American Academy of Professional Coders

CODING edge

July 2009

PT’s Full Capacity

Plus: Uterine Fibroids • Compliance Plan • Contract Negotiations • ED Fingertip Injuries • HITECH Act
Author Michael Miscoe, JD, CPC®, CASCC™, CUC™, CHCC, uses his expertise as a nationally recognized lecturer and author with over 12 years experience as a coding expert in civil and criminal post-payment cases to help you learn compliant and defensible coding.

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On the Cover: Shannon Sullivan, CPC, CMBS, and William Pena, PT, DPT, ensure proper code selection while Carl Petitto, OTR/L, performs ultrasound on Tammy Carbino at Adirondack Physical & Occupational Therapy, LLC, Canton, N.Y. Cover photo by Devin Kelley, designer/owner, Kelley Graphics (kelleygraphics.com).
Serving 79,000 Members – Including You

Targeting the AAPC Audience
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.

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 and adhere to 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.
Put Health Care Reform in Perspective

We may not know the final face health care reform will have, but there is little doubt that it is coming. Every proposal from our nation’s capitol suggests the same three objectives for health care: providing access to all, reducing its cost, and improving its quality. These are large challenges that may be difficult to achieve. Here is a summary of the various proposals:

Providing Insurance for All
This will be the easiest to achieve and will probably be legislated this year. Both parties support this goal, as do most major health care related groups: payers, providers, and patients. The significant debate centers at whether the payer that will provide insurance to those currently uninsured will be private carriers or a public (government) entity. Republicans appear to be solidly behind private carriers while Democrats are split between the public-only plan and a combination of public and private carriers. Other smaller debate areas are over coverage for illegal immigrants and how to pay for additional coverage for the uninsured. A combination of tax increases, physician payment reductions, and increased government expenditures will pay for this.

Reducing Costs
Cost reduction is the objective driving health care reform. Projections indicate that if health care costs continue to rise, it will put Medicare, Medicaid, and other public health care programs in jeopardy. The task, however, will be extremely difficult. The huge baby boom generation is just beginning to hit retirement age, and the health care cost for these 77 million people is only beginning to rise. When you combine this with the current financial struggles of hospitals and the shortage of physicians in some areas, it is difficult to see how costs can be substantially reduced. Some suggest that electronic medical records (EMRs) and electronic health records (EHRs) can both reduce costs and improve quality. My personal analysis indicates this may save 3-4 percent but more likely will produce little to no savings. I recently heard of practices that see fewer patients after EMR system implementation, which if widespread, will only increase costs.

Improving Quality of Care
Until now, all initiatives to improve quality of care have increased insurance costs. Because of higher utilization or more expensive treatment new surgical procedures, new drugs, better equipment, etc. have all increased costs. We have the ability to increase our longevity and make our lives more comfortable, but have yet to do so without increasing cost. If we can put in place EHR systems with true interconnectivity (permission granted, fast access to patient records by all providers) and true interoperability giving providers quick information access, then we have a chance to provide better health care at slightly reduced costs with fewer diagnostic errors, better treatments from the beginning, and reduced recurrences.

Our individual choices, commonly called lifestyle choices—obesity, smoking, substance abuse, etc.,—are the biggest factors in health care costs. The cost of unhealthy lifestyle choices is more than all prescription drug costs, half of all Medicare costs, and is the largest, rapidly-growing cost in health care. Insuring all, using the best EHR systems, and providing the best procedures and equipment will not reduce these costs—only we can do so by living healthy. My hope is to focus on real health care reform, rather than politically nipping at the edges.

Sincerely,

Reed E. Pew
CEO and President
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The Pros and Cons of Working from Home

Over the past decade, the phrases “paradigm shift” or “working out of the box” have gained popularity. Translation: Thinking outside the norm. Telecommunication is a good example of a paradigm shift as it often allows for both increased productivity and improved options for the workforce.

On the Upside

It all began with telemarketers, who could work from home, call from cell phones and/or work from a central office. It wasn’t long before the health care industry jumped on the bandwagon seeing telecommunication as an opportunity to remedy the medical transcriptionist shortage. Both health information management (HIM) directors and medical transcriptionists were quick to agree the situation was ideal.

Transcriptionists gained the flexibility they needed to fulfill family needs by working odd hours or shifts from home. Some worked late nights, long after the physicians had finished pre-op notes for the next day’s surgeries. HIM directors saw improved productivity, a decrease in overhead, and they could pay transcriptionists by the line, so time was not an issue. The transcriptionists could make whatever income they wanted depending on the number of lines they transcribed. As time passed, other departments found ways to provide work from home. With the introduction of natural language processing, hospital and physician office coders were soon able to adopt work-at-home positions, as well.

This paradigm shift has had a positive impact on the health care profession—I can attest to this. It is because of this technology that I am able to hire certified coders (CPCs), and I utilize the skills of an additional six contract CPCs from Hawaii. My remote and local coders sign into my system and code from home through the Internet. With the six-hour time difference between New York and Hawaii, the west coast coders can easily complete what the east coast coders didn’t complete for the day.

On the Flipside

With the cost of gas, clothes for the office, and babysitters, many of us today would jump at the opportunity to work from home. The catch is that working from home requires discipline and a certain kind of mindset. It is very easy to procrastinate when you don’t have to punch a time clock or have a supervisor peering over your shoulder. If you fall behind, it’s easy to say “I can do more later,” or “I will work tonight after the kids go to bed,” or “I will work this weekend to make up the hours I missed,” but it never gets done. Your friends and family may interrupt your work day because they know you’re home, and for some of us, it’s hard to say “I am busy working.”

And then there’s the solitary aspect of working at home. There is no one sitting next to you to chat with (hence the increased productivity). If you have a question, you may be able to call or email a co-worker your question, but asking a fellow co-worker or supervisor who sits by you in the office would be simpler and faster.

Before long, whether it is the lack of discipline or the inability to work alone, your supervisor will realize that your productivity and/or accuracy is not what it should be and that working from home is not right for you.

Knowing the pros and cons to telecommuting will help you decide if working at home is right for you.
Follow-up Letter on Lap Band Adjustments Guidance

Dear Coding Edge,

In “Letters to the Editor,” April 2009 Coding Edge, there is a question about lap band adjustments, the answer to which advises, “Any adjustment of the gastric band occurring BEYOND the 90 day postoperative period would factor into E/M code level assignment for that visit.”

Does this mean we should only be billing an Evaluation and Management (E/M) level when the patient comes in for a band adjustment? In our practice, we’ve been billing S2083 Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline, or using the unlisted code 43999 for all carriers who don’t recognize the S code, when the patient has presented for an adjustment.

Thank you,
Marcy McDowall, CPC

Dear Marcy,
The advice in April’s Coding Edge is based on AMA instructions as provided on page 19 of the April 2006 CPT® Assistant (emphasis has been added):

“The first adjustment of the band usually occurs 4 to 6 weeks after placement, and subsequent band adjustments are included as part of the global postoperative period for this procedure and are not separately reportable. Adjustments performed after the global postoperative period may be accounted for in the evaluation and management coding. Therefore, there is no CPT® code to report for adjustment to a patient’s gastric band.”

Despite the AMA’s advice to factor post-global period adjustments into any same-day E/M services, in practice coding for adjustments outside of the global period will be payer dependent:

• Some payers will accept S2083. Medicare does not accept S codes
• Other payers will accept unlisted procedure code 43999 Unlisted procedure, stomach

Remember to follow your payer’s instructions for proper coding of these services. Do not report 96379 Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion for gastric restrictive band adjustments for any payer. This code is specifically for “intra-arterial or intravenous” injections.

In any case, a separate E/M service on the same day as a band adjustment may be warranted, as explained in Bariatric Times, ISSN: 1044-7946, Volume 3, Issue 8, October 2006:

“No CPT® code exists for gastric band adjustments. However, because the extent of evaluation and management (E&M) differs with each clinical situation, standard E&M codes are applicable. In addition, some insurance companies actually recognize a gastric band code, S2083, which was created by Blue Cross/ Blue Shield. Therefore, when evaluating the patient for an adjustment, the standard E/M coding applies, the level of which is determined by the amount and complexity of the work done. If you decide to perform an adjustment, you have a choice of using S2083 [or 43999], depending on what that particular insurance company recognizes.”

If an E/M service is indeed separately identifiable and significant, you may report it separately at the appropriate E/M service level, as supported by documentation, with modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service appended.

Fluoroscopic guidance, if used during adjustment of the gastric restrictive device, may be reported using 76000 Fluoroscopy (separate procedure), up to 1 hour physician time for some payers.

Note that 43999 is payer-priced. For some payers, if the lap band adjustment is provided on the same day as an E/M service, only the E/M service may be paid.

Thanks,

Coding Edge

Let Us Help You Find a Job

Dear Coding Edge,

In May’s “Bulletin Board” you posted that you are looking for coders to send in unique problems or benefits of coding from home. I was wondering if you know where I can find a remote coder job or if you can send me in the right direction to find one. Are there any Web sites that you would recommend? I am a certified specialty coder and my current company does not have the option of working from home.

Thanks for your time,
Anonymous

Dear Anonymous,

There is a job center on the American Academy of Professional Coders (AAPC) Web site where you can post your resume and look for coding jobs. Just log onto the Member Area of the AAPC Web site and use this link to get started: www.aapc.com/education/medical-coding-career.aspx.

Coding Edge

An Apology:

In the June Coding Edge we forgot to acknowledge Jerry Godolphin, who took the photos for the conference round-up article, “Coders Hit the Jackpot in Vegas.” Jerry graciously photographs AAPC’s conferences every year. We apologize for our oversight.

Coding Edge
Get the full story

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2010 IPPS
Commenting Period Closes
By Renée Dustman, senior editor

The Centers for Medicare & Medicaid Services’ (CMS) commenting period closed on June 30 for the 2010 Inpatient Prospective Payment System (IPPS) proposed rule. The proposed rule includes meager payment updates for approximately 3,500 acute care hospitals paid under the IPPS and 400 long-term care hospitals paid under the Long-Term Care Hospital Prospective Payment System (LTCH PPS), a few revisions mandated by legislation, and little else. Affected acute care hospitals will experience an overall $979 million decrease for operating and capital payments in 2010. A final rule will be made public no later Aug. 1.

If you haven’t seen the proposed rule, it was placed on display at the Federal Register May 1, and can be found under Special Filings at: www.archives.gov/federal-register/public-inspection/index.html or on the CMS 2010 Proposed Rule Home Page at: www.cms.hhs.gov/AcuteInpatientPPS/FY2010RULE/List.asp.

Check AAPC News online for the complete story.

Mild HCPCS
Drug/Bio Changes for July
By Brad Ericson, director of publications

CMS announced a handful of changes to HCPCS Level II codes effective July 1. The following codes will be payable for Medicare:

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>TOS Code</th>
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<tbody>
<tr>
<td>Q2023</td>
<td>Injection, Factor VIII (Antihemophilic Factor, Recombinant) (Xyntha), Per I. U.</td>
<td>1</td>
<td>E</td>
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<tr>
<td>Q4115</td>
<td>Skin substitute, Alloskin, per square centimeter</td>
<td>1</td>
<td>E</td>
</tr>
<tr>
<td>Q4116</td>
<td>Skin substitute, Alloderm, per square centimeter</td>
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<td>E</td>
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The Medicare Coverage Indicator for certain J codes was incorrectly listed on the January 2009, HCPCS Level II code set file. With the July 2009 quarterly update to the HCPCS Level II code set, CMS is correcting the file to show a Medicare Coverage Indicator of the letter “D.” The letter “D” indicates that “special coverage instructions apply” and the applicable special coverage instructions are provided in the local coverage determinations (LCD) regarding inhalation drugs.

