THE 2011 OIG WORK PLAN FOR PHYSICIANS

On October 1, 2010, the Office of Inspector General (OIG), Department of Health and Human Services (HHS), released its 2011 Work Plan which provides an overview of priority areas on which the OIG intends to focus its audit and enforcement activities in the upcoming fiscal year. Physicians and other healthcare providers should use the Work Plan as a guide for prioritizing and updating their own compliance activities.

Many areas addressed in the 2011 Work Plan concern ongoing focus areas from previous years’ work plans. In fact, the 2011 Work Plan includes very few new initiatives. Areas of focus that are most relevant to physician practices include the following:

NEW INITIATIVES

Beneficiary Payments

The OIG will determine whether physicians and other suppliers are billing Medicare beneficiaries in excess of the copayment and deductible amounts allowed by Medicare.

Under the assignment rules, participating providers agree to accept the Medicare allowable charge as payment in full for the services or supplies provided.

Imaging Services

Medicare Part B pays for imaging services on the basis of physician professional cost, malpractice costs, and practice expenses. The OIG will review payments for Part B imaging services to determine whether Medicare payments accurately reflect the practice expenses incurred and whether the utilization rates reflect industry standards. The Work Plan also calls for a review of portable x-ray suppliers to identify unusual claim patterns.

Diagnostic Testing

The OIG will examine the types of laboratory tests and the number of laboratory tests ordered to ensure they were medically necessary and to identify how physician specialty, diagnosis, and geographic differences in the practice of medicine may impact laboratory test ordering.

In particular, the OIG will review claims to determine the appropriateness of Medicare payments for Glycated Hemoglobin A1C Tests. The Medicare National Coverage Determinations Manual, Pub. 100-03, Ch. 1, pt. 3, § 190.21, states that it is not considered reasonable and necessary to perform a glycated hemoglobin test more often than every 3 months on a controlled diabetic patient unless documentation supports the medical necessity of testing in excess of national coverage determinations guidelines.

RMC RECOMMENDS: Medicare will pay for a hemoglobin A1c every three months for stable diabetic patients. Make sure you have an electronic or manual system, such as a diabetes flow sheet, in place to track this.

Appropriateness of Medicare Payments for Polysomnography

Per the CMS Medicare Benefit Policy Manual, Pub. No. 102, ch. 15, § 70, sleep studies are reimbursable for patients who have symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia. Medicare payments for polysomnography increased from $62 million in 2001 to $235 million in 2009, and coverage was also recently expanded. The OIG will examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements.

RMC RECOMMENDS: If your practice performs sleep studies, make sure the diagnosis and medical necessity is clearly documented to support the service billed.
ONGOING FOCUS AREAS

Place-of-Service Errors

The OIG will continue to review physician claims to determine whether physicians properly indicated the place of service on claims for services provided in ambulatory surgery centers and hospital outpatient departments.

**RMC RECOMMENDS:** Check place of service codes to make sure they are correct before submitting claims.

Evaluation and Management (E&M) Services

Medicare paid $25 billion for E&M services in 2009, representing 19 percent of all Medicare Part B payments. E&M codes represent the type, setting, and complexity of services provided and the patient status, such as new or established. Providers are responsible for ensuring that the codes they submit accurately reflect the services they provide. The OIG will continue its review of E&M claims to determine the extent of potentially inappropriate payments for E&M services.

Documentation is key to substantiating the level of E&M service provided and electronic medical records (EMR) can be a valuable tool for complete and efficient documentation of services provided. The Work Plan specifically notes, however, that Medicare contractors are seeing an increased frequency of records with identical documentation across services, especially among EMR users. The OIG will review multiple E&M services for the same providers and beneficiaries to identify EMR documentation practices, such as cloning, associated with potentially improper payments.

Medicare initiated the global surgery fee concept in 1992. Physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E&M services provided during the global surgery period. The OIG will continue to review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee.

**RMC RECOMMENDS:** Audit your documentation or hire a coding and compliance professional like RMC to audit for you. Make sure the documentation supports what was coded and billed. If you are using an EMR, beware of over-documentation with templates. Do not document to meet a level of service. Rather, provide the service and use the templates as a tool to facilitate coding and documentation of the service provided. If your practice performs surgery, be diligent about tracking global periods and make sure you understand when you may or may not bill an E&M code during the global period.

