

HEALTHCARE BUSINESS MONTHLY

Coding | Billing | Auditing | Compliance | Practice Management



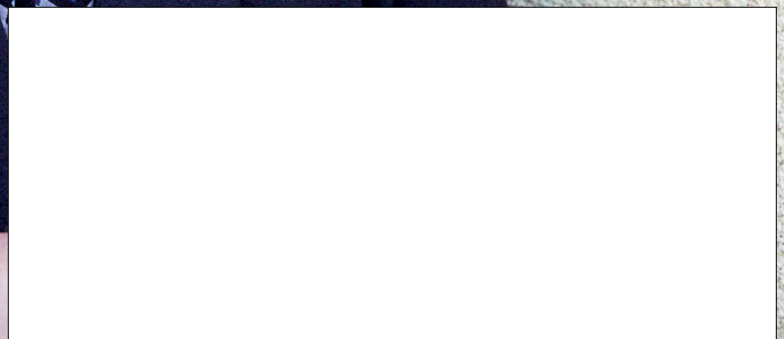
AAPC

SEPTEMBER 2023

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Check
Out the
New
ICD-10-CM
Codes From
A to Z

MEMBER OF THE MONTH
Lisa Livingston, BSN, RN, CPC, CPMA



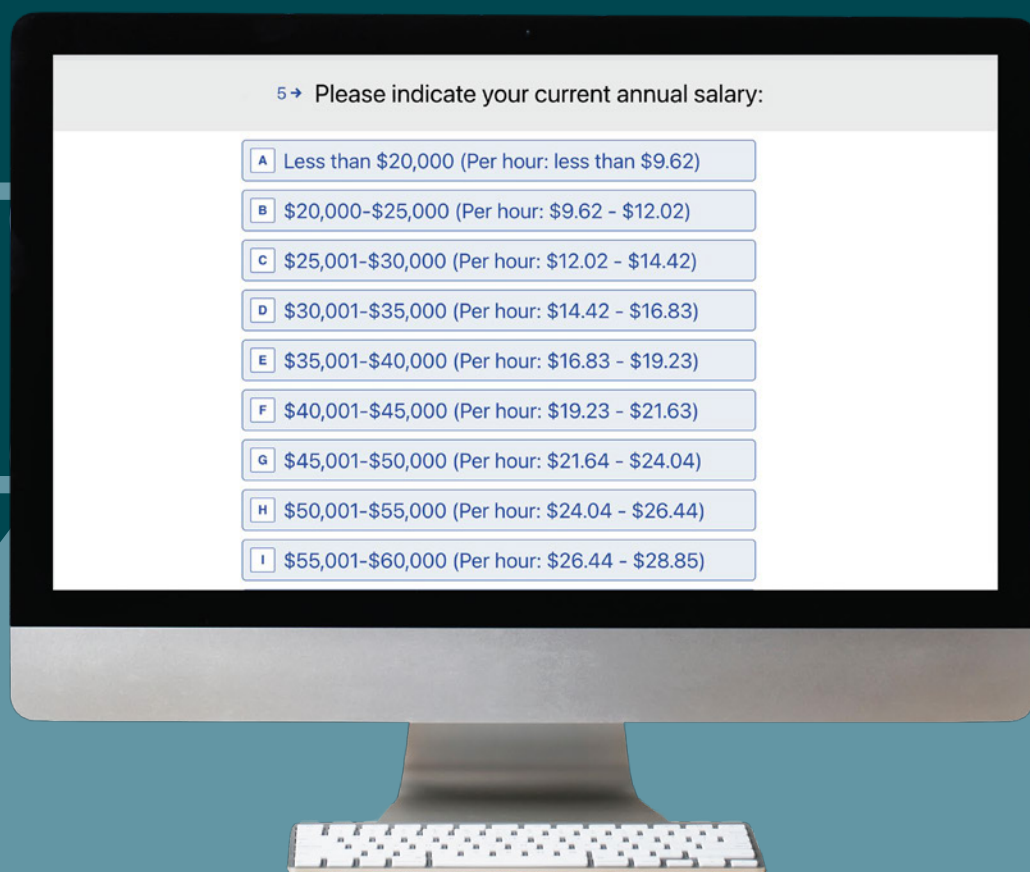
There's strength in numbers. Know your worth.

Take a few minutes to help your friends – you included.

Help ensure fair pay for all.

It's time again for us to gather information for our annual salary survey. Your input is used for our comprehensive salary report as well as our Salary Survey Calculator, keeping employers and employees up to date on appropriate compensation and variances from region to region.

In the end, it's about members helping members. The data you provide helps ensure that across the country, people in our profession are getting fair pay by industry standards. As you know, we earn it.



5 → Please indicate your current annual salary:

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☐ H	\$50,001-\$55,000 (Per hour: \$24.04 - \$26.44)
☐ I	\$55,001-\$60,000 (Per hour: \$26.44 - \$28.85)



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Live in the Present

Failures of the past, fears of the future, and distractions of the present often become roadblocks to our personal and professional growth. How can we let go of these productivity zappers?

Use Your Brain

Jill Bolte Taylor, PhD, is a neuroanatomist and brain scientist who lost the ability to speak, understand language, and engage in analytical thinking after experiencing a stroke in the left hemisphere of her brain.

The left side of the brain operates like a serial computer, processing one instruction after another, and controls analysis, logic, ideas, facts, math, and training. The right side of the brain controls creativity, intuition, art, creation, feeling, and imagination, and is capable of parallel processing with multiple instructions simultaneously.

Thinking predominately with the right hemisphere of her brain, Dr. Taylor had no recollection of the past or concern for the future. Without the sequential “noise” from her left brain, she felt immense peace and connectedness with herself and the world around her.

Count to 90

After a lengthy recovery, Dr. Taylor regained the full use of her brain, but she realized through her experience that the brain has the power to choose what information it filters and analyzes and what it casts aside as unimportant. According to Dr. Taylor, the more we step into the present moment, the more peaceful we will be. Too often, she says, we allow elements of our environment to affect us much longer than they should.

When a person has a reaction to something in their environment, there's a 90-second chemical process that happens in the body. After that, any remaining emotional response is just the person choosing to stay in that emotional loop. They are choosing to stay mad, emotional, and responsive to the stimulus, which is now likely in the past.

Let It Go

This is a powerful message that resonates with the teachings of Buddhism and something called “monkey mind,” which is the restless, incessant chatter and movement of the mind from one thought to the next. It's a state of mental agitation and distraction, when our thoughts are in flux and our minds are filled with worry, doubt, fear, and an array of distractions.



There are several techniques for calming monkey mind. In the article “Monkey Mind: Shifting the Habit of Feeling Distracted Throughout the Day,” author Leo Babauta (<https://zenhabits.net>) explains that our brains naturally jump from one thought to the next, so the first step is to not berate yourself when your mind wanders. When you lose your train of thought, gently encourage it to come back. Babauta also recommends meditation, removing distractions from your workspace, and remembering to pause now and again. Put these techniques into practice and see what being more present does for you.

“The future depends on what we do in the present.”

— Mahatma Gandhi

Until next time,

Bevan Erickson
AAPC CEO

“Too often we allow elements of our environment to affect us much longer than they should.”

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Healthcare in Australia

Chandrashekhar Boreda, CPC, AAPC MACRA Proficient, and
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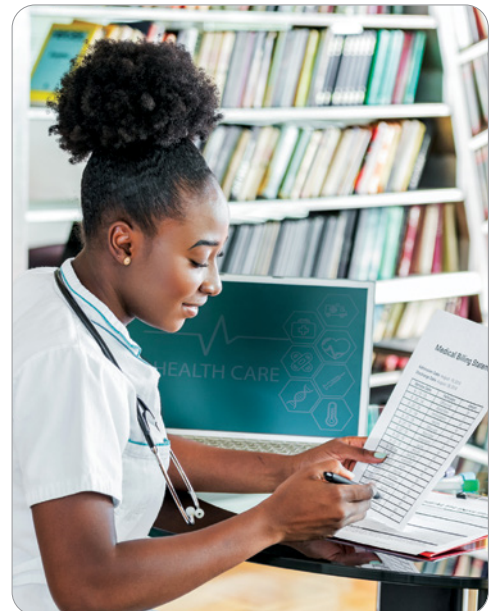
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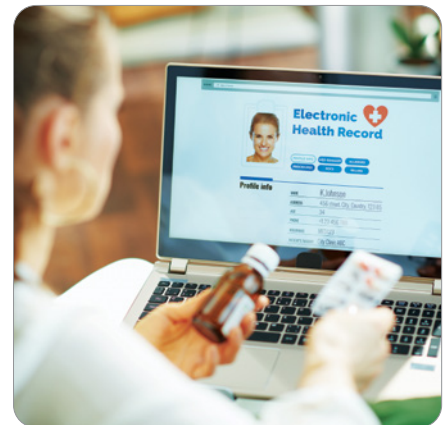
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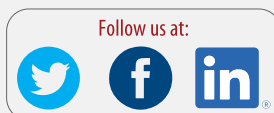
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Availability expires on the 1st, 1 year after cover date.

COMING UP:

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On the cover: Meet our Member of the Month, Lisa Livingston, BSN, RN, CPC, CPMA, on page 34.
Cover photography by Fred Castleberry.
Cover design by Mahfooz Alam.

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To get in front of our audience, contact **Michelle Miller** at **385-207-2317** or michelle.miller@aapc.com.

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Cindy Garner, CPC, CPB, CPC-I, CMA-AAMA, HITCM-PP

patient care and managing the revenue stream. I completed the program and achieved my first national certification.

I then began my studies with AAPC. Once I earned my Certified Professional Biller (CPB™) and Certified Professional Coder (CPC®) credentials, I was able to review chart notes and coding. With my education in place, I was hired as an office manager in a small clinic where I put all my training and knowledge into practice. I scheduled and registered patients. I verified insurance benefits and performed the billing for all office claims. I managed the revenue cycle by applying claim payments, as well as tracking unpaid claims and writing appeals. When I won my first appeal, my provider bought sparkling apple cider for us to celebrate!

I was 50 when I decided to change careers. I was a stay-at-home mom until my kids went off to college. As they took charge of their lives, I thought I had better take charge of my own, too. With so much free time, I decided to go back to school to refresh my work skills and then jump back into the work force.

When I thought about what I wanted to do, I decided on a career in the medical front office. I had previously been an office manager and receptionist at a medical clinic, and I loved working with and caring for patients. I also enjoyed the documentation and organizational skills that are required in the office setting.

Making the Grade

I pursued the Medical Assistant program at Clackamas Community College (CCC), which was a fantastic experience. I learned many clinical and front office skills such as soft skills in patient interactions and the importance of proper documentation. I also learned basic insurance billing and medical coding, which further cemented my career goals. And, after taking a front office administration class, I knew for sure that I wanted to work in that setting facilitating

Teaching Others

During this time, I was also hired as a part-time instructor at CCC in the same Medical Assistant program I had taken, teaching the front office class. I loved where I was in my career: Teaching students and working in a medical clinic. I loved my new careers so much that I thought I could help others pursue their dream careers, too. I enlisted my supervisor, who mentored my creation of the Medical Billing and Coding program at CCC, and I had the support of many angels on my journey. I established the program in 2020 and became a certified AAPC instructor.

Learning More

I completed my Health Information Technology Certified Manager for Physician Practice training this year to cement my overall knowledge of technology in clinical offices. I am currently taking AAPC's auditing training and I am excited to expand my knowledge further, as well as create more opportunities for my students.

We all spend 50 percent of our waking hours at work, so enjoy it. My advice to other professionals is to do more of what makes you happy. If you are looking for a career change or to grow your career, don't let anything stop you. **HBM**

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We want to feature you in *Healthcare Business Monthly*! Tell us in 350 to 500 words why you became a member of AAPC, how your AAPC credentials have helped you in your career, and the best part of being an AAPC member. Send your story and a digital photo of yourself to iamaapc@aapc.com.

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New-Member ORIENTATION

Starts You on the Right Track

The value of new membership starts with this informative meeting.

AAPC membership gives you access to a host of benefits, including a member orientation meeting to provide you with a roadmap of all AAPC has to offer. The virtual new-member orientation meetings are held once every quarter. You should receive an email invitation with a link to the meeting; the meetings are also promoted via AAPC's member newsletter and local chapters.

Meeting Agenda

The orientation begins with an overview of AAPC and then delves into navigating member benefits, including:

- *Healthcare Business Monthly* magazine;
- Four free webinars;
- Local chapter membership;
- Member professional development library (where you can spend your 25 free vouchers on on-demand professional development courses);

- Online forums;
- Savings center (where you can find free and low-cost resources for continuing education units (CEUs); discounts on code books; and deals on insurance, entertainment, dining, and travel);
- Mentorship program; and
- Much more!

Additionally, the meeting covers resources to jump-start your career, the value of joining the mentorship program and your local chapter, insights into the coding industry, and medical coding job listings. All aspects of becoming certified are explored, plus opportunities for AAPC education and training, including conferences, workshops, webinars, local chapter events, and virtual career fairs. Each meeting wraps up with a question-and-answer session. **HBM**

"Informative introduction for me with great resources, thank you!"

"Thank you for the very helpful information! I just recently passed the CPC® exam and had some questions, but they all got answered!"

AMA Posts CPT® Codes for Early Release

The American Medical Association (AMA) posted a CPT® early release documentation, June 30, for Category I immunization codes, Category III codes, and proprietary laboratory analyses (PLA) codes. These code changes will be included in the CPT® 2024 code set but have various effective dates. Here's what you need to know.

According to the documentation posted on the AMA website, the most recent changes to the CPT® PLA codes are as follows:

- Revision of seven codes (0269U, 0271U, 0272U, 0274U, 0277U, 0278U, 0362U), deletion of four codes (0066U, 0357U, 0386U, 0397U), and addition of 18 codes (0402U–0419U)
- Addition of duplicate PLA test symbol and parenthetical note to code 0345U
- Addition of the term “quantitative” to the code descriptor for code 0389U
- Correction of abbreviation CAD to CHD for coronary heart disease in the descriptor for code 0401U

These changes go into effect Oct. 1 of this year. Before using the new codes, however, verify that the payer is prepared to accept them. For the most recent changes for immunization vaccine codes and Category III code additions, read the rest of this story at www.aapc.com/blog. **HBM**

OIG Final Rule Determines Penalties for Information Blocking

On June 27, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) posted its final rule implementing penalties for information blocking. The final rule establishes the statutory penalties created by the 2016 21st Century Cures Act, which made sharing electronic health information the expected norm in healthcare.

This final rule amends the civil money penalty (CMP) regulations of the OIG to:

- Incorporate new CMP authority for information blocking;
- Impose CMPs, assessments, and exclusions upon individuals and entities that engage in fraud and other misconduct related to HHS grants, contracts, and other agreements; and
- Increase the maximum penalties for certain CMP violations.

The final rule, effective Aug. 2, does not include new requirements for what constitutes information blocking. To learn more, read the rest of this story at www.aapc.com/blog. **HBM**

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Healthcare Business Monthly accepts article submissions from AAPC members and other industry experts.

If you have news or know-how that can benefit other healthcare business professionals, share it with AAPC's over 237,000 members by becoming an author for *Healthcare Business Monthly* or AAPC's Knowledge Center blog.

You don't have to be an experienced writer; our editors will work with you to translate your ideas to the page and screen. Write what you know about a coding, billing, auditing, compliance, or practice management topic.

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Submit your article via our website (<https://www.aapc.com/publications/healthcare-business-monthly/contribute.aspx>).



Catching Member Maynia

Attendees went crazy for this year's local chapter events in May.



Event attendees were excited to participate in the fun, education, and social connection with their fellow chapter members.

This year's Member Maynia (formerly, May MAYnia) was a great success. Chapters were able to showcase their talent with different themes for each event. Themes ranged from a Hawaiian luau to the Roaring '20s. The Chennai local chapter even hosted a hybrid event, with more than 1,000 members participating via Zoom. A huge thank you goes out to everyone who made each and every Member Maynia event entertaining and rewarding.

Back in Action

Randi Schneider Goldberg reflected the thoughts of many chapters saying, "Member Maynia has arrived — finally live! — in Garden City, New York.

Officer Rhonda Starker from the Stockbridge, Georgia chapter noted their event was the "largest attendance for an in-person meeting since February 2020."

"We were very happy to connect and engage with chapter members in person after years," the Chennai chapter added.

Nina Carr Da Silva from the Long Beach Torrance, California chapter enthused, "It was great to be able to get together once again. A small group, but lots of fun, prizes, giveaways, and good food. I think we all had a great time."

An Enthusiastic Turnout

Event attendees were excited to participate in the fun, education, and social connection with their fellow chapter members. Attendees from the Kirkland, Washington chapter said, "The event was fantastic and put together really well," and, "This was the first Member Maynia I've attended, and it was awesome!"

Montgomery, Alabama wished to thank their wonderful speakers Dr. Vanosia Faison and Dr. Aaron Schaffner for imparting their knowledge on internal medicine, while Stephanie Krasley Kaleycik from the Allentown, Pennsylvania chapter praised the amazing turnout for their three speakers. Great presentations, breakfast, a full coffee and tea bar, and 20 raffles made it a great morning for all in the Keystone State who attended.

Gainesville, Georgia chapter members had an incredible time at their Roaring '20s themed Member Maynia event. Great costumes from the Jazz Age provided a stylish background to speaker Annette Baker's presentation on HCC coding.

Officer Lakeisha Thomas from the Leonardtown/Southern Maryland chapter said, "Our Member Maynia celebration was magnificent!"

Game Day

The Forth Worth, Texas local chapter played “Catch a Code,” where coding round tables were hosted by officers and volunteers. “We learned a lot, ate well, and of course, our members also got to go home with some awesome giveaways, which they had to go fishing for!” said officer Gigi Longino de Groot. “I’d like to thank our officers and volunteers for all of their help.”

