Effective Denials Management

Audio Seminar/ Webinar

April 16, 2009

Practical Tools for Seminar Learning
The American Health Information Management Association makes no representation or guarantee with respect to the contents herein and specifically disclaims any implied guarantee of suitability for any specific purpose. AHIMA has no liability or responsibility to any person or entity with respect to any loss or damage caused by the use of this audio seminar, including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this program. AHIMA makes no guarantee that the use of this program will prevent differences of opinion or disputes with Medicare or other third party payers as to the amount that will be paid to providers of service.

CPT® five digit codes, nomenclature, and other data are copyright 2009 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

As a provider of continuing education the American Health Information Management Association (AHIMA) must assure balance, independence, objectivity and scientific rigor in all of its endeavors. AHIMA is solely responsible for control of program objectives and content and the selection of presenters. All speakers and planning committee members are expected to disclose to the audience: (1) any significant financial interest or other relationships with the manufacturer(s) or provider(s) of any commercial product(s) or service(s) discussed in an educational presentation; (2) any significant financial interest or other relationship with any companies providing commercial support for the activity; and (3) if the presentation will include discussion of investigational or unlabeled uses of a product. The intent of this requirement is not to prevent a speaker with commercial affiliations from presenting, but rather to provide the participants with information from which they may make their own judgments.

The faculty has reported no vested interests or disclosures regarding this presentation.
Faculty

Melissa Ferron, RHIA, CCS

Melissa Ferron, RHIA, CCS, is principal of Melissa Ferron Healthcare Consulting, LLC, providing expertise on an array of services associated with coding, claims submission, and reimbursement. Ms. Ferron has several years of experience working with private payers in setting up their claims payment systems and contracts. In addition to providing direct consultation to hospitals, physicians and payers, she offers coding education through seminars and workshops, having previously established college courses.

Diana McWaid-Harraah, MS, RHIA, CCS

Diana McWaid-Harraah, MS, RHIA, CCS, is director of medical coding and revenue integrity at UCLA Medical Center in Los Angeles, CA, where she is responsible for supporting the revenue cycle operation by both ensuring the timely and complete coding for inpatient, emergency room, and all surgeries for both of UCLA's hospitals, and supporting the business office coding-related claim and denial issues. Previously, Ms. McWaid-Harraah was associate director for health information at Cedars-Sinai Medical Center. She has over 18 years of experience in the HIM field.
# Table of Contents

Disclaimer ................................................................................................................... .. i  
Faculty ...................................................................................................................... ... ii  
Objectives .................................................................................................................... . 1  
Agenda ....................................................................................................................... 1  
Important Topics Will Include: ........................................................................................ 2  
Life Cycle of a Claim ....................................................................................................... 2  
Comprehensive Denial Management Program ................................................................. 3  
Patient Encounter ........................................................................................................... 3  
Charges Entered ............................................................................................................ 4  
Coding ....................................................................................................................... . 4  
Examples of Chargemaster Coding. ................................................................................... 5  
Adjudication for Expected Reimbursement........................................................................ 5  
Editing and Correction of Claims ...................................................................................... 6  
Billing ...................................................................................................................... .. 6  
Reimbursement Methodologies ........................................................................................ 7  
Financial Responsibility ................................................................................................... 7  
Financial Risk Matrix/DOFR ............................................................................................. 8  
Managing Medicare Denials  
  Direct Data Entry (DDE) ................................................................................................. 9  
  “Claim Return Buffer” .................................................................................................... 9  
  T Status in DDE ................................................................................................................ 10  
  Denial Reason Codes ...................................................................................................... 10  
  MCE and I/OCE ............................................................................................................. 11  
  I/OCE Description of Edits/Claim Reasons Table ......................................................... 11  
  Medicare Rejection Reason Codes Examples .................................................................. 12  
Let’s Look at Some Specific Examples  
  CT Colonography ....................................................................................................... 13  
  Code V64.3 .................................................................................................................. 13  
  Per NGS LCD L25233 .................................................................................................... 14  
  Obesity/Bariatric Claims ................................................................................................. 14  
  Clarification of Payment Errors from CMS ................................................................. 15  
More Examples  
  Inpatient Psych .......................................................................................................... 16  
  Billing Blood Factors .................................................................................................... 16  
  Device Dependant Procedures ....................................................................................... 17  
  Radiopharmaceuticals ................................................................................................... 17  
  Medically Unlikely Edits (MUE) .................................................................................. 18  
Other Payer Issues  
  Understanding Payer Specific Guidelines ..................................................................... 19  
  Coding Clinic 3Q 2000, Volume 17, Number 3, Pages 13-15 ...................................... 19  
  Common Payer Concerns ............................................................................................. 20

