AMN Healthcare

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Revenue Cycle Solutions

January 2020 Newsletter

We hope you enjoy the information provided as we continue to bring you the latest in industry news.

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Cancer Registry and Coding: The Hidden Relationship

Jennifer Rohleder, BS, CTR & Daniel Land, RHIA, CCS

Cancer registry data collection starts with a process known as case-finding or case ascertainment, and it is exactly that, finding cases that must be included in a reporting facility's cancer registry. Each year the standard setters: Commission on Cancer, SEER, North American Association of Central Cancer Registries, and State Central Registries determine a list of reportable cases. These lists are based on confirmed malignancy, history of malignancy, screening, and/or treatment for malignancy. There are also numerous benign, hematopoietic and lymphoid reportable diseases included in the list.

All facilities are required to have a process for identifying, collecting, and reporting specific neoplasms. The process should include concurrent monitoring of:

- Disease indices from the facility and all associated medical practices
- Pathology, cytology, and autopsy reports
- Log sheets and other registration reports from treatment clinics or departments that have separate billing/coding processes such as medical oncology, infusion, radiation oncology, and surgical centers.

Historically, Cancer Registries have had to be innovative in order to perform proper case-finding depending on their environment. In addition to the gold standard sources which are the Disease Index and pathology reports, a Cancer Registrar would collect other "source documents" which translated into mounds of paper. These included daily Admission, Discharge and Transfer (ADT) report, weekly billing reports, medical oncology and/or radiation oncology log sheets, imaging logs and reports, outpatient surgical units, and autopsy reports. After data collection was complete, the Cancer Registrar would manually cross-reference the paper reports with the cancer registry database to determine if a patient was already in the database (and only required updates) or if the case was entirely new.

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Cancer Registry and Coding: The Hidden Relationship, | *Continued from page 1*

Although the electronic health record (EHR) has reduced the need for manual data gathering, some cancer registries still use paper methodologies to perform case-finding as they feel it is a necessary failsafe. Although this approach may have validity, it is inefficient as cost-benefit analyses have proven. Current best practices include electronic import of the disease indices from all departments with billable services and pathology reports with a reportable diagnosis.

The ongoing challenge is to capture cases that have had a biopsy or surgical procedure with a negative outcome after a procedure that had previously generated cancerous tissue. The final procedure would not generate pathologically demonstrating cancer but is required to complete the treatment portion of the database for the individual patient.

Hospitals that implement best practices will utilize information found during case-finding to update cases with subsequent treatment and additional follow-up information such as date and type of the first recurrence, disease status, and vital status, which are required data items.

Disease indices and positive pathologic outcomes are considered the gold standard for case finding because of the integrity of the coded data that informs them. Accurately coded data paints the true clinical picture of the patient and drives the work of Cancer Registries nationwide. Without it, patients are lost to Cancer Registries as well as the benefits of cancer control and epidemiological research, public health program planning, and patient care improvement. Although documentation in the patient's record can be unclear or ambiguous at times, it is incumbent upon the coding professional to seek clarification when necessary. Coded data has a long and influential life span, and its importance goes beyond today's revenue. It is important to remember the micro and macro purposes of coded data, including quality outcomes, risk adjustment, predictive analysis, population health, medical research, fiscal integrity, and institutional longevity. Accurately coded data improves patient care and ultimately saves lives.

A disease index should identify all ICD-10 codes that indicate a patient has a reportable diagnosis, a history, and/or screening diagnosis as identified annually by the State Cancer Registry and accrediting bodies. In many cases, multiple disease indices will be required depending on the facility's affiliations and billing practices for specific physicians, procedures, and office visits. Ideally, the disease index would be the only "tool" required for case finding; however, due to the complexities of billing practices and individual facility practices, pathology reports must also be monitored to ensure at a minimum all-new pathologically diagnosed cases are captured in a timely manner. At the November 20-21, 2019 Commission on Cancer Educational Summit, an announcement was made that in the very near future, most likely by 2021-concurrent abstracting will be required to comply with the Rapid Cancer Reporting System (RCRS). A timely, efficient and comprehensive case-finding process will be required as compliance with this process will require monthly submission of all newly identified cases as well as monthly updates for all cases that remain incomplete or require an update of surveillance information in the cancer registry database. The power of ICD-10, harnessed by accuracy and specificity, plays a vital role in winning the War on Cancer.

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New and Expanded Revenue Cycle Solutions (RCS) Education Webinar Series in 2020

Virginia Bailey, RN, CCDS, CRC
Content Manager, Revenue Cycle Solutions, AMN Healthcare

RCS Education is excited to announce a new and expanded Webinar Series schedule for 2020, offering a minimum of 3 educational webinars per month! RCS Consultants, prospective clients, and consultants alike are cordially invited to attend all of the new RCS Webinars for 2020.

