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NEWS | TRENDS | OUTCOMES

JANUARY 2011

Annual Wellness Visit New Benefit – New Year

DOC2DOC

Are You Ready for ICD-10?

TALKING POINTS

2011 Updates for Billing Influenza Vaccines and
Changes to Counseling Codes

Rehab for Therapy Services Reimbursement

MODIFIERS CORNER

New Modifier 33

MedAssets

CCFN

CODING & COMPLIANCE FOCUS NEWS

FEATURE ARTICLE

Annual Wellness Visit



3

New Benefit, New Year, New Codes

The New Year brings many new and exciting opportunities. This year brings an additional benefit for Medicare patients: annual wellness checkups are now a covered benefit, thanks to Congress for passing legislation that added more preventive services. Understanding the timeframe of the benefits is necessary to ensure the proper code selection, advises Ardith Campbell, CPC, CPC-H, CCP, in her article this month. The legislation also dictated the services would be paid by fee schedule, and designated the Medicare Physician Fee Schedule (MPFS), notes Campbell.

DOC2DOC



6

Are You Ready for ICD-10?

“Why in the heck do we need to go from ICD-9-CM to ICD-10?” you might ask. The simple fact: ICD-9 is running out of codes, reports Denise M. Nash, MD, CCS, CIM. The intention of ICD-10 is to allow providers to better identify certain patients with specific conditions who will benefit from tailored disease management programs, all of which lends itself quite nicely to global disease budgets and physician quality report cards – thus proving that there is a reason for everything in life!

TALKING POINTS



8

Rehab for Therapy Services Reimbursement

CMS will be reviewing multiple codes often provided in conjunction with one another during a single service or encounter, reports Rebecca Kidder, RN, CS-P. Expect a multiple procedure payment reduction (MPPR) discount to select therapy services.

10

2011 Updates for Billing Influenza Vaccines and Changes to Counseling Codes

It is important to differentiate between the descriptions and specifications (i.e. pediatric dose, regular dose, high dose, preservative free, etc.) for HCPCS/CPT codes that describe the various influenza vaccines, writes Susan Cinquino, CPC.

MODIFIERS CORNER



12

New Modifier 33

There's a new modifier – Modifier 33 – and it's used to report preventive services, explains Sandy Palmer, RHIT. Under the Patient Protection and Affordable Care Act, (PPACA), all new health plans must cover certain preventive services without charging a deductible, co-pay or coinsurance.

ALSO...

[FAQs](#), [MedAssets Events](#), [Crossword Puzzle](#)



FEATURED ARTICLE

By Ardith Campbell, CPC, CPC-H, CCP

Annual Wellness Visit

A New Benefit For A New Year

Start of a New Year

At the start of a new year, many people make resolutions – lose weight, get in shape, quit smoking, or scale Mount Everest. One piece of good advice is to check with your healthcare professional. There are several reasons for this, but ensuring there is no underlying issue hindering your health is of paramount importance.

For Medicare beneficiaries, an annual checkup has not been a covered benefit. Congress has passed legislation adding more preventive services, and 2011 finally adds an annual wellness visit.

One important benefit of the healthcare reform legislation is the removal of deductible and coinsurance requirements. This also removes the coinsurance and deductible requirement from other screening services, such as the screening colonoscopies. Further information regarding the curtailing of the deductible and coinsurance waiver that applies to preventive services is found in Transmittal 739 for change request 7012.

Start of a New Benefit

The Annual Wellness Visit (AWV), Including Personalized Prevention Plan Services (PPPS) was included as part of the legislation passed in the Affordable Care Act (ACA), and became effective as of Jan. 1, 2011. This legislation amended the section of the Code of Federal Regulations which lists the routine physical examinations excluded from coverage.

The legislation also dictated the services would be paid by fee schedule, and designated the Medicare Physician Fee Schedule (MPFS). Accordingly, hospitals will see that the services are assigned to status indicator A Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPSS, for example: Ambulance Services; Clinical Diagnostic Laboratory Services (Not subject to deductible or coinsurance); Non-Implantable Prosthetic and Orthotic Devices; EPO for ESRD Patients; Physical, Occupational, and Speech Therapy; Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital; Diagnostic Mammography; Screening Mammography (Not subject to deductible). Not paid under OPSS. Paid by fiscal intermediaries/MACs under a fee schedule or payment system other than OPSS.

Reporting The Benefits

Two new codes have been created for the services:

G0438 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), first visit

Short description: Annual wellness first

G0439 – Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

Short description: Annual wellness subseq

Of course, when the beneficiary can make use the benefit is somewhat confusing. When to use it is a matter of timing, and

that depends on which benefit is available for the beneficiary. Submitting the correct service may be challenging, particularly in light of the benefit coverage for wellness benefits. Similar to other preventive visits, there are time-based limits to meet.

Within the first 12 months of eligibility on the Medicare program, the beneficiary may use the Initial Preventive Physical Exam (IPPE), or Welcome to Medicare physical benefit. If the AWV service is submitted during this window of time, the service will be denied. Additionally, 12 months must pass between the provision of the IPPE and coverage of the AWV.

After the window of opportunity for the IPPE has closed, and as long as 12 months have passed since the provision of the IPPE, the beneficiary is eligible for the AWV. The first time the beneficiary receives his or her annual wellness visit, the code reported is G0438. The G0438 has been designated as a once in a lifetime procedure, and Medicare Administrative Contractors (MACS) will have edits in place to deny claims submitted with the second submission of the G0438.

It is important to understand these if you are presenting the Advance Beneficiary Notice of Noncoverage (ABN), to ensure the proper notification of the beneficiary. This includes the service to be provided and cost estimation.

