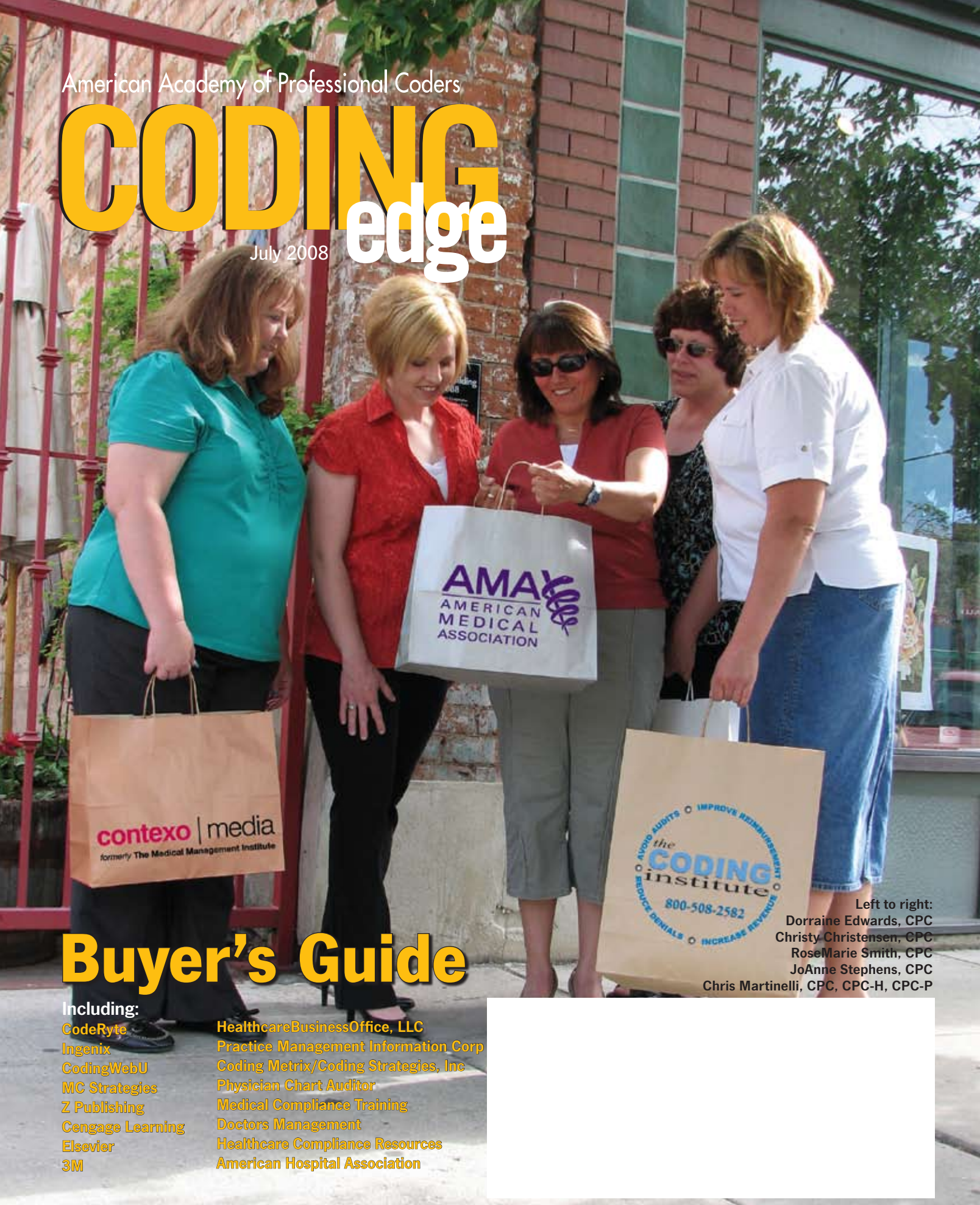
American Academy of Professional Coders

CODING edge

July 2008



Left to right:
Dorraine Edwards, CPC
Christy Christensen, CPC
RoseMarie Smith, CPC
JoAnne Stephens, CPC
Chris Martinelli, CPC, CPC-H, CPC-P

Buyer's Guide

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Buyer's Guide

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Features

On the Cover: A day out shopping for (left to right) Dorraine Edwards, CPC; Christy Christensen, CPC; RoseMarie Smith, CPC; JoAnne Stephens, CPC; and Chris Martinelli, of the Ogden, UT chapter of AAPC CPC, CPC-H, CPC-P, means choosing the right coding resources while enjoying a relaxing afternoon chatting with friends. Cover photo by Brad Ericson on historic 25th Street, Ogden, Utah.

In Every Issue

Education

People

Next Month

ICD-9-CM Changes
Orlando National Conference
Smoking Intervention
Echocardiology
OIG Interrogation

Targeting the AAPC Audience

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

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

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

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

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

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

American Academy of Professional Coders

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Address all inquires, contributions and change of address notices to:

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Equip Yourself with the Right Tools

Armed with little more than core coding books (and for some, not even current books), coders often rely on their expertise and ability to find the most up-to-date and accurate information to ensure regulatory compliance and approved claims. For many, keeping up with government regulations, code changes, and industry trends has left some coders in need of fast, easy, and cheap outside help.

In our recent Work of a Coder survey, we found this to be a struggle for many coders:

"I am overwhelmed with the practice's expectations of me. I work overtime all the time and am exhausted."

"We are a small practice with one doctor and EMR. When I started here there were no coding books in the office. The coding information was only available in the EMR and it is only as accurate as the information that is inputted."

"I am the only coder in a small insurance company. I believe I am a valued employee because I am a CPC®. I just wish I knew of more resources that would help me in my very specialized arena."

"I spend too much time searching for information in order to be compliant with the work of coding outpatient cases."

"Knowing of my CPC®, I am constantly engaged for coding assignments; relied upon to answer questions and instruct the practices on coding issues (who are not staffed with certified coders). I often feel stressed to provide the most accurate information."

An ongoing initiative at AAPC has been to deliver the information members need to perform their jobs efficiently and effectively. Frankly, it wasn't an AAPC priority in the past and members learned to find their answers at other places, often at significant cost. Our goal is provide more information: easily, fast, and without cost.

We're close to that goal. Today, members may log in to their accounts at www.aapc.com and utilize powerful search tools that enable them to find answers from hundreds of coding related websites and tens of thousands of pages of information with a single keyword phrase. You can use a search box to filter through archived *Coding Edge* and Edge*Blast* articles, news and stories. Direct links to more than 200 online resource Web sites are categorized for easy and quick access to code, government, regulatory, compliance, and specialty-specific information. Use the "Search" box from any page in the member area, or go to the "Resources" section for individual links and tools.

To further help members, use our most powerful bank of knowledge—you. Some of the quickest answers to your questions can be found directly within our online Member Forums. Our new search tools help you easily find what you need among the tens of thousands of posts from other CPCs®. If you can't find your specific answer immediately, you can post your question and allow various responses from others; sometimes with direction for where to find the answer, but often, exactly the answer you need. We only ask that you keep with the spirit of the community and contribute as much as you can to help other members. Look for opportunities to share by answering and helping other discussions, posting to your local chapter forums, and submitting your favorite coding resources and tools.

Our goal is to provide for you as many resources as possible and give you quick access to them. We are continually adding information and resources for you to take advantage of and making it easy for you to obtain the most effective tools for your job. Go online today and login at www.aapc.com (if you haven't yet registered, you'll need your member ID). We believe free is the most cost effective way to get you the information you need.

Sincerely,

Reed E. Pew
CEO and President

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Buyer's Guide

What Do You Look For in Coding Software?

Whenever I present a seminar, I'm always asked, "What tools and resources do you use?" One of the most valuable tools I have is electronic coding software. Some refer to this as a "coding look-up" program. When electronic coding programs were first introduced in the late 90s, they were basic and only provided a method to look up the codes. Although basic, some of the programs included crosswalks from CPT® to ICD-9-CM. Today, the programs are more sophisticated and provide necessary information with more features than you can imagine to code appropriately. With so many choices and variables in coding software, it is important before you make this important purchase to first do your homework.

There are many features and software programs on the market from which to choose, and knowing the essential tools you need is a must before you invest in coding software. We all need access to CPT®, HCPCS Level II codes, and ICD-9-CM codes for finding correct codes. A crosswalk from the procedure code to the diagnosis code is a must. All coding software programs have this basic feature. You want the program to be easy to use and provide you with a top-notch search engine to find a code based on the description. Other features programs may have are the Correct Coding Initiative (CCI) edits, global days for procedures and services for Medicare, Ambulatory Payment Classification (APC) assignments, modifiers, and Medicare resource-based relative-value scale (RBRVS) information. Most coders need this information to select the appropriate code.

Some coding programs include the Medicare Physician Fee Schedule (MPFS), Medicare coding rules and policies, terms for procedures and services, bookmarks, and a note section for the user to make notes. Other programs include anatomical illustrations, links to *CPT® Assistant* and *ICD-9-CM Coding Clinic*, correct modifier usage, and medical terms.

When searching for the right coding program, ask the question, "What do you want your coding software to do?" Many software programs are available for use on the internet for easy access. To ensure current information, most internet coding software programs are updated daily. If you travel you don't always have the internet at your fingertips, so software that you can house on your hard drive is appropriate for your coding needs. Typically, software programs you house on your hard drive are updated each quarter with CCI updates. I recommend you visit coding software vendors' Web sites and review products. Once you do the research, download at least three programs to try. Eliminate any you don't like early on. Some vendors allow you to test drive a product to help you decide if you want to buy it. If the vendor doesn't offer a trial period for use, contact them to ask for a trial period. Most vendors are willing to let you sample their product before you buy it.

Keep in mind, not every program is the same and once you purchase the program you have to live with it for a year. Electronic coding programs are a vital tool in today's coding world, and they provide valuable information at our fingertips. I could not live without mine.

When someone develops an electronic coding program that cooks, cleans, and launders clothes, I will be a happy coder.

Until next month …

Deborah J. Grider

Deborah Grider,
CPC, CPC-H, CPC-P, CPC-EM, CPC-I, CCS, CCS-P

National Advisory Board President

Road Map to ICD-10-CM
Follow the ICD-10-CM Road Map with GEM

Follow the ICD-10-CM Road Map with GEM

By Deborah Grider, CPC, CPC-H, CPC-P, CPC-EM, CPC-I, CCS, CCS-P

This month we follow the ICD-10-CM roadmap to crosswalking with general equivalence mappings (GEMs). The GEM system, developed by the National Center for Health Statistics (NCHS), maps ICD-10-CM and the ICD-9-CM volumes one and two and helps facilities and payers create crosswalks. You can access it on the CMS Web site at: www.cms.hhs.gov/ICD10.

Mapping—or crosswalking—helps you find the corresponding diagnosis between two codes sets and their correlation. In ICD-9-CM, codes are three to five digits in length plus alphanumeric E and V codes, approximately 13,500 codes in total. ICD-10-CM consists of three to seven alphanumeric characters with more than 68,000 codes possible. There isn't a simple crosswalk from ICD-9-CM to ICD-10-CM, and the GEM files attempt to organize the differences. When mapping a code from ICD-9-CM to ICD-10-CM, there may be more than one code in ICD-10-CM that maps to ICD-9-CM. There are separate GEM files for ICD-9-CM Volume 3 to ICD-10-PCS.