The Albany, Georgia chapter’s event drew more than 60 attendees. They performed “The Life of a Claim” and played Kahoot for prizes.

Jacksonville, Florida held their event outside in the park, with lots of educational games and prizes.

A Hearty Thanks

Thank you to all the local chapter officers, volunteers, and speakers who made their Member Maynia events a rousing success. Your hard work and dedication are what keep your chapters open and thriving. **HBM**



Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.



- 1 “Catch a Code” was the game of the day for the Forth Worth local chapter.
- 2 The Gainesville event roared to life with members dressed as flappers.
- 3 Covington held their second annual Hawaiian luau. Officer Nikki Perkins said, “Thank you all for taking the time to be a part of our event! Our Covington family showed out!”
- 4 Jacksonville met in the park for educational games, a short presentation, and prizes.



September is **Leukemia** and **Lymphoma** Awareness Month

This month we shine a spotlight on cancers of the blood.

adobestock / Marcela Rutty Romero

While September is known for welcoming fall, going back to school, and 9/11 commemorations, this month is also leukemia and lymphoma awareness month. Both are aggressive forms of blood cancer with a 72 percent survival rate. An estimated 150,000 cases are predicted to be diagnosed by the end of 2023 in the United States.

Leukemia or Lymphoma?

Both leukemia and lymphoma impact an individual's white blood cells.

Leukemia strikes the cells of the bone marrow, which aid the body in the formation of blood. There are 13 different types of leukemia. Distinct forms of leukemia include acute lymphoblastic leukemia, chronic lymphocytic leukemia, acute myeloid leukemia, chronic myeloid leukemia, and chronic myelomonocytic leukemia.

Lymphoma impinges upon both the lymph nodes and lymphocytes. The three major forms of lymphoma are:

- Chronic lymphocytic leukemia, also known as small lymphocytic lymphoma (CLL/SLL),
- Hodgkin lymphoma (HL), which has five of its own subcategories, and
- Non-Hodgkin lymphoma (NHL), which has over 90 of its own subclasses.

Any lymphoma that is not of the CLL/SLL classification or does not involve Reed-Sternberg cells is commonly classified as non-

Hodgkin lymphoma. There are roughly 81,560 people diagnosed with a form of NHL each year in the United States.

How Blood Cancers Begin

Leukemia is thought to develop when blood cells encounter mutational changes in the cells' genetic material or DNA. The cells' DNA instruct their function, such as their growth and death rates.

Lymphoma ordinarily begins in the lymphocyte, a type of white blood cell. These cells work together with other cells in the immune system to help defend the body from invading bacteria and viruses. Lymph nodes, a critical part of the lymphatic system, can be considered the Paul Revere of the immune system. Lymph nodes generally become enlarged when the body develops an immune response to invading bacteria or viruses.

The body's three main types of lymphocytes include:

- B lymphocytes (or B cells), which make antibodies to fight infections,
- T lymphocytes (or T cells), which help B cells produce antibodies, and
- Natural killer (NK) cells, which attack and kill cancer cells and virus-infected cells.

Some T cells attack and kill infected cells while others help to regulate the way other various parts of the immune system fight infections.

“Both leukemia and lymphoma impact an individual’s white blood cells.”

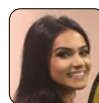
Signs and Symptoms of Blood Cancers

The signs and symptoms of lymphoma and leukemia are similar to those of many other illnesses, so it’s important that patients communicate with their healthcare provider when experiencing swelling of lymph nodes (which may or may not be painless), fever, unexplained weight loss, sweating that often occurs during the night, chills, lack of energy, and itching. Leukemia patients may also experience easy bleeding or bruising, reoccurring nose bleeds, and petechiae.

It’s important for individuals with persistent symptoms to be examined by a medical professional to make sure lymphoma is not

present. The medical professional should take a complete health history and perform an appropriate medical examination along with conducting or ordering any appropriate testing, which may or may not include an excisional biopsy of the suspected site. A pathologist or hematologist will examine the biopsied sample under a microscope to determine if cancerous cells are present.

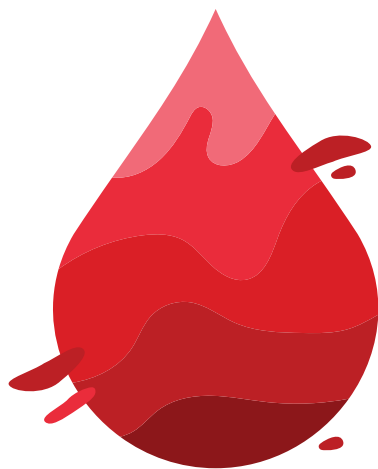
Doctors are trained to recognize different cell types by visually examining the shape and size of cells, along with how the identified cells are grouped inside bodily tissue. A doctor will discuss the risks, benefits, and potential side effects associated with any procedures that may be necessary to properly diagnose a patient’s condition. It’s highly recommended patients share any questions and concerns with the doctor so that a course of action can be decided upon together. **HBM**



Salma Tahir, CPC, has 20 years of experience as a qualified healthcare professional, with an emphasis on patient care, management, medical coding, billing, and compliance. She has a Master of Arts in Psychology and is passionate about recognizing and providing awareness on mental health and chronic illnesses.



Erica Murphy, CPC, CPCO, CPMA, is an industry veteran educator with 22 years of experience in medical billing, coding, and compliance, as well as medical policy construction, patient policy application, and reimbursement methodologies, with a demonstrated history of working in the hospital and healthcare industry.



— SEPTEMBER —

LEUKEMIA & LYMPHOMA
awareness month

Resources

- Leukemia & Lymphoma Society
- Nature Communications
- Healthline
- National Today
- Medical News Today
- Lymphoma Research Foundation

When Patients Understand Their Medical Record

Quality care cannot be achieved if your patient portal creates a barrier.



The 21st Century Cures Act requires healthcare providers to give patients access to their medical records upon request. Providers and facilities have been so focused on complying with this law, however, they may not have considered the repercussions: Patient comprehension of the information they are accessing is one concern, and security of that information is another. The undue stress on patients being given timely and complete access to their protected health information (PHI) is an unintended consequence of the 21st Century Cures Act that providers must act on to mitigate.

What Information Can Patients Access?

The 21st Century Cures Act indicates that almost all medical notes must be shared with patients. These notes include:

- History and physical notes
- Progress notes
- Consultation notes
- Procedure notes
- Discharge summary notes
- Imaging narratives
- Laboratory report narratives
- Pathology report narratives

There are eight exceptions where documentation or notes can be withheld from shared information. Some exceptions include psychotherapy notes that are separated from the rest of the medical record, information related to a civil, criminal, or administrative action or proceeding, and any note that a doctor perceives may cause harm or danger to a patient.

Causes for Concern

Increased transparency and communication between clinicians and patients are goals of information sharing. Studies show that sharing medical notes with patients who have a chronic condition (e.g., diabetes mellitus) and understand the information in the notes helps them feel more engaged in their healthcare, better understand their medical condition(s), and participate more in their care plans, including taking medications properly.

The key word is “understand.” Unfortunately, it’s more common for patients to not understand what they’re reading in their medical record. The patient may not understand common medical terminology, like obesity related to body mass index (BMI), test results, medi-

cation changes, or surgical reports. Patients may be concerned about test results if they are misinterpreted or not explained thoroughly.

Timing of patient access to their information is also a concern. Many systems are set up to notify the patient whenever new information is added to their record, so the patient often sees the information before their physician does. Even if the attending physician is notified at the same time, they may be busy with other patients or other duties and can't look at a report immediately.

It's common in online cancer support groups to see a message such as, "I just saw my pathology report online. I can't reach my doctor until Monday. What does this mean?" Patients are relying on internet research and message boards to answer questions that should be answered by a clinician who is familiar with their case.

A patient's first indication of their cancer diagnosis should not be reading something on a computer or phone screen. Consider the emotional harm caused to a patient who is first notified of a potentially life-changing diagnosis in such an impersonal manner and then left for days without being able to discuss it with their physician.

Consider the Source

The electronic health record (EHR) is the most common digital form of communication between clinicians and patients. The EHR is a common data repository that serves many purposes. There are many uses of the data stored within the EHR — communication between facilities and payers, sharing clinical research data among providers, and analysis of population health statistics.

The primary purpose of the EHR is for healthcare providers to document patient care and make that information available to other healthcare providers. The common medical terminology used by providers who are communicating peer-to-peer describes the patients' conditions, provides interpretation of test results, defines surgeries or procedures, and is intended for clinical communication.

When sharing health information with other providers, there may be a discrepancy with how each individual views diagnostic results. While one provider may view results as worrisome, another provider may view the results and determine there is no cause for concern. Some providers feel that they should downplay symptoms when documenting, especially when they know the patient will see what is in the note, and other providers may embellish symptoms. Interpretation may also be skewed if the provider omits certain information from their discussion with the patient or another provider.

Anyone whose job entails entering data into a patient's EHR must be aware of how the data is used and who's using it. No matter who enters data, it's vital to follow documentation standards and adhere to compliance policies adopted by facilities to help ensure the integrity of the data entered and how that data can be shared.

When communication between the clinicians and patients is via the EHR, facilities need to address questions such as:

- What is shared between clinicians and patients?
- How can we meet clinical communication standards and patient understanding?
- How does the facility follow compliance policies for shared information?
- How is the patient able to access their information?
- How can facilities train employees and patients to use information portals?

The checklist below, presented in a November 2021 article from the *Journal of the American Medical Association (JAMA)*, can be a helpful tool for patients. Facilities and practices should also consider establishing a patient-clinician liaison who could provide general definitions and information to assist the patient until they can speak with their own physician.

What to do when reading your medical notes

Patients typically have the option to access and read their medical notes through a patient portal to their electronic health record.

- ☑ **Review the care plan (sometimes called an "assessment and plan") for any medication changes and new orders made by your doctor.**
Use this to make a "to-do" list for yourself prior to your next appointment (such as blood work, imaging, vaccinations, and referrals to specialists).
- ☑ **Wait for your doctor to contact you regarding laboratory results, imaging results, or pathology results before becoming worried about any measurements or findings.**
Sometimes these reports may automatically be made available to you before your doctor has had a chance to review them.
- ☑ **Review your medication list to make sure it is accurate and up to date.**
- ☑ **Let your health care team know about any major errors or missing information (such as allergies).**
- ☑ **Share your medical notes with people close to you who are involved in your health care.**
- ☒ **Do not get caught up in medical jargon, terminology, or abbreviations.**
If you have a question about the meaning of a word or sentence, ask someone on your health care team to explain.
- ☒ **Do not feel that all the language in the notes is directed at you personally.**
The purpose of medical notes is to provide succinct and straightforward documentation and communication between doctors. The notes do not reflect how doctors would actually speak to you, or their colleagues, in person.
- ☒ **Do not attempt to interpret the details of procedure notes, pathology reports, laboratory reports, or imaging reports without talking to your doctor.**
These notes can be even more technical and confusing for those without a medical background than other types of notes. They will be interpreted by your doctor and incorporated into your care plan.

Source: <https://jamanetwork.com/journals/jama/fullarticle/2785714>

Put Compliance Into Perspective

Sharing health information has both privacy and security concerns regardless of whether the information is being shared with the patient, law enforcement, state health officials, or other healthcare facilities. These concerns are shared by not only the patient but also clinical and administrative staff, healthcare providers, and healthcare facilities, as well as the IT departments of software companies. As such, every healthcare organization should include information sharing policies as part of their compliance plan. Considerations include:

- Policies and procedures for making sure the patient's progress reports, medication lists, immunizations, radiology and laboratory reports, and operative notes are uploaded to the patient's portal in a timely manner.
- Guidance for what is and isn't shared.
- Procedures for ensuring accuracy and that any possible amendments to the patient's care plan have been noted. Concerns may arise if documents are incorrect, uploaded to the incorrect patient, or if the provider has not reviewed the results to possibly make amendments to the patient's care plan.

There should be someone in place within the organization, whether it's clinical or administrative staff, to oversee adherence to these policies and report any violations to the compliance officer.

Education Is Key

Education and training should be provided to not only the staff within the healthcare facility but also the patients. Staff members should be made aware of who is responsible for uploading documents, what types of information are being uploaded, and how to access the information.

Staff should know how to handle any questions or concerns a patient may have regarding their information on the portal. Patients may also need to be educated on how to access the portal, view their medical charts, and send messages to staff with any questions or concerns. Training staff how to handle a patient's confusion and anxiety toward information viewed in their chart may prevent the situation from escalating and promote better patient care.

When sharing PHI electronically, monitoring and auditing should be performed routinely for early detection of a possible security breach or unauthorized access to a patient's chart. Security breaches are the largest concern when it comes to patient privacy. Working closely with your EHR vendor and your organization's IT department is essential for cybersecurity. At the very least, ePHI should be encrypted and unique logins and two-step authentication processes should be used. Monitoring and auditing may also allow the provider to know when the patient reviewed their information, if they sent their information to another specialist, and whether the patient sent the provider a message or comment and is awaiting a response.

Best Practices

Quality patient care and a positive patient experience are both tied to data in modern healthcare. With privacy as the overarching concern, documentation must be compliant and thorough to support continuity of care; compliance policies must be specific and understood by all staff with access to medical records; regular audits should be employed to ensure standards are met; and patients accessing their records online must be instructed on how to use the portal platform and understand what they are seeing. **HBM**

AAPC Compliance Advisory Committee Members:

Kimberly Garner Huey, MJ, CHC, CPC, CCS-P, PCS, CPCO, COC

LisaRae Roper, MS, MHA, CCS-P, CPC, FAHIMA, AAPC Approved Instructor

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Resources

Dong Z, Leveille S, Lewis D, Walker J. People with diabetes who read their clinicians' visit notes: Behaviors and attitudes. *Chronic Illness*. 2023;0(0). doi:10.1177/17423953231171890

Individuals' Right under HIPAA to Access their Health Information. 45 CFR Sec 164.524

The Office of the National Coordinator for Health Information Technology (ONC), Cures Act Final Rule: Information Blocking Exceptions

Jin J. What to Consider When Reading Your Medical Notes. *JAMA*. 2021;326(17):1756. doi:10.1001/jama.2021.16493

21st Century Cures Act. [Congress.gov](https://www.congress.gov)



adobestock / zimmytw

By Deborah Marsh, JD, MA, CPC, CHONC

Use Codify Indexes? Don't Miss This Timesaving Tip

Make the most of the Refine button.

Code set indexes are long, but they can be essential to finding the correct code. Take a shortcut by using the index search features in Codify by AAPC.

Step 1: Access the code set index you need, such as by opening Code Indexes on the top menu (**Figure 1**).

Step 2: On the index page, enter your search term. Select an entry from the dropdown list to go to an exact entry (**Figure 2**).

Step 3: To search within long index entries, enter a term in the Refine search box. You may need to scroll up to see the box. After

you click Refine, you'll see the result highlighted and italicized in the index. Click the code to open its details page or click Next to see additional index entries for the term (**Figure 3**). [HBM](#)



Deborah Marsh, JD, MA, CPC, CHONC, is a senior development editor at AAPC. She has explored the ins and outs of coding for multiple specialties, particularly radiology, cardiology, and oncology.

Figure 2

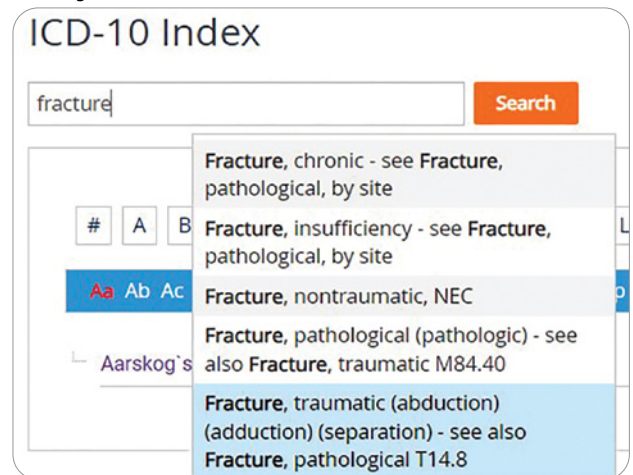


Figure 1

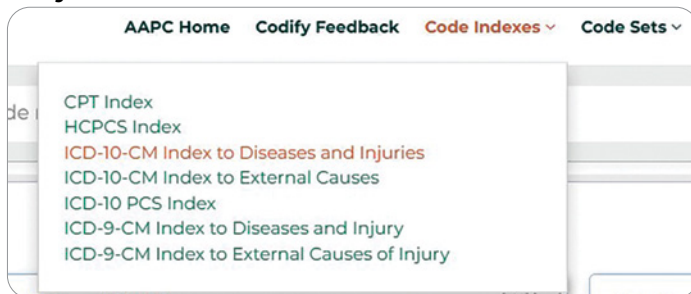
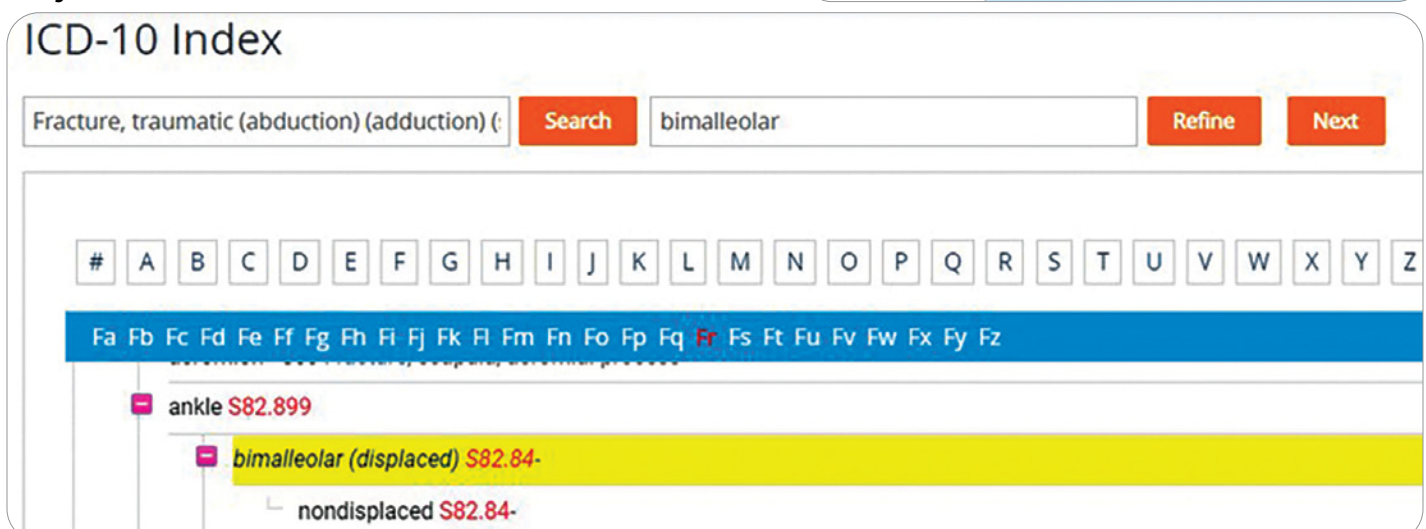


Figure 3





Knoxville, Tennessee local chapter at the Thompson Proton Center

X-rays (Photons) vs. Protons: Key Differences

Tissue sparing, cost, and coding are at stake.