Once the G0438 Annual wellness visit first has been provided, providers then submit code G0439 Annual wellness visit subseq each year. Also, the beneficiary is not eligible for the subsequent visit until the 12th month following the G0438.

Documentation Requirements

There are documentation requirements for both services outlined in the Claims Processing Manual (see references), with variations for the services. The Benefit Policy Manual is scheduled to be updated to include specific definitions for terms such as detection of cognitive impairment, voluntary advance care planning, and others.

G0438 Annual wellness visit first documentation requirements:

- Establishment of the individual's medical/family history
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual
- Detection of any cognitive impairment that the individual may have
- Review of an individual's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional organizations

- Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations

- Establishment of a written screening schedule for the individual, such as a checklist for the next five to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and Advisory Committee of Immunizations Practices (ACIP), the individual's health status, screening history, and age-appropriate preventive services covered by Medicare

- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits

- Provision of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition

- Voluntary advance care planning upon agreement with the individual **

- Any other element(s) determined appropriate by the Secretary through the National Coverage Determination (NCD) process

***An update was made on Jan. 10, 2011 to the documentation requirements for the first visit G0438 Annual Wellness Visit. The requirement for the advance care planning has been removed. Watch for the updates to the Internet Only Manuals, as the documentation will need to catch up to the changes.*

G0439 Annual wellness visit subseq Documentation Requirements:

- Update to the individual's medical/family history

- Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history

- Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first AWW

- Detection of any cognitive impairment that the individual may have

- Update to the individual's written screening schedule as developed at the first AWW

- Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWW

- Furnish appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs

- Voluntary advance care planning upon agreement with the individual, and

- Any other element determined appropriate by the Secretary through the NCD process

The Benefit Policy Manual is scheduled to be updated to include specific definitions for terms such as detection of cognitive impairment, voluntary advance care planning, and others.

It is imperative to verify with the patient whether or not they have had the first AWW with another provider and request records, as appropriate.

Evaluation and Management (E&M) Service Same Encounter

It may be reasonable and necessary to provide an E&M service during the same encounter as the AWW, using the appropriate code from range 99201 – 99215. Modifier 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service should be appended to the E&M level indicating it is a significant, separately identifiable service.

Transmittal 2109 related to change request 7079 provides a caution for this scenario. Since some of the components of an E&M service are also a portion of the AWW, those data elements should not be used when selecting the E&M level. This is a subtle hint that they would not expect a high level E&M service to be reported on the same date.

RAC Risk

One of the approved audit issues for the Recovery Audit Contractors (RAC) is for items considered to be once in a lifetime procedures. Both the IPPE and the Annual wellness visit first are considered to be once in a lifetime. While MACs should have edits in place to deny payment for subsequent submissions of these procedures, providers need to be vigilant to ensure the payment for the procedure is appropriate.

Hints To Help

To assist you in explaining the services to the beneficiary, you may want to print portions of the Beneficiary Manual.

Additional patient printouts may be needed for updates to the screening services or any referred services. Since patients may have questions regarding advance care planning, information on who may set up advance care plans could be useful.

In Conclusion

The New Year brings many new and exciting opportunities. This year brings an additional benefit for Medicare patients. Understanding the timeframe of the benefits is necessary to ensure the proper code selection.

About the Author

Ardith Campbell, CPC, CPC-H, CCP, is Manager of Charge & Revenue Integrity Services for MedAssets. Beginning her healthcare career in 1987, she has also worked for Central Washington Comprehensive Mental Health and Yakima Valley Radiology where her jobs have included working with coding, reimbursement and utilization review. In her current role, Ardith works with the internal controls of three MedAssets products to ensure compliance with federal regulations and established coding conventions. Ardith has also written articles for several industry publications, and has spoken at several industry-related events throughout the country. Recently, she was appointed to the advisory board of the medical billing & coding program of her local community college. She is certified as a CPC and CPC-H through the American Academy of Professional Coders, and as a CCP through the Professional Healthcare Institute of America. ■

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Trade Shows & Events

JANUARY 31 - FEBRUARY 4

ECRI Institute National Sales Meeting

Plymouth Meeting, PA • View [Website](#)
 “The Future of GPOs” presented by Rand Ballard, Senior Executive Vice President, COO and CCO, MedAssets

“The Effects of Healthcare Reform on Supply Chain Management” presented by Nick Sears, M.D., Chief Medical Officer, MedAssets

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ANAE 2011 Equipment Planner, Architect and Construction “Double Reverse” Tradeshow and Conference

Dallas, TX • View [Website](#)
 Keynote Session presented by Rand Ballard, Senior Executive Vice President, COO and CCO, MedAssets

MARCH 13 - 16

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Tampa Bay, FL • Booth: 221 • View [Website](#)

APRIL 13 - 16

AONE 44th Annual Meeting and Exposition - The American Organization of Nurse Executives

San Diego, CA • Booth: 918 • View [Website](#)

APRIL 28 - 30

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MAY 11 - 14

ASCs 2011

Orlando, FL • Booth: TBD • View [Website](#)

MAY 17 - 19

ASCP's 33rd Midyear Conference and Exposition

Las Vegas, NV • Booth: TBD • View [Website](#)

MAY 19 - 20

Becker's Hospital Review Annual Meeting

Chicago, IL • View [Website](#)
 “How to Have a Margin Discussion With Your Doctors” presented by Nick Sears, M.D., Chief Medical Officer, MedAssets



Are you ready for ICD-10?

(Sung to "Are you ready for some football?")

Have you begun to assemble all the necessary pieces that need to be in place by Oct. 1, 2013? The government is not backing down this time from this drop-dead deadline!

"Why in the heck do we need to go from ICD-9-CM to ICD-10?" you might ask. After all, most physicians were just recently indoctrinated by their hospital/office coders on the proper documentation necessary to code for ICD-9 diagnosis and procedure codes. The simple fact: ICD-9 is running out of codes.