Medicare Payments for Sleep Testing at Sleep Disorder Clinics

A preliminary OIG review identified improper payments when certain modifiers are not reported with sleep test procedures. The OIG will examine Medicare payments to physicians and independent diagnostic testing facilities for sleep test procedures to determine whether they were in accordance with Medicare requirements as per the CMS Medicare Benefit Policy Manual, Pub. No. 102, ch. 15, § 70.

**RMC RECOMMENDS:** If your practice performs sleep studies, make sure the diagnosis and medical necessity is clearly documented to support the service billed.

Modifiers

The OIG will review modifier usage, specifically, the GA, GZ, and GY modifiers. For the GA or GZ modifiers, focus will be on whether the services were reasonable and medically necessary. For the GY modifier, focus will be on proper use. The -GY modifier signals to Medicare contractors that the claim should be denied because the item or service represented by the claim is not covered by Medicare either because coverage is excluded by statute or because the service does not meet the definition of a covered service.

This is just a brief overview of some of the areas relevant to physician practices. It would be wise for physicians to familiarize them-

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**Connie Eckenrodt, RHIT, CHCA, CHC**

Ms. Eckenrodt is the Director of Physician Coding & Compliance at RMC. With over 15 years in the HIM field, her focus has been on outpatient coding, with particular emphasis on professional fee coding and documentation improvement. Areas of expertise include: new provider coding orientations; individual and group coding education for providers and professional fee coders; pre-bill and retrospective coding audits; and risk assessment and focus review audits for internal compliance initiatives and compliance initiatives pursuant to federal investigations. Consulting has been provided in myriad settings, from small practices to large multi-specialty practice groups.
ICD-10 Training

One of the biggest changes in ICD-10-CM is the number of codes that specify laterality, right side versus left side. For example, while ICD-9-CM utilizes a single code to identify a benign neoplasm of the ovary (220), the parallel ICD-10-CM code identifies three codes:

- D27.0 (benign neoplasm of right ovary)
- D27.1 (benign neoplasm of left ovary)
- D27.9 (benign neoplasm of ovary, unspecified side)

Coders are trained to assign the most specific diagnosis code, but in order to do so, the provider must document it. Providers will need to be specific in their documentation as to which side of the body the injury or diagnosis has occurred.

Other conditions that will require documentation of laterality include:

- Joint pain
- Joint effusion
- Injury
- Fractures
- Sprains
- Tears, meniscus, cruciate ligament
- Dislocations
- Arthritis
- Cerebral infarction
- Extremity atherosclerosis
- Pressure ulcers
- Cancers, neoplasms (breast, lung, bones, etc.)
- Arthritis

Just as with ICD-9-CM, provider documentation will be important in assigning appropriate ICD-10-CM codes. Providers should get into the habit of documenting laterality now so that when ICD-10-CM is implemented, services will be reported more accurately.

RAC High Risk Vulnerabilities

The primary goal of the RAC demonstration project was to determine if recovery auditing could be effective in Medicare. The Centers for Medicare & Medicaid Services (CMS) directed the RAC staff to organize their efforts primarily to attain that goal. Two high-dollar improper payment vulnerabilities for physician claims were identified through the RAC demonstration project. The high-risk vulnerabilities identified are:

**Other services with excessive units** - Units billed exceeded the number of units per day based on the CPT code descriptor, reporting instructions in the CPT book, and/or other CMS local or national policy. Pre-appeal improper payment amount: $6,635,558.

Physicians are required to bill using the appropriate CPT code and to accurately report the units of service. Ensure that the units billed do not exceed the number of units per day based on the CPT code descriptor, reporting instructions in the CPT book, and/or other CMS local or national policy.

**Duplicate Claims** - Physician billed and was paid for two claims for the same beneficiary, for the same date of service, same CPT code, and same physician. Pre-appeal improper payment amount: $1,094,751.

An overpayment exists when a physician bills and is paid for services that have been previously processed and paid. Routinely submitting duplicate claims to Part B Carriers and MACs for a single service encounter is inappropriate.

