Orthopedic Coder's Pink Sheet

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Essential news and guidance to solve your toughest specialty coding challenges

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IN THIS ISSUE

CEU APPROVED

CCI policy manual update

Include dislocations in multiple fracture treatment bundles in 2016

You'll need to be mindful about separately coding treatment of dislocations in addition to multiple fractures in the same hand or foot starting in January.

Medicare's National Correct Coding Initiative (CCI) policy manual has extended its multiple-fracture bundling policy to include dislocations starting Jan. 1.

Prior to this, the manual restricted practices to billing one code per cast when treating multiple closed fractures without manipulation, regardless of the number of closed fractures

*(see **CCI**, p. 5)*

Transition to ICD-10

Flesh out documentation to gain upper hand in ICD-10-CM coding

Open the lines of communication with your providers and let them know they may be leaving money on the table if you're one of the many practice facing persistent documentation challenges with ICD-10.

Chances are your coders aren't receiving the full detail they need to successfully code a patient encounter; 86% of practices don't receive all of the documentation they need to correctly

*(see **ICD-10-CM**, p. 7)*

Ask Margie

Use these Z codes for 1 year checkup on healed arthroplasty patient

***Question**: For patients who are seen one year after their total joint replacements, what ICD-10 code would you use for the visit? I'm looking at **Z09** (Encounter for follow-up examination after completed treatment, other than malignant neoplasm) or **Z47.1** (Aftercare following joint replacement surgery) with a code from the **Z96** category (Presence of other functional implants).*

Answer: You would report code Z09 and the appropriate Z96 code, for example: **Z96.651** (Presence of right artificial knee joint). Once the provider says the patient is healed, you stop using the aftercare healing code Z47.1.

For aftercare of bunionectomy, look at Z codes not seventh character

***Question:** For a bunion repair case, what is the correct way to code for suture removal in ICD-10? Should I use **Z48.02** (Encounter for removal of sutures) or the injury S code with a seventh character of D? Where is this written?*

Answer: It is in your ICD-10-CM manual, as well as in the official coding guidelines for ICD-10. If the bunion is the result of an injury, fracture or trauma, you would assign the appropriate S code with a seventh-character D. If that is not the case, report a code from the **Z47** range related to aftercare when stitches are removed.

CCI Version 22.0

Look for Medicare coding restrictions on new spine, hip X-ray codes

If you are billing Medicare for one of the new X-ray codes for the entire spine (**72081-72084**), don't expect to also get paid for codes for views of individual spinal regions (**72020-72080**). Thanks to a new batch of National Correct Coding Initiative (CCI) code pairs, you'll see denials for those regional X-rays.

A modifier will permit you to override the code pairs when warranted. However, you won't be able to use a modifier to unbundle when you bill for more than one of the new "entire spine" codes on the same claim. For example, code **72082** (Entire spine, two or three views) includes **72081** (One view), while code **72083** (Four or five views) includes **72081** and **72082** as components.

These changes were among the 57,000 new code pairs that take effect Jan. 1 as part of CCI Version 22.0.

CCI created another set of code pairs for the new hip and pelvis codes (**73501-73523**), bundling existing pelvis X-ray codes **72170** and **72190** as non-billable components. You may bill just one of the new hip and pelvis X-ray codes per day. For example, if you coded **73501** (Hip, unilateral, with pelvis) in addition to **73503** (Minimum of four views), only **73505** would be paid. Note that all of these code pairs have a "0" modifier indicator, meaning you cannot append a modifier to override them.

Note that the new pelvis and hip X-ray codes are themselves bundled components of code **20696** (Application of multiplane external bone fixation system on one arm or leg) and **20697** (Application of multiplane external bone fixation system). A modifier may be used to unbundle when appropriate.

CCI edits restrict codes for services billed for the same patient by the same provider on the same date. The code pairs are used by Medicare administrative to process your claims.

Here is a snapshot of other new code pairs that impact ortho practices in CCI Version 22.0:

- **No separate billing of new paravertebral block codes with musculoskeletal procedures.** Codes **64461** and **64463** are bundled into most if not all musculoskeletal codes with a "0" modifier indicator, meaning you may not append a modifier to unbundle the edits. New endovascular intracranial infusion code **61650** is also bundled into virtually all musculoskeletal codes, but a modifier will unbundle when appropriate.
- **Watch for new edits involving 20660** (Application of cranial tongs, caliper or stereotactic frame, including removal [separate procedure]). The code is now a bundled component of spinal fusion codes

22532-22533 and **22633**, as well as stereotactic head frame code **61800** and neuroelectrode implant add-on codes **61864** and **61868**. These edits will not permit you to use a modifier to override them. Note that code 20660 is a "separate procedure" code, meaning it is billable only when it is the lone service performed or unrelated to other services.

