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Meet the Presenter…

Jeffrey Restuccio,
CPC, COC, MBA

On the topic:
Revenue Maximizing Tips and Techniques
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CPT® is a registered trademark of the American Medical Association.
Maximizing Revenue through Accurate Coding, Billing, Documentation, and Compliance

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Ranking of Guidelines (CPT™ Concepts)

- State Regulations
- State Boards
- Medicaid Guidelines
- Private Payor Guidelines
- **Medicare Guidelines**
- General CPT Concepts – AMA Guidelines

If Medicare guidelines disagree with AMA CPT guidelines who do you go with?
TIP$: Using Time: Encounter Dominated by Counseling or Coordination of Care

- Always document two times:
  1. Total time
  2. Counseling time (> 50% of total)

- Always something unique to the patient and this individual encounter on this Date of Service (DOS) in your notes.

- Don’t copy the exact same note from date to date or patient to patient. That is a “cloned note.”

- Don’t just document:
  - We discussed risks . . . (what specific risks?)
  - We discussed options . . . (what specific options?)
  - We discussed medications (List medications)

History and Exam elements are no longer necessary or considered. Do not document all of them.

3

TIP$: Special Codes: 99050

- 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service. Medicare does not pay on this service.

Report both codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>1</td>
</tr>
<tr>
<td>99050</td>
<td>1</td>
</tr>
</tbody>
</table>
**TIPS: Special Codes: 99058**

- 99058: Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service. Not paid by Medicare.
- Can a carrier request you not bill their patients this code?

| Report both codes: |  
|-------------------|---|
| 99214             | 1 |
| 99058             | 1 |

**TIPS I Get Paid; You Don’t Get Paid**

- I’ve conducted well over 365 live seminars in over 50 different cities.
- What I’ve learned.
  - First, learn the basics
  - Then learn all the exceptions (aka, Carrier-Specific Rules).
  - But this is something different: Sometimes you are denied for no reason at all; and/or you get bad advice from the carrier representative.

- WDIC?
### TIP$ Consultation Codes

- Do you report these?
- Medicare has not accepted them for many years but some private carriers may still accept them.
- They typically pay higher than office E & M Codes. There are no Medicare RVU’s for these codes.

<table>
<thead>
<tr>
<th>Office Visit Code</th>
<th>Consultation Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212/99202</td>
<td>99242</td>
</tr>
<tr>
<td>99213/99203</td>
<td>99243</td>
</tr>
<tr>
<td>99214/99204</td>
<td>99244</td>
</tr>
<tr>
<td>99215/99205</td>
<td>99245</td>
</tr>
</tbody>
</table>

### TIP$ Medical Decision Making

- This is the gating factor on all E & M encounters; it is not history or exam.
- Most EMR’s do not calculate MDM.
- Many auditors use a scoring system developed by the Marshfield Clinic. I will be happy to send it to you.
- The easiest, quickest way to confirm moderate MDM (is three chronic illnesses such as:
  - Diabetes, HTN, COPD.
- But there is much more to the scoring system.
- It’s worth an hour or two training the Providers.
MDM Tables

Table A or 1
Diagnoses and Management Options
Number of Illnesses
Status: stable, worsening, improving, New today or chronic

Table B or 2
Data Reviewed
Diagnostic Tests
Reviewing data or history from other providers.

Table C or 3
Table of Risk
Further divided into 3 columns:
1) Presenting Problem(s)
2) Diagnostic Procedures Ordered
3) Management Options Selected

Only two of the three components need to be at a given level. Sometimes you will see these listed as Tables 1, 2 and 3

Tip$ Relative Value Units (RVU’s)

- All reimbursable procedures/services have an RVU value.
- These are established by Medicare and determine your Fee Schedule.
- E & M codes, surgical procedures, diagnostics, labs, radiology.
- Small procedures have low RVU
- Large procedures have high RVU’s
- Determines your reimbursement.
- Coding specialty manuals
- List CPT™ codes in decreasing RVU value.
- Not in the CPT™ manual.
**RVU’s 2019 (Atlanta GA)**

