

Health Insurance and Billing Resource Guide

AHIMA's Textbooks:

Coding and Reimbursement for Physician Services

Coding and Reimbursement for Hospital Outpatient Services

Principles of Health Care Reimbursement

Effective Management of Coding Services

A detailed description of the content of these books is supplied at the AHIMA bookstore website where they are sold (<http://imis.ahima.org/orders/>). Please note the date of publication for these textbooks and keep in mind that recent changes to the billing and reimbursement systems may not have been reflected in the above texts at this point.

AHIMA's Seminars: <http://campus.ahima.org/audio/2007seminars.html> To access the presentations—just choose the option to “Download the resource material” Change the year as needed.

April 17, 2007 Revenue Cycle Management

November 9, 2006 Medical Necessity for Outpatient Services

July 27, 2006 Coding and Reimbursement for CMS Preventative Care Benefits

There are also seminars on the UB-04, DRGs, MS-DRGs, APCs, modifier reporting, updates on the OPSS, the IPPS, as well as seminars specific to a particular healthcare setting like rehabilitation that include billing and reimbursement information pertinent to that setting. Please note the date of publication for these seminars and keep in mind that recent changes to the billing and reimbursement systems will not be reflected in them.

AHIMA's Courses:

AHIMA has courses on reimbursement and billing principles such as one called “A guide to revenue cycle management”

http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html

Reimbursement Overview course and assessment

Here is the description from the website below:

"This 5 CEU refresher course and its related 10-question, 1 CEU assessment explore reimbursement in general, as well as claims processing issues, freestanding ASC, reimbursement for professional services, inpatient and outpatient PPS, and PPS for skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health and hospice services. Compliance issues related to reimbursement are also covered." Please note the date that this course (or any other course) was last updated and keep in mind that recent changes to the billing and reimbursement systems may not have been reflected in the courses depending on the last update date.

http://campus.ahima.org/campus/course_info/CATS/CATS_over.html

Here is one final thing to keep in mind: The main principles that you want to learn prior to taking an AHIMA coding credential are those related to Medicare that are specified in the multiple choice competencies for the exam you are taking. Knowledge about other insurances is not applicable or tested. In fact, the instructions in the Candidate Handbook specifically instruct one to not code based on insurance or payer guidelines. On page 13, the AHIMA candidate handbook states the following:

"Follow the procedures that appear in Appendix A for coding the CCS examination. These procedures will also be used for Part II of the examination. The test will be scored using them. Do not use facility, regional, or insurance standards that differ from the examination procedures."

Similar instructions are given for the CCS-P as well on page 14 of the candidate handbook.

It has been suggested to save in-depth studies of varied insurance and payer policies for after the coding exam because insurance guidelines are often different from basic official coding guidelines, CPT guidelines, and other principles that are actually tested in the AHIMA coding credentials.

The **key resources** for a practicing billing or coding professional with regards to billing, insurance, and reimbursement will be the written policies and coding guidelines established by the FI, carrier, or other specific kind of insurance. These policies should be obtained directly from the payer and will most likely be posted to a website or provided in a hard-copy or downloadable provider or policy or benefit manual. Updates and revisions to these policies and guidelines take place frequently and these must be constantly monitored. Many payors have listservs or mailing lists that you can sign up to in order to receive news and information about policy changes. Keep in mind that in many cases, insurance policies and coding and reporting guidelines and requirements will in some cases be dictated by state law such as in the case of Medicaid or other special state reporting like CHIME in Connecticut or OSHPOD in California. Each healthcare provider should have a general file of insurance policy manuals, provider contracts, patient benefit manuals, and spreadsheets or databases that clarify specific requirements for different areas for each insurance that they are contracted with. Specific requirements for different areas often involve coverage and coding guidelines especially for special

procedures, supplies, and preventative measures. Each healthcare provider should also have facility or office-specific guidelines available regarding any special state or local reporting or other guidelines or requirements applicable to that particular facility or office

General Billing Websites:

Free Billing Listservs: *One word of caution on listservs—not all information on a listserv is accurate or updated. Keep that in mind as you surf through these. Also, I have noted that some of the guidance given is based on whether or not a 3rd party payer will deny or accept the claim. I do not recommend basing your coding on that issue, but it should be based on the documentation given only.* There are many yahoo groups that claim medical billing and/or coding, but many of them have nothing but spam on them. This is the only medical billing yahoo group that I was able to find that is properly moderated enough to virtually keep the spammers out and has the best information, most activity, and most knowledgeable members on it. It is owned by Jo Ann. If you choose to join this group, be sure to do a search on the message with this title “teaching medical insurance and billing.” Melinda Brown’s replies on that thread contain invaluable knowledge and advice. <http://health.groups.yahoo.com/group/MedicalBillers/>

Ericacodes website

Carefully examine the links and documents of the pages of Erica Schwalm’s main website and you will find lots of good information on physician billing and insurance as well as things like reading the EOB, the encounter form, surgery coding and the global period, unbundling and the Correct Coding Initiative (CCI) edits, and more. In her links, she lists some great listservs one of the best of which is the free one sponsored by the Medical Association of Billers (MAB).

<http://www.ericacodes.com>

Another great listserv is Intelicode and the way to sign up to that listserv is to send an blank email message to this email address as it is an email-only list: INTELCODE-on@mail-list.com

Another great listserv is the Trenches at this link

http://mail.askleslie.net/mailman/listinfo/the_trenches-1_askleslie.net

Speaking of the global period, here are a couple of links that helps you calculate the global period.

90-day Global Surgery Period Tracker

http://www.medicarenhic.com/providers/billing/billing_calc_global_period.html

Printable calendar for 2008

http://www.myaccountability.org/content/calendar_2008.pdf

<http://www.medicalbillingpro.com/surgery-calendar.html>

List of all procedure codes and their global periods (it comes from the physician fee schedule on CMS's website which is referenced in this guide later on)

www.donself.com

Another good site that used to explain the difference between a medical biller and coder and gives lots of websites for medical billing, but now, it still provides a reference for an at-home billing company.

<http://www.wmedclaimsbilling.com/index.html>

Free billing quizzes and other educational tools:

Don Self's billing quiz is a general quiz with many insurance and billing questions thrown in there too.

<http://www.donself.com/documents/employeequiz.doc>

KZA has a very focused billing quiz that gives you an idea of the basics that you need to know about medical billing. Use these quizzes to help you focus your studies and research.

