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

Transition to ICD-10
CMS: You'll be able to report lesser-specified I-10 codes until Oct. 1, 2016 1

Proposed 2016 Medicare physician fee schedule
CMS' incident-to plan: Bill under NPI of provider who supervises not initiates care 1

Getting paid
CMS proposes major overhaul to joint-replacement payment policy 2

Ask Margie
Check interpositional CMC arthroplasty technique to correctly code graft 3

Consider 2 ICD-10 codes for E/M and single knee injection on patient with bilateral OA 3

ICD-10 tip of the week
When doctor doesn't specify acute or chronic, use ICD-10 default rule 3

Teaching practices
Be specific about 'physically present,' 'immediately available' to avoid denials 4

TipSheet
Fracture code 7th character finder ..... Insert

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Transition to ICD-10

CMS: You'll be able to report lesser-specified I-10 codes until Oct. 1, 2016

Practices will have an additional year after ICD-10 implementation Oct. 1 to get their diagnosis coding exactly right as CMS and the AMA announced July 6 that a lack of code specificity will not cause claims denials for Part B providers.

But because the required level of specificity is not well defined and valid codes will be required, it's unclear how big of a break it will be.

*(see **ICD-10**, p. 5)*

Proposed 2016 Medicare physician fee schedule

CMS' incident-to plan: Bill under NPI of provider who supervises not initiates care

Practices that rely on non-physician practitioners (NPPs) and auxiliary medical staff may have to adapt to new processes if CMS goes through with proposed incident-to changes. The agency intends to tie billing to the supervising provider for incident-to services.

Medicare would revise incident-to rules to state the "physician or other practitioner who bills for incident-to services must also

*(see **Physician fee schedule**, p. 6)*

Getting paid

CMS proposes major overhaul to joint-replacement payment policy

You'll find financial risk and reward in a major hospital initiative that CMS proposed July 9 involving the post-operative care of patients who've undergone hip and knee replacement surgeries.

The proposed payment model — Comprehensive Care for Joint Replacement (CCJR) — would launch Jan. 1 and would retrospectively add or subtract to a hospital's current fee-for-service reimbursement level in the year following a patient's joint replacement surgery. The deciding factor will be how well the hospital managed the patient's post-acute costs.

The initiative targets high-volume procedures based on inpatient stays marked by MS-DRG 469 and 470, which primarily cover single-joint replacement procedures of the hip and knee. In 2013, the two joint-replacement MS-DRGs were associated with about 400,000 inpatient procedures and more than $7 billion in hospital costs, according to Medicare data.

Given the costs involved, CMS seeks "to hold hospitals accountable" for the patient's entire episode of care, the agency states in the proposed rule.

The rule and its potential ramifications amount to a "major sea change in reimbursement," says Tom Barber, M.D., chair of the council on advocacy with the American Academy of Orthopaedic Surgeons based in Rosemont, Ill.

For physicians, the CCJR initiative appears to create some opportunity and risk, says Barber. Providers can seek "to work with well-functioning hospital systems or hospitals to manage the [patient's] care appropriately — and if they do so, they can benefit economically." But those that don't "might lose money," warns Barber.

Managing a patient past discharge will be essential for ortho docs and their practices if they want to realize incentives, says Jonathan Pearce, CPA, FHFMA, principal of health care advisory firm Singletrack Analytics in Woodbury, N.J.

Prepare to see utilization data and get involved in analyzing post-acute providers, says Pearce. A common situation that Pearce sees is that the orthopedist is unaware of the patient's status or setting after discharge.

"A big key is that the data for post-acute institutional usage was never available," he says. With CCJR, that might change, as hospitals will likely seek to work with providers in a revised capacity. Pearce envisions hospitals approaching physicians with the following premise: "We can't make clinical decisions about your patients. But here's the data [on post-acute options]."

How the payment works and who's involved

The proposed rule stipulates that all hospitals, with limited exceptions, in 75 metropolitan areas will be required to participate in the CCJR model starting in 2016 (*see the Center for Medicare and Medicaid Innovation link on p. 3 for all required areas*). Hospitals already participating in the Bundled Payments for Care Improvement (BPCI) initiative, critical access hospitals, long-term care hospitals and children's hospitals will be excluded. Otherwise, "there's not an opt-out option," said a CMS official during a July 16 webinar on the CCJR proposed rule.

Participating hospitals will not be on the hook for decreased payments in the program's first year, meaning hospitals won't be penalized for not meeting target costs until 2017. However, all participating hospitals are eligible to receive bonus payments based on 2016 episodes of care.

