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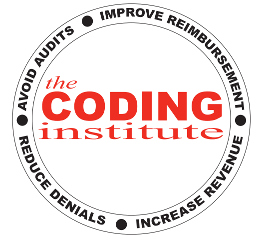

Part B Insider

News & Analysis on Part B Reimbursement & Regulation

December 2011, Vol. 12, No. 44 (Pages 345-352)

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Part B Revenue Booster

Keep These 6 Essential Coding Tips in Mind for 2012

Ring in the New Year without a hitch by implementing these simple strategies.

As your practice prepares for the calendar to turn to 2012, you want to ensure a smooth transition while continuing to collect your reimbursement. Follow these simple tips to ensure that Jan. 1 doesn't throw a wrench into your coding systems.

1. Look to new code G0444 for depression screening. Effective Oct. 14, 2011, Medicare now reimburses depressing screenings for Medicare patients, as we reported in Vol 12, No. 41 of the *Insider*. To collect your due for this service, you'll report G0444 (*Annual depression screening, 15 minutes*) to your MAC. Deductibles and coinsurance do not apply to these services.

To read more about Medicare's coverage of depression screening, check out CMS Transmittal 2359 at www.cms.gov/transmittals/downloads/R2359CP.pdf.

2. Keep an eye on CPT®'s 'errata. Everyone makes mistakes—even the AMA—and the organization lists CPT® 2012 errors on its Web site (www.ama-assn.org/resources/doc/cpt/cpt-2011-corrections.pdf) so you can find out which codes require corrections in your new CPT manual.

For example: At the request of many physicians, CPT® 2012 now defines the term "other qualified healthcare professional." Although this definition didn't make it into the 2012 manual, the AMA lists it as part of the "CPT® 2012 Errata" on its Web site and the definition is as follows:

"A 'physician or other qualified health care professional' is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports a professional service. These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service. Other policies may also affect who may report specified services."

This example only scratches the surface of CPT®'s errata for the coming year. In fact, the online listing includes a full 13 pages of corrections, so don't miss the AMA Web site to research all of the changes you should implement before Jan. 1.

3. Performing anesthesia in critical access hospital? Get to know modifier 'AA.' If you bill anesthesia services on behalf of a provider through a Method II critical access hospital (CAH), your bottom line could improve starting in January 2012.

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Background: Anesthesiologists who provide services in a Method II CAH (sometimes referred to as CAHs that have elected the "optional" method) have the option of reassigning their billing rights to the CAH. The CAH then submits a bill with revenue code 0963 (*Professional fees for anesthesiologist [MD]*) to receive pay for anesthesia services. When the service is reported with modifier AA (*Anesthesia services performed personally by anesthesiologist*), CMS currently calculates pay based on a 20 percent reduction of the fee schedule amount before calculating deductible and coinsurance.

Change: CMS transmittal 2268 dated August 1, 2011, removes the 20 percent reduction when calculating payment for these services. The change takes effect January 3, 2012.

Supporting information with the transmittal explains that "when a medically necessary anesthesia service is furnished within a HPSA [health professional shortage area] area by a physician, a HPSA bonus is payable. … Pay physicians the HPSA bonus when CPT® codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and 'QB' or 'QU' in revenue code 963."

4. Don't report nerve block codes 64490-64495 unless physician uses imaging. Although CPT® 2012 did not change the descriptors for these paravertebral facet joint injection codes, it did add an important notation in the introductory notes.

"Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by codes 64490-64495," the new notation says. "If imaging is not used, report 20552-20553."

Auditors will be watching: The CPT® notation about this situation is important to remember because auditors are sure to keep an eye on this issue going forward. **Why?** Trigger point codes 20552-20553 pay between $52 and $59—whereas nerve block code 64490 reimburses a hefty $196. Therefore, if you miscode this service even ten times a year, you're collecting almost $1,500 more than you deserve.

5. Know what makes a new patient. CPT®'s definition of a "new" patient changes slightly for 2012, with the CPT® manual stating, "A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." The portions of the description that are new for 2012 are underlined.