Take appropriate action now to ensure your practice is meeting Medicare’s billing requirements to avoid unnecessary denial of your claims and limit risk of recoupment and potential penalties under a RAC audit.
2011 CPT Code Changes-
New Codes and Deleted Codes Effective January 1, 2011

- Evaluation and Management – 3 New Codes
  Code added and resequenced
  Subsequent Observation Care, Low Severity - 99224
  Subsequent Observation Care, Mod. Severity - 99225
  Subsequent Observation Care, High Severity - 99226

- Integumentary System – 3 New & 2 Deleted
  Code added and resequenced – (Add-on Codes)
  Debridement, each additional 20 sq cm
    Subcutaneous Tissue - 11045
    Muscle/Fascia - 11046
    Bone – 11047

  Deleted
  Debridement; skin; partial & full thickness – 11040 & 11041

- Musculoskeletal System – 5 New Codes
  Neck & Spine Fusion, Additional – 22551
  Add’l Neck & Spine Fusion (Add-On Code) - 22552
  Code added and resequenced
  Hip Arthroscopy with
    Femoroplasty – 22914
    Labral Repair – 22915
    Acetabuloplasty - 22916

- Respiratory System – 4 New Codes
  Nasal Sinus Endoscopy with Dilation of:
    Maxillary Sinus – 31295
    Frontal Sinus – 31296
    Sphenoid Sinus – 31297
  Bronchoscopy with Balloon Occlusion - 31634

- Cardiovascular System – 20 New & 23 Deleted
  New Codes
    Application of Pulmonary Artery Bands - 33620
    Transthoracic Insertion of Catheter or Stent - 33621
    Reconstruction Complex Cardiac Anomaly - 33622
    Revascularization with Stent
      Iliac, Femoral/Popliteal Artery, Tibial/Peroneal Artery 37220 - 37235
      Intraoperative Identification of Sentinel Lymph Nodes - 38900

  Deleted Codes
    Transluminal balloon angioplasty - 35454 – 35474
    Transluminal peripheral atherectomy – 35480 - 35495
    Repair, diaphragmatic hernia – 39520 - 39531

Continued on following page...
January 1, 2011

2011 CPT Code updates continued...

- **Digestive System – 18 New & 4 Deleted**
  
  **New Codes**
  
  Laparoscopy, Esophageal Lengthening (Add-On) - 43283
  Esophagogastric Fundopasty - 43327 – 43328
  Hiatal Hernia Repair - 43332 – 43338
  Gastric Intubation & Aspiration, Necessitating Physician Skill - 43753
  Gastric/Duodenal Intubation & Aspiration - 43754 - 43754
  Laparoscopy Placement of Interstitial Device - 49327
  Placement of Interstitial Device (Add-On) - 49412
  Insertion of Tunneled Intraperitoneal Catheter – 49418

  **Deleted**
  
  Esophagogastric fundoplasty – 43324 & 43326
  Biopsy of Stomach - 43600

- **Urinary System – 1 New Code**
  
  Transurethral Radiofrequency Treatment for Stress Incontinence - 53860

- **Female Genitourinary System – 1 New Code**
  
  Insertion of Vaginal Brachytherapy Device - 57156

- **Nervous System – 8 New & 2 Deleted**
  
  Stereotactic Computer Assisted Cranial Procedures – 61781 -61783
  Posterior Tibial Neurostimulator - 64566
  Cranial Nerve Neurostimulator Electrodes - 64568 – 64570
  Chemodenervation of Parotid & Submandibular Glands - 64611

- **Eye and Ocular Adnexa – 4 New Codes**
  
  Placement of Amniotic Membrane on Ocular Surface – 65778 – 65779
  Transluminal Dilation of Eye Canal - 66174 - 66175

- **Radiology – 5 New Codes**
  
  CT Angioplasty Abdomen/Pelvis
    Without Contrast – 74176
    With Contrast – 74177
    Without Contrast 1+ Body Regions – 74178
  Ultrasound Extremity Non-Vascular
    Complete - 76881
    Limited – 76882

- **Pathology & Laboratory – 15 New & 13 Deleted**

- **Medicine – 40 New & 41 Deleted**
  
  **New Codes**
  
  Immunization Administration thru 18 years
  First Vaccine/Toxoid – 90460
  Each Additional – 90461
  H1N1 Immunization Administration, including counseling - 90470
  Meningococcal Vaccine, 2-15 months - 90644

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New Codes

- Intranasal – 90664
- Intramuscular, Preservative Free – 90666
- Intramuscular, Split Virus, Adjuvanted – 90667
- Intramuscular, Split Virus – 90668
  - Therapeutic repetitive transcranial magnetic stimulation treatment; planning – 90867
  - Delivery and management, per session - 90868
  - Esophageal Motility (Add-On Code) – 91013
  - Sleep Study 95800 - 95801

Deleted Codes

- Immunization Administration – 90465 – 90468
  - Esophageal/Gastric Intubation/Motility – 91000-91105
  - Telephonic Transmission of Post-Symptom EKG strips
    - 93012 & 93014
  - Holter Monitors
    - 93230 - 93233
    - 93235 - 93237