ICD-10 will allow for more codes, greater specificity and therefore better epidemiological tracking. Did you know that a physician, Jacques Bertillon, first developed ICD codes in 1893 in France? They were called the Bertillon Classification of Causes of Death. In 1898, they were adopted in the United States, and so ICD-1 was born.

Remember that the International Classification of Disease (ICD) system was originally set up to code and classify mortality data from death certificates, and the ICD-9-Clinical Modifications (CM) is used to code and classify morbidity data from the inpatient and outpatient records, physician offices as well as from most National Center for Health Statistics (NCHS) surveys.

NCHS serves as the World Health Organization (WHO) Collaborating Center for the Family of International Classifications for North America, and in this capacity it is responsible for coordinating all official disease classification activities in the United States relating to the ICD, in addition to its

use, interpretation and periodic revision. ICD was never meant to be a model for a payment system. That was an afterthought.

The intention of ICD-10 is to allow providers to better identify certain patients with specific conditions who will benefit from tailored disease management programs (diabetes, Hypertension), all of which lends itself quite nicely to global disease budgets and physician quality report cards – thus proving that there is a reason for everything in life!

We have been hearing that ICD-10 is coming (no Paul Revere) for a long time, starting with the endorsement by the 43rd World Health Assembly in 1990. ICD-10 has been in use since 1994 by members of the WHO (the organization, not the rock group). Had it been mandated in the U.S. at that time, it would have been a much easier transition (many physicians did not have electronic systems).

ICD-10 has been available in the six official languages (Arabic, Chinese, English, French, Russian and Spanish) of the WHO since 2009. It is also available in 36 other languages. Yes folks, there are other countries way ahead of the U.S. that have already implemented and are using ICD-10 including our neighbors to the north. Go figure!

The United States began using ICD-10 to code and classify mortality data from death certificates in January 1999. Implementation of ICD-10 for morbidity coding has been slower, with only two countries using it for this purpose in 1994, and 13 coming on board after 1996.

The Department of Health and Human Services (HHS) announced on Aug. 15, 2008, a long-awaited proposed regulation that would replace the ICD-9-CM code sets currently used to report healthcare diagnoses and procedures with greatly expanded ICD-10-CM (diagnosis) and ICD-10-PCS (hospital procedure) code sets.

In a separate proposed regulation, HHS also proposed adopting the updated X12 standard, Version 5010 (Health Care Transactions), and the National Council for Prescription Drug Programs standard, Version D.0, for electronic transactions, such as healthcare claims. It is important to note that Version 5010 is essential for using ICD-10 codes.

I had been hearing so long that ICD-10 implementation would be mandated, first 2010 then 2011 (a lot of lobbying went on to delay implementation), that I thought it was just a bad dream when I finally heard that it was a go for implementation on Oct. 1, 2013.

ICD-9 currently has 17,000 codes. When we move to ICD-10-CM, there will be 68,105 Diagnosis, and ICD-10-PCS (inpatient hospital procedural coding) will contain 86,916 codes. Why do we need not only to change the diagnosis but also the procedures, after all the specificity necessary for coding procedures is found in Current Procedural Terminology (CPT®)?

In my opinion, it would be easier at this juncture to just adopt one procedural coding system. Politics! The government controls ICD and CPT codes are developed, main-

tained and copyrighted by the AMA (American Medical Association). Publications of all the software, books and manuals needed by those who use them bring in millions in income each year. Enough said!

ICD-9 DX currently has three, four or five characters. There is a decimal point after the third character. The first three characters are designated a category and the last two characters designate etiology, anatomic site or manifestation.

So what will the new system look like? The first character will be alpha, followed by up to seven characters. There will be a decimal point after the third character. Valid codes can have three, four, five, six or seven characters.

In ICD-10, the first three characters still designate a category, the next three still designate etiology, anatomic site, or manifestation, and the last character designates extension.

Here are some examples:

- C52 Malignant neoplasm of vagina
- D16.5 Benign neoplasm of lower jaw bone
- C81.70 Other Hodgkin's disease, unspecified site
- H04.132 Lacrimal cyst, left lacrimal gland
- T45.1x2a Poisoning by antineoplastic and immunosuppressive drugs, intentional self-harm, initial encounter

Currently, in ICD-9 when you code Hypertension (HTN), you have three choices: malignant HTN (401.0), benign (401.1) and the one that is most often used essential HTN, unspecified (401.9). In ICD-10, hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) is coded to I10. The hypertension table is gone, and hypertension is no longer classified to malignant, benign or unspecified.

There will still be codes for elevated blood pressure readings without the evidence of HTN. The old code was 769.2, and the new code will be R03.0. This will also hold, as the old code for low blood pressure reading without the evidence of HTN is coded to 796.3; the new code will be R03.1.

You will now need to designate right and left clearly in your documentation to achieve code specificity. Example: ICD-9 coding for malignant neoplasm of ovary was coded to 183.0. ICD-10 malignant neoplasm right ovary C56.0, malignant neoplasm left ovary C56.1, and of course if you do not specify in your documentation, the coder will have no choice but use code C56.2 malignant neoplasm ovary, unspecified.

What is all of this change going to cost?

Medical Group Management Association (MGMA) conducted a survey that resulted in estimates of roughly \$84,000 for the average small physician practice to upgrade to ICD-10. Large practices could be facing an implementation price tag in the neighborhood of \$3 million dollars. For health plans, depending on size, estimates range between half a million and nearly \$14 million dollars to implement ICD-10 with the most monies aimed at training, systems upgrades and contract negotiations. Nationwide, estimates are as high as \$8 billion dollars to fully implement ICD-10.