<http://www.karenzupko.com/downloads/billingspecialistknowledgeassessment.doc>

Jeffrey Restuccio has posted several quizzes on various topics including insurance, modifiers, E/M coding, HCPCS coding etc.

<http://www.ritecode.com/quizzes/quiz.html>

Another great practice management/billing quiz (deals with state laws on insurance)

http://www.mtbc.com/practice_management_quiz.aspx

Noridian has a large list of presentations that are helpful to the learning process

<https://www.noridianmedicare.com/p-meddb/train/presentations/index.html>

Steps in the Revenue or Claims Lifecycle:

An Excellent Presentation on the Revenue or Claims LifeCycle:

www.healthsystem.virginia.edu/internet/som-admin-dev/RevCycle-Presentation-Final.ppt

An article on the Revenue Cycle

http://www.fortherecordmag.com/archives/fttr_09182006p22.shtml

http://www.fortherecordmag.com/archives/fttr_052305p26.shtml (front-end focus and medical necessity)

http://www.fortherecordmag.com/archives/fttr_100404p38.shtml (focus on denials and billing errors)

http://www.fortherecordmag.com/archives/fttr_072604p30.shtml

http://www.fortherecordmag.com/archives/fttr_110104p12.shtml (an overview of the challenges in the claims process and how technology helps in this process)

From the HFMA—look under the topics under the revenue cycle tab—they even have an assessment that you can take at this link to determine what may be lacking your claims processing process:

http://www.hfma.org/library/revenue/denials/denials_self_assessment.htm

<http://www.hfma.org/library/revenue/billing/>

HcPro now has a Revenue Cycle Institute – check it out.

One of the biggest challenges in medical billing is getting all the information about a patient's coverage prior to submitting the claim. Patients don't always have the most updated info on their insurance available, but this website maybe useful to you for Medicare patient's to check their eligibility and coverage status. Also, be sure to find out all the different types of current insurance coverage and benefits that they have. Medicaid may also have a website that you can go to depending how it is set up in that particular state. Other possible solutions are Medicare Csnap or Passport Health Communications. <https://www.checkmedicare.com/Client/Default.aspx>

HIPAA reason code lists—these are codes that are supposed to be used by all third party payers in claims transactions. Click on each type of code to get an idea of the information that is conveyed by each one. These will appear on the remittance advice (RA) or an electronic remittance advice (ERA) which is the document that is sent from the payer to the provider that explains what amount of reimbursement was supplied or denied and why. A similar form, called the explanation of benefits (EOB), is usually sent to the patient. For Medicare patients, this form is called an MSN or Medicare Summary Notice.

<http://www.wpc-edi.com/products/codelists/alertservice>

<http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=ascending&itemID=CMS061410&intNumPerPage=10>

Here is some other information regarding denials and the reasons for them:

<http://www.trispan.com/factsheets/TopDenialReasons4thQuarter2008.pdf>

<http://www.insure.com/articles/healthinsurance/claim-denial.html>

Sample Health Claim Forms:

http://www.synvisc.com/pdf/sample_CMS1500_claim_form.pdf (CMS 1500 for physician office)

Instructions on filling out this form are found here:

<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

Pages 4-5 of the document at this link illustrate a filled out inpatient and outpatient UB-04. The information at this link may not be totally updated for the most recent changes.

http://www.passporthealthplan.com/pdf/providercenter/providercom/orient_reference/2007/reference/ub04_form_instructions.pdf

Instructions on filling out the UB-04 are found here (this manual also includes all the revenue codes for FL 42 on the UB-04:

<http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf>

General Tips about key information on an insurance card (with sample card illustrations)
Note: General front-end or front-office policy is to make a copy of the patient's insurance card(s) both front and back:

http://www.bcbsil.com/PDF/stn_ins_card_ele_ref_guide.pdf (BCBS)

<http://healthcare.qwertypuppy.com/2008/04/30/blue-cross-prefix-list/> (BCBS prefix list by state)

http://www.ugsmedicare.com/provider_education/manuals/documents/cah/Introduction%20FY05%20Q1.pdf (Medicare)

Prompt Pay Laws

Each state has their own prompt pay laws established for third party payers to adhere to. These laws are designed to protect healthcare providers from undue delay in receiving payment for their services. The link below is a grid that lists the laws by state. Most laws require payment within 30 days.

http://www.conomikes.com/Prompt_Pay_State_Grid.pdf

State recoupment laws (updated 2008)

Again, each state has their own recoupment laws established for third party payers to adhere to. These laws usually specify the extent to which 3rd party payers may seek refunds on payment that they have rendered to the provider. Most state laws limit recoupment to only 2-3 years after initial payment.

www.askleslie.net

Electronic Billing:

Chapter 24 of the Medicare Claims Processing Manual deals with electronic billing requirements for Medicare. Most practices use a practice management system or billing system which allows them to submit their claims electronically to a clearinghouse. Others may choose to bill directly to the insurance using their websites since this option may often be free. The clearinghouse is basically another entity takes the claims and directs them to the correct insurance company for payment. Clearinghouses or other electronic billing software or services often catch various errors in claims submission as well prior to them being sent to the payer. Medicare carriers specify a list of acceptable billing software and clearinghouses that handle their claims and meet their requirements and this list is often on the website for the carrier, FI, or other entity contracted with Medicare. It would not hurt to check with other payers or on the website for other payers to see if they have any special requirements for electronic claims billing also. Despite what insurance or payer is involved, the one requirement that must be met is for the software, clearinghouse, or any other billing service to be HIPAA compliant because personal health information is being processed. Some of the clearinghouses may be free such as Availity or Office Ally. One highly recommended one is Claim Remedi : see the recommendation below by Barbara Cobuzzi: “You might want to look at the clearinghouse you are using. If you used a clearinghouse like Claim Remedi, this would not be happening and the clearinghouse would be working with you if anything was coming from you to be causing the rejects. If a format coming from you is not right, they convert it to the format for the payer. They reverse engineer to make sure all the needs of the payer are met. And they do more, real time claim editing, claim cycle management. Check them out at www.claimremedi.com If you want an on line demo, let me know directly at b.cobuzzi@att.net and I will put you in contact with the people I know there.” It is imperative to be thoroughly familiar with the workings of whatever practice management system or billing software through which patient information and claims will be submitted. One common practice management system software is Medisoft and another is AdvancedMD.