New & Deleted Heart Catheterization Codes

New
- 93451 - 93464
- 93563 - 93568

Deleted
- 93501
- 93508 - 93511
- 93514
- 93524
- 93526 - 93529
- 93539 - 93545
- 93555 - 93556

- Category II Codes (F Codes) – 31 New Codes
  - Major Depressive Disorder
  - Parkinson’s Disease
  - Epilepsy
  - Body Mass Index
  - Cervical Cancer Screening
  - BloodTyping
  - Clinical Tumor Staging
  - Anesthesia
  - Tobacco Use & Cessation Counseling

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2011 CPT Code updates continued...

**Category III Codes (T Codes) — 52 New Codes & 13 Deleted Codes**
- Cryopreservation Ovary Tissue / Oocyte – 0058T & 0059T
- Audiology and Speech Audiology – 0208T – 0212T
- Injection Paravertebral Facet Joint – 0213T – 0218T
- Placement Posterior Intrafacet Implants – 0219T – 0222T
- Transluminal Peripheral Atherectomy – 0234T – 0239T
- Esophageal Motility – 0240T – 0242T
- Measurement of Wheeze Rate for Bronchodilator – 0243T & 0244T
- Open Treatment of Rib Fractures – 0245T – 0248T
- Ligation Hemorrhoid with Ultrasound – 0249T

**Category III Codes (T Codes) — 52 New Codes & 13 Deleted Codes**
- Bronchial Valve Procedures – 0250T – 0252T
- Endovascular Repair – 0254T – 0256T
- Aortic Heart Valve Replacement with and without Cardiac Bypass – 0258T & 0259T

### New ICD-9-CM Diagnosis Codes,
Additional Digits Required, and Deleted Diagnosis Codes – EFFECTIVE 10/01/10

- **Hypothermia, Neonate, 28 days or less** – 0260T & 0261T

- **Neoplasms**
  - Schwannomatosis - 237.73
    - One form of a genetic disorder called neurofibromatosis (NF) that has only been recently recognized
  - Neurofibromatosis, NEC - 237.79

- **Endocrine, Nutritional & Metabolic, Immunity**
  - **Deleted**
    - Disorders of Iron Metabolism – 275.0
      - Additional 5th Digit Required
        - Hereditary Hemochromatosis – 275.01
        - Hemochromatosis – RBC transfusions – 275.02
        - Hemochromatosis NEC - 275.03
        - Other Disorders of Iron Metabolism – 275.09

  - **Deleted**
    - Fluid Overload 276.6
      - Additional 5th Digit Required
        - Transfusion associated circulatory overload – 276.61
        - Other fluid overload – 276.69

  - **New Code**
    - Obesity hypoventilation syndrome – 278.03
    - Post-transfusion purpura - 278.41

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Blood and Blood-Forming Organs
Deleted
Secondary Thrombocytopenia - 287.4
Additional 5th Digit Required
Other secondary thrombocytopenia – 278.49

Mental Disorders
New Code
Childhood onset fluency disorder – 315.35

Circulatory System
New Codes
Other disorders of arteries and arterioles - 447.7
Aortic Ectasia - 447.71 – 447.73

Respiratory System
Deleted
Influenza due to identified avian influenza virus – 488.0
Additional 5th Digit Required
Influenza due to identified avian influenza virus with:
Pneumonia – 488.01
Other Respiratory Manifestations – 488.02
Other Manifestations – 488.09

Deleted
Influenza due to identified novel H1N1 influenza virus – 488.1
Additional 5th Digit Required
Influenza due to identified novel H1N1 influenza virus with:
Other Respiratory Manifestations – 488.12
Other Manifestations – 488.19

Digestive System
New Code
Fecal impaction – 560.32

Musculoskeletal System
New Code
Spinal stenosis, lumbar region, with neurogenic claudication – 724.03

Congenital Anomalies
Deleted
Other anomalies of uterus – 752.3
Additional 5th Digit Required:
752.31 – 752.47

Symptoms, Signs and Ill-Defined Conditions
New Codes
Post traumatic seizures – 780.33

Continued on following page...
Febrile non-hemolytic transfusion reaction – 780.66
Fluency disorder in conditions classified elsewhere – 784.52

**Jaw pain – 784.92**

**Signs and Symptoms involving cognition**

- Attention or concentration deficit – 799.51
- Cognitive communication deficit – 799.52
- Visuospatial deficit – 799.53
- Psychomotor deficit – 799.54