How Should You Prepare for ICD-10?

All we have been talking about thus far is ICD-10, but remember what I noted earlier in the article about V 5010 being essential to the use of the ICD-10 codes? Before you can implement the new coding mechanism, you first need to upgrade to new HIPAA software. Whether you are aware or not, you are likely using V4010.

You need:

- Version 5010- the new version of the X12 standards for HIPAA transactions;
- Version D.0 (Part D Prescription Drug Benefit)—the new version of the National Council for Prescription Drug Program (NCPDP) standards for pharmacy and supplier transactions; and
- Version 3.0 – a new NCPDP standard for Medicaid pharmacy subrogation (State Medicaid agencies recoupment of funds for payments they have made for pharmacy services for Medicaid recipients, when a third party payer has primary financial responsibility).

You also need to prepare for the implementation of these standards by communicating with your billing vendor, software vendor, or clearinghouse to inquire about their readiness plans for these standards.

It is important for you to be aware of the 5010/D.0/3.0 implementation deadline as set forth by CMS is Jan. 1, 2012. CMS had recommended the development phase begin 2009. CMS feels that internal testing should have begun in 2010 and that external testing should begin on or after Jan. 1, 2011. If you have not begun to think about ICD-10 or the more urgent implementation of 5010/D.0/3.0, you should really start now because you are already behind schedule. Waiting for industry changes or rule changes is not going to happen, and it won't make these requirements go away.

Suggestions:

First, buy an ICD-10 book and start reading the introductory chapters. You'll need to start converting your ICD-9 codes you use to ICD-10. Training, training, and training – this doesn't have to cost a fortune if you start now. One of the strongest suggestions that I can make (although the conversion of Y2K didn't come to fruition) when the system breaks, and it will, you'll need about three to -six months worth of cash in reserve.

Start **saving now** so that you will have much revenue built up for 2013. I suggest you call your vendors and get all their written information on 5010. Please contact your clearinghouse and get all their information on 5010. If you already have an EMR/EHR, will they have an EMR/EHR solution that allows an algorithm for documentation and code selection? If you haven't done so, pull your contracts and start looking for what this is going to cost you for upgrades to 5010.

Also, have your staff start a file on 5010 and have them check all payor Websites for testing and implementation. Run an ICD-9 productivity report for a 12-month period showing the top 100 codes you or your other colleagues use in your practice. Your practice should begin the process of mapping your ICD-9 codes to ICD-10 codes and creating a master list. Make sure that you and other providers in your

...continued on page 13



Rehab for Therapy Services Reimbursement

Among the numerous health-related provisions of the Patient Protection and Affordable Care Act (PPACA) signed into law last March is one that should be of special interest to coders: Section 3134 of the Act, requiring CMS to identify potentially mis-valued codes by reviewing multiple codes that are often provided in conjunction with one another during a single service or encounter. As a result, Medicare is applying a new multiple procedure payment reduction (MPPR) discount to select therapy services.¹

Providers are already accustomed to similar reductions that have been applied to the performance of multiple surgical procedures or multiple radiological procedures performed during the same encounter. As in the past, CMS holds the belief that it requires less in the way of resources to perform the additional services than is required for the initial service; therefore, reasons CMS, payments should be reduced proportionately.

Despite vigorous objections from the health-care community, CMS has stood firm behind its plan to expand payment reductions for multiple services provided by Physical, Occupational, and Speech Therapy. However, CMS did modify the original proposal of reducing payments by 50 percent to a reduction of 25 percent for services rendered in an institutional setting.

Soon after this information was made public, CMS released a new transmittal announcing a further reduction of the discount to 20 percent for services rendered in offices and other non-institutional settings.

This change in policy was made as a result of the Physician and Therapy Relief Act of 2010.² Although CMS has made these compromises for CY 2011, the agency was quick to say in its response to comments in the final rule that it would continue to look at higher reductions in coming years.

Reimbursement of Therapy Services

Currently, therapy services are reimbursed according to the Physician Fee Schedule (PFS). Each payment for physician services is calculated by giving due consideration to the work required to perform the services, the overhead costs related to the service and the risk of malpractice.

Each CPT® code is assigned a relative value unit (RVU) that represents the sum of the costs of each of these elements.³ It is the practice expense (PE) portion of the RVU representing overhead costs such as space, wages, supplies and equipment that will be subject to the reduction. In the CY 2011 Final Rule, CMS states its belief that there is significant overlap in payments for these overhead costs when multiple services are provided.⁴

Despite the fact that payment rates are set utilizing cost data related to physician office practice, CMS has also stated quite clearly in the Final Rule that the payment reduction will apply to office-based therapy services as well as those provided in institutions paid under Part B at Physician Fee Schedule rates.

Time-based Codes

The majority of therapy procedure codes are time-based in that they are commonly reported for each 15-minute unit of service. A single patient encounter may involve multiple units of therapy services by a single discipline as well as multiple units of service provided by multiple disciplines. For instance, a patient might receive 30 minutes (two units) of gait training by the Physical Therapist and then 30 minutes (two units) of exercise by the Occupational Therapist. The MPPR will apply across all units of therapy on the same date of service as well as across disciplines.

The first unit of the service with the highest assigned PE value will be paid at 100 percent. The remainder of the units and all other services will receive a payment that reflects a 25 percent reduction in the portion of the payment resulting from the PE assignment as shown in table one.