The affected J codes are:

- **J7611**  Albuterol non-comp con
- **J7612**  Levalbuterol non-comp con
- **J7613**  Albuterol non-comp unit
- **J7614**  Levalbuterol non-comp unit

These updates are based on transmittal 1752 (www.cms.hhs.gov/transmittals/downloads/R1752CP.pdf), change request (CR) 6477, issued June 5, and are effective for claims with dates of service on or after April 1, 2008.
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<th>Early Bird Price</th>
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<td>Single attendee</td>
<td>$775</td>
<td>$725</td>
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<tr>
<td>Two attendees</td>
<td>$725 each</td>
<td>$675 each</td>
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<tr>
<td>Three attendees</td>
<td>$700 each</td>
<td>$650 each</td>
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<tr>
<td>Four or more attendees</td>
<td>$625 each</td>
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<td>The Confident Coder: How To Accurately Code For Professional Services In Anesthesiology</td>
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<td>Raemarie Jimenez, CPC®, CPC-I®, CANPC™, CRHC™</td>
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<td>12/08/09</td>
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<td>Betty Johnson, CPC®, CPC-I™</td>
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<td>2010 Complete Code Update For Professional Services In Anesthesiology + OIG Report</td>
<td>Marc Leib, MD, JD</td>
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<tr>
<td>12/16/09</td>
<td>2010 Complete Code Update For Professional Services In General Surgery + OIG Report</td>
<td>LuAnn C. Jenkins, CPC®, CEMC™, CFPC™</td>
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Whether you work in a physician’s office or a hospital, negotiating and understanding third-party payer contracts may be intimidating. The terms can be difficult to understand and the stakes are high. A poorly performing insurance contract, however, can lead to financial devastation for an organization.

Professional coders are trained to analyze complicated medical records and pay attention to detail. Applying the same principles to contract negotiation and management will help you feel more in control. Assistance from an attorney with health care experience is always a good idea; if this is not an option, use caution, avoid making assumptions, and take the time to understand what you read.

Contracts Should Be a Win/Win

An adversarial attitude toward your payer is counterproductive to everyone’s goal of patient satisfaction and timely and accurate payment for services rendered. Thinking of the insurance company as one of your customers goes a long way in establishing a good working relationship.

The benefits of contracting with an insurance company include channeling those patients to your practice, stabilizing your accounts receivable (knowing how much you’ll be paid and when), and providing a process to resolve disputes if they occur. Getting everything in writing clearly defines who is responsible for what, when and where, and for what price.

Every state has its own regulations governing health care and contract requirements. You should have at least a basic knowledge of these laws and rules as they apply to your organization. A good place to start is the Web site for your Secretary of State or the office that has oversight of insurance plans. In California, health maintenance organization (HMO) plans are regulated by the Department of Managed Health Care, and indemnity plans fall under the Department of Insurance. Most self-funded plans are regulated by federal law under the Employee Retirement Income Security Act (ERISA). If an insurance company tells you certain language is required by law, don’t just take their word for it—check it out.

Although generally thought of as a payment mechanism, a contract contains much more than just payment terms. A crucial first step to understanding a contract is reading the document carefully. Some contracts are written in complex legal terms and others are written in more everyday English. As simple as it sounds, if you don’t fully understand the meaning of a word you see, look it up.

Part 1 of a 2-part series

The first step is to incorporate concise contract negotiations.

By David Peters, CPC, CPC-P, PCS, CCP-P
For example, if you see the word “whereas” at the beginning of a statement, don’t just gloss over it as an officious-sounding legal word. It actually means “in view of the following facts,” and could put an entirely different spin on what follows. Again, if you don’t have an attorney at your disposal to decipher complicated terms, a good legal dictionary is an invaluable tool.

**Know Your Contract Piece by Piece**

You should also familiarize yourself with the components of a typical contract. Most contracts contain six components:

1. **The Preamble** is the opening statement. It names the parties to the agreement and usually indicates the legal status of each party (i.e., John Smith, MD, an individual, or local medical group, a limited liability corporation). It is important to use the parties’ legal names, and to be sure it (and the legal status, if listed) is correct. The preamble also will usually establish a reference name for each party, rather than repeating the full legal names (which can be lengthy) throughout the contract. For instance, “The Biggest Insurance Company of America and All of Its Legal Affiliates (the COMPANY)” would be referred to as COMPANY, instead of the full name, throughout the contract.

The preamble also may contain the contract’s effective date. Contracts should never be postdated to cover services previously provided. Previously-provided services should be addressed apart from contract negotiation.

2. **The Recital** is sometimes called the background statement, and describes the contract’s purpose or its reason. The recital is typically no more than one paragraph and doesn’t usually require close scrutiny.

3. **The Definitions** provide standard meaning for terms used throughout the contract, and are usually expressed in capital letters to reduce confusion. An example might be: “COVERED SERVICES means those Medically Necessary comprehensive health care services that Enrollees are entitled to receive pursuant to one or more Service Agreements with the Prepaid Plan.” In this case, covered Services is now defined to have a singular meaning.

Because the above definition also contains the terms “Medically Necessary,” “Enrollees,” “Service Agreements,” and “Prepaid Plan,” there should be definitions describing those terms as well. If a definition is unclear to you, or seems to be confusing, ask for the term to be redefined to eliminate ambiguity. Be wary if a company resists clarification: Purposefully vague terms may cause problems down the road.

4. **The Operative Language** is the body of the contract. It contains most of the provisions and describes the obligations and responsibilities of both parties.

Contracts with government agencies (Medicare, Medicaid and Civilian Health and Medical Program of the Uniformed Services [CHAMPUS or, more recently, TRICARE]) are generally written in stone and cannot be modified. All contractors sign the same agreement, follow the same rules, and are paid the same. Private insurers may try the same approach; saying, for instance, “This is our standard contract that everyone signs.” Don’t let the conversation end there. A good reply would be, “It’s a good start, but there need to be changes before it’s acceptable. How

If your state mandates payment within 30 days of receiving the claim, and you agree to 90 days in the contract, guess what? You may have just given up your right to invoke the state regulation!
do we accomplish this?” You haven’t said no, and you’ve let them know you are willing to negotiate.

You should be able to identify key elements in the body of the contract. There should be a section for each party describing its obligations. The insurance company will expect you to:

- Abide by and cooperate with their utilization management and quality assurance programs.
- Not bill the patient for any money due from the insurance plan or charges other than copayments and deductibles. (This “hold harmless” language is often required by state regulation.)
- Submit your claims in an acceptable format.
- Provide services to their members just as you would any other patient.
- Refrain from encouraging the patient to change to another insurance company.
- Use a process such as binding arbitration to settle disputes, rather than going to court.

In turn, you have the right to expect the insurance plan to pay your claims in a timely manner. Time limits are frequently regulated by the state but beware. If your state mandates payment within 30 days of receiving the claim, and you agree to 90 days in the contract, guess what? You may have just given up your right to invoke the state regulation!

You also expect the insurance company not to deny retroactively services that have been approved, and to get your permission before they use your organization’s name in any marketing and advertising material. You’ll have additional concerns, of course, but hopefully this discussion will get you thinking at the level of detail required for effective language review.

The body of the contract will also contain standard provisions you need to understand and, if necessary, question:

**Independent contractors**—Language should not imply that you are creating any type of employment, partnership, or joint-venture agreement.

**Term**—What is the initial term length of the contract? Does it have an end date or does it renew automatically?

**Termination**—What are the provisions for terminating the agreement? Are there provisions for terminating for cause (agreement breach), as well as terminating just because you no longer want to work with that plan (at will termination)?

**Obligations after termination**—How will patients be handled that are in the midst of care if the contract is terminated? How will you be paid for those services?

**Dispute resolution**—Defining the preferred process here will save time should a dispute arise. Usually, the first step is a “meet and confer” between the two parties. If meet and confer is not successful, it is usually better to initiate a binding arbitration process, rather than going to court for trial.

**Governing law**—This is usually the state in which the payer resides. If you and the insurer are in the same state, there’s no problem. If it’s an out-of-state insurer, however, be sure the contract is compliant with your state’s laws. If the contract is to provide federally-funded programs, language must meet federal requirements (ie, Health Insurance Portability and Accountability Act (HIPAA) and records availability).

**Severability**—This means it’s possible to remove a portion of the contract if it’s found to be in violation of the law or other regulations without invalidating the entire contract.

**Amendments**—Changes should be allowed only if mutually agreed on and signed by both parties. Upon signing, the amendment becomes a part of the original document.
5. **The Signature Page.** Sometimes the first page allows for easy document storage and retention, but usually follows the agreement terms.

Make sure all parties are signing the same document, and have the proper authority to sign the contract. Usually contracts are done as multiple counterparts. This means there may be more than one original document. This is usually done so both parties have an original document for their files. The contract should be signed and dated by all parties, but the signature date may not be the agreement’s effective date.

6. **Exhibits or Attachments.** This is usually where the payment rates and other information that may change periodically (such as a listing of the physician names in a group practice) are defined. Exhibits are easily amended as needed so the contract’s body isn’t changed. Other documents may become a part of the contract by reference. One such document is commonly the payer’s provider manual. This will be noted by a statement such as, “Medical Group hereby agrees to follow and abide by the prior authorization requirements in **AA Insurance Provider Manual included by this reference and hereby incorporated into this Agreement.**” Be very careful with these references. Provider manuals are updated regularly; should a change be made that would significantly change your obligations, you will either need to amend or terminate the contract.

In an upcoming issue, we’ll address contract negotiations more specifically.

David Peters, CPC, CPC-P, PCS, CCP-P, is contracts manager for Sutter Medical Foundation - North Bay, in Santa Rosa, Calif.
Select a Single Code when Tracing a Sentinel Node
By G. John Verhovshek, MA, CPC

Sentinel nodes are the first lymph nodes to receive drainage from nearby cancerous tissue. Biopsy of these nodes allows for early detection of a cancer’s spread.

Introduction
To locate a sentinel node precisely for biopsy, the radiologist injects technetium-99m (Tc-99m) (a radioactive tracer) near the tumor. The tracer drains with the lymphatic fluid to the sentinel node, where it is absorbed. If the operating surgeon uses a handheld counter (often called a gamma probe) to track the tracer and identify the sentinel node, the radiologist should claim CPT® code 38792, “Injection procedure; for identification of sentinel node for the injection only.”

“In some cases, the physician will only perform the injection of the radioactive tracer … When identification through injection of a radioactive tracer of a sentinel node(s) is performed without scintigraphy imaging, report code 38792,” confirms CPT® Assistant (Vol. 9, Issue 12). If the radiologist supplies the Tc-99m filtered sulfur colloid tracer at his own cost, he may report also HCPCS Level II code A9541 Technetium Tc-99m sulfur colloid, diagnostic, per study dose, up to 25 millicuries.

The surgeon would not code separately for use of the gamma probe, as it is considered incidental to the sentinel biopsy.

Separate Services
If the surgeon injects blue dye (such as isosulfan blue) to identify the sentinel node, he or she would also report 38792. If a payer denies either the radiologist’s or surgeon’s injection as a duplicate service, the affected physician should appeal the rejection with an explanation that the radioactive tracer injection and the blue dye injection represent separate (and separately billable) services. To avoid confusion, some payers instruct the radiologist to submit a claim for 38792 first, and the surgeon to submit a subsequent claim for 38792 with modifier 77 Repeat procedure by another physician appended.