If a patient's total Medicare Part A and Part B costs in the 90-day post-op period are less than Medicare's target costs, CMS will reimburse the hospital up to 20% of the target price in the following year, according to CMS officials. On the reverse side, hospitals would be required to repay CMS up to 20% of target prices if the cost of care comes in over the mark.

The rule states that hospitals should continue to bill for services under the current fee-for-service structure, while the value-based payment mechanism will be applied retroactively. "It's kind of an unusual arrangement," notes Barber.

CMS intends to provide a price target "for each participant hospital" based on three years of historical cost and utilization data, according to the proposed rule. In the first two years, CMS will base a hospital's target price for the 90-day episode on a blend of historical hospital-specific and regional costs — with two-thirds of the target price based on hospital-specific costs and one-third of the target price based on regional costs. Ultimately, the target price will transition to being fully regionally based.

Each episode of care will include all post-acute charges, including physician visits. The only exclusions

are events or exacerbations "unlikely to be related" to the surgery, note CMS officials. — *Richard Scott (rscott@decisionhealth.com)*

RESOURCES:

- Comprehensive Care for Joint Replacement Model, Center for Medicare and Medicaid Innovation: *http://innovation.cms.gov/initiatives/ccjr*
- Comprehensive Care for Joint Replacement proposed rule: *www.federalregister.gov/articles/2015/07/14/2015-17190/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals*

Ask Margie

Check interpositional CMC arthroplasty technique to correctly code graft

Question: *When coding an interpositional carpometacarpal (CMC) arthroplasty (**25447**), I read somewhere that you should code the graft as **20924** (Tendon graft, from a distance [e.g., palmaris, toe extensor, plantaris]). Is that correct?*

Answer: Coding of the graft will depend on the arthroplasty technique the hand surgeon documents, the AMA states (CPT Assistant, January 2005).

If the surgeon documents an excisional arthroplasty, with insertion of autograft as an interpositional spacer in place of resected bones and the tendon graft is harvested from a different site through a separate incision, the AMA states that you may report 20924 for the graft harvest. However, if the surgeon uses a local tendon such as the flexor carpi radialis (FCR) tendon or the abductor pollicis longus that is obtained through the same incision as the arthroplasty, that service would be included in code 25447, CPT Assistant states.

However, if your surgeon performed the more complicated suspension arthroplasty technique, where the FCR is accessed through a series of incisions in the forearm and then used to create a new intercarpal ligament between the first and second metacarpals, CPT Assistant directs you to report the FCR transfer using either code **26480** (Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon) or **25310** (Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon), as appropriate. "The transfer of the FCR to the base of the first metacarpal is not part of the basic first CMC arthroplasty procedure and must be coded in addition to 25447," CPT Assistant states.

Consider 2 ICD-10 codes for E/M and single knee injection on patient with bilateral OA

Question: *With ICD-10 we have bilateral diagnosis codes for some conditions, including osteoarthritis. But what happens if we have a patient with a confirmed diagnosis of bilateral osteoarthritis of the knee who is receiving an injection for the left knee only in addition to an office visit? Would we still use the bilateral diagnosis code?*

Answer: Your point is a good one. You might want to report two codes, one for each of the two services. For example, assign code **M17.0** (Bilateral primary osteoarthritis of knee) to the E/M service and **M17.12** (Unilateral primary osteoarthritis, left knee) for the left knee injection (**20610-LT**).

Ultimately, though, correct coding for situations like this will come down to individual payer and carrier policies, so don't forget to query them.

ICD-10 tip of the week

When doctor doesn't specify acute or chronic, use ICD-10 default rule

In cases where you don't know whether a condition is acute or chronic and you can't query the doctor to determine the details, use this solution for locating the most appropriate code, care of the ICD-10 coding guidelines.

Your first step is always to check with the provider, explains *OCPS* technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR. But when that isn't possible, you should use the I-10 default rule to select the correct code.

Look up the condition in the ICD-10 alphabetical index. There you'll find a code listed next to a main term for the condition. That's the default code for the condition.

"The default code represents that condition that is most commonly associated with the main term or is the unspecified code for the condition," explain the ICD-10 Official Guidelines for Coding and Reporting. "If a condition is documented in a medical record (for example,

appendicitis) without any additional information, such as acute or chronic, the default code should be assigned."

When you look up appendicitis, for example, you are directed to **K37** (Unspecified appendicitis).

In a more typical orthopedic scenario, the physician documents that the patient has a bucket-handle meniscus tear without specifying whether it is acute or chronic, then leaves for extended sabbatical.

No problem. Look up "tear" in the ICD-10 index and under that "meniscus" and then "bucket-handle." You are referred to default code for current injury as it states tear (acute); meniscus (current) — the condition defaults to acute.