Sparing of healthy tissue is critical when it comes to cancer treatment. Thanks to the Bragg peak, shown in **Figure A**, protons can have an “edge” for treating solid tumors. The Bragg peak plots the energy path of ionizing radiation as it travels through matter, so protons can be planned to stop and not go past the tumor, as well as to deliver the highest treatment dose at the tumor itself.

Proton Therapy

Protons may be newer than X-rays for treating cancer, but they have been used in treatment for more than 30 years. The Food and Drug Administration (FDA) approved proton therapy in 1988, with the first patient treated at a hospital-based facility in Loma Linda, California, in 1990. There are currently 41 operational proton therapy centers in the United States, several at well-known

“Protons may be newer than X-rays for treating cancer, but they have been used in treatment for more than 30 years.”

healthcare organizations such as MD Anderson, Mayo Clinic, and Johns Hopkins.

Solid tumor cancers are treated with proton therapy. Proton therapy is commonly used for:

- Breast
- Central nervous system
- Head and neck
- Gastrointestinal
- Lymphomas
- Pediatric cancer
- Prostate cancer
- Re-irradiation
- Sarcoma
- Thoracic

Proton therapy uses the same image-guided radiotherapy (IGRT) as traditional X-rays, while also taking several computed tomography (CT) images throughout treatment that are included in the quality assurance codes 77336 (billed weekly) and 77301. These images are studied to monitor changes and adapt plans to continue to spare healthy tissue and target the tumor most accurately.

Why can't all cancers be treated with proton therapy?

Proton therapy can cost twice as much as traditional X-rays, so saying that it is safe and effective is not enough. For payers to cover some diagnoses, they require more data showing that proton therapy would be appropriate for a patient's condition and needs. For example, it must be shown that it would result in fewer side effects and would save certain amounts of healthy tissue/vital organs. Through research data, proton therapy has proven to be beneficial for many cancers and creating a better quality of life for the patient during the treating and beating of cancer.

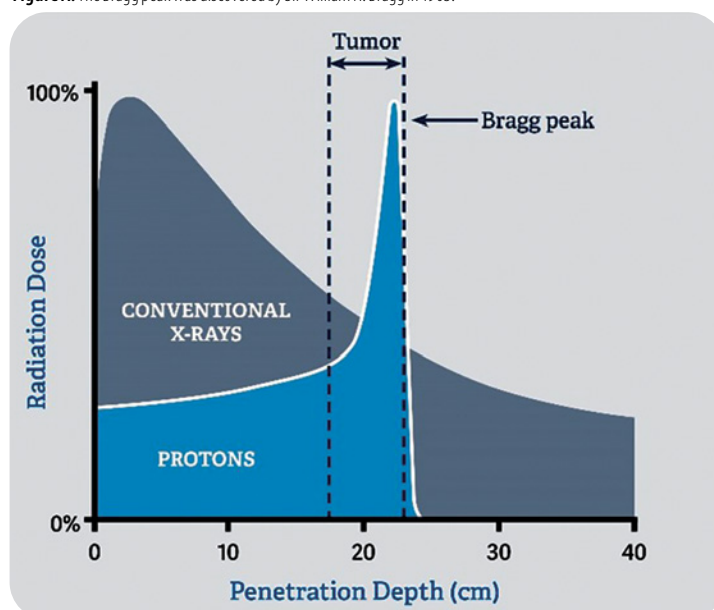
What are the coding differences?

Intensity modulated radiotherapy (IMRT) and intensity modulated proton therapy (IMPT) use the same planning CPT® code (77301). There are specific IMRT rules for simulation (77290), which cannot be billed because it is considered to be included in the treatment planning.

Although we cannot bill the simulation, we can bill devices created during the simulation:

- 77332** Treatment devices, design and construction; simple (simple block, simple bolus)
- 77333** ... intermediate (multiple blocks, stents, bite blocks, special bolus)
- 77334** ... complex (irregular blocks, special shields, compensators, wedges, molds or casts)

Figure A: The Bragg peak was discovered by Sir William H. Bragg in 1903.



"Did you know that a proton particle leaves the cyclotron at two-thirds the speed of light?"



Proton treatment delivery room at Thompson Proton Center, 360-degree IBA gantry

Treatment Delivery

The delivery codes pose the biggest difference: CPT® codes 77385 and 77386 report X-ray IMRT for hospital-based procedures, and HCPCS Level II codes G6015 and G6016 report IMRT delivery for freestanding facilities. IGRT codes are typically G6002 for X-ray and 77014 for CT, either globally or with modifier 26 *Professional component*.

Proton delivery codes are 77520, 77522, 77523, and 77525. Intermediate code 77523 is the most common and is used for proton treatment delivery to one or more treatment areas utilizing two or more ports, or one or more tangential/oblique ports with custom blocks.

National Correct Coding Initiative edits state that none of the proton delivery codes can be billed the same day as a plan (77301). This makes adaptive planning (or a second plan, if tumor size changes) not billable, as this plan is typically created and approved on a treatment day.

Complex code 77525 is used when there are matching or patching fields and/or multiple isocenters. One example would be one treatment for a bilateral breast cancer, or when there is more than one solid tumor on opposing sides of the body.

The Grand Tour

I am so thankful some of our Knoxville, Tennessee local chapter members agreed to come by and take a tour of the Thompson Proton Center and learn about proton therapy and its coding during one of our monthly meetings. We really had a fun night getting to know one another and learning about protons. Did you know that a proton particle leaves the cyclotron at two-thirds the speed of light? **HBM**



James Mitchell, CPC, is a Marine veteran and a former diesel technician. He went back to school after a back injury that required him to look for an office career. He was able to take the AAPC courses online and attended a local technical school for medical office training to get his foot in the door doing accounts receivable. Working in AR for six years, he gained tons of knowledge about the revenue cycle and medical necessity. All the steps along the way have helped him be a better coder.

Resources

Wikipedia: William Bragg

Center count and FDA approval

Coding guidance from Astro Radiation Oncology Coding Resource

AMA CPT® 2023 code book

Extended device descriptions from CMS LCD 31617

Copyright: All pictures and diagrams are from Thompson Proton Center

Common Abbreviations for Clinical Medical Professionals

As medical coders, billers, and auditors, you're already familiar with abbreviations for the most common types of clinical professionals in the medical field such as medical doctor (MD), physician assistant (PA), and registered nurse (RN). The healthcare field is expanding, however, creating many new roles in patient care. Here are some abbreviations for healthcare workers you may be less familiar with.

APP Advanced practice provider	DPM Doctor of podiatric medicine/ podiatrist	OTA Occupational therapy assistant
AUD Audiologist	EMT Emergency medical technician	P Paramedic
CNA Certified nursing assistant	LCSW Licensed clinical social worker	PharmD Pharmacist
CNM Certified nurse midwife	LMFT Licensed marriage and family therapist	PsyD/PhD Psychologist
CRNA Certified registered nurse anesthetist	LPN Licensed practical nurse	PT Physical therapist
DC Doctor of chiropractic/ chiropractor	MA Medical assistant	PTA Physical therapy assistant
DDS Doctor of dental surgery	MLS Medical laboratory scientist	RD Registered dietitian
DH Dental hygienist	NP Nurse practitioner	RDMS Registered diagnostic medical sonographer
DMD Doctor of dental medicine	OD Optometrist	RT Respiratory therapist or radiologic technologist
DO Doctor of osteopathic medicine	OT Occupational therapist	SLP Speech language pathologist



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Coding E/M in the ED, Part 2

Questions about 2023 evaluation and management guidelines in the emergency department, answered.



AAPC's HEALTHCON, May 21-24, offered several sessions on the subject of evaluation and management (E/M) coding, including "Emergency Department Professional Fee E/M Coding," presented by **Raemarie Jimenez, CPC, CDEO, CIC, CPB, CPMA, CPPM, CCS, AAPC Approved Instructor**, AAPC's chief product officer.

In this session, Jimenez reviewed the 2023 E/M guidelines as they apply in the emergency department (ED) and clarified certain known misconceptions. But the guidelines are just that, guidelines, and attendees still had questions.

Questions From the Audience

Several questions came out of Jimenez's discussion on documentation challenges for independent historians and discussions with other providers.

Q: *Do all pediatric patients automatically qualify for an independent historian?*

Rae: It depends on what the parent's information is and the age of the patient but, yes, if the parent provides their own observations and information, then it is an independent historian because the patient can't verbalize what's going on and the parent just knows what they have observed, so the provider has limited information.

Q: *If information in the medical record just says "historian," can the provider get credit for it?*

Rae: Yes, if you know that it was a parent that came into the ED with the patient and provided that information, then you could count it toward medical decision making.

Q: *What's the age cutoff for pediatric independence?*

Rae: There is no age cutoff. If the parents are giving the information, the age of the patient doesn't matter.

Q: *We have providers counting independent historian when the patient is a child and there is no documentation to support that the history was actually obtained from the parent. Do we just assume?*

Rae: No, you don't assume. You need to know what information was obtained from the parents, or independent historian.

Q: *If it's a 2-year-old patient and there is a history of present illness (HPI), clearly, they got the HPI from somebody other than the patient. Is that inferred that it came from the parent?*

Rae: No, you want to know where the HPI came from. It could be information from the emergency medical technician who brought the patient into the ED. It could be the parent. It could be a teacher. You need to know where the providers are getting the information.

Q: *Does independent historian include translations?*

Rae: No. A translation is not the translator's observations of the patient. It's what the patient would have said if they could communicate on their own.

Q: *What if the provider reads another provider's note. Is that a discussion?*

Rae: No, they have to have two-way communication with each other for it to be a discussion. And it can only be counted once. So, if the provider talks to the other provider a couple of times, it only counts as one data element.

Q: *If a provider reaches out to another provider for discussion about a patient, but they do not reach that provider on the day of the encounter, does it count?*

Rae: That is included in the guidance: If the provider attempts to reach out to another provider for a discussion, even if it is a failed attempt, it counts. The discussion might happen later and then the provider has to go back and addend their note. **HBM**



Renee Dustman, BS, is the managing editor of content and editorial for AAPC's Publishing Department. She is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

It's Blood Cancer Awareness Month

Together, let's be a part of the solution.

Throughout September, a portion of proceeds from all CHONC™ exam purchases will be donated to The Leukemia & Lymphoma Society. If you are interested in becoming a certified hematology and oncology coder, this is the month to take that next step.

Did you know?

Blood cancers, also called hematologic cancers, occur when abnormal blood cells start growing out of control and interrupt the function of normal blood cells. The three main types of blood cancers are leukemia, lymphoma, and myeloma.

<20

Leukemia is the most common cancer diagnosed in people younger than 20 years old



About every 3 minutes, 1 person in the US is diagnosed with leukemia, lymphoma, or myeloma

186,400 people

are expected to be diagnosed in the US each year

Symptoms



Persistent fatigue/weakness



Fever, chills, and night sweats



Bone/joint pain



Itchy skin or skin rash



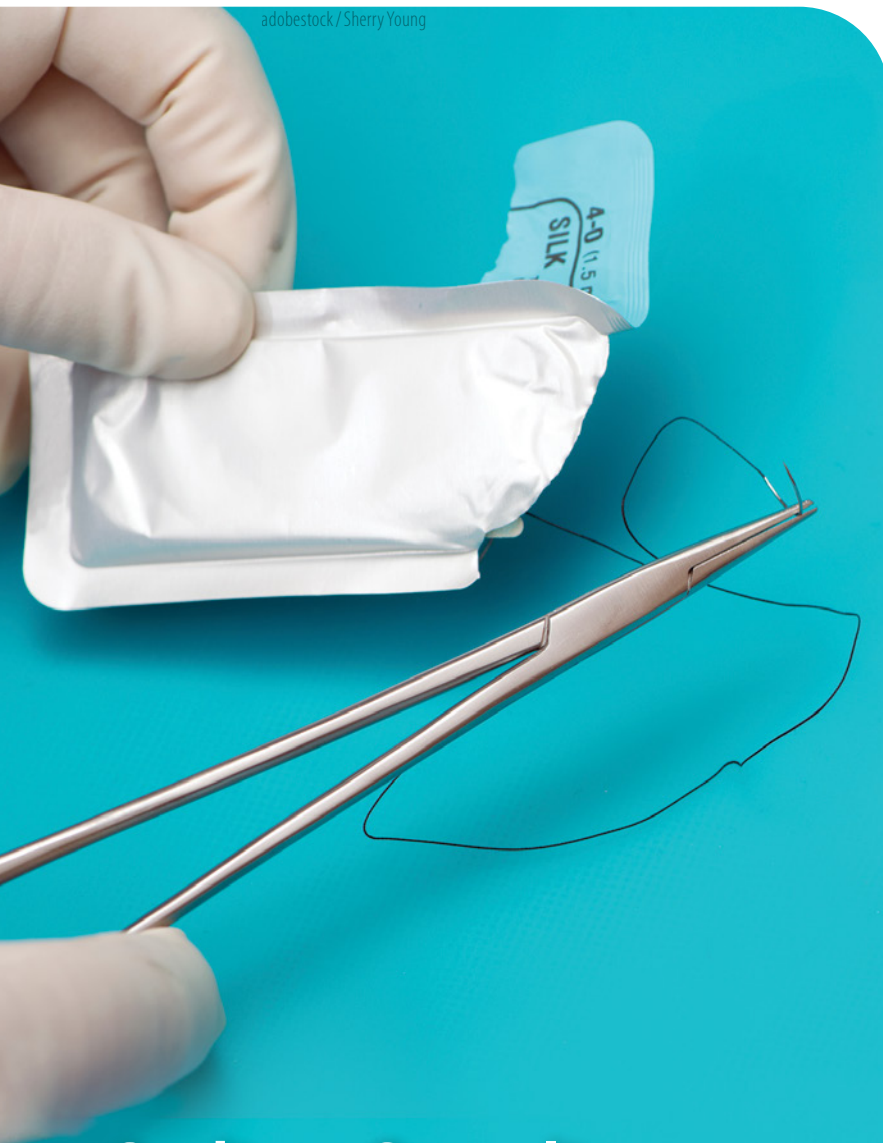
Loss of appetite, nausea, or unexplained weight loss



Swollen lymph nodes in neck, underarms, or groin

Learn more about the CHONC certification
at aapc.com/certifications/chonc

Sources:
Leukemia and Lymphoma Society
Cancer Treatment Centers of America



Coding Supplies, Implants, and Devices

Ensure optimal reimbursement for items that are not billed as durable medical equipment.

Assigning the proper codes to supplies, implants, and devices can have a direct effect on coding compliance, charging accuracy, and the amount of outpatient reimbursement that a hospital or facility receives. Healthcare providers routinely use many items that should not be separately charged, but if the item is assigned a HCPCS Level II code, then the item should be represented on the claim with the appropriate code. Many organizations struggle with accurate HCPCS Level II code selection, however, because the medical coder is not given sufficient information. Here's what every coder needs to know.

Know When It Is DME

There are a variety of HCPCS Level II codes for supplies, implants, and devices. The most commonly used codes begin with the letters A, C, J, L, Q, and V, followed by four numerical digits. It's important to differentiate between these items, which are used in the clinical setting, and durable medical equipment (DME), which is distributed and charged through other channels.

To charge Medicare and most other payers for DME, an organization must have a DME license, which most healthcare organizations do not have. Coders should check with their billing or compliance department before using DME codes. If you are not a licensed DME supplier, the item must be used in the clinical setting and not as a "send home" item or DME for you to bill for it.

For items that are not classified as DME, and depending on the billing structure being used at an organization, select items have pass-through status with Medicare and other select commercial payers. An item with pass-through status can generate a payment allowance in addition to typical reimbursement amounts.

Know What the Item Is

When choosing a HCPCS Level II code for a supply, implant, or device, pay special attention to the code description and then compare it to the item description. There can be very specific differences, for example:

- C1874** Stent, coated/covered, with delivery system
- C1875** Stent, coated/covered, without delivery system
- C1876** Stent, non-coated/non-covered, with delivery system
- C1877** Stent, non-coated/non-covered, without delivery system

In this case, it's important to understand the type of stent, if the stent is coated/covered or non-coated/non-covered, and if the delivery system used to place the stent comes in the packaging.

“To charge Medicare and most other payers for DME, an organization must have a DME license, which most healthcare organizations do not have.”