Professional Component
A gamma camera (unlike the gamma probe) provides multiple static images from different angles to pinpoint the sentinel node’s location. The radiologist marks the node’s location on the skin so the surgeon can identify it. If the radiologist provides the radiotracer injection as described above, but also uses a gamma camera to capture dynamic, real-time images mapping the tracer’s path and sentinel node uptake, the radiologist would instead report 78195 Lymphatics and lymph nodes imaging with modifier 26 Professional component appended.

The radiologist may still report A9541 in addition to 78195 if he or she supplies the Tc-99m tracer for injection. The radiologist should not, however, report 38792 in addition to 78195. The injection is included in the more extensive lymphoscintigraphy. “The injection of radioactive tracer is included in the lymphoscintigraphy procedure performed at the same session and is not reported separately. It is inappropriate to report 38792 when lymphoscintigraphy is performed,” instructs CPT® Assistant (Vol. 9, Issue 12).

When the radiologist claims 78195, the operating surgeon may separately report 38792 to describe a separate injection of isosulfan blue for direct visualization. The radiotracer injection, however, is always included in 78195.

G. John Verhovshek, MA, CPC, is AAPC’s director of clinical coding communications.
You know you’re good. As a coder in the payer environment, you have to be. So why not let everyone else know too by validating your expertise with the Certified Professional Coder-Payer® (CPC-P®) credential?
If you can’t remember the last time you updated your coding compliance plan, you’ve got a problem.

An effective compliance plan is an active compliance plan, and an active compliance plan will keep pace with rapidly changing government regulations, payer requirements, office operations, and technology.

A static compliance plan, in contrast, is almost certainly an unused compliance plan. And an unused compliance plan—even if prominently displayed—provides no protection. In fact, that dusty folder on the shelf might put you at a greater risk because it shows that the practice or facility knows better, but ignores its own policies and procedures.

Get Your Ducks in a Row

Auditors frequently will select several policies outlined in a compliance plan, and will poll the staff, “How would you handle this situation?” If the responses don’t line up with what’s in the plan, the auditor is reasonable to be suspicious. Perhaps the compliance plan isn’t current, or perhaps your staff hasn’t been educated, or perhaps the plan was never really implemented in the first place. Often, methods change in response to day-to-day realities, regardless of official policy. In any case, if your daily office or facility operation doesn’t reflect your compliance plan, you should be concerned.

Storing your compliance plan electronically facilitates revision, and also provides the benefit of quick access from any location. Smaller files are more manageable, so divide the plan into sections or chapters, and create a separate file for each. Create a new file each time you make a compliance plan revision. Do not, however, write over or erase previous files. You want to be sure that you have a record of past policies. This creates an effective audit trail so you can defend prior claims against the appropriate criteria.

Be sure to date all files, and archive old files in a separate folder. Create an icon for access to the most recent version of the compliance plan, and make sure that icon is on the desktop of every computer in the office or facility, preferably through an intranet.

Compliance plan updates should acknowledge government regulation and payer requirement changes, but should also incorporate lessons from within your own office or facility. Over time, you may find more efficient methods or incorporate new technology to achieve your compliance goals. You can customize your compliance plan to work best for you.

For example, while working with a billing company that had not touched its Health Insurance Portability and Accountability Act (HIPAA) plan (which, like a coding compliance plan, requires regular updating) since the
plan was first required in April 2003, a consultant asked about password protection and email policies for accessing and sharing electronic files. The consultant told the policies were no longer active, and an entirely new method had been adopted. Such changes should be evaluated for compliance prior to adoption, and then officially incorporated into the plan.

Even the most up-to-date compliance plan is of no use if the only person who knows the policies is the individual in charge of keeping the compliance plan current. Staff education should be a regular and recurring part of any compliance program. If an auditor asks your staff about compliance policies, they should be able to give the correct answers. An easy way to keep education current and documented is to scan (or file) the sign-in sheet with the educational agenda from each class into the education section of the compliance records, documenting what and who was trained, as well as when the education took place.

**Out swim Alligators by Investing Time and Expense**

An effective compliance plan requires time and expense. Regular compliance updates and staff education might not seem like a priority in the face of falling bottom lines and the press of daily responsibilities. When you're trying to out-swim the alligators, you haven't got time to drain the swamp, right?

A truly effective compliance program is one of the best investments any practice or facility can make. With Recovery Audit Contractor (RAC) audits and greater scrutiny from third-party payers—not to mention the increasingly sophisticated software employed by all payers to detect aberrant or suspicious coding patterns—improper coding and other compliance problems are less likely than ever to go undetected. Payers are becoming more aggressive.

A rock solid compliance plan will catch errors before they go out the door, and will provide a clear set of procedures to resolve unintentional errors. If you take corrective action and come clean with the payer when you find a problem, you're likely to fair much better than if the payer discovers the problem first. In terms anyone working in health care should understand, coding compliance is "preventive medicine."

Even the best plan may not forestall an audit, but it will help you to withstand the scrutiny. For instance, a pediatric neurology practice in northern New Jersey recently was shocked by a payer's request to refund approximately $4.8 million in payments as a result of a payer audit. Quite aside from legal fees, the damage to a physician or facility's reputation is enough to cause financial ruin. The potential emotional damage can't be measured.

An effective compliance plan actually may pay direct dividends by identifying coding opportunities. For instance, a comprehensive compliance review might reveal that a provider is undercoding, and may legally claim a higher service level or is missing service opportunities that are not getting billed.

As already noted, your compliance plan should be mostly prospective. That is, it should establish effective internal controls to ensure that its coding and documentation practices are in full compliance with the law prior to claims submission.

An effective compliance plan also looks back, however. Regular retrospective audits, or review of claims already filed, are valuable to identify coding errors, as well as high risk services and providers. This allows you to target education efforts where they are needed, and gives you the opportunity to settle with a payer over past mistakes. It is recommended that retrospective audits be performed with your health care attorney.

Consider hiring an outside consultant to audit your coding compliance at least once per year. Very few medical practices do their own taxes. Instead, they hire a professional to do the job. The same attitude should prevail when it comes to evaluating a compliance plan.

Coding compliance is every bit as important to a medical practice as is following tax law, so why not consult an expert? A credible consultant will take the time necessary to evaluate your plan and coding compliance, and help you identify and correct any problem areas. A consultant can answer questions and provide guidance if a payer announces an audit of its own. Just as we all have the April 15 deadline to file taxes, practices and facilities should have a deadline each year to complete their compliance review and update it accordingly.

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**Let’s Talk Money and Reputation**

The cost of fraud charges resulting from a pattern of abusive coding (even if "unintentional") can escalate quickly. Quite aside from legal fees, the damage to a physician or facility’s reputation is enough to cause financial ruin. The potential emotional damage can’t be measured.

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**Barbara Cobuzzi**

Barbara Cobuzzi is president of CRN Healthcare Solutions. She holds CPC, CPC-H, and CPC-I certifications and a specialty certification in Otolaryngology from the AAPC. Barbara is a past member of the AAPC National Advisory Board as well as their Executive Board. She has also earned her certification as a health care compliance consultant from Healthcare Compliance Resources. Barbara is a nationally recognized consultant in compliance, coding and billing.
In the face of an economic crisis, the Obama administration has seized an opportunity to strengthen the medical record privacy landscape for all Americans by making significant modifications to the privacy and security regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications were drafted in the “Health Information Technology for Economic and Clinical Health Act” (HITECH Act), passed as part of the American Recovery and Reinvestment Act of 2009 (ARRA), signed into law by President Obama on Feb. 17.

The HITECH Act was designed to facilitate the widespread adoption of health information technology (HIT) for a variety of purposes, including the electronic use and accurate exchange of medical information.

Throughout the HITECH Act, it has been clear that the nation is well on the path to adopting a national framework of electronic medical records (EMRs). It has also been broadly accepted that to establish a national HIT infrastructure, the privacy and security features protecting medical records must be rooted firmly within this framework. The HIPAA Privacy and Security regulations, which have been in effect for most covered entities since April 2003 and April 2005, respectively, have made great strides in this effort. The HITECH Act takes what should be the final step at plugging many of the perceived holes and inadequacies of HIPAA Privacy and Security regulations.

The provisions of the HITECH Act that modify the HIPAA Privacy and Security regulations are as follows.

**Business Associates and HIPAA**

Traditionally, business associates (entities such as record copying services, collection agencies, attorneys, consultants, and outside auditors) were not subject to HIPAA Privacy or Security regulations. Now, as a result of the HITECH Act, business associates are directly subject to the HIPAA Security regulations, including civil and criminal penalty provisions. Business associates are also directly responsible for compliance with the HIPAA Security Rule provisions requiring administrative, physical, and technical safeguards must be in place to protect electronic patient information. Business associates are required to take certain administrative actions, such as appointing a designated security official, drafting written policies, addressing electronic protected health information they create, store, or transmit, as well as conducting employee training on information security policies.

**Breach Notification**

The long-awaited federal regulation on breach notification is here. All but a handful of states have existing legislation on breach notification that is fairly consistent in regard to the fundamental notice requirements (for example, written notice is required for patient electronic medical information breaches). The HITECH Act offers no shocking deviations from the breach notification legislation most of the states have already enacted; the only exception is an expanded notice requirement to the U.S. Department of Health and Human Services (HHS) and to media outlets in certain instances. If a breach involves 500 or more persons in a particular state or jurisdiction, in addition to the notice that must be sent to the affected individuals, the covered entity must also notify prominent media outlets in the state or jurisdiction where the individuals reside. The covered entity must also notify HHS immediately, so the notice can be posted on the HHS Web site. For breaches that involve less than 500 patients, covered entities may notify HHS by submitting a log, listing all of the covered entity’s breaches involving less than 500 patients. If state breach notification laws
are more stringent than the provisions contained in the HITECH Act, the state’s laws will continue to apply.

PHR Vendors
The HITECH Act also expands the scope of entities subject to security breach reporting provisions and requires personal health record (PHR) vendors such as Google and Microsoft to issue breach notices. The Federal Trade Commission (FTC) has been recruited to enforce these rules on PHR vendors. A PHR vendor’s failure to comply is considered an unfair and deceptive act or practice under the FTC Act.

Patient Requests for PHI Disclosure Restriction
Under the current HIPAA Privacy Rules, a covered entity is not required to approve any requests by a patient for disclosure restrictions of he or she’s protected health information (PHI). Now, if a disclosure of PHI is to a health plan, is not for treatment related purposes, and pertains solely to an item or service the provider has received full payment for, then the covered entity is required to approve the restriction.

Accounting of Disclosures from Electronic Record Systems
If a covered entity uses or maintains an electronic health record (EHR), an individual has the right to receive accounting of disclosures from this EHR. Under the current HIPAA Privacy Rules, covered entities do not need to track PHI disclosures for treatment, payment, and health care operations. Now, under the HITECH Act, the EHR disclosure must be recorded even if it is for treatment, payment, or health care operations. The covered entity must maintain accounting of the disclosure and provide a copy to the patient upon request. Because most disclosures of PHI are typically for treatment, payment, and health care operations, this new requirement will likely result in an exponential increase in covered entities’ accounting responsibilities. The endeavor will be extremely challenging and, very likely, costly for covered entities to implement logging mechanisms (both automated and manual) across their EHRs.

If the EHR was acquired and/or put into use on or before Jan. 1 this year, Jan. 1, 2014 is this provision’s effective date. For covered entities acquiring an EHR after Jan. 1, the requirement will be effective Jan. 1, 2011 or the date the EHR is acquired.

Prohibition on Sale of PHI Electronic Records
Subject to a limited exceptions’ list, the sale of PHI for remuneration now is prohibited unless written authorization is first obtained from the patient.

Right to Obtain Copies of PHI in Electronic Format
Where PHI is kept in electronic format, individuals can now request copies of that PHI in electronic format.