What this means to you: If your practice employs various subspecialists, CPT® now makes it clear that claims for patients who see different doctors with different subspecialties can be billed using a new patient code (such as 99201-99205). ❑

Part B Insider (USPS 023-079) (ISSN 1559-0240 for print; ISSN 1947-8755 for online) is published weekly 45 times per year by The Coding Institute - an The Coding Institute LLC, 2222 Sedwick Drive, Durham, NC 27713. ©2011 The Coding Institute. All rights reserved. Subscription price is $299. Periodicals postage is paid at Durham, NC 27705 and additional entry offices.

POSTMASTER: Send address changes to Part B Insider, PO Box 50028, 2222 Sedwick Drive, Durham, NC 27713.

Keep These Additional 3 Non-Coding Tips in Mind As 2012 Approaches

While January 1 is typically a great time to catch up on your new code options, a new year is also an excellent opportunity to polish your billing and compliance skills. Don't forget these three essential tips as the calendar turns to 2012.

1. Get Your 5010 Ducks in a Row. The deadline for transition to the 5010 standard remains Jan. 1, 2012, despite the fact that CMS announced that it won't initiate compliance enforcement until March 31, 2012.

Whether or not you're ready on Jan. 1, you need to be able to demonstrate that you are making a "good faith effort" to become compliant with the new HIPAA standards by that date, CMS announced.

If you haven't talked to your vendors or participated in a test submission with your MAC, now is the time to get on board.

2. Prep Your 'HRA' Form. As we reported in the *Insider* Vol. 12, No. 40, Medicare has increased the RVUs for its annual wellness visit (AWV) codes G0438 and G0439 to account for the fact that your staff members may have to assist patients in filling out health risk assessment (HRA) forms.

You'll create the form so the patient can fill out information about herself, and it should take each patient 20 minutes or less to complete. According to CMS, your form should include the following topics, at a minimum:

- Demographic data, including age, gender, race, and ethnicity
- Self-assessment of health status, frailty, and physical function
- Psychosocial risks including depression/life satisfaction, stress, anger, loneliness/social isolation, pain, or fatigue
- Behavioral risks including tobacco use, physical activity, nutrition and oral health, alcohol consumption, sexual practices, motor vehicle safety (seat belt use), and home safety
- Activities of daily living, including dressing, feeding, toileting, grooming, physical ambulation (including balance/risk of falls), and bathing
- Instrumental activities of daily living, including shopping, food preparation, using the phone, housekeeping, laundry, transportation, responsibility for own medications, and ability to handle finances.

3. Keep An Eye out for Revalidation Requests. Between now and 2015, CMS will require all Medicare providers to revalidate their provider enrollment information. If you enrolled in PECOS after March 25, 2011, you should be off the hook, but everyone else will have to face revalidation. You shouldn't do anything until you receive a revalidation request from your MAC--but once they do send you that letter, you should revalidate in a timely fashion.

If you don't respond within 60 days, your MAC could revoke your billing privileges, so take the letter seriously, CMS reps have warned practices. ❑

Documentation

Make Audit-Proof Record Corrections With These 5 Tips

Documentation clarifications can be a big help — if you use them wisely.

With the plethora of government entities poring over more and more of your patient records, it may be time to use a valuable weapon: documentation corrections and additions. But overuse of late entries may do more harm than good.

This is a topic of greater concern given the number of entities that are now looking at Medicare claims, warns consultant **Judy Adams** in Chapel Hill, N.C. "And the scrutiny is just beginning!"

"Record tampering undermines a clinician's credibility in the event of litigation," warns a guidebook on medical documentation by the University of North Texas. "It is important not to jeopardize the integrity of a patient's medical record by using a questionable correction method."

Rumor: Some medical office staff believe they are not allowed to make corrections to a medical record if someone else (i.e., a supervisor) asks them to do so.

(Continued on next page)

Truth: It is perfectly OK for a clinician to make changes to the record at another person's request, Adams notes. That is, as long as the clinician actually remembers the information, or reads notes or other written information that triggers their memory of the additional information, adds Washington, D.C.-based attorney **Elizabeth Hogue.**

Often such correction requests will be made of staff in the course of internal quality reviews, notes regulatory consultant **Rebecca Friedman Zuber** in Chicago, Ill. Examples can include during initial supervisory review of the assessment and plan of care or during quarterly record reviews, Zuber says.