Know How Many Units to Bill

Select codes have a per unit specification in the description. For example:

- A2014** Omeza collagen matrix, per 100 mg
- C9355** Collagen nerve cuff (NeuroMatrix), per 0.5 centimeter length
- Q4116** Alloderm, per square centimeter

With the per unit HCPCS Level II codes, the coder or biller must know the quantity of the units that were used and adjust the quantity charge accordingly.

For example, if the provider documents using a piece of Integra bilayer matrix wound dressing and the HCPCS Level II code is Q4104 *Integra bilayer matrix wound dressing (BMWD), per square centimeter*, then the size is needed to accurately charge for it. If documentation indicates the dressing measured 3 centimeters by 5 centimeters, you will need to compute the square centimeters indicated in the code description for this item as such:

3 cm x 5 cm = 15 square centimeters
The quantity in this case is 15 units of Q4104.

Know What Is Separately Billable

For procedures that involve a coded supply, implant, or device, the CPT® code for the procedure could have an edit that requires a supply, implant, or device code to be included on the claim: These procedures are either device-intensive or device-dependent. It's important to understand the relationship between the procedure and supply codes because, in many cases, if the related codes aren't included, the revenue and reimbursement could be reduced, or the claim denied.

For example, the patient had a hernia repair surgery with mesh. This is reported with CPT® 49591 *Repair of anterior abdominal hernia(s) (ie, epigastric, incisional,*

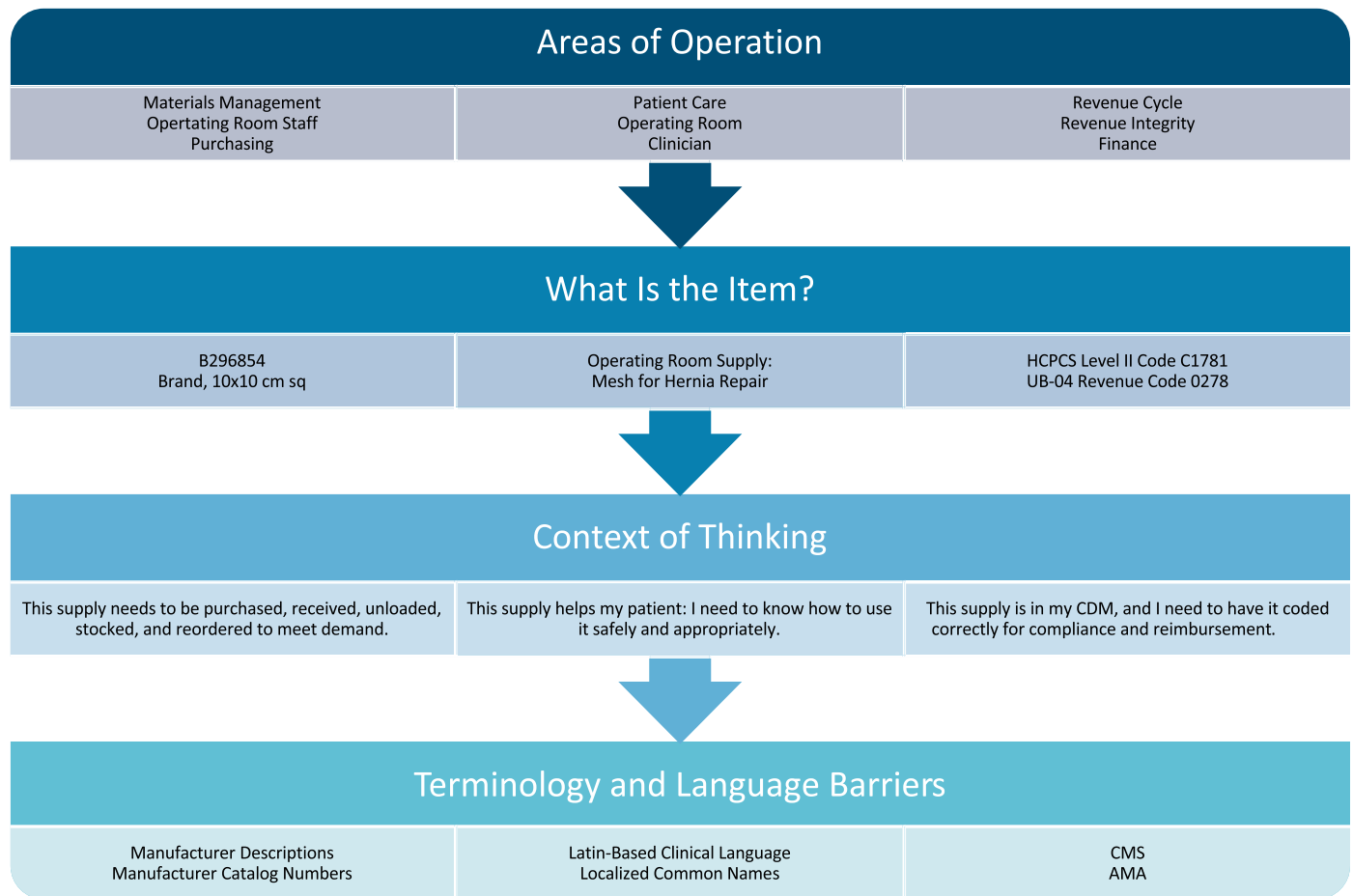
ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible. For proper coding, billing, and reimbursement, the HCPCS Level II code for the mesh implant that was used in the procedure also needs to be on the claim: C1781 *Mesh (implantable)*.

In some instances, there is an implantable or inserted device used in the procedure that doesn't have a specific code. For these, C1889 *Implantable/insertable device, not otherwise classified* may apply.

If a device-dependent procedure was performed, but a device was not used for the patient, then consider C1890 *No implantable/insertable device used with device-intensive procedures*.



Information and expertise from all three areas of operations is needed for a robust supply, implant, and device coding process.



Work Together for Maximum Return

With the need for coders to understand what an item is and how it will be used to select the most accurate codes, the supply chain, revenue cycle, and clinical operations must work together. The challenge is that these three entities think and classify items using different methodologies:

- The supply chain has a system of classifying items based on the United Nations Standard Products and Services Code (UNSPSC) along with the manufacturer part numbers and internal inventory numbers.
- The clinical staff understand what the item is and how it is used.
- The coding/revenue integrity/billing staff understand the coding and billing aspects.

Some supply chain departments use software that has cross-walked data files that include the HCPCS Level II codes, so inquiring with internal resources is a good practice. Another option is for the coder/biller/revenue integrity staff to contact the item manufacturer for code and reimbursement information, as well as for information on how the item is clinically used.

Some organizations have a coder add the HCPCS Level II code for the supply, implant, or device when they code the procedure. Others have the HCPCS Level II codes attached to the Charge Description Master line items so when an item is charged, the code is automatically added on the claim. A coder, biller, or revenue integrity staff member must be aware of the methodology at their organization and also be on the lookout for missing codes or missed charges that contribute to the missing supply codes for a patient's procedure. As with most codes, it's also important to understand the associated Medically Unlikely Edits and the applicable modifiers that may apply to each code.

By becoming familiar with the HCPCS Level II codes related to supplies, implants, and devices, and then applying those codes to the applicable items used in the clinical setting, one can directly contribute to the coding accuracy that drives reimbursement. **HBM**



Jennifer Lavoie, RN, CPC, is a member of AAPC's National Advisory Board and works as the director of revenue integrity at Rush University Medical Center in Chicago, Illinois. Her work of bridging clinical care to revenue integrity to provide fair and accurate billing to each patient, while funding the mission of healthcare, has spanned multiple health systems, software providers, and consulting. Lavoie has a degree in corporate communications in addition to her nursing degree and AAPC certification.

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New ICD-10-CM Codes From A to Z

Get ready for all the diagnosis code changes coming next month!

The ICD-10-CM code set update for fiscal year (FY) 2024, effective Oct. 1, 2023, adds 395 new codes, deletes 25 existing codes, and revises 22 codes (nine of which are to the short descriptor only). There are also 131 new headers and four revised headers. There aren't changes in *every* section from A to Z, but it's close!

The ICD-10 Coordination and Maintenance Committee Meeting, Sept. 13-14, 2022, offers insight into why many of these codes were requested. Here's a look at some of the code requests the Centers for Medicare & Medicaid Services (CMS) approved for the 2024 update, as well as a general overview of the changes.

Chapter 1 (A00-B99)

Several new codes are added throughout the code set to identify known conditions with improved specificity. Of note in this chapter, you'll want to familiarize yourself with this new code:

A41.54 Sepsis due to *Acinetobacter baumannii*

New codes often create a ripple effect of changes throughout the code book. In relation to A41.54, there are many revisions to the index and tabular list. For example, you'll also find one new code under B96 *Other bacterial agents* ..., two new codes under J15 *Bacterial pneumonia, not elsewhere classified*, and a few additions under Z22 *Carrier of infectious disease*.

Chapter 2 (C00-D49)

Familial adenomatous polyposis (FAP) is an inherited disorder which predisposes individuals to colon polyps and colon cancer. There are three types of FAP — classic, attenuated, and autosomal recessive — but only one new code. A second code is added to capture benign neoplasms elsewhere in the digestive system.

D13.91 Familial adenomatous polyposis

D13.99 Benign neoplasm of ill-defined sites within the digestive system

In the Table of Neoplasms, D13.9 is revised to D13.99 for a handful of applicable body areas. There is also a collection of new Z codes to report history of FAP.



New codes for desmoid tumors (D48.11-) and other specified neoplasms of uncertain behavior of connective and other soft tissue (D48.19) are also added in this chapter.

Chapter 3 (D50-D89)

You'll find several additions and revisions in this chapter for reporting sickle-cell disorders. There are also new codes for reporting Shwachman-Diamond syndrome (D61.02) and IgG4-related disease (D89.84), and many parenthetical revisions.

Chapter 4 (E00-E89)

Autosomal dominant hypocalcemia (ADH) is a genetic disorder of calcium metabolism mediated by hypoparathyroidism. There are two types of ADH: Type 1 is caused by mutations in the calcium-sensing receptor (CaSR) gene protein and type 2 is caused by mutations in the GNA11 gene. A new subcategory houses several new codes to identify individuals with ADH:

E20.81 Hypoparathyroidism due to impaired parathyroid hormone secretion

E20.810 Autosomal dominant hypocalcemia

E20.811 Secondary hypoparathyroidism in diseases classified elsewhere

E20.812 Autoimmune hypoparathyroidism

E20.818 Other specified hypoparathyroidism due to impaired parathyroid hormone secretion

E20.819 Hypoparathyroidism due to impaired parathyroid hormone secretion, unspecified

E20.89 Other specified hypoparathyroidism

Also in this chapter, there are several new codes for reporting various lipid storage disorders; new codes for improved reporting of leukodystrophies; one new code for lysosome-associated membrane protein 2 [LAMP2] deficiency (E74.05); new codes for metabolic disorders such as E88.810-E88.819 to identify insulin resistant

“Under G43 Migraine, you’ll find new subcategories and codes for reporting this condition and differentiating whether the pain is manageable.”

metabolic syndrome types A and B and unspecified insulin resistance; and one new code for wasting disease (syndrome) due to an underlying condition (E88.A).

Chapter 5 (F01-F99)

There are no new codes in this chapter for mental, behavioral, and neurodevelopmental disorders, but there are several revisions and additions to parenthetical notes.

Chapter 6 (G00-G99)

The International Classification of Headache Disorders, 3rd edition, defines chronic migraine as “a headache occurring on 15 or more days a month for more than three months, which on at least eight days a month has the features of migraine headache.” Under G43 *Migraine*, you’ll find new subcategories and codes for reporting this condition and differentiating whether the pain is manageable. To learn more about migraines, read “A Migraine Is Not a Run-of-the-mill Headache,” by **Kathy Ware, MCLS, RHIT, CPC, CPB, AAPC Approved Instructor**, at www.aapc.com/blog.

There are also new codes under these categories:

- Hereditary ataxia (G11)
- Parkinson’s disease (G20)
- Other demyelinating diseases of central nervous system (G37)
- Epilepsy and recurrent seizures (G40)
- Disorders of autonomic nervous system (G90)
- Other disorders of brain (G93)

With these new codes come many additions and revisions in the tabular list and index.

Chapter 7 (H00-H59)

Several new subcategories and codes for reporting extraocular muscle entrapment are added under H50 *Other strabismus*. The new codes (H50.62-H50.68) identify which part of the extraocular muscle is affected and laterality.

Other tabular modifications in this chapter include a new subcategory and new codes under category H36 *Retinal disorders*

in diseases classified elsewhere for reporting proliferative and non-proliferative sickle-cell retinopathy. There are also new codes under H54 *Blindness and low vision* and H57 *Other disorders of eye and adnexa*.

Chapter 8 (H60-H95)

There aren’t many changes in this chapter for diseases of the ear and mastoid process. Of note, you’ll find minor Code first revisions for H62.4 *Otitis externa in other diseases classified elsewhere* and H91.0 *Ototoxic hearing loss*.

Chapter 9 (I00-I99)

Angina is a common ailment that can lead to coronary microvascular dysfunction (CMD). This condition is associated with significantly higher rates of major adverse cardiac events, according to code requester Abbot Laboratories, Inc. The following new codes track these conditions:

- I20.81** Angina pectoris with coronary microvascular dysfunction
- I20.89** Other forms of angina pectoris
- I21.B** Myocardial infarction with coronary microvascular dysfunction
- I24.81** Acute coronary microvascular dysfunction
- I24.89** Other forms of acute ischemic heart disease
- I25.85** Chronic coronary microvascular dysfunction

Also in this chapter, new codes are added for other hypertension (I1A-) and inappropriate sinus tachycardia (I47.10-I47.19). There are additional tabular modifications in this chapter related to the addition of these codes and several code revisions.

Chapter 10 (J00-J99)

A new subcategory and new codes to identify bronchiolitis obliterans and bronchiolitis obliterans syndrome are added:

- J44.8** Other chronic obstructive pulmonary disease
- J44.81** Bronchiolitis obliterans and bronchiolitis obliterans syndrome
- J44.89** Other specified chronic obstructive pulmonary disease

“Now there are several codes to identify the different types of breast density.”

- J44.9** Chronic obstructive pulmonary disease, unspecified
- J4A** Chronic lung allograft dysfunction
 - J4A.0** Restrictive allograft syndrome
 - J4A.8** Other chronic lung allograft dysfunction
 - J4A.9** Chronic lung allograft dysfunction, unspecified

Be sure to review the Code first and Code also notes for these new codes, as well as other deletions, additions, and revisions to parenthetical notes in this chapter.

Chapter 11 (K00-K31)

Intestinal microbial overgrowth encompasses small intestinal bacterial overgrowth (SIBO), intestinal methanogen overgrowth (IMO), and small intestinal fungal overgrowth (SIFO) — each diagnosis is treated differently. Current coding is commonly A04.9 *Bacterial intestinal infection, unspecified* or K63.8 *Other specified diseases of intestine*. Specific codes are added to identify intestinal microbial overgrowth and its subtypes:

- K63.82** Intestinal microbial overgrowth
 - K63.821** Small intestinal bacterial overgrowth
 - K63.8211** Small intestinal bacterial overgrowth, hydrogen-subtype
 - K63.8212** Small intestinal bacterial overgrowth, hydrogen sulfide-subtype
 - K63.8219** Small intestinal bacterial overgrowth, unspecified
 - K63.822** Small intestinal fungal overgrowth
 - K63.829** Intestinal methanogen overgrowth, unspecified

There are also new codes added for acute appendicitis (K35.200-K35.211, K35.219), disorders of the retroperitoneum (K68.2-K68.3), short bowel syndrome with or without continuity between the short bowel and colon (K90.821-K90.822, K90.829), and intestinal failure (K90.83).

Chapter 12 (L00-L99)

In this chapter for diseases of the skin, there is one revision to a Code first note under L53.0 *Toxic erythema*. This is to account for a code change in the Table of Drugs.

Chapter 13 (M00-M99)

Age-related osteoporosis with current pathological fracture of pelvis is currently coded as *osteoporosis with current pathological fracture, femur*. “This is anatomically incorrect,” according to the Agency for Healthcare Research and Quality. For improved reporting, new codes are added under new subcategories M80.0B *Age-related osteoporosis with current pathological fracture, pelvis* and M80.8B *Other osteoporosis with current pathological fracture, pelvis*.

Chapter 14 (N00-N99)

The Renal Physicians Association requested a new code for immunoglobulin A nephropathy (IgAN), the most common form of glomerulonephropathy. IgAN cases are currently coded as N02.8 *Recurrent and persistent hematuria with other morphologic changes*. After Oct. 1, look to the new codes under N02.B *Recurrent and persistent immunoglobulin A nephropathy* to indicate the severity or course of IgAN.

Membranous nephropathy (MN) is another condition that affects the genitourinary system. The National Kidney Foundation requested new codes for the primary and secondary forms of MN. “Since treatment is often targeted at the etiologic cause in secondary MN, differential diagnosis is critical to distinguish between the two forms,” the requesters stated. The new codes are added under categories N04 *Nephrotic syndrome* and N06 *Isolated proteinuria with specified morphological lesion*.

Chapter 15 (O00-O9A)

The National Center for Health Statistics received a request to clarify coding related to current code O90.4 *Postpartum acute kidney failure*, under which anuria, oliguria, and hepatorenal syndrome complicating the puerperium are currently classified. The new codes that separate these conditions are:

- O90.41** Hepatorenal syndrome following labor and delivery
- O90.49** Other postpartum acute kidney failure

Also in this chapter, new codes O26.64- are added for the reporting of intrahepatic cholestasis in pregnancy. The six-character codes allow you to specify trimester.