- **Percutaneous discectomy (62287) now includes tissue graft harvest** (**20926**), though a modifier will override the code pair.

- **Don't add vertebral excision to discectomy and kyphectomy procedures.** You'll need to address different areas of the spine to report these services separately. For example, kyphectomy codes **22818** and **22819** now include excision codes **22103** and **22116** as well as vertebral fracture treatment add-on code 22328. Also, percutaneous discectomy (**62287**) now includes lumbar vertebral excision (**22102**).

- **Look for new edits on lumbar spinal arthrodesis.** In particular, code **22586** (Arthrodesis, pre-sacral interbody technique) now includes components including spinal fusion (**22558**) and placement of spinal fixation (**22845**) and cage (**22851**).

- **You may report new Category III code 0396T (Intraoperative use of a kinetic balance sensor for knee replacement) with a knee arthroplasty code.** However, if you report it with any other type of knee or leg procedure, open or arthroscopic, only 0396T will get paid in may cases.

- **Lumbar neuroplasty (64714) now includes as components a number of leg procedures**, including decompression fasciotomy (**27496** and **27600-27610**), as well as tendon lesion removal (**27630**). The edits will permit you to use a modifier to override them, if appropriate.

- **You can't bill separately for debridement with adjacent tissue transfer.** Debridement codes **11000-11006** and **11042-11047** have been bundled in various combinations as components of adjacent tissue transfer codes **14000-14350**. The edits will allow you to unbundle to bill a separate debridement when it addresses a different body area. — *Laura Evans, CPC (levans@decisionhealth.com)*

Understanding E/M

Use of new clinical staff prolonged service codes should be infrequent

Two new E/M prolonged service codes added in the 2016 CPT manual allow you to report extended observation services provided by clinical staff in the office. However, the reimbursement is low and occasions when you would use the codes should be rare, say coding experts.

Medicare has awarded active status to add-on codes **99415** (Prolonged clinical staff service [the service beyond the typical service time] during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour [list separately in addition to code for outpatient Evaluation and Management service]) and **99416** (…; each additional 30 minutes [List separately in addition to code for prolonged service]).

On the physician fee schedule, the codes are priced at about $9 and 0.72 cents, respectively (all fees par, not adjusted for locality).

But because of strict time requirements and limited occasions for the codes' use, practices should not expect to report them often, observes Ann Silvia, CPC, CPMA at Reid Hospital in Richmond, Ind.

Codes report extended observation

The AMA CPT panel issued the codes because prior to this, "no codes existed to identify circumstances in which the physician's staff was required to provide effort beyond the typical time for circumstances that required observation," according to the book CPT Changes 2016 — An Insider's View.

Code 99415 is meant to be billed in conjunction with the physician's office or outpatient E/M code and may be reported with codes **99201-99215**, according to the CPT manual. You can't report the code with physician prolonged service codes **99354** and **99355**.

You would use the clinical staff prolonged service codes in cases when extended observation of the patient is required; for example, you've given the patient a new oral/injected medication or inhaled drug and you want to make sure the patient has no adverse effects in the first hours after ingestion, according to CPT Changes.

Such services don't require continuous face-to-face

monitoring by the physician or qualified health care professional. Instead, "the effort of observing the patient beyond the time ordinarily included within the E/M service is provided by the clinical staff," CPT Changes states.

For example, after a patient has received a nebulizer treatment, "it could take a long time observe," Silvia explains.

Spend at least 45 minutes to bill new codes

And to bill these codes, it will have to take a long time. As with other prolonged service codes, the clock doesn't start for code 99415 until the typical time for the primary E/M service has elapsed. For example, if you are reporting code 99214, prolonged services would not begin until after 25 minutes of face-to-face clinical staff time has been performed, the CPT manual states.

If you are reporting it after an infusion or nebulizer treatment, you can't bill a prolonged service code for the time it takes you to perform those services, warns coding consultant Betsy Nicoletti, CPC, president of Medical Practice Consulting in Northampton, Mass.

When observing patients after such treatments, you can count only the time the clinical staff member spent in the room providing face-to-face care with the patient; the nurse providing the service will have to carefully document time spent in the room. And if the time spent is than 45 minutes, you may not report a prolonged care code. Instead, clinical staff time would be included in the E/M service, the CPT manual states.

