then readmit the patient on the same calendar day for the evaluation or management (E/M) of that same condition he or she was initially treated for in your facility, combine the initial and subsequent inpatient stays into a single claim submission for a single MS-DRG payment. The Medicare program has built edits into their systems to prevent payment of these services, but there are ways to override...
As a facility, review your adverse event reporting process, as it is most likely to be a new, more expanded process than in the past. Prior to these requirements, dealing with adverse events was the problem of the medical director and the risk management/quality assurance divisions.

these edits in the event a patient is discharged and readmitted on the same day for a different medical rationale. The OIG plans to review claims for patients discharged and readmitted to the same acute care facility on the same day, to see if these edits were overridden properly, or if claims were paid inappropriately.

If you do not currently have a process in place in your billing system to force review of each of these types of claims, it’s a good idea to discuss this with your billing director to determine if some kind of automatic edit can be put into place. If you do have an automatic edit, you may wish to do some auditing of the claims submitted when this edit is overridden to determine whether the override was appropriate.

**Adverse Events**—There are five items specifically directed at the new Adverse Event policies under the Medicare program. These reviews are:

- Hospitals: National Incidence Among Medicare Beneficiaries
- Hospitals: Methods To Identify Events
- Hospitals: Early Implementation of Medicare’s Policy for Hospital-Acquired Conditions
- Hospitals: Responses by Medicare Oversight Entities
- Public Disclosure of Adverse Event Information

These reviews are all directed at determining if hospitals are appropriately identifying and reporting adverse events, and whether the current list of Medicare adverse events is appropriate. It is also an indicator of whether their list should be expanded further to match the list published by the National Quality Forum.

As a facility, review your adverse event reporting process, as it is most likely to be a new, more expanded process than in the past. Prior to these requirements, dealing with adverse events was the problem of the medical director and the risk management/quality assurance divisions. Under these new Medicare guidelines, adverse events span to a much wider group within the facility, including not only the medical director and risk/quality divisions, but also the compliance department, finance, billing, and operations. Be sure there is working communication between each of these areas, and tweak those new policies and procedures as necessary to make them work well in this new realm. Consider examining your state Medicaid regulations regarding the same topic.

Each state is implementing its own plan to correlate with these regulations, and some have significantly different lists of adverse events than the Medicare program. Check the requirements in your state, and make sure you’re in compliance with each set of necessary requirements.

**Note Other Items in the Hospital Work Plan**

There are many other important items in the Work Plan this year that involve hospitals. Some are new and some have been in the plan for a while. They include:

- Part A Hospital Capital Payments
- Provider-Based Status for Inpatient and Outpatient Facilities
- Part A Inpatient Prospective Payment System Wage Indices
- Payments to Organ Procurement Organizations
- Inpatient Rehabilitation Facility Submission of Patient Assessment Instruments
- Critical Access Hospitals
- Medicare Disproportionate Share Payments
- Duplicate Graduate Medical Education Payments
- Interrupted Stays at Impatient Psychiatric Facilities Payments
- Provider Bad Debts
- Medicare Secondary Payer

There are also reviews in other sections of the work plan that may be pertinent to your facility, such as the Medicaid program sections, the Recovery Act Work Plan, or the Public Health program sections. Check out the entire Work Plan to know where you stand with the items they’ll be reviewing this year. The 2010 OIG Work Plan is available for free online at [http://oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf](http://oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf).
“What do you want to do today?”
“I don’t know. What do you want to do?”
“I don’t know. I asked you first.”
“I’ll do whatever you want to do.”
“Well, I’ll do whatever you want to do.”
“Then what do you want to do?”

If this conversation sounds familiar when planning your chapter meetings, you’re not alone. Many chapters feel they have exhausted their resources when it comes to local chapter meetings. If you’ve had a visit from the AAPC national office, you’ve covered CPT® changes and ICD-9 changes—what’s left to draw in and educate your members?

**Get Members Involved**

Try a “coders teaching coders” workshop. Ask members to sign up ahead of time for their topic of choice to teach the others in the group. The topics could be a regularly seen coding problem in their practices, a current event topic related to a news item or celebrity, or a common coding issue. Divide your group into smaller groups, and then divide the teaching time into 15-20 minute increments.

**Invite a Doctor to Speak**

There’s no better way to understand a procedure, a new technique, or a disease state, than to hear from the physicians who work with it each day. Doctors are usually thrilled to bring coders into the loop of their trade. Coders get a wealth of information and a better understanding of why the code pays so high, why the physicians want one code billed over another, and why the documentation is written the way it is.

**Start Game Night**

Think of ways to add a coding twist to any standard game. Here are some suggested coding game favorites:

**Jeopardy**—The prep work for Jeopardy is to write the words, codes, etc. on cards. Put the cards on a white board, chalk board, or poster. Have all the “answers” marked on index cards for the host. The “questions” also need to be written on the cards. (Remember: In Jeopardy, the answers are questions and the questions are answers.) The day of the game, appoint a host and divide the group into teams or have contestants.

Visit the officer forums on the AAPC Web site for additional coding Jeopardy information.

**Jenga**—You’re probably familiar with this tower-building block game, but what if each block has a number on it and you have to code based on the blocks that fall? When the blocks fall, the first member to put together a valid CPT® code wins that round. It’s an exciting way to learn the entire CPT® book and expand your knowledge.

Game night results in learning the fun way, building camaraderie, and if your budget allows, awarding small prizes to those with the highest points. Everyone is a winner in these games.

**Ask Payers to Talk**

Most payers have representatives whose sole responsibility is to speak to their provider community. Most payers offer this free of charge, including Medicare contractors. Of course, these sessions are incredibly helpful.

**Consider Plastic Surgery**

Not really—you look gorgeous already, but do realize that plastic surgery is always introducing new and innovative procedures. Plastic surgeons often sponsor open houses to illustrate a new technique or to discuss different services offered. They will usually do this as a courtesy. It offers the coders a chance to learn more about these procedures.

**Swap with a Local Chapter**

What about having a local chapter swap? Talk to your neighboring chapters and see which speakers were their favorites. Consider swapping your member speakers with another chapter’s member speakers.
Take a Field Trip
There are often health exhibits and health care professionals that tour the country. Take the whole chapter to these area attractions and you can often get discounts for bringing larger groups. You may want to rent a bus so all can go together. Prepare a test for participants and answer questions as a group. You’ll be amazed at what everyone learns and how fun it can be.

Exhibits such as “BodyWorld” are fantastic learning opportunities for coders. Several local chapters can attend when they come through town.

Tour a Hospital
Hospitals often offer tours of their facilities, especially if they’ve been remodeled. These are great learning opportunities for coders to understand how things happen in relation to patient care.

Peruse “Meeting Ideas” on AAPC’s Web site
You’ll find PowerPoint presentations and other suggestions for meetings on the AAPC Web site. If you are an officer, you can find the meeting ideas by clicking the “My AAPC” tab, selecting “Officer Resources,” and then choosing “Meeting Ideas.”

If your chapter has an idea for a successful meeting, feel free to pass it along to your American Academy of Professional Coders Chapter Association (AAPCCA) regional representative or post it on the forums for all to see. We’d love to print another article like this with your ideas.

Suzan Berman, CPC, CEMC, CEDC, is senior manager of coding and compliance for the Department of Surgery and Departments of Anesthesiology at the University of Pittsburgh Medical Center. She is past president of the Central Pittsburgh AAPC, and serves on the national AAPCCA Board of Directors and the Ingenix advisory boards. She speaks at several AAPC national conferences, chapter meetings, and many other events.
EHR Primer: Get the Basics

Knowing the challenges can help with implementation and orientation to a new system.

Electronic health records (EHRs) are electronic versions of a patient’s medical history as maintained by a physician or other health care provider. EHRs contain elements such as patient information, past medical, family and social history, clinical notes, prescriptions, and diagnostic testing results. These records are accessible to other health care providers and serve as a legal record of everything that happened to a patient during a specific encounter. EHR adoption is key to the current administration’s health strategy. If you are confused about what’s happening, here’s a primer.

Taking the Next Step in Health Care Data

The Centers for Medicare & Medicaid Services (CMS), Electronic Health Records, Overview (www.cms.hhs.gov/ehealthrecords/) says, “EHRs are the inevitable next step in the continued progress of health care that can strengthen the relationship between patients and clinicians. The data, and the timeliness and availability of it, will enable providers to make better decisions and provide better care.”

Examples of how EHRs can improve patient care include the following:

- Reducing incidence of medical error by improving the accuracy and clarity of medical records.
- Making the health information available.
- Reducing duplication of tests.
- Decreasing treatment delays.

The government is uncovering and addressing implementation issues through a series of demonstration projects prior to the 2014 projected nationwide rollout. CMS is engaged in a five-year EHR demonstration project, which began on June 1, 2009 and is anticipated to continue through May 21, 2014 (found at CMS, Medicare Demonstrations, Details for Electronic Health Records Demonstration: www.cms.hhs.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1204776).

The goal of the demonstration is “to foster the implementation and adoption of EHRs and health information technology (HIT) more broadly as effective vehicles to improve the quality of care provided and transform the way medicine is practiced and delivered … The demonstration is designed to leverage the combined forces of private and public payers to drive physician practices to widespread adoption and use of EHRs,” (CMS, Medicare Demonstrations, Details for Electronic Health Records Demonstration). The demonstration provides incentives to participating primary care physician practices fulfilling established criteria and serves as an operational outline for practices across the country in relation to infrastructure, physician education, tracking and reporting quality measures, and community outreach.

Increase Financial Benefits with Early Implementation

In February 2009, President Obama signed the American Reinvestment and Recovery Act (ARRA, or stimulus act), which included the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH includes more than $19 billion used to increase EHR use nationwide. Under the stimulus plan, physicians can qualify for $44,000...
in Medicare incentives if they demonstrate “meaningful use” of an EHR starting in 2011. High-volume Medicaid providers can be eligible for up to $20,000 more in incentives, for a maximum incentive of $64,000. Physicians in health professional shortage areas (HPSA) are eligible for an additional 10 percent incentive.

Specific criteria must be met before a provider is eligible for stimulus payments. The two most important criteria require that (1) the EHR must be a "qualified" EHR and (2) the provider must demonstrate "meaningful use."

To be considered qualified, an EHR must:

- Include patient demographic and clinical health information.
- Have the capacity to provide clinical decision support.
- Support physician order entry.
- Capture and query information relevant to health care quality.
- Be able to exchange electronic health information and integrate information from other sources.

The definition of meaningful use is muddy and will be clarified further by the Health IT Policy Committee. Meaningful use most likely will involve consistent use of the EHR for prescribing, electronic exchange of health information between clinical organizations, and the submission of information on selected quality measures. A provider who purchases an EHR system but fails to use it would be disqualified from stimulus payments if they are not meaningful users of a qualified EHR system. It is imperative to work with the business office or central business office in cases of large group practices with many locations. The new EHR system will not provide return on investment if it does not interface with the existing billing and accounts receivable system. Practice managers and clinicians need to consult with the billing and accounts receivable (BAR) office about evaluating vendors to achieve optimal interoperability between systems and offices. Failure to include the front and back ends of the revenue cycle will result in significant cash flow problems during implementation.