The reduction applies only to those services that have been defined by CMS to be "always therapy" codes. These are separately payable services that require therapy modifiers GP, GO or GN indicating they were provided by or under the supervision of a skilled therapist. Evaluation and re-evaluation services are also included in the list of "always therapy" codes. The following list contains those codes designated as "always therapy" for CY 2011.⁵

TABLE ONE

| RVU Element | PROCEDURE 1 1st Unit | PROCEDURE 1 2nd Unit | PROCEDURE 2 2 Units | 2010 Total | 2011 Total | Payment Calculation |
|--------------|-------------------------|-------------------------|------------------------|----------------|----------------|---------------------|
| Work | \$7.00 | \$7.00 | \$11.00 | \$25.00 | \$25.00 | No Reduction |
| PE | \$10.00 | \$10.00-25% | \$8.00-25% | \$28.00 | 23.50 | MPPR Applied |
| Malpractice | \$1.00 | \$1.00 | \$1.00 | \$3.00 | \$3.00 | No Reduction |
| Total | \$18.00 | \$15.50 | \$18.00 | \$56.00 | \$51.50 | |

**CPT/HCPCS
CODE****SHORT
DESCRIPTOR**

| | |
|-------|-------------------------------|
| 92506 | Speech/hearing evaluation |
| 92507 | Speech/hearing therapy |
| 92508 | Speech/hearing therapy |
| 92526 | Oral function therapy |
| 92597 | Oral speech device eval |
| 92607 | Ex for speech device rx, 1hr |
| 92609 | Use of speech device service |
| 96125 | Cognitive test by hc pro |
| 97001 | Pt evaluation |
| 97002 | Pt re-evaluation |
| 97003 | Ot evaluation |
| 97004 | Ot re-evaluation |
| 97012 | Mechanical traction therapy |
| 97016 | Vasopneumatic device therapy |
| 97018 | Paraffin bath therapy |
| 97022 | Whirlpool therapy |
| 97024 | Diathermy eg, microwave |
| 97026 | Infrared therapy |
| 97028 | Ultraviolet therapy |
| 97032 | Electrical stimulation |
| 97033 | Electric current therapy |
| 97034 | Contrast bath therapy |
| 97035 | Ultrasound therapy |
| 97036 | Hydrotherapy |
| 97110 | Therapeutic exercises |
| 97112 | Neuromuscular reeducation |
| 97113 | Aquatic therapy/exercises |
| 97116 | Gait training therapy |
| 97124 | Massage therapy |
| 97140 | Manual therapy |
| 97150 | Group therapeutic procedures |
| 97530 | Therapeutic activities |
| 97533 | Sensory integration |
| 97535 | Self care mngmt training |
| 97537 | Community/work reintegration |
| 97542 | Wheelchair mngmt training |
| 97750 | Physical performance test |
| 97755 | Assistive technology assess |
| 97760 | Orthotic mgmt and training |
| 97761 | Prosthetic training |
| 97762 | C/o for orthotic/prosth use |
| G0281 | Elec stim unattend for press |
| G0283 | Elec stim other than wound |
| G0329 | Electromagnetic tx for ulcers |

CMS estimates that as a result of the application of the MPPR providers can expect to see a seven percent reduction in payments for therapy services.⁶ Providers may be tempted to offset these losses by extending treatment sessions across more dates of service. However, CMS has warned that it will monitor future claim data to detect any pattern changes related to the scheduling frequency of patients.

Each treatment regime should continue to reflect a plan and pattern of care that is most clinically appropriate for the patient.

About the Author

Rebecca Kidder, RN, CS-P, has more than 30 years of healthcare clinical and management experience. She has worked in critical care areas, long-term care and acute inpatient rehabilitation. Prior to joining MedAssets she served, for 10 years, as the Director of Corporate Integrity for a mid-sized community hospital. In that role she gained expertise in many aspects of revenue cycle management including CDM management and maintenance, medical necessity, denial management, compliance, and internal auditing. Becky implemented a number of processes directed toward enhancing the revenue cycle to both capture and prevent the loss of revenue. Becky has an Associate Degree in Nursing, and became a Certified Professional Coder (CPC-P) through the American Academy of Professional Coders. She maintains that credential through membership in the American College of Medical Coding Specialists. Becky has been a guest speaker for HFMA, AAHAM and NAHAM and has contributed articles to Coding and Compliance Focus News as well as teaching coding and healthcare reimbursement courses at a local college. Becky lives in West Virginia. ■

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6. **CY 2011 Final Rule**, Federal Register, Vol. 75, No. 228, Page 73238, Nov. 29, 2010.



2011 Updates for Billing Influenza Vaccines and Changes to Counseling Codes

ED. NOTE: There are two types of seasonal influenza vaccines, an inactivated vaccine (also referred to as “killed” viruses) which is given via intramuscular (IM) injection, or a nasal-spray flu vaccine which contains attenuated or “live” viruses. The live attenuated influenza vaccine (LAIV) is approved for healthy patients between two and 49 years of age, whereas the inactivated flu shot is approved for individuals six months or older with chronic conditions such as severe allergies or asthma.

Each season, the Centers for Disease Control and Prevention (CDC), through the use of research, defines the strains of viruses that are most commonly circulating throughout the United States. The 2010 – 2011 flu vaccine provides protection against influenza A/H1N1 and two other influenza viruses, influenza A/H3N2 and influenza B.

Of a significant note, unlike in 2009, only one vaccine is required to protect against H1N1 strain as it is included in the 2010 – 2011 flu vaccine. Of course, if you are only administering the H1N1 (Swine) flu vaccine HCPCS codes G9141 (Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family) and G9142 (Influenza A (H1N1) vaccine, any route of administration) still exists, take note that the codes are not eligible for separate reimbursement.

A “high dose” inactivated influenza vaccine is also available (also referred to as enhanced immunogenicity) that is generally given to patients who are 65 years of age and older. A physician’s order is not necessary and physician supervision is not necessary; that is how patients are able to get a flu shot at the drugstore.