5 Steps To Successful Record Additions

Late entries will help you only if they are completed according to the rules, experts agree. Follow these steps to make sure your corrections will pass muster during review:

1. Cross out, don't black out. If you are correcting an incorrect statement in the record, you should draw a line through the statement and put the word "error" next to it, Zuber counsels. Then sign or initial it (depending on your policy) and put the date.

Documentation Red Flags: Know When A Clarification Hurts Instead of Helps

If you correct or add to every medical record that gets reviewed, you may come to regret it.

"With regard to supplementing documentation in preparation for … audits, providers certainly need to proceed with care," advises Washington, D.C.-based attorney **Elizabeth Hogue.** "Whether or not it is appropriate to supplement documentation must be decided on a case-by-case basis."

You should not be routinely making revisions to clinical records prior to sending them off in response to an advance development request (ADR), counsels regulatory consultant **Rebecca Friedman Zuber** in Chicago, Ill.

Red flag: If you make a lot of corrections in your clinical records, that will raise questions should your records be reviewed, Zuber warns. "It will look like they are writing what they want to have there, not documenting what actually occurred during the delivery of care."

When correcting or adding to the medical record, "the greatest error of all is to write information just because someone told you to do so, but you have no memory of the information," stresses consultant Judy Adams in Chapel Hill, N.C. "With all of the patients seen and visits made, sometimes a clinician just cannot remember additional information or actually forgot to do something on a visit."

Bottom line: "Making up information that actually never happened is fraudulent documentation and can never be justified," Adams maintains.

How Late Is Your Late Entry?

Whether your correction or late entry is helpful or harmful may depend on its timing. "The later after the fact that documentation is added or changed, the less credible it becomes," Adams points out. "The most accurate documentation occurs when it is written at the time of the event."

Changes "should not be common, particularly if time has elapsed," Zuber agrees.

Modifications at almost the same time as the original documentation, however, are usually more acceptable — especially if you are making a big push to improve charting. Practices that are working to improve staff documentation should be working concurrently with those staff members, so any documentation changes that result should be pretty contemporaneous with the original entry, Zuber says.

Don't Get Scared Off Of Corrections

Don't let the caution you must exercise with corrections or additions scare you away from using them altogether. "We all find times ... when someone else reads what we have written, or we re-read" and it's not as clear as we originally thought, Adams ob-serves. "Or we left some key information out of the documentation," she adds. "Whenever this occurs, additions or corrections to our documentation can occur."

In fact, "sometimes it is the questions of others that trigger us to improve our documentation," Adams relates. "We suddenly realize that 'what I meant as I was writing did not communicate what I thought it did.'"

And making such changes can spur clinicians to produce better documentation in the future, experts add. ❑

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Plus: "The original information must still be readable and included in the record," Adams tells Eli. Use just a single line to cross it out.

2. Don't forget the title. The cardinal sin of making corrections is failing to note the late entry. Be sure to clearly mark the correction or supplementation as a late entry, Adams advises.

3. Include a date and signature. Any late entry should include its date, Hogue says.

"This means no back dating," Zuber stresses.

And corrections or additions to documentation should be made by the documentation's original author, experts agree. That person should sign the correction as well as dating it. There's "no making it look like the entry was made by the original writer if it wasn't," Zuber cautions.

In rare cases, another person can make a documentation change, Zuber allows. But the record should clearly indicate who made the entry and "coordination of that person's input with the original writer should be documented in the late entry."

4. Don't be stingy. It's a good idea to jot down the purpose of the entry — for example, clarification, Adams suggests. And "it is also helpful to indicate … the source of the additional information, such as based on notes jotted during the visit," she says.