Weigh the Impact on Patient Care and Finances

As a result, every practice should assess its specific needs for a qualified EHR system. It is imperative to work with the business office or central business office in cases of large group practices with many locations. The new EHR system will not provide return on investment if it does not interface with the existing billing and accounts receivable system. Practice managers and clinicians need to consult with the billing and accounts receivable (BAR) office about evaluating vendors to achieve optimal interoperability between systems and offices. Failure to include the front and back ends of the revenue cycle will result in significant cash flow problems during implementation.

Your physicians also will need sufficient preparation to become acclimated to a new system, so there will be limited impact on the number of patients seen in a day with no adverse effects on patient care quality. Careful planning is necessary to implement the EHR system gradually, starting with the clinical data first, and then moving to implementation of the billing system where encounter form data is entered. If care quality and billable hours are affected substantially because a physician is spending excessive time in front of a computer keying in data, there will be a negative return on investment.

Computerizing the nation’s health records as part of the economic stimulus plan has resulted in mixed emotions. Although providers agree that quality of patient care quality will increase with EHRs, they are faced with the challenges of implementation and orientation to a new system. With the topic of EHRs on the CMS agenda since the early 90s, it's still a top priority as CMS moves forward with the EHR demonstration project as part of their value-driven health care initiative. As the President designates funds and resources to fulfill the goal of Americans having access to a secure, interoperable health record by 2014, analyzing your practice’s current capacity and resources for implementing EHR is critical to your five-year strategic plan.

Incur Financial Penalties with Late Adoption

The biggest obstacle in implementing EHRs in private and group practices is cost. With the financial incentive program, expense should be less of an issue for physician practices to adopt a functional EHR. In an ongoing effort for full compliance, further negative incentives will be implemented after the demonstration project is over. Beginning in 2015, penalties (reduced fee schedule payments) will be assessed for providers that are not meaningful users of a qualified EHR system. The penalty will increase each subsequent year of noncompliance, to as much as 5 percent by 2018.

Janice G. Jacobs, CPA, CPC, CCS, RDCC, has over 25 years of experience. She has worked on numerous ambulatory payment classifications (APC), diagnosis-related groups (DRG), and physician billing and coding projects, as well as chargemaster (CDM) reviews. She has also served in various interim-staffing engagements such as billing office manager and director of compliance at a major West Coast academic medical center. She also owned and managed a full-service, multi-specialty medical billing company.
Keep E/M Documentation Priorities in Order

By G. John Verhovshek, MA, CPC

Aggressive claims review by government and private payers has brought a much needed spotlight to the shortcomings of medical documentation in support of optimal coding and reimbursement. This is a positive development, but what’s important to remember is that coding never should drive documentation. The idea, for instance, that “if only the doctor had documented one more bullet ...,” even if well-meant, is wrong-headed. Rather, documentation rooted in medical necessity that accurately reflects the service level provided always will drive coding to the optimal level.

Let Physicians Document Completely from a Clinical Standpoint

“Optimize the medical record and the coding so that results do not depend on documenting anything extra,” advises Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting and a coding, billing, and compliance consultant. “It depends only that physicians better record what they are thinking and doing already.” In other words, a complete medical record results when physicians think and act as physicians—and document that process carefully—not by asking physicians to think or act as coders or auditors.

“Clinicians don’t evaluate patients in terms of bullet items or check lists,” Hammer notes. “The criteria are dynamic and vary from patient to patient depending on the nature of the presenting condition.” But a physician who captures his or her thought process (in determining the assessment and plan, as well as an appropriate history and exam) to arrive at a diagnosis and determine treatment creates a complete medical record that also yields optimal coding for the evaluation and management (E/M) service provided. The medical record alone should be sufficient to recreate the circumstances of a physician/patient encounter (note that legibility plays a role here). Nothing pertinent to medical decision-making should go unnoted. If it’s important to the patient’s case, it should be in writing.

“The documentation should paint a clear picture of ‘here’s what was found, here’s what was done, and here’s why,’” Hammer says. “Coders often say ‘not documented, not done.’ But if you as another clinician [or for instance, an auditor] are seeing the documentation for the first time, if something isn’t documented, you have to assume it wasn’t even considered.” Likewise, minimal documentation or inconsistencies within a note are of little clinical value, and create serious legal and/or malpractice liabilities.

Clinical Completeness Ensures Continued Quality Care

“I encourage physicians to think of the medical record first and foremost as a communication tool,” Hammer continues. “I ask, ‘If you were the next physician (whether as a partner or as a referral) to see this patient, what would you want/need the medical record to contain?’ This ensures quality and continuity of care for patients. Any physician should be able to look at any other physician’s notes and know not only the patient’s chief complaint at the prior visit, but also the documenting physician’s thought process in arriving at a diagnosis and treatment recommendations: What information was obtained from the history and exam? Which tests were ordered and why? Which drugs were prescribed and why? Are there co-morbidities or other pertinent factors? Complete documentation comes not from noting only what was done, but also why it was done.”

In other words, encourage your doctors to document completely not for coding, but for other doctors. Selecting an E/M service level is incidental to and should not compete with the goal of complete clinical documentation in the patient’s best interest. But one naturally will follow the other. The best documentation—from medical, legal, and coding perspectives—describes in some detail the physician’s clinical thought process. Many physicians undervalue this cognitive work, yet E/M service levels are intended to reflect not just of the extent of exam or history-taking, but the physician’s mental effort. In fact, documentation outlining the physician’s thought process in evaluating a patient’s presenting problem(s) (medical decision-making) drives and supports the extent of the exam and history.

In those cases when counseling dominates a visit, the physician should describe the encounter in sufficient detail to clarify what was discussed (for instance, what specific questions did the patient have? What was the physician’s recommendation?), why, and for how long. Again, the point is not to document anything additional or to dissect the encounter moment by moment, but only to describe what actually was done, for the benefit of other physician’s who may
review the note at a future visit (and, ultimately, for the benefit of the patient).

Documentation of what was discussed, the education provided, etc., also helps the performing provider assess patient understanding and compliance. “So for instance, if the provider has counseled the patient multiple times on the same points, she can make the cognitive decision to change the plan due to patient compliance or lack of understanding,” Hammer says. “Not only does such documentation help other providers, it is also a good reference point for the performing provider.”

**Pull Physicians Out of the “One More Bullet” Trap**

Templates and electronic health records (EHRs) that use prompts to elicit “one more bullet” can be valuable tools to help physicians avoid minor oversights, but they also have a serious risk for abuse and for undermining the quality of documentation by focusing a physician’s attention on the wrong documentation issues. Remember: Coding based on documentation not warranted by medical necessity is a huge compliance risk.

Even the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, which essentially are coding instructions, insist on the primacy of clinical concerns, stating, “Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.” Claims payment and submission are secondary and tertiary concerns.

The clinical examples contained in Appendix C of the CPT® manual don’t discuss bullet points or even the elements of exam and history. Rather, the examples rely primarily on the nature of the patient’s presenting problem and the presumed level of medical decision-making necessary to evaluate and treat a patient with that condition. It is up to the physician to document completely his or her cognitive work (including interpreting the information obtained from the history and physical exam to form an assessment and care plan) to support the service at the level described by any given example.

This isn’t to suggest that counting bullets is inappropriate to determine an E/M service level, or that E/M guidelines are illegitimate. Quite the contrary: Objective criteria are necessary to allow for consistent coding. But E/M documentation guidelines are coding tools, not clinical tools. Focusing on coding as the reason to improve documentation is putting the cart before the horse. Rather, what clinicians and coders alike must embrace is that the medical record is, first and foremost, a medical document. As such, physicians should be encouraged to improve documentation to improve medical outcomes. Those physicians whose documentation best supports optimal coding (and compliance) also are those physicians whose documentation best meets medical and clinical requirements, and whose documentation best describes his or her cognitive process during the E/M service. Such documentation naturally provides support (medical necessity) for services and procedures rendered, at the appropriate level.

**Help Physicians See the Big Picture**

“This issue is larger than simply E/M,” notes AAPC Vice President of Clinical Coding Content Sheri Poe Bernard, CPC, CPC-H, CPC-P. “If your physician isn’t documenting with enough detail for you to choose the correct diagnosis or procedure code, he isn’t documenting enough to withstand a malpractice suit or to understand in six months exactly what the condition and treatment of the patient was. This is a great approach to use when requesting more information from an under documenting physician: Not that you need it for coding (although you do), but that he needs to include it so that he is protected from any liability associated with under documentation.” There is nothing inherent to code selection—procedure, diagnosis, office visit—that shouldn’t be in the documentation for medical and legal reasons.

The bottom line: Documentation isn’t about coding, and it’s certainly not about bullets. Documentation always is about patient care. Coders who keep this in mind will have an easier time communicating with physicians about how to improve their documentation, from both clinical and coding perspectives. Encouraging physicians to do what they do best—provide the highest possible level of patient care and document accurately the cognitive work associated with that care—will create a win/win outcome for everyone.

G. John Verhovshek, MA, CPC, is AAPC’s director of clinical coding communications.
Question: I have been treating Medicare patients for the last three years and my office manager recently told me there are specific chiropractic guidelines for a Medicare patient on the initial visit. I did not know that. I just perform my normal history and examination, take X-rays, and do not follow any special system. Should I be doing something different?

Answer: Your office manager is correct: There are specific guidelines Medicare wants doctors of chiropractic to follow. Whether you are meeting those guidelines is hard to tell for sure without knowing what you are documenting presently when you perform your history, exam, and X-ray findings.

A chiropractor is defined in the Social Security Act (section 30.1.) as a physician only for manual manipulation or treatment of subluxation of the spine. The following eight items must be documented in the Medicare patient’s clinical record on the initial visit, whether the required subluxation is demonstrated either by X-ray or physical examination:

1. **History**—A chief complaint must be documented, including the symptoms present causing the patient to seek chiropractic treatment.

2. **Present Illness**—This can include any of the following, as appropriate:
   - Mechanism of trauma
   - Quality and character of problem/symptoms
   - Intensity of symptoms
   - Frequency of symptoms occurring
   - Location and radiation of symptoms
   - Onset of symptoms
   - Duration of symptom
   - Aggravating or relieving factors of symptoms
   - Prior interventions, treatments, including medications
   - Secondary complaints
   - Symptoms causing patient to seek treatment

3. **Family History**

4. **Past Health History**—This should include:
   - General health statement
   - Prior illness(es)
   - Surgical history
   - Prior injuries or traumas, past hospitalizations (as appropriate)
   - Medications

5. **Physical Examination**—Evaluation of musculoskeletal/nervous system through physical examination to identify:
   - P = Pain/tenderness evaluated in terms of location, quality, and intensity;
   - A = Asymmetry/misalignment identified on a sectional or segmental level;
   - R = Range of motion abnormality (changes in active, passive and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and
   - T = Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned are required, one of which must be asymmetry/misalignment or range of motion abnormality.