(CONTINUED)
# Table of Contents

Screening vs. Diagnostic: A Patient's Perspective .................................................. 20
Managing Denials Related to Coding Practices ...................................................... 21

The Appeals Process
- Determining When to File An Appeal ............................................................. 22

Tracking Denials
- Tools for Tracking Denials ............................................................................. 23-24

Understanding the Role of the HIM Professional in Denials Management
- What Can You Do As An HIM Professional to Reduce Denials ?............... 25-26
- Business Office States - «You Coded This Wrong» - Now What ? ............. 26
- Additional Strategies ..................................................................................... 27

Resource/Reference List .................................................................................. 27

Audio Seminar Discussion ................................................................................. 28
Become an AHIMA Member Today ! .................................................................. 28
Audio Seminar Information Online .................................................................... 29
Upcoming Audio Seminars ................................................................................ 29
Thank You/Evaluation Form and CE Certificate (Web Address) ....................... 30

Appendix .......................................................................................................... 31
- Resource/Reference List ................................................................................ 32
- CE Certificate Instructions
Objectives

- Discuss the role of HIM in denials management
- Identify keys to successfully appealing denials
- Identify best practices for revenue cycle
- Explain the purpose of denials management in relation to revenue cycle management

Agenda

- Life Cycle of a Claim
- Payer Reimbursement Methodologies
- Specific Payer Issues
  - Medicare
  - Medicaid
  - Other Payer
- Claims Processing Edits
- Appeals Process
- Tracking Denials
Important Topics Will Include:

- Rejections vs. denials
- What is the DDE and T screen
- What are Error Reason Codes
- What are the MUE and MCE
- How to decipher the denial
- Working to correct the error on the claim
- Working with clinical departments and the CDM manager to correct the underlying issues and reduce denials
- Tracking and trending the rejections
- Successful appeals strategies for overturning denials

Life Cycle of a Claim

- Patient Encounter Created
- Services Rendered
- Charges Entered
- Coding
- Adjudication for Expected Reimbursement
- Editing and Correction of Claim
- Billing
- Collections and appeals
Comprehensive Denial Management Program

- Health Information Professionals are skilled at normalizing, tracking, trending and determining collectability of information.
- In the course of our leadership in HIM, we have worked with a number of clinical and non-clinical departments and understand the flow of information.
- This experience and training has prepared HIM professionals to be an integral part of a comprehensive denial management program.

Patient Encounter

- Demographic
  - Patient name as it appears on insurance card
  - Patient sex, birth date and guarantor
- Insurance Information
  - Correct payer verified
    - Methods of verifications include contacting the payer of record for benefits or utilizing a clearing house to validate eligibility
    - There may be lag times between the payer at the beginning of the months when patients switch insurance
  - Preauthorization
    - Will depend on the type of services being provided and the hospital contract
Charges Entered

- Charges are posted by clinical departments
  - Ancillary services will be charged by separate department, e.g. lab, radiology, etc
  - Office visits and procedural charges will be entered by the clinical service area
- CPT® coding may be linked to the charge by the charge master
- Late charge issues

Coding

- Soft Coding of CPT® and HCPCS
  - Codes are entered by the service area at the time of charge posting
  - Codes are entered by the Health Information Department through abstracting
- Hard Coding of CPT® and HCPCS
  - Codes are linked to the charge
  - Modifiers may be embedded
Examples of Chargemaster Coding

- Revenue codes
- CPT®/HCPCS
  - HCPCS S codes used for some payers
  - In some states, Medicaid specific coding
- Sometimes NDC codes
- Sometimes IDE #s
- General ledger coding
- Service Description
  - Room & Board for level of accommodation, ancillary services and other hospital department charges
- Used for all hospital bill types
  - About 100 categories with a total of about 700 detail codes