"I can see that it would be helpful on occasion," Silvia says, though how helpful "will depend on the specialty."

Other key points

- **A physician or qualified heath care professional must provide direct supervision**, i.e., be present in the office suite while the prolonged service is performed. The service cannot be performed in a facility, nor can a facility report the codes.
- **Codes 99415-99416 can't be reported for more than two simultaneous patients.**
- **You may report code 99415 just once a day for the same patient.**
- **Be prepared for Office of Inspector General (OIG) scrutiny.** The OIG is studying physician practices' use of prolonged service codes, according to OIG's 2016 Work Plan. "They feel that billing of prolonged care should be rare and unusual," says *OCPS* technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR.
- **Keep a close eye on National Correct Coding Initiative edits for 99415 and 99416.** In version 22.0, for example, if you report certain services such as blood draws (**36591** and **36592**), diagnostic tests (**90940**, **92531**, **92532** and **99172**), or psych services (**96150**-**96154**) on the same day andpatient as 99415, only the prolonged service code will be paid and you won't be able to append a modifier to override the edit. *(For more on CCI version 22.0, see p. 2.)* *— Laura Evans, CPC (levans@decisionhealth.com)*

Practice management

New DMEPOS fee schedule has some steep price cuts for your patients

CMS' new fee schedule for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) mandates steep price drops for some medical equipment — but may lead to availability issues as suppliers are driven out of competition.

For providers, that means some DMEPOS items on which patients previously couldn't afford the steep co-insurance will become financially viable options.

The DMEPOS competitive bidding program prompted the price cuts for several items, CMS announced Nov. 23 in the DMEPOS fee schedule. This program, which was preceded by a DME pilot in 2007 and expanded to its current form in 2011, puts pressure on DMEPOS vendors in pre-selected competitive bidding areas (CBAs) to lower their prices on a list of some common items, including power wheelchairs and enteral pumps. Starting in January 2016, CMS will begin nationalizing the lowered prices "based on a 50/50 blend of current rates and adjusted rates," with separate prices for sales in urban and rural districts.

Some new prices represent double-digit cuts. **K0823** (Power wheelchair rental, group 2 standard, captain's chair, patient weight capacity up to and including 300 pounds), previously pegged at $577.42, goes down to $430.87 in urban areas and $445.20 in rural areas — a 25% and 23% drop, respectively. **E0277** (Powered pressure-reducing air mattress) goes from $662.42 to $451.74 in urban areas and $463.70 in rural areas — a 32% and

30% cut, respectively.

Note that those are prices for the contiguous U.S.; prices in other states and territories vary.

The changes should save the Medicare program a little money, says Pamela Thompson, owner of Thompson & Associates, a practice management consultancy in Los Angeles. While Medicare's payments for DME is only 5% of its budget, "as the population ages, the need for DME will continue to rise, so evaluation of pricing and use of competitive bidding by CMS will help curb health care costs to some degree," she says.

This is obviously good news for some patients too as their 20% co-insurance will drop on these items. But it's hard on suppliers — particularly those who are in the CBAs, says Giles Canter, vice president of supplier Bryant Pharmacy & Supply in Anderson, S.C. Those suppliers must abide by their bid prices and are stuck in that situation until the next bidding round. Those who were not awarded contracts don't get to participate.

Expect distribution headaches

Long term, Canter believes suppliers will be affected by the downward pressure on prices, and some will be forced out of business. As that happens, some beneficiaries will be reliant on far-out-of-town suppliers — and delivery charges are not included in the CMS prices. "It's totally not true that beneficiaries will be ensured 'access to quality items and services'" as the CMS press release promises, says Canter. "They are not ensuring anything except headaches and roadblocks to access for the beneficiary."

The effect of these cuts has become a live political issue, especially in rural areas; Sen. John Thune, R.-S.D., has introduced a "DME Access and Stabilization Act of 2015," which medical equipment purchasing organization The VGM Group describes as a "competitive bidding relief bill" that would adjustment prices upwards in some jurisdictions "to address the challenge of serving large geographical areas."

Prices unaffected for physician-supplied DME

Prices on many common equipment pieces will remain unaffected. "The current competitive bidding initiative does not yet include items that, in my opinion, will heavily impact most private practice physicians who use DME as ancillary sources of income -- notably orthopedics and podiatry," says Thompson.