Insurance and billing term glossaries:

<http://theinformatician.com/hci-glossary/>

<http://www.msha.com/pfb.cfm?id=144>

<http://www.thebodyworker.com/ins-bill-glossarya-e.htm> (a little lengthy, but this is a really good one)

<https://www.mercycare.org/patients/billing/glossary.aspx> (another good list)

<http://www.elcaminohospital.org/body.cfm?id=64> (short list with a few terms not found in other lists)

<http://www.uhs.net/onlineservices/glossary.asp> (short list with a few terms not found in other lists)

<http://www.insure.com/articles/interactivetools/glossary/glossary.jsp> (this is pretty comprehensive too and covers all kinds of insurances (auto, life, everything—last resort) This site is also good for other information regarding insurances.

Training for a fee:

American Association of Medical Billers

This is an association that offers classes and education on medical billing. Their library site (see link below) has the listings for several of the great billing and insurance books published by Delmar for a low fee. They also offer the Certified Medical Reimbursement Specialist (CMRS) certification.

<http://www.ambanet.net/library.htm>

Medical Association of Billers

This is an association that offers classes and education on medical billing. One of the leaders in this association is Steve Verno and his book *Insurance Handbook for the Medical Office* is excellent. They also offer the Certified Medical Billing Specialist (CMBS) certification.

<http://www.e-medbill.com/>

Delmar textbooks (There are a few really good texts under here especially Understanding Health Insurance by Michelle Green and Jo Ann C. Rowell)

http://www.delmarhealthcare.com/Medical_Insurance_Coding/

McGraw-Hill sells an excellent book also that includes the Medisoft Software for practice

<http://primiscontentcenter.mheducation.com/mhhe/viewProductDetails.do?isbn=0073256455>

Medicare-specific links:

Keep in mind that many other third party payer policies are very similar to Medicare's; in fact, other third party payers are gradually changing their policies to make them more similar to the ones that Medicare has. Also, most providers, nowadays, have Medicare as one of their main payers especially with the aging of the baby-boomer population. Therefore, learn Medicare and learn it well, that way when you go to learn other payer policies, many of them will already be familiar to you.

These brief overview articles outline Medicare's reimbursement systems and other key info relating to Medicare

http://health-information.advanceweb.com/common/EditorialSearch/AViewer.aspx?AN=HI_p25.html&AD=10-16-2000

http://health-information.advanceweb.com/common/EditorialSearch/AViewer.aspx?AN=HI_hifeature4.html&AD=10-16-2000

Most of the resources guide you to the CMS website (<http://www.cms.hhs.gov>) that we all know about, but have trouble finding so much there. But here is a general list of links to help you navigate around the CMS website
<http://www.medscape.com/viewarticle/494892>

Education resources specific to Medicare: This is a list of free educational resources specific to Medicare. The topics covered are numerous and they include preventative services billing, the PPS systems, specialty providers, quick reference guides, and much more. The recently updated MLN product catalog lists specific resources that can be downloaded. Carefully study this list of products to determine what is available for your specific needs.

<http://www.cms.hhs.gov/MLNProducts/downloads/MLNCatalog.pdf>

Medlearn Courses: This is the direct link to 17 CMS's Medlearn courses on topics like the IPPS and the Outpatient Code Editor. I have not evaluated these myself (I just found them this morning while trying to navigate deeper into the Medlearn section of the CMS website), but I would advise taking the recently updated/revised ones first. The Medlearn articles are actually CMS transmittals.

http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1

Medicare/CMS FAQ's (Enter one search term and you can review all the FAQs on that topic such as "edits" or "modifiers"):

http://questions.cms.hhs.gov/cgi-bin/cms_hhs.cfg/php/enduser/std_alp.php?p_sid=9ftg42ui

A link explaining the acronyms used in Medicare and other government-related healthcare entities

<http://www.cms.hhs.gov/apps/acronyms/>

A glossary of CMS terminology

<http://www.cms.hhs.gov/apps/glossary/>

Direct link to Medicare claims processing manual

The chapters in this manual cover all sorts of topics including all the prospective payment systems and fee schedules and instructions for filling out the CMS 1500 and UB-04 forms.

<http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912&intNumPerPage=10>

National Coverage Determinations Manual:

<http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS014961&intNumPerPage=10>

National Coverage Determinations:

<http://www.cms.hhs.gov/mcd/indexes.asp?from2=indexes.asp&>

Place of Service codes for Professional Claims:

http://www.cms.hhs.gov/PlaceofServiceCodes/03_POSDatabase.asp#TopOfPage

Main Medicare Mailing lists: Comprehensive list of CMS mailing lists to keep up with main Medicare policies specific to a variety of healthcare providers and healthcare settings.

<http://www.cms.hhs.gov/apps/maillinglists/>

Final Rule Summaries/ICD-9-CM Committee Meeting Minutes Summaries: AHIMA has made it easier to understand the final rulings for the IPPS or OPSS settings. Don't waste time being overwhelmed with a 60,000+ page FR document. Let the experts explain it to you in simple terms. AHIMA also summarizes the ICD9 C&M meetings (originally posted here:

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp#TopOfPage) also.

<http://www.ahima.org/dc/>

FI and carrier look-up site: Use this link to look up various FIs or carriers. They are often divided by state, although in some cases, the same carrier or FI may span more than one state. The contact information for each of these entities should include a website. Go to the website and navigate it for further information about policies, local coverage determinations, educational information, etc. Several of these sites are packed with good coding educational references and information. Look under the provider and education and training sections. The resource-rich ones usually have courses, web-based training, manuals and billing guides, newsletters, mailing lists or listservs, workshops, publications, articles, presentations, forms, lists of frequently used CMS links, and quick reference guides or other tools.

<http://www.cms.hhs.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip>

This is the list of CMS Regional Offices. *Coding Clinic* 2000, 3rd qtr., p.13-15 advises providers to contact these offices when an FI or carrier issue regarding policies that conflict with official coding guidelines and cannot be resolved with the carrier or FI. One solution for resolving disputes when it is a guideline issue (instead of a coverage issue) is to forward to the payer or carrier the documentation from the official coding guidelines or the CPT official guidelines, etc that shows how the situation should be handled. Show it to them in writing.