GEMs are available for your computer as "flat" text files with each file containing a list of code pairs identifying the correspondence between a source system code and a target system code. The code set is mapped from the system of origin (source system) to the destination system (target system). There is one GEM file for mapping ICD-9-CM to ICD-10-CM and one file for mapping from ICD-10-CM to ICD-9-CM. Included are the ICD-10-CM code descriptions in a text file.

When one ICD-9-CM or ICD-10-CM code contains several diagnoses, it is considered a "combination code." The following are combination codes:

ICD-9-CM

250.21 Diabetes mellitus; diabetes with hyperosmolarity; type I [juvenile type], not stated as uncontrolled

404.00 Hypertensive heart and chronic kidney disease; malignant; without heart failure and with chronic kidney disease stage I through stage IV, or unspecified

823.02 Fracture of tibia and fibula, upper end, closed; fibula with tibia

ICD-10-CM

R65.21 Severe sepsis with toxic shock

T58.01 Toxic effect of carbon monoxide from motor vehicle exhaust, accidental

E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy

When ICD-9-CM codes are more detailed than ICD-10-CM, a single ICD-10-CM code may link to more than one ICD-9-CM code or vice versa, as indicated in Table 1:

Table 1

ICD-9-CM	ICD-10-CM
010.00 Primary tuberculous infection; unspecified examination	**A15.7** Primary respiratory tuberculosis
010.01 Primary tuberculous infection; bacteriological or histological exam not done	
010.02 Primary tuberculous infection; bacteriological or histological exam unknown (at present)	
010.03 Primary tuberculous infection; tubercle bacilli found (in sputum) by microscopy	
010.04 Primary tuberculous infection; tubercle bacilli found (in sputum) by microscopy	
010.05 Primary tuberculous infection; tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically histologically	
010.06 Primary tuberculous infection; tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods [inoculation of animals]	

Mapping where a combination code corresponds to two or more diagnoses in the other code sets requires linkage to two or more codes in the other code set.

Table 2 illustrates crosswalking from ICD-9-CM to ICD-10-CM.

Table 2

ICD-9-CM Source	ICD-10-CM Target
115.11 Histoplasmosis; infection by Histoplasma duboisii; meningitis	**B39.5** Histoplsamosis duboisii **G02** Meningitis in other infectious and parasitic disease classified elsewhere

Mapping from ICD-10-CM to ICD-9-CM is shown in Table 3.

Table 3

ICD-10-CM Source	ICD-9-CM Target
125.710 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris	**414.02** Other forms of chronic ischemic heart disease; coronary atherosclerosis; of autologous biological bypass graft **411.1** Other acute and subacute forms of ischemic heart disease; intermediate coronary syndrome

Because the files are "flat" text files, they load into databases, such as Access. (Excel can be cumbersome as multiple files are simultaneously referenced.) Each file contains a list of code pairs. Each code pair identifies a corresponding code in the source file (ICD-9-CM or ICD-10-CM) and in the target system. The first step would be to perform forward mapping from ICD-9-CM to ICD-10-CM as shown in Table 4, and then backward mapping from ICD-10-CM to ICD-9-CM.

Table 4

ICD-9-CM Source	ICD-10-CM Target
599.7 Other disorders of urethra and urinary tract; hematuria	**R31.0** Gross hematuria **R31.1** Benign essential microscopic hematuria **R31.2** Other microscopic hematuria **R31.9** Hematuria, unspecified

Note: Table 4 has one ICD-9-CM code that maps to four ICD-10-CM codes. Detailed documentation in the medical record is required to determine the correct diagnosis code.

Backward mapping, shown in Table 5, from ICD-10-CM to ICD-9-CM describes an ICD-10-CM combination code for severe sepsis with shock. An ICD-9-CM combination code does not exist for both conditions, and each condition (if both exist) is reported together.

Table 5

ICD-10-CM Source	ICD-9-CM Target
R65.21 Severe sepsis with shock	**995.92** Certain adverse effects not elsewhere classified; systemic inflammatory response syndrome (SIRS); severe sepsis **785.52** Symptoms involving cardiovascular system; shock without mention of trauma; septic shock

When using GEM, there are two files for ICD-9-CM and ICD-10-CM. **Note:** Table 6 shows that the ICD-9-CM and ICD-10-CM codes do not have decimals between the additional characters in column one and column two. Column one is the source file (ICD-10-CM) because we are mapping the codes to the target file (ICD-9-CM).

Road Map to ICD-10-CM cont...

Table 6

ICD-10-CM (Source)	ICD-9-CM (Target)	GEMS Flags
R6521	**99592**	**10111**
R6521	**78552**	**10112**

In the third column, the first three digits are flags and the last two digits are used for combination entries. In GEM systems, there are combination code flags that map from the source to the target of the table. When there is not a code in the target system or a combination code with the same meaning, an approximate flag is turned on. The digits applicable to the flag are:

- **0**—approximate flag is turned off and there is not a code or combination code in the target system.
- **1**—the approximate flag is turned on and there is a linked code or combination code in the target system.

Often, ICD-9-CM and ICD-10-CM codes have "1" in column three's first digit. Column three's second digit is a flag called the "no map" flag and is used when a diagnosis cannot be identified. The digits used in the no map file are "0" and "1."

- **0**—indicates a code for mapping the source code to the target code, either a single code or combination code.
- **1**—indicates no code for mapping the source code to the target code that identifies the diagnosis.

As shown in Table 7, the third column is the combination flag. If the combination flag is turned on from the source to the target, a combination code exists. Table 7 identifies flags in the third column and Table 8 shows the GEM text file.

Table 7

ICD-10-CM	ICD-10-CM-Description	ICD-9-CM Code	ICD-9-CM Description	Approximate Flag	No Map Flag	Combination Flag
R65.21	Severe sepsis with shock	**995.92**	Severe sepsis	**1**	**0**	**1**
R65.21	Severe sepsis with shock	**785.52**	Septic shock	**1**	**0**	**1**

With code 65.21 in ICD-10-CM, there is a linked code (approximate flag), and a combination code (combination flag) in GEM. In Table 8, The Scenario and Choice List are the third column's last two digits in the GEM text files. The meaning of the third column digits is the same for the ICD-9-CM GEM and the ICD-10-CM GEM files. When a combination flag is turned on with a "1," a scenario (digit 4) and a choice list field (digit 5) have a number other than "0." If there is a "0" a combination code does not exist.

What is meant by a scenario?

Note: In R65.21 of Table 8, "1" appears in column three's fourth digit indicating that when mapping with R65.21 for a patient who had severe sepsis with shock, two codes are required in ICD-9-CM.

The last digit in column three of the GEM table is the Choice List. If a combination code does not exist, and there is a one to one mapping relationship between the source code and target code, the digit is "0." If a combination code exists, there is either a "1" or "2" as the last digit in the column.

- No combination code exists; column three's last digit is "0"
- Combination code exists with only one combination; choice "1"
- Combination code exists with more than one code combination; choice "2"

Table 8

ICD-10-CM	ICD-10-CM Description	ICD-9-CM Code	ICD-9-CM Description	Approximate Flag	No Map Flag	Combination Flag	Scenario	Choice List
R65.21	Severe sepsis with shock	**995.92**	Severe sepsis	**1**	**0**	**1**	**1**	**1**
R65.21	Severe sepsis with shock	**785.52**	Septic shock	**1**	**0**	**1**	**1**	**2**

For example, 995.92 only maps to R65.21 as there is not a code in ICD-10-CM to cover sepsis only; however, R65.21 maps to both 995.92 and 785.52.

In a medical practice, it's not necessary to map every code in ICD-9-CM to ICD-10-CM and vice versa (for example, the insurance carrier and/or hospital might map every code and crosswalk in ICD-9-CM and ICD-10-CM because their ICD-9-CM code use is more extensive). However, it is important for the medical practice to map and crosswalk between the two coding systems prior to implementation.

How do you begin using GEM?

Here are key steps to follow:

1. It is helpful to utilize a database when using the text files.
2. Make sure the person using the system understands coding and crosswalks.
3. Obtain the GEM files from the CMS Web site at www.cms.hhs.gov/ICD10. The files are in a zip format, and the user needs to save the files on the hard drive.
4. Unzip the files and review the guidelines for using the GEM system. You may need to read the guidelines several times to understand the methodology.
5. Pull down the ICD-9-CM text files for the CDC Web site which is helpful for obtaining ICD-9-CM descriptors in GEM.
6. Map the files from ICD-9-CM (source) to ICD-10-CM (target).
7. Map the files in reverse from ICD-10-CM (source) to ICD-9-CM (target).

Don't rely on your hardware and/or software vendor to map files for you. As ICD-10-CM moves ahead, vendors may be available to map and crosswalk for you, but to fully understand the system you should learn to map on your own.

Deborah Grider, CPC, CPC-H, CPC-P, CPC-E/M, CPC-I, CCS, CCS-P, is the president of the AAPC's National Advisory Board. She is also writing the *ICD-10-CM Implementation Guide*, which will be released in 2009.

Letters to the Editor

Put Away the Pencil—Test Yourself Online

Dear Editor,

I just wanted to write a note of thanks. Although I try to do the *Coding Edge* self tests, and I completely ignored the Edge*Blast* self tests, it wasn't until I received the Edge*Blast* newsletter this evening and saw that both are now available online. I can't thank you enough! I dreaded doing the *Coding Edge* self tests on paper—my hand would hurt from writing to the extent that I avoided doing them until I had a whole bunch piled up (no wonder my hand hurt!). Now that I know these are available online, I'll pay closer attention and not skip the self tests.

Thank you again,

Louise Cavanaugh, CPC

Dear Louise,

Happy to hear it. Thanks for the feedback. The other features, of course, are that you are able to learn what answers are right and be able to correct yourself, and your 1 credit of CEU will post immediately to your CEU Tracker.

Coding Edge

Partial Removal Is Key to Shave Biopsy Coding

Dear Editor,

In the April 2008 issue of *Coding Edge*, under "biopsy" Dr. Spain writes "shave biopsies should be coded with the CPT® series 11300-11313." I disagree, citing the CPT® guidelines for the 11300-11313 series on page 53 of the AMA Professional edition CPT® 2008. The guideline under shaving or epidermal or dermal lesions states this procedure is for the "removal of a lesion," implying that the intent is to remove the *entire lesion*, and send to pathology for a reading. The intent of a biopsy, be it shave or punch, is to remove a *portion* of a lesion (not the entire lesion) to submit to pathology for diagnosis, and the code for a biopsy, shave or punch, should be 11100 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion*, 11101 *Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; each separate/additional lesion (List separately in addition to code for primary procedure)*, or the specific code for lip, ear, etc. I have never read or heard of the 11300-11313 series suggested for shave biopsy coding.

Sincerely,

Jacqueline Watrous, CPC

Dear Ms. Watrous,

Thank you for your comments on my article.

A biopsy's intent is to obtain tissue for pathologic interpretation. It is a misconception that a biopsy implies only partial removal. It is most common to remove only a portion of the lesion, but it is not unusual for the entire lesion to be completely removed. Discuss the biopsy excision procedures with your dermatologists for a clear understanding of the concept. It is common for skin biopsies to be both diagnostic and curative for many skin lesions.