You'll still want to look in the tabular section to code for other details, such as whether it was a medial versus lateral meniscus, right or left knee and whether the encounter was for initial care, follow up or a late effect. — *Laura Evans, CPC (levans@decisionhealth.com)*

Teaching practices

Be specific about 'physically present,' 'immediately available' to avoid denials

Make sure your physicians provide detailed notes when they supervise residents at the hospital, as sloppy and scanty documentation can lead to contractor challenges — and worse.

It's no secret that attending physicians can be harried, and one of the more common ways for them to cut corners is in their teaching physician notes. "Doctors forget because they get so busy," says Lori-Lynne A. Webb, a coding consultant in Melba, Idaho. "So on the coder side, you have to be diligent about asking the doctor for the documentation."

Bad documentation can have serious consequences in these teaching-physician cases. "I've been involved in a number of cases" related to teaching physicians' notes, says Harry Nelson, a partner with the Nelson Hardiman law firm in Los Angeles. He sees "a widespread practice of documenting supervision that often consisted of nothing more than signing off on what the resident did independently."

It gets worse: "For example, in one case, a woman presented to the hospital with symptoms of chest pain and elevated levels of troponin, indicating a possible heart attack," says Nelson. "The resident evaluated her and sent her home on his own, while writing 'discussed and confirmed recommendation with attending.' In fact, there had been no such discussion; the resident knew that this attending cardiologist did not want to be bothered and in the past had told him to handle straightforward cases all by himself. The woman came back a few hours later with more severe symptoms of a heart attack, and it was clear that sending her home had been a mistake."

Show you did the work

Even if it doesn't blow up like that, experts acknowledge that "reviewed, discussed and agreed" notes won't do for E/M work. The teaching physician's documentation "should reflect the analysis of the patient's condition" at the level required to make the claim, Nelson says.

For example, teaching physicians should document involvement in as many elements as the claimed service requires — that is, two of three or three of three elements of history, exam and medical decision-making for established patients and all three for new ones. If the resident does two and the teaching physician actively participates in only one, the claim may be questioned, says Kelly Berge, online chair at the Berkeley College School of Health Studies in Clifton, N.J.

Keep your terms straight

Key phrases document the presence of the teaching physician in notes and should be consistent, says Doris Branker, president of DB Healthcare Consulting & Education in Fort Lauderdale, Fla. For example:

Physically present — The teaching physician is located in the same room — or in the partitioned or curtained area, if the room is subdivided to accommodate multiple patients — as the patient and/or performs a face-to-face service.

Immediately available — The teaching physician is within a distance that allows him or her to return to the surgical suite immediately if needed.

Critical or key portion — The part or parts of a service that the teaching physician determines is or are a critical or key portion(s).

In procedures, a good rule of thumb is that the doctor should attest that "I was physically present for the critical and key portions and immediately available for the whole procedure." When a procedure is five

minutes or fewer, the physician must be physically present throughout and continuously or she can't report it, Branker adds.

You don't need to spell out what portions are "key and critical" because no good official measurement of the term exists. "It's still a fluffy gray cloud," says Webb.

One thing auditors are very clear on, though, is "immediately available," to which physicians often give a liberal interpretation. "Sometimes physicians claim they were immediately available, and it turns out they'd gone to lunch," Branker says. "Your hospital may require that the teaching physician be on call and available, say, within 30 minutes — but that's not the same as what the government requires. In anesthesia for obstetrics, patients can be in labor for hours. Doctors may say, 'they have my pager, I can be back in 15 minutes,' but that's not immediately available."

Should it come to an investigation, your physician's access trail may be tracked by his or her IP address if he attested remotely, which would blow any "immediately available" claim, Branker points out.

Beware unmodified macros

Teaching physicians need to beware of cloned or cloned-looking notes. The hospital electronic health records may populate fields in a way auditors find suspiciously generic. For example, a macro or template for an anesthesiologist might say, "present for all key and critical elements and immediately available to furnish services including, if applicable, Swan-Ganz, central line, etc." If the physician leaves it unedited, it could be problematic, Branker says.

"The auditor could question it because information within the record that is customized to the patient would not include this statement when the patient did not have those ancillary services performed," says Branker.

Watch your modifiers, time

While teaching physicians generally add the **GC** modifier (Service has been performed in part by a resident under the direction of a teaching physician) to claims for services they supervise, they may overlook the coding change they have to make when they do a procedure on the hospital floor by themselves — or with a non-resident colleague.