<http://www.cms.hhs.gov/RegionalOffices/>

Local Coverage Determinations (each local area has policies--additional to and more specific than the NCD--according to the particular carrier or FI that services that region)

http://www.cms.hhs.gov/DeterminationProcess/04_LCDs.asp

<http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf> (contains guidelines for LCD creation)

There are special forms that a Medicare patient must sign in the case that a facility or practice determines that a particular procedure will not be covered. In the facility or hospital setting, this form is called a HINN (Hospital-issued notice of non-coverage). In the office setting, this form is called an ABN (Advanced Beneficiary Notice). There are also other special non-coverage notices that are for other special care or care settings.

http://www.cms.hhs.gov/BNI/05_HINNs.asp (examples of HINNs)

http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage (examples of ABNs)

http://www.cms.hhs.gov/BNI/01_overview.asp#TopOfPage (other notices—see left column)

Medicare HMO info (Part C or Medicare Advantage)

www.medicareadvocacy.org/FAQ_ManagedCare.htm

www.medicarehmo.com

<http://www.medicare.gov/Choices/Advantage.asp>

<http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019326&intNumPerPage=2000>

Medicare as Secondary Provider Info

This link is from one of the Medicare carriers and it is a logic-based tool that guides you through the process of determining if Medicare should be secondary providers. Other links to presentations and articles related to MSP are listed and they are from other Medicare carriers that explain this concept in more detail using various approaches. The last two links are straight from Medicare or CMS.

<http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Ohio%20Part%20B%20Carrier~Resources~Medicare%20Secondary%20Payer?open>

<https://www.noridianmedicare.com/macj3b/claims/msp/calculator.html> (actual calculator)
http://www.cahabagba.com/part_b/msp/index.htm
<https://www.noridianmedicare.com/p-medb/train/presentations/msp.pdf>
http://www.wpsmedicare.com/part_b/business/msp_claims.shtml
<http://www.medicarenhic.com/providers/pubs/Medicare%20Secondary%20Payer%20Guide.pdf>
<http://www.highmarkmedicare.com/parta/guides/pdf/msp.pdf>
<http://www.cms.hhs.gov/MedicareSecondPayerandYou/>
<http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS019017&intNumPerPage=2000>
 (Manual on the subject)

Other government sponsored insurance-specific links:

Medicaid Information (you have to check with each state for individual policies)
<http://www.cms.hhs.gov/home/medicaid.asp>
<http://www.cms.hhs.gov/Manuals/PBM/list.asp?intNumPerPage=all&submit.x=&submit.y=&submit=Submit> (paper-based Medicaid Manual)
<http://www.nasmd.org/links/links.asp> (use this site to check for each state's Medicaid)
http://www.geocities.com/CapitolHill/5974/#State_Links (good general site for Medicaid info)
<http://64.82.65.67/medicaid/states.html> (Medicaid info by state)
<http://www.ncdhhs.gov/dma/medbillcaguide.htm> (here is NC's basic Medicaid Billing Guide, just for an example)

Texas Medicaid is special in that it requires a TPI number for provider enrollment.
<http://www.tmhp.com/C10/Applying%20to%20Medicaid/default.aspx>

Workers Comp Websites by state

<http://www.comp.state.nc.us/ncic/pages/all50.htm#al>

<http://www.workerscompensation.com/> (more information on Workers Comp)

Note: When coding for workers comp claims, it is often important to include all the necessary E codes to describe the injury, including the place of occurrence. For other insurances, E codes serve a purpose in determining coverage status such as in the case of auto insurance. The following links are helpful to explain the use of E codes and to provide a quick reference guide for their use. The individual states often have E code reporting requirements dictated within state law as well. For example, in New Jersey, Z codes are assigned instead of E codes to report place of occurrence. Front office billing personnel or facility registration personnel must ensure that they get all the appropriate information that is required if a case involves an accident or work-related injury.

<http://health-information.advanceweb.com/common/editorial/editorial.aspx?CC=94577>

<http://www.cdc.gov/nchs/about/otheract/ice/matrix.htm>

Indian Health Service

<http://www.ihs.gov/>

CHAMPVA

<http://www.va.gov/hac/hacmain.asp>

TriCare

<http://www.tricare.mil/mybenefit/home/overview?>

SCHIP

<http://www.cms.hhs.gov/home/schip.asp>

Retired Federal Employee Insurance:

<http://www.opm.gov/retire/>

Railroad Medicare:

<http://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Medicare>

Other Insurance-specific links:

Insurance Directory

The American Health Insurance Plans Association has a large list of the main or most popular insurances or payers and their website/contact information as a tool for personal research and self-education. This is not a comprehensive list, but it is fairly good. Some vendors actually sell “comprehensive” insurance directories. (Note: Some payers (other than Medicare carriers or FIs) do require a provider log-in to access some of the educational materials on their websites)

<http://www.ahip.org/content/default.aspx?bc=31|42|55>

Link to state insurance websites which includes auto insurance, workers comp, and most everything else that is regulated by the state. (It is probably best to focus the insurances specific to your state after looking at the general list of popular insurances across the nation):

http://www.naic.org/state_web_map.htm

Do note that sometimes you have to go to your state government or other local government website for any legal issues regarding insurance and healthcare. Look under the list of state or local agencies and identify the state department of Health and Human services or the state department of labor for issues like unemployment, disability, workers compensation, etc.

<http://www.loc.gov/rr/news/stategov/stategov.html>

State law resources—remember some reimbursement and statistics-related guidelines are dictated by state law

http://www.alllaw.com/state_resources/

Blue Cross and Blue Shield directory

<http://www.bluecross.com/coverage/find/plan/>

HMO-managed care information

<http://www.mcareol.com/factshts/mcolfact.htm>

HMO directory (they have one for a pretty penny, but just browse this site for a general idea of information—they also have a free products section) Note: you may can obtain a managed care plan directory from your state (county or local) department of health

<http://www.themcic.com/>

Membership here costs less than the directory mentioned above and looks as if you get lots more info; they even have a national directory of insurance agents at this link:

http://www.managedcareinfo.com/national_insurance_agent_directory.htm

<http://www.managedcareinfo.com/>

<http://www.managingmanagedcare.com/default.htm>

Glossary of Managed Care terms

<http://www.pohly.com/terms.html>

ERISA info

www.erisaclaim.com

Personal Injury Claims

<http://www.ican2000.com/uspersnl.html>

Miscellaneous other resources:

Important notice: In this section, a lot of specialty references, software vendors, or other entities are cited. Remember to use caution in using these guides, software, or other resources because they are not authoritative coding or billing advice and can be misleading, outdated, and/or conflict with official coding guidance. I try to specify some additional examples and details within this section.

Last, but not least, don't forget about AMA and AHA and other specialty associations and websites especially the ones that pertain to your state or local area. For example, the Florida Hospital Association website or the New Jersey Medical Association website etc. These websites sometimes have additional education or even courses or classes about specific guidelines for billing and insurance specific to the geographical location. The AMA also lists the specialty websites and each of these could have their own state or other local divisions with or without websites. The specialty websites have billing and information and guidelines that are specific to the particular specialty.