<table>
<thead>
<tr>
<th>E &amp; M</th>
<th>Total RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>2.15</td>
</tr>
<tr>
<td>99203</td>
<td>3.05</td>
</tr>
<tr>
<td>99204</td>
<td>4.63</td>
</tr>
<tr>
<td>99205</td>
<td>5.82</td>
</tr>
<tr>
<td>99212</td>
<td>1.27</td>
</tr>
<tr>
<td>99213</td>
<td>2.09</td>
</tr>
<tr>
<td>99214</td>
<td>3.06</td>
</tr>
<tr>
<td>99215</td>
<td>4.10</td>
</tr>
</tbody>
</table>

**Medicare Allowable 2019 (Atlanta GA)**

CF: $36.04

<table>
<thead>
<tr>
<th>E &amp; M</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>$77.61</td>
</tr>
<tr>
<td>99203</td>
<td>$110.20</td>
</tr>
<tr>
<td>99204</td>
<td>$167.31</td>
</tr>
<tr>
<td>99205</td>
<td>$210.35</td>
</tr>
<tr>
<td>99212</td>
<td>$44.65</td>
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<tr>
<td>99213</td>
<td>$74.20</td>
</tr>
<tr>
<td>99214</td>
<td>$110.44</td>
</tr>
<tr>
<td>99215</td>
<td>$147.72</td>
</tr>
</tbody>
</table>
TIP$ Setting Fees

- Most clinics calculate their fee schedule as 130%, 150% or 200% of the Medicare allowable.
- The CY 2019 proposed MPFS conversion factor is $36.04.
- WDIC? Most clinics don’t review their fee schedule pricing every year. For one, it should map to the Medicare RVU’s; second, the amounts you establish will impact both your self-pay patients and conversely your highest reimbursement carriers. Many private carriers post their own fee schedules.

Tip$ Medical Necessity

- There is always a one-to-one linking of the ICD-10 code to the CPT™ procedure code or E & M code. If two codes are required, link both in Box 24E.
- Sometimes, sequencing of the ICD-10 codes will impact reimbursement. For example, for a screening of long term use of the drug Plaquenil (hydroxychloroquine) instead of linking the Z79.899 code first, link the rheumatoid arthritis code first.
- Sequencing guidelines are in the AHA 2019 ICD-10 Coding Guidelines.
- The best source of linking information is your Medicare carrier’s Local Coverage Determination.
TIPS Medicare Tips

- Download every Local Coverage Determinations (LCD) for every procedure you perform from your local Medicare carrier.
- Most carriers (over 74%) follow Medicare guidelines.
- Medicare and the OIG will audit you.
- Medicare Concepts:
  - “Incident To” Services
  - 1997 Exam Guidelines
  - Create a carrier-specific manual.

TIPS: Carrier Tips and Techniques

- When calling your carrier always get the person's name and email address if possible.
- Chat them up and compliment them on how hard they work. Be nice even if you are frustrated with them.
- When you ask them what modifier to use they will say, “we cannot tell you how to code.”
- Always work to get a carrier representative for your top carriers (Medicare, Medicaid, Blue Cross).
Tips on Appeals

- State the facts.
- Be clear on your credentials or background.
- Know your CPT™, ICD-10 and HCPCS rules and guidelines.
- Always reference medical necessity, modifier rules, NCCI edits, the bilateral surgery modifier and global days number as necessary.
- Be clear that you understand the appeals process.

Top Ten Medicare Part-B Denials (all specialties)

1. Duplicate Claims
2. Medical Necessity
3. Medicare Advantage Plans
4. Provider Eligibility
5. NCCI Edits
6. Screening/Routine
7. Non-Covered Service
8. Patient Supplies
9. Non-Covered Charge
10. Timely Filing
Tip$: Twelve Appeal Steps

1. Identify a rejection VS denial
2. Get organized before you call
3. Identify the carrier / gather the manual or LCD.
4. Is this a non-covered service?
5. Is pre-authorization always required?
6. ICD-10 Linking of every code on the claim
7. NCCI Edit?
8. Correct modifier?
9. Is this a carrier-specific rule?
10. Is this worth appealing? Can you win?
11. Contact the carrier
12. Appeal as many times (levels) as necessary to get paid.