Under the heading, "Biopsy" in the Surgery/Integumentary System Section of the 2008 CPT® manual, you will find this instructional clarification:

"During certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals, the removed tissue is often submitted for pathological examination. The obtaining of tissue during these procedures is a routine component of such procedures. This obtaining of tissue is not considered a separate biopsy procedure and is not separately reported."

This text explains that if the intent of the shave procedure was to obtain tissue for biopsy, the shave procedure should be coded (the 11300-11313 codes I referenced in my article) and the biopsy code(s) should NOT be used in this circumstance.

I appreciate your careful reading, and your thoughtful question.

Sincerely,

Stephen C. Spain, MD

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

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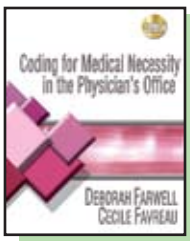

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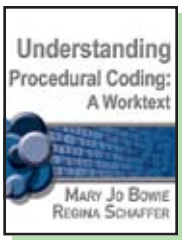

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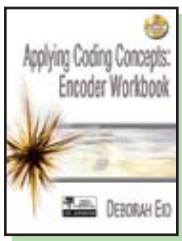

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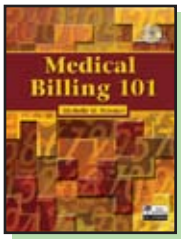

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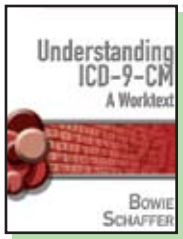

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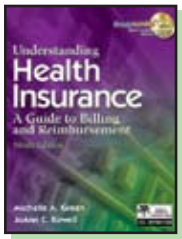

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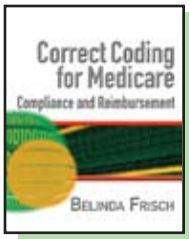

ISBN: 1-4180-1561-X
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- Learn how to code correctly and maximize reimbursement.
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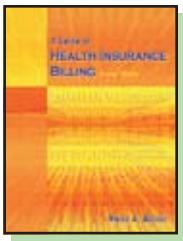

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coding news

by Michelle A. Dick

Use G0257 for ESRD EPO and Aranesp Payment

Effective Oct. 1, CMS change request (CR) 6047 revises billing for end stage renal disease (ESRD) related epoetin alfa (EPO) and darbepoetin alfa (aranesp) administrations during unscheduled or emergency dialysis treatment in an outpatient hospital setting.

It revises CR 3184, which required the presence of hospital emergency room visit revenue code 045X to allow payment for ESRD-related epoetin alfa (EPO) and darbepoetin alfa (aranesp) provided with an emergency dialysis treatment. Revenue code 045x is no longer required for EPO and aranesp payment for an unscheduled or emergency dialysis treatment.

With the revision, payment of EPO and aranesp is allowed for HCPCS Level II codes, Q4081 *Injection, epoetin alfa, 100 units (for ESRD on dialysis)* and J0882 *Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis)* only when G0257 *Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility* is present on the same claim.

In an outpatient hospital setting (13x and 85x bill types), Medicare contractors should only pay for ESRD-related EPO or aranesp when code G0257 appears on the same claim.

If G0257 does not appear on the same claim, the outpatient hospital claims should be returned to the provider.

Go to www.cms.hhs.gov/Transmittals/downloads/R1503CP.pdf for the CMS transmittal.

For questions, contact your FI or A/B MAC found at www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

Big Fraud Stats in South Florida

South Florida makes up 20 percent of all filed federal Medicare fraud prosecutions, according to U.S. Attorney General Michael Mukasey. Last year, U.S. Attorney Alexander Acosta and the Department of Justice (DOJ) established the Medicare Fraud Strike Force in Miami. The strike force has charged more than $638 million in fraud with 120 criminal and civil cases against 200 defendants in South Florida. Fraud cases involve the following:

- Billing Medicare for unnecessary medical equipment and prescriptions
- Billing Medicare for services never provided
- Stealing information from physicians and hospitals
- Submitting false claims to Medicare

According to an Associated Press (AP) story, South Florida has been a hot spot for Medicare fraud. Mukasey said, "Fighting the fraud and theft committed by these criminals is vital to preserving our health care system—vital to its financial solvency, as well as its integrity"

Source: www.medicalnewstoday.com/articles/109237.php

TOP 10 Coding Resources

10. My specialty's professional society
9. Good pathophysiology/anatomy book (*Netter's, Merck, AMA Netter's Atlases of CPT®* and *Orthopaedics*, etc.)
8. Good medical dictionaries and resources (*Dorland's, Stedman's, Merck, Coders' Desk Reference, Plain English Descriptions*, etc.)
7. Individual payer websites, newsletters, and personal relationships
6. HHS web sites including OIG, Medicare Learning Network, CMS transmittals, Publication 100
5. Coding software—EncoderPro, CodeManager, CodeCorrect
4. Other core code books: ICD-9-CM, HCPCS Level II, current year and past years for references
3. CPT® *Professional* book—current year, and keep past years for references
2. AAPC—local chapter meetings, educational events, *Coding Edge* and Edge*Blast*, Coding Discussions, and other resources.
1. **Our colleagues**

American Academy of Professional Coders
www.aapc.com

This list was compiled from a survey of AAPC National Advisory Board members

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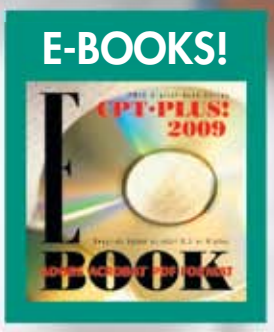

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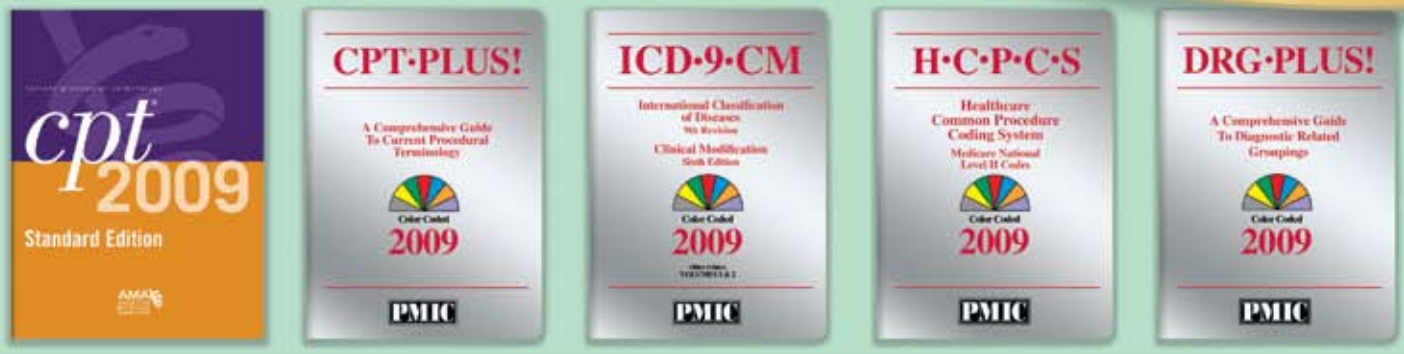

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Buyer's Guide

Looking for a Consultant? Consider This

by Deborah Grider,
CPC, CPC-H, CPC-P, CPC-EM, CPC-I, CCS-P, CCS, CCS-P

EXPERT

What are the benefits of hiring a health care consultant? A health care consultant brings measurable accountability, scheduled timelines, and low costs to achieve an answer that can prove more financially sound than in-house efforts. Before you hire a health care consultant, it's important to have a clear understanding of what you are hiring him or her to do. A health care consultant should assist with the following:

- Managed care contract review
- Employment contract review
- Practice start-up
- Review of coding and reimbursement systems
- Medical record chart audits
- Accounts receivable reviews
- Medical staff issues
- Operations overview

The best protection is to clearly spell-out everything in writing before hiring the consultant.

With a consultant's duties in mind, what's the best way to find one? You can find a consultant using the following resources:

- **Referrals from friends:** This is probably the best resource.
- **State and county medical societies:** These are great local resources.
- **Residency programs:** Residency programs use consultants to assist them with developing and presenting their practice management curriculum.
- **Professional journals:** Frequently, consultants write or contribute to articles published in professional journals.
- **Professional associations:** Make note of who writes articles for professional journals, makes presentations at conferences and in workshops, and who the members of consultant sections might be.
- **Referrals from attorneys:** Attorneys encounter consultants and their work quite often.

When choosing a consultant, find one that is reputable and fits your needs. The most valuable asset of a health care consultant is his or her reputation. Unprofessional conduct quickly puts a consultant out of business. Judge your own consulting candidates by their reputations. Factors to consider are:

Size: Bigger isn't always better and there are pros and cons to working with both large and small firms. A large firm may have specialty departments to address such issues as coding, billing, practice management, etc. One disadvantage is a client may not work with the same consultant over a period of time. The project or job may be assigned to a consulting "team." A smaller firm can provide a personal touch to the relationship with the practice; however, it could also fall short on capabilities.

Stability: Although longevity doesn't always reflect quality, it's a good idea to ask how long a firm has provided consulting services.

Location: Most consulting firms require the client to pay the consultant's travel expenses to the practice or facility. Most clients prefer to work with firms

located within their geographic regions. Depending on the types of services the client requests, this might not be an option. In some cases, it's not practical to choose a firm providing services nationally when the problem to be addressed is regional.

Qualifications: Is the consultant qualified to perform the service? A medical record auditor should be a certified coder either with AAPC or AHIMA. Does the consultant have the expertise to perform the service? Experience and background are important.

Availability: Questions you can ask yourself that are indicators of the consultant's availability are: "Were you able to speak to someone right away?" or "Was your phone call promptly returned?"

When making the initial call to a firm, ask if the phone consultation is free. Most firms realize the marketing potential of providing a free initial assessment. How potential clients are treated during initial encounters serves as a barometer to the tone of the professional relationship. If a consultant is overly-subscribed, they will not have time to give the practice the attention it deserves.

The most valuable asset of a health care consultant reputation. Unprofessional conduct quickly puts a consultant out of business. Judge your own consulting candidates by their reputation.

Find out if the consultant is the person assigned to work with your practice or facility, or if the project will be assigned to someone else within the firm (for example, a less-experienced associate). If the majority of work on the project is handled by someone else, it is not necessarily a bad thing. The benefit is that the client may receive quality work at less cost. However, the firm should disclose this up front, so there are no disagreements as the project progresses.

If someone else in the firm is assigned to the project, make sure he or she is qualified to perform the project's scope. Sometimes, large firms hire less qualified staff to work under a more experienced consultant.

Needs Analysis: Describe the practice or facility needs to the consultant. Be sure he or she understands the expected results.

The consultant should ask probing questions, help the potential client, and clearly describe the state of affairs. To have a successful relationship with the consultant and a favorable outcome, clear and accurate communication is essential.

Specialty Experience: Does the individual or firm have experience in working with the specialty and to what capacity?

Fees: How does the consulting firm charge for its services? Some firms bill by the hour and others quote clients with a flat rate for a service (e.g. contract review or coding audit). How does the firm expect to be paid on retainer or in one lump sum? Are payment plans available? Is the client required to make a down payment with balance due at the conclusion of the engagement? The hourly rates of firms vary widely.