Frontal lobe and executive function deficit – 799.55

- Other signs and symptoms involving cognition – 799.59

**Deleted Codes**

**Hemoptysis – 786.3**

**Additional 5th Digit Required:**

- Acute idiopathic pulmonary hemorrhage in infants – 786.31
- Other hemoptysis – 786.39

**Incontinence of Feces – 787.6**

**Additional 5th Digit Required:**

- Incomplete defecation – 787.61
- Fecal smearing – 787.62
- Fecal urgency – 787.63

**Injury and Poisoning**

**Deleted**

Poisoning by other specified central nervous system stimulants – 970.8

**Additional 5th Digit Required:**

- Poisoning by cocaine – 970.81
- Poisoning by other central nervous system stimulants – 970.89

**ABO incompatibility reaction – 999.6**

**Additional 5th Digit Required:**

- ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed – 999.61

- Acute – 999.62 Delayed – 999.63
- Other ABO incompatibility reaction - 999.69

**Deleted**

Rh incompatibility reaction – 999.7

**Additional 5th Digit Required:**

- Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed – 999.71
- Acute – 999.72 Delayed – 999.73
- Other Rh incompatibility reaction – 999.74

**Non-ABO Incompatibility**

- Non-ABO incompatibility reaction, unspecified – 999.75

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Not specified as acute or delayed – 999.76
Acute – 999.77 Delayed – 999.78
Other non-ABO incompatibility reaction – 999.79

New Codes

- Transfusion reaction, unspecified – 999.8
- Hemolytic transfusion reaction, incompatibility unspecified – 999.83
- Acute hemolytic transfusion reaction, incompatibility unspecified - 999.84
- Delayed hemolytic transfusion reaction, incompatibility unspecified – 999.85

- **External Causes of Injury and Poisoning**

  New Codes

  - Volunteer Activity – E000.2

- **Factors Influencing Health Status (V Codes)**

  New Codes

  Personal History of:

  - Combat & operational stress reaction – V11.4
  - Vaginal dysplasia – V13.23
  - Vulvar dysplasia – V13.24

  Other (corrected) congenital malformations of:

  - Genitourinary system – V13.62
  - Nervous system – V13.63
  - Eye, ear, face and neck – V13.64
  - Heart and circulatory system – V13.65
  - Respiratory system – V13.66
  - Digestive system – V13.67
  - Integument, limbs and musculoskeletal – V13.68

  Retained foreign body fully removed – V15.53

  Do not resuscitate status – V49.86

  Physical restraints status – V49.87

  Homicidal ideation – V62.85

  Acquired absence of pancreas – V88.1

  Total – V88.11 Partial – V88.12

  Retained:

  - Foreign body – V90
  - Radioactive fragment – V90.0
  - Depleted uranium fragments – V90.01
  - Other radioactive fragments – V90.09
  - Metal fragments – V91
  - Metal fragments, unspecified – V90.10
  - Magnetic metal fragments – V90.11
  - Non-magnetic metal fragments – V90.12

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ICD-9 Code updates continued...

Plastic fragments – V90.2
Organic fragments – V90.3
Animal quills or spines – V90.31
Tooth – V90.32
Wood fragments – V90.33
Other organic fragments – V90.39
Other specified foreign body – V90.8
Glass fragments – V90.81
Stone or crystalline fragments – V90.83
Other specified foreign body, NEC – V90.89
Foreign body, unspecified material – V90.9

Multiple Gestation Placenta Status
Codes V91.0 – V91.99

Deleted

Encounter for insertion of intrauterine contraceptive device (IUD) – V25.1
  Insertion of IUD – V25.11
  Removal of IUD – V25.12
  Removal and re-insertion of IUD – V25.13

Body Mass Index (BMI) 40 and over, adult – V85.4
  BMI 40.0 – 44.9, adult – V85.41
  BMI 45.0 – 49.9, adult – V85.42
  BMI 50.0 – 59.9, adult – V85.43
  BMI 60.0 – 69.9, adult – V85.44
  BMI 70 and over, adult – V85.45

Remember to change the following to reflect the new ICD-9-CM diagnosis and CPT procedure codes for 2011:
- Superbill / Encounter Form
- Update ICD-9-CM and CPT Books

Q&A with RMC

Q. When we bill Medicare for bilateral procedures, are we legally required to bill Medicare at 150% of our charges rather than 200% for 2 procedures? How should we bill other Medicare subcontractors (Medicare advantage plans, etc.) for bilateral procedures?