Official Coding Guidelines for 2024

The National Center for Health Statistics posted, July 5, the 2024 update to the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are essential to diagnosis coding and should be reviewed by medical coders and auditors at least annually. With this latest version going into effect Oct. 1, 2023, now is a good time to look at any changes.

Note: Narrative changes to the guidelines are bolded; text that has been moved is underlined; and heading revisions are italicized.

Under section I.C.1.g.1, the following is added:

(f) Screening for COVID-19

For screening for COVID-19, including preoperative testing, assign code Z11.52, *Encounter for screening for COVID-19*.

This code was added Jan. 1, 2021, and replaced Z11.59 *Encounter for screening for other viral diseases*. For COVID-19 screening encounters on or after Oct. 1, 2023, assign code Z11.52.

Under section I.C.9.e. Acute myocardial infarction (AMI), the following is added:

6) Myocardial Infarction with Coronary Microvascular Dysfunction

Coronary microvascular dysfunction (CMD) is a condition that impacts the microvasculature by restricting microvascular flow and increasing microvascular resistance. Code I21.B, *Myocardial infarction with coronary microvascular dysfunction*, is assigned for myocardial infarction with coronary microvascular disease, myocardial infarction with coronary microvascular dysfunction, and myocardial infarction with non-obstructive coronary arteries (MINOCA) with microvascular disease.

Under section I.C.18.e. Coma, the following is added:

Code R40.20, Unspecified coma, **should be assigned when the underlying cause of the coma is not known, or the cause is a traumatic brain injury and the coma scale is not documented in the medical record.**

Do not report codes for unspecified coma, individual or total Glasgow coma scale scores for a patient with a medically induced coma or a sedated patient.

1. Coma Scale

2. The coma scale codes (R40.21- to R40.24-) can be used in conjunction with traumatic brain injury codes. These codes **cannot be used with code R40.2A, Nontraumatic coma due to underlying condition**. They are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code(s).

Under section I.C.21.c, the following is added:

8) Follow-up

Codes Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, and Z09, Encounter for follow up examination after completed treatment for conditions other than malignant neoplasm, may be assigned following any type of completed treatment modality (including both medical and surgical treatments).

Under section III. Reporting Additional Diagnoses, two impactful words were added to the definition for "other diagnoses:"

For reporting purposes, the definition for "other diagnoses" is interpreted as additional **clinically significant** conditions that affect patient care in terms of requiring . . .

The FY 2024 ICD-10-CM **guidelines** are available for download from the NCHS website.

Chapter 16 (P00-P96)

There are no new codes in this chapter for conditions originating in the perinatal period, but there are several revisions and deletions to parenthetical notes.

Chapter 17 (Q20-Q28)

Alagille syndrome is a rare genetic disorder that primarily affects the liver but can affect multiple organ systems, according to the Global Liver Institute (GLI). This condition is currently classified under Q44.7 *Other congenital malformations of the liver*, which also in-

cludes accessory liver, congenital absence of liver, congenital hepatomegaly and congenital malformation of liver NOS. New codes and inclusion terms allow for clearer identification of Alagille syndrome.

Q44.70 Other congenital malformation of liver, unspecified

Q44.71 Alagille syndrome

Q44.79 Other congenital malformations of liver

Also in this chapter, several codes are added under Q75 *Other congenital malformations of skull and face bones* to better identify craniosynostosis; three codes are added under Q87.8 *Other speci-*

“The American Academy of Pediatrics requested new codes for reporting foreign bodies entering into or through a natural orifice.”

fied congenital malformation syndromes, not elsewhere classified to identify Bardet-Biedl syndrome, Laurence-Moon syndrome, and MED13L syndrome; and Q93.52 *Phelan-McDermid syndrome* is added to identify this genetic neurodevelopmental condition with multi-system manifestations.

Chapter 18 (R00-R99)

Many women are told they have “dense breast tissue.” Now there are several codes to identify the different types of breast density. You will find these codes under new subcategory R92.3 *Mammographic density found on imaging of breast*. Code also inconclusive mammograms (R92.2), if applicable.

Also in this chapter, you’ll find new codes for reporting foreign body sensation in various areas of the circulatory and respiratory systems (R09.A-) and a new code for the diagnosis of nontraumatic coma due to an underlying condition (R40.2A).

Chapter 19 (S00-T88)

Codes for gadolinium (T56.821-T56.824) are added to the Table of Drugs and Chemicals. There are also some added and deleted parenthetical notes.

Chapter 20 (V00-Y99)

The American Academy of Pediatrics requested new codes for reporting foreign bodies entering into or through a natural orifice. Instead of category T16-T19 codes, appropriate for the run-of-the-mill Cheerio-in-the-nose encounter, you’ll look under new category W44 *Foreign body entering into or through a natural orifice* to code more serious objects being inserted where they don’t belong such as a swallowed button battery (W44.A1) or sharp glass (W44.C1).

Chapter 21 (Z00-Z99)

A new code is added for reporting a child welfare exam (Z02.84); two new codes are added under Z05.8 *Observation and evaluation of newborn for other specified suspected condition ruled out*; a new code is added for identifying resistance to carbapenem (Z16.13); and (as mentioned earlier) new Z22.34- codes are added for reporting carriers of other specified bacterial diseases.

Also in this chapter, a new code is added for acute HIV infection syndrome and HIV pre-exposure prophylaxis (PrEP) to increase awareness of PrEP among some at-risk groups, to enable wider use,

and to reduce the burden of HIV disease, according to the requester.

Z29.81 Encounter for HIV pre-exposure prophylaxis

Z29.89 Encounter for other specified prophylactic measures

There are also new Z codes to provide coding specificity for family history of adenomatous polyps for individuals with this familial risk factor.

Lastly, in this chapter, there are new codes for reporting additional social determinants of health such as a child in custody of a non-relative guardian (Z62.24) and other specified problems related to upbringing (Z62.8-).

Chapter 22 (U00-U85)

This chapter is reserved for special purpose codes such as assignment of new diseases of uncertain etiology or emergency use. Note the changes under U07.1 *COVID-19*, as follows:

Add **Use Additional** code, if applicable, for associated conditions such as:

COVID-19 associated coagulopathy (D68.8)
disseminated intravascular coagulation (D65)
hypercoagulable states (D68.69)
thrombophilia (D68.69)

Delete **Excludes2:** coronavirus infection, unspecified (B34.2)

Learn More About the Code Update

This is not an all-inclusive list of the changes in the October update to ICD-10-CM. You can learn more about diagnosis coding for FY 2024 in a Sept. 13 webinar hosted by AAPC and presented by **Jill Young, CPC, CEDC, CIMC**. To register, go to www.aapc.com/medical-coding-education/webinars/2024-icd-10-cm-updates. **HBM**



Renee Dustman, BS, is the managing editor of content and editorial for AAPC’s Publishing Department. She is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

Resources

CDC ICD-10 Coordination and Maintenance Committee Meeting, Sept. 13-14, 2022

CMS.gov 2024 ICD-10-CM



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AAPC Recognizes Lisa Livingston

Meet a member who demonstrates exemplary professionalism and leadership skills.

“Through professional development and continuing education opportunities, AAPC opened doors to advance my career.”

Each month, AAPC selects a member who demonstrates exemplary leadership qualities. This month, we’ve chosen **Lisa Livingston, BSN, RN, CPC, CPMA**. Livingston is a long-time member who has consistently shared her expertise with others through writing, education, and leadership roles. We asked Livingston to share her professional journey in her own words. This is her story.

A Career in Clinical

Thirty-four years ago, I began my journey as a dedicated nursing professional. Since then, I have delivered patient-focused care to patients across a diversity of healthcare settings including a large hospital system, physician-owned medical practices, home health, and hospice. I worked for more than 20 years in a specialty medical practice, where I coordinated and provided patient care for more than 50 providers across four states, with a primary emphasis in allergy, asthma, and immunology care for patients of all ages. For 10 of those years, I provided strategic direction to the clinical operations of a freestanding research center affiliated with the medical practice. It was during that time when we implemented a centralized web-based clinical trial management system to improve research tracking, reporting, data management, and financial administration for pharmaceutical research-sponsored clinical trials.

From Clinical to Compliance

With a medical coder on maternity leave in 2012, the accounts receivable administrator asked for my support to prepare medical records for third-party payer audits. Soon after, the senior management team approached me regarding a newly created position for a compliance specialist. I decided to become a member of AAPC to gain a better understanding of the business side of healthcare. I knew it would be important to understand the fundamentals of the revenue cycle and how to maximize reimbursement for the practice.

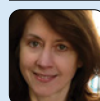
As a registered nurse, I had a strong foundation in anatomy, physiology, and medical terminology. With the right education and training resources, I earned my Certified Professional Coder (CPC®) and Certified Professional Medical Auditor (CPMA®) credentials. This led me to contribute to the growth and success of an internal compliance program by implementing audit software to improve operational efficiencies and risk reduction across the practice. Thanks to a robust clinical background and leadership experience, the transition from a clinical setting to compliance specialist was not difficult for me.

Through professional development and continuing education opportunities, AAPC opened doors to advance my career. Almost three years ago, I accepted a position as nurse consultant with the Tennessee Bureau of Investigations Medicaid Fraud Control Division, performing comprehensive medical reviews for civil and criminal investigations of provider fraud allegations.

Looking Ahead

The landscape of healthcare is continuously evolving and is undergoing unprecedented changes. Key stakeholders and leadership in any organization must also change, both in response to and in anticipation of emerging trends. With a growing membership, AAPC remains committed on advancing the careers of healthcare professionals. Being a member of AAPC’s National Advisory Board provides me with a unique opportunity to be an ambassador of AAPC’s mission, advocating for positive change and bringing unique skills and diverse expertise to drive meaningful progress throughout the organization.

I plan on sitting for the Certified Professional Compliance Officer (CPCO®) exam this year. It will be exciting to see what doors this will open for me. **HBM**



Renee Dustman, BS, is the managing editor of content and editorial for AAPC’s Publishing Department. She is a member of the Flower City Professional Coders local chapter in Rochester, N.Y.

A New Way to Audit Incident-to Services

Proper documentation and accurate billing are essential aspects of healthcare compliance.



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The Centers for Medicare & Medicaid Services (CMS) sets guidelines and regulations to ensure adherence to reimbursement rules for incident-to services. Some of CMS' rules center around practices that employ advanced practice providers (APPs). When auditing medical records, it's crucial to understand and apply CMS' incident-to rules. This article aims to provide guidance on auditing medical records to ensure compliance with those rules.

Circumstances for Billing APP Services Incident-to

CMS' incident-to requirements dictate the circumstances under which services provided by APPs can be billed under a supervising physician's National Provider Identifier (NPI). To comply with CMS guidelines, the following key elements must be met.

APP Qualifications

APPs must be qualified healthcare professionals, such as nurse practitioners (NPs), physician assistants (PAs), or clinical nurse specialists

(CNSs), and must work under the direct supervision of a physician. This means the physician must be physically present in the office suite and available to assist, even if they are not physically present in the same room during the service.

One exception to the supervision requirement is when certain behavioral health services are performed. The 2023 Medicare Physician Fee Schedule (MPFS) final rule allows general supervision for these. Under general supervision, the supervising physician does not need to be physically present while the service is being performed by the APP. However, the physician must be available for consultation or assistance if needed. The physician's involvement may include providing general instructions or guidelines to the APP regarding the patient's care, being available for questions or consultation, and periodically reviewing the services provided.

There are other exceptions as well, such as during the public health emergency (PHE) for COVID-19. CMS temporarily modified the regulatory definition of direct supervision, which requires the

"Incident-to services are only allowed for office visits in the physician's office and in the outpatient clinical setting."

supervising physician to be "immediately available" to furnish assistance and direction during the service, to include "virtual presence" of the supervising clinician through the use of real-time audio and video technology. This flexibility is currently set to return to pre-PHE rules on Dec. 31, 2023.

Keep in mind that each state may have different rules, commonly known as the "scope of practice," that indicate which services APPs can perform either under direct or general supervision.

Established Plan of Care

The APP's services must be consistent with an established plan of care, initiated by the physician during a face-to-face encounter with the patient.

Take Steps to Compliance

When conducting an audit of medical records to assess compliance with CMS' incident-to requirements, consider the following steps:

Review documentation of supervision: Ensure that the medical records clearly indicate the presence and availability of the supervising physician during the service. Look for evidence of collaboration, communication, and consultation between the APP and the supervising physician. If possible, look at the physician's appointment schedule for that day to see if they were in the office seeing patients.

Assess plan of care documentation: Examine the medical records for documentation of an established plan of care by the supervising physician. Look for evidence of a face-to-face encounter with the patient, during which the physician initiates and documents the plan of care that includes services to be provided by the APP. Then make sure that the physician has been actively engaged in the treatment. The physician cannot just initiate treatment and allow the APP to treat the patient independently.

In addition, no new problems can be addressed if the service is going to be billed under the physician. The APP can only follow the treatment plan given by the physician. If the patient does have a new problem that needs addressed, the physician will either need to see the patient and treat the problem or the service will need to be billed under the APP.

Check billing and coding accuracy: Verify that the services rendered by the APP, billed under the supervising physician's NPI, are appropriately coded using CMS' billing guidelines. Ensure accurate documentation of the place of service, modifiers, and any other relevant billing requirements. Incident-to services are only allowed for office visits in the physician's office and in the outpatient clinical setting. In the inpatient, observation, and skilled nursing home setting, the split/shared rules are used instead.

As you can see, an incident-to audit requires reviewing more than just one date of service. An auditor should have access to the electronic medical record system to review the entire chart, as well as appointment and vacation schedules.

Address audit findings: If any deficiencies or non-compliance issues are identified during the audit, it's important to take appropriate action. This may involve implementing corrective measures, providing additional training to the healthcare providers, or developing policies and procedures to ensure future compliance. Document the audit findings, actions taken, and any follow-up steps to demonstrate due diligence.

If major issues are found, consider billing the claim directly under the APP rather than using the incident-to guidelines. We have many clients that do this because the guidelines do have some loopholes and are hard to track. Another benefit to billing under the APP is that when the patient gets the bill, you won't receive phone calls wondering why they got a charge for a physician they did not see. Remember, though, that this will subject you to the 85 percent payment reduction: APPs are paid at a lower rate per CMS (and many payers).

Maintain Regulatory Compliance

Auditing medical records for compliance with CMS' incident-to requirements is vital to maintain regulatory compliance, accurate billing, and proper reimbursement. By understanding the key components of CMS' incident-to guidelines and following a systematic auditing process, healthcare organizations can ensure adherence to regulations and optimize patient care. Compliance with CMS' incident-to requirements promotes transparency, reduces the risk of improper billing, and enhances overall quality of care in the healthcare industry. **HBM**



Lori A. Cox, MBA, CPC, CPMA, CPC-I, CEMC, CGSC, CHONC, has over 20 years of experience in the business side of healthcare. She began working as a patient accounts representative and then transitioned to the billing department. She was promoted to billing supervisor and later became the compliance officer. Currently, Cox works for AAPC Services as director of client engagement, performing audits and education for clients across the country.

Cox has served on AAPC's National Advisory Board, presented at national and regional HEALTHCONs, and traveled the country speaking to coders and providers on a variety of topics.

Resources

Levine S., Weber, E., "Medicare Compliance Basics: Incident to Billing," Foley & Lardner LLP, Feb. 16, 2023

Powe, M., "What Pas Should Know About the 2023 Physician Fee Schedule Rule," AAPA, Nov. 10, 2022

CMS, "Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19," June 26, 2023

When to Use Modifier QW

Know the rules for CLIA waived tests to ensure proper claims payment.

Modifier QW indicates a Clinical Laboratory Improvement Amendment (CLIA) waived test performed by a lab with a CLIA certificate. Appending modifier QW to a code indicates that the test was performed at a waived complexity level. Let's make sure you understand what a CLIA waived test is so that you can use modifier QW appropriately to get claims paid.

What Is CLIA?

CLIA regulations include federal standards that are applicable to any U.S. facility that performs laboratory testing on specimens derived from humans for the purpose of providing information for:

- Diagnosis or treatment of disease or impairment
- Health assessments

The objective of CLIA is to ensure the accuracy, reliability, and timeliness of test results regardless of where the test is performed.

CLIA Certifications

Every lab should have at least one of the five types of CLIA certifications to perform a lab test. These certifications include:

- **Certificate of Waiver** – For performing simple laboratory examinations and procedures that have an insignificant risk of an erroneous result
- **Certificate of Provider Performed Microscopy Procedures (PPMP)** – In addition to the waived tests, can perform an additional 12 microscopic tests
- **Certificate of Registration** – Temporarily issued to a non-waivered lab until registration is completed
- **Certificate of Compliance** – Can perform moderately and/or highly complex tests. This certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements. Compliance facilities are inspected by their CMS CLIA state agency.
- **Certificate of Accreditation** – Can perform moderately and/or highly complex tests. This certificate is issued to a laboratory after an inspection by the laboratory's accreditation organization to determine compliance with all applicable CLIA requirements. Accredited facilities are inspected by their accrediting agency. The accrediting agency must be approved by CMS.

The CLIA certificate number must appear on claims in Loop 2300 or 2400 REF/X4, 02 for electronic claims or Item 23 of the CMS-1500 for paper claims.



When to Code Modifier QW

If a lab has a certificate of waiver or certificate of PPMP, then modifier QW is mandatory for procedures included on the Centers for Medicare & Medicaid Services' (CMS') waived list, with a few exceptions. The following CPT® codes do not require modifier QW to be recognized as CLIA waived:

- 81002** Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
- 81025** Urine pregnancy test, by visual color comparison methods
- 82270** Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)
- 82272** Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening

- 82962** Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use
- 83026** Hemoglobin; by copper sulfate method, non-automated
- 84830** Ovulation tests, by visual color comparison methods for human luteinizing hormone
- 85013** Blood count; spun microhematocrit
- 85651** Sedimentation rate, erythrocyte; non-automated

PPMP Microscopic Procedures

In addition to waived tests, labs with a PPMP certification can perform an additional 12 microscopic tests. The 12 CPT® codes used to bill these tests do not require the addition of modifier QW.