If the consultant has to travel to the facility, what expenses will be billed; for example, if airfare is covered, does this mean coach, first class, or stand-by? Is the practice or facility expected to cover lodging, meals, ground transportation, and long-distance phone call expenses.

The consultant should clarify what follow-up services are billable; for example, if the consultant returns to the practice for additional staff training, is it an additional charge or is it covered in the initial fee? Find out the same information for telephone consultation and written reports.

Interest Conflicts: Does the consulting firm have a vested interest in a particular product, such as a software program? If it does, that should not necessarily disqualify it. If the firm is aggressive about promoting a product, the consultant should also provide other similar products for the practice or facility to consider.

Check References: Ask the consultant to provide the practice or facility with references. Refusal to provide appropriate (or any) references, is a red flag.

Speak with the person who worked closely with the consultant. In many cases, this will be the practice manager or administrator, not the physician.

Ask Questions

Sample questions to ask references:

1. What type(s) of service(s) did the consultant provide?
2. Was the project completed within the estimated time frame?
3. Did the consultant adhere to the estimated costs?
4. How accessible was the consultant?
5. Was it easy to get answers to questions?
6. How did the consultant (if service was provided on-site) get along with personnel?
7. Was the consultant available to help implement recommendations?
8. Was the consultant willing to provide follow-up assistance? If so, was there an additional charge?
9. Would they work with the consultant again?
10. Would they recommend the consultant to a colleague?

After a complete request for proposals (RFPs) and request for quotations (RFQs) from two or three firms with checked references, the client should make a final decision.

Formally engage the consultant's services with a contract, letter of agreement, or prepared statement of work that defines the agreed terms. Typically, it is the consultant's responsibility to prepare this document. Both parties should sign the document.

Request for Proposal

Ask the consultants to provide the practice or facility with the following information in writing:

- Detailed description of the process to be undertaken for your practice
- Description of desired outcome
- Anticipated timeframe for completion of the project. Clearly spell-out expectations if the project is not completed within the proposed timeframe.
- Billable charges
- Estimated fee for completing the project. Clearly spell-out expectations if the project is going over-budget.
- Provisions on what will be done if the client is not satisfied with the final results.

It's Your Responsibility

As a client, you are responsible for the consultant's relationship with your practice or facility. To help smooth both parties' transition when hiring the consultant(s):

1. Prepare the staff and physicians for the arrival of the consultant(s). If the project involves working on-site, the presence of a consultant may feel imposing to staff members, especially if they are unaware of problems existed in the practice.
2. Cooperate with the consultant. If relevant practice information is requested, comply; for example, while conducting a reimbursement audit, a consultant may want to review many years of insurance payment history. Also, it might be necessary to pull medical records to review documentation. Assign a key staff person to be the consultant's on-site contact.
3. Request ongoing progress reports. The consultant should provide updates about how things are going.
4. Listen to the consultant's recommendations with an open mind. If the practice does not agree, you should discuss this with the consultant early on. The advantages a consultant brings to the situation are expertise and objectivity.

As a client, you are responsible for the consultant's relationship with your practice or facility.

5. Implement the consultant's recommendations with a positive attitude. Impending change is daunting. An optimistic outlook conveyed by the practice's leadership can go a long way to motivate the rest of the staff to make progress.
6. Poor communication is the most frequently-cited cause of relationship deterioration with unfavorable results. The client should make sure there is good communication with the consultant(s). Consultants want to do a good job for their clients and should be willing to work with the client.
7. The best protection is to clearly spelled-out everything in writing before hiring the consultant. CE

Jo Ann Baker, CCS, CPC, CPC-H, CHCC

Coding analyst for CodeRyte

Coding Edge (CE): Tell us a little bit about your career—how you got into coding, what you've done during your coding career, what you're doing now, etc.?

Jo Ann: I became interested in a medical career while working as a unit receptionist on a hospital surgical floor. Prior to my receptionist position, I had taken courses in medical terminology and had read medical records. When a position opened in health information, I transferred over to the hospital's coding department.

Within the next few years, I graduated from college with an associate degree in arts and social science, and obtained multiple certifications in coding including AHIMA's CCS, AAPC's CPC®, CPC-H®, PMCC approved instructor program, and Certified Healthcare Compliance Consultant (CHCC).

During my career, I held positions as lead coder in an acute care hospital setting and education specialist for the veterans hospital medical administration department. I am also an adjunct instructor for Morris County College and a workshop presenter for AAPC. I have authored several articles for the *Coding Edge* and the *Advance for HIM* publications.

I work out of my home office in NJ, employed by CodeRyte located in Bethesda, Md. As a coding analyst, I provide client and technical support for our computer assisted coding (CAC) application. I also serve as a subject matter expert internally and to our clients.

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

Jo Ann: I am founder and past president of the Essex County, N.J. AAPC local chapter and I attend meetings and present seminars at the Morristown and Monmouth-Ocean AAPC Chapters. Also, I am a former member of AAPC's National Advisory Board.

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

Jo Ann: My biggest challenge as a coder was transitioning from coder to educator, consultant, and coding specialist. I set my goals high, passed multiple certifications, and obtained a college degree to prepare for advancement in my profession. In my current role, my challenge is to help fellow coders transition to "21st century coding" by overcoming their anxiety and making the most of technology (CAC).

CE: What do you advise other coders to do if they disagree with the way a physician has coded his chart?

Jo Ann: If a discrepancy is found with how a chart was coded or billed between the physician and a coder, ask the provider for a one on one meeting. Always be respectful of the physician and listen to their side. There may be a clinical explanation for why a particular code was selected that a coder may not be aware of. Be prepared in advance with examples of the doctor's notes, with cited official resources, and to offer suggestions to make the most of the time you have with them!

In addition, it is a good idea for the practice to schedule monthly interdepartmental meetings. This provides a forum for administrative and revenue cycle team members to discuss issues that require further investigation. Proactive research, auditing, and problem-solving before discrepancies occur ensures a healthy, profitable, and compliant practice.

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

Jo Ann: I would love to be an author or a journalist! I enjoy writing and solving mysteries, and would like to write a novel, become a research journalist, or featured writer—after all, coding is about doing research and solving mysteries!

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

Jo Ann: I have been married for 24 years and live in northwest N.J.; we have a daughter in college, and a son who will be a senior in high school in the fall. I enjoy visiting New York City, watching my son play lacrosse, and spending time with my family. I have a talent for art and when time allows, I pencil and charcoal sketch. I am an avid reader of mysteries and novels. CE

Kudos to AAPC members

Kudos to AAPC's customer service team from **JD Rigdon, CPC, NCICS, BS-HA,** of University Physicians in Aurora, Colo. JD said, "Over the last few years, I have made several calls to the customer service department and every time I have been treated with profound professionalism, courtesy, and expediency. One example is the most recent call I placed to AAPC: Dawn Riding was the pleasant voice on the other end of the line yesterday when I inquired about an order I had placed. She found the order and checked on the status. It was only a short time later I received an email from her apologizing for the delay—but I didn't think there was a delay at all. AAPC's outstanding customer service team is an example many other businesses should model. Too bad you can't package it! AAPC's tag line, 'Upholding A Higher Standard,' is no joke, and you always outdo yourself. Thanks for consistently great customer service!"

Share the joy of the AAPC of KC. Sandra Soerries, CPC, CPC-H, of Medical Revenue Solutions, explains that the Kansas City (KC) local chapter is in their 15th year. She recalls Marti Johnson, director of local chapter support, calling her 15 years ago to ask, "Sandy, would you like to start a local chapter in Kansas City?" Sandy thought, "Would I like to? I would LOVE to start a local chapter in KC!" And that was the beginning—Sandy was on a mission. She said, "I would make fliers and put them in hospital elevators throughout KC. I did not even ask permission because I did not want anyone to tell me I could not do it. My husband, Greg, would help me send 400 faxes a month to the medical managers throughout the KC area. Back then, we had to do it one page at a time.

Today, the AAPC of KC has more than 500 members, with an average of 100-150 attending at each monthly meeting and local chapters have spun off from KC; Omaha, Neb.; Wichita, Kan.; Topeka, Kan.; Columbia, Mo.; Springfield, Mo. CE

If you deserve kudos, please email your accomplishments to our editors at kudos@aapc.com.

Buyer's Guide

PROFESSIONAL

Meet Your Coding Needs With the Right EHR

by Patricia S. Wilson, RT (R), CPC, PMP

An integral part of the coding process is to verify that documentation supports procedures and services performed. Although documentation of medical services and procedures seems a logical part of medical practice, it sometimes is a secondary function of medical care. The concept of medical documentation as a secondary function in medical care is not a new concern, as Florence Nightingale referred to it in 1863:

> "In attempting to arrive at the truth, I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purposes of comparison. If they could be obtained … they would show subscribers how their money was being spent, what amount of good was really being done with it, or whether the money was not doing mischief rather than good…"

Service documentation is sometimes considered by clinicians as an onerous obligation of their profession. They rarely see the immediate benefit of clearly and completely dictating or writing down what they did. Many see it as a means to keep the HIM, coding, and compliance departments out of their hair.

As Florence Nightingale indicated, it is the lack of precise, clear, and complete medical documentation that often causes mischief—not only for the provider, but for the patient, too.

In 1999, the Institute of Medicine (IOM) published a study indicating 98,000 patients die every year primarily due to inadequate medical record charting and reporting. The use of an electronic health record (EHR) was sited as being a key mechanism to support quality and efficiency in patient care. The health care industry took this information to heart. Over the following years, a variety of EHRs came on the market to solve the problem of incomplete, low quality medical documentation. The federal and state payers are changing the reimbursement paradigm from frequency based to quality based.

There are as many different types of computerized or electronic health record types as there are acronyms used to describe them. The health care industry has struggled to define what is necessary to make health care information consistently of good quality and used by the provider. Less than 10 percent of small physician practices use a form of an EHR and with large practices about 30 percent use one. The adoption of EHRs by hospitals across the country is somewhere in the range of 16 percent to 56 percent. The reason for

The health care industry has struggled to define what is necessary to make health care information consistently of good quality and used by the provider.

the huge variance in hospital EHR adoption statistics is due to the variable definition of an EHR.

The professional coder can lend a voice in the area of EHR definition and adoption. There is a significant shift in health care reimbursement with the desire to provide high-quality health care. The EHR is the silver bullet to assure good documentation and provide quality health care. However, the silver bullet may shoot right through the coding process and—more importantly—compliance if the coder and compliance officer are not included in the process up front.

The medical coder and compliance officer are sometimes overlooked as important stakeholders when a medical practice or hospital is purchasing an EHR. Instead of waiting for an invitation to the decision making process, the coder and compliance officer, in most cases, need to outline their points of concern. Here are some 'gotcha' points for the coder to consider when purchasing or implementing an EHR.

The overarching question to ask is how will the EHR operate with the existing billing system? The answer to this single question determines additional questions asked and to what extent the EHR could change your current coding practices.

Here are secondary questions to ask that determine how the EHR will impact coding:

Is it a stand-alone EHR? This means that it does not interface with any other electronic medical system, especially the billing system. A stand-alone system requires double entry of outside information into the EHR. It is highly unlikely that even a solo medical practice would never refer a patient to a hospital, imaging center, laboratory, nursing home or other medical service. Double entry data leaves room for human error and inconsistencies, takes extra time and effort, and is a red flag for a compliance officer.