For reporting seasonal influenza vaccines, the appropriate HCPCS/CPT® codes are reported with a separate administration HCPCS code. Administration of influenza vaccine should be reported with HCPCS G0008 and based on Medicare guidance, ICD-9-CM code V04.81 should be reported on the claim.

The administration HCPCS for the pneumococcal vaccine should be reported with G0009 and ICD-9 code V03.82. When both an influenza and pneumococcal vaccination are given to a patient during the same visit, it would correct to report G0008 and G0009 for both administrations and ICD-9 code V06.6 would instead be reported.

Frequency requirements do exist for both. Influenza vaccines may be given once per season, however Medicare may allow additional seasonal flu vaccines when medically necessary. Pneumococcal vaccines are covered once in a lifetime. When high risk conditions exist, additional vaccinations may be covered.

Hepatitis B vaccines are also reported with the appropriate HCPCS/CPT code in conjunction with administration code G0010 unless services are provided in a hospital outpatient setting. For OPSS billing the CPT code 90471 – Immunization administration and 90472 – each additional vaccine would be reported. Medicare also expects ICD-9 code V05.3 to be on the claim.

Payment Allowance Limits

The Medicare Part B payment limits for influenza vaccines are 95 percent of the average wholesale price (AWP), except when the vaccine is furnished in a setting that follows a cost-based or prospective payment system. Under Medicare, such services provided in a hospital outpatient setting are paid on a reasonable cost basis. Annual Part B patient deductible and coinsurance amounts do not apply.

All physicians and non-physician practitioners, as well suppliers must take assignment on the claim. See table one for current payment allowances.

New Q Codes for 2011 Seasonal Flu Vaccine

CMS created five new HCPCS codes for reporting the seasonal influenza vaccine that are specific to brand-name vaccine products for patients three years and older. Effective for claims with dates of service beginning Jan. 1, 2011, the new Q-codes replaced CPT 90658 (Influenza virus vaccine, split virus, when administered

TABLE ONE

| | | |
|-------|--|---------|
| 90655 | Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use | 14.858 |
| 90656 | Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use | 12.375 |
| 90657 | Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use | 6.296 |
| 90660 | Influenza virus vaccine, live, for intranasal use | 22.316 |
| 90662 | Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use | 29.213 |
| 90669 | Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use | 95.481 |
| 90670 | Pneumococcal conjugate vaccine, 13 valent, for intramuscular use | 123.833 |
| 90732 | Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use | 49.734 |
| 90740 | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use | 119.415 |
| 90743 | Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use | 24.216 |
| 90744 | Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use | 24.216 |
| 90746 | Hepatitis B vaccine, adult dosage, for intramuscular use | 59.708 |
| 90747 | Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use | 119.415 |

to individuals 3 years of age and older, for intramuscular use) as Medicare no longer recognizes this code for payment. Although the Q-codes were released on Oct. 1, 2010, CMS instructed contractors to hold claims until Jan. 1, 2011 based on Transmittal R8150TN, in order to allow time for updating their systems.

Administration HCPCS code G0008 should be reported with the appropriate Q-code based on the FDA approved manufactured drug being administered. The fifth code however is to be reported when the vaccine does not fall under a specific manufacturer trade name (i.e. Q2039 Not Otherwise Specified (NOS) for flu vaccine, three years and older given by intramuscular injection). Q2039 also should be reported with administration code G0008. As with all influenza vaccines, CMS guidance states

that ICD-9-CM code V04.81 should be reported for the diagnosis.

National payment allowable for the Q2036 is set at \$7.439, Q2037 is \$13.253, and Q2038 is \$12.593, however HCPCS codes Q2035 & Q2039 do not have national payment limits and will be determined on the local Medicare carrier level. (table two)

2011 Brings Changes to Counseling Codes

CMS created new two CPT codes 90460 and 90461 that replaced deleted codes 90465-90468 for dates of service on or after Jan. 1, 2011. The new codes are reported for a single vaccine or combination vaccine administration "via any route of administration" for services provided by a physician or other qualified non-physician practitioner when face-to-face counseling is provided at the time of administration.

90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component

90461 – each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

These codes are reported per vaccine/toxoid component and CPT guidance defines a component as "each antigen in a vaccine that prevents disease(s) caused by one organism." Combination vaccines may contain multiple vaccine components. The CPT manual states that the new administration codes are to be reported with the appropriate vaccine and toxoids codes from the range of 90476 – 90749. When reporting administration of combination vaccines, code 90460 is reported for the first component and add-on code 90461 is reported for each additional component and Modifier 51 is not required. CPT 90460 does not only apply to combination vaccines, but also to single component vaccines as well. As indicated by CPT, the base code is reported for each vaccine administration to patients 18 years of age and under who receive counseling about the vaccine. If counseling is not provided, you would, instead, refer to CPT codes 90471 – 90474.

TABLE TWO

| HCPCS | Description | National Payment |
|-------|--|------------------|
| Q2035 | Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria) | locally priced |
| Q2036 | Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval) | \$7.439 |
| Q2035 | Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin) | \$13.253 |
| Q2035 | Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone) | \$12.593 |
| Q2035 | Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified) | Locally priced |

...continued on page 13

Preventive Services: Introducing New AMA Modifier 33

The American Medical Association (AMA) has created a new modifier to be used when reporting preventive services – Modifier 33.

Modifier 33 was mentioned at the November CPT® Symposium, and the AMA recently published information regarding this new modifier. The article titled, “New CPT Modifier for Preventive Services,” can be found on the AMA website in the CPT Assistant, December 2010, Volume 20 Issue 12. The new modifier is effective Jan. 1, 2011.

According to the AMA article, Modifier 33 is defined as follows:

“Preventive Service: When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending Modifier 33, Preventive Service, to the service. For separately reported services specifically identified as preventive, the modifier should not be used.”