Adjudication for Expected Reimbursement

- The billing system calculates what the payment should be for each visit
  - Medicare expected reimbursement based on APC and MS-DRGs
  - Other Payers expected reimbursement is based on the modeling of each contract
    - Modeling is when the terms in contract are converted into coding terms
    - An example might be a lab visits paid at 80% of charges. The model might look at revenue codes or a range of CPT® codes to calculate the payment
**Editing and Correction of Claims**

- Providers may have an internal system or they may outsource the process of “scrubbing” claims.
- The purpose of a claims scrubber includes but not limited to reviewing the claim for:
  - Duplicate/ illogical/ invalid coding
  - Modifier requirements
  - Coverage determinations
  - Units for service
  - Missing CPT® or HCPCS

**Billing**

- Once a claim passes through the providers adjudication process and the claims scrubber it is ready to be submitted to the payer.
  - A claim may be rejected by a payer if their system cannot identify the subscriber or if a data element, e.g. HCPCS, is not in synch with their system requirements.
  - A claim may be accepted and paid or accepted and denied or partially paid/ denied.
Reimbursement Methodologies

- Medicare - APCs and MS-DRGs
- Medicaid - The various State programs have specific coding requirements, e.g. California has X, Z codes and S Diagnosis Codes
- Other Payers - Most pay pursuant to their contract with the hospital

Financial Responsibility

- When a patient is covered by an HMO, the financial responsibility for the hospital services may be assigned to the Health Plan or the IPA/Medical Group
- The financial responsibility is determined through what payers call a financial risk matrix or a DOFR (division of financial responsibility)
- Financial risk matrix determines which services are paid by whom
## Financial Risk Matrix/ DOFR

<table>
<thead>
<tr>
<th>Service</th>
<th>Health Plan Responsibility</th>
<th>IPA/ Medical Group Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visit</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

The services are defined by the coding on the claim, e.g. revenue code and/or CPT® codes

---

### Managing Medicare Denials
Direct Data Entry (DDE)

- The DDE is the process that allows remote users online connectivity to the Fiscal Intermediary Standard System (FISS)
- There are different statuses within DDE such as:
  - Suspended - S status (consideration for payment)
  - Return to Provider - T status (mail back for correction)
  - Rejected - R status (action depends on error - correct, send additional information or wait for denial)
  - Denial - D status (can only overturn with appeal)

Claim Return Buffer

<table>
<thead>
<tr>
<th>Claim Rejection</th>
<th>There are one or more edits present that cause the whole claim to be rejected. A claim rejection means that the provider can correct and resubmit the claim but cannot appeal the claim rejection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Denial</td>
<td>There are one or more edits present that cause the whole claim to be denied. A claim denial means that the provider cannot resubmit the claim but can appeal the claim denial.</td>
</tr>
<tr>
<td>Claim Return to Provider (RTP)</td>
<td>There are one or more edits present that cause the whole claim to be returned to the provider. A claim returned to the provider means that the provider can resubmit the claim once the problems are corrected.</td>
</tr>
<tr>
<td>Claim Suspension</td>
<td>There are one or more edits present that cause the whole claim to be suspended. A claim suspension means that the claim is not returned to the provider, but is not processed for payment until the FI makes a determination or obtains further information.</td>
</tr>
<tr>
<td>Line Item Rejection</td>
<td>There are one or more edits present that cause one or more individual line items to be rejected. A line item rejection means that the line item is denied but cannot be appealed.</td>
</tr>
<tr>
<td>Line Item Denials</td>
<td>There are one or more edits present that cause one or more individual line items to be denied. A line item denial means that the claim cannot be processed for payment with some line items denied for payment. The line item can not be resubmitted but can be appealed.</td>
</tr>
</tbody>
</table>
**T Status in DDE**

T Claim has reached final disposition with no reimbursement and has been returned to the Provider with billing errors.

This status allows on-line corrections to be made to a claim for the FI.

---

**Denial Reason Codes**

- Denial Reason terminologies are not standard across payers
- The Denial Reason does not always identify the “real” issue
  - Procedure code is experimental
    - What this really means is that the diagnosis does not substantiate medical necessity for the procedure
  - HCPCS invalid
    - What this may really mean is that the rev code is incorrect for the HCPCS code
MCE and I/OCE

- Medicare Code Editor (MCE)
- Integrated Outpatient Code Editor (I/OCE)
  - Standardized editing process that all hospital claims will be run through by their Fiscal Intermediary prior to payment
- The I/OCE performs three major functions:
  - Edit claims data to identify errors and return a series of edit flags; and
  - Assign an ambulatory payment classification (APC) number for each service covered under OPPS and return information to be used as input to the PRICER program.
  - Assign an Ambulatory Surgical Center (ASC) payment group for services on claims form Non-OPPS hospitals.