To what extent does the EHR "auto-code?" EHRs have a mechanism for suggesting both diagnostic and procedural coding based on the clinician's data input. The system could be a template-based format that prompts the clinician to fill in information they may otherwise have missed. Other systems use natural language processing to parse out certain words and phrases to determine the diagnosis and procedure. The issue with EHRs that auto-code is the extent to which they can adhere to specific coding rules established by local and even federal insurance carriers. Even the best auto-coding system requires some measure of review and a method to override the suggested codes. This leads us to the next question to ask:

If the EHR does auto-coding and is able to interface with data flowing into your existing billing system, **can data flow back out of your billing system and into the EHR?**

This is an essential component for auditing and compliance. If a suggested EHR diagnosis or procedure code should be over-ridden for claim submission, the change should be input into the EHR for the purpose of audit tracking. Many EHR systems are recognizing this need and upgrading their systems to provide a complete coding audit trail.

There are several other questions to consider depending on your practice. The most important is how flexible is the candidate system at implementing coding and billing changes required by the industry. Medical practices rely on coders and compliance officers to provide accurate, complete, and consistent coding for their financial benefit. It is up to you to take an active role in staying abreast of how an EHR will impact your workflow and the bottom line.

Patricia S. Wilson, RT (R), CPC, PMP, is team lead and government project manager for the 3M Healthcare Data Dictionary team. She is a member of International Healthcare Terminology Standards Development Organization (IHTSDO) Mapping Work Group and also the Logical Observation Identifiers Names and Codes (LOINC) standards committee. She has been a CPC® since 1990.

Establish a Great E/M Education Program

by Kim Harper, MBA, RHIA, CPC

PROFESSIONAL

Since the 1995 and 1997 Documentation Standards implementation, physicians have been made aware of history of present illness elements, review of system bullets, physical exam components, and medical decision making issues which constitute an evaluation and management (E/M) level of service. The big question most physicians have is, "How am I ever going to remember this?" The answer to the question is not easy. The best solution is to implement a *great* education *program* to provide on-going education for your physicians.

I emphasize the words *great* and *program* for several reasons. You must have a great educator to identify issues, communicate those issues to physicians, and offer solutions to the issues. Identifying the issues is the easy part. Offering solutions to a group of physicians who are frustrated with government billing regulations can be a challenge. Establish a program comprised of a series of lectures to help the physicians focus on one issue at a time to keep the physicians interested in E/M coding. If you bombard the physicians with an overabundance of criticism all at once, it will overwhelm and the information won't be retained. The education session should not convey the message, "You are a bad doctor and you are going to jail." The education sessions should cover both negative and positive aspects of physician documentation. Your program should implement an accuracy goal to help physicians see where they stand and what improvement is made since the last review. With this system, they will rise to the challenge of being "graded" and strive for the best.

The first step in establishing a great education program is to perform a quarterly or monthly audit. The audits will determine your issues and what the education session should focus on. The audits should reflect your documentation accuracy and show where you need to improve. Remember: both over-coding and under-coding lead to financial burdens. If the group is over-coding, you risk paying fines, and if the group is under-coding, you deny the physicians money they work hard for.

The second step is preparing and presenting great education sessions. Education sessions should be held at least once a month. The more face-to-face time you have with physicians to discuss the importance of documentation, the better. If you are in a multispecialty group, it's important each group has its own education session as each group's patients and services differ. Your education session should allow

For the program to be successful you need an "enforcer" of accuracy rates and the incentive program. The best enforcer is usually another physician.

your physicians to ask a lot of questions. This helps the group stay interested in the discussions. For instance, if the education session is scheduled to last an hour, plan for a 30 minute presentation and use the remaining 30 minutes for questions. When the physicians ponder different real life scenarios, the questions start flowing. If you feel uncomfortable allowing your physicians to ask questions because you don't like being put on the spot, remember a great educator is not afraid to say "I don't know but I will look that up and get back with you." This provides you with a chance to research the correct answer. Take time to research prior to the education session to help alleviate the stress of presenting and the pressure of being put on the spot. To be a great educator, it's necessary to be knowledgeable and comfortable presenting the information. Physicians love examples and they may have a hard time believing they make mistakes. Seeing their documentation and its shortcomings can help get their attention. However, be careful in presenting this in a group session because no one likes to be singled out for bad practices. These issues should be addressed in a one-on-one session. One-on-one sessions are great for struggling or new physicians.

To have a great education program, all physicians should be aware of the expectations and the importance of proper documentation. Once the audit process and education program is implemented, the physicians should understand excepted accuracy rates and the importance of attending education sessions. For example, if you have an 80 percent coding accuracy rate, the physicians should be informed if this accuracy rate includes both under and over coded claims. If it does include both and the audit consists of 10 charts, the physicians must have eight records documented to the correct level of service submitted. If the physicians have consistently poor audit outcomes, the plan may need an incentive program to reward physicians for scoring above the accuracy goal and discourage physicians from incorrect documentation. If this seems extreme, consider the impact on a physician's practice when the documentation isn't taken seriously. It is important physicians realize the importance of compliant documentation.

The final step in having a great education program is to get support from your hospital administrator and your physician director. The educator must be a person the physician feels comfortable asking questions to and feels is acting in their best interest. For the program to be successful you need an "enforcer" of accuracy rates and the incentive program. The best enforcer is usually another physician.

Establishing a great education program is beneficial as it provides a layer of defense from an outside audit and also ensures the group is billing for all services provided. Both lead to financial success and a good night's sleep.

Kim Harper, MBA, RHIA, CPC, is a coding and compliance manager at Golden Cross Academic Clinic.

Buyer's Guide

Master the Art of Negotiation

Get the Books and Software You Need

by Michelle A. Dick, Senior Editor

APPRENTICE

On the road of life, differences in opinion and how to reach a compromise are part of the journey. We first learn to negotiate our needs as a toddler. We move on to negotiate about toys and homework. As an adult, we realize the full potential of negotiation with our spouse, employer, clients, and colleagues in our office or business.

We negotiate in our personal and professional lives every day. We negotiate when we want to get a bargain at a garage sale, when we want to eat at a particular restaurant, or when we want to make a change at work. Sometimes it's easy to negotiate; but at other times, when we have a lot at stake or we are upset, the task is intimidating and difficult. Negotiating to a reluctant employer that up-to-date coding books are a medical necessity or negotiating to a vendor for a fair software price can be intimidating.

Fortunately, all you need is a strategy to keep your coding books or software current and eliminate undue negotiation stress. We'll step you through the process with our list of negotiation "dos" and "don'ts" to help you tactfully obtain the coding books or software you need, so both parties benefit from the outcome.

Avoid Confrontation

Effective negotiation is both parties working together to find a solution. It isn't a contest to be won or a battle of wills. A surefire way to get what you want is to look for a solution where both parties are winners.

Attitude is everything when entering into a negotiation. A hostile or defensive attitude will get you nowhere fast. If you are confrontational, you will have a fight on your hands. Set the tone for a cooperative interaction.

For more on how to effectively communicate to coworkers, please read the article, "Which Hat Do You Wear?" in June's issue of *Coding Edge*.

Watch the Timing

There are good times and bad times to negotiate. Avoid entering into your negotiation at a bad time, which include:

- high stress levels (i.e., right before or after a physician sees a patient)
- tiredness or hunger on either side of the involved parties
- anger on either side
- preoccupation with another pressing issue

If the negotiation is to take place during one of these times, reschedule for a better time.

Be Prepared for "No"

Before entering into a negotiation session, prepare

other options to suggest if the preferred solution is not acceptable. Anticipate why the employer may resist your suggestion, and prepare a counter alternative. If the cost of purchasing books for the entire coding staff is an issue, suggest sharing books with coworkers (for example, one set of books for two-three staff members).

Be Clear on the Goal

It's important to discuss what you need and why you need it. Often disagreement exists because of the solution's method or costs, but not about the overall goal.

Throw Emotions Aside

When a negotiation is important to you, it's normal to become emotional. Always maintain control. The more emotional you become, the less apt you are to channel the discussion into constructive directions. It can be particularly hard to maintain emotional control with someone you don't particularly like or agree with. Stay focused, as it's important to put aside individual differences, and stick to the issue of obtaining necessary coding books and software.

Find Out What the Hang-up Is

When negotiating for new coding books, use questions to find out what the other person's concerns are. Ask questions such as, "What are your concerns with purchasing up-to-date coding books?" and "Is there anything I can do to help expedite this, such as filling out and sending the purchase order?" Listen to the response and address the concerns.

The more emotional you become, the less apt you are to channel the negotiation into constructive ways.

Understand the Other View

Finding an acceptable solution for both parties involves understanding the other side's differences regarding the issue. If you don't know what the person's concerns are, you can't negotiate properly.

Find the Solution, Not Who's Wrong

Negotiating is about finding solutions. You shouldn't try to prove the other person is wrong. If you disagree with the answer, state your disagreement in a gentle, yet assertive, way. If you argue, you won't get the books or software you need, so don't waste your time. Power struggles don't lead to resolution.

Using these negotiation "dos" and "don'ts," can help you effectively resolve any difficult situation. Remember, you are the one who controls the outcome of the negotiation and has the power to get what both parties want. CE

Michelle A. Dick holds a BS in graphic design from Buffalo State College. She has been editor-in-chief for six graphic design tutorial publications, editor for the Coding Institute's *Part B Survival Guide*, and is now engulfed in the world of medical coding.

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ICD-9-CM
Coding Books for 2009

Most ICD-9-CM code books contain identical information—the official government data—and some customized data from the publisher. Because most people want the same added features, the books are fairly similar and choice is based on personal preferences for how the information is displayed, cost, and customer service. All books reviewed include the following: official codes and descriptions, updated for 2009 and identified as new or revised; official ICD-9-CM Coding Guidelines; unabridged index and all of Volumes 1 and 2 and official appendixes (Volume 3 for hospital books); bound and printed format. They have Medicare edits, illustrations and annotations, and notations on AHA Coding Clinic references, unless noted. Generally, coders in physician office, clinics, or outpatient facilities need Volumes 1 and 2, while payers and inpatient coders need Volumes 1, 2, and 3.