The Minimum Necessary Standard
Covered entities are required to apply the minimum necessary standard to certain PHI disclosures. Previously, covered entities could rely on the party requesting the information to define the minimum amount of information necessary for the disclosure. Now, covered entities are required to make that determination themselves. The HITECH Act requires HHS to provide additional guidance on the minimum necessary standard to further define what constitutes “minimum necessary” and how covered entities may implement this requirement.

State Attorney General Enforcement
Now through the HITECH Act, state attorney generals have authority to bring suit against any individual for

Throughout the HITECH Act, it has been clear the nation is well on the path to adopting a national framework of electronic medical records (EMRs).
HIPAA Privacy and Security Rule violations. HHS also has the option to intervene in the suit. This should certainly spur enforcement activity in this area.

**Penalty Enhancement**

The HITECH Act has developed a four-tiered penalty system for HIPAA Privacy and Security violations:

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<tr>
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<th>Minimum Penalty</th>
<th>Maximum Penalty</th>
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<tr>
<td>Person did not know of violation and by exercising reasonable diligence would not have known of violation.</td>
<td>$100 for each violation</td>
<td>Not to exceed $50,000 per calendar year</td>
</tr>
<tr>
<td>Violation due to reasonable cause (not willful neglect)</td>
<td>$1000 for each violation</td>
<td>Not to exceed $100,000 per calendar year</td>
</tr>
<tr>
<td>Violation due to willful neglect</td>
<td>$10,000 for each violation</td>
<td>Not to exceed $250,000 per calendar year</td>
</tr>
<tr>
<td>Violation is due to willful neglect and is not corrected within 30 days of the first date the person liable for the penalty knew or should have known that the violation occurred.</td>
<td>$50,000 for each violation</td>
<td>Not to exceed $1,500,000 per calendar year</td>
</tr>
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**HHS Periodic Audits**

Lastly, HHS will now be responsible for performing periodic audits to ensure that covered entities and business associates are in compliance with the HIPAA regulations. Many of the HITECH Act provisions’ effective dates vary; however, the tiered enforcement penalties take effect immediately. Certainly, most covered entities need considerable time to plan for these changes. As regulations are finalized for many of these provisions, the precise requirements and expectations will become clearer. It is evident, though, that the role of compliance professionals who work in this area will be instrumental in meeting our new national electronic health information framework requirements.

You can download the operating plan for the HITECH Act provisions the Office of the National Coordinator for Health Information Technology released mid-May by going to www.hhs.gov/recovery/reports/plans/onc_hit.pdf.

David Behinfar, J.D., LL.M, CHC, CIPP, is HIPAA compliance manager for the University of Florida College of Medicine – Jacksonville (UFCOM-J), and is responsible for UFCOM-J campus and UFCOM-J satellite clinics’ privacy and security of patient information. He holds a Master of Law (LL.M) in health law, is certified in health care compliance (CHC), and has also earned a certification as a Certified Information Privacy Professional (CIPP). David has also been admitted to practice law in Florida, Illinois, Texas, and Arizona.
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**What’s in it for YOU?**

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<thead>
<tr>
<th>NUMBER OF REFERRALS</th>
<th>YOUR PRIZES FOR MEMBER REFERRALS</th>
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<tbody>
<tr>
<td>1</td>
<td>FREE Logo Product: credential frame, USB wristband, mug or key chain</td>
</tr>
<tr>
<td>2</td>
<td>NEXT membership dues waived ($120 value)</td>
</tr>
<tr>
<td>5</td>
<td>NEXT membership dues waived + FREE 2010 Code Books ($300 value)</td>
</tr>
<tr>
<td>10</td>
<td>NEXT membership dues waived + FREE 2010 Code Books + FREE 2010 Audio Subscription ($1,000 value)</td>
</tr>
</tbody>
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| 10+                 | PRIZES ACCUMULATE
EXAMPLE: 11 referrals = FREE membership dues waived + FREE 2010 Code Books + FREE 2010 Audio Subscription + any "Logo Product" in our Online Store |

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In Coding Edge’s April article, “PT and OT: Extend Coding Know-how to Full Capacity,” we discussed what constitutes reasonable and necessary physical therapy (PT) and occupational therapy (OT) services according to Medicare guidelines. We also explained how to determine whether a service is skilled; and we elaborated on untimed codes, timed codes, and individual treatment. In this second installment of a three-part series on PT and OT, we’ll explain the coding differences in group therapy and individual therapy.

**Group vs. Individual Therapy**

Let’s say the provider treats two patients during the same time period. Before choosing between group therapy code 97150 *Therapeutic procedures(s), group (2 or more individuals)* and individual therapy code 97530 *Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes* (examples include activities such as bending and/or pulling), there are guidelines to consider.

When providing direct one-on-one patient contact, the therapist should bill for individual therapy and count the total service minutes to determine how many units of service to bill each patient. These direct, one-on-one minutes may occur continuously (15 minutes straight), or in notable episodes (for example, 10 minutes now, five minutes later). Each direct one-on-one episode should be long enough to provide the appropriate skilled treatment in accordance with each patient’s care plan. The manner of practice should clearly distinguish the care from that provided simultaneously to two or more patients.

**One-on-one example:** In a 45-minute period, a therapist works with patients A, B, and C, providing therapeutic exercises to each patient with direct one-on-one contact in the following sequence: Patient A receives eight minutes, patient B receives eight minutes, and patient C receives eight minutes. After this initial 24-minute period, the therapist returns to work with patient A for 10 more minutes (18 minutes total), then patient B for five more minutes (13 minutes total), and finally patient C for six additional minutes (14 minutes total). During the times the patients are not receiving...
direct one-on-one contact with the therapist they are each exercising independently. The therapist appropriately bills each patient one 15-minute unit of therapeutic exercise (97110 Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility), corresponding to the time of the skilled intervention with each patient.

Group therapy consists of simultaneous treatment to two or more patients who may (or may not) be doing the same activities. If the therapist is dividing attention among the patients, providing only brief, intermittent personal contact, or giving the same instructions to two or more patients at the same time, it is appropriate to bill each patient one unit of untimed group therapy (97150).

**Group example:** In a 25-minute period, a therapist works with patients A and B, spending a minute or two at a time with each patient, providing occasional assistance and modifications to patient A’s exercise program, and offering verbal cues for patient B’s gait training and balance activities on the parallel bars. The therapist does not track continuous or notable, identifiable episodes of direct one-on-one contact with either patient. In this case, the therapist would correctly bill each patient one unit of group therapy (97150).

**Refer to Medicare Policy for Guidelines**

The document guidelines in the Centers for Medicare & Medicaid Services (CMS) pub. 100-02, Medicare Benefit Policy Manual, chapter 15, sections 220 and 230 (“Group Therapy vs. Individual Therapy”), identify the minimal expectations of documentation by providers, suppliers, or beneficiaries submitting claims for payment of therapy services to the Medicare program. Medical review decisions are based on the information submitted in the medical record, so the medical record should be accurate and complete to ensure a fair payment decision.

Medical record information submitted should:

- paint a picture of the patient’s impairments and functional limitations requiring skilled intervention;
- describe the prior functional level to assist in establishing the patient’s potential and prognosis;
- describe the skilled nature of the therapy treatment provided;
- justify that the type, frequency, and duration of therapy is medically necessary for the individual patient’s condition;
- clearly document both Timed Code Treatment Minutes and Total Treatment Time to justify the units billed; and
- identify each specific skilled intervention/modality provided to justify coding.

For example, a physical therapist may document services provided by stating, “Patient was provided with ultrasound at 1 mhz, 1.8 w/cm2, 80 percent duty (10 min.) to area of R piriformis followed by light sustained stretch to piriformis (16 min.), concluding with patient education to SROM as part of HEP (11 min.). Patient was educated with visual, verbal, and written instruction. She demonstrated full competency and was without questions.”

The above interventions also may be documented on an attached flow sheet that shows treatment provided and the duration of each. In the therapist’s note, he or she would document, “See attached treatment log.”

Non-covered indications for maintenance programs include the following:

- Non-individualized services
- Services considered routine or non-skilled (eg, supportive nursing services)
- Maintenance programs for patients without a complex condition that requires development of such a program by a skilled therapist
- Exercises or activities that could have been transitioned to an independent or caregiver assisted program (eg, consistently repetitive exercises/activities)
- Non-cooperation by patient or caregiver(s)
- Continuation of treatment solely for the purpose of staff training and education or development of a formal maintenance program after rehabilitative therapy completion.

In an upcoming issue of **Coding Edge**, we’ll complete this three-part series with a discussion on documentation guidelines and what constitutes as unauthorized personnel providing outpatient therapy services.
In this three-part series on the driving components of level selection for the majority of evaluation and management (E/M) services, we discuss the history, examination, and medical decision-making components. In May’s issue of Coding Edge, we featured part 1, which provided an in-depth explanation of the history component. This month, part 2, we’ll focus on the exam component.

Exam Levels
An E/M service’s exam component is, as the name implies, the patient’s examination by the physician. CPT® identifies four “levels” of exam, depending on the extent of the physician work:

- Problem focused
- Expanded problem-focused
- Detailed
- Comprehensive

The 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, jointly developed by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA), define differently the specific elements that determine the exam level. The downfall of the 1995 guidelines is specific acknowledgment of the normal work and documentation of many specialists is not included. The downfall of the 1997 guidelines is too many specific documentation elements are required.

1995 and 1997 Documentation Guidelines
Currently, Medicare allows physicians and providers to use the set of guidelines they prefer most. CMS audits according to whichever set of guidelines are most beneficial to the physician or provider in a particular case.

Resource tip: You can access both 1995 and 1997 guidelines on the CMS Web site at www.cms.hhs.gov/MLNEdwebGuide/25_EMDOC.asp. Remember, you may not “mix and match” the 1995 and 1997 guidelines. If you select the 1997 guidelines for an E/M service’s exam component you should use the same guidelines to determine the level of history and in medical decision making. Consider your specialty’s nature, and the typical documentation the physician generates, to determine which guidelines set to use. Both 1995 and 1997 guidelines recognize the same body areas, including:

- Head, including the face
- Neck
- Chest, including the breast and axillae
- Abdomen
- Genitalia, groin, and buttocks
- Back, including spine
- Each extremity

Both guidelines recognize the same organ systems, including:

- Constitutional (for example, the patient’s
- General appearance and vital signs)
- Eyes
- Ears nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
• Skin
• Neurologic
• Psychiatric
• Hematologic, lymphatic, and immunologic

Both 1995 and 1997 guidelines require the provider to elaborate on abnormal findings and describe unexpected findings. Both guidelines also allow a brief note of “negative” or “normal” to document normal findings or unaffected areas or systems.

As noted, however, the 1995 and 1997 guidelines define the four levels of exam (problem-focused, expanded problem-focused, detailed, and comprehensive) differently. The 1995 guidelines define the levels of exam as follows:

**Problem Focused**—a limited examination of the affected body area or organ system (that is, a limited exam on only one affected body area or organ system)

**Expanded Problem Focused**—a limited examination of the affected body area or organ system and other symptomatic or related organ system(s) (that is, a limited exam of at least two body areas or organ systems)

**Detailed**—an extended examination of the affected body area(s) and other symptomatic or related organ system(s) (that is, an extended examination of at least two body areas or organ systems)

**Comprehensive**—a general multi-system examination or complete single-organ system examination (The medical record for a general multi-system examination should include findings about eight or more of the 12 organ systems)

The 1997 guidelines eliminate this subjectivity by exactly specifying—using bulleted items—the exam requirement for a particular body area or organ system. These requirements provide objective, exact criteria from which to measure physician documentation against. Although too lengthy to list here, detailed list of bulleted exam requirements may be found on pages 13-42 of the documentation guidelines, as available at www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf.