Link to all the state AHA sites

<http://www.pohly.com/assoc.html>

Link to all the state AMA sites

<http://www.ama-assn.org/ama/pub/category/7630.html>

Link to many of the specialty society websites from AMA

(When you go to the website, look under Practice Resources, Practice Management, Resources, Reimbursement, Coding, etc.)

<http://www.ama-assn.org/ama/pub/category/7634.html>

Link to other specialty websites

<http://www.pohly.com/assoc2.html>

Medical Group Management Association

www.mgma.com (it has state-specific chapters as well and a **free 14-day membership trial**)

For specialty billing, there are some carriers that offer excellent guides such as Medicarenhic (http://www.medicarenhic.com/ne_prov/publications.shtml), Wellmark (http://www.wellmark.com/e_business/provider/prov_guides.htm), and Highmark (<http://www.highmarkmedicareservices.com/parta/guides/index.html>); (<http://www.highmarkmedicareservices.com/partb/guides/index.html>).

Don't forget to check out the listservs featured on Erica's website (www.ericacodes.com) particularly the Medical Association of Billers (MAB) list serv, the Decision Health listservs and the coding911 listservs. Experienced professionals in nearly every specialty are on those listservs and you can network with them to learn about any specialty you are interested in or working in. If you are looking for a good list of resources or discussion groups for a particular specialty or healthcare setting, feel free to contact me for a specialized list formulated just for your specific needs. cmbenjamin@bellsouth.net

Also note that the AHIMA association has local and regional associations that sometimes post educational materials to their websites or offer educational classes, conventions, or other programs including coding roundtables. Check the list below for all the local HIMA websites. <http://www.ahima.org/directory/csa.asp>

AAPC has a similar list, but you have to enter in the information for each state to see what educational options are available to you. The websites for each local AAPC chapter are not listed here, but I have a separate list of those if you are interested.

<http://www.aapc.com/localchapters/index.aspx>

Vendors and other entities also publish guides specific to a particular healthcare setting or specialty including AHIMA, PMIC, Ingenix, HcPro, and Decision Health. A fairly comprehensive list of these kinds of resources are at these links:

http://www.pohly.com/books_healthcare_coding_books.html

http://www.pohly.com/books_healthcare_magazines_periodicals.html

Use caution in using these guides because they are not authoritative coding or billing advice and can be misleading, outdated, and/or conflict with official coding guidance.

Also, there are software solutions for keeping up with and managing insurance and billing policies and such as CodeCorrect, CustomCoder, IDX, Medical Management, Quadramed MD, Medisoft, Encoder Pro, etc. Again, the information supplied by these vendors or software products is not official and can be erroneous.

Other topics that are often related to insurance billing

If **E/M coding** for physician services is your struggle, Trailblazer and Highmark (two Medicare carriers) have many helpful tools for you. I also included the link to the main Medicare E/M billing guide (one of the Medical Learning Network products). Also, refer to my articles on E/M coding.

Remember that E/M coding for physician services is different than E/M coding for facility or hospital outpatient services. The subjective kind of E/M code assignment that involves either the 95 or the 97 guidelines is that kind that is for physician services.

<http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf> (1995 guidelines)

<http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf> (1997 guidelines)

Facility or hospital E/M code assignment is more straightforward and the guidelines for it are usually individual to each facility.

<http://www.trailblazerhealth.com/Education/Evaluation%20and%20Management%20Services/Default.aspx?DomainID=1>

<http://www.highmarkmedicare.com/partb/reference/scoresheets.html>

http://www.highmarkmedicare.com/faq/partb/pet/1pet-evaluation_management_services.html#3

<http://www.medicarenhic.com/providers/pubs/Evaluation%20and%20Management%20Billing%20Guide.pdf>

http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf

<http://www.emuniversity.com>

<http://www.codesmarter.com/forums/showthread.php?p=267#post267> (a link to another excellent presentation that was posted to the Intelicode forum)

Special additional -25 modifier guidance:

http://www.medicarenhic.com/cal_prov/articles/modifier25_1006.htm
https://www.ouhsc.edu/bc/documents/oei-07-03-00470useofmod25_000.pdf
<http://www.radrx.com/ToolsTips/Modifier%2025%20Quick%20Tips.pdf>
<http://www.cms.org/enews/Jan07/CIGNAMod25.pdf>
<http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA5025.pdf>

Incident-To articles and information:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0441.pdf>

<http://www.aafp.org/fpm/20011100/23thei.html> (has some outdated info, but it helped me understand the basics)

http://www.medicarenhic.com/providers/articles/incidenttosrvs_0108.pdf (quick sheet)

<http://www.arkmedicare.com/provider/provnewslet/pdfformat/mcb200709.pdf> (page 32)

Presentations: <http://www.medicarenhic.com/providers/pubs/nonphyguide.pdf>

Provider numbers (NPI, taxonomy, Medicaid)

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

<http://hmedata.com/>

<http://www.npidentify.com/wi/>

National CMS E/M Utilization Rates\

http://www.cms.hhs.gov/MedicareFeeforSvcPartsAB/04_MedicareUtilizationforPartB.asp

Also, www.donself.com and Frank Cohen

<http://www.cmpasupport.com/download/download.html> has these rates by specialty...if not on their website, they can send to you by specialty if you contact them directly.

If you struggle with the proper assignment of **V codes**, check out the V code table referred to below. This is an all-in-one resource that will guide you through the process of assigning V codes correctly as the payers do look at these closely to determine reimbursement and may deny it based on improper use of those codes. Check under general coding references on my website at www.tools4coding.com

If you struggle with **modifiers**, review the principles and try the links below.