TIP$: “Casino” Health Insurance

- What is it? It’s the best insurance plan in your area.
- Actually, casinos really do have good insurance.
- Use coding to find these plans. Examples are codes 99050 (non-work hours) and 99058 (disruption of schedule). Only a few carriers in any given city pay on these; those that do are considered “provider friendly” insurance companies.
- Find out which employers use this insurance.
- Market to their employer. Visit the HR director. Conduct an health-fair once a year. Sell your medical-screening services.
TIP$ Always Report Encounters at Highest Allowed Level

- Most clinics are throwing money away every day because they are unsure of proper coding and documentation guidelines.
- They fear the "red flag."
- Remember, compliance first and code with confidence.

TIP$ What about red flags?

- Don’t be concerned about red flags—audit-proof your documentation. You want to be reporting higher level visits and more diagnostic tests than your competitors. It means you’re successful. You’re better doctors. You see sicker patients. Remember, there always is a top 10%.
- Just be able to explain why you selected a particular code.
- Common targets:
  - Upcoding (Level IV and V exams)
  - Modifier 25 and 59
  - Cloned notes
TIP$ Medicare PFSRVU database

- Physician Fee Service and Relative Value Unit database. An ASCII/excel file on the Medicare website. It is free to download. **This is information not found in the CPT™ manual!** The file is updated every year.
- Includes:
  - RVU data
  - Bilateral surgery modifier
  - Global Days
  - Breakable or not breakable NCCI edit flag.
  - Professional and Technical Component
  - Much more.

TIP$ Global Period

- Also called Global Fee or Global Days
- Applies to surgical procedures.
- Zero days
- 10 days
- 90 days
- Not applicable to diagnostic tests.
- Co-management (cataracts: 90 day global procedures)

Why do I care?
**TIP$: Bilateral surgery modifier**

- 1 = Unilateral
- 2 = Bilateral
- 9 = Concept does not apply
- 3 = 150% rule does not apply (get paid 100% for each side)

These flags are in the Medicare PFSRVU database.

Some diagnostic codes are inherently bilateral such as **fundus photography** and **visual field exams**.

If you perform a unilateral procedure on both the right and left side on the same DOS, you are reimbursed 150% for both, not 200%.

This information is **Not** in the CPT™ manual.

**Why Do I Care?**

---

**TIP$: Medical Terminology and Anatomy**

- This is very important in coding, auditing and understanding diseases and conditions.
- Know your sub-terms, prefixes and suffixes.
- Know the format of the ICD-10 manual.
The surgical operative report details:
- "The hemangioma on the patient's back was destroyed."
- "The port wine stain on the patient's eyelid was ablated."
- "The strawberry birthmark from the patient's chest was removed via laser."
- The coder/biller asks the provider if these lesions are malignant or benign. The provider responds, "These are benign neoplasms."

The coder reports them as:
- 11440: Excision...benign lesion...eyelids...5 cm or less.
- The RVU is 3.91 and approximate Medicare allowable (2019) in Atlanta GA is $141.03.
- Ten years later, the coder discovers that these are considered "cutaneous vascular proliferative lesions." The destruction codes are 17106 to 17111 and the RVU for 17106 is 9.78; approximate allowable (2019) in Atlanta GA is $353.48.
- That's over twice as much as the benign lesion code!
**TIP$ Other Place of Service (POS) Codes**

- 03 School
- 04 Homeless shelter
- 09 **Prison (correctional facility)**
- 12 Home (most common DME-MAC POS)
- 13 **Assisted Living facility**
- 14 Group home

**Other Place of Service (POS) Codes**

- 15 **Mobile unit**
- 22 Outpatient hospital
- 26 Military
- 31 Skilled Nursing Facility
- 32 **Nursing facility**
- 51 **Inpatient psychiatric facility** (includes dual-diagnosis facilities)
- WDIC?
TIP$ Allergy Testing

- Both Primary Care and specialties (optometry) have found allergy-testing to be valuable for their patients and a profitable adjunct to their business. The key is knowing if the tests meet “scope of practice” requirements, which carrier’s pay and how much. Work with your testing lab concerning local carrier-specific rules. You may have to appeal denials.
- The Academy of Allergy & Asthma in Primary Care, a not-for-profit promotes the interests of primary care physicians promoting allergy testing and immunotherapy.
- For some this practice may be considered controversial so be sure to perform a comprehensive “due-diligence” before offering the service.