- Q0111** Wet mounts, including preparations of vaginal, cervical or skin specimens
- Q0112** All potassium hydroxide (KOH) preparations
- Q0113** Pinworm examinations
- Q0114** Fern test
- Q0115** Post-coital direct, qualitative examinations of vaginal or cervical mucous
- 81015** Urinalysis; microscopic only
- 81000** Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
- 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
- 81020** Urinalysis; 2 or 3 glass test
- 89055** Leukocyte assessment, fecal, qualitative or semiquantitative
- G0027** Semen analysis; presence and/or motility of sperm excluding hühner
- 89190** Nasal smear for eosinophils

Test Your Knowledge

With the proper certifications, CLIA labs can perform tests at both waived and complex levels. Usually, the tests do not need modifier QW unless the documentation mentions the service was provided at a waived level. Only CPT® codes that need modifier QW to be recognized as waived need to be appended.

Here are some real-world examples for better understanding:

1. A patient came to a CLIA waived lab for a urinalysis test (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, without microscopy). Is it appropriate to use modifier QW for this test?

Answer: Yes. The CPT® code for this test is 81003 and the patient is in a CLIA waived lab. Per CMS, modifier QW is required to indicate the test was performed at a waived level.

2. A patient came to a CLIA compliance lab for a urinalysis test (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, without microscopy). Is it appropriate to use modifier QW for this test?

Answer: No. CLIA compliance does not require modifier QW unless the provider documented the service was performed at a waived level.

3. A patient came to a CLIA PPMP lab for a urinalysis test (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, without microscopy). Is it appropriate to use modifier QW for this test?

Answer: Yes. The CPT® code for this test is 81003 and CLIA PPMP labs perform waived tests only. Per CMS, modifier QW is required to indicate the test was performed at a waived level.

4. Does 87635 require modifier QW when performed in a CLIA waived lab?

Answer: Yes. CPT® 87635 was added to the code set in 2020 and must have modifier QW appended to be recognized as a test that can be performed in a facility with a CLIA certificate of waiver.

5. Is it appropriate to add modifier QW to 81001 when performed in a CLIA PPMP lab?

Answer: No. 81001 is one of the 12 microscopic procedures a PPMP lab is allowed to perform, making modifier QW unnecessary.

6. Is it appropriate to add modifier QW to 81000 or 81001 when performed in a CLIA waived lab?

Answer: No. 81000 and 81001 are not acceptable procedures to be performed in a CLIA waived lab (with or without QW); you cannot use these CPT® codes in a CLIA waived lab. If you receive a medical record coded with 81000 or 81001 under CLIA waived, query the physician for clarification. Note: In a CLIA PPMP lab, you can code 81001 but not 81000.

Remember: QW is a fee-affecting modifier and should be added as the first-listed modifier to a code. CMS updates its waived list every year, so make sure to check it annually to ensure billing accuracy. **HBM**



Archana Murali, CPC, has 14 years of experience in the healthcare industry, including coding for ambulatory and hospitals on the front end and in denial management and as a healthcare business analyst. Murali works at Athenahealth Technology Pvt Ltd as a team training manager, identifying training needs and designing and implementing training programs.

Resources

CDC: Tests Granted Waived Status Under CLIA

CMS: MLN Matters MM13253

U.S. FDA CLIA search database

CDC CLIA Law & Regulations

Do You Have the Skills to Become a CDI Specialist?

The need for clinical documentation improvement specialists is on the rise.

You've probably seen the acronym CDI (clinical documentation improvement), but do you understand the CDI specialist's role in an organization's daily workflow with regard to educating and training physicians, non-physician practitioners (NPPs), and other clinical staff?

CDI specialists are an integral part of ensuring that provider documentation and the medical record are complete, accurate, compliant, reflect the patient's severity of illness, and support billed diagnosis codes. CDI bridges the gap between coders and practitioners. This is why we've seen an increase in both onsite and remote job postings and programs created for CDI specialists in recent years.

Roles of a CDI Specialist

CDI specialists often work in the inpatient setting, reviewing patients' charts for diagnosis coding. Most importantly, they ensure documentation supports patient care and management of diseases and chronic conditions. CDI specialists may also work in the outpatient setting on a compliance auditing team, analyzing data algorithms and reviewing documentation guidelines, medical necessity, and diagnosis specificity, all of which may affect risk adjustment, claim denials, and provider reimbursement. The CDI specialist will often work with a "CDI physician champion," a provider who recognizes and supports the mission of CDI and its initiative to improve documentation. The physician champion serves as a bridge between CDI and other physicians/colleagues.

Daily duties of a CDI specialist may vary depending on the organization and department they work in, but a day as a CDI specialist may include the following:

- Ensures the accuracy and completeness of clinical information for measuring and reporting physicians' and hospitals' documentation and medical records
- Conducts concurrent reviews to ensure there is proper documentation as required for Medicare, Medicaid, and commercial payers

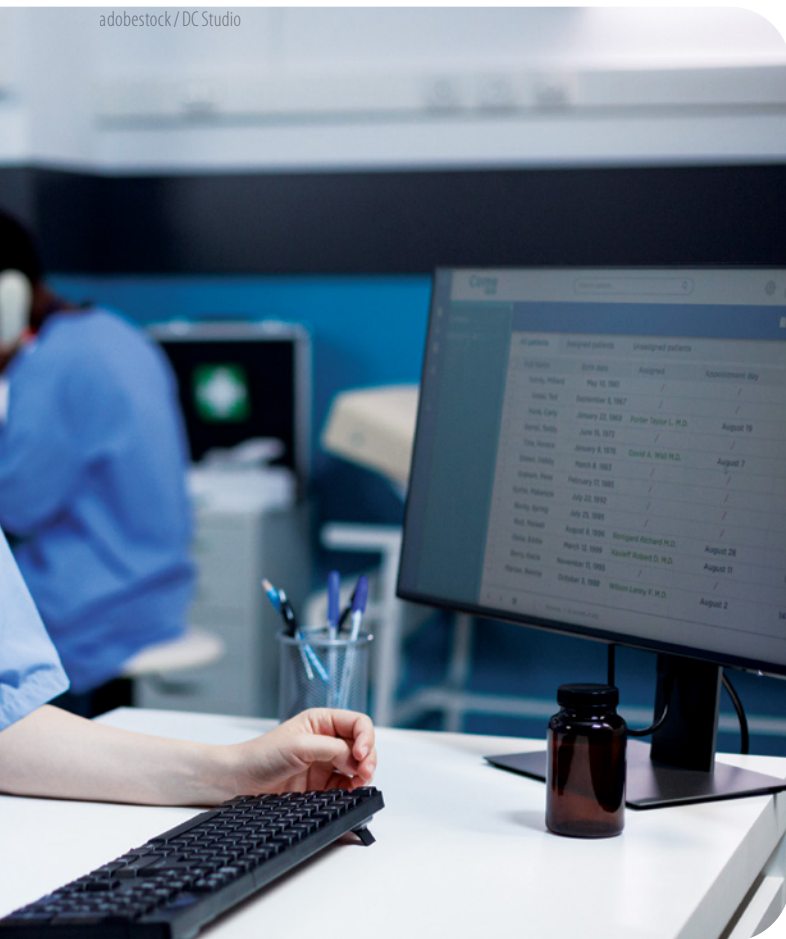


- Analyzes statistical and clinical data of patients, treatment plans, and discharge summaries
- Tracks outcomes for individual patients to measure the quality of services provided
- Tracks responses and queries into the organization's database/tracking tool and follows up with doctors and nurses where needed to complete a patient's records
- Collaborates with coding staff and CDI physician champions to ensure patient records reflect clinical status and care provided
- Educates medical and coding staff on clinical documentation opportunities, coding and reimbursement issues, and performance improvement methodologies
- Demonstrates an understanding of complications, comorbidities, case mix, and the impact of procedures on the billed record
- Participates in CDI initiatives and provides opportunities for documentation improvement for systems

CDI Education and Job Requirements

If you search job listings on websites, a CDI specialist will require a clinical background and may look for nurses, NPPs, and advanced practice providers (APPs) like nurse practitioners, physician as-

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"Some outpatient CDI programs may not require a nursing degree but may require that applicants have completed or hold a certification from an accredited program."

Some outpatient CDI programs may not require a nursing degree but may require that applicants have completed or hold a certification from an accredited program such as AAPC's Certified Documentation Expert Outpatient (CDEO®), Certified Documentation Expert Inpatient (CDEI™), or Certified Risk Adjustment Coder (CRC®). These courses cover medical terminology, anatomy and physiology, pharmacology, documentation requirements, chronic conditions, disease processes, coding guidelines, management of patients' conditions, and how to educate a provider efficiently after review.

What Is on the Horizon for CDI?

As healthcare moves toward value-based payments, organizations will continue to see the importance of implementing CDI roles and programs to support the increasing demand for accurate and compliant clinical documentation in inpatient and outpatient settings. Remember, a CDI specialist's role is not to work against providers and other clinical and coding staff, but to work with them to ensure a decrease in population risk, an increase in data quality for patient care, quality reporting of documentation, and an increase in revenue. **HBM**



Keisha Wilson, CCS, CPC, CPB, CPMA, CRC, AAPC Approved Instructor, has worked in healthcare for more than 20 years, holding various positions in hospitals and acute and ambulatory care systems, including outpatient coding specialist, CDI specialist, compliance operations manager, and interim director. She has consulted for various coding companies and collaborated on AAPC's *Primary Care Coding Alert*. Wilson recently started her own healthcare consulting company, KW Advanced Consulting, LLC, which provides compliance training on documentation and coding as auditing services, as well as virtual coding courses, live and on-demand webinars, and additional consulting services based on clients' needs. She currently sits on the board of directors for an outpatient and mental health clinic in Brooklyn and is a member of the Manhattan, N.Y. local chapter.

sistants, and even physicians. If you're interested in transitioning to a role as a CDI specialist, speak to someone already in the role who can provide advice, and research various postings to understand the educational requirements and job descriptions. Some CDI roles may require you to have the following:

- A clinical background, with a minimum of an associate or bachelor's degree in nursing and a master's degree in health informatics
- Current state license to practice in the state in which you will work, unless it's a remote job, which only requires an active license
- A minimum of 2 to 5 years of experience in a CDI role
- Proficiency in a medical record review
- Excellent presentation skills
- Soft skills, including excellent interpersonal and written skills
- Excellent analytical skills
- Strong computer skills, with knowledge of Microsoft 365 (Excel, Word, PowerPoint)

Strong computer skills have moved up the ladder of requirements lately as hybrid and remote work has increased significantly since the COVID-19 pandemic. Employers want to ensure candidates have what it takes to work independently and communicate virtually.

Resource

CMS Pub 100-04 Transmittal 11288



5 Questions to Ask When Verifying Speech Therapy Benefits

Understanding the intricacies of speech therapy coverage helps bolster all areas of the revenue cycle.

Verifying insurance benefits and obtaining accurate information are important steps in the revenue cycle, especially when billing speech therapy. Many insurers say they cover speech therapy services, but what they don't always tell you is that only certain types of services are covered. This can lead to claim denials, balance write-offs, and unexpected bills for patients. Therefore, it's crucial to ask the right questions before billing for these services.

In addition to asking about applicable deductibles, co-insurance, and copays, be sure to thoroughly read the patient's benefit booklet or ask the insurer's customer service representative for the following five pieces of information.

1 Does the plan cover both rehabilitative and habilitative services?

Some insurers cover all services for speech therapy, whereas others cover services only under certain conditions. When it comes to coverage, there are two branches to these services: rehabilitative and habilitative.

Rehabilitative services help a person keep, get back, or improve skills that were lost because of illness or injury. For example, a patient who has had a stroke or traumatic brain injury may have lost the ability to communicate or has difficulty finding words.

Habilitative services help a person attain skills they may not have developed in the first place that impact their daily living. Think of a child who can understand what a person is saying and follows directions but has limited or even no words to express their wants and needs, or a child with articulation errors who can speak but is difficult to understand. The latter is most commonly considered to be a non-covered service or a covered service only for those under a specific age.

2 Is there a visit maximum?

Many speech therapy services are subject to a visit limit, but it's important to understand that these visit limits are classified as either a hard or soft maximum.

Insurance plans with a soft maximum on visit limits will often approve additional visits beyond their maximum based on medical necessity; though, unlike Medicare's outpatient therapy cap, this cannot be overridden with a simple modifier. If your patient's plan is a soft max, notate the steps for requesting additional visits. This could be in the form of submitting documentation through a provider portal, via fax, or requesting additional visits through the authorization department.

Plans with a hard maximum make it harder to obtain additional visits unless there is a policy clause for patients being seen for certain rehabilitation services. Some plans may also state there is no visit limit for certain diagnosis codes. It's possible to come across a plan that states that limits don't apply to mental health, with the majority of the F-series codes that speech therapists use being classified as such.

Additionally, ask if the visit limit applies for conditions such as autism or if additional visits are allowed in cases of certain conditions such as stroke or other illness or injury.

3 Is a referral from the primary care provider required?

The purpose of a referral is to ensure that a patient receives specialty care and treatment for their concern from the most appropriate provider. With such a wide selection of specialty areas that fall under the umbrella of a speech language pathologist's scope of practice, a referral can also provide additional details about the primary concern, helping your provider determine if they're the right fit for that patient.

An initial referral also may have the diagnosis code(s) of relevant medical concerns, which helps your office get paid for claims. Not all clinics require a referral to initiate services, but some insurers require the ordering or referring physician to be included on the claim or be sent directly to the insurance in order for payment to be made. Decide whether you want to require a referral for every patient from their primary care provider or only when required by insurance.

4 Is authorization required for the evaluation and/or treatment?

Insurers may require prior authorization before the start of treatment or evaluation. This allows health insurance companies to manage costs, control utilization management, and ensure the requested services are covered under the patient's policy. Prior authorization typically requires the submission of the evaluation

report, care plan, and even chart notes. The insurance then reviews the records and makes a determination based on medical necessity, coverage policies, and other factors. The downside of prior authorization is a delay in receiving care, as the approval process can take days or even weeks. If an authorization is denied, check the patient's member handbook or the insurer's provider manual regarding the appeal process.

5 What are the other exclusions?

The member handbook is a convenient resource for identifying specific speech therapy services that will not be covered by your patient's plan. What is considered an excluded service will differ between insurers and plans within the same insurance company. Anything considered "educational," such as a reading disorder or dyslexia, or services considered "maintenance" in nature is almost always an exclusion. Accent reduction is another example of a non-covered service as it's viewed as a cosmetic service.

Submit Claims With Confidence

Becoming familiar with aspects of each patient's insurance plan to identify what services are allowed or excluded, visit limits, and prior authorization or referral requirements can help medical offices significantly reduce the number of unexpected claim denials they receive. It also allows offices to communicate coverage gaps with their patients, ensuring not only a more efficient reimbursement process, but also a reduction in additional unexpected patient costs. This comprehensive understanding enables offices to provide better support and guidance to patients, promoting a more positive experience while navigating the complexities of insurance. **HBM**



Alyssa Carr, CPPM, has been the office manager for a speech and occupational therapy clinic since 2017. She entered the healthcare field in 2010 and earned her bachelor's in healthcare administration from Pacific University in 2016. She is a member of the Albany, Oregon local chapter.

"Not all clinics require a referral to initiate services, but some insurers require the ordering or referring physician to be included on the claim or be sent directly to the insurance in order for payment to be made."



Scrub Away Debridement Billing Confusion

Know when to bill for debridement separately from surgery.

Debridement removes foreign material and/or devitalized or contaminated tissue until healthy tissue is exposed. It essentially cleans up the area and is often performed with other orthopedic surgical procedures. As an auditor who specializes in orthopedics, I frequently see providers bill for debridement in addition to an extensive surgery. For billing purposes, however, debridement is generally considered a component of a more extensive procedure.

Per National Correct Coding Initiative (NCCI) Policy Manual, Chapter 4, under General Policy Statements, “Debridement of tissue in the surgical field of another musculoskeletal procedure is not separately reportable.”

Sounds easy enough, right? Think again. As with all things ortho coding related, just when you think you understand a concept

well, there are exceptions to remember. In this case, there are three instances in which you can, and should, bill for a debridement procedure separately from a surgical procedure.

1. Debridement at the Site of an Open Fracture or Dislocation

Open fracture pertains to the diagnosis (bone sticking through the skin), not the type of repair or procedure (e.g., open reduction). When debridement is performed at an open fracture or dislocation site, look to CPT® code range 11010-11012 (Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation). Bill the debridement procedure in addition to any fracture treatment code(s).

“Debridement is generally included with other arthroscopic shoulder procedures, even when performed in different areas of the shoulder.”

2. Arthroscopic Shoulder Debridement

Debridement is generally included with other arthroscopic shoulder procedures, even when performed in different areas of the shoulder. However, you can bill extensive debridement (29823), which is defined as ... *3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body(ies))*, with 29824 *Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface (Mumford procedure)*, 29827 *Arthroscopy, shoulder, surgical; with rotator cuff repair*, and/or 29828 *Arthroscopy, shoulder, surgical; biceps tenodesis* when performed in different areas of the shoulder.

It should be noted that between the dates of Oct. 1, 2022, and Dec. 31, 2022, there was an NCCI edit that bundled 29823 with the abovementioned procedures. However, that edit was removed as of Jan. 1, 2023, so no modifier is required other than the anatomical modifier for these code pairs.

ment/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed and 29881 Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed. Since the descriptions of these procedures include “chondroplasty in a same OR separate compartment,” you cannot report G0289 for debridement/chondroplasty when performed with a meniscectomy, regardless of which compartment is treated. You can, however, bill G0289 for loose body removal when a meniscectomy is performed, as long as the loose body is removed from a separate compartment. **HBM**



Julie Harper, CPC, CPCO, CDEO, CPMA, COSC, has over 15 years of experience in healthcare administration. She has a bachelor of science degree in business and currently works as a multispecialty medical auditor with a special interest in orthopedic surgery. In her current role, Harper performs quality assurance audits to ensure compliance with all coding and documentation guidelines.