5. Consider these issues for computer records. When you correct an electronic record, remember that the original information must remain in the record, advises the University of Michigan Health System in its medical documentation policy. And "in situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected." ❑

Reader Question

Don't Heed Hearsay When Coding Teaching Physician Services

Question: *We are getting a lot of feedback that our emergency physician faculty members, who are supervising residents, can't report procedures that allow "supervision of key components." Rather, we are told that they must remain at the bedside the entire time in order to bill for the procedure. For many procedures, this isn't a problem, but watching a 1st year resident sew up a 15cm laceration for an hour isn't practical in a busy ED. Of course, the physicians are always within the department, but do they have to remain at the bedside for the entire procedure? Our charting system offers two check boxes: 1. "I was present for and supervised the entire procedure" and 2. "I was present for key components of the procedure." For number 2, we aren't billing. While we are on that topic, what exactly is "present"? Does it mean in the same room, in the department, or in the hospital?*

Answer: You should question the source of that information. For Medicare patients, the answer to your questions can be found in Transmittal 1780 and

(Continued on next page)

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Transmittal 811. These transmittals contain rules about the level of supervision required for various procedures performed in a teaching setting.

In general, Medicare will pay for physician E/M services furnished in a teaching setting under the Physician Fee Schedule only if the services are furnished by a resident seeing a patient in the “physical presence” of a teaching physician who documents his or her presence during the performance of the critical or key portions of the service and participation in the management of the patient.

Alternatively the teaching physician and the resident may be seeing the patient at different times during a visit, provided the teaching physician independently performs the critical or key portions of the service.

For procedures, a distinction is made by Medicare between minor procedures (those lasting less than 5 minutes) and major procedures which typically take longer than 5 minutes. Basically, the teaching physician must be physically present at the bedside for the entire time in order report a minor procedure, defined as one that takes three to five minutes to complete.

On the other hand, major procedures (defined as anything taking longer than five minutes) require only that the attending or teaching physician be present for the key aspects of the procedure and it is up to the attending to determine the key aspects of the service. Very few procedures involving a resident performed in an academic setting take less than five minutes to complete.

For those procedures where they are not physically present for the entire service, the teaching physician must be immediately available to assist as needed. Be sure the chart documentation supports the teaching physicians’ actual involvement in the case and the other documentation requirements are met before reporting the service. ❑

Part B Coding Coach

94640: Take This Quick Short-Interval Inhalation Therapy Quiz to Aid Your Coding

If demo is inevitable, you may have to look beyond a diagnostic procedure.

Does your physician administer airway inhalation therapy treatment several times a day at short intervals (e.g., 10 minutes)? If you don’t know the distinction between 94640 and other inhalation treatment codes, you may find your claim in limbo land.

Here’s an opportunity to test your skill with some tricky 94640 situations. Check out the scenarios and figure out how you’d code these examples before reading the answers below.

Scenario 1: When an established patient with emphysema presents complaining of shortness of breath, the physician administers inhalation treatment. During the therapy, the physician trains the patient on using the nebulizer at home, and provides an expanded problem-focused examination and medical decision-making of low complexity. How should you report it?

Scenario 2: Say the physician from the first scenario -- after performing an inhalation treatment -- determines that the patient’s plan of care should include inhalation therapy. The patient is new to this therapy and does not know the administration techniques involved in the procedure, so the physician provides a demo. This warrants both 94664 and 94640 on the same day, but does Medicare allow pairing?

Scenario 3: The patient receives nebulizer treatment followed by a bronchodilation responsiveness test to measure the patient’s response to the treatment. Should you report only the nebulizer treatment?

Quiz Solutions:

E/M will usually comprise diagnostic inhalation treatment provided in the office, but your best bet on properly billing 94640 when a demo takes place includes discussing with the physician the medical necessity of providing tutoring service.

Find out if you’re all set to accurately code your physician’s inhalation treatment services by checking your answers to the three scenarios on page 76 against the following solutions.

Don't Limit CPT® to 94640 When E/M Is Identifiable

Solution 1: First, report 94640 (*Pressurized or nonpressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes [e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device]*) to cover the comprehensive service the physician provided.

Don't stop there yet. Because the physician also performed an office visit to assess the patient's acute condition which resulted in the decision for the nebulizer treatment, report 99213 (*Office or other outpatient visit for the evaluation and management of an established patient* ...), based on your documentation of an expanded problem-focused exam with low-complexity decision-making. Treat the how-to discussion with the patient as part of the E/M. Attach modifier 25 to 99213 to indicate that the E/M service was significant and separately identifiable from 94640.