In any case, the Medicare provider's biggest DMEPOS concerns are left unaddressed, says Thompson. Paperwork remains onerous, and "competitive bidding does nothing to solve the work-flow problems DME presents to treating physicians, who usually receive no compensation for work required to determine the need for DME for a patient and prescribe the appropriate supply" when they get request from the DME supplier itself. — *Roy Edroso (redroso@decisionhealth.com)*

RESOURCE:

- Medicare fact sheet on DMEPOS fee schedule changes: *www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-11-23.html*

CCI

(continued from p. 1)

within the cast. The new rules have "added dislocation treatment, which now broadens the noncoding for closed treatment of a fracture or dislocation," explains *OCPS* technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR.

Now, "if multiple dislocations and/or fractures are treated without manipulation and stabilized with a single cast, strapping or splint, only one CPT code for closed dislocation or fracture treatment (without manipulation) may be reported," Chapter 4 of the policy manual states. Keep in mind that a cast does not have to be applied to fall under this new guideline.

That means you'll want to code dislocations the same as you do fractures. **Example:** "If a cast is applied without manipulation to treat fractures of multiple metatarsals of the same foot, only one unit of service of CPT code **28470** may be reported for that treatment," states the policy manual.

CCI also clarified billing protocol for code **20650** (Insertion of wire or pin with application of skeletal traction, including removal [separate procedure]), which "should not be reported for insertion of wires or pins without application of skeletal traction," according to the CCI policy manual.

With this, CMS is "further reminding that 20650 can't be used for positioning of the patient during surgery," notes Vaught.

Bill toenail treatments on separate toes

• **Report separate digits separately.** You can bill CPT code **11055** (Paring or cutting of benign hyperkeratotic lesion) with code **11720** (Debridement of nail[s] by any method; 1 to 5) as long as the two procedures are performed on different fingers. The two codes are bundled, but you can use modifier **59** to signal that they are distinct procedures.

"This means that if you are paring a callus on the right great toe near the nail area (11055), you can report 11720 with a modifier 59 if you are debriding the right second and third toes," explains Vaught. "But if you are paring a corm/callus of the right great toe near the nail area and also debriding that great toe nail you can only report the column-one code [11055]."

• **Follow size guidelines for lesion removal and repair.** Be careful how you report an intermediate or complex repair procedure following a lesion removal, advises the NCCI policy manual. Specifically, you should avoid reporting a repair code with lesion-excision codes **11400**, **11420** and **11440** when the lesion measures 0.5 cm or less. This batch of codes "includes simple, intermediate or complex repairs, which should not be reported separately," states the policy manual.

However, the new guidance allows you to report a repair code in addition to the lesion-removal code when the lesion or lesions is larger than 0.5 cm. "If more than one lesion is removed and one of those lesions is larger than 0.5 cm, an intermediate or complex repair may be reported, if performed, for a lesion larger than 0.5 cm," states the policy manual.

Also, don't let a small lesion dissuade you from reporting a repair code when other, larger lesions are also present. "Removal of one lesion smaller than 0.5 cm does not preclude also reporting an intermediate or complex repair for a larger lesion," states NCCI.

Add total minutes when unbundling timed codes

Make sure you are following Medicare rules for billing timed services such as therapy, CMS reminds in new rules added to Chapter 1 of the CCI policy manual.

The rules appear to apply only when CCI edits exist for a given pair of codes that are billed based on time and you plan to override the edit with modifier **59** (Distinct procedural service) to bill both codes on the same claim.

That means the CCI manual now includes the "eight minute rule" for timed codes that is spelled out in the Medicare Claims Processing Manual, 100-04, Chapter 5, Section 20.2. Instead of sequentially reporting 15-minute therapy codes such as **97112** (Neuromuscular reeducation) and **97036** (Hubbard tank), you'll need to add up the total time that therapeutic services were provided and report units of service based on that time, Chapter 1 of the manual now instructs.

For example, if you spent the minimum time of eight minutes doing neuromuscular education and eight

CCI's bundled fracture and dislocation policy at a glance

When coding multiple fractures and dislocations, consult this table to sort out the bundling policy in the 2016 version of the National Correct Coding Initiative Policy Manual, Chapter 4.