I/OCE Description of Edits/Claim Reasons Table

<table>
<thead>
<tr>
<th>Edit #</th>
<th>Description</th>
<th>Non-OPPS Hospitals</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Invalid diagnosis code</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>2</td>
<td>Diagnosis and age conflict</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>3</td>
<td>Diagnosis and sex conflict</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>4</td>
<td>Medicare secondary payer alert (v1.0 &lt; v1.1)</td>
<td></td>
<td>Suspend</td>
</tr>
<tr>
<td>5</td>
<td>E-diagnosis code cannot be used as principal diagnosis</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>6</td>
<td>Invalid procedure code</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>7</td>
<td>Procedure and sex conflict (Not activated)</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>8</td>
<td>Procedure and sex conflict</td>
<td>Y</td>
<td>RTP</td>
</tr>
<tr>
<td>9</td>
<td>Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion.</td>
<td>Y</td>
<td>Line item denial</td>
</tr>
<tr>
<td>10</td>
<td>Service submitted for denial (condition code 21)</td>
<td>Y</td>
<td>Claim denial</td>
</tr>
<tr>
<td>11</td>
<td>Service submitted for PIMAC review (condition code 20)</td>
<td>Y</td>
<td>Suspend</td>
</tr>
<tr>
<td>12</td>
<td>Questionable covered service</td>
<td>Y</td>
<td>Suspend</td>
</tr>
<tr>
<td>13</td>
<td>Separate payment for services is not provided by Medicare (v1.0 &lt; v0.3)</td>
<td>Y</td>
<td>Line item rejection</td>
</tr>
<tr>
<td>14</td>
<td>Code indicates a site of service not included in OPPS (v1.0 &lt; v0.3)</td>
<td>Y</td>
<td>Claim RTP</td>
</tr>
<tr>
<td>15</td>
<td>Service unit out of range for procedure</td>
<td>Y</td>
<td>RTP</td>
</tr>
</tbody>
</table>

Medicare Rejection Reason Codes
Examples

- ErrorCode **7C202** Description **HCPCS**
  - G0332 MAY ONLY BE BILLED WITH ONE UNIT PER DATE (AND) MUST BE BILLED WITH AN ADDITIONAL IVIG DRUG CODE (J1566 +/- OR J1567). NOTE: FOR DATES OF SERVICE ON OR AFTER JULY 1, 2007, IVIG DRUG CODE Q4087, Q4088, Q4091, OR Q4092 IS REQUIRED.

- ErrorCode **32404** Description
  - THE REVENUE CODE FILE INDICATES THAT A HCPC IS REQUIRED FOR THIS REVENUE CODE HOWEVER, THE HCPC THAT WAS ENTERED ON THE CLAIM IS NOT LOCATED ON MEDICARE'S FILE.

- ErrorCode **W7017** Description
  - EXTERNAL NARRATIVE: INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE

Let’s Look at Some Specific Examples
**CT Colonography**

**INDICATION:** Incomplete optical colonoscopy, polyps.

**CONCLUSION:** Extensive sigmoid diverticular disease in an otherwise negative colon examination.

What is the pt’s DX?

---

Would anyone code V64.3?

(V64.3: Procedure not carried out for other reasons)
**Per NGS LCD  L25233**

**ICD-9 Codes that Support Medical Necessity**

For the purposes of this LCD, ICD-9-CM code V64.3 indicates that the instrument colonoscopy has been attempted and was incomplete or when a board certified or board eligible gastroenterologist, a surgeon trained in endoscopy, or a physician with equivalent endoscopic training determined from an evaluation of the patient that optical colonoscopy can not be safely attempted. In addition to reporting ICD-9-CM code V64.3, one (or more) of the ICD-9-CM codes below must be reported in order to support medical necessity...