2009 ICD-9-CM Publisher/Edition	New feature or extras	Price	Tabs/other navigation tools	Binding	Other information
(1-800-626-2633)					
AAPC 1&2	Official ICD-9 CM Guidelines integrated into tabular section	$59.95	Color bleed tabs	Plastic spiral	8x11 size; Bank of full-page full-color anatomy illustrations
AAPC 1,2&3	POA and HAC indicators; Official ICD-9-CM Guidelines integrated into tabular section	$69.95	Color bleed tabs	Plastic spiral	8x11 size; Bank of full-page full-color anatomy illustrations
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AMA 1&2 softbound	Free bonus publication outlining code changes	$89.95	Color bleed tabs	Paperback	8x11 size
AMA 1&2 Compact	Free bonus publication outlining code changes; Official ICD-9-CM Guidelines integrated into tabular section	$74.95	Color bleed tabs	Paperback	6x9 size
AMA 1,2&3	Free bonus publication outlining code changes	$102.95	Color bleed tabs	Wire Spiral	8x11 size
AMA 1,2&3 Compact	Free bonus publication outlining code changes	$79.95	Color bleed tabs	Paperback	8x11 size
(1-800-248-2882)					
Channel generic 1&2	Black and white economy version.	$64.95	Black bleed tabs	Paperback	8x11 size; No illustrations, annotations or Official ICD-9-CM Guidelines
Channel 1&2	Black and white	$74.95	Black bleed tabs	Paperback	8x11 size; No Official ICD-9-CM Guidelines
Channel 1,2&3 paperback updateable	Black and white	$109.00	Black bleed tabs	Soft, smaller binder	7x10 size
Channel 1,2&3	Black and white	$79.95	Black bleed tabs	Paperback	8x11 size; No Official ICD-9-CM Guidelines
Channel 1,2&3 Generic	Black and white economy version.	$69.95	Black bleed tabs	Paperback	8x11 size; No illustrations, annotations; No Official ICD-9-CM Guidelines
Channel 1,2&3 Postbinder	Black and white	$195.00	Card stock dividers	Large postbinder	8x11 size
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Contexo 1&2 Compact	Email alerts of changes; Official Guidelines integrated into tabular	$84.95	Color bleed tabs	Paperback	6x9 size; Bank of full-page full-color anatomy illustrations
Contexo 1&2 Spiral	Email alerts of changes; Official Guidelines integrated into tabular	$94.95	Color bleed tabs	Plastic spiral	8x11 size; Bank of full-page full-color anatomy illustrations
Contexo 1, 2&3 Compact	POA and HAC indicators; Email alerts of changes; Official Guidelines integrated into tabular	$89.95	Color bleed tabs	Paperback	6x9 size; Bank of full-page full-color anatomy illustrations
Contexo 1,2&3 Spiral	POA and HAC indicators; Email alerts of changes Official Guidelines integrated into tabular	$99.95	Color bleed tabs	Plastic spiral	8x11 size; Bank of full-page full-color anatomy illustrations
(1-877-652-9093)					
DecisionHealth 1&2	Economy version.	$59.95	Color bleed tabs	Lay-flat paperback	8x11 size
DecisionHealth 1&2		$64.95	Color bleed tabs	Plastic spiral	8x11 size; extra code table resources
DecisionHealth 1,2&3	Specific to home health; OASIS and RUG III	$199.00	Color bleed tabs	Paperback	8x11 size;no illustrations

	data and benchmarking tools				
Elsevier 1&2	Official Guidelines integrated into tabular	**	Color bleed tabs	Paperback	8x11 size; photographs
Elsevier 1,2&	Official Guidelines integrated into tabular	**	Color bleed tabs	Plastic spiral	8x11 size; photographs
Elsevier 1,2&3	Official Guidelines integrated into tabular	**	Color bleed tabs	Paperback	8x11 size; photographs
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(1-800-633-7467) **PMIC 1&2 softbound**	Economy version.	$74.95	None	Lay-flat softbound	6x9 size; Bank of full-page full-color anatomy illustrations
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Coding Books for 2009

CPT®, unlike ICD-9-CM and HCPCS Level II, is developed and copyrighted by a non-governmental entity. CPT® codes, descriptions, and guidelines are owned by the American Medical Association (AMA), which develops them with input from specialty societies, governmental agencies, and other constituents. As a result, only the AMA's CPT® *Professional and Standard* have all the CPT® information, although other publishers amend parts of the data with Medicare and other information. Every coder should start with the AMA book, then augment it with other publications that include desired additions. All of the books reviewed below include these common elements: all the 2009 CPT® codes and descriptions, modifiers, and icons denoting usage of the codes.

2009 CPT® Publisher/ Edition	New feature or extras	Price	Tabs/other navigation tools	Binding	Other information	Phone number
AAPC/ Procedural Coding Professional	RVUs Coding tips for radiology and lab.	84.95	Color tabs	Plastic spiral	Not allowed for CPC® core and specialty exams	1-800-626-2633
AMA Press/ Professional Edition	Official publication of codes' owner. Crosswalk table of 2008 to 2009 and E/M decision tree.	102.95	Color tabs	Wire spiral	**Can** be used for CPC® core and specialty exams	1-800 621-8335
AMA-Press/ Standard Edition	Official publication of codes' owner. Crosswalk table of 2008 to 2009 and E/M decision tree.	74.95	n/a	Paperback	**Can** be used for CPC® core and specialty exams	1-800 621-8335
Contexo/MMI/ Procedural Coding Professional	Coding tips for radiology and lab.	94.95	Color tabs	Plastic spiral	Not allowed for CPC® core and specialty exams	1-800-324-5724
Ingenix/Current Procedural Coding Expert	Organized by body system Medicare global/ follow-up days Brand name vaccinations Icons for PQRI. Two formats; Spiral and trade paperback	99.95 (Spiral) 89.95 (Paperback)	Color Tabs	Plastic spiral/ Paperback	Not allowed for CPC® core and specialty exams	1-800-464-3649
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Buyer's Guide

HCPCS level II

Coding Books for 2009

HCPCS Level II books contain all the latest codes and descriptions at time of publishing. Some provide Web updates and Ingenix offers a quarterly updated product. All HCPCS books include full descriptions, Medicare coverage information, and material from the ANWEB table posted by the CMS. Most of these books include enhanced indexes and drug tables. Some include brand name crosswalks and icons denoting coverage. Some include information for payment systems that use HCPCS codes, such as APCs or ASCs.

2009 HCPCS Level II Publisher/ Edition	New feature or extras	Price	Tabs/other navigation tools	Binding	Other information	Phone number
AAPC/ HCPCS Medicare Level II Codes	DMEPOS icons Integrated illustrations G codes for PQRI	74.95	Colored Tabs	Plastic spiral	Web code Updates	1-800-626-2633
American Medical Association/ AMA HCPCS 2009 Level II	Icons denoting PQRI, MPFS, ASC, DMEPOS, and OPPS related codes.	94.95	Color Tabs	Paperback	n/a	1-800 621-8335
Contexo/MMI/HCPCS Level II Professional 2009	DMEPOS icons Integrated illustrations G codes for PQRI	94.95	Color Tabs	Plastic spiral	Web code updates	1-800-324-5724
DecisionHealth/HCPCS Level II Expert	Icons denoting PQRI, MPFS, ASC, DMEPOS, and OPPS related codes.	89.95	Color Tabs	Plastic spiral	n/a	1-877-652-9093
DecisionHealth/HCPCS Level II Professional	Icons denoting PQRI, MPFS, ASC, DMEPOS, and OPPS related codes.	89.95	Color Tabs	Paperback	n/a	1-877-652-9093
HCPro/HCPCS Level II Manual	Age and sex edits APC and ASC edits	79.00	n/a	Metal spiral	n/a	1-877-727-1728
Ingenix/ HCPCS Level II Expert	Spiral Paperback Updateable binder Icons denoting PQRI, MPFS, ASC, DMEPOS, and OPPS related codes. Medicare and Commercial fee data	99.95 (Spiral) 86.95 (Paper-back) 149.95 (Binder)	Color Tabs Thumbtabs on Binder	Plastic spiral/ Paperback/ Binder	n/a	1-800-464-3649
Ingenix/HCPCS Level II Professional	Icons denoting PQRI, MPFS, ASC, DMEPOS, and OPPS related codes. Includes age and sex edits. AHA Coding Clinic	72.95	Color Tabs	Paperback	n/a	1-800-464-3649
MedBooks, Inc/HCPCS Level II National Supply Code Book	Pricing and multiple pricing indicators Anesthesia base units	79.95*	n/a	Metal Spiral	n/a	1-800-443-7397
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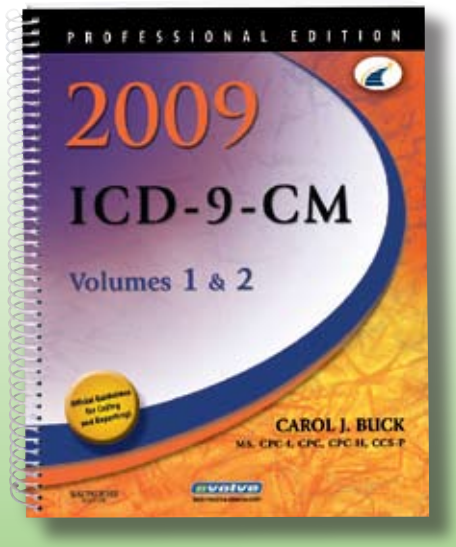

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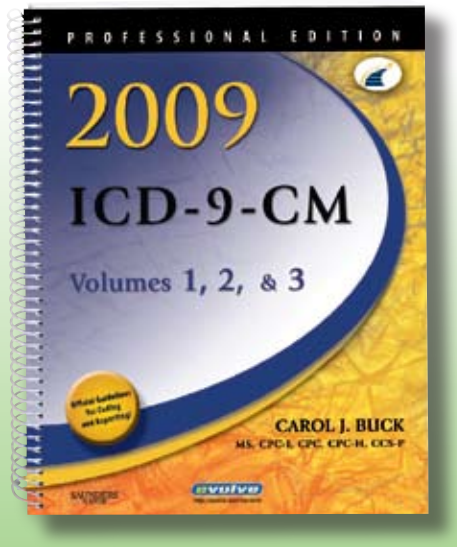

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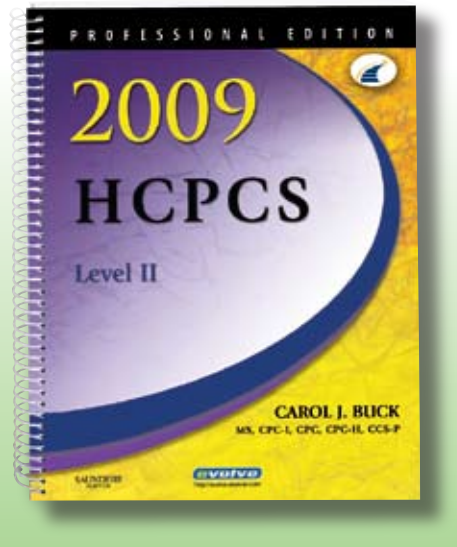

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Why you should attend: You should attend if you are a coder, biller, in the allied healthcare industry, or any part of your job involves responsibility for the physician coding or billing of surgical procedures.

CMS RAC Status Document

According to CMS' 2007 report on the use of Recovery Audit Contractors (RACs), more than $357 million was collected to recover overpayments caused by incorrect coding, insufficient documentation, and other avoidable errors in only 3 states. This class will feature an important break-out session to help you learn how to win against unfavorable audit results.

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ID	Coeur D' Alene	10/15/08	NY	Syracuse	10/17/08	WI	Milwaukee	10/17/08
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A Famous Case of Multiple Organ Removal

May's operative note was an account of a woman who recently had six organs removed , prepped and replaced, allowing for the excision of an "inoperable" leiomyosarcoma. The cancer had wrapped itself around vital vasculature making normal surgical techniques for removal a death sentence. We didn't know everything necessary to code the case accurately, so instead of asking for the codes, we asked you to address the issues you need to know before you code the scenario accurately. After all, if it isn't documented it shouldn't be coded.

We received several responses from our readers. Unfortunately, they skipped the items not addressed in the case. We asked Nancy Reading, BS, RN, CPC, CPC-I, vice president of education at the AAPC, for her take. Here's what she suggested a coder would want to look for in a complicated and first-time case like this.