Note that a patient’s subluxation/condition is considered chronic when it is not expected to resolve completely, as is the case with an acute condition, but where the continued therapy is expected to result in some functional improvement. If an extensive, prolonged course of treatment is necessary, clearly document it in the clinical record. Coverage will be denied if it is not reasonably expected that continued treatment will result in improvement of the patient’s condition. Continued repetitive treatment without a clearly defined clinical end point is considered maintenance therapy and is not covered.
Complete requirements for chiropractic services under Medicare may be found in the Medicare Benefit Policy Manual, chapter 15, section 240, “Chiropractic Services,” which may be found on the Centers for Medicaid & Medicare Services (CMS) Web site: www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf. Be sure to read your local Medicare carrier’s guidelines for chiropractic services.

6. Diagnosis—Most Medicare carriers require the primary diagnosis to be subluxation with the neuromusculoskeletal condition causing the treatment to be listed as the secondary diagnosis.

7. Treatment Plan—This should include:
   - Therapeutic modalities to effect cure or relief (patient education and exercise training)
   - The recommended care level (the duration and frequency of visits)
   - Specific goals to be achieved with treatment
   - Objective measures that will be used to evaluate the effectiveness of treatment
   - Date of initial treatment

8. Signature/initials—This is required to authenticate the records.

For additional information, see also the American Chiropractic Association (ACA) Web site: www.acatoday.org/pdf/part_process.pdf.

Continued repetitive treatment without a clearly defined clinical end point is considered maintenance therapy and is not covered.

Marty Kotlar, DC, CHCC, CBCS, is the president of Target Coding. Dr. Kotlar is certified in Healthcare Compliance and CPT® coding, and has been helping chiropractors nationwide with coding, documentation, and compliance for over 10 years. Dr. Kotlar can be reached at (800) 270-7044; Web site: www.targetcoding.com; e-mail: drkotlar@targetcoding.com.

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Webinars
Prepare for Yearly Changes
Webinars are a convenient way to stay informed of coding updates.
By Michelle A. Dick

The start of a new year for coding students and professionals means a truckload of new code additions, deletions, and revisions. All these yearly changes can slow down your coding momentum quickly. Fortunately, the AAPC can get you up to speed fast because they are delivering 2010 Webinars to a computer near you.

Online Webinars reach coders globally and provide current topics taught by expert instructors in a format that allows questions to be asked of the instructor via an online chat interface during the live Webinar. For those who can’t attend a classroom style event or a conference, Webinars offer education at work or home.

Stay a Step Ahead in 2010

2010 Webinars have coding know-how for your specialty. You can find a wide array of topics from “ASCs Coding and Billing for 2010” presented by Stephanie G. Ellis, CPC, to “New Rules for CMS When Reporting Consultations,” presented by Deborah Grider, CPC, CPC-H, CPC-P, CPMA, CPC-I, CEMC, COBGC, CPCD.

For those looking for specialty training and CEUs, there are Webinars to fine-tune coding skills and stay current in your specialty area. Specialty Webinars vary from topics such as “Pregnancy - How to Bill Before, During, and After,” presented by Kerin Draak, CPC, CEMC, COBGC, to “Plastics and Reconstructive Surgery,” presented by Susan Ward, CPC, CPC-H, CPC-I, CEMC, CPCD, CPRC.

Other specialty topic Webinars include:
- Lesions
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- Surgical Chart Auditing
- Insurance Contracting Made Simple
- Cardiac Catheterization and Coronary Artery Interventions
- E/M Auditing
- E/M Coding for the Emergency Department
- Injections, Immunizations, and Administrations


Get a Jump Start on 2011 in 2010

Being a coder means staying up-to-date with yearly code changes to ensure compliant coding when submitting claims. A great way to keep coding students and seasoned coding professionals current is to focus on upcoming code changes with Webinars. AAPC Webinars help students:
- Use the most current codes correctly when taking exams.
- Learn coding from industry experts.
- Achieve higher efficiency and code more accurately.
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Webinars can help coding professionals:
- Get a jumpstart on 2010 and 2011 code changes.
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- Collect maximum equitable reimbursement.
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- Easily communicate changes with other coders.

Webinars beginning in September 2010 will prepare you for 2011 ICD-9-CM coding changes. Specialty-specific Webinars featuring top 10 errors to avoid and coding updates in your specialty area start in November. You also can find 2011’s complete CPT® and HCPCS Level II coding updates at the end of 2010.

Webinar vs. Audio Conference

You may be asking “What’s the difference between Webinars and audio conferences?” The comparison below shows how much more convenient and user-friendly Webinars are:

**Webinars**
- Prepare for Yearly Changes
- Webinars are a convenient way to stay informed of coding updates.
- By Michelle A. Dick

**20 AAC Coding Edge**
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Michelle A. Dick is senior editor at AAPC.
Capture Total Service or Procedure with 26 and TC
Don’t settle for a portion of payment—get the full amount.
By Meera Mohanakrishnan, CPC, CPC-H

Frequently, the total service/procedure described by a single CPT® code is comprised of two distinct portions: a professional component and a technical component.

The professional component of a diagnostic service/procedure is provided by the physician, and may include supervision, interpretation, and a written report. The extent and nature of the professional component depends on the precise service/procedure rendered. For example, a written report generally is required, but may not be necessary for a supervising pathologist to claim professional services in a clinical laboratory (see “Professional Services in the Clinical Lab: Billable or Not?” Coding Edge, July 2009, pages 48-49). When required, the interpretation of a diagnostic test should be a separate report, signed by the physician.

The technical component of a diagnostic service/procedure accounts for equipment, supplies, and clinical staff (such as technicians). Payment for the technical component also includes the practice and malpractice expenses. Fees for the technical component generally are reimbursed to the facility or practice that provides or pays for equipment, supplies, and/or clinical staff.

Procedures/services that may include both a professional and technical component are found commonly within the Radiology, Pathology and Laboratory, and Medicine chapters of CPT®. The surest way to identify codes with separate professional and technical components for Medicare payers is to consult the National Physician Fee Schedule Relative Value File, available for download on the Centers for Medicare & Medicaid Services (CMS) Web site. (The most recent file as of January 2010 may be found at: www.cms.hhs.gov/PhysicianFeeSched/pfsrvf/list.asp?listpage=4.) If the Relative Value File lists separate line items for a code with modifiers 26 Professional component and TC Technical component, the service/procedure described by that code includes both a technical and professional component.

For example, the 2010 Relative Value File lists three separate lines for 70480 Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material. The first of these lines corresponds to the “global” service, which is assigned 6.10 relative value units (RVUs) (all RVUs cited are fully implemented facility and non-facility totals). The second line details the technical component only, with 4.37 total RVUs. The third line describes the professional component of 70480, at 1.73 RVUs. Note that the RVUs for the technical and professional components will equal the total RVUs for the global service (4.37 + 1.73 = 6.10).

Professional Services Call for Modifier 26
Separate payment can be made for the technical and professional components of a procedure when each is performed by different professional providers. For instance, the technical component of a service/procedure may be performed by the clinic, but the professional component is performed by an outside physician or laboratory. In such situations, providers must submit their claim and bill only for the service performed.

To identify professional services only for a service/procedure that includes both professional and technical components, append modifier 26 to the appropriate CPT® code, as instructed in CPT® Appendix A, “Modifiers.” Note that modifier 26 is appropriate when the physician supervises and/or interprets a diagnostic test, even if he or she does not perform the test personally.
When only the professional component of a service is provided, failure to report modifier 26 will cause the claims to adjudicate incorrectly and lead to recovery as permitted by law. Modifier 26 should not be used, however, if there is a specific code that already describes only the professional/physician component of a given service. For example, it is inappropriate to append modifier 26 to 93722 Plethysmography, total body; interpretation and report only because the code does not include a technical component, but describes professional services solely.

**Modifer TC Identifies Technical Component Only**

Appending modifier TC indicates that only the technical component of a service/procedure has been provided. Generally, the technical component of a service/procedure is billed by the entity that provides the testing equipment. Note that physicians providing services for Medicare patients in a hospital or facility setting cannot claim the technical portion of a procedure regardless of whether the physician owns the testing equipment. Under the diagnosis-related group (DRG), the hospital/facility receives payment for the technical component of Medicare inpatient services. Similarly, Medicare rules require payment for non-physician services provided to hospital patients (such as the services of a technician administering a diagnostic test) to be made to the hospital.

Just as there are codes describing professional-only services for Medicare, so are there codes describing technical component-only services. Do not apply modifier TC (or 26) with such codes. For example, 93005 Electrocardiogram; tracing only, without interpretation and report is covered only as a diagnostic test and does not have a related professional code. The total RVUs for technical component-only codes include values for practice and malpractice expenses only.

Global Billing Doesn’t Require 26/TC

As explained previously, the global service includes both the professional and technical components of a single service. When reporting a global service, no modifiers are necessary to gain payment for both components of the service. Never report a single procedure code with both modifiers 26 and TC.

For example: Code 76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete describes a service that includes both a technical component (the ultrasound machine, along with necessary supplies and clinical staff to support its use) and a professional component (physician supervision, interpretation, and report).

If pelvic ultrasound is performed at the physician’s office, either by a physician or a technician employed by the practice, the physician reports 76856 without a modifier because the practice provided both components of the service.

On the other hand, if the physician performs the same procedure at the hospital, the physician would report 76856-26 for the professional component only. The hospital would claim separate reimbursement for the technical component (76856–TC) because it owns the ultrasound equipment.

Note that in all reported cases, modifiers 26 and TC are considered payment modifiers and must be reported in the first modifier field.

Note that physicians providing services for Medicare patients in a hospital or facility setting cannot claim the technical portion of a procedure regardless of whether the physician owns the testing equipment.
**AAPC Code of Ethics**

Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.

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I'm Wendy Atkinson, CPC-A, continuing education unit (CEU) vendor analyst, and a unique gal here at the AAPC.

I am an outgoing and easygoing person. I would love to talk to you, so don't feel shy around me. Please feel free to send an instant message, e-mail, or call me on the phone. My extension will be reached through an interpreting service on a special phone called a video-phone, so I can communicate effectively with you.

As you have probably already guessed, I am deaf. My hearing impairment did not stop me from passing my CPC® exam, and it did not stop the AAPC from hiring me to evaluate educational products submitted by vendors who want to offer AAPC CEUs.

I come from a medical family: My mom is a medical transcriptionist, my brother-in-law is a radiologist, and my other brother-in-law is an anesthesiologist. While I worked at the Internal Revenue Service (IRS) as a data entry clerk, I got another data entry job at First Health Insurance Company. There, I worked with UB-04 and CMS-1500 forms, entering billing information. I knew I had found something interesting in medical coding. I decided to go back to school to take medical office classes. I successfully completed the course and graduated with honors. Soon after, I sat for the CPC® exam and passed on my first attempt. I stepped up to the challenge despite my disability with an “I can do it” attitude. I hoped to become a medical coder and today I am.