A. Medicare, nor any payer “requires” you to bill at 150% for bilateral. Actually, on the contrary, you should bill at 100% of charges because Medicare and other payers will automatically reduce your charge by 50% of the allowable for the bilateral (the second side). In essence, they will pay a total of 150% of the allowable for the bilateral procedure. If you bill at a reduced rate and your contract states you will be paid at allowable or billed charges, whichever is less, you may lose reimbursement if the automatic 50% reduction the payer takes from your reduced billed charges is less than their actual allowable for the procedure. Remember, Medicare wants you to bill bilateral charges on one line with modifier 50 appended to the CPT code and one unit only. Check with other payers for their policy concerning reporting of bilateral procedures. Some payers want you to bill on two lines.
Q. A new patient had a straightforward problem focused evaluation for hand pain with an x-ray and resulted in closed reduction with manipulation of two finger fractures during the same encounter. The provider wanted to code a new patient E/M with a 57 modifier appended to the code in addition to the closed fracture care code. Is this appropriate?

A. No, this scenario would not qualify for modifier 57. If the history, examination and decision making documented were pertinent only to the isolated injury/fracture, they would not meet criteria for modifier 25 either. Noridian policy (NAS Bulletin “Coding for Definitive or Restorative Treatment”), CPT Assistant (multiple references) and Coding Clinic (“When a Bone Breaks”) all advise that the initial treating physician, who evaluates the fracture, treats/reduces the fracture and assumes follow up care for the fracture should report the global fracture care code only. AAOS advises (AAOS article “Coding for Closed Treatment of Fractures”, AAOS June 2002 Bulletin “Understanding Fracture Care Coding”) that when only minimal evaluation and management services pertinent to an isolated fracture are performed, they should not be additionally reported with modifier 57.

Q. The provider removed a superficial foreign body with forceps. Can I code for the foreign body removal or is this just an E/M visit?

A. If incision is not required for removal of foreign body, only the E/M code may be reported. In order to code surgical CPT codes for foreign body removal, there must be a medically necessary incision to remove the foreign body from subcutaneous tissue or deeper tissues/structures.

Angela Harrington, CPC  
Professional Fee Coding Compliance Auditor at RMC  
Angela Harrington is a Certified Professional Coder and member of the American Academy of Professional Coders with over 15 years of health care experience. Her experience includes working as a Coding Analyst and External Audit Investigator for a health plan, contributing her coding expertise in the establishment and maintenance of payment policies, bundling edits, and other claims payment set up, as well as providing education to the provider network, investigating health care fraud, waste and abuse and working in collaboration with local law enforcement, the OIG, and various board certification organizations. She has also worked for a large Portland area multi-specialty practice with multiple locations performing provider education.

2011 RMC AUDIO CONFERENCE SCHEDULE  
February 17th  
“Diabetes” with Judy Terry, RHIA, CCS  
March 17th  
“Injections and Infusions Basics” with Jane Barta, RHIA  
April 21st  
“Pregnancy Coding” with Stacy Hardin, CCS  
May 19th  
Physician Coding topic TBA With Connie Eckenrodt, RHIT, CCS  
June 16th  
“CVAs and TIs” with Marcia Vaqar MPH, RHIA, CCS, CCS-P  
Cost is $10/person or $25/facility. FREE for all current RMC clients.  
AHIMA CEUs pending.  
Contact Kristin Gibson at kristin@rmcinc.org for registration details!

We hope you’ve enjoyed this edition of As the Practice Codes. At RMC, we want to be your resource for all your coding and documentation needs. Articles in our newsletter will include current events, tips to improve coding and documentation, and Q & A (feel free to submit questions). If you have any questions, suggestions, or would like to subscribe/unsubscribe to the quarterly newsletter, please contact Connie Eckenrodt at Connie@rmcinc.org or (800) 538-5007.
How can we help you?

Are you capturing all revenue possible for your services?
On average, longer-practicing doctors tend to under-code the services they provide.

Are you backlogged in coding?
If you are looking to improve your accounts receivable from payers, RMC can help.

Are you feeling your coding skills aren’t up-to-date?
Coding guidelines and payment rules change frequently.

You can take advantage of RMC’s services, including:
- Comprehensive Audits
- Customized Education
- Accurate Coding Support
- Thorough HCC Audits

“Partnering with our clients to ensure appropriate reimbursement and effective compliance”