In a case like this, Nancy told us, prior approval is important and a coder would want to present the payer with information to over-approve the case. Documentation of clinical efficacy, outcomes, and cost savings are paramount in getting a case like this considered by a third party payer as anything but experimental. Removal and replacement of the same organs in the same surgical session require submission of unlisted codes. Based on the documentation, argument can be made to code backbench work, but documentation we received did not illustrate with enough depth and description the work done there. All vascular work done as part of the removal of the tumor would be coded but we don't know vessels or to what extent.

Establishing the pricing for the unlisted procedure is done by comparing the cost for similar procedures. Liver transplant can be used to benchmark a jumping off point and each additional organ replaced could be assigned a value at 50 percent of the liver transplant. Each vessel re-anastamosis can be coded once the sites are known, in addition to the unlisted code. Back bench work can be coded if appropriate

Chances are a payer may not cover such an experimental procedure, Nancy said, so it would be prudent to negotiate a contract of payment from the patient beforehand.

Team Coding Leader Dr. Mohammed Ali Hadi, CPC, CPC-H, India, did help us with diagnoses, which is well-documented in the news reports and press releases we used to construct the case.

205.30 Myeloid leukemia; myeloid sarcoma; without mention of remission

V67.1 Follow-up examination; following radiotherapy

V67.2 Follow-up examination; following chemotherapy

Can You Code This Note?

The Nutcracker Stent

Like so many conditions affecting the kidneys, nutcracker phenomenon or syndrome (NCS) is caused by problems within the renal pelvis, the compression of the left renal vein between the aorta and superior mesenteric artery. On an X-ray, it looks like a nutcracker is being used to crush the vein and stem blood flow. It is a rare cause of hematuria in children and its treatment, which ranges from conservative management to arterial bypass, is controversial. The flank pain, renal hypertension, and other symptoms associated with this "nutcracker" are not something even Clara's Mouse King would want. Below is an approach chosen after a lot of testing and head-scratching was done. How would you code this?

Diagnosis: Nutcracker Syndrome

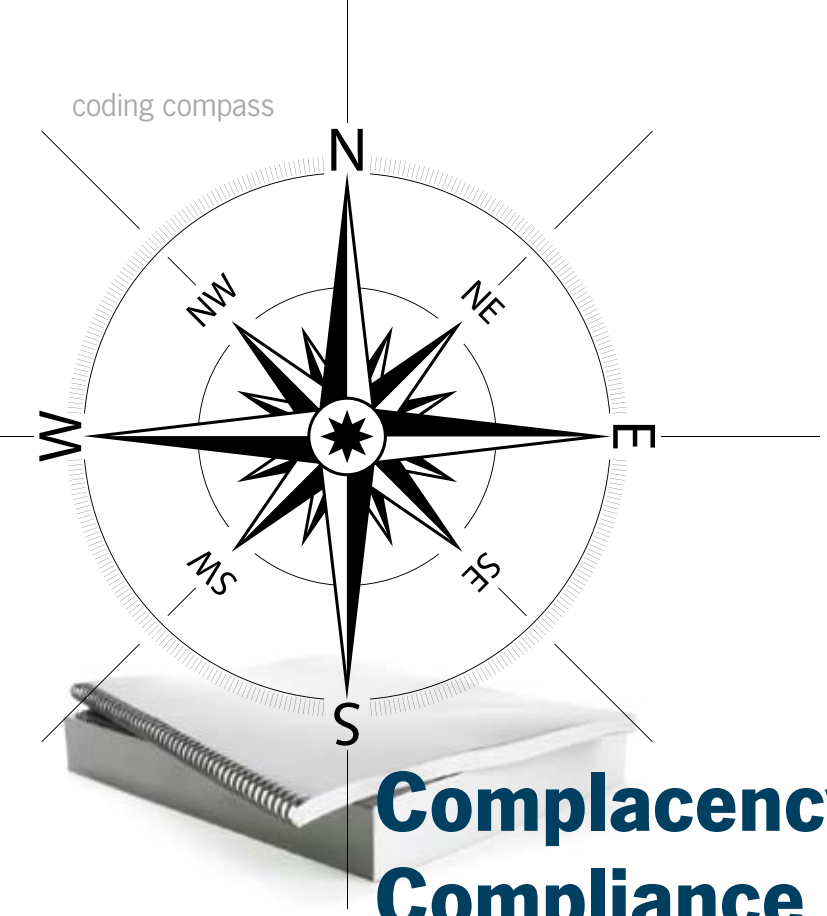
Findings: A 15-year-old male presented with a three-month history of intermittent macroscopic hematuria and left plank pain. The patient had no family history of hematuria or any hematological or renal diseases. Urinalysis revealed numerous red blood cells (RBC) per high power field with RBC casts. RBC morphology was predominantly (>90 percent) isomorphic, suggesting that it was of non-glomerular etiology. Other tests were of normal range. Renal ultrasound and abdominal computerized tomography (CT) scan didn't detect nephrolithiasis, tumors, or lesions. The patient's cystoscopy, however, showed bleeding that emanated solely from the left renal system. A renal biopsy failed to show any glomerular pathology on light and electron microscopy. Immunofluorescence microscopy was negative for immune reactants. A biplanar abdominal aortography with left renal arteriography was requested and showed an abnormal venous phase on the left renal vein with varicosities of collateral veins between the superior mesenteric artery and aorta. Informed of a diagnosis of nutcracker syndrome, the patient and his parents selected conservative management.

After two years, persistence of hematuria and left flank pain prompted the family to seek intervention. Despite a lower than normal hematocrit, the patient was normotensive without hemodynamic compromise.

Procedure: The patient underwent endovascular stenting of the left renal vein where a 14 mm X 6 cm stent was inserted. A final venogram was performed to check proper dilation and adequate vein dilatation. The patient left the next day.

Have You Gone to Extremes?

Have you got a challenging scenario you'd like to see discussed in this forum? Send your op report to extreme.coding@aapc.com. Before forwarding it to us, please safeguard the patient's personal information by changing dates and removing unique identifiers.



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Civita Fahey, CPC, CHCC, CCS-P, PCA

Complacency Creates Compliance Concerns

Buying the Right Books is Good Protection

by Julie E. Chicoine, JD, RN, CPC

Health care providers operate under an increasingly scrutinized regulatory environment for fraud and abuse involving federal health care programs1 including Medicare and Medicaid. Recent statements by Senator Patrick Leahy (D-VT) at a Feb. 27 hearing on "The False Claims Act Correction Act of 2008" note the current Federal False Claims Act's enforcement actions led to the United States Treasury recovering more than $20 billion from fraud and abuse cases involving various industries, including health care, since 1986.

Be Up-to-Date

Given the financial risks of coding and billing for health care services, it is important for coding professionals to use up-to-date references and materials when submitting claims for health care providers.

The False Claims Act ("Act") is an effective government enforcement tool against fraud and abuse in the health care sector. Currently under the False Claims Act, it is unlawful for a person (individuals or organizations) to knowingly submit or cause to be submitted, a fraudulent claim to an officer or United States government employee for payment or approval. The Act defines "knowingly" as presenting a claim with "actual knowledge" that the information is false and/or acting in "reckless disregard" or "deliberate ignorance" of a claim's truthfulness or accuracy. In other words, the government's position on health care fraud and abuse is that with the wide variety of coding references and resources available, coding professionals and/or providers should know their conduct departed from accepted business practices.

Liability under the False Claims Act can lead to civil monetary penalties ranging from $5,000 to $10,000 for every claim filed. With the busy demands placed upon coding professionals, fines can quickly add up to significant financial government settlements.

Besides the success of government enforcement activities against fraudulent health care providers, two other initiatives raise scrutiny and financial liability to a higher level. The first initiative is the proposed "False Claims Correction Act of 2008" (S. 2041), which is a response to recent interpretation of the False Claims Act by various federal courts. The False Claims Correction Act of 2008 expands the current law to increase its effectiveness in targeting fraud and abuse practices.

In addition to legislative changes, the Office of Inspector General (OIG), who oversees the integrity of federal health care programs, recently issued a press release of an "Open Letter to Health Care Providers" which discusses clarifications the OIG believes will increase use of its Provider Self-Disclosure Protocol. The Provider Self-Disclosure Protocol was released in 1998 to enable the government and

Given the financial risks of coding and billing for health care services, it is important for coding professionals to use up-to-date references and materials when submitting claims for health care providers.

the provider to jointly resolve program abuses, correct problems leading to program abuse, and further participation integrity of federal health care programs such as Medicare and Medicaid.

The OIG's open letter indicates initial disclosure should include the following:

- A complete description of the disclosed conduct;
- A description of the provider's internal investigation or a completion commitment;
- An estimate of damages (i.e., overpayments) to federal health care programs and the method used to calculate the damages or a commitment as to when the provider will complete the estimate; and
- A statement of laws potentially violated by the conduct.

In addition, the open letter indicates providers must be in a position to complete an investigation and damages assessment within three months after entering into the OIG's disclosure process. This process allows a provider to preemptively disclose serious billing problems and minimize significant penalties for billing misconduct. However, any investigation revealing a lack of compliance by using outdated coding and billing materials may lead to further problems for the provider.

Minimize Risk

In light of these new initiatives, it behooves coding professionals and health care providers to minimize the risk of fraudulent activity by adopting proactive practices such as using up-to-date coding resources and materials, including the latest Current Procedural Terminology (CPT®) manuals.

The CPT® code set was developed in 1969 by the American Medical Association (AMA) to establish an accurate and consistent description of medical, surgical, and diagnostic physician services and is the primary source for coding and billing information for coding professionals. In 1983, CMS adopted the CPT® coding system to ensure accurate coding and billing for Medicare services. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 included CPT® as part of the Health Care Common Procedure Code Set (HCPCS) as the national standard for health care electronic transactions for physician and other outpatient services.

The AMA holds copyright to the CPT® manual and updates the manual on a regular basis. The AMA's CPT® editorial panel, a team of physicians and other professionals, evaluates requests for new codes and identifies the necessary code modifications based on evolving technologies and new services.

The revised manual is published annually in late fall and takes effect at the beginning of the new calendar year. Coding professionals should order this manual every year and review it for changes. You should devote special attention to the deletion of existing codes and the addition of modifiers and codes. Reviewing the CPT® helps the coder and other billing professionals update transaction forms such as charge tickets, fee schedules, and related documents for accurate and compliant billing. CPT® manuals should be shelved and maintained for reference as a business record in the unlikely event of a payer audit or investigative government action.

In addition to CPT® manuals, coding professionals should follow similar practices with other coding resources, including the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). ICD-9-CM is the coding reference for disease classification, diagnoses, and injury causes. The World Health Organization (WHO) developed ICD-9 for monitoring and tracking morbidity and mortality internationally. The ICD-9-CM is updated and maintained by the United States National Center for Health Statistics (NCHS) and is the official code set for diagnoses and procedures in the United States. Both NCHS and CMS oversee all changes and modifications to the ICD-9-CM manual, which are published annually with new

changes effective in October of each year. As with CPT® manuals, coding professionals must obtain updated materials annually and review them for changes to ensure compliant coding, documentation, and reimbursement for health care services.

The evolving regulatory arena of fraud and abuse enforcement leaves no room for business as usual. It is imperative that coding professionals update their knowledge base and skills with current reference materials used in their daily activities. In doing so, one is reminded of the old adage "an ounce of prevention is worth a pound of cure," which are wise words given today's enforcement standards.

References:

The Social Security Act at Section 1128B(f)defines "Federal Health Care Programs" includes any plan or program that provides health benefits, whether directly or through insurance, which is funded in whole or in part by the United States government.