When using 1997 guidelines, the physician may select from the general multi-system exam or any of the single organ system exams. The coder must review each documented element to determine which single-organ system exam is the most appropriate E/M service level selection. For instance, a problem-focused, general multi-system examination requires the documentation of at least one bullet. For an expanded problem-focused exam, at least six bullets must be documented. For a detailed examination, there should be documentation to support two bullets in at least six organ systems or body areas, or a total of 12 bullets in two or more organ systems or body areas.

For example, a patient presents with a complaint of wheezing, cough, and fever. The physician performs the following exam:


According to 1995 guidelines, the documentation supports a detailed exam because the physician performs an extended exam of two to seven body areas/systems.

**1995’s Gray Areas Can Confuse Level Determination**

The 1995 guidelines, although generally clear, contain two gray areas that may complicate your ability to determine the exam level:

- An expanded problem-focused exam and a detailed exam both require examination of at least two body areas and/or organ systems; the expanded problem-focus level requires that these exams are “limited,” whereas the detailed level requires these exams are “extended.” The terms limited and extended are not defined specifically.
- The definition of a comprehensive single system exam is defined only as “complete.” The term complete is also not defined specifically.

**1997 Draws a Line Between Black and White**

The 1997 guidelines eliminate this subjectivity by exactly specifying—using bulleted items—the exam requirement for a particular body area or organ system. These requirements provide objective, exact criteria from which to measure physician documentation against. Although too lengthy to list here, detailed list of bulleted exam requirements may be found on pages 13-42 of the documentation guidelines, as available at www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf.

According to the musculoskeletal exam template in the 1997 guidelines, the physician performed an expanded problem-focused exam (at least six bulleted items from the musculoskeletal examination documented).
Physicians should focus on the medical necessity of an exam, and should never document “just one more bullet” to achieve a higher service level.

“The type (general multi-system or single organ system) and content of examination are selected by the examining physician and are based upon clinical judgment, the patient’s history, and the nature of the presenting problem(s),” according to the 1997 guidelines.

For instance, it might be considered necessary to perform a comprehensive exam when a new patient presents, but medically unnecessary to repeat a complete review on every follow-up.

More to Come

If you have trouble differentiating between the review of systems (ROS) elements and the exam elements, you are not alone. To help you make a determination using just one question, we’ve included the sidebar “Distinguish ROS from Exam Element” in this issue.

Coming up in this three part series is the medical decision-making component. When this article trilogy is complete, you will have the basic information needed to choose E/M service levels with confidence, and also to audit E/M claims for accuracy and consistency.
When reading a chart note, it can be difficult to distinguish between elements belonging to the review of systems (ROS) and those elements that are relevant to the exam. The ROS and the exam elements are not interchangeable, and for most payers you may never count a single element toward both the ROS and the exam. Such double dipping will quickly compromise your coding accuracy for payers that prohibit the practice.

The ROS is a series of written or verbal “questions and answers” relevant to signs or symptoms the patient is experiencing at the time of service. Often, the ROS is gathered by having the patient complete a history or intake form given to the patient at the front desk check-in. The form is a list of questions that generally asks the patient to check off and/or briefly explain signs and symptoms the patient currently has or has had in the past. For instance:

Have you now or have you ever had any of the conditions listed below? If yes please describe.

Respiratory:
- Severe shortness of breath or wheezing
- Had a cough for more than one month
- Chest pain when you cough hard or take a deep breath
- Cough up blood
- Difficulty breathing
- Shortness of breath when exercising

The ROS may also occur verbally with the provider or other staff. For instance, an assistant may ask the patient, “Do you have any problems breathing? Do you have shortness of breath when exercising, walking, or climbing the stairs?”

The patient’s response might be documented in a note by the provider as briefly as:

Patient states his chest hurts when he coughs but not when he takes a deep breath. No SOB. No complaints of pain in joints. No problems sleeping.

If the provider uses a subjective, objective, assessment, and plan (SOAP) documentation format, the ROS elements should appear under the heading “Subjective.”

The office may instead use a formatted progress note sheet with check boxes, such as:

- Respiratory
- SOB
- Cough
- Wheeze

In contrast to ROS elements, the exam elements are actual visual or hands-on findings. For example, the provider uses an otoscope to inspect the middle ear visually, an ophthalmoscope to check the eyes and their reaction to light, and a stethoscope to listen to lung, heart, and bowel sounds. The provider will document what she sees with statements such as:

- Pupils are equal and reactive to light
- Chest: bilateral rales and rhonchi
- Bowels sounds are normal
- Extremities: no cyanosis or edema

In the SOAP documentation format, the exam elements should appear under the heading “Objective.”

Using a templated progress note, the documentation format of the exam might look something like this:

**Physical Exam:**

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Here’s the bottom line: When reading the notes, ask yourself if the notation is something the patient answered, or if it is something the provider observed. An answered question belongs to the ROS; whereas something that is seen, heard, or measured by a provider is an exam element.

Janalynne Thorley-Kilgo, CPC, CPC-I, CCS, is a coding education specialist at AAPC.
Coding from Home

Before taking the leap, there are a few things you should consider.

By Michelle A. Dick, senior editor

When it comes to coding from home, you’ll find there is an up side and a down side, as there is with any situation. To find out if working at home fits your career needs, we’ll give you the good news first, the bad news second, and provide solutions to make the bad news not so bad.

By working at home, you can:

Reduce stress levels – Do this by working in an environment that reflects your style and supports your working frame of mind. You aren’t part of the office chaos so you can remove yourself from stressful distractions and concentrate on the task at hand.

Avoid the morning commute – This means no wear and tear on the car, no heavy traffic that may make you late for the office, and no driving in bad or hazardous weather.

Deduct home office expenses – If you work in a home office, you may be able to deduct separate office phone lines, purchases of office equipment, software and other supplies, and a portion of your domicile expenses—such as the mortgage, utilities, and upkeep. Check with your tax preparer for details.

Skip showers and wear sweatpants – If you want to get up in the morning and start working immediately, you can! Your coworkers will never know you are wearing slippers.

Control your work day – You can establish a work schedule supportive of your best production time or needs, even if it doesn’t coincide with the office staffs’ hours.

Save money – You don’t have to pay for gas and there is no need to purchase office attire. We do, however, recommend you look great for the interview or job training, if it’s in person.

No office gossip – You can fully concentrate on work when you aren’t interrupted with the drama of your co-workers’ personal lives.

Streamline office and home tasks – During the time you’d normally commute to work, you can make your bed, throw in a load of laundry, and vacuum the floor. During the time you’d normally commute home, you can pick up a few groceries and make dinner.

However, working at home can be a bad career move if you aren’t disciplined enough to handle the responsibility. The following can prevent you from being a steadfast home worker:

Becoming distracted – The television, a family member, or a particularly nice day can put you in procrastination mode.

Accessing tech support – When tech support is half-way across the country, you have to rely on yourself to identify the problem, seek help, and communicate your needs to the office help desk. Sometimes it can take months before your home office is totally functioning properly.

Communicating to coders – It is easier to have a coding discussion with the person sitting next to you, than to email the billing case to someone you’ve never met who sends quoted guidelines back to you.
Keeping current with office coding standards – You may miss out on important informal coding discussions in the office.

Balancing work and home responsibilities – If you focus on one area too much the other will suffer.

Overcome Home Distractions
Cheryl Lobaugh, RN, CPC, CCS-P, an at-home independent contractor for more than 10 years, discovered the secret to working at home success. She said, “Along the way, I have discovered there are two principles that should be applied for an individual to work successfully from home. The first is having discipline and the second is maintaining balance.”

Discipline is the key to overcoming home distractions. Identify what your best working hours are, establish a schedule, and commit to those hours. Motivate yourself to work even when there are other things you’d rather be doing. Having a separate office area may help you stay on task. Make sure your family members know that when you are working, they should not distract you. Others may see your being at home as a free pass for them to pop in for a visit or ask you to run errands. Be clear on your working hours and discourage visitors. If Aunt Mae, whom you haven’t seen in five years, happens to visit you when you’re on the clock, log out of work and make up the time at your earliest opportunity. Be sure your employer knows when there is a disruption in set work hours.

Overcome Tech Support Challenges
Computer and technical support can be problematic for at-home workers. Home workers don’t necessarily have more computer issues than office workers. They do, however, have communication issues, as office tech support doesn’t usually swing by to make long distance house calls. At-home workers may see the office environment’s easily accessible help desk staff as a luxury. It is much easier to show someone the problem you are having with your computer than to communicate it via phone or email. Setting up internet connections, accessing remote office systems, purchasing a printer, installing software, and troubleshooting fax machine issues are just a few technical issues that need to be addressed for a functional home office. Before you choose to work remotely, make sure you have the equipment and software you need. For example, have your fax machine hooked up to a separate phone line before your first day of work. That way, you won’t waste time scrambling when you’re on the clock.

A quick internet connection is essential for the home office. Working through a remote desktop is slow at times, so if your internet connection is also slow, you have a double whammy to hinder your production time. When the internet connection is down or other technical problems arise, you’ll have to make up the missed work to ensure a steady paycheck.

Look for Opportunities to Stay Current
Because you aren’t in the office on a daily basis, you may find you miss out on important coding information your office colleagues forgot to pass onto you. To keep in the loop, designate a time to address any questions or concerns that billing staff has or to discuss changes in policies. If you are within driving distance from the office, attend meetings. For long distance workers, schedule regular teleconferences and communicate frequently with coworkers. Keep current with coding standards and seek educational opportunities as necessary. Ensure that your are on the same page as fellow office and remote workers when it comes to choosing codes.

Perform the Delicate Dance of Balance
There is a delicate balance between managing work commitments and fulfilling home responsibilities, which many home workers have not mastered. You can, however, maintain a happy balance using time management, honesty, and professional coding excellence.

Stay focused on work and don’t spend too much time checking email. Leave personal emails for hours you aren’t working. Don’t attend to household chores and other personal commitments when you should be working. Save chores for before you start working or after you are finished.

Schedule doctor appointments for days and times you won’t be working and schedule client meetings for times you will be working. It will help you maintain a black and white work schedule.

If you continually meet the expectations set by clients and your company, while keeping a happy household, you’ll know that you can walk the working-at-home tightrope.

There is a delicate balance between managing work commitments and fulfilling home responsibilities, which many home workers have not mastered.
Banish Unwarranted Doubt

Working at home sometimes creates dissension among coworkers. Office-based colleagues may assume you aren’t working as diligently as they are. Your workload may increase to counteract this assumption. Shannon Kay, CPC, experienced this when she switched from working in the office to working at home. Kay said, “My workload increased with extra duties steadily over the first few months. So besides coding, billing, and collecting, I am also confirming appointments, checking patient’s benefits, and helping with scheduling.” The good news is the time she has put into earning her doctor’s trust has been well worth her effort.

To eliminate your coworkers’ unwarranted doubts, prove your worth by working harder and documenting production by using time clocks, implementing production trackers, and filling out status reports. Once your employer and coworkers see you meet and exceed production requirements, you can take a deep breathe and reap the benefits of coding in your slippers.

Find Home Coding Work

If you are considering a work-at-home coding position, and you are currently employed with a practice, a facility, or a billing company, find out if working from home is an option for you.

If you are currently unemployed or want to see what coding-at-home careers are out there, start with a job search on the Internet. You can post your resume and search for jobs at:

AAPC Job Center
(www.aapc.com/education/medical-coding-career.aspx)

HealthCareers Network (www.healthecareers.com)

Maxim Health Information Services
(www.maximhealthinformationservices.com)

Medhunters (www.medhunters.com)

Monster Job Search (www.Monster.com)

Independent or Isolated?