When an attending who's been doing teaching physician claims finds herself without a resident on the floor, needs assistance on a procedure, pulls an M.D. colleague in and then puts the claim in with two providers, they should remember that the GC no longer applies. An assistant-at-surgery modifier, such as **82** (Assistant at surgery when a qualified resident surgeon is not available to assist the primary surgeon), should be used, says Berge.

Also, be aware that certain types of procedures and work-sharing require tweaks to the claims. For example, with timed critical care E/M services, if the resident stabilizes the patient and the physician follows up, the physician can't claim his or her own time toward the critical care E/M. — *Roy Edroso (redroso@decisionhealth.com)*

RESOURCE:

- Medicare Claims Processing Manual (100-04) Chapter 12, section 100: *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*

ICD-10

(continued from p. 1)

Medicare administrative contractors (MACs) and recovery auditors (RACs) will be instructed not to deny claims "through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code, as long as the physician/practitioner used a valid code from the right family," according to guidance in the form of frequently asked questions (FAQs) that accompanied the announcement.

CMS and AMA stress that ICD-10 codes will still be required starting Oct. 1.

Practices will get more leeway, but it looks like you'll still be on the hook for including all the characters required by ICD-10 for valid coding, coding experts point out.

Keep in mind that CMS says a practitioner must use "a valid code from the right family." For injury, fracture or trauma codes, a code must have seven characters to be valid, explains *OCPS* technical adviser Margie Scalley Vaught, CPC, CPC-H, CCS-P, ACS-EM, ACS-OR.

In effect, you might be able to report an other/unspecified ICD-10 code, but you'll still have to assign a seventh character (e.g., "A" for initial encounter or "D" for subsequent encounter) for the code to be valid.

For example, it seems that during the grace period, CMS will accept **S42.001A** (Fracture of unspecified part

of right clavicle, initial encounter for closed fracture) as opposed to the more specific **S42.011A** (Anterior displaced fracture of sternal end of right clavicle, initial encounter for closed fracture).

For certain codes, you will also have to include "placeholder Xs" to ensure that the seventh character appears in the seventh place of the code, she adds.

Unclear definition of family for ICD codes

How specific codes need to be to avoid denials is unclear as "family" is not an appropriate term for ICD codes — the preferred nomenclature is "category" or "subcategory," explains Betsy Nicoletti, CPC, president, Medical Practice Consulting in Northampton, Mass. "Family" is a term used with CPT codes.

By "code family" CMS appears to mean the three-digit code category headings for codes, Vaught says. For example, **M16** is the heading for all the codes for osteoarthritis of the hip, while **M17** codes would describe all osteoarthritis of the knee and **S42.0** describes clavicle fractures, she says. But CMS was not clear in the announcement and has not responded to inquiries from *OCPS* sister publication *Part B News*.

An ICD-10 "grace period" for providers has been the subject of some recent Congressional bills as well as an AMA House of Delegates resolution passed June 8.

The CMS and AMA guidance also applies to the Physician Quality Reporting System (PQRS), value-based modifier and meaningful use stage 2. Contractors will not assess penalties based on ICD-10 code use in reporting, nor will they deny eligible providers' (EPs') informal review requests, so long as "a valid code from the right family" is used, the right number and type of measures in appropriate domains have been submitted for the specified number/percentage of patients and the errors are related only to the specificity of the ICD-10 diagnosis code, according to the FAQs.

If Medicare contractors have trouble processing claims as a result of ICD-10 issues, "an advance payment may be available" if the claim is otherwise valid, pending submission of a request by the provider to the appropriate MAC. The usual conditions, described in 42 CFR Section 421.214, must be met.

CMS says it will set up "a communication and collaboration center" with an "ICD-10 ombudsman to help receive and triage physician and provider issues" and promises further guidance on these issues closer to Oct. 1, including a National Provider Call scheduled for Aug. 27.

Mixed opinions on the policy

Industry leaders seem encouraged by the move, though not completely satisfied. The policy doesn't address the dilemma of practices that haven't been able to upgrade or replace billing software because of financial or vendor issues, says Robert Tennant, senior policy adviser for the Medical Group Management Association (MGMA) in Washington, D.C.

CMS' plan to establish an ICD-10 ombudsman to assist providers could help, but "the team supporting the ombudsman has to know about coding and billing cycles," cautions Carolyn Hartley, CEO of Physicians EHR Inc. in Cary, N.C., and a noted ICD-10 expert.

"I think the announcement will likely ease the transition, as it will give physicians the perception that the AMA has 'won' something for them and that it won't be as bad as they originally feared," says Minnette Terlep, business development/chief compliance officer for Amphion Medical in Madison, Wis. "It will hopefully remove the opposition from the AMA and other physician societies and let ICD-10 go through as planned. However, it does not let physicians off the hook from submitting valid codes."