3. Arthroscopic Knee Debridement

In general, you can separately bill arthroscopic debridement/chondroplasty of the knee when it is performed in a separate compartment. There is an NCCI edit, however, bundling 29877 *Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)* with all other knee scope procedure codes (29866-29889), which cannot be overridden. Instead, when debridement or loose body removal is performed in a different compartment, consider whether you can use HCPCS Level II code G0289 *Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee*.

Of course, there is an exception to the exception, which is seen with 29880 *Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debride-*



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Apply QI Principles to Patient Satisfaction

Documentation and data can illuminate weak points in customer service.

Medical practices may not always think about customer service as a cornerstone of their daily endeavors. But in the United States, where healthcare is a business, making sure customers — patients — are satisfied with the services they receive is paramount to success.

Using quality improvement (QI) principles to evaluate customer service can provide a useful framework. Identify strengths and weaknesses by collecting some hard data on how patients feel about their experiences at your practice via patient satisfaction surveys and incorporate additional QI tips to help patients feel good about your services.

Know How a Survey Can Help

Asking patients about their experiences can help you understand if there are any aspects of your practices' services you might consider improving.

For example, most patients expect to spend at least some time in a doctor's waiting room before an appointment. But practices that struggle to get patients into exam rooms or with a clinician in a reasonable amount of time may inadvertently encourage their patients to seek services elsewhere.

Of course, each individual may have a different threshold for what constitutes too long of a wait, but surveying a critical mass of patients can provide the answers you need.

"You don't have to have a 10-page survey. You don't need to have a one-page survey. You don't need to have even three questions!" said **Sheila Sampath, BBA, MHSA, CPB**, associate professor and faculty chair, Healthcare Administration, DeVry University, in her presentation "The Art of Practice Management" at AAPC's 2023 HEALTHCON.

You can have just a one-question survey, at the front desk, and when you sign patients out, keep a spreadsheet open and ask, "How did today go?" and write down the answer, Sampath said. And if you ask a different question every month, you'll have 12 surveys in a year.

Watch this part of Sampath's presentation in the electronic version of *Healthcare Business Monthly*, available at www.aapc.com/publications/healthcare-business-monthly when signed in to your account.



Don't just conduct a survey, even if it's brief and informal, without utilizing the data. If you know your wait times are tough, ask patients how they feel about it.

"Get the data," Sampath said. Then get staff together or bring in other professionals to help you figure out where to make changes to help get your wait times down.

Sampath mentioned how universities regularly collect feedback from students via course evaluations and pulse surveys. Collecting the data is not enough, she said — delving into the responses, identifying themes, and then reporting any patterns or conclusions back to the audience is crucial to helping people feel heard.

"Put it in a newsletter, change something and say, 'OK, we're changing this and seeing how it works,'" she said.

Create a Comfortable Culture

Most practices are familiar with the phrase "patient-centered care" and aim to provide services that meet patients' needs. But it can be easy to get bogged down in the minute-to-minute and day-to-day monotony of seeing patients and forget that patients are people and have needs beyond their medical conditions.

"Why are we not talking? We're just getting patients in and out," Sampath said. "When I go to any medical office and they take the



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"Asking patients about their experiences can help you understand if there are any aspects of your practices' services you might consider improving."

in a business's cafeteria), there's usually at least one person with a phone in their hand.

Sampath recommended role playing as a way to help team members develop or exercise their communication skills, as well as their bedside manner. Everyone in your practice should be able to feel comfortable when interacting with other people, whether they're scheduling patients, answering phones, taking patient vitals, or delivering a diagnosis.

While staff members, especially clinicians, may not want to make the time to role play such basic interactions, even acknowledging the significance of communication skills and bedside manner can help staff think about the ways in which they speak, listen, and connect with patients. **HBM**



Rachel Dorrell, MA, MS, CPC-A, writes about the Minimum Data Set, practice management, and ICD-10 coding for AAPC, focusing on the issues that keep nursing facility and medical office personnel up at night. She has a Master of Science degree in narrative medicine from Columbia University and a Master of Arts from York University, in the U.K. She also runs an organic farmstead in the New York Finger Lakes region, focusing on sustainably raising happy, healthy heritage-breed livestock.

time to ask, 'How are you doing?,' I actually answer the question to see if they're listening."

Sampath recommended cultivating a practice culture where staff feel like family to one another and patients are treated as if they're visitors to the family's home. She didn't recommend getting comfy-cozy, like urging folks to kick off their shoes when they walk in, but emphasized the significance of listening.

If a patient shows up late and said the traffic was bad, meeting their gaze and acknowledging the frustration of traffic can go a long way in helping them relax — and a relaxed person will probably have a better, calmer experience at your practice than a harried person.

Bring Continuing Education to Communication

Technology and isolation have eroded in-person communication or at least ratcheted up the potential for anxiety for many people in many situations. If a group of colleagues goes out to lunch (or meets

This article is reprinted from the *Practice Management Alert* (2023, vol. 23, no. 7). For more articles like this, as well as other specialty-specific articles, check out AAPC's full line of newsletters at www.aapc.com/newsletter.



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Establishing Usual, Customary, and Reasonable Values for Services

Medical coders, billers, and auditors have the expertise to weigh in.

This article discusses forensic work with respect to healthcare usual, customary, and reasonable (UCR) fee ranges. This is a peer review article in which the author (me) requests my peers (you) to provide your objective thoughts on the information provided within.

The Work of a Forensic Expert

Medical claims review often involves a forensic expert — often a medical coder, biller, or auditor — if an injured person is claiming financial damages related to an accident in a legal case. The forensic expert works with either the attorney for the injured person (plaintiff) or the insurance carrier (defendant). The outcome of the report is the same regardless of who the forensic expert works with. In other words, the forensic expert remains objective regardless of which side they are working with.

The forensic expert reviews the medical bills in question to ascertain the following:

- Was the medical service related to the date of injury? For example, a red flag would be if the diagnosis on the invoice, or claim, is for a visit to a healthcare provider for birth control, but the patient is claiming a back injury.
- Did the dates of service occur prior to the date of injury? If so, these services would not be included in the review. An exception would be a note in the report stating that a similar diagnosis was made prior to the date of injury.



- Where was the patient treated? The geographical area where the healthcare provider rendered care is important for establishing what other healthcare providers charge in the same geographical area.
- Were any of the procedures unbundled? If the main procedure includes multiple services, an analysis and review of the healthcare procedures being billed should be completed to ensure the patient is not being overcharged. An example would be an epidural injection that is described by the CPT® code to include fluoroscopy, and the healthcare provider bills for fluoroscopy in addition to the epidural injection.

Once the forensic expert determines these things, it's time to evaluate the amount billed.

What Is UCR?

Healthcare providers can charge any amount they want as long as it's their customary charge. It's inappropriate or considered economic bias if a healthcare provider charges some patients one fee and others a different fee for the same service. The charge for each service should remain the same regardless of type of payment or insurance status.



“A percentile is a comparison between the total billed amounts collected during a year and geographical area.”

The American Medical Association (AMA) defines UCR under the AMA Policy H-385.923 as:

- Usual; fee means that fee usually charged, for a given service, by an individual physician to his patient (i.e., his own usual fee);
- A fee is ‘customary’ when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
- A fee is ‘reasonable’ when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have not been discounted under governmental or private plans.

Usual and customary refers to the prevailing rate charged in a geographical area and time period. In most data sets, that would be the 50th percentile, or median.

Reasonable is above the usual and customary 50th percentile (to take into consideration special circumstances), but lower than the 100th percentile. A percentile is a comparison between the total billed amounts collected during a year and geographical area. For example, the 80th percentile represents that 20 percent of other billed amounts are higher than the 80th percentile amount listed.

Special circumstances to consider for the higher reasonable fee amount might include specialized training, fellowship in the area of the medical provider’s specialty, and presentations or publications to physician peers regarding their field of expertise — to name just a few.

If the usual and customary is the 50th percentile of a data set of fees charged (median) in a geographical area and time period, what would represent reasonable? Per the AMA, reasonable is above usual and customary, which is the 50th percentile. To determine reasonable, research is conducted to see what others across the country consider reasonable.

For example, the Texas Division of Insurance (SB 1264) states that the 80th percentile is considered reasonable in regard to surprise bills or those paying out of network. The Veterans Administration also uses the 80th UCR percentile. Connecticut uses the 80th percentile when defining UCR. New York’s out-of-network calculation uses the 80th UCR percentile. Liberty Mutual Auto Insurance recognizes the 80th percentile as reasonable.

Collecting Data

Billed amount data sets collected by a third party are often used by healthcare providers to set their fee schedules. Proprietors must be

The Federal Trade Commission (FTC) stated in October 2022 that competition in healthcare benefits the consumer to contain cost and improve quality.

Healthcare providers have been trained since their residency program that they can’t discuss or compare charges with their peers, lest they be charged with price fixing, collusion, or antitrust. Thus, healthcare providers need reliable data resources that contain fully billed amounts to ascertain that the prevailing rates are in their geographical areas to set their fee schedules.

Hardship policies should be in place in every medical office in case some patients can’t pay the healthcare provider’s fee and the healthcare provider has a lower amount that they offer for such hardships. This is acceptable as long as the lower fee is not less than the Medicare Physician Fee Schedule (MPFS), so as not to violate a most-favored nations clause.

The *Federal Register* provides good references regarding customary charges for healthcare providers. For example, 42 CFR 405.503 states that customary charges refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. The *Federal Register* also provides appropriate and inappropriate examples of billing a patient less than, or more than, their prevailing (customary) rate.

"It's my opinion that data from commercial claims, government claims, and third-party biller information is the most diverse data set and what should be used to set fee provider schedules or when conducting an UCR analysis."

careful that the data is collected carefully and made available for use by many, especially since the data set includes most of us reading this article. Only fully billed amounts are allowed in the data set, not paid amounts or insurance allowed amounts. Paid amounts or allowed amounts are available for purchase in a separate data set.

There are many UCR data resources available. (So as not to discredit any entity, I will not discuss the publisher of the data resource.) The data is obtained from insurance claims submitted to insurance carriers or by third party billers that are working on claims or patient invoices. Only the fully billed amount is collected for the purpose of UCR.

Data can be divided into three categories:

1. Data obtained from healthcare claims submitted to commercial and government payers.

This first group of data submitted to commercial payers and government payers is sold by several entities. The data can be in the form of a book or an online platform. The data is grouped into year and geographical area. Some sellers of this data will not allow the data to be used in legal court cases.

2. Data obtained from claims submitted to commercial, government, and private payers.

This second group of data is more diverse because it includes commercial, government, and private payers.

3. Data submitted to government payers.

This third set of data is collected from government payers, such as Veterans Administration or Medicare.

Other types of methodology used to set healthcare provider fee schedules would be to use a percentage of the MPFS. Some experts use 130 percent to 300 percent of the MPFS to set a reasonable fee amount. The problem with this method is that data collected from the MPFS only comes from Medicare providers who see patients over the age of 65. And not all CPT® codes are represented in the MPFS such as outpatient consultations codes 99242-99245.

In 2021, I conducted research to see what method healthcare providers used to set their fee schedules. I asked the American Medical

Billing Association (AMBA) to send out a survey to its members who bill for healthcare providers. The survey asked the billers what data tools the healthcare providers used to set their fee schedules. Over 300 medical billers responded that the majority of healthcare providers used data collected from commercial payer claims, government claims, and from third party billers (option 2). Some providers said they used a percentage of the MPFS (option 3).

Call to Action

Healthcare providers are trained as clinicians, not as economists. It's rare if a medical school or residency program offers medical coding, billing, or fee schedule design in their curriculum. That is why the career paths of medical coding, billing, and compliance were born — to assist clinicians with non-clinical business tasks.

Medical coders, billers, and office managers understand medical coding and billing. They assist the healthcare provider with setting fee schedules. These non-clinicians are the economists of the medical office and are vital to assisting patients, attorneys, judges, and juries understand how fee schedules are set and how to determine the UCR value of services rendered in the past or projected for future care estimates. UCR is important to give perspective on the fees charged for healthcare services during a specific time period, within a specific geographical area.

It's my opinion that data from commercial claims, government claims, and third-party biller information is the most diverse data set and what should be used to set fee provider schedules or when conducting an UCR analysis. The 50th percentile (median) represents the usual, customary, or prevailing charge, and the 75th to 80th percentiles represent the reasonable billed amount. This is based on what many states and payers are using in an official capacity or for reimbursing surprise bills, out-of-network services, and special circumstances.

Please submit your questions or thoughts about this article to letterstotheeditor@aapc.com so that AAPC can share them with me. Your identify will not be revealed to me. I will answer your questions or comments and email them back to AAPC.

Please let AAPC know if you are interested in having me discuss this topic/career virtually at your chapter meeting. **HBM**



Jacqueline Nash Bloink, MBA, RHIA, CFE, CHC, CPC, CPC-I, CMRS, has 29 years of work experience in healthcare as a medical office manager, coder, biller, and compliance director with medical office and hospital experience and multiple medical disciplines. She has worked as an expert witness and consultant since 2016. She is honored to be co-presenter with CMS and OIG regarding healthcare compliance and the Affordable Care Act in 2014.

Resources

AMA Policy H385.923, Definition of Usual, Customary and Reasonable

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Billing Encounters Under Another Physician's Credentials

Situations where you can legally use another physician's information must meet specific criteria.

Picture this: You sign on a new physician in your practice, their first day arrives, and they're contracted with only two payers. One of the other doctors is frustrated that the new employee cannot yet shoulder much of the workload. The established doctor says, "Just use my information to bill the new doc's encounters!"

This might bring in some money, but are you courting disaster — or at least an uncomfortable visit from a federal regulatory agency — if you try this maneuver?

Go By the Book

The Federal Bureau of Investigation (FBI) is the federal agency tasked with investigating healthcare fraud for federal and private insurance programs. The FBI says fraud is the intentional deception of the healthcare system to receive unlawful benefits or payments.

The Office of Inspector General (OIG), which can audit organizations, emphasizes that most stakeholders in the U.S. healthcare

“Some payers may allow retroactive participation for providers they credential; if you find any that do, make sure patients with that insurance are also funneled to the new provider.”

system rely on physician honesty for both quality of patient care and integrity of documentation and reporting of that care. The OIG explains:

Because the Government invests so much trust in physicians on the front end, Congress provided powerful criminal, civil, and administrative enforcement tools for instances when unscrupulous providers abuse that trust. The Government has broad capabilities to audit claims and investigate providers when it has a reason to suspect fraud. Suspicion of fraud and abuse may be raised by irregular billing patterns or reports from others, including your staff, competitors, and patients.

Of course, there are some situations where providers can bill their services under another physician's information. Many commercial carriers follow the lead of the Centers for Medicare & Medicaid Services (CMS) when determining when organizations can legally bill services in this manner.

For example, Medicare may reimburse an organization when an encounter involves incident-to services, Locum Tenens agreements, or reciprocal billing. Providers may be legally allowed to bill the services they provide under a different physician's information, but only when very specific criteria are met. In some of these situations, like incident-to services, the reimbursement rate may be different for nonphysician practitioners (NPPs) than physicians.

Different payers may have different policies for each of these situations, but Medicare Administrative Contractors (MACs) provide information on Medicare's perspective on these situations, which, again, tend to form the foundation for many commercial carrier policies.

Intentionally billing services rendered by one “uncredentialed” physician under a credentialed physician's information probably does not fall into any of the aforementioned scenarios.

Do This Instead

If you could turn back time, you could start credentialing the new physician before their first day of work. “I recommend as soon as

contracts are signed,” says **Christine M. Speroni, CPC, CEMC**, manager of revenue cycle at NHPP Gynecologic Oncology. But even if you're a wizard at credentialing new providers, you may still have some lag time. Speroni offers four recommendations on how to utilize a provider while minimizing any compromising behavior.

1. Funnel self-pay patients and patients who have the credentialed insurance to the new provider. While you may spread patients out to various physicians in the practice eventually, right now you can try and schedule patients according to their payer.

2. Check the retroactive participation date for respective payers. Some payers may allow retroactive participation for providers they credential; if you find any that do, make sure patients with that insurance are also funneled to the new provider.

3. Assign the new provider to attend to services that aren't billable. There's plenty of work for providers that cannot be billed, including services like prescription renewal phone calls, talking through test results with patients, postoperative care that falls under global care, peer-to-peer authorization reviews, or rounding at a hospital if another physician also saw the respective patients that same day.

4. Describe the new provider as out of network and let patients decide whether to see them. If you go this route, make sure you provide good faith estimates to patients. Patients may want to see the new out-of-network provider if they will be seen earlier than a fully booked credentialed physician. **HBM**



Rachel Dorrell, MA, MS, CPC-A, writes about the Minimum Data Set, practice management, and ICD-10 coding for AAPC, focusing on the issues that keep nursing facility and medical office personnel up at night. She has a Master of Science degree in narrative medicine from Columbia University and a Master of Arts from York University, in the U.K. She also runs an organic farmstead in the New York Finger Lakes region, focusing on sustainably raising happy, healthy heritage-breed livestock.

This article is reprinted from *Practice Management Alert* (2023, vol. 3, no. 8). For more articles like this, as well as other specialty-specific articles, check out AAPC's full line of newsletters at www.aapc.com/newsletter.

Healthcare in AUSTRALIA

Expand your horizons with a look at medical coding down under.

Australia's health system is not so different from the health system in the United States. The Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) aim to provide affordable access to medical services and prescription medications to all Australians.