People with hearing disabilities can be successful medical coders because so much of the work we do is by computer, which makes communication easy. Because we have to overcome obstacles in our day-to-day lives, coding challenges don’t bother us at all. If you get a chance to hire a deaf coder, you won’t be disappointed. I like the challenges at work because they make the job more fun here. My biggest challenge as a CEU vendor analyst is communication. Customer service and making members happy is my number one responsibility. Because English is my second language (American Sign Language (ASL) is my first language), I sometimes misunderstand what the vendor is requesting, but with perseverance, we always find a way. I am working to improve my written communication skills on the job.

My supervisor and coworkers have begun to learn ASL so we can chat more. They make me feel like part of a very special team.

How do you spend your spare time?
I am married with five children, and they certainly keep me busy! While my spare time is limited, I cross-stitch whenever possible, and continue my education to keep my coding skills current. I also love to go hiking and explore nature, and enjoy the spectacular views from the Utah mountains. The beauty of creation is amazing. I also enjoy traveling. You can only imagine how much fun a road trip is with my husband, four daughters, ages 4-12, and one son, age 2.

If you could do any other job what would it be?
Right now, I don’t want any other job. I feel satisfied. I have worked hard proving my abilities. I wanted to be a coder and I earned my credentials. In the future, I would like to pursue an active coding position, possibly in a pediatric practice. As you can guess from my personal information, I’m pretty good with kids!
Auto-Population Gone Wild

EMR documentation creates risky record keeping and frustration.

By Cheryl L. Toth
Documentation like the following is becoming more common as coding consultants audit practices that have moved to an electronic medical record (EMR):

- A 90-year-old woman who “denied pregnancy as a sign.”
- An infant with “good dentation.”
- The note for every female patient in a general surgery practice indicating a “full pelvic exam performed.”

“The overarching issue here is lack of visit template customization,” says Mary LeGrand, RN, MA, CPC, CCS-P, consultant with Chicago-based KarenZupko & Associates. “A critical component of EMR planning is customizing your visit templates—in addition to tailoring other elements of the system,” says LeGrand. “In most cases, you get little to no template customization help from the vendor. It’s up to a busy physician to do in his or her ‘spare time.’ And many practices fail to realize the importance of this step.”

There are several common reasons for this. If EMR planning and implementation is curtailed to shave several thousand dollars off the total cost, template customization often falls by the wayside. If the trainer sent by the vendor doesn’t know much about the practice of medicine—and nothing about your specialty—he or she will be of little help. Or, if physicians abdicate the task of customization to non-clinicians, they risk being left with faulty templates.

Kim Pollock, RN, MBA, CPC, also with KarenZupko & Associates, Inc., is all too familiar with the latter. “In a five-man neurosurgery group, the billing manager, physician assistant, and practice manager customized the templates because the surgeons wouldn’t attend the demo meetings and had to be coerced to go to training.”

A family practitioner who didn’t customize ended up using the same cardiac systems template for everyone—from a 50-year-old with chest pain to a toddler in for a well-child visit. Obviously, these evaluations are very different, and the result was documentation that simply was not accurate.

“Well done templates are an investment with a quick pay off,” according to Rhonda Buckholtz, CPC, CPC-I, CGSC, CPEDC, COBGC, CENTC, VP of business and member development for the AAPC. “Developing templates for your most specific encounter types is how to begin. I suggest taking samples of your practice’s ‘paper world’ notes for these encounters, and make templates from them. It’s true that this can create more work for primary care physicians than for specialists, but it’s necessary to create solid documentation.”

Key to the process, according to Pollock, is having a physician champion lead in development. Otherwise, it will not work. The partners won’t be happy with the result and the notes aren’t likely to be user-friendly to physicians. “So often, physicians haven’t customized the templates, or they haven’t done enough granular customization, or they failed to think about it at all,” says Pollock.

Unfortunately, experts see firsthand the problems that occur when practices fail to customize visit templates, and are adamant that spending time on the front end is a must.

**Risk 1: History of Present Illness “Cloning”**

In a documentation review, one of the first things an auditor looks at is history of present illness (HPI).

“In the paper chart world, the patient typically self-reports this on a form, and the physician re-dictates it after examination,” LeGrand explains. But in an EMR world, the EMR often automatically “pulls forward” the HPI from the previous encounter—requiring the provider billing for the visit to review it and make changes based on the current illness or condition. According to LeGrand, many providers get busy and forget to review the “cloned” HPI from the previous visit. “Letting the system pull the previous history into an auto-generated form without reviewing it is risky,” she warns. “According to E/M documentation guidelines, each record must be allowed to stand on its own. Paying close attention to what is being pulled forward is critical because the patient problem could be completely different.”

Buckholtz shares the example of a recovering alcoholic who had been sober for six months. “The HPI in the electronic record stated that ‘patient is now up to six or seven alcoholic beverages per day,’ which was inaccurate—it was simply carried forward from previous encounters.” Commonly, EMR templates pre-populate with documentation for “normal”—it’s up to the provider to change it. “It’s too easy to click the ‘Reviewed and Agreed’ button in the EMR, without actually reviewing the note,” Buckholtz says.

Pollock adds another example: “A patient came in to see an ENT (ear, nose, and throat) two years after her initial visit and with profound bilateral hearing loss. The system pulled ‘hearing, normal’ from [a] previous visit, and no one reviewed the documentation to change it.”

“We see a lot of EMR documentation cloning in vein clinics because of the similarity of the patient population,” says Teri Romano, RN, MBA, consultant with KarenZupko & Associates,
“Some surgeons have told me that the routine nature invalidates the credibility of the entire note.” This is one reason many physicians resist purchasing an EMR.

Inc. “In one clinic, all the op notes I reviewed were close to being identical.” According to Romano, it doesn’t matter if your patient population is homogenous, physicians must identify something unique about the patient and include this in the note. “Make sure to add something specific to the note, or you risk the EMR pulling forward essentially the same information for each patient.”

In one case Romano monitored, the patient on the table told the physician she was going out of town and asked if plane travel was okay later that week. The physician said “yes” and suggested she walk around a few times on the plane during flight to minimize the potential for clotting. “I immediately suggested to the scribe that this be added to the note,” Romano says. “It was discussed with the patient during the operative session. It was unique to that particular case.”

Pollock notes another common issue with the cloning process—it creates a verbose chart note that’s not reader-friendly and contains rote responses that don’t necessarily call out pertinent positives. “Referring physicians complain about getting ‘canned’ EMR chart notes from consulting specialists. The note has way too much stuff to wade through, so the referring physician skips to the bottom. Who’s to say he didn’t skip something important?”

Indeed, many of the physicians LeGrand works with say these rote notes, which are obviously system-generated, are questionable. “Some surgeons have told me that the routine nature invalidates the credibility of the entire note.” This is one reason many physicians resist purchasing an EMR.

Contrary to what some might think, “Your EMR note should essentially mirror what your handwritten notes looked like—only legible,” Buckholtz says. “If you were only documenting a half page into the paper chart, your new documentation will likely be about the same length.”

**Risk 2: Ease of Use Creates Easy-to-Make Errors**

EMR documentation pick lists can be an excellent timesaver. Problem is, physicians are usually in a hurry, and assume the EMR is going to do most of their documentation work for them. When the medical assistant is knocking on the door signaling “hurry up,” physicians can take risky shortcuts.

“I worked with a physician who was unable to find a cerumen impaction diagnosis in the diagnosis code pick list,” Buckholtz explains. “So he picked, ‘hearing loss, unspecified’ instead. No one caught it, so that was the diagnosis billed for the patient. Now, ‘hearing loss’ is on that patient’s permanent claims history.” This potentially could cause the patient a pre-existing condition denial in the future—for a condition the patient never actually had.

Those practices still in the process of transitioning to a fully paperless process may need to slow down and review the old paper note, as well as the electronic one, to get the patient’s full history. “A vascular clinic was transitioning to EMR and not all paper records had been scanned in yet,” Romano explains. “The EMR’s review of systems for a patient had every category noted as ‘denied,’ but the practice had overlooked the still-on-paper referral form from the primary care physician—which indicated the patient was an insulin-dependent diabetic. Obviously, the person who took the review of systems just clicked ‘normal’ and didn’t even think to look at what was not yet scanned.”

LeGrand warns practices to pay careful attention to EMRs that use “bubble sheets” for patients to report their review of systems (ROS). According to documentation guidelines, anyone can provide or collect past family and social history, but the physician must sign off on the form before it’s entered into the record. If the EMR uses a bubble sheet tool that patients complete prior to being seen, many busy offices often just scan it in before it’s signed by the physician.

“This might save time, but it’s essentially creating an invalid document,” according to LeGrand.

LeGrand cites an example from an orthopaedic practice she worked with. “The bubble form listed possible values under each of the systems—fractures, joint pain, spasms, etc. But there was no option for ‘no complaints’; the patient was supposed to select all that applied, although this was not clear on the form. Medicare says it’s okay to use a checklist for ROS, but the patient must respond to all systems. And because the bubble sheet had no negative response option, the EMR was automatically generating a note stating ‘negative for joint pain, muscles, pain’—even though the patient hadn’t specifically responded to anything on the bubble sheet.”

In this case, the practice should have insisted the EMR vendor added a “Yes/No” option for all values under each system—or provided a “No Complaints” option for each.

Another issue with this same bubble form was how family history is collected. LeGrand said, “If the patient didn’t respond to any questions about family history, the computer generated: ‘Family History: Insignificant.’ More accurately, it should have generated: ‘Patient did not provide this information.’ As a result the physician billed for a code level that credited him for the family history component, but the information wasn’t in the note.

“In the paper world, we know that practices are busy and proper collection of family history is sometimes overlooked,” LeGrand continues. “But in the electronic world, this becomes more dangerous because not only is family history getting overlooked; the auto-population from the system indicates there was some kind of response—when, in fact, no information was ever provided.”
Risk 3: Letting the EMR Pick the Code

“There is no EMR system out there that truly can code an encounter,” Buckholtz insists. “The vendor will tell you, ‘you can point and click and it will be done before the patient leaves.’ The reality is that anytime you enter free hand text—in the history or medical decision-making—there is no way for the system to recognize whether you are describing an established problem worsening or stabilizing, a new problem, or whether there is additional work-up needed. Today’s EMRs simply don’t have that kind of logic or rules engines built in.”

In other words, if physicians enter notes about the encounter, the system typically won’t integrate them into the code calculation it pre-determines. And if you don’t use free form text, you probably aren’t documenting complete information.