If you're part of a health system that has other types of providers, take note: This announcement is "focused on physicians and other practitioners who bill under the physician fee schedule" and does not apply to Plan A providers, a CMS official explained to *OCPS* sister publication *Home Health Line*. — *Roy Edroso (redroso@decisionhealth.com)*

RESOURCE:

- CMS and AMA Guidance document: *https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf?utm_source=HOPPS+Newsletter+07-07-2015&utm_campaign=ICD-10-CN&utm_medium=email*

Physician fee schedule

(continued from p. 1)

be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident-to services," according to the proposed rule released July 8. Medicare also would delete a sentence from the regulation that says the provider supervising the auxiliary personnel who perform the incident-to services "need not be the same physician (or other practitioner)

upon whose professional service the incident-to service is based."

That means NPPs would bill incident-to services not under the physician who initiated the care but under the national provider identifier (NPI) of the physician who is in the office at the time of the NPP's service.

"Currently, some offices just bill incident-to services under the first doctor that was seen," says Jennifer Searfoss, president, SCG Health in Ashburn, Va. "Others, those that I personally feel are more compliant, bill under the physician(s) who is/are onsite."

Practices can run into trouble when some physicians insist the practice bill a patient visit incident to his name, even when he isn't in the office, says Ann Silvia, CPC, compliance auditing and education, Reid Physician Associates, Richmond, Ind. "[CMS] has known for a long time there's a problem [with incident-to billing], so I'm not surprised they're trying to address it."

The difference in whether the services are billed incident to a physician's care or directly by an NPP is in the practice's reimbursement. Medicare pays services performed incident to a physician's work at 100%; NPP services billed directly are paid at 85%.

The proposed rule would also explicitly prohibit billing services incident to another physician or NPP when they're performed by people who have been excluded or lost their enrollment for any reason, CMS says. Since the start of 2015, seven medical providers have entered settlements that stemmed from the employment of excluded nurses.

Unequal phase-in of big RVU reductions

If a service you perform is facing a relative value unit (RVU) reduction of 20% or more, you could see most of the pain in the first year.

CMS proposes that when the value of RVUs drops by 20% or more, practices would see a 19% reduction in the first year and the balance of the cut in the second year, according to the proposed 2016 Medicare physician fee schedule.

In its example of splitting the larger cuts evenly, CMS says a service facing a 19% reduction would have the entire cut imposed in the first year, while a service facing a 20% cut would see a 10% cut one year and a 10% cut the next year.

The phased-in approach to big RVU cuts applies only when the code is not changed, as specified by the Protecting Access to Medicare Act (PAMA).

CMS also proposes to apply the phase-in only to those components of a code that are impacted by the reduction of more than 20%. In other words, if an RVU reduction to a code would be 22% in the office setting but only 13% in the facility setting, the office reduction would be phased in at 19% in the first year and 3% in the second year while the entire facility reduction would be implemented in the first year.

The same principle would apply to technical and professional components of a service, which could result in scenarios where the reduction to one component is implemented fully in the first year, while the other component is phased in over two years.

CMS makes changes to PQRS

The proposed rule changes measures for the Physician Quality Reporting System (PQRS) and starts on the Merit-based Incentive Payment System (MIPS). PQRS will remain up and running until 2018, but Medicare is seeking comment on the shape of MIPS, the all-in-one quality program that will combine quality reporting, value-based payment modifier and meaningful use.

Under the proposed rule, the basic requirements for PQRS participation will stay the same — a provider will report nine measures, including one cross-cutting measure, across three national quality strategy domains. But don't assume the quality measures you reported this year will be available in 2016. Medicare intends to delete 12 individual measures, add 45 individual measures including four cross-cutting measures and shift reporting methods and national quality domains for another 18. You'll also see three new measures groups if Medicare's proposed rule remains unchanged.

The proposed rule opens the door to comments on the shape of MIPS. For example, CMS proposes that for the first two years of the program, the value modifier would apply only to physicians, nurse practitioners, physician assistants, certified registered nurse anesthetists and certified nurse specialists. Providers such as physical therapists and anesthesia assistants would not be subject to a pay cut.

New payment for advance care planning

Providers could receive payment for providing end-of-life planning using two CPT codes:

99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member[s] and/or surrogate).

99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; each additional 30 minutes [List separately in addition to code for primary procedure]). — *Julia Kyles, CPC-A (jkyles@decisionhealth.com), Roy Edroso (redroso@decisionhealth.com), Scott Kraft (pbnfeedback@decisionhealth.com)*

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