Don't report 94664 (*Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device*). The physician's primary intent is to treat the obstruction, so 94640 will suffice.

Overrule 94640, 94664 Edits With Modifier 59

Solution 2: Medicare allows this pairing -- but there's a catch. If you bill 94664 along with 94640 on the same day to Medicare, make sure you justify that the physician provided 94664 distinctly separate from the airway inhalation treatment by appending modifier 59 (*Distinct procedural service*). This will notify the payer that the physician performed 94664 separate from 94640.

The documentation should include details on the medical necessity for separately providing this separate service. Specifically, the physician's note should clearly identify that the physician demonstrated the inhaler to the patient separate from the administration for treatment. Otherwise, the insurer may think the service is redundant. Expect a request for documentation by the payer to review the documentation and ensure appropriate payment.

CPT® 94664 is appropriate to use for [inhaler] demonstration and evaluation, says **Gary N. Gross, MD,** executive vice president of the Joint Council of Allergy, Asthma & Immunology. As with the first scenario, you would report 99213 and 94640 in addition to 94664.

You may link separate diagnosis codes to the E/M and the nebulizer treatment (94640). For instance, you could link 786.05 (*Shortness of breath*) to 99213, and link the emphysema code (492.8, *Other emphysema*) to 94640.

Bundle 94060 Into Spirometry Test

Solution 3: No. You should code 94060 (*Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration*) inclusive of the nebulizer treatment. Correct Coding Initiative (CCI) Edits bundles the inhalation treatment (94640) into 94060 where 94640, in fact, shows up in column 2. The training/demo (94664) is bundled into 94060, as well.

CPT® 94060 describes the spirometric evaluation procedure — the measuring of the respiratory gases — not evaluation of the patient's condition, when performed. You would not use an E/M code (99211-99215, *Established patient office visit*) if the patient solely received the bronchodilation responsiveness test since evaluation the patient's immediate condition pre-and post-procedure is a inherent part of the procedural service.

(Continued on next page)

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Coders would sometimes confuse 94640 to include the drug (e.g., albuterol). Beware of this misunderstanding. If the drug represents a cost to your physician's practice, and the service was performed in a private office setting, report 94640 and the drug separately (e.g., J7620, *Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg [albuterol] or per 0.5 mg [levalbuterol]*). ❑

Physician Notes

CMS to Change NPI Listings in PECOS

Plus: A clinician's signature can cost them money—and jail time.

You may have to tweak your procedures for checking whether your referring physicians are in Medicare's PECOS system.

Background: Although it still hasn't implemented the postponed claims edits for physician enrollment in PECOS, CMS wants doctors who order and refer for Medicare services to be enrolled in the online system. You should be checking each of your referring physicians against the PECOS enrollment database and NPI registry, experts advise.

Now that registry will look different, however. "In response to concerns raised by the provider community, CMS will no longer post the complete NPI on the ordering & referring reports," the agency says in an e-mail message to providers. The pending and enrolled PECOS reports now will contain only the last four digits of the docs' NPIs.

Links to the reports are in the "Downloads" section online at www.cms.gov/MedicareProvider SupEnroll/06_MedicareOrderingandReferring.asp.

In other news…

Practitioners should never sign documents without reading them first—that's the lesson learned from a recent Department of Justice bust that resulted in an occupational therapist (OT) facing 10 years in prison.

A Detroit-based OT pleaded guilty last week of conspiracy to commit health care fraud, and faces not only prison time but a $250,000 fine. She was an uncertified OT who was hired to create and sign falsified therapy files for a therapy practice, according to the DOJ news release. In fact, however, she never provided these therapy services, the DOJ reports. During the course of her time at the practice, the OT and her employer submitted $807,760 in false claims to Medicare.

To read the complete news release, visit www.stopmedicarefraud.gov/HEATnews/michigan.html#dec-01-2011. ❑

part B insider

Published 45 times annually by *The Coding Institute Company*
Subscription rate is $299.

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