- Also, keep in mind that there are two kinds of modifiers: CPT modifiers and HCPCS Level II modifiers. While HCPCS Level II modifiers can be appended to either CPT codes or HCPCS codes, CPT modifiers can only be appended to CPT codes and not to HCPCS codes.
- No modifiers should be appended to an unlisted procedure code.
- Laterality modifiers should only be appended to CPT procedure codes that reference a specific bilateral body part (e.g. eyes, ureters, etc.) only. For example, the integument system section has CPT codes that refer to multiple body parts including bilateral body parts such as ears, hands, feet, etc, but that is not the only type of body part listed in that code description so the use of the laterality modifiers would be inappropriate.
- Body-site specific modifiers such as the HCPCS Level II modifiers for the fingers and toes and eyelids or a specific body part (finger, toe, etc.) should only be appended to CPT codes that refer to that specific body part only. For example, the integument section has CPT codes that refer to multiple body parts such as fingers, eyelids, etc. but that is not the only type of body part listed in that code description so the use of the body-site specific modifiers would be inappropriate. Also, the finger and toe modifiers refer to the phalanges only, and not the metacarpals or metatarsals.
- Modifier 50 is to be reported with only one unit of a surgical code to represent a bilateral procedure; However, for most radiology codes, the code has to be reported twice with modifier LT and RT to represent a bilateral procedure. The likely rationale behind is this different rule for radiology codes is because there is no multiple procedure reduction applied to radiology codes. Remember that modifier -50 should not be assigned if the CPT procedure description includes the terms “bilateral” or “unilateral or bilateral.”
- Also, sequencing of modifiers can be confusing as well: the modifiers that directly affect the amount of reimbursement that will be provided on that CPT or HCPCS code should be listed first and all other modifiers should follow.
- One thing that is helpful when studying modifiers is to determine when they are needed for any particular billing situation/specialty or healthcare setting. For example, under the Hospital outpatient prospective payment system, there is a set list of modifiers that can be used. As another example, the genetic testing modifiers in Appendix I of the CPT coding manual by AMA are only for use on the molecular diagnostic and molecular cytogenetic codes in the Pathology and Laboratory section of CPT or with any related HCPCS Level II codes.
- Some limited guidance is provided in Appendix A of the CPT manual that is published by the American Medical Association (AMA); there is also a quick modifier guide sheet on the front cover. Also, the AMA puts out a popular book called *Coding with Modifiers* and it is a great official reference also.
- Special modifier -59 guidance
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>
<http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf> (report of inappropriate uses)
- Presentations on Hospital Outpatient Modifiers:
<http://campus.ahima.org/audio/2008/RB041708.pdf>

- Note: An updated list of modifiers approved for hospital outpatient use are at this link. <http://www.trailblazerhealth.com/Publications/Job%20Aid/ub-92.pdf>
Presentation on Physician and Specialty Modifiers:
- http://www.wpsmedicare.com/part_b/education/modifiers.shtml
- <http://www.rimedicare.org/provider/datanaly/modflow/default.htm> (decision trees)
- www.donself.com/documents/modifier-reference.doc (explains how to rank modifiers (pricing first, statistical second, informational third, etc.)
- https://www.cahabagba.com/part_b/education_and_outreach/general_billing_info/modifiers.htm (I like the way they group them based on category—really helps you to understand their uses for your particular billing situation, plus it specifies whether there is an effect on payment or not)
- <http://www.palmettogba.com/palmetto/providers.nsf/docsCat/Providers~Ohio%20Part%20B%20Carrier~Articles~Modifier%20Lookup?open> (another excellent modifier reference)
- <http://www.accuchecker.com/AccuLibrary/Articles/modifiergrid.asp>
- <http://health-information.advanceweb.com/common/editorial/editorial.aspx?CC=84815>
- Here are some links to a few modifier manuals:
<http://www.trailblazerhealth.com/Publications/Training%20Manual/Modifiers.pdf>
<http://www.medicarenhic.com/providers/pubs/Modifiers%20Guide.pdf>
<https://www.noridianmedicare.com/macj3b/train/presentations/modifiers.pdf>
- Here is the link to information about CCI edits
http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp#TopOfPage
- Here is the link to the CCI manual
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>
- Here is the link to the NCCI edits for physicians
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp?intNumPerPage=all&submit.x=20&submit.y=8&submit=Submit>
- Here is the link to the Outpatient Coding Editor (which includes the CCI edits except those related to anesthesia, E/M, mental health, and dermabond plus additional edits particular to outpatient billing)
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp?intNumPerPage=all&submit.x=18&submit.y=14&submit=Submit>
- These edits are updated quarterly so it is important to keep track of the changes to them. CMS posts changes or updates to the OCE and the latest changes effective 1/1/2008 are at this link www.cms.hhs.gov/transmittals/downloads/R1403CP.pdf; Frank Cohen, MPA has a website where he posts his analysis of the changes to the CCI edits every quarter. <http://www.cmpasupport.com/download/download.html>
- The Medically Unlikely Edits are now published
http://www.cms.hhs.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you struggle with using **HCPCS codes** whether stand-alone or in relation to CPT codes, refer to the information included below. Do keep in mind that some payers have their own special codes and/or modifiers that they have concocted for their specific need other than the HCPCS codes and modifiers.

Sometimes there are both CPT or HCPCS Level I codes and HCPCS Level II codes available for certain procedures. The question arises as to when to use the HCPCS Level II codes and when to use the CPT codes. The main thing that you have to identify is whether the two codes from the two code sets indeed describe exactly the same procedure. If the procedure description is exactly the same, then the general rule is that the HCPCS codes should be used for Medicare and the CPT code should be used for any other payer. If the HCPCS procedure description best describes the procedure, then the general rule is that the HCPCS code should be assigned regardless of the kind of payer. Of course, if the payer does not accept the HCPCS code and/or if there is no CPT code (either category I CPT or category III CPT) or HCPCS Level II code that best describes the procedure, service, or supply, then an unlisted code must be used and a detailed report must be submitted with that unlisted procedure code.

A special category of HCPCS codes that may have “equivalent” CPT codes for the same service is the G code category. These codes are also used a lot for preventative or screening services offered by Medicare. Here is a link that covers preventative services and proper use of the screening G codes and the other screening or preventative services HCPCS codes in more detail. Chapter 18 of the Medicare Claims Processing Manual as well as other publications in the MLN Matters catalog covers preventative services coding in more detail.

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

http://www.cms.hhs.gov/MLNProducts/downloads/gr_immun_bill.pdf

<http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf>

What is very helpful as you learn HCPCS codes is to group the HCPCS codes into categories based on the setting or specialty in which they are used the most. A good specialty handbook or coding manual or other educational reference tool would cover all the specific HCPCS Level II codes and modifiers that are frequently used just in that specialty or healthcare setting.