Services you performed:	What CCI says you can bill:
Multiple closed fracture treatments without manipulation, with application of a single cast, strapping, splint or no cast	One closed fracture treatment
One or more fractures with manipulation multiple fractures without manipulation, Application of a single cast, strapping or splint	Only the fractures treated with manipulation
Open or percutaneous treatment of a fracture and Closed fracture(s) without manipulation	Only the open or percutaneous reduction
Multiple dislocations or combinations of multiple closed fractures and dislocations treated without manipulation, Application of a single cast, strapping, splint or no cast	One code for closed fracture or dislocation treated without manipulation
One closed dislocation or fracture with manipulation multiple fractures and/or dislocations treated without manipulation, Application of a single cast, strapping, splint or no cast	One code for closed treatment with manipulation of the dislocation or fracture.
Open or percutaneous treatment of a dislocation and/or fracture, Closed dislocation and/or fracture treatment without manipulation	Codes for the open or percutaneous treatment(s)

Source: DecisionHealth analysis of CCI policy manual

minutes attending the patient in the tank, you would add the total time — 16 minutes — and report just one of the codes, not both, the CCI manual instructs.

Fortunately, only a few CCI edits are in place for therapy codes, so in most circumstances, you won't need to worry about it. But you will want to keep a close eye out for new therapy code pairs in the quarterly CCI updates. *— Laura Evans, CPC (levans@decisionhealth.com) and Richard Scott (rscott@decisionhealth.com)*

ICD-10-CM

(continued from p. 1)

code ICD-10, and four in 10 practices (39%) state they receive 70% or less of the detail they need to code successfully, according to a DecisionHealth survey assessing how practices are grappling with ICD-10.

The lack of documentation may be leading to extra work hours that coders and billers are clocking since the ICD-10 switch . But experts tell *OCPS* that you can take steps — focusing on communication first — to improve your documentation accuracy and keep the productivity lag to a minimum.

- **Make the financial argument.** "If the note doesn't meet standards, it is not coded nor billed," says Jody McIntyre, compliance officer and security officer with Arizona Community Surgeons in Tucson. That means improper or incomplete documentation is, in short, a fiscal drain.

Use transparent discussions with physician staff to reinforce the importance of complete documentation, urges McIntyre. "By including the providers in the process, with full disclosure of what a non-specific note means to the compliance outcome, they were more than willing to participate."

Sometimes this requires a delicate touch. "I have my coders communicate with the physicians they code for," explains McIntyre. "If my coders do not have great communication skills, then I step in."

- **Seek improvement, if not perfection.** "I'm not sure any provider has 100% [correct documentation] all the time. Everyone can improve," says Robin Hayes, CPC, CPMA, coding and reimbursement manager with MD Resource and Central Valley Family Physicians based in Forest, Va.

Routinely audit the provider's documentation to uncover specific areas that can be improved, suggests Hayes. "We started reviewing documentation long before the 'go live' date on Oct. 1," she says. But if you haven't audited any records yet, it's not too late to start. Have your staff be on the lookout for potential holes in your patient notes, such as the correct date of service, the complete patient diagnosis or other sixth- and seventh-character attributes.

- **Ease documentation stress for providers.** You can streamline the documentation process by building templates into your electronic health record (EHR) that

essentially serve as "check boxes," says Penny Sue, practice administrator of Century City (Calif.) Primary Care.

"The matter of documentation will always be a challenge," notes Sue. But you can take steps to ease the burden. Where possible, create templates in the EHR that can "automatically populate the info that their doctors need to cover," she advises.

You can build automation to denote laterality or other increased specificity you'd like to capture, notes Sue.

Added bonus: You can get a boost in physician quality reporting system (PQRS) and meaningful use requirements too. At Century City, for example, Sue's team developed a template for the PQRS preventive care objective, "which has all the measures they need to cover available for them to easily check the boxes and also includes the code that billers need to have to bill."

Another strategy is to create a quick-reference guide for your physicians that includes your most common diagnoses and a crosswalk from ICD-9 to ICD-10 codes. You can customize this superbill to your physician's preference, allowing for greater specificity that can improve your efficiency.

Ultimately, experts say that investing in shortcuts and pre-arranged templates is a smart move. "If I send them cheats in a grid format, easily readable, eye-catching and minimal verbiage, they respond much better," notes McIntyre.

Physicians report lost productivity

The switch to ICD-10 has taken a modest but perceptible toll on the productivity of physicians and non-physician practitioners (NPPs) as well as coding and billing staff. The DecisionHealth survey data show that the average physician and NPP is experiencing 10 hours of lost productivity per month or two-and-a-half hours per week.

Survey respondents cited a number of reasons driving the extra time, but two causes led the pack — unfamiliarity with the new code set (61%) and the need to create additional documentation (51%).

But the good news, as noted above, is that the leading causes are fixable. If you're finding change hard to come by, you may want to revisit the financial consequences, suggests McIntyre. "I hit them in the audit pocketbook. If they do not document well, they put themselves at risk." — *Richard Scott (rscott@decisionhealth.com)*

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