**Obesity/ Bariatric Claims**

**From CMS 4/ 28/ 06: Claims will be denied without an appropriate diagnosis code...and will be denied if 278.01 for morbid obesity is the principal diagnosis on an inpatient Medicare claim**

The AHA Coding Clinic for ICD-9-CM, 2Q 2003, Volume 20, Number 3, Pages 3-8 advises to assign ICD-9-CM 278.01 as the principal diagnosis for patients with morbid obesity admitted for gastric surgery.
Clarification of Payment Errors from CMS

• From CMS 4/27/07
  • Some claims not involving bariatric surgery are being denied in error; and
  • Some covered bariatric surgery claims are being held rather than paid.

More Examples...
**Inpatient Psych**

- IPF PPS claim has been submitted with revenue code 0901 but no procedure code 9427 is present. Please verify billing and if appropriate, correct.
  - Rev Code 0901 Electroshock therapy
  - Inpatient Medicare claims must have ICD-9 proc code 94.27

**Billing Blood Factors**

- DATES OF SERVICE GREATER THAN 12/31/05 and
  
  J7188, J7189, J7190, J7191, J7192, J7193, J7194, J7195, J7198 OR J7199;
  
  THEN DIAGNOSIS CODE 286.0, 286.1, 286.2, 286.3, 286.4, 286.5 OR 286.7 SHOULD BE PRESENT.

  On DDE: Please verify billing and if appropriate, correct. Online providers - PF9 to store the claim. Other providers - return to the intermediary.
Device Dependant Procedures

- Multiple edits for the device to procedure edits
- Multiple edits for the procedure to device edits
  - Complete listing of requirements located on the CMS website (see resource/reference list for link)

Radiopharmaceuticals

- Effective January 1, 2008, the OPPS implemented OCE edits that required hospitals to include a radiopharmaceutical HCPCS code when a separately payable nuclear medicine procedure is present on a claim. This has been challenging for these services since hospitals often provide the isotope days prior to the exam.
Medically Unlikely Edits (MUE)

- Dates of service on and after 01/01/07; it has been determined the units of service are in excess of the medically reasonable daily allowable frequency. The excess charges due to units of service greater than the maximum allowable may not be billed to the beneficiary and this provision can neither be waived nor subject to an advanced beneficiary notification (ABN). Please verify billing and if appropriate correct. On line providers - PR9 to store the claim. Other providers - Return to the intermediary.

Other Payer Issues
Understanding Payer Specific Guidelines

- HIM departments need to understand LCD and payer coding requirements
- They may not be aligned with the coding standards
- Flexibility in coding is needed
  - How many times have we heard “you can’t code differently for a payer”
  - See Coding Clinic 3Q 2000, Volume 17, Number 3, Pages 13-15 to see what Coding Clinic says about this

Coding Clinic 3Q 2000, Volume 17, Number 3, Pages 13-15

This Coding Clinic provides guidance on modifying coding guidelines to meet payer specific requirements.
**Common Payer Concerns**

- For Medicaid in California, code 73.59 manual assist for delivery for vaginal delivery claims
  - Using the X or Z codes for Medi-Cal
- Other payers may have:
  - No V codes as PDx
  - Using old versions of codes
  - Using only the first procedure to assign a case rate

**Screening vs. Diagnostic: A Patients Perspective**

- Patients will initiate requests to the Business Office to have the coding updated, e.g., mammogram or colonoscopy
  - A patient’s copayment and coverage may change if a services is screening versus diagnostic
  - In these cases the coding should be based on the physician’s documentation
Managing Denials Related to Coding Practices

In Summary:
- Develop policies and procedures for processing denials and rejections that are based on coding
- Develop policies and procedures for requests made to change codes that may originate from the physician or patient
- Always keep an audit trail as to why the codes were changed

The Appeals Process
Determining When to File An Appeal

- Timely Filing
- Level of Care
- Medical Necessity
- Underpayments

Tracking Denials
Tools for Tracking Denials

- When Collecting and Measuring Denials You Should Develop Your Tools With These Objectives In Mind:
  - Tracking, trending and collectability of claim denials for enabling root cause analysis
  - Allowing users to define and categorize denial codes
  - Create a denial hierarchy
  - Create a denial database
  - Analyze data against key performance indicators

Tools for Tracking Denials

- Claim Denial Spreadsheet
  - Reason for denial
  - Status for follow up
  - Identify services and areas responsible for the majority of denials
  - Show impact on net income
Tools for Tracking Denials

• **Departmental Dashboard**
  - Used to measure individual department against a benchmark
  - Compare individual departments against the organization as a whole
  - Trend success within a department

Tools for Tracking Denials

• **Denial Tracking By Payer**
  - Identify, quantify, and sort by carrier
  - Identify trends which are not “true” denials but stall tactics
  - Share specific examples with Managed Care/Contracting Departments
Understanding the Role of the HIM Professional in Denials Management

What Can You Do As An HIM Professional to Reduce Denials?