“Many vendors are giving practices false promises,” says Buckholtz. If an EMR vendor is touting increased revenue from higher coding, or a return on investment (ROI) within six months, caveat emptor! “Don’t even think about ROI until you are fully up and running for a couple years,” Buckholtz advises. “The rollout process can take up to a year—or longer for bigger practices.”

The AAPC recommends that codes be omitted from EMR credentialing requirements. “Automated coding is an EMR vendor sales point that has failed to deliver quality in the marketplace,” Buckholtz states. “Instead, AAPC believes that EMR credentials [as defined by the Certification Commission for Health Information Technology (CCHIT)] should focus on issues of portability, interoperability, security, privacy, and clinical quality.”

One group of surgeons told Pollock, “We don’t pay attention to anything except the free text box.” That’s where they type in what they want to remember—and none of this free text can be read by the system and integrated into the code pre-determination. “The physicians say, ‘[the pick lists] aren’t easy for us to use so we go right to the meat, and skip the template.’” Pollock believes this is one reason that so many practices hire a scribe to do the work; because there is still data entry to be done, beyond using the pick lists.

EMR trainers can also perpetuate the myth, telling practices that the system will code for them, “EMR vendors are saying, ‘if you buy our EMR you can code higher and make more money!’ but that is not necessarily true. The goal of the EMR is to improve the efficiency of the physician in documenting services and ensuring all work performed is captured in the record. If you buy it and set it up correctly, then you may have achieved the goal of documenting your work performed and the benefit is higher reimbursement. But the up-front customization work must come first,” LeGrand concludes.

CCHIT Certification: Not a Coding Cure-all

“My EMR is CCHIT certified,” you say. “Doesn’t that mean it meets the coding and documentation standards?”

In short: No.

AAPC analyzed the criteria required for credentialing by the Certification Commission for Health Information Technology (CCHIT) and uncovered multiple areas for concern. According to AAPC’s analysis, many of the CCHIT requirements conflict with federal mandates for correct coding, or with what AAPC promotes as appropriate coding principals. According to AAPC:

1. **CCHIT ignores coding rules.** While CCHIT does require codes to be provided by an electronic medical record (EMR), it doesn’t require rules-driven coding. Essentially, a physician can select any code he or she chooses, without consideration of guidelines or compliance issues.

2. **CCHIT encourages the use of pick-lists for code selection**, which doesn’t necessarily provide effective data. There are more than 28,000 valid medical codes within ICD-9-CM, CPT®, and HCPCS Level II. Including all appropriate codes in pull-down menus or pick lists is sometimes easy, but getting to those codes may be complex. It’s difficult to get all the appropriate codes winnowed into a manageable list.

3. **CCHIT advocates for the auto-selection of evaluation and management (E/M) coding without consideration of Medical Decision Making (MDM).** This could result in erroneous CPT® coding. And, AAPC believes that CCHIT puts physicians in harms way by inadvertently providing a framework for cloning (pulling forward) data that may lead to institutionalized upcoding.

4. **There are no coding compliance requirements within CCHIT.** To say an EMR “meets certification requirements for compliance” does not relate to coding compliance. It means CCHIT criteria compliance. Keep that in mind when evaluating vendors.

When evaluating the purchase of an electronic hospital record (EHR) system, proceed with a critical stance and be prepared to verify the system you are considering delivers on its promises. Here are a few points to consider:

1. **Ignore vendor promises** of “boost your coding revenue!” and “download and implement our system in 24 hours!” You will not, repeat, NOT be up and running in two weeks—despite what vendors tell you. Planning and implementation are hard work and customizing your visit templates takes many hours. Even if you do everything right, full implementation will take six to 12 months after you go live. Complete adoption of the electronic medical record (EMR) system can take 18-24 months.

2. **Carve out time**—lots of it—for customizing your visit templates. The EMR vendor will provide stock templates in your specialty. Review and customize everything they provide—from normal gynecological exam and acute sinusitis, to knee pain and flu. If you don’t, you risk the system spitting out multi-page, rote notes that don’t necessarily document what you actually did. After you’ve worked through all the templates provided by the vendor, create additional templates for the conditions you treat for which there are no stock templates. Your hard work will pay off in the long run. “An ENT practice I worked with smartly set aside every Monday afternoon for many months to develop their templates and prepare for implementation,” says Mary LeGrand, RN, MA, CPC, CCS-P, consultant with Chicago-based KarenZupko & Associates. “During these afternoons, they didn’t see patients—the surgeons and staff painstakingly reviewed and customized templates for every major visit type. And when they launched the EMR, they had far fewer issues and a quicker transition time than most of the other practices we’ve seen.”

3. **Verify the algorithms are generating the visit documentation accurately.** Don’t assume the algorithms are correct. A surgeon practicing in an ear, nose, and throat (ENT) group in the South found that the EMR allowed him to create additional bullet points that got him to a Level V evaluation and management (E/M) code for kids with otitis media. “He figured he could just add the bullet, and bill for the higher code,” LeGrand explains. “But there is no medical necessity for conducting a full cranial nerve assessment in a 5-year-old with otitis media. Just because the system calculated the Level V, doesn’t mean you can actually bill for it.”

4. **Review all notes brought forward from previous visits**—look for rote text, redundancies, and anomalies generated by the EMR. Pay attention to every note and every visit—just like you would in a paper chart world. LeGrand said, “The notes of an orthopaedic group that didn’t do this were outrageous. They looked like ransom notes. Some of the information was clearly copied and pasted. Other note components were obviously pulled forward by the system, since they were rote. There was so much redundancy—multiple incidences of the SF-36 form the doctors used for research, multiple copies of the HPI from different sources, all caps, no caps. The record was all over the place; nobody had done anything to review or clean up the templates.”

5. **Thoroughly train and/or direct your scribes, if you use them.** “You just can’t assume they know what the clinicians are doing during the exam,” warns Teri Romano, RN, MBA, consultant with KarenZupko & Associates, Inc. “You need to talk through the exam and specifically say, ‘ok, lungs are clear, respiration normal, heart is good—no murmurs.’ Saying, ‘normal’ is not acceptable—you must say ‘heart is clear, no murmurs’ so the scribe knows what to document.”

6. **Ask an auditor to review your documentation early on.** Schedule the review during the planning and implementation process, as physicians practice using the system, or just after the system goes live. The key is to have an external auditor take a look at what is being generated on your behalf. This is not something the vendor can or should do for you; getting an outside opinion is money saved—and risk avoided—in the long run.
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2010 Courses Are Now Available
On Nov. 20, 2009, the Centers for Medicare & Medicaid Services (CMS) published the Final Rule in Federal Register regulation CMS-1414-FC; Changes to the Hospital Outpatient Prospective Payment System and CY 2010 Payment Rates; Changes to the Ambulatory Surgical Center Payment System and CY 2010 Payment Rates. The determinations in this final rule are effective Jan. 1. Officially, these regulations only affect reimbursement from the federal government to Medicare participating providers and suppliers. It is not unusual, however, for private third-party payers to follow suit.

For an ambulatory surgical center (ASC) to become a Medicare participating provider, surgical services offered cannot require the patient to stay in the facility for more than 24 hours. Unexpected circumstances requiring a patient to stay longer should occur rarely. ASCs are not permitted to share space with a Medicare-participating independent diagnostic testing facility (IDTF) or a hospital (e.g., a hospital outpatient surgery department).

**ASC Payment Rates**

Per the final rule, the 2010 ASC conversion factor (CF) includes a 1.2 percent increase allowance for inflation. This is the first year that CMS is permitted, by law, to include such a payment update. The annual increase, the inflation allowance, and the wage adjustment for budget neutrality resulted in a final conversion factor of $41.873—higher than the proposed factor of $41.625 and an increase over the 2009 conversion factor of $41.393.

The new rates may be based on a 25/75 or 50/50 blend of 2007 payment rates and 2010 rates to create a transitional cushion, or they may be approved with no transition and be paid at 100 percent of the 2010 weights.

For many surgical and radiological procedures and services performed at an ASC, reimbursement rates are determined by applying a scaler to the payment amount approved for the outpatient prospective payment system (OPPS) relative weights. The proposed ASC scaler for 2010 was 0.9514; however, the final payment weight scaler for 2010 ASC reimbursement is 0.9567. Separately payable covered ancillary services with their own (or a predetermined) reimbursement rate are not subject to scaling.

**Impact Varies With Specialty**

Whether the 2010 changes are good news or bad news depends on the specialty focus of the procedure. Based on the changes without the transition (total implementation), procedures performed on the hematologic and lymphatic systems are looking at an estimated 40 percent increase in their reimbursement (a 22 percent increase with a 25/75 blend). Other specialties seeing strong increases are those providing services for the respiratory system (37 percent increase); musculoskeletal system (29 percent increase); and cardiovascular system (27 percent increase). ASC facilities that specialize in procedures on the genitourinary system and the auditory system can both look forward to an estimated 17 percent increase in their 2010 payments, while those providing procedures and services involving the integumentary system are looking at an estimated 20 percent increase.

**Resource Tip:** For more information on payment changes by specialty, refer to Table 75 in the Final Rule, available for download on the ASC Payment > ASC Regulations and Notices > Details for CMS-1414-FC page of the CMS Web site: www.cms.hhs.gov/ASCPayment/ASCRN/ItemDetail.asp?ItemID=CMS1230100.

Procedures of the digestive system are looking at a 10 percent decrease. ASCs specializing in procedures treating the nervous system are expected to realize a 5 percent decrease with full implementation (or a 4 percent decrease with a 25/75 transition blend). Those treating the eye and ocular adnexa system, as well as those providing ancillary items and services, are looking at an estimated 1 percent decrease in Medicare program payments for the coming year with full implementation, or no change in reimbursement levels at all with the 25/75 blend.
Individual Procedure Rates

General estimations by specialty may provide a perspective that will support planning in your facility for 2010. Before deciding anything, however, you might find a clearer picture in the details. There are changes in the number of procedures approved for ASC provision reimbursement, as well as changes in the payment rates for specific procedures.

Although six ASC surgical procedures covered in 2009 are changed to office-based designation in 2010, the overall number of procedures slated for ASC payment coverage has increased (see Details for CMS-1414-FC: Table 62).

On the positive side, a total of 28 procedures are now ASC-covered surgical procedures for 2010. Specifically, four musculoskeletal CPT© procedure codes, nine digestive system procedures, five neurological procedures, and four procedures on the urinary system now are covered. Three new Category III codes now are ASC-approved. These include two codes for sacroplasty injection, 0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s) including the use of a balloon or mechanical device, when used, 1 or more needles and 0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, both with a proposed ASC payment indicator of G2 (non-office based surgical procedure), and with reimbursement rates of $881.92 and $1,272.77 respectively (higher than the proposed rates).