Modifier 33 was created due to requirements in the Patient Protection and Affordable Care Act (PPACA). Under the act, all new health insurance plans (beginning on or after Sept. 23, 2010) must cover certain preventive services without charging a deductible, co-pay or coinsurance. This applies when the preventive services are separately billed and are provided “in-network.”

The AMA article says the following four categories of preventive services may be identified with Modifier 33 when provided without cost-sharing:

1. Services rated “A” or “B” by the US Preventive Services Task Force (USPSTF) (see Table 1) as posted annually on the Agency for Healthcare Research and Quality’s Website: www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm;
2. Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for children as recommended by Bright Futures (American Academy of Pediatrics) and Newborn Testing (American College of Medical Genetics) as supported by the Health Resources and Services Administration; and
4. Preventive care and screenings provided for women (not included in the Task Force recommendations) in the comprehensive guidelines supported by the Health Resources and Services Administration.

For further information on PPACA and a list of preventive services covered under the act, see the links under the references below.

The AMA also states that when a service, represented by a CPT or HCPCS code, is inherently preventive, Modifier 33 would not be used, but rather Modifier 33 should be appended to codes for other preventive services. The modifier may be appended to multiple codes when more than one preventive service is provided.

Medicare has HCPCS codes that are reportable for many of the preventive medicine services that are a Medicare benefit. These services are inherently preventive and they would not require Modifier 33. For example:

G0103 – Prostate cancer screening; prostate specific antigen test (PSA)

G0202 – Screening mammography, producing direct digital image, bilateral, all views

G0389 – Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening

To date, Medicare has not provided any guidance related to the use of Modifier 33. Medicare created Modifier PT (Colorectal cancer screening test; converted to diagnostic test or other procedure) to be used when a preventive colorectal cancer screening service becomes converted to a diagnostic or therapeutic service due to the findings. Modifier PT is effective Jan. 1, 2011. At this time, it is unclear whether Modifier 33 will be recognized or required for Medicare reporting.

Preventive Services (continued)

...continued from [page 12](#)

PPACA is making changes that affect health insurance reporting such as requiring that beneficiaries receive free preventive care. Although the uses and requirements for reporting Modifier 33 with these services are not completely clear at this time, we recommend following up with your Medicare contractor and other insurance payors for their individual requirements when it comes to reporting the covered preventive services.

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REFERENCES:

AMA article on Modifier 33:

www.ama-assn.org/ama1/pub/upload/mm/362/new-cpt-modifier-for-preventive-services.pdf

Preventive Care and Services:

www.healthcare.gov/law/provisions/preventive/index.html

Preventive Services Covered under the Affordable Care Act:

www.healthcare.gov/law/about/provisions/services/lists.html

Are you ready for ICD-10? (continued)

...continued from [page 7](#)

group review the new terminology and start documenting with greater specificity by the end of 2011. Internal testing with your vendor should have been done by December 2010. External testing should be done June 2011.

Begin having meetings with other practice providers and your staff to ensure that documentation tools are available and efficient. Periodically have someone review documentation to ensure provider documentation patterns are changing to support more strict ICD-10 documentation as needed.

GOOD LUCK!

About the Author

Denise M. Nash, MD, CCS, CIM, is the Medical Director and Product Owner for Episodes of Care for MedAssets. Denise has over 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise has also worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals, and insurance plans and has worked for the OIG of New Hampshire for its Fraud and Abuse Division. ■

2011 Updates (continued)

...continued from [page 11](#)

Summary

It is important to differentiate between the descriptions and specifications (i.e. pediatric dose, regular dose, high dose, preservative free, etc.) for HCPCS/CPT codes that describe the various influenza vaccines. A good reference is the Part B drug pricing files that also include National Drug Code (NDC) to HCPCS crosswalks and payment allowance limits. The files are located on the CMS website at www.cms.gov/crPartBDrugAvgSalesPrice.

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Susan Cinquino, CPC, is a Quality Review Analyst with MedAssets. She brings more than 27 years of healthcare experience in various areas that include coding and compliance, revenue cycle management, physician education, consulting services, practice management and healthcare administration for independent and facility-based physician practices. ■

REFERENCES:

CMS Quick Reference Information: Medicare immunization Billing (Seasonal Influenza Virus, Pneumococcal, and Hepatitis B)

www.cms.gov/MLNProducts/downloads/qr_immun_bill.pdf

2010 – 2011 Seasonal Influenza (Flu) Virus Educational Products and Resources

www.cms.gov/MLNProducts/Downloads/flu_products.pdf

ASP Drug Pricing Files

www.cms.gov/McrPartBDrugAvgSalesPrice/01a18_2011A/SPFiles.asp#TopOfPage

Transmittal R815OTN

www.cms.gov/Transmittals/downloads/R815OTN.pdf



FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Q Prior to 1/1/11, we have charged the following CPT® codes to represent a Left Heart Catheterization without an LV-gram:

- 93510 – Left heart catheterization
- 93545 – Selective injection of coronary
- 93556 – S & I of selective coronary angiography

What new 2011 replacement CPT will be used?

MedAssets Response

New CPT code 93458 (Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed) includes the phrase “when performed” to describe left ventriculography. The new CPT guidance for cardiac catheterization includes the instruction, “Codes for left heart catheterization (93452, 93453, 93458-93461), other than those for congenital heart disease, include intraprocedural injection(s) for left ventricular/left atrial angiography, imaging supervision, and interpretation, when performed.”

Based on this guidance, new code 93458 may be reported for a left heart catheterization with coronary angiography without a left ventriculogram.