Medicare and the public hospital system are jointly run by all levels of Australian government: federal, state, territory, and local. Private health insurance is also an option.

Medicare has been Australia's universal healthcare program since 1984. Medicare covers the entire cost of public hospital services and some or all of the costs of other health services. Physiotherapy and basic dental services for children are also available.

Medical coding has been an established process in Australia for more than two decades. There are many other similarities to the U.S. healthcare system, as you will learn in this article.

Coding Classifications

As shown in **Table 1**, the Australian healthcare system relies heavily on standardized classification systems, such as the International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM) and Australian Classification of Health Interventions

(ACHI) codes, as well as the Australian Coding Standards (ACS) guidelines for ensuring accuracy when coding diagnoses and procedures. Health professionals are required to use ICD-10-AM and ACHI codes when submitting claims to the MBS and PBS for reimbursement.

Independent Health and Aged Care Pricing Authority (IHACPA) is the governing body and responsible entity for the data sets. Data is produced in the form of code books, mapping tables, and electronic code lists.

The code books are:

ICD-10-AM Tabular: This book provides a list of codes and categories for the systematic classification of diseases and other health conditions.

ICD-10-AM Alphabetic Index: This book provides an alphabetical index of diseases and other health conditions that are classified using ICD-10-AM.

ACHI Tabular: This book is used to classify procedures, interventions, and other treatments. As shown in **Table 2**, ACHI codes have seven numeric digits. Where an intervention has an MBS equivalent, the first five digits are the MBS item number, followed by a two-digit extension representing specific interventions included in that item.

ACHI Alphabetic Index: This book provides an alphabetical index of procedures, interventions, and other treatments that are classified using ACHI.

Table 1: Data sets used in the Australia healthcare sector

Service Category	Classification	Current Version
Admitted care	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI), Australian Coding Standards (ACS)	ICD-10-AM/ACHI/ACS Eleventh Edition
Admitted acute care	Australian Refined Diagnosis Related Groups Classification (AR-DRGs)	AR-DRG Version 10.0
Subacute and non-acute care	Australian National Subacute and Non Acute Patient Classification (AN-SNAP)	AN-SNAP Version 5.0
Emergency care	Emergency Department ICD-10-AM Short List (ED Short List)	ED Short List Eleventh Edition
	Urgency Related Groups (URGs) and Urgency Disposition Groups (UDGs)	URGs Version 1.4 and UDGs Version 1.3
	Australian Emergency Care Classification (AECC)	AECC Version 1.0
Non-admitted care	Tier 2 Non-admitted Services Classification (Tier 2)	Tier 2 Version 7.0
Mental health care	Australian Mental Health Care Classification (AMHCC)	AMHCC Version 1.0
Teaching, training, and research	Australian Teaching and Training Classification (ATTC)	ATTC Version 1.0

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Table 2: ACHI Tabular code format

MBS-ACHI Extension	Descriptor
16520-00	Elective classical caesarean section
16520-01	Emergency classical caesarean section
16520-02	Elective lower segment caesarean section
16520-03	Emergency lower segment caesarean section

ACS: The Australian Coding Standards were developed to support sound coding convention for use with ICD-10-AM and ACHI. They apply to all public and private hospitals in Australia. The ongoing revision of the ACS ensures the guidelines reflect changes in clinical practice, clinical classification amendments, and various user requirements of admitted patient data collections.

Note: These publications are updated every two years. ICD-10-AM/ACHI/ACS Twelfth edition has been in practice since July 1, 2022.

Mapping tables: Mapping tables provide a link between two editions of a classification. There are two types of mapping tables provided in the ICD-10-AM and ACHI maps:

- Backward maps provide equivalent codes for new codes in the update.
- Forward maps provide equivalent codes for deleted codes in the update.

Both maps provide an equivalent code that best matches the concept from a clinical perspective (called historical maps) as well as an Australian Refined Diagnosis Related Group (AR-DRG) perspective (called logical maps). Sometimes the historical map and the logical map are the same code.

Electronic code lists (ECLs): These files are used in the development of software or are integrated into existing patient software using the ICD-10-AM and ACHI codes for private or commercial purposes. The products available under an ECL license include ICD-10-AM ECLs and ACHI ECLs.

Medicare Benefit Schedule: Similar to the Medicare Physician Fee Schedule, the MBS is a list of medical services and procedures that are subsidized by the Australian government. It covers a wide range of healthcare services, including consultations with doctors, pathology tests, and surgery. The MBS ensures that Australians have access to a variety of medical services regardless of their ability to pay.

Licensing

Countries wishing to use the AR-DRGs or ICD-10-AM/ACHI/ACS classification systems or products are required to enter into a license agreement with IHACPA. Country license agreements are strictly government-to-government. As such, IHACPA will only sign license agreements with government agencies, and financial quotes or payments will only be communicated to and accepted from government agencies. Organizations that are not a government agency require a letter of authorization from a government agency to act on its behalf in discussing country license agreements.

There are two types of agreements for country licenses:

- Use only – the licensed country has the right to implement the system within its territories without modification.
- Develop – the licensed country has the right to use the products as a base, with the option of further developing aspects to accommodate the local system.

Formal requests for a country license agreement, including the free 12-month trial, must be made by emailing the licensing team. Licensing can be obtained through external vendors as well.

Primary Health Networks

Primary health networks (PHNs) are organizations that coordinate health services in local areas. There are 31 PHNs across Australia. The work of a PHN is to:

- Support community health centers, hospitals, general practitioners (GPs), nurses, specialists, and other health professionals to help improve patient care
- Coordinate different parts of the health system — for example, between the hospital and GP when a patient is discharged
- Assess the health needs of a local area
- Provide extra services that are needed such as:
 - After-hours services
 - Mental health services

- Health promotion programs
- Support for primary care (GPs), including continuing education

Australian National Subacute and Non-Acute Patient Classification (AN-SNAP)

AN-SNAP only applies to episodes of admitted patient hospital care (same-day and overnight). AN-SNAP V4 classifies admitted subacute and non-acute care into five care types:

- Rehabilitation care;
- Palliative care;
- Geriatric evaluation and management (GEM);
- Psychogeriatric care; and
- Non-acute care (sometimes referred to as maintenance care).

In December 2021, IHACPA released the Australian National Subacute and Non-Acute Patient Classification Version 5.0.

Australian Emergency Care Classification

Public hospitals in Australia group emergency department patient presentations to the Australian Emergency Care Classification (AECC), while emergency service patient presentations are grouped to the Urgency Disposition Groups (UDG) classification. Data collected at the emergency department or the emergency service is reported to IHACPA to ensure each emergency presentation is assigned an AECC or UDG class. The data collected includes:

- The type of visit for the presentation (that is, whether it is an emergency presentation; a planned return visit; or a pre-arranged admission)
- What happens to the patient once the emergency presentation is complete. (For example, the patient may be admitted to hospital; be discharged or transferred to another hospital; or may choose to leave before treatment is completed)
- How urgently the patient needs to receive treatment, based on the triage score given to the patient upon initial assessment
- How the patient arrived (For example, did the patient travel by ambulance or helicopter?)
- The diagnosis given for the presentation

IHACPA implemented the UDG classification to classify emergency services in July 2012. UDGs group patient presentations and services on the basis of the type of visit, episode end status, and triage. The classification groups into 17 end classes. UDG Version 1.3 is the current version.

The Tier 2 Non-Admitted Services Classification (Tier 2) is the current activity-based funding classification for non-admitted care.

Tier 2 categorizes a hospital's non-admitted services into classes which are generally based on the nature of the service provided and the type of clinician providing the service.

Tier 2 provides a standardized framework for classifying non-admitted services across different healthcare settings, ensuring consistent reporting, data collection, and reimbursement. It helps healthcare providers, policymakers, and researchers understand the types and volume of services being delivered outside of hospitals, facilitating resource planning and policy development, including but not limited to:

Medical services: Consultations with medical practitioners, general practitioners, specialists, and other medical professionals

Surgical services: Minor surgical procedures, biopsies, endoscopies, and other diagnostic and therapeutic procedures performed on an outpatient basis

Diagnostic services: Radiological imaging, pathology tests, diagnostic tests, and investigations conducted in non-admitted settings

Therapeutic services: Physiotherapy, occupational therapy, speech therapy, psychology, counseling, and other allied health services

Dental services: Non-admitted dental procedures and treatments, including examinations, cleanings, fillings, and extractions

Mental Health

IHACPA implemented a new classification for mental health in July 2017 known as the Australian Mental Health Care Classification (AMHCC). The goal of the classification is to improve the clinical meaningfulness of the way that mental healthcare services can be classified.

AMHCC version 1.0 includes two types of mental healthcare settings:

- Admitted setting structure
- Community setting structure

This classification has six major splitting variables, with the first three being categorical and the last three being complexity:

- Assessment only
- Acute
- Functional gain
- Intensive extended
- Consolidating gain
- Unknown

There are three consumer age groups:

- Children and adolescents (0-17 years)
- Adults (18-64 years)
- Older persons (65+ years)

The classifications are split by the admitted setting (hospital) and community setting (ambulatory).



Healthcare for All

The Australian healthcare system's journey underscores the pivotal role of healthcare in a nation's development and the importance of continually evolving and adapting to meet new health challenges. This is a lesson that is relevant to not just Australia, but every nation that aspires for holistic growth and development for its citizens. **HBM**



Chandrashekhar Boreda, CPC, is a senior product manager and has been associated with AAPC since 2014. In his current role, he works on AAPC's new product development, Codify, and data files.

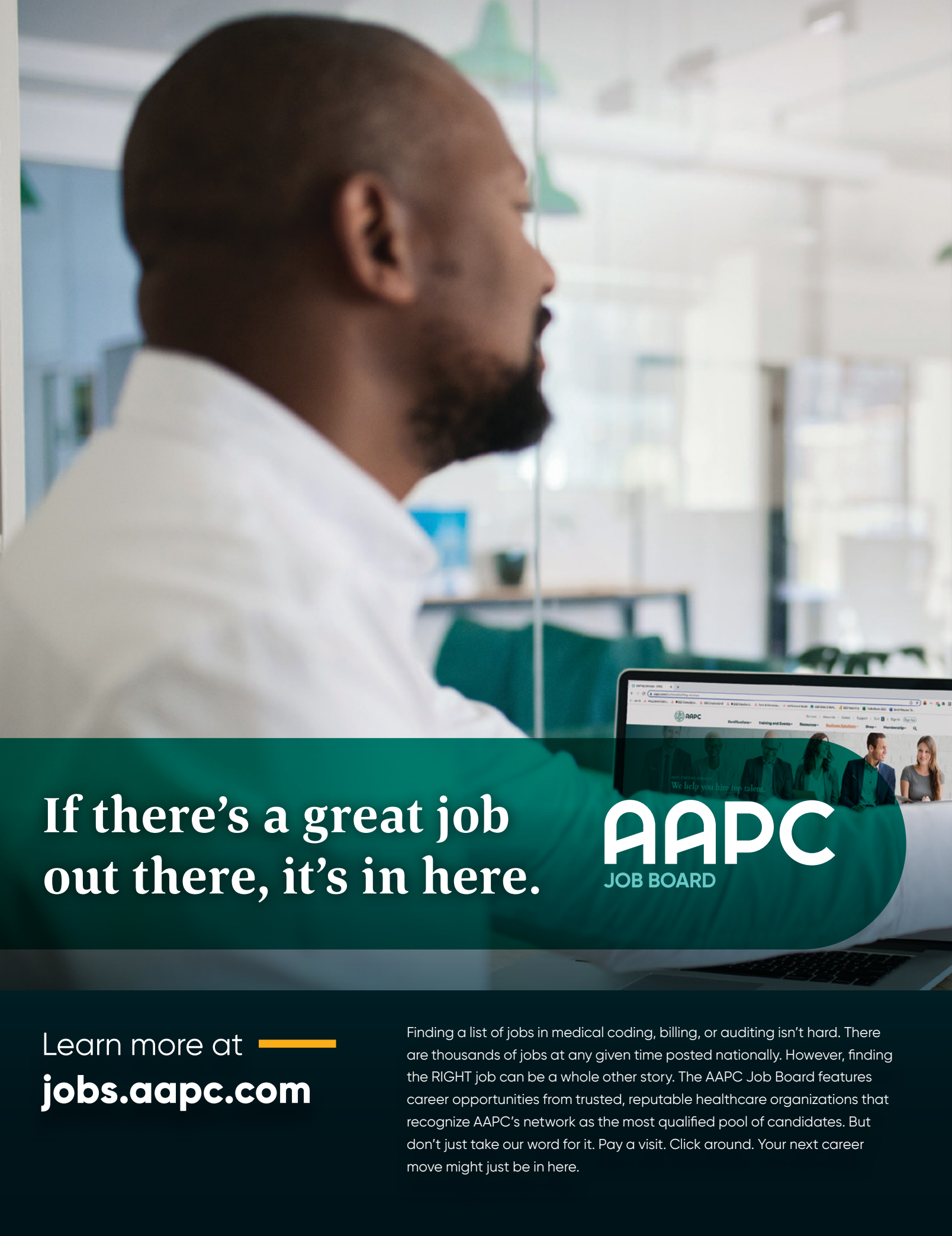


Rahul Koul, BAMS, CPC, is a doctor of Indian system of medicine and has been associated with AAPC since 2014. In his current role, he works on AAPC's Codify and data files.

Resources

IHACPA

Australian Government Department of Health and Aged Care; Medicare Benefits Schedule (MBS) Review



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Advice From a CHONC™



AAPC member **Susan Suwinski, CPC, CDEI, CDEO, CPB, ACPMA, CRC, CGSC, CHONC**, has worked in healthcare for over 20 years in many industry settings, including hospitals, physician practices, health plans, skilled nursing, and physical therapy. She has hands-on experience across the revenue cycle in coding, billing, follow-up, denials, reimbursement analysis, and managed care contracting. Suwinski currently works as a radiation oncology coder for the Toledo Clinic Cancer Centers and is a Region 2 representative on the 2023 AAPC Chapter Association Board of Directors.

AAPC asked Suwinski about her experience with earning the Certified Hematology and Oncology Coder (CHONC™) credential, how it has helped her career, and what sort of advice she has for anyone considering the specialty certification.

What led you to obtain the CHONC™ credential?

Oncology is a specialty that is near and dear to my heart. I had worked in healthcare for many years but had never felt drawn to focus on any one specialty. After my mother's battle with breast cancer, I knew I wanted to use my skills to support the dedicated providers who make

a difference in the lives of oncology patients. Earning the CHONC™ credential was instrumental in helping me transition to a position at a cancer center.

Do you have any tips for individuals preparing for the CHONC™ exam?

Know your infusion codes and hierarchies! I worked in radiation oncology, so my infusion coding knowledge had gotten rusty. I spent time studying the infusion hierarchy and working through practice cases. I found helpful YouTube videos on infusion coding and took AAPC's on-demand webinar "Coding for Injections & Infusions."

AAPC's CHONC™ course, study guide, and practice exam were also beneficial in my preparation. After successfully working through the practice exam, I knew I was ready for success on exam day.

How has the CHONC™ credential helped you in your job/career?

Having the CHONC™ credential has helped demonstrate my commitment to the oncology specialty. I had worked with oncology claims while employed by a hospital system. Still, it wasn't until I pursued the CHONC™ credential that I transitioned to an oncology specialty coder position.

Who do you think would most benefit from the CHONC™ credential?

Anyone who works in hematology and oncology would benefit from having the CHONC™ credential. The training will help give teams the knowledge to improve coding, billing, and prior authorization processes and reduce denials. Additionally, the CHONC™ credential could be helpful for anyone who wants to work in oncology in the future.

What resources do you use most to earn your continuing education units (CEUs)?

AAPC is an excellent source for CEUs. I attend local chapter meetings and have an eNewsletter subscription for the *Oncology/Hematology Coding Alert*. Additionally, I receive radiation oncology education through an AAPC-approved vendor. I also belong to my state's Hematology and Oncology Society, which offers AAPC CEUs for its annual meeting. **HBM**



Lee Fifield, BS, is a development editor at AAPC. She has a Bachelor of Science degree in communications from Ithaca College, Ithaca, N.Y., and has worked as a writer and editor for 17 years.

"Having the CHONC™ credential has helped demonstrate my commitment to the oncology specialty."

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 Chelsea Settle, **CPC-A**
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 Cheryl Ann Gurganus, **CPC-A**
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 Chonaly Lim Tarrayo, **CPC-A**
 Christin Espinola, **CPC-A**
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 Christine Hagen, **CPC-A**
 Christine Salsbury, **CPC-A**
 Christine Sopko, **CPC-A**
 Christopher Kaye, **CPC-A**
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 Cindy Hein-Sjurset, **CPC-A**
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 Constance Haines, **CPC-A**
 Courtney St. Laurent, **CPC-A**
 Daiserie Botona, **CPC-A**
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 Danica Thomas, **CPC-A**
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 Kung Hee Kim, **CPC-A**
 Ladon Wolfe, **CPC-A**
 Lakia Dore, **CPC-A**
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 Larissa Matthews, **CPC-A**
 Lasheba Mortimer, **CPC-A**
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 Laureen O'Regan, **CPC-A**
 Lauren Martinez, **CPC-A**
 Leah Britton, **CPC-A**
 Leah Goins, **CPC-A**
 Le'Ana Bagwell, **CPC-A**
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 Leslie Fullilove, **CPC-A**
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 Lisa Anderson, **CPC-A**
 Lisa Grissom, **CRC, CPC**
 Lisa Ritzmann, **CPC-A**
 Lisa Schneider, **CPC-A**
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 Lori Fleming, **CPC-A**
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 Mariacelia Villar, **CPC-A**
 Mariah Moreau, **CPC-A**
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Alyssa Moyer, **CRC**
Amanda Bass, **CPC, CPMA, CEMC, CEDC**
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