- Get involved with your Managed Care/Contracting Departments to assist with contract language and coding
- When you identify areas where the payers are not following coding guidelines, engage your Managed Care/Contracting Department to address with the payer
- If the problem with your FI, challenge them by initiating a provider inquiry and give them the justification of why they are incorrect
- Understand the differences with “Correct Coding” and “Administrative Policy” for a payer. Identify types of cases where the coding requirements conflict with standard coding methodology for a particular payer due to their administrative processing and see if the requirement can be incorporated into your coding policies, e.g. manual assist with delivery if the payer cannot/will not update their system
What Can You Do As An HIM Professional to Reduce Denials?

- Get involved with your Business Office and find out what types of issues they are seeing, related to coding, in the claims scrubber and on DDE’s T screen
- Assist with updating charge tickets for ancillary services to ensure diagnoses are updated
- Sign up for the listserv for your FI and CMS to keep current on changes in coverage decisions

Business Office States - “You Coded This Wrong”- Now What?

1. Have them send you the payers “reason for rejection/ denial”
2. Validate the coding for the claim
3. If the issue is related to a charge/ CPT® which was hard coded, engage the Charge Master Manager to correct the charge
4. Once validated work with Business Office and Managed Care to understand why the correct coding is being denied
   1. You may need to access the coverage information for the payer
   2. You need to be able to differentiate the nuances for the individual payer issues which are “administrative” issue within their adjudication systems versus a “coding” issue.
**Additional Strategies**

- Set up process for communication for “Claims with Coding Issues”
- Determine if it works better to designate one employee from your HIM department to receive and communicate change requests or to have multiple staff
- Once you see what issues there are in the scrubber, should HIM be responsible for handling all issues related to coding? Have that discussion between Business Office and HIM
- If a coding change is made on the claim, is the source system also updated to reflect the change?

---

**Resource/Reference List**

- ICD-9-CM Official Coding Guidelines for Coding and Reporting
  
- AHA Coding Clinics
- CMS, Table 4: Description of Edits/Claim Reasons
  
- 2009 - Device to Procedure Edits and Procedure to Device Edits
  
  [http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage)
Audio Seminar Discussion

Following today’s live seminar
Available to AHIMA members at
www.AHIMA.org

Click on Communities of Practice (CoP) - icon on top right
AHIMA Member ID number and password required - for members only

Join the Coding Community
from your Personal Page under Community Discussions,
choose the Audio Seminar Forum

You will be able to:
• Discuss seminar topics
• Network with other AHIMA members
• Enhance your learning experience

Become an AHIMA Member Today!

To learn more about becoming a member of AHIMA, please visit our website at ahima.org/membership to Join Now!
AHIMA Audio Seminars

Visit our Web site
http://campus.AHIMA.org
for information on the
2009 seminar schedule.
While online, you can also register
for seminars or order CDs,
pre-recorded Webcasts, and *MP3s of
past seminars.

*Select audio seminars only

Upcoming Seminars/Webinars

Procedure Coding for Skin Lesions and Lacerations
April 30, 2009

Auditing Your RAC Results: What It Means for Your Organization
May 7, 2009

Cardiac Catheterization: Successful Coding and Chargemaster Practices
May 21, 2009
Thank you for joining us today!

**Remember** – sign on to the AHIMA Audio Seminars Web site to complete your evaluation form and receive your CE Certificate online at:


Each person seeking CE credit must complete the sign-in form and evaluation in order to view and print their CE certificate.

Certificates will be awarded for AHIMA Continuing Education Credit.
Appendix

Resource/Reference List ........................................................................................................... 32
CE Certificate Instructions
Appendix

Resource/Reference List


http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage

To receive your 

**CE Certificate**

Please go to the AHIMA Web site


click on the link to

“**Sign In and Complete Online Evaluation**”

listed for this seminar.

You will be automatically linked to the 

CE certificate for this seminar after completing the evaluation.

*Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.*