Many of the approved changes to specific procedures reflect the overall financial impact discussed earlier. For example, colonoscopy and biopsy (45380 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple), diagnostic colonoscopy (45378 Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)), and lesion removal colonoscopy (45385 Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyyp(s), or other lesion(s) by snare technique) are all estimated to reflect the 11 percent decrease in payments with full implementation, but only an estimated 5 percent decrease with a 25/75 blend transition (see Details for CMS-1414-FC: Table 76). Colon screening procedures (HCPCS Level II, G0105 Colorectal cancer screening; colonoscopy on individual at high risk and G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) are slated for potential 17 percent and 16 percent decreases, respectively, with full implementation; or an 8 percent decrease for both under a 25/75 blend.

Arthroscopic surgeries, however, are estimated to have healthy increases in reimbursement, especially on the knee (29880 Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) and 29881 Arthroscopy, knee, surgical; (medial OR lateral, including any meniscal shaving)) at 30 percent increase for full implementation and 17 percent with a 25/75 blend, arthroscopy on the shoulder (29826 Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release) estimated at 54 percent increase with full implementation (28 percent with the 25/75 blend), and rotator cuff repair (29827 Arthroscopy, shoulder, surgical; with rotator cuff repair), with a 42 percent increase for full implementation (or 22 percent at 25/75 transition blended rates). The correction of a hammertoe (28285 Correction, hammertoe (eg, interphalangeal fusion, partial or total phalanectomy)) has an estimated payment that is 25 percent higher in 2010 with full implementation, or 14 percent at 25/75.

But, it is not looking up for all things musculoskeletal. For example, injections of anesthetic agents in additional levels (add-on code 64480 Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)) will decrease an estimated 8 percent with full implementation, or decrease 4 percent at the transitional 25/75 blended rate. Add-on code 64484 Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) will have a greater affect on reimbursement with a 38 percent decrease for the fully implemented rate, and a 19 percent decrease at the 25/75 blended rate.

Those facilities performing cataract surgeries (specifically codes 66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage and 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)) can expect an estimated 2 percent decrease in reimbursement (with full implementation), and a harder hit with an estimated 20 percent decrease under full implementation (or 10 percent decrease with the 25/75 blend) when providing a discus-
On the positive side, a total of 28 procedures are now ASC-covered surgical procedures for 2010. Specifically, four musculoskeletal CPT® procedure codes, nine digestive system procedures, five neurological procedures, and four procedures on the urinary system now are covered.

Open transluminal balloon angioplasty, both venous (35460 Transluminal balloon angioplasty, open; venous) and for brachiocephalic trunk or branches (35475 Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel), will become 2010 ASC-covered procedures, each with a transition payment weight of 48.4864 and a transition payment of $2,030.27.

The newly-approved, ASC-covered procedure to repair a tibial non-union or mal-union (27720 Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)) has been assigned a transition payment weight of 43.499 to be reimbursed at a transition payment of $1,821.43.

The Bottom Line
As a result of this update to the ASC payment system, the additional expenditures for 2010 from the federal government to Medicare providers and suppliers are estimated at $33 million.

In 2010, many ASC facilities may discover long-term financial security by offering a wider scope of services. This variety may enable the facility to better balance the negatives with more positives. Creating diversification of third-party payers with which your facility participates, types of procedures performed, and ancillary services offered, can protect your facility’s financial health now and into the future.

New to ASCs
One of the new ASC-covered surgical procedures for 2010 is 0193T Transurethral, radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence. This code has a 2010 third year transition payment weight of 19.1572, with a third year transition payment of $802.17 (see Details for CMS-1414-FC: Addendum AA). Removal of kidney stones (specifically CPT® 50080 Percutaneous nephrostolithotomy or pyelolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm and 50081 Percutaneous nephrostolithotomy or pyelolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm), now ASC-covered procedures, have a 2010 third year transition payment of $1,870 each. Urinary-cutaneous anastomosis revisions or any type of ureostomy (50727 Revision of urinary-cutaneous anastomosis (any type ureostomy)) have a transition payment of $802.17.

On the positive side, a total of 28 procedures are now ASC-covered surgical procedures for 2010. Specifically, four musculoskeletal CPT® procedure codes, nine digestive system procedures, five neurological procedures, and four procedures on the urinary system now are covered.

Revision of a secondary membranous cataract using laser surgery (66821 Division of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)). Perhaps the ASC can make up some of those losses when performing a blepharoplasty of excessive skin weighing down the upper lid (15823 Blepharoplasty, upper eyelid; with excessive skin weighing down lid). This procedure will bring in an estimated 21 percent increase with full implementation, or 15 percent with 25/75 transition rates; while the repair of blepharoptosis, external approach of a (tarsus) levator resection or advancement (67904 Repair of blepharoptosis; (tarsus) levator resection or advancement, external approach) is estimated to bring in 2 percent additional with full implementation, or no change at all if the 25/75 transitional blended rate applies.

Shelley C. Safian, MAOM/HSM, CPC-H, CPC-I, CCS-P, CHA, is a health information management (HIM) consultant performing revenue efficiency audits for physicians offices. She is also an associate university professor teaching medical billing and coding and HIM courses. She has written five books on coding, reimbursement, and HIM compliance.
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CAN A CLAIM BE CODED ONLY FROM ITS DICTATION?

**Question:** For my specialists who have many subsequent visits, the doctor provides specific detail (i.e., the degree of burn, stage of ulcer, infecting organism, etc.), but only on the initial visit. Must a claim be coded per its own dictation only? That is, must the dictated record stand on its own, separate from the patient’s complete medical record?

Nicole Lopez, CPC, CPC-P

**Answer:** The answer may vary depending on the payer. Because the payer here hasn’t been specified, I will answer according to Medicare standards.

The Social Security Act (42 U.S.C. §1395l(e)) provides the following mandate for providers submitting claims to Medicare (emphasis added):

“(e) Information for determination of amounts due

No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.”

This requirement essentially is repeated in the federal regulations (42 C.F.R. §424.5(a)(6)): 
“(6) Sufficient information. The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.”

Although the statute focuses on information necessary to determine the amounts due, the regulation clarifies by including a requirement that the information also support “whether payment is due”—suggesting a requirement to demonstrate the necessity of care.

Overlooking the question of whether “information” is limited to documentation, it is clear there is no temporal (time) limitation on when this information must be created. Unfortunately, many auditors assume the information must be contemporaneous; however, there is no statutory support for such an assumption under the Medicare statute or regulations.

Looking to the interpretive guidance published in the Medicare Program Integrity Manual (PIM) pertaining to either pre-payment or post payment review, there is clear guidance that the contractor may use any information deemed necessary to make a pre-payment or post-payment claim review determination (Pub. 100-8, Ch. 3, §3.4.1.1). During pre-payment or post-payment review, there usually is a request for the provider to submit documentation to support the claim so this provision does not apply. Instead, when documentation is requested, the PIM requires that contractors “shall review and give appropriate consideration to all documentation that is provided,” (Ibid. §3.4.1.2). This provision expressly provides (emphasis added):

“Documentation provided for pre- or post-payment medical review shall support the medical necessity of the item(s) or service(s) provided. The treating physician, another clinician or provider, or supplier may supply this documentation. This documentation may take the form of clinical evaluations, physician evaluations, consultations, physician letters, or other documents intended to record relevant information about a patient’s clinical condition and treatment(s).

“The date that an individual document was created, or the creator of a document is not the sole deciding factor in determining if the documentation supports the services billed.

“In instances where medical necessity is not supported by contemporaneous information in physician progress notes, physician progress notes shall be the determining factor. In instances where documentation is provided in lieu of contemporaneous progress notes, contractors shall determine if the documentation is sufficient to justify coverage.”

In the context of your question, when certain information is not in the contemporaneous notation for the service in question, but is reliably contained within an earlier record establishing the basis for a care plan of which the audited treatment or service is a part, it appears the carrier is required to consider “relevant information about a patient’s clinical condition and treatment(s)” to determine if the documentation as a whole is “sufficient to justify coverage.” Unfortunately, this does not always occur; however, such a hyper-technical basis for denial can often be overturned in the appeal process. Recognizing that such technical analysis often occurs, providers should consider incorporating by reference the information in the earlier document (by date and content) to avoid unnecessary duplication of information, as well as avoid unnecessary denials.

Michael Miscoe has a bachelor’s of science degree from the U.S. Military Academy and a juris doctorate degree from Concord Law School. He is the president of Practice Masters, Inc., a current member of the AAPC Legal Advisory Board, and is admitted to the Bar in the state of California as well as to the practice of law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. Michael has nearly 20 years of experience in health care coding and over 13 years as a compliance expert testifying in civil and criminal cases.
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Many professional coders are unaware of the valuable coding resource available at our 85,000-plus members’ fingertips. AAPC forums are full of coding know-how and a good deal of coding problem solving can be accomplished through these forums. Forum discussion helps answer questions about exams, CEUs, educational events, member benefits, coding news, general and specific coding in each area of expertise, and local chapters.

If you are unfamiliar with how the AAPC forums work, take this article to your computer. We’ll navigate through the forums so you can take advantage of the coding resource that’s right in front of you.

A Community Answers
Hard-pressed Coding Problems

You can access the forums on the AAPC Web site by clicking the Coding Discussions link on the AAPC homepage (www.aapc.com). Here you are taken to the AAPC Medical Coding & Billing Forums where you can log into your account for full access to the forums.

On this page there is a forum navigation bar at the top with the links: user control panel (User CP), Forum Rules, frequently asked questions (FAQ), Member List, Calendar, New Posts, Search, Quick Links, and Log Out. These will help you find information about posting and managing threads, and communicating with other coders.

Once you’re logged in, you’ll see the forum threads are categorized by:

- **AAPC Discussions.** Here AAPC staff post announcements, reminders, events, and discounts for members to comment or ask questions about. You can also discuss Coding Edge articles, post how to better the AAPC, announce events, or generate interest on coding news here.

- **Local Chapters.** This is a great place to become acquainted with other coders in your chapter and find local chapter meeting information or post regional questions here. Talk about things at a local level and have private forums with other members in your local chapter.

- **Employment.** Post your resume, look for jobs, hire a consultant, or discuss general employment for coders in the Employment thread area.

- **Education.** Want to know about AAPC exams or have a CEU question, stop here for the information.

- **Medical Coding.** Here is general medical coding postings as well as specialized threads categorized by topics such as modifiers, dermatology, ambulatory surgery centers (ASCs), cardiology, and family practice; just to name a few. Post your pressing medical coding questions or share your expertise with other coding professionals at the Medical Coding Forums. You can post general discussions or post specialty questions for other coders in your field.

- **Off Topic.** Post threads that aren’t coding related but may be of interest to the coding community.

You can easily keep an eye on your private threads and posts in the user welcome area under the Log In/Join tab at the top-right corner of the page.

Thread Like a Pro

Once you become familiar with AAPC forums, you can subscribe to RSS feeds, create voting polls and buttons, use private messaging, and add images to your threads.

If you’re knowledgeable and helpful to other coding professionals in a particular area of coding, you may be rewarded and asked to become a moderator in your area of expertise. Moderators oversee specific forums. They generally have the ability to edit and delete posts, move threads, and perform other forum manipulations.