S. 2041, sponsored by Senator Charles Grassley (R-IA) is available at: www.govtrack.us/congress/bill.xpd?bill=s110-2041

31 U.S.C. § 3729

Senator Leahy's statements can be read in their entirety at http://judiciary.senate.gov/member_statement.cfm?id=3161&wit_id=2629

31 U.S.C. § 3729(b)

www.oig.hhs.gov/fraud/docs/openletters/OpenLetter4-15-08.pdf

www.ama-assn.org/ama/pub/category/3113.html CE

Julie Chicoine is an attorney, registered nurse and certified professional coder with several years of health care legal and regulatory experience, delivering presentations and writing several articles on compliance and regulatory topics. She is the compliance director for The Ohio State University Medical Center, where her responsibilities include administrative oversight of the medical center's integrity and compliance program.

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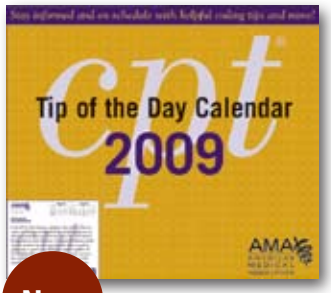
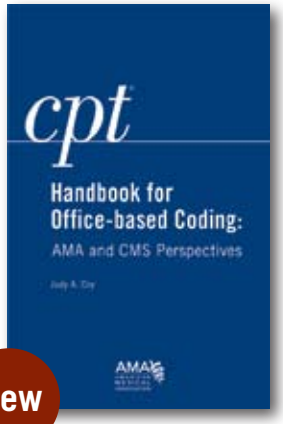


New

CPT® Calendar

Let the American Medical Association (AMA) help you keep track of appointments and important industry dates throughout the year. Featuring valuable coding tips from the source of Current Procedural Terminology (CPT®), the 2009 calendar is available in a convenient tear-off format perfect for the desktop.

Order #: OP060209
Price: $34.99
AMA member price: $24.99

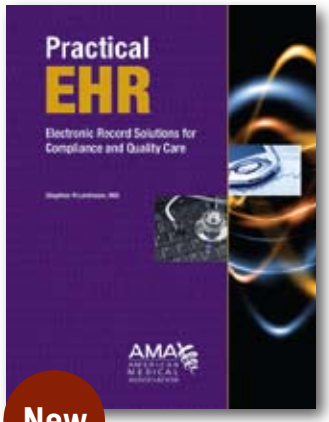


New

CPT® Handbook for Office-based Coding

Developed as an easy-to-navigate and timesaving handbook, this resource allows readers to quickly find coding and policy information needed to accurately report and reduce claim denials. Includes information for both national Medicare policy and CPT code information for the office-based physician.

Order #: OP057409
Price: $84.95
AMA member price: $63.95



New

Practical EHR

An essential reference for physicians and their staff seeking to better understand critical components of electronic health records (EHRs) and their impact on physicians and patients at the point of care.

Order #: OP324408
Price: $84.95
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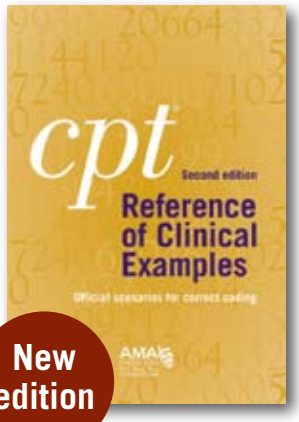
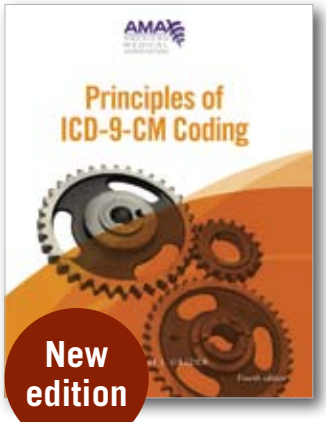


New edition

CPT® Reference of Clinical Examples, second edition

Straight from the AMA, the only reference organized by CPT codebook section that provides more than 1,000 clinical examples of the top-reported codes pulled from the proprietary CPT information database and Medicare claim data. New illustrations enhance this one-of-a-kind resource.

Order #: OP153907
Price: $99.95
AMA member price: $74.95



New edition

Principles of ICD-9-CM

This coding resource provides helpful guidelines for identifying and locating the most appropriate codes for your practice, as well as chapter learning objectives, checkpoint exercises and informative coding tips. Practical and educational, the fourth edition includes a new CD-ROM teaching tool so instructors can administer tests using questions and answers developed by the AMA; new chapters covering symptoms, signs, ill-defined conditions, injury and poisoning; an overview of ICD-9-CM, Volume 3 and a comparison between ICD-9-CM and ICD-10-CM conventions; and more.

Order #: OP065808
Price: $74.95
AMA member price: $59.95

New edition

Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage, third edition

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Coding Edge Tests Your Knowledge

July 2008

Index: CE07002008A

Get One CEU

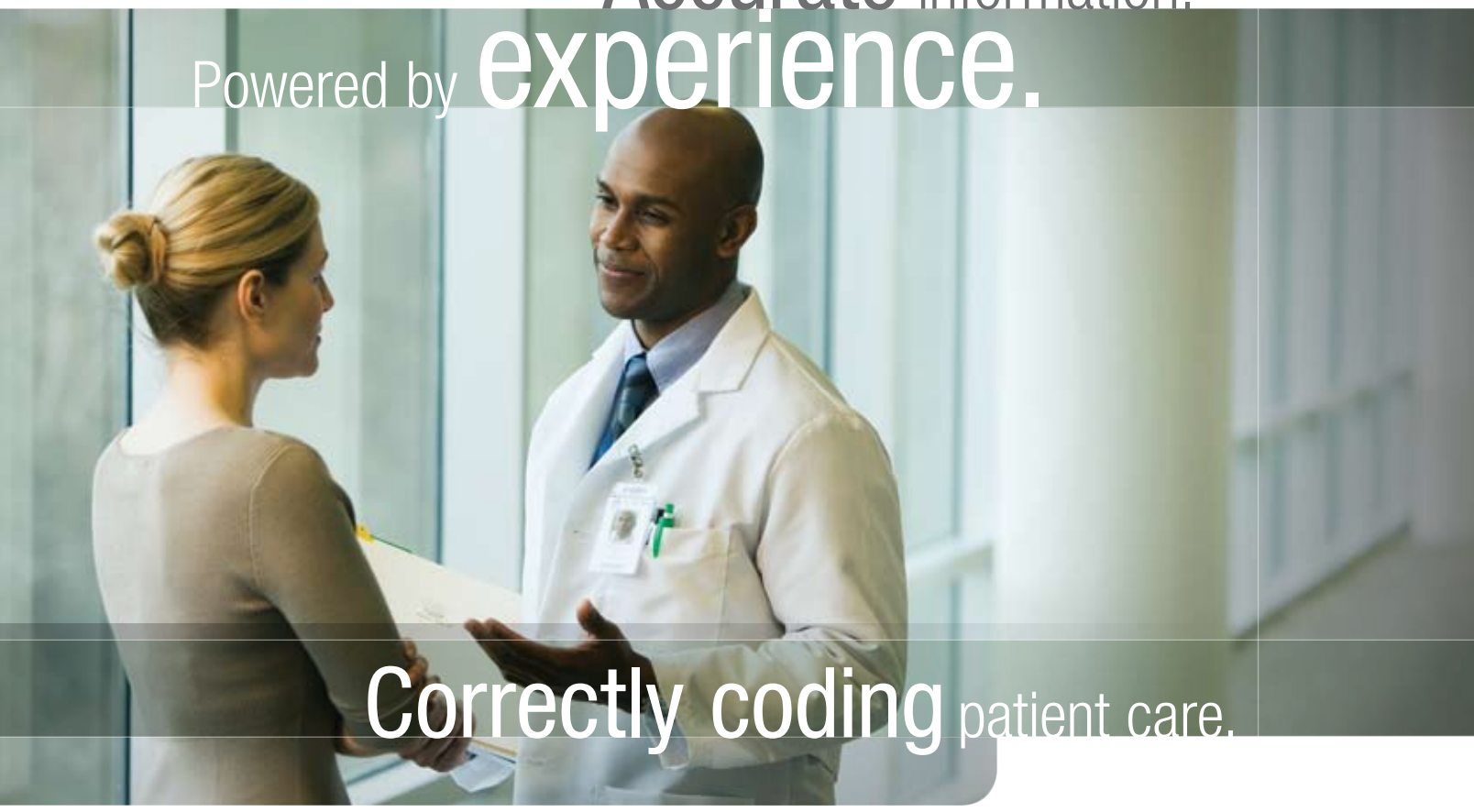
These questions are answered in articles throughout this news magazine. For answering all questions correctly, you will receive one CEU at the time of your renewal. These CEUs are awarded in addition to the CEUs available annually for submitting summaries from *Coding Edge*. Please do not submit until your renewal date.

Test Yourself Online

These same questions can be accessed online at www.aapc.com/testyourself/. Once you go there and take the test, you can automatically grade your answers, correct any mistakes and have your CEUs automatically added to your *CEU Tracker* for submission.

Note: All *Test Yourself* questions can be accessed online.

1. GEM stands for what?
   a. General elbow manipulation
   b. General equivalence maintenance
   c. General equivalence mapping
   d. General extradural measurement
2. GEM is necessary because:
   a. ICD-9-CM and ICD-10-CM codes crosswalk directly
   b. ICD-9-CM and ICD-10 CM codes have different functions
   c. ICD-9-CM and ICD-10-CM codes don't directly crosswalk
   d. ICD-9-CM and ICD-10-CM codes are never going to change
3. The second step of a great E/M education program is:
   a. Making certain all physicians have the latest E/M codes
   b. Finding a physician who has real interest in the subject
   c. Preparing and presenting great education sessions
   d. Calling the OIG to let them know you are having one.
4. A big fault in negotiation is
   a. Asking for too much
   b. Getting emotional
   c. Understanding the other's view
   d. Being clear on the goal
5. The following is true about CPT® books
   a. The codes, descriptions, and guidelines are owned and copyrighted by the AMA
   b. Only the AMA's CPT® Professional and Standard can be used for CPC® exams
   c. There are several reasons to have up-to-date CPT® manuals
   d. All of the above
6. The best resource for finding a consultant is what?
   a. Advertising in Advance
   b. Soliciting referrals from friends and colleagues
   c. Craig's List
   d. Referrals from attorneys
7. EHRs are becoming more common-place because of what?
   a. Lack of certified coders
   b. The desire to provide high-quality health care
   c. Nobody can ready anyone's hand-writing
   d. They are mandated.
8. Having up-to-date code books help prevent fraud and abuse claims under what federal act?
   a. Medicare Modernization Act
   b. False Claims Act
   c. Health Insurance Portability and Accountability Act
   d. National Provider Compliance Act
9. The GEM files will help you do what?
   a. Apply the correct TOS codes
   b. Circumvent CCI
   c. Crosswalk ICD-9-CM to ICD-10-CM
   d. Help you cut rejected claims
10. AAPC is unveiling a new Web search tool that:
    a. Helps you find answers to coding questions.
    b. Link to coding-related Web site
    c. Access information shared by colleagues
    d. All of the above



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