Q At the hospital we currently bill the following charges with the left heart catheterization.

| | |
|-------------------------------|----------------|
| INJ PROC FOR LV OR LA ANGIO | CPT CODE 93543 |
| INJ PROC FOR AORTOGRAPHY | CPT CODE 93544 |
| INJ PROC FOR CORONARY ANGIO | CPT CODE 93545 |
| IMAG SUP&REPT VENT OR ART ANG | CPT CODE 93555 |
| IMAG SUP&REPT AORTA OR CORON | CPT CODE 93556 |

Based on the 2011 CPT code book, “For right ventricular or right atrial angiography performed in conjunction with cardiac catheterization for congenital or noncongenital heart disease (93451-93461, 93530-93533), use 93566. For aortography, use 93567.”

Would it be appropriate to code 93567 for the Aortogram?

MedAssets Response

CPT code in question:
93567 - Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravulvular aortography (List separately in addition to code for primary procedure)

Based on the following guidance, it is appropriate to use new CPT 93567 for an aortogram performed during left heart catheterization. This new add-on code has more specificity than the previous code, 93544, as it specifies supravulvular aortography. Deleted code 93544 simply stated, “Injection procedure during cardiac catheterization; for aortography.”

The CPT guidance for Injection Procedures includes aortography and new code 93567 in the following instruction to separately report this code when performed with heart catheterization:

“When injection procedures for right ventricular, right atrial, aortic, or pulmonary angiography are performed in conjunction with cardiac catheterization, these services are reported separately (93566-93568).”

For CPT 93567, the AMA’s 2011 CPT Changes – An Insider’s View lists CPT codes 93544 and 93556 as common coding combinations typically reported prior to 2011.

CCFN CROSSWORD JANUARY 2011

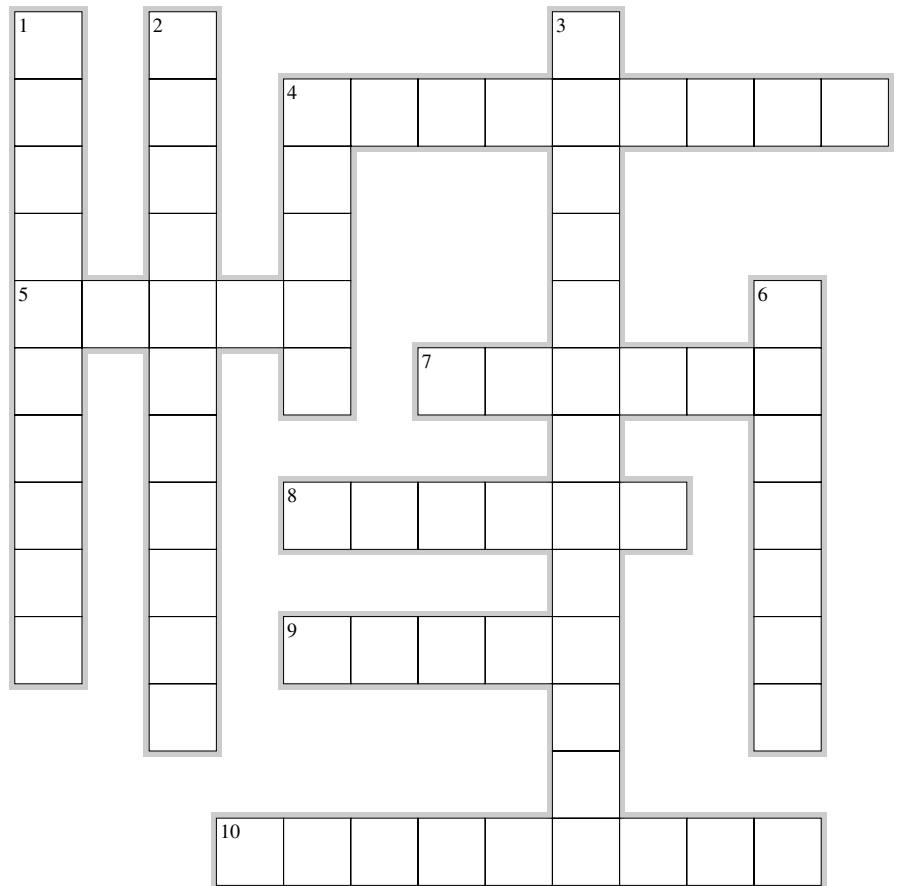
By Toueria Morris, CPC-H

Across

4. Beneficiaries are not eligible for the subsequent visit (G0439) until the 12th month ___ the G0438.
5. Medicare Administrative Contractors (MACS) will have what in place to deny claims submitted with the second submission of the G0438 code?
7. How many months must pass between the provision of IPPE and coverage of the AWV?
8. One of the documentation requirements for G0439 is an ___ to the individual's written screening schedule as developed at the first AWV.
9. One of the approved ___ issues for the Recovery Audit Contractors (RAC) is for items that are considered to be once in a lifetime procedures, like both the IPPE and the AWV first (G0438).
10. Coinsurance and deductible requirements have been removed from ___ services.

Down

1. Congress passed legislation that added more of these types of services.
2. Beneficiaries may use the Initial Preventive Physical Exam (IPPE), or Welcome to Medicare physical benefit within the first 12 months of what?
3. When reporting G0438, establishment of the individual's medical/family history is what kind of requirement?
4. G0438 is the code reported the ___ time the beneficiary receives their annual wellness visit (AWV).
6. A provider will need to request these to determine/verify if a patient had their first AWV with another provider.



ANSWERS
 ACROSS 4. FOLLOWING 5. EDITS 7. TWELVE 8. UPDATE 9. AUDIT 10. SCREENING
 DOWN 1. PREVENTIVE 2. ELIGIBILITY 3. DOCUMENTATION 4. FIRST 6. RECORDS

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