Being isolated from coworkers can help you master working independently and fine-tune your problem-solving skills. You rely on yourself for solutions until all options are utilized. The downside is that you can miss out on important office information. At-home coders tell us what they enjoy and dislike about being isolated from other coders while working remotely.

Isolation Causes Coding Problems

“It is difficult communicating with the coders … only through email. When coding questions arise, the answer does not come from a formal discussion with a group of coders, instead it comes via email responses quoting coding guidelines, etc.”

“It is easier to like everyone you work with when you do not know them personally, though it can also make for a lonely day.”

Linette Anderson, CPC, Peak Health Solutions
Works in California, lives in Rhode Island

“Probably the biggest con for me is I can be left out of new office policies/rules and discussions because I’m not in the immediate area. I do attend staff meetings, but generally, it’s the informal discussions that take place and I should be part of that I’ve been left out of.”

Jennifer Grace Wujcik, CPC, John C. Lincoln Health Network,
Phoenix, Ariz.

Independence as a Plus

“I am 65 years old, the oldest employee in the department … No one else is trained to do my work—so I really do work very independently. Although I don’t miss the day-to-day interaction with my co-workers. I do enjoy seeing them when we all get together.”

Pamela W. Christensen, CPC, Centegra Health System. Lives in Wisconsin, works in Illinois
2009 AAPC Regional Conferences
LEARN | NETWORK | PLAY

Hawaii
SEPTEMBER 10-12 | 11.5 CEUs | $249
- 15 educational sessions with topics including ER, gastroenterology, E/M, facility coding, anatomy, Medicare, cardiology, emergency department and more.
- JW Marriott Ihilani Resort and Spa
- AAPC Discount Hotel Rate: $215

Virginia
OCTOBER 8-10 | 12.5 CEUs | $299
- 22 educational sessions with topics including ICD-9 guidelines, CMS & Medicare, general surgery, audits, radiology, sleep apnea, anesthesia and more
- Sheraton Norfolk Waterside Hotel
- AAPC Discount Hotel Rate: $123

Register Today!
View locations at www.aapc.com/2009RC
Set Your Sights on ICD-10-CM

Our checklist will pave the way for a smooth transition.

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

Only 53 months and counting before we go live with ICD-10-CM. There are so many tasks to accomplish before Oct. 1, 2013 that you may not know where to start your journey toward implementation.

Before concentrating on specific ICD-10-CM guidelines and codes, your organization needs a plan or a “road map.” Your road map toward ICD-10-CM implementation should include communication and significant collaboration in information technology, finance, clinical areas, payers, and outcomes. Knowing where you are going will get you to where you want to go.

AAPC Has a Plan for You

The American Academy of Professional Coders’ (AAPC) Web site is a great place to find the information needed to contrive an implementation plan. Take time this week to begin reviewing the ICD-10-CM training plan on the AAPC Web site (www.aapc.com/ICD-10/training.aspx), if you have not already done so.

Once you have reviewed the plan:

Log into your member area.

1. In the ICD-10 Preparation area at the right side of the Member Area Web page, select the type of organization you work for from the pull-down menu. There is guidance for health plans/payers, very small practices (1-3 physicians), small practices (4-10 providers), medium practices (11-49 providers), and large practices (50-plus providers). This is called the ICD-10 Tracker.

2. Click the Save button once you have selected an implementation plan according to your organizations needs. The Web page “My Personal ICD-10 Implementation” displays implementation plan guidance. If you chose a small practice, there are 14 steps you will need to take for a successful ICD-10 transition. If you are a medium or large practice, you may have a couple more steps to take.

3. Click on a step under “My Personal ICD-10 Implementation,” such as “Step 1: Organize the Implementation Effort.” You are taken to a new Web page, where each step hosts a detailed, numbered checklist to further explain how to achieve implementation success.

Take it One Step at a Time

Every time you complete an implementation step, check off the step and click the Save button on your online ICD-10-CM implementation plan. The yellow lines next to the track steps will turn green as the actions are checked off. This indicates that you have completed the step in the recommended time frame. Steps have end dates. If one or two of the step end dates pass without all of the actions being checked off, the progress light turns to amber, warning that you have fallen behind. If more than two of the step end dates pass without all of the actions begin checked off, the progress light will turn red—and we all know what that means.

Begin the implementation process step by step. Focusing on all elements that need addressing at one time will lead to frustration. Systematically focusing on one step at a time and creating a timeline to phase in ICD-10-CM will streamline the process and eliminate getting overwhelmed with unnecessary work. The amount of work necessary to implement ICD-10-CM and the resources required depends on the practice size. A large practice may need to recruit key persons from many different departments to assist with the transition; whereas a small practice might incorporate only one or two person(s) to assist in the transition.

Step 1: Organize the Implementation Effort

The first step to a successful transition using the online implementation plan is to “Organize the Implementation Effort.” Every practice needs to assign a project team or key person to organize and to manage
All staff members should be involved in some way in the ICD-10-CM transition. Understand that the transition effort will not succeed without input and cooperation from all practice members.

the implementation effort. If you have several people in your practice involved in the ICD-10 transition, form a team and assign projects with completion dates for each step along the way. The project team or key person is responsible for the initial planning process. Each practice should include at least one physician in the implementation process. Physician “buy in” is critical for ICD-10-CM.

Physicians need to be involved so they understand the importance of preparation as ICD-10-CM implementation occurs. Get coding staff involved. Provide periodic progress reports to the implementation project team and/or physicians, so everyone is made aware of the progress, problems, and barriers to your organization’s implementation.

A small practice might benefit from hiring a consultant to either participate in the project or coordinate the overall transition plan. In a large practice, leadership staff should be involved in the transition plan development.

Once the project team is set and leadership roles are identified, it is time to get to work. Begin by preparing a project summary, including an overview description of regulations, changes to code sets, and anticipated internal and external work processes. For larger practices this could mean reading the ICD-10 final rule; for smaller practices this could mean reading materials prepared by a professional society. The project summary and an outline of project steps will serve as the roadmap for completing implementation. This summary should include the scope of work anticipated to accomplish successful implementation and it should be shared with the physicians in your medical practice.

Within the scope of “Organizing the Implementation Effort,” a preliminary impact analysis should be performed. This analysis will identify all areas that will be impacted within the practice such as the clinical areas, IT systems, documentation, etc. When you have developed the analysis, draft a simple written report to share with your physicians or project team. This information must be shared with the providers so they can understand the impact on their practice. In this planning stage, identify who in the medical practice or organization has decision-making authority.

One of the main concerns with ICD-10 implementation is the delay of claim submission resulting from the ICD-10-CM learning process. People’s short term productivity decreases when they are in training or learning a new skill. These productivity slowdowns can include charge capture and reimbursement, and can affect a practice’s financial health. The project team should anticipate a decrease in productivity by measuring and analyzing the transition prior to beginning the training process.

**Take a Proactive Role**

Every practice should begin this process immediately. Preparing for this change will take a great deal of time and effort. The project team is instrumental in the success of implementing ICD-10-CM and should be proactive in its preparation. All staff members should be involved in some way in the ICD-10-CM transition. Understand that the transition effort will not succeed without input and cooperation from all practice members. Personnel involved in the transition process should begin planning early to avert potential problems in the process.

In June and July of 2009, the AAPC will conduct audio conferences and Webinars on implementation guidance. A distance learning module will be available in September 2009 to help with implementation guidance. Watch the AAPC Web site and news and updates for these important dates, and review the online ICD-10 Implementation Plan. Take advantage of the tools we have created to assist you in this important transition.

Next time … Developing the ICD-10-CM Communication Plan.
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38 AAPC Coding Edge
Fibroids are benign growths in the womb’s muscle. They are common, especially in older women. Many women with fibroids are fertile and have no problems delivering a pregnancy, but if the fibroid significantly distorts the cavity of the womb, it may interfere with embryo implantation. Fibroids may also displace the fallopian tubes and ovaries.

Because fibroids are almost always benign, it is rare (less than one in 1,000 cases) for a cancerous fibroid (leiomyosarcoma) to occur. No one knows for sure what causes fibroids. We do know, however, they are under hormonal (both estrogen and progesterone) control. Fibroids grow rapidly during pregnancy, when hormone levels are high, and shrink when anti-hormone medication is used. They also stop growing and may shrink when a woman reaches menopause.

**Location Determines Diagnosis Code**

ICD-9-CM coding depends on the fibroid’s exact location. Most fibroids grow within the uterus wall. These are known as intramural fibroids and are reported using 218.1 *Intramural leiomyoma of uterus* (*interstitial leiomyoma of uterus*). Whereas submucosal fibroids (218.0 *Submucous leiomyoma of uterus*) grow into the uterine cavity; and subserosal fibroids (218.2 *Subserous leiomyoma of uterus*) grow outside of the uterus.

Other fibroids grow on stalks from the uterus’ surface or in the uterus’ cavity (they might look like mushrooms). These are called pedunculated fibroids and are reported with 218.9 *Leiomyoma of uterus, unspecified*. You should also report 218.9 if the provider does not specify the location of the uterine fibroid.

**Diagnostic Procedure Codes**

The physician may perform imaging tests to confirm fibroids. These tests might include:

- **Ultrasound**—The ultrasound probe can be placed on the abdomen or inside the vagina. For pelvic exam, report 76856 *Ultrasound, pelvic (nonobstetric) real time image documentation; complete*. For transvaginal examination, use 76830 *Ultrasound, transvaginal*.

- **Magnetic resonance imaging (MRI)**—Report MRI using 74181-74183, as appropriate.

- **X-rays**—Report with code 74020 *Radiologic examination, abdomen; complete, including decubitus and/or erect views*.

- **Computed tomography (CT) scan**—For procedures without contrast, select from 74150 *Computed tomography, abdomen; without contrast material* or 72192 *Computed tomography, pelvis; without contrast material*, depending on location. For procedures with contrast, consider either 74160 *Computed tomography, abdomen; with contrast material(s)* or 72193 *Computed tomography, pelvis; with contrast material(s)*.

- **Hysterosalpingogram (HSG) or sonohysterogram (SIS)**—An HSG involves injecting dye into the uterus and taking X-ray pictures. A sonohysterogram involves injecting water into the uterus and taking ultrasound pictures. You should report either of these procedures with 58340 *Catheterization and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography*.

For a HSG, the corresponding radiological supervision and interpretation code is 74740 *Hysterosalpingography, radiological supervision and interpretation*. For a SIS, the appropriate code is 76831 *Saline infusion sonohysterography (SIS), including color flow Doppler, when performed*.
The physician may also perform hysteroscopy to confirm fibroids. The doctor passes a long, thin scope with a light through the vagina and cervix into the uterus; no incision is needed. The doctor can look inside the uterus for fibroids and other problems, such as polyps. Report 58555 Hysteroscopy, diagnostic (separate procedure) for a simple diagnostic hysteroscopy for this procedure. Code 58555 is designated as a “separate procedure” according to CPT® guidelines and would not be billable if a more extensive procedure is performed hysteroscopically. If a biopsy is taken, report instead 58558 Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C.

**Surgical Treatment Options**

A physician may recommend surgery as the treatment of choice for fibroids with moderate to severe symptoms. Surgical options include the following:

**Myomectomy**—Fibroids are removed without taking healthy uterus tissue. It is best for women who wish to have children after fibroid treatment, or who simply wish to keep their uterus intact. Myomectomy can be accomplished as an open or laparoscopic procedure.