The most frequently assigned HCPCS codes in the outpatient setting include the J codes, the G codes, the C codes, A codes, Q codes, and the P codes. The C codes are often used for reporting supplies such as catheters and stents used in interventional procedures. In fact, the C codes are only applicable for use under Medicare’s hospital outpatient prospective payment system. Hospital Observation services are reported with only 2 G codes. The A and Q codes are often used to report contrast or radiopharmaceutical materials used in radiology testing and treatment. The P codes are often used to report blood product supplies and the J codes are used to report the supply of medicines, vaccinations, and other agents. A frequently asked question about J codes is how to bill them out when the amount of the medicine administered does not match the listed amount under the J code. The answer is on page 5 of chapter 17 of the Medicare Claims Processing Manual. <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> Basically what you do is round up: if the code says per 10 mg and the provider gave 18 mg, you assign two units of that code. And if the provider only gave 8 mg, you code one unit of that code. Also, remember that you cannot bill for the amount of any substance

that was wasted; only bill for what was used or for what remained after use, but had to be discarded. This guidance is on page 25-26, 74 of chapter 17 of the same manual referred to above.

Another frequently asked question is how to address a situation when a patient brings their own medication, but the physician administers the medication such as via an injection. The answer is to still code the J codes along with the appropriate CPT code(s) for the injection administration, but to also submit a \$0.00 dollar charge on the claim for the J code(s). If your billing system won't accept a \$0, put a \$0.01 (penny) charge.

For Durable Medical Equipment providers, there is a group of HCPCS codes just for them and the mnemonic that I use to remember those is “Beklev”—B, E, K, L, and V HCPCS codes are reported by DME providers only. If your provider is a licensed DME provider, then it is imperative to report a specific HCPCS code that describes the supply instead of the general HCPCS Level I code for supplies.

The D codes are actually the copyright of the American Dental Association and are used for reporting dental procedures only.

Some HCPCS codes are distinguished by the payer that recognizes them: for example, S and T codes are not recognized by Medicare but are recognized by Medicaid and other private insurers or commercial payers.

This is a link to an article that also covers HCPCS Level II codes: <http://health-information.advanceweb.com/common/editorial/editorial.aspx?CC=83319>

There is also a Coder's Desk Reference for Procedures (which explains CPT surgical codes) and a Coder's Desk Reference for HCPCS (which explains HCPCS codes); bear in mind that these references are not official sources of coding advice. The official authority on CPT is the AMA *CPT Assistant* and the official authority on HCPCS Level II for hospital outpatient reporting is the *AHA Coding Clinic for HCPCS*. Otherwise, there really is no official guidance for HCPCS Level II codes and their use would be based on individual payer policies.

Recall that the Professional Edition of CPT by the American Medical Association is the only CPT codebook with the official CPT guidelines included in it. In my experience, the Expert edition of HCPCS Level II by Ingenix seems to give very good guidance on each section of the HCPCS codes and proper usage thereof, however it is not official.

Unfortunately, CMS does not publish a “HCPCS Changes—An Insider View” like AMA does for CPT nor does it discuss the changes in AHA Coding Clinic for HCPCS as it does annually in the 4th qtr of AHA CC for ICD-9. However, the rationale for some changes are easy to interpret. HCPCS codes were originally created to represent services that CPT did not represent, and, while there are some HCPCS codes that represent services for which there are also CPT codes, in some cases, if there are new CPT codes

added that represent some services for which HCPCS codes had been created, sometimes, CMS chooses to delete those HCPCS codes.

For example, effective 1/1/2009, the following laparoscopic hernia repair HCPCS codes were deleted as result of new CPT codes that were added for these: S2075 Laparoscopy, surgical; repair, incisional or ventral hernia, S2076 Laparoscopy, surgical, repair, umbilical hernia. HCPCS codes G0308-G0327 which represented ESRD services were deleted because the new CPT code range for ESRD services was consistent with many of the old G codes for these services. For example, the old ESRD CPT codes did not represent the number of physician visits for the ESRD services such as the following HCPCS code did: G0319 End stage renal disease (ESRD) related services during the course of treatment, for patient twenty years of age and older; with 1 face-to-face physician visit per month. Therefore, when the information regarding the number of M.D. visits was included in the new CPT codes for these services, the HCPCS codes were deemed as no longer needed and were deleted. In addition, there were no CPT codes at all to represent home ESRD services, but when the CPT codes 90963-90966 were added, codes G0320-G0327 which represented ESRD services for home dialysis were no longer needed and were deleted.

HCPCS code additions are also related to changes to the CPT codes. One special addition to the HCPCS codes (effective 1/1/2009) resulted from changes to 4 CPT codes for treatment of pelvic bone fractures (27215-27218). The revision to these codes was done to indicate that the procedures were considered unilateral, thus clarifying that modifier -50 could be appended to these codes for additional payment (150% of the unilateral rate) if the treatment was done bilaterally. CMS did not agree with this change and thus created 4 new HCPCS codes similar to those 4 revised CPT codes (G0412-G0415); however, the HCPCS codes included the term “unilateral or bilateral” in the code description. Thus, Medicare will not render any additional payment for these procedures if they are done bilaterally. It is interesting to note how CMS analyzes the changes that the AMA makes and responds accordingly. When changes like this are made, the coder must take care to use the appropriate HCPCS codes for Medicare patients even though CPT codes for the exact same service may be available.

G0412	OPEN TREATMENT OF ILIAC SPINE(S), TUBEROSITY AVULSION, OR ILIAC WING FRACTURE(S), <u>UNILATERAL OR BILATERAL</u> FOR PELVIC BONE FRACTURE PATTERNS WHICH DO NOT DISRUPT THE PELVIC RING, INCLUDES INTERNAL FIXATION, WHEN PERFORMED	27215 Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), <u>unilateral</u> , for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed
G0413	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS THAT DISRUPT THE	27216 Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, <u>unilateral</u> (includes ilium, sacroiliac

	PELVIC RING, <u>UNILATERAL OR BILATERAL</u> (INCLUDES ILIUM, SACROILIAC JOINT AND/OR SACRUM)	joint and/or sacrum)
G0414	OPEN TREATMENT OF ANTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION FOR FRACTURE PATTERNS THAT DISRUPT THE PELVIC RING, <u>UNILATERAL OR BILATERAL</u> , INCLUDES INTERNAL FIXATION, WHEN PERFORMED (INCLUDES PUBIC SYMPHYSIS AND/OR SUPERIOR/INFERIOR RAMI)	27217 Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, <u>unilateral</u> , includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior ram)
G0415	OPEN TREATMENT OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS THAT DISRUPT THE PELVIC RING, <u>UNILATERAL OR BILATERAL</u> , INCLUDES INTERNAL FIXATION, WHEN PERFORMED (INCLUDES IPSILATERAL ILIUM, SACROILIAC JOINT AND/OR SACRUM)	27218 Open treatment of posterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, <u>unilateral</u> , includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum)