TIP$ Telemedicine and Primary Care

- Telemedicine is an exciting prospect for both specialists and rural doctors. These codes include:
  - Remote patient face-to-face services seen via live video conferencing.
  - Non-face-to-face services that can be conducted either through live video conferencing or via store and forward telecommunication services.
  - Home telehealth services.
- The service must be provided to an eligible Medicare beneficiary in an eligible facility. E & M codes for the office visit are listed.
Online Assessment and E & M

Internet codes: “previous 7 days”

- **98969** Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the Internet or similar electronic communications network.
- **99444** Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network.

By Time: “discussion and review”

- **99446** Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; **5-10 minutes of medical consultative discussion and review**
- **99447** 11-20 minutes of medical consultative discussion and review
- **99448** 21-30 minutes of medical consultative discussion and review
- **99449** 31 minutes or more of medical consultative discussion and review

[Practice Management Institute](www.pmiMD.com)
Online Assessment and E & M

- Time: “of medical consultative time”

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99451</td>
<td>Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, <strong>5 minutes or more of medical consultative time</strong></td>
</tr>
<tr>
<td>99452</td>
<td>Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, <strong>30 minutes</strong></td>
</tr>
</tbody>
</table>

Monitoring Remotely

- Remote monitoring

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99453</td>
<td>Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment</td>
</tr>
<tr>
<td>99454</td>
<td>Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days</td>
</tr>
<tr>
<td>99457</td>
<td>Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month</td>
</tr>
</tbody>
</table>
HCPCS Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0406</td>
<td>Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth</td>
</tr>
<tr>
<td>G0407</td>
<td>Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth</td>
</tr>
<tr>
<td>G0408</td>
<td>Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth</td>
</tr>
<tr>
<td>G0425</td>
<td>Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth</td>
</tr>
<tr>
<td>G0426</td>
<td>Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth</td>
</tr>
<tr>
<td>G0427</td>
<td>Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth</td>
</tr>
<tr>
<td>G0459</td>
<td>Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy</td>
</tr>
<tr>
<td>G0460</td>
<td>Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment</td>
</tr>
<tr>
<td>G0508</td>
<td>Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth</td>
</tr>
<tr>
<td>G0509</td>
<td>Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth</td>
</tr>
</tbody>
</table>

Online Assessment and E & M

- This is by no means an exhaustive discussion on tele-health. There are firms specializing in providing these services.
- Codes are changing rapidly.
- Payment will follow all the state-specific and carrier-specific rules already discussed.
TIP$ Primary Care Marketing: Ways to Impress

- Diabetes Awareness Month.
- Drugs That Could Have An Adverse Effect On A Specific Organ-System Month.
- Collagen Vascular Disorders Month: Distribute a one-page document with these autoimmune disorders (e.g., rheumatoid arthritis, lupus, and psoriatic arthritis) and how they can impact other systems. Educate the entire staff about these conditions.
- You’re Giving Me A Headache Month.
- Asymptomatic Condition Month: You don’t even know until it’s too late. This includes glaucoma, hypertension, and the early stages of diabetes.

TIP$ Utilization Reviews and Comparative Analytics

- Every clinic should perform comparative analytics and utilization review of their top 25 CPT codes. These should be broken out as office visit codes, and then organized by type. A clinic could compare lab code utilization to determine if any individual provider is performing excessive labs. A high number is not necessarily bad; you just need to be able to explain it. The answer should always be: we see sicker patients as supported by Medical Necessity and medical decision making.
TIPS Utilization Reviews and Comparative Analytics

- The current Medicare Part-B National Summary Data File was previously known as BESS. This only applies to Medicare submissions so it will skew toward conditions common with those over 65. It also only reports codes with 10 or more submissions.

- If the code is often reported less than 10 times per year (for example, codes 99205 and 99215 in primary care) then the data will skew higher than the median number. The data sets are summarized by CPT™ code ranges. The file is free and updated annually and available in September. It is a very large file so it requires an industrial strength database like MySQL. The file is too large for MS Excel or Access.


TIPS Weighted-Average Analysis

- For best results you want to review those procedures that have the highest weighted-average total.

- To obtain this you multiply the total quantity of procedures performed annually by the Medicare Allowable amount (RVU's).

- You would then sort the list and work your compliance and training issues based on the totals.