Post at Your Own Risk

This awesome tool is a limitless resource for answering and posting anything coding related; however, remember to verify any given forum advice with coding and billing resources such as coding books, Centers for Medicare & Medicaid Services (CMS), payer guidelines, etc. Not everyone who answers an AAPC forum question is certified or considered a coding expert, so use good judgment before you apply advice out in the coding world.

Realize Your Full Potential

AAPC forums are a give and take network of coding knowledge. If you find yourself only posting questions, consider answering posts, as well. If you know an answer to someone’s post, help that coder. You’ll find the rewards of teaching can quickly build your own coding confidence. You’ll be the go-to person for coding guidance.

Michelle A. Dick is senior editor at AAPC.
The American Society of Health Informatics Managers™, Inc is a professional member association for IT professionals who specialize in Health IT (HIT). ASHIM™ is a non-profit, non-governmental organization that conducts a nationally recognized credentialing exam to certify the healthcare industry knowledge of working level IT professionals, known as the Certified Health Informatics Systems Professional (CHISP™).

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Financial Services Administrator, Department of Public Health
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Coding Edge (CE): Tell us a little bit about your career—how you got into coding, what you’ve done during your coding career, what you’re doing now, etc.

Esther: My interest with coding began when I worked for patient accounting at our hospital. We had to verify that the services billed were documented in the medical record. I loved coding so much that I grabbed any opportunities to learn more. When there was an opportunity for hospital staff to attend a coding training in the U.S. mainland, I took it. After the training, I took the certification exam and earned my CPC®. My career has been a combination of patient billing, coding, and health financing and information. Past positions I’ve had were business office manager, health information department manager, and remote coder. Now, I am chief financial officer. At every position, I applied my coding knowledge. I am an AAPC vendor, bringing in-service training and AAPC CEUs to the hospital staff. I am very passionate about coding education and I was successful in obtaining a grant to bring coding education to our health information management (HIM) and business office staff.

CE: What is your involvement level with your local AAPC chapter?

Esther: Like the rest of the U.S., there is a growing interest in medical coding at our territory. Living in a remote location, however, I realize the difficulty in bringing coding training to staff at the only hospital in the island of Saipan and in the Commonwealth of Northern Mariana Islands (CNMI), a U.S. protectorate/territory. A local chapter was the most practical solution because it allowed other coders a means of networking and it brought workshops closer. With the help of Jean Matsushita, CPC, of Palmetto Medicare and Kay Boyce of AAPC, I learned of someone from Guam who was also interested in developing a local chapter, Kahiwa Aki, CPC. We connected and I accepted the position of 2009 president-elect for AAPC’s local chapter for Guam and the islands of the Northern Marianas.

CE: What has been your biggest challenge as a coder?

Esther: My biggest challenge as a coder is keeping up with the changes and compliance rules. It’s a must to read the monthly coding newsletters, EdgeBlast, and especially the AAPC Coding Edge.

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?

Esther: Approach him or her. You’d be surprised how interested providers get when you explain the appropriate way to do it. They share the same desire to “code it right.” Once I opened that door of communication, I’ve been asked to present at staff meetings and hold one-on-one sessions. In whatever form of communication you choose, be respectful and attentive to the physician’s questions and show confidence of your skill and knowledge.

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart? Do you approach the physician, or have a monthly meeting?

Esther: I’d do what I’m doing now. I love to code so I do that in my spare time. I also love being an administrator because it allows me to help others improve their own careers by finding funds and opportunities for training. I love to see more coders in Saipan, Guam, Tinian, and Rota because this is a great career and I want to be part of making that happen.

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

Esther: My family loves playing and watching sports. My oldest son lives in Seattle and I love the Seattle Seahawks and Seattle Mariners. But even more, I’m a huge fan of my children when they play sports in Saipan leagues or inter-scholastic games. All work must stop to watch them play and, on a tropical island, that’s practically year-round.

Family time is my favorite time. I am the youngest of 13 and hanging out with the rest of the Lizama clan is always filled with fun times. I strive to mirror that closeness with my own family. My husband, Nick, and I place our children, Jonathan, Nick, and Juliana, as the priority in our daily lives. I have been fortunate as a member of our modern society to have been given many opportunities. My challenge has been to take advantage of these opportunities while not abandoning my core values and principles. 
Physicians expect to be paid for the services they provide; however, the reality today is many physicians receive only 35 cents per dollar for performed procedures. Accordingly, accurate coding and a skilled patient accounting staff must work together to ensure all deserved reimbursement is recovered. Here are a few tips to get you started.

Contracting

- Be familiar with your market when negotiating contracts. Contract with insurance companies who insure the most members in your region. This is especially vital for specialty practices.
- Complete credentialing prior to providers performing services. When timely credentialing does not take place, it stunts reimbursement.
- Have an experienced person negotiate your contracts. It can be the difference between outstanding, fair, or poor reimbursement.

Front Desk

- Have skilled front desk staff who are knowledgeable about insurance requirements.
- Verify patient insurance benefits prior to appointments.
- Collect accurate information from patients, such as demographics, updated insurance, and additional information that may be necessary.
- Collect co-pays upfront. Some patients prefer providers to bill them for co-pays. Explain to patients co-pays are a part of the insurance carrier contract and should be paid at the time of service, in line with contracted benefits he or she chooses.

Coding

- Timely completion of medical records is necessary to guarantee procedures can be coded and billed in a timely manner.
- Clear provider documentation is vital to accurate coding.
- Open communication with physicians and coders regarding documentation is crucial.

Business Department

- Forward denials to account representatives/collection staff when payments are posted, so they can inquire why certain claims were denied or not reimbursed properly.
- Use a consistent approach with denials. After a denial determination has been made, use proper action to get the claim paid. Contact the insurance carrier regarding a denial, or set in motion a claim appeal. Create follow-up tasks to ensure timely and appropriate adjudication.
- Target accounts receivable. Ensure insurance carriers have received the claims. Electronic claims filing is a must in this respect. This aids in forecasting when a claim will be reimbursed.
- Realize that appeals are more important than ever. Insurance carriers have been known to deny line items on claims incorrectly. A knowledgeable person should be assigned to follow up on this task. It takes proficiency, determination, and enthusiasm to accomplish proper claims adjudication.
- Audit claims. This is crucial to ensure accurate payment for procedures. This information should be conveyed to the individual who performs contract negotiations for your practice.

These tips are only a snapshot of what you can do to create a remarkable reimbursement program for your physician practice. With a solid foundation for reimbursement, a thriving practice can be built to weather the storms associated with the steady decline of reimbursement.
Go Beyond the Basics of Time-Based E/M Coding
When time captures reimbursement, every minute counts.

By G. John Verhovshek, MA, CPC

As CPT® evaluation and management (E/M) service guidelines explain, “When counseling and/or coordination of care dominates … the physician/patient and/or family encounter … time may be considered the key or controlling factor to qualify for a particular level of E/M services.” Specifically, in the office setting, time-based E/M coding requires that the physician spend half or more of the visit face-to-face with the patient and/or family providing counseling and/or coordination of care. In a hospital or nursing facility, the counseling/coordination of care time needn’t be face-to-face, but may include floor/unit time within a 24-hour period. CPT® E/M guidelines allow unit/floor time to include “the time that the physician is present on the patient’s hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient’s chart, examines the patient, writes notes and communicates with other professionals and the patient’s family.”

Time References are Crucial
Only those E/M services with a time reference may be reported using time as the key component. The time reference is stated in the final sentence of the CPT® E/M code descriptor. For instance, consider the descriptor for new patient outpatient service 99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. Note that it specifies, “Physicians typically spend 30 minutes face-to-face with the patient and/or family.”

In contrast, according to CPT® guidelines, “Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity bases.” Likewise, observation codes 99234-99236 do not have a time reference. Because these services do not include time references, you should not report them with time as the controlling element.

With regard to time references, CPT® explains that “specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.” In other words, not every level III, new patient, outpatient service (99203, as described above) will last 30 minutes. Conservative coding suggests the stated time reference is the minimum necessary to report a service by time. For instance, to report 99203, the visit would be at least 30 minutes, with at least 16 (50 percent or more) spent on face-to-face counseling and coordination of care. To report a level IV, new patient, office visit (99204) by time, the visit would need to last at least as long as the stated time reference of 45 minutes, and so on, as shown in the table on page 46.

Note that time spent taking the patient’s history or performing an examination does not count as counseling time.

Count the Minutes, Note the Substance
Documentation is crucial when reporting time-based E/M services. As CPT® explains, “The extent of counseling and/or coordination of care must be documented in the medical record.” Actual start and stop times for the service, if ideal, are not necessary. What is required, however, is the physician’s note for how long the session lasted (e.g., “28 minutes”), as well as what portion of that time was devoted to counseling and/or coordination of care.

Just as importantly, documentation should describe the substance of the counseling and/or coordination of care, advises Marcia Brauchler, MPH, CPC, CPHQ, with Physicians’ Ally, Inc. in Littleton, Colo. For example, CPT® instructions allow counseling to include discussion of one or more of the following:

- Diagnostic results
- Prognosis
- Risks and benefits of treatment options
- Impressions
- Instructions for management
- Importance of compliance with chosen treatment options
- Risk factor reductions
- Patient and family education
A common example is a patient with a new diagnosis of diabetes. The physician may spend extensive time with the patient discussing lifestyle modifications, including proper diet and exercise, as well as the nature of the disease, the importance of control, and so forth. The substance of the discussion should be included in the physician note to support an E/M service coded by time.

**Use It, Don’t Abuse It**

Coding E/M services by time is simpler than reporting services according to history, exam, and medical decision making (MDM), but don’t be tempted to report all E/M services by time. Keep in mind: the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services’ (CMS) guidelines consider history, exam, and MDM to be the key components of E/M services, and allow coding by time only when 50 percent or more of the visit involves documented counseling and/or coordination of care. The physician should include the components of history, exam, and MDM—even if cursory—in the documentation of every visit. Good medical record keeping requires documenting relevant and pertinent information. Using time as the controlling factor to qualify for a given E/M level does not negate this requirement.

**Time-based E/M and Prolonged Services**

Prolonged services codes (+99354–+99357) may be combined with other E/M services to report extended, face-to-face patient/provider visits. To report prolonged services, the physician must document at least an additional 30 minutes of face-to-face beyond the time reference of the chosen E/M service level, as illustrated in Table A. Do not report prolonged service codes in addition to any E/M services (such as observation services) that do not include a time reference.

Heads up: Codes +99358 Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); first hour (List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service) and +99359 Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (eg, review of extensive records and tests, communication with other professionals and/or the patient/family); each additional 30 minutes (List separately in addition to code for prolonged physician service) report non face-to-face prolonged services, but these are not recognized by Medicare and many other payers.

Time counted toward prolonged services need not be continuous, but it must occur on the same service date. Do not consider time spent discussing the patient’s case with other physicians, time reviewing data or tests without the patient present, or other activities not involving direct patient contact toward prolonged services.