For billing of supplies or drugs (HCPCS Level II coding), try these official CMS links—they have the National Drug Code to HCPCS crosswalk as well as resources for supplies.
<https://www.dmepdac.com/> (general website)

<https://www.dmepdac.com/crosswalk/index.html>

(NDC crosswalk—now published by Noridian instead of Palmetto)

<http://www.fda.gov/cder/ndc/database/default.htm> (National Drug Codes)

<https://www.dmepdac.com/dmecsapp/do/search> (HCPCS code search database for supplies)

You might also check with the supplier, vendor, or the company who sells the products because they often offer coding advice for the particular product that they sell. Examples are Medtronic and Boston Scientific, two suppliers of medical devices that offer coding guidance for those products on their websites. Bear in mind, that you cannot just take their advice—you must also check the official coding references such as *AHA Coding Clinic for HCPCS* (if you are coding for hospital outpatient services), *CPT Assistant*, and the official CPT guidelines in the Professional Edition of CPT by the American Medical Association for guidance first. The above-referenced official guidelines or the guidelines given by the payer or insurance (especially CMS's guidance for drugs and supplies referenced above) trumps or overrules any guidance given by the company or supplier on how to code/bill for medical supplies represented by HCPCS Level II codes.

Remember that **HCPCS Level II codes are updated** quarterly (January, April, July, October) and both the updates and the full list of HCPCS codes are available on the CMS website.

Updates to C codes, G codes and other codes

http://www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#ToPofPage

Full HCPCS lists including the index and the Table of Drugs:

<http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp?intNumPerPage=all&submit.x=17&submit.y=2&submit=Submit>

HCPCS look-up site:

http://www.hipaaspace.com/Medical_Billing/Coding/Healthcare_Common_Procedure_Coding_System/HCPCS_Codes_Lookup.aspx

HCPCS Level I codes or CPT codes have a different schedule. Category I of the CPT codes are updated yearly in January, but category II and III of CPT are updated twice a year (January and July). Usually, after the annual update to the entire CPT books in January, additional Category III codes that did not make it in the CPT books as well as errata are also published.

July updates and CPT Errata are found at this website:

<http://www.ama-assn.org/ama/pub/category/3884.html>

Because CPT is copyrighted by the AMA, a full list of these codes is very hard to find due to the new CPT copyright restrictions. AMA itself did post the presentations from its November CPT synopsis, but the codes are not conveniently listed there, and this was not done in 2009. Ritecode.com is a very good site to check -- there is usually a free writeup on the new codes in there, but the list is not comprehensive. Accuro (CodeCorrect) usually provides a good list of all the changes, but that is available only to members. The Coder's Club at PMIC sends out free CPT and HCPCS updates to its members in mid-December, but these are designed for the members only probably according to a CPT user's license for the number of users and should not be distributed to others not in the club. Sometimes a vendor will send out a list also if you happen to be a customer/subscriber to their software products. But again, this is based on the fact that the vendor already has the CPT license for their customers and users and these lists should not be distributed to others. Some CMS carrier sites may list some of the codes with short descriptions but they are incomplete and don't include the revised codes. However, CMS has two files that do include all the updates CPT codes (with short descriptors) that are effective for the following year (2008) (with quarterly updates): the OPSS Addendum B code file and the Physician Fee Schedule (RVU) file.

The most updated hospital outpatient system file is at this link:

<http://www.cms.hhs.gov/apps/ama/license.asp?file=/hospitaloutpatientpps/downloads/OctAddB.09302008.zip>

In my opinion, this file is easier to follow than the physician fee schedule file as there is only one option for downloading once you unzip the folder and there is less clutter in the spreadsheet and you can focus on the CPT codes better.

The main link to check on updates to the hospital files is below. This file is updated quarterly and includes the updates from all the CPT and HCPCS categories just like the physician fee schedule file does. Pick Addendum B out of these files.

<http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp?intNumPerPage=all&submit.x=8&submit.y=11&submit=Submit>

The most updated RVU file is currently found at this link:

<http://tinyurl.com/3ybnnn>

Note: When you download the zipped files, the one that you will need to open will be called "PPRRVU09" and the excel spreadsheet icon above it will **not** have the alphabet 'a,' on it.

The main link to check on updates is below. Pick the highest level alphanumeric figure assigned to the file list for that year:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?intNumPerPage=all&submit.x=6&submit.y=10&submit=Submit>

The updated list of CPT codes with payment rates are also published in the OPSS Final Rule and the Physician Fee Schedule Final Regulation that comes out in the Federal Register in November of each year--one of which, is at this link:

http://www.access.gpo.gov/su_docs/fedreg/a071127c.html

To be informed of the latest proposed and final rules send an email to this address:

listserv@list.nih.gov leave the subject line blank, but add this info in the first line of the message body: subscribe HIPAA-REGS first-name last-name

This is a good site for looking up CPT codes and the associated RVUs.

https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp?checkXwho=done (this site does have a limit so here is a back-up site:

<http://www.fchp.org/Extranet/Providers/ProcedureCodeLookup/Index.aspx>)

The IT aspect:

Success stories of physician office EMR implementation

Look at the right hand column for additional information especially the tutorials section.

<http://www.centerforhit.org/x2107.xml>

It is recommended that any EHR be CCHIT-certified:

<http://www.aafp.org/online/en/home/publications/news/news-now/practice-management/20070925cchitcertguide.html>

Check out these AAFP articles on EMR's (look under the topic "computerization")

<http://www.aafp.org/online/en/home/publications/journals/fpm/indexes/index2007.html#8>

Additional EMR/software and other **practice management** info is here

<http://www.practicesupport.com/tools.php>

<http://www.elizabethwoodcock.com/resourceGuide.html>

Compliance:

OIG Workplan 2009

<http://www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf>

List of those that are OIG excluded

<http://exclusions.oig.hhs.gov/search.aspx>

Tamper resistant prescription pads—Medicaid regs

<http://www.nasmd.org/issues/TRPP.asp>

Physician Signature issues

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0829.pdf> (no rubber stamps)

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6100.pdf>

(not required for clinical lab fee schedule tests that are ordered)

State laws regarding copy fees

<http://www.lamblawoffice.com/medical-records-copying-charges.html>

State laws regarding co-signs w/ physician assistants (this updated only to Dec. 2006)

www.aanpa.org/memberarea/doc/cosignatures-per-state-dec06.doc