- This is a better strategy than reviewing your most common procedures or the highest dollar amount procedures separately.
### Top 30 Codes (Primary Care)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Count (2015 MCR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>99214 E &amp; M</td>
<td>18,799,062</td>
</tr>
<tr>
<td>2</td>
<td>99213 E &amp; M</td>
<td>16,679,500</td>
</tr>
<tr>
<td>3</td>
<td>J1071 Injection, testosterone</td>
<td>9,937,372</td>
</tr>
<tr>
<td>4</td>
<td>86413 Venipuncture, blood draw.</td>
<td>7,662,210</td>
</tr>
<tr>
<td>5</td>
<td>92232 E &amp; M</td>
<td>5,132,522</td>
</tr>
<tr>
<td>6</td>
<td>G0008 Vaccine admin for influenza</td>
<td>2,837,814</td>
</tr>
<tr>
<td>7</td>
<td>J6372 Injection, IM</td>
<td>2,255,314</td>
</tr>
<tr>
<td>8</td>
<td>85225 Blood count; complete</td>
<td>2,173,183</td>
</tr>
<tr>
<td>9</td>
<td>85610 Prthrombin time</td>
<td>1,801,284</td>
</tr>
<tr>
<td>10</td>
<td>80061 Lipid Panel</td>
<td>1,760,034</td>
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</table>

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Count (2015 MCR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>99308 E &amp; M (nursing care)</td>
<td>1,712,352</td>
</tr>
<tr>
<td>12</td>
<td>G0009 Administration of pneumococcal</td>
<td>1,707,433</td>
</tr>
<tr>
<td></td>
<td>vaccine</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>G0009 Hemoglobin; glycosylated (A1C)</td>
<td>1,687,310</td>
</tr>
<tr>
<td>14</td>
<td>J1100 Injection, dexamethasone sodium</td>
<td>1,683,398</td>
</tr>
<tr>
<td></td>
<td>phosphate, 1 mg</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>80053 Comprehensive metabolic panel</td>
<td>1,658,607</td>
</tr>
<tr>
<td>16</td>
<td>10897 Injection, denosumab, 1 mg</td>
<td>1,641,380</td>
</tr>
<tr>
<td>17</td>
<td>G0439 Annual wellness visit, includes a</td>
<td>1,554,474</td>
</tr>
<tr>
<td></td>
<td>personalized prevention plan of service</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(pps), subsequent visit</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>90670 Pneumococcal conjugate vaccine,</td>
<td>1,535,624</td>
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<tr>
<td></td>
<td>13 valent [PCV13], for intramuscular use</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>J3301 Injection, triamcinolone acetonide</td>
<td>1,395,565</td>
</tr>
<tr>
<td></td>
<td>not otherwise specified, 10 mg</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>99233 E &amp; M</td>
<td>1,314,037</td>
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Top 30 Codes (Primary Care)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>Count (2015 MCR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>99309 E &amp; M (nursing care)</td>
<td>1,208,834</td>
</tr>
<tr>
<td>22</td>
<td>J0696 Injection, ceftriaxone sodium, per 250 mg</td>
<td>1,120,478</td>
</tr>
<tr>
<td>23</td>
<td>90662 Influenza virus vaccine (IIV)</td>
<td>1,068,495</td>
</tr>
<tr>
<td>24</td>
<td>93000 Routine ECG with at least 12 leads; w/ interp &amp; report</td>
<td>1,057,390</td>
</tr>
<tr>
<td>25</td>
<td>99215 E &amp; M</td>
<td>1,020,405</td>
</tr>
<tr>
<td>26</td>
<td>84443 Thyroid stimulating hormone (TSH)</td>
<td>1,006,312</td>
</tr>
<tr>
<td>27</td>
<td>81002 Urinalysis, non-automated</td>
<td>949,897</td>
</tr>
<tr>
<td>28</td>
<td>99967 Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml. [Used as contrast material in X-rays]</td>
<td>944,836</td>
</tr>
<tr>
<td>29</td>
<td>81003 Urinalysis, automated</td>
<td>940,836</td>
</tr>
<tr>
<td>30</td>
<td>99212 E &amp; M</td>
<td>924,938</td>
</tr>
</tbody>
</table>

Summary

- Remember to always optimize compliance before embarking on a maximizing revenue strategy.
- Today we covered a wide variety of revenue maximizing tips and techniques: coding, training, working with carriers, marketing, and analysis.
Maximizing Revenue through Accurate Coding, Billing, Documentation, and Compliance

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