Documentation must explain why the physician provided prolonged services. For example, CMS’ Internet Only Manual instructions state, “to support billing for prolonged services, the medical record must document the duration and content of the E/M code billed.” A notation that the physician spent an extra 40 minutes with the patient, for instance, is not adequate. The medical record must support specifically medical necessity for the extra time spent.

Combining prolonged services with time-based E/M services raises interesting issues, Brauchler notes. “Looking at Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6.15.1, you don’t have to max out the highest E/M level to add prolonged service time. This doesn’t necessarily make sense if you’re using time-based coding because, for instance, a 75 minute 99213 ought to be (by definition) a 99215, not a 99213 with 99354.”

Here’s the answer: Generally E/M levels are assigned according to history, examination, and MDM. If the physician spends 30 minutes or more beyond the time reference of the chosen E/M level on counseling and coordination of care, you’d apply prolonged services codes. If the physician spends fewer than 30 additional minutes beyond the reference time of the appropriate E/M level (as determined by history, exam, and MDM) with the patient—and counseling and coordination of care exceed 50 percent of the time allotted to the visit—you may choose to code a higher E/M level based on time.
For example, the physician sees an established patient with a newly-confirmed diagnosis of cancer. Based on the components of history, examination, and MDM, the visit warrants only a level III visit (99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family). The physician spends an additional 40 minutes (beyond the 15-minute time reference of 99213) answering questions and discussing treatment with the patient. In such a case, you could report the office visit (99213) and one hour of prolonged services (99354 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (eg, prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)).

If the same patient presents for the same visit but lasting 20 additional minutes beyond 99213’s 15-minute time reference, don’t report prolonged services (because the 30-minute threshold for 99354 was not met). But, as long as the physician spends more than half the visit on counseling and coordination of care, you may use time as the key component when assigning the E/M level (which, in the case of this 45-minute visit, would result in a level V service, 99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family).

Note that time spent taking the patient’s history or performing an examination does not count as counseling time.

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### Office Visit Time-Based E/M Coding Quick Reference Chart

<table>
<thead>
<tr>
<th>Code</th>
<th>Reference Time</th>
<th>Threshold Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minutes</td>
<td>to bill 99354</td>
</tr>
<tr>
<td>99201</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
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<td>99211</td>
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<tr>
<td>99213</td>
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<td>99214</td>
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<td>55</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>70</td>
</tr>
</tbody>
</table>

* Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and family’s needs.

“Chart courtesy of Marcia Brauchler, MPH, CPC, CPHQ, with Physicians’ Ally, Inc. in Littleton, Co, as adapted from CMS guidelines. Reference and Threshold times for reporting prolonged services with additional (inpatient) E/M service categories may be found in Medlearn Matters article # 6740 Revised, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf.”

G. John Verhovshek, MA, CPC, is AAPC’s director of clinical coding communications.
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Minimize ICD-10’s Impact

Conduct a high-level analysis to face challenges and pull organizational resources.

By Deborah Grider, CPC, CPC-I, CPC-H, CPC-P, COBGC, CEMC, CDERC, CCS-P

Recently, I testified in front of the National Committee for Health Care Vital Statistics (NCHVS) about the impact of ICD-10-CM on medical practices, outpatient hospital facilities, health plans, etc. During the meeting, the NCHVS heard from various organizations involved in ICD-10 implementation. One thing everyone agreed on was that health care organizations, providers, and health plans must begin the implementation process now, or the impact of ICD-10 will be devastating in 2013. How do you protect your practice, department, and business processes from this ill-fated premonition? Before all else, conduct an impact analysis.

An impact analysis allows you to think about all the ways you currently use ICD-9-CM—in your practice management systems, electronic medical records (EMRs), coding and submission of claims, quality reporting, clinical reporting, claims adjudication, and so on—and determine which business and clinical areas will be impacted most by the transition from ICD-9 to ICD-10. It’s also a good tool for auditing your current systems for ICD-10 compatibility.

IT Begins

Begin your impact analysis by conducting a comprehensive audit of all data systems that currently use ICD-9-CM. The following questions will get you started on the right path:

1. How are ICD-9-CM codes used in each information system?
2. What is the use of vendor software applications versus internally developed system interfaces or customizations and other affected software, like Charge Description Masters, practice management software, financial software, etc.?
3. How are codes entered? Are they manually entered or imported from another system or software?
4. What is the current character length specification in the system? (The 5010 conversion should resolve this problem.)
5. Can the system handle alpha-numeric? (This is a must.)
6. Can the codes, code descriptions, and supported documentation be obtained in a machine-readable format?
7. Does the code format include a decimal?
8. Can the current system house both ICD-9-CM and ICD-10 codes simultaneously; and can the vendor or internal information technology (IT) personnel map forward from ICD-9 to ICD-10 and back again?
9. How is the quality of data checked?
10. How do the systems interface (if applicable)?

Once you have performed a review of your IT system(s), map the electronic data flow to inventory all reports containing ICD-9-CM codes. Consider how long ICD-9-CM will be accessible, what staff will need to access ICD-9-CM, and how long the legacy data needs to be available. Perform a detailed analysis of changes that need to be implemented for the transition to ICD-10. A simple spreadsheet will help you to accomplish this task.

At this point, you should identify which forms and reports will need to be reformatted or will require revision. Your IT staff also will need to evaluate the systems’ storage capacity to see if it can support both ICD-9-CM and ICD-10 during the transition period. If not, its capacity will need to be increased.

Contact system vendors during this phase to ensure both the legacy and the new coding system will be supported, and for how long.

Factor In Costs

This is an ideal time to identify costs for upgrading software and storage capacity, as well as contract issues with the vendor. This will help budget the system conversion over the next several years.

Your organization may need to contact software and hardware vendors during the analysis phase to identify potential budget-influencing costs for:
If your organization has not already converted to an EHR or EMR, consider doing so during the ICD-10 transition.

- Hardware
- Software
- System upgrades
- Customization
- Staffing and overtime

When we speak of customization, we speak of potentially costly modifications to current software that may include:

- Alphanumeric structure
- Longer code descriptors
- Field size expansion
- Edit and logic changes
- Use of decimals
- Table structure modification
- System interfaces
- Expansion of flat files containing diagnosis codes
- Redefinition of code values and their interpretation

Other systems and applications that use coding data which must be analyzed include those for:

- EMRs and electronic health records (EHRs)
- Billing
- Clinical
- Code look-up
- Encoding
- Computer-assisted coding
- Medical record abstraction
- Scheduling and registration
- Accounting
- Quality management and utilization
- Clinical protocols
- Test ordering
- Script writing
- Clinical reminder

If your organization has not already converted to an EHR or EMR, consider doing so during the ICD-10 transition. If your coding process currently uses a manual system for coding (code books), think about switching to electronic tools such as a code look-up program or encoder when ICD-10 is implemented. Keep in mind: This may result in additional software and hardware expenses, and additional time and personnel will need to be factored into the schedule.

You might also want to include the cost for additional chart audits to make sure documentation will support diagnosis coding for ICD-10.

**Compliance and Quality**

In the clinical area, documentation will have the largest impact on ICD-10 implementation success. Since ICD-10 is more robust and has up to seven digits of specificity, you should verify that your current documentation in the medical record can support ICD-10 on the go-live date. By analyzing the documentation and conducting medical record documentation audits, impact can be assessed.

Your organization should use an experienced auditor(s) to conduct the audits either internally or externally. Evaluate random samples and review various types of medical records during these audits. For example, in a surgeon's practice, evaluation and management (E/M) services, surgical procedures, and other diagnostic services should be reviewed. Make sure the current documentation adequately supports ICD-10. A clinical documentation assessment tool should be utilized.

Take an in-depth look at the current level of documentation in the medical record. Review the lack of specificity in the documentation and analyze how to begin the improvement process. Based on your practice's specialty, review the most common diagnosis codes you use and their frequency.

Most practice management billing software is capable of running a frequency report of the most used proce-
Since reimbursement is tied to procedural and diagnosis coding, don’t forget to consider the financial impact on your business.

Education and Training

The key issue when assessing coding and billing during the impact analysis is education and training on the new ICD-10 code set. The organization must first identify who needs to be trained, how many hours of training will be required, and the most beneficial method of training.

Start by identifying who will require training. First and foremost, the physicians, nurse practitioners (NPs), physician assistants (PAs), etc. will need to be trained. You might also consider nurses and medical assistants (MAs) who sometimes use diagnosis codes. Of course, the coders, billers, and managers will need training, as well as the front office and ancillary staff.

Next, determine how much ICD-10 training will be necessary for the various personnel, how many days of training will be required, what revenue will be lost if the physicians and non-physician practitioners (NPPs) need to be out of the office for training, and how productivity will be affected. These are all valid concerns which need to be part of your impact analysis.

Finance

Since reimbursement is tied to procedural and diagnosis coding, don’t forget to consider the financial impact on your business. For example, after the implementation date, if the insurance carrier cannot yet accept ICD-10 codes, it is likely the medical practice will not be paid. If your organization is not ready and cannot transmit claims, this will impact the financial area of the practice, as well. Review the current reporting for procedures and services using ICD-9-CM codes and analyze them in comparison to ICD-10 codes. Professional services are paid based on procedure codes; however, diagnosis codes support medical necessity, which is the driving factor in payment for all medical procedures and services.

One final area that may be affected by the ICD-10 transition are reports tied to diagnosis codes, such as the accounts receivable analysis, pending claims reports, analysis by provider type, collection reports, etc. Your impact analysis should include an assessment as to what reports are impacted by ICD-9-CM currently and what impact ICD-10 will have on them.

An impact analysis will deepen your organization’s understanding of the challenges you face with implementation. Through a high-level impact analysis, your project team will be able to predetermine the organizational resources that will need to be allocated to the project. This assessment approach will assist in staff planning and organizing the ICD-10 budget prior to embarking on this multi-year project. The information collected during the analysis will serve as collateral for subsequent phases to help ensure that nothing slips through the cracks.

Come learn how to deal pro-actively with EMR issues that plague the industry, such as copy and paste functionality, computerized assisted coding options that ease documentation but raise risk, “Smart Tools” that assist in getting coding elements necessary for billing and other important foundational options needed in the EMR. We will also explore how ARRA impacts EMR selection, functionality required to gain maximum grant dollars and the implementation and optimization process as it impacts the HIM world.

This workshop will help you:

- Learn what the American Recovery and Reinvestment Act offers regarding incentives for immediate implementation
- Learn the alphabet soup of HIT and ARRA requirements for “meaningful use” that trigger $17 billion in Medicare and Medicaid incentives
- Understand the importance of having coding and HIM professionals at the table during the EMR selection, implementation and optimization process
- Explore the inevitable shift in a coder’s responsibilities from the paper world to the electronic world
- Understand how accurately setting up documentation and coding rules into the system drives auto-adjudication of claims
- Evaluate the pros and cons and how to tackle the problematic areas of the EMR

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