To report an open procedure, you must know the approach and total number and/or weight of removed fibroids:

- **58140** Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; abdominal approach
- **58145** Myomectomy, excision of fibroid tumor(s) of uterus, 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myomas; vaginal approach
- **58146** Myomectomy, excision of fibroid tumor(s) of uterus, 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g, abdominal approach

Note: There is no vaginal approach procedure code for fibroids larger than 250 grams because they are generally too large to be removed vaginally.

For laparoscopic myomectomy, turn to 58545 Laparoscopy, surgical, myomectomy, excision; 1 to 4 intramural myoma(s) with total weight of 250 g or less and/or removal of surface myoma(s) or 58546 Laparoscopy, surgical, myomectomy, excision; 5 or more intramural myomas and/or intramural myomas with total weight greater than 250 g.

Regardless of approach, when five or more fibroids are removed, or when the combined weight of all fibroids removed exceeds 250 grams, the CPT® codes representing these services will reimburse at a higher rate. Documentation should specify the number and weight of the fibroids, to ensure payment reflects how much work was done.

**Hysterectomy**—Uterus removal is the only certain way to cure uterine fibroids. For a hysterectomy performed via the abdomen, look to code range 58150-58240. For a hysterectomy by vaginal approach, select a code from 58260-58294. Final code selection will depend on uterus size/weight, the extent of uterus removed, and any additional procedures performed.

In some cases, hysterectomy may be performed laparoscopically. Code choice will depend on the extent of the removal, as well as the uterus’ size, and whether the tubes and/or ovary(s) are removed at the same time.

**Laparoscopic supracervical hysterectomy:**
- **58541** Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
- **58542** Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
- **58543** Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
- **58544** Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

**Laparoscopic vaginal hysterectomy:**
- **58550** Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
- **58552** Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
- **58553** Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
- **58554** Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

**Laparoscopic total hysterectomy:**
- **58570** Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
- **58571** Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
Regardless of approach, when five or more fibroids are removed, or when the combined weight of all fibroids removed exceeds 250 grams, the CPT® codes representing these services will reimburse at a higher rate.

58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Endometrial ablation—In this procedure, the lining of the uterus is removed or destroyed to control bleeding. It may be performed with laser, wire loops, boiling water, electric current, microwaves, freezing (cryoablation), or other methods. This procedure can be done on an outpatient basis. Approximately half of the women who have this procedure stop menstruating, and three in 10 women have much lighter bleeding. A woman cannot have children after this surgery, however.

You must choose between hysteroscopic (58563 Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)) and non-hysteroscopic (58353 Endometrial ablation, thermal, without hysteroscopic guidance) methods when selecting an endometrial ablation code. For cryoablation with ultrasonic guidance, report instead 58356 Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed.

Myolysis—This procedure uses a needle inserted into the fibroids, usually guided by laparoscopy. When activated, various energy sources (such as, neodymium-doped yttrium aluminium garnet (Nd: YAG) laser, bipolar electrocautery, cryotherapy, radiofrequency ablation) induce fibroid devascularization and ultimately target tissue ablation. When the Ob/Gyn uses radiofrequency, the procedure is known as Hysterectomy Alternative (HALT).

Report myolysis using Category III code 0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue or 0072T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater than or equal to 200 cc of tissue.

Remember: You must use a Category III code if it is available. Do not report an unlisted-procedure code unless a payer instructs you to do so in writing.

Uterine fibroid embolization (UFE) or uterine artery embolization (UAE)—During this procedure, a thin tube is threaded into the blood vessels supplying blood to the fibroid. Next, tiny plastic or gel particles are injected into the blood vessels. This blocks the blood supply to the fibroid, causing it to shrink. UFE can be an outpatient or inpatient procedure.

Report UFE using 37210 Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization and all radiological supervision and interpretation, intra procedural roadmapping and imaging guidance necessary to complete the procedure.

Note that this code “includes all catheterization and intraprocedural imaging required for a UFE procedure to confirm the presence of previously known fibroids and to roadmap vascular anatomy to enable appropriate therapy.” There is not a separate HCPCS Level II code to report for microspheres, but some non-Medicare payers will allow separate payment for supplies in the office setting with 99070 Supplies and materials (except spectacles), provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided).

Vinoth Ramdass, BPT, CPC, holds a bachelor of physiotherapy from M.G.R. Medical University, India, and a diploma in acupuncture. He currently works as an executive coder for Perot Systems Business Process Solutions.
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This case involves a return to the operating room for the third time to correct a right flank bulge, using existing mesh and Mitek quick anchors to hold the mesh in place. Accessing the site is made more difficult by the substantially altered surgical field. Could you code the complete operative report from May’s issue? If not, here’s the solution.

Diagnosis coding in this case is fairly straightforward. The “flank bulge” is located at the site of a previous incision, making it an incisional hernia. Repeated attempts at repair also mark it as recurrent. Because documentation does not substantiate either obstruction or infection, ICD-9-CM code selection is 553.21 Incisional hernia of abdominal cavity without mention of obstruction or gangrene. A note following 553.21 in the ICD-9-CM manual specifies both “postoperative” and “recurrent” for this code.

Although the hernia may be a complication of surgery, a code from category 996 Complications of surgical and medical care, not elsewhere classified would not be appropriate because an exclusion note says not to use these codes for specified complications classified elsewhere. Incisional hernias are classified in the digestive chapter of the ICD.

Because the patient has had a right nephrectomy, you may also report V45.73 Acquired absence of kidney.

The same criteria that determine the diagnosis—that is, the type of hernia (incisional), the lack of obstruction, and initial or recurrent—also determine the appropriate CPT® repair code. In this case, the best selection is 49565 Repair recurrent incisional or ventral hernia; reducible. Unlike other hernia repair codes (such as many inguinal hernia repairs), 49565 does not take into account patient age.

The note substantiates significant additional work for this repair, justifying the application of modifier 22 Increased procedural service to 49565. To help with compensation for the services rendered, the surgeon should create a brief, additional note explaining the difficult circumstances of the procedure, including the substantially altered surgical field, and requesting additional compensation above and beyond the usual amount for 49565. This information should be available for payer review.

The surgeon allows the existing mesh to remain, but places additional anchors to hold it in place. The anchors may count as “other prosthesis,” as described by +49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incision or ventral hernia). It’s debatable whether the use of modifier 22, appended to 49565, is sufficient to describe the procedure. Note that when reported, add-on code 49568 is applicable only with those hernia repair codes describing incisional or ventral hernia. For all other hernia repairs, mesh or prosthesis insertion is an included repair component.
A right-handed, 56-year-old man was scheduled for coronary artery bypass graft (CABG) using the left internal mammary artery, and radial artery grafting from the left arm. Preoperative Allen’s testing was normal. During the radial artery harvesting, the artery was clamped both proximally and distally with adequate palmar circulation demonstrated with a pencil Doppler. After ligating the distal radial artery, there was good back bleeding seen from the distal stump. The intraoperative course was uneventful.

On postoperative day one, the patient complained of left forearm pain. His examination demonstrated some pitting edema of the left hand and forearm, good capillary refill, and intact palmar Doppler signals. Because of edema, the patient was given several doses of diuretics.

The edema decreased, but the patient continued to complain of forearm pain, and on postoperative day six, the patient developed wrist drop and he was unable to extend his fingers. An orthopedic surgeon was consulted, and a diagnosis of radial neurapraxia was suspected due to retraction or possibly a hematoma, or both. A splint was ordered and plastic surgery consultation was obtained for nerve exploration and possible hematoma decompression. At evaluation, the patient found that he lacked sensation in the radial nerve distribution and suffered from loss of extensor function in his left wrist and hand.

The patient underwent operative exploration and was found to have forearm extensor and supinator muscle necrosis. There was no hematoma or signs of a hemorrhage found. At this point, the surgeon suspected a missed diagnosis of acute compartment syndrome. This occurs when the pressure within a contained fascial space exceeds capillary blood perfusion. If untreated, irreversible muscle damage with subsequent fibrosis and contracture occur. Compartment syndrome of the extremity is a recognized clinical condition associated with necrosis of the muscles and nerves within the involved compartment, which has significant morbidity.

The extensor and supinator muscles were debrided and the posterior interosseous branch of the radial nerve was identified in anticipation of an innervated muscle transfer. There was no iatrogenic injury to the brachial, ulnar, or radial recurrent arteries, and a 1-cm proximal radial artery stump was visualized. The patient subsequently underwent two operative debridements. An upper extremity angiogram was performed that demonstrated a patent ulnar artery and its branch, the posterior inter-osseous artery.

On postoperative day 22 after CABG, the patient underwent an innervated gracilis free muscle transfer and tendon transfers. The patient had metacarpal-phalangeal joint stiffness develop, and seven months after the muscle transfer, he underwent intraoperative joint manipulation. Nine months after the gracilis transfer, his sensation returned in the radial nerve distribution, he was able to extend his wrist, and he regained some ability to extend his metacarpal phalangeal joints.

On last follow-up, the patient still had stiffness of his metacarpal phalangeal joints and the transferred muscle was still gaining function.
The finger is composed of many tissue types. Injuries to the fingertip may involve the skin, nail bed, nails, blood vessels, nerves, bone, or any combination of these tissues.

Patients with fingertip injuries frequently seek treatment in the emergency department (ED). A procedure’s complexity may range from simple hematoma evacuation to debridement for open fracture care. Reporting procedures with accuracy requires the coder to understand complex finger anatomy, recognize the appropriate CPT® codes and descriptors, and be aware of applicable code bundles.

Look to Depth for Laceration Repair

Finger laceration is a very common ED presentation. Lacerations involving only the skin and sparing more specialized nail structures and deeper tissues are reported with laceration repair codes. Superficial repairs involving uncontaminated wounds, closed with a single layer, are reported with codes 12002-12007 and are based on the laceration length. For example, 12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet) 2.5 cm or less is appropriate for wounds less than 2.5 cm in length, and 12002 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet) 2.6 cm to 7.5 cm is appropriate for lacerations between 2.6 cm and 7.5 cm.

Closure with simple laceration repair is generally performed with non-absorbable suture material, such as nylon, Ethilon, or Prolene. Alternately, the physician may use tissue adhesive, which is also reported with the simple laceration repair CPT® codes for non-Medicare patients. Medicare, however, requires G0168 Wound closure utilizing tissue adhesive(s) only use for reporting single layer tissue adhesive repairs.

If the wound is heavily contaminated or requires a layered closure, move from the simple repair codes to intermediate codes 12041-12047. Final code selection depends on laceration or repair length. If tissue adhesive is used in addition to suture material, the repair is reported with the 12041-12047, as appropriate to wound length, for both Medicare and non-Medicare payers.

Note that when tendon repairs are performed, musculoskeletal section codes, such as 26418 Repair of extensor tendon, finger, primary or secondary; without free graft, each tendon, should be reported.
Apply Nail Bed, Avulsion Codes with Care

Some fingertip lacerations may involve the nail bed. Nail bed repair generally requires the use of absorbable sutures such as Vicryl, chromic, or gut utilized in a single layer repair (11760 Repair of nail bed). Occasionally the physician needs to remove the nail to allow for access to the nail bed for repair. The removal will be documented as an avulsion and should not be reported in addition to the nail bed repair. Avulsion performed without an associated procedure may be reported with 11730 Avulsion of nail plate, partial or complete, simple; single.

Coders need to be clear that the physician is documenting a procedure, not the wound description. Both the diagnosis (for example, 883.0 Open wound of finger, uncomplicated) and the procedure may be described as an “avulsion.” Procedures involving the nail bed may also have a physician noting the replacement of an avulsed nail over the wound as a splint for protection. This splint is not separately reportable.

Quick Tip: Code bundles, such as those described above and below, are common when reporting fingertip injury repairs. Coders should review current coverage policies when applying these codes.

Contusions and More

Call for Dedicated Coding

Crush injuries may result in a wide range of injuries from contusion to maceration and open fracture. Contusions involving the nail area may result in a subungual hematoma. Bleeding under the nail can result in increased pressure and pain. The physician may elect to drain this hematoma either through drilling or cautery. These procedures—which might also be documented as a “trephination”—would be reported with 11740 Evacuation of subungual hematoma. Macerated tissue may require debridement. The physician will perform extensive cleaning and explore the wound for additional injuries. Debridement may include subcutaneous tissue alone, or muscle and even bone. Severely damaged tissue may result in the need for bone debridement and finger shortening to allow for tissue to close the wound, as noted by bone rougnering and flap creation. A wound requiring this repair level would be reported with 11044 Debridement; skin, subcutaneous tissue, muscle, and bone or 11012 Debridement; skin, subcutaneous tissue, muscle fascia, muscle, and bone if associated with open fracture.

Fingertip crush injuries may also result in distal phalanx fracture. When applying ICD-9-CM codes, finger fractures are identified by location (proximal, middle, and distal phalanx) and may be reported as open or closed. For instance, code 816.02 Closed fracture of distal phalanx or phalanges of hand represents closed fracture of distal phalanx.

Fracture care procedures are differentiated by manipulation, location, and procedure type. These codes are also identified as open or closed procedures, and with or without anesthesia. Open procedures refer to surgical incision to repair the fracture. Coders should be aware that procedures identified as “open” and/or “with anesthesia” are generally reserved for the operating room and do not fit into the scope of this article.

Fractures involving fingertip injuries generally affect the distal or possibly the middle phalanx. Fracture treatments may range from stabilization to definitive care. Stabilization would include temporary splinting while the patient awaits definitive care. Splints are reported with 29130 Application of finger splint; static for finger splint and 29125 Application of short arm splint (forearm to hand); static for short arm splint.

A thumb spica splint is considered a short arm splint, and would be reported with 29125.

Fractures requiring manipulation represent definitive care. For example, reduction of a displaced fracture of the finger’s proximal phalanx would be reported with 26725 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; with manipulation. In this case, splinting is considered bundled in fracture care and should not be reported separately.

Include Digital Block in Overall Procedure

Many finger injuries require local anesthesia for pain control. Frequently, the ED physician may provide the anesthesia as a digital block. Digital blocks are considered local anesthesia and are included in the global surgical package. If the digital block is performed without a subsequent procedure, it may be reported separately with 64450 Injection, anesthetic agent; other peripheral nerve or branch.

Sarah Todt, RN, CPC, CEDC, is associate director of Quality Assurance and Compliance with emergency medicine coding and reimbursement specialist MRSI, Inc. Sarah has served on the National Advisory Board for AAPC and on the AAPC steering committee for the CEDC exam.
Professional Services in the Clinical Lab: Billable or Not?

By G. John Verhovshek, MA, CPC

A payer representative recently wrote to Coding Edge with a problem:

“A clinical pathologist is also the medical director of a hospital-based laboratory. He is paid a hospital salary for his services as the lab director. He has been billing lab codes with modifier 26 Professional component appended. Some commonly-billed codes are 80053 Comprehensive metabolic panel, 81001 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy, 85025 Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count, and 85610 Prothrombine time. We deny these services because we pay the hospital a global rate (based on RBRVS) for lab services. Additionally, documentation does not substantiate that the pathologist performed any professional service related to the lab code(s) billed. Is the pathologist’s coding appropriate?”

In this particular case, because the pathologist receives a salary from the hospital for his services, separate billing for the professional component of lab services is not appropriate: This would amount to double dipping.

The basic question of whether a pathologist may report professional services in a clinical laboratory, however, goes to the heart of an ongoing coding controversy.

CAP, AMA Back Professional Component Billing

The College of American Pathologists (CAP) and other physician advocacy groups defend separate billing for the professional component of clinical laboratory services. CAP’s Professional Relations Manual states:

“Professional component billing is one valid method of billing for the professional services of pathologists in the clinical laboratory. In many communities, the standard practice is for the pathologist to directly bill patients for the professional component of clinical laboratory services. When the pathologist bills a professional component to a non-Medicare patient, no payment is made by the hospital to the pathologist for this service. The hospital’s bill for the technical component covers hospital costs for laboratory equipment, supplies and non-physician personnel—it does not include the professional services of the pathologist.”

In other words, CAP reasons that non-Medicare payers do not take the pathologist’s services into account when making hospital payments for laboratory services, and the pathologist may seek separate professional component payment directly from the patient, or the patient’s insurer. For Medicare beneficiaries, the rules are different.

The American Medical Association (AMA) supports CAP’s position. Most recently, CPT® Assistant Vol. 15, Issue 8 (August 2005) noted, “Pathologists often report the professional component of clinical laboratory tests because they oversee the clinical laboratory and are responsible for the results.” The article insists modifier 26 is required for codes 80048-89356 “in those instances when the physician is only billing for the professional component of the laboratory tests (eg, medical direction, supervision or interpretation).”

The AMA further asserts, “A written report for an individual patient is not a requirement for having performed a professional component service.”

This last instruction runs contrary to that published by Ingenix and adopted by some payers. Ingenix Insights article, “Laboratory Services and Modifiers,” (www.shopingenix.com/content/eAlert/081004-article3.asp) states, “Laboratory and pathology services that have a professional component require that the physician interpret a test, slide, or sample and provide a written report of that interpretation. It is considered inherent to the service that if there is an interpretation, there must be a report of that interpretation, even if ‘with interpretation and report’ is not stated in the code description.”
In an open response to Ingenix (www.qmbs.com/Articles/AMAIngenix.pdf), the AMA countered: “We disagree with your opinion that a written report must be generated by the pathologist in order to append the professional component modifier to pathology and laboratory CPT® codes … Specifically for pathology and laboratory services, the modifier 26 can be used for medical direction, supervision and/or interpretation for all laboratory CPT® codes … In using Modifier 26 for pathology and laboratory codes 80049-87999, a written report for an individual patient is not a requirement for having performed a professional component service since it can be reported for medical direction of the tests performed.”

The AMA reasoned that Ingenix had interpreted the intent of modifier 26—and the definition of “professional services”—too narrowly. The AMA lists a pathologist’s responsibilities as medical director of hospital clinical laboratories, to include:

- Assuring that tests, examinations, and procedures are properly performed, recorded, and reported;
- Recommending appropriate follow-up diagnostic tests, when appropriate;
- Supervising laboratory technicians and advising technicians regarding aberrant results;
- Evaluating clinical laboratory data and establishing a process for review of test results prior to issuance of patient reports.

Ingenix concedes a pathologist’s billing for clinical laboratory professional services has withstood legal scrutiny, stating, “Current case law favoring this billing methodology involves facilities that have billed and have been reimbursed by a private payer over an extended period of time.”

A policy statement on the New Jersey Society of Pathologists’ Web site (www.njpath.org/billing.htm) sums up the situation well: “This practice [separate billing for the professional component of clinical laboratory services] has been in effect for many years in Texas, California, Illinois, and Florida, and pathologists from other states have been rapidly adopting it. Although its validity and legality have been challenged by commercial carriers and other entities several times, it has successfully been defended by several State Pathology Societies and is fully endorsed by the College of American Pathologists and the American Pathology Foundation. Although it is your right, it is also worth noting that engaging in this practice carries significant responsibilities from the Pathologists, requiring an active involvement in the Clinical Laboratory as physicians.”

CMS Makes a Single Payment
Payers following Centers for Medicare & Medicaid Services (CMS) guidelines will not make separate payment for the pathologist’s professional services in the hospital. Medicare pays a single “global” fee to the hospital to cover all expenses, and the pathologist must negotiate with the hospital for service compensation. CAP’s Professional Relations Manual explains, “Medicare rules require pathologists to seek payment from the hospital for the professional component of clinical pathology services to Medicare patients because the hospital’s Medicare payment rate includes payment for these physician services.”

Several payers have clearly adopted the Medicare standard. Blue Cross/Blue Shield of Montana, for instance, has published a Clinical Laboratory Compensation Policy stating, “BCBSMT compensates one global fee for clinical lab services. Compensation includes payment for the performance of the laboratory test and clinical oversight.” Clinical oversight specifically includes the pathologist’s professional services in the clinical lab.

Payment Should Come from Somewhere
Ingenix “Laboratory Services and Modifiers” concludes, “Until CMS or CPT® guidelines are specific to using modifier 26 for physician oversight or further clarification is given, the issue of billing for physician oversight will need to be addressed on a payer-by-payer basis [for non-Medicare payers].”

The bottom line, however, is this: A pathologist in a clinical laboratory has a legitimate claim to reimbursement for his or her supervisory services, either through payment from the hospital, the patient, or the patient’s insurer. Although insurers may elect to make a single payment for clinical laboratory services, as Medicare does, they cannot elect to forego payment altogether for professional services. When a single payment does not include reimbursement for professional services, or the pathologist is not otherwise reimbursed (through a hospital salary, for instance), separate payment should be made for the professional component of medically-necessary laboratory services, as reported with an appropriate CPT® code and modifier 26 appended.

G. John Verhovshek, MA, CPC, is AAPC’s director of clinical coding communications.
minute with a member

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Lori M. Shore, CPC, RCC

Vice president of coding and compliance at Medical Billing and Management Services

Concordville, Pa.

Coding Edge (CE): Tell us a little bit about your career.

Lori: I became involved in coding by accident the summer between my freshman and sophomore years in college. I worked at a mall steakhouse the summer before my freshman year and decided the restaurant business was definitely not for me. I looked for a Monday through Friday job so I could spend my weekends on the beach at my family’s summer home. I found a job working for the billing office of a radiology practice. I continued to work in billing every summer and whenever I was available throughout the year.

Since then, I have changed companies due to merges and acquisitions; however, I still work with some of the women I began with in 1979. I have worked most of the billing positions in our company at one time or another in my career; coding, data entry, payment posting, and A/R follow-up. I became a CPC® in 2002 and was certified by the Radiology Coding Certification Board the year before. Although I have coded for several specialties, radiology remains my favorite.

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

Lori: I belong to the SEPA chapter in Upland, Pa. Unfortunately, I have not been able to attend monthly meetings like I have in the past because my office has moved. I do, however, always try to make their workshop in October. It is always presented well and informative.

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

Lori: I believe the biggest challenge is getting the physicians to understand the importance of proper documentation. It is not just a medical record, but also a legal record. As the compliance officer of our company, I do random monthly audits to verify our clients are compliant.

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?

Lori: I believe the best policy is to have open communication with your doctors. I usually supply a copy of the source material that I am referencing for validation.

CE: If you could have any other job, what would it be?

Lori: I would probably teach special education. I have a teaching degree but realized too late in the process that I should have become specialized. I did one of my co-op experiences working with 5- to 8-year-old multi-handicapped children and found it extremely rewarding.

CE: How do you spend your spare time?

Lori: I spend my spare time with my husband, Dave, and son, Josh. We are big sports fans and I guess you can say I am a true “Soccer Mom.” I am the team manager for the Rose Tree Mustangs U-16 boys’ soccer team. Most of our weekends are spent on a soccer field, an ice hockey rink, or watching whichever sport is in season on TV.
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Your Audit Team

Susan Garrison, CHCA, CPC, CHC
Susan Thurston, CHCA, CPC-I, CHCO
Robin Linker, CHCA, CPC-I, CHC
Steven Levinson, MD, CHCA

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The 4-Day Intensive Practicum has the prior approval of the American Academy of Professional Coders (AAPC) for 32 continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.