There is no cost, so be sure to sign up and grow your skills in your chosen professional field (CDI, HIM, Trauma Registry, Case Management, Social Work). Attendees will also be able to earn FREE CEUs toward accreditation and licensing renewals from many national organizations such as AHIMA, AAPC, ACDIS, CCMC, and NASW!

The RCS Webinar Series will be presented via Webex on Wednesdays at Noon EST (9 am PDT) of that week.

This premier education includes robust and interactive sessions on subjects which you, our consultants, and attendees, have requested or our research has indicated would be beneficial. We will be covering clinical information, yearly updates, and changes specific to each division, including updates for CPT/HCPCS and ICD-10 CM/PCS.

On the following page is a list of the Webinar topics for the 1st quarter of 2020. Please be aware that this schedule is subject to change, so watch for an email soon with instructions on registering for each Webinar. As mentioned, all RCS Webinars are conducted via WebEx, and all attendees must register. AMN RCS Consultants will receive a link to register via email no later than two days before each live session.

We will continue to upload a copy of the email for distribution to prospective clients and consultants, including a link to the registration page. Once registered, each person will receive a confirmation email with instructions on joining the session. Please note: RCS Webinars offer free CEUs from AHIMA, AAPC, ACDIS, CCMC, NASW, and NCRA; however, not all listed CEUs are available on all webinar topics.

Please join us for the new and expanded 2020 RCS Webinar Series!

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New and Expanded Revenue Cycle Solutions (RCS) Education Webinar Series in 2020 | *Continued from page 3*

Month	Division	Lunch & Learn Topic
January 2020	ODM	NAACCR Webinar Series: Prostate
	Trauma	2020 National Trauma Data Standard (NTDS) Updates
	CDI	Evaluation and Management (E/M) Essentials for the CDI Professional
	HIM	Understanding & Applying ICD-10-PCS Root Operations
February 2020	ODM	NAACCR Webinar Series: An In-depth Look at SSDI's
	HIM	Bronchoscopy Procedures: CPT & ICD-10-PCS
		ICD-10-CM: Back to Basics
	CDI	Leap into the 20s: A New Decade for Query Compliance
March 2020	ODM	NAACCR Webinar Series: Abstracting and Coding Boot Camp: Cancer Case Scenarios
	CDI	Outpatient CDI
	Trauma	Vaping
	HIM	Coding top MCC and clinical validation

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Hot Candidates

AMN has Talented CDI Experts Fresh Off of Successful Assignments and Ready to Work for You!

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 4.5 years Nursing – 14.5 years
- Units/Clinical Strengths: Oncology, ICU, CCU, Trauma, Surgery, Medical, Cardiac, Neurology, Oncology, Transplant, Urology, Vascular, Emergency, OB/GYN, Ortho
- **Systems Experience:** Epic, 3M 360, 3M CDIS, Sunrise, Optum 360, PowerSign, CDI Monitor, Eagle & Microsoft Office Products
- **Environment:** 627-bed level I trauma teaching facility, 1500 bed teaching facility, 519-bed facility, 362-bed level III trauma teaching facility, 583-bed facility, 452-bed tertiary an adult care teaching hospital
- **Remote CDI experience**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 4.5 years Nursing – 20 years
- **Units/Clinical Strengths:** ICU, CCU, Trauma, Surgery, Medical, Cardiac, Neurology, Oncology, Transplant, Urology, Vascular, Ophthalmology, Rehab, Ortho
- **Systems Experience:** Epic, Cerner, 3M 360, Clintegrity & Microsoft Office Products
- **Environment:** 972-bed level I trauma teaching facility, 516-bed teaching facility, 180-bed facility
- **Remote CDI Experience**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 9 years Clinical – 34 years
- **Units/Clinical Strengths:** ICU/CCU/PACU, Med-Surg, Cardiac/Telemetry, Trauma, Neurology, Oncology, Urology, Vascular, Ortho, Emergency Room, Pain Management,
- **Systems Experience:** 3M/360, 3M, EPIC, Cerner, Powerchart & Microsoft Products (Outlook, Word & Excel)
- **Environment:** CHS-Grandview Regional, 402 beds, Level III Teaching and Trauma
- **Remote Experience**
- **Appeals and Auditing Experience**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 12 years Nursing – 15+ years
- **Units/Clinical Strengths:** Medical, Surgical, Cardiac, Trauma, Neuro, Oncology, Transplant, Ortho, Pulmonary, ICU/CCU/SICU, Telemetry, Renal, and Vascular
- **Systems Experience:** 3M 360, Epic, JATA Guide, Artifact, Cerner/PowerChart, ClinView, 3M Encoder, Access Anywhere, Quantum, Microsoft Office and G-Suite applications
- **Environments:** Teaching facilities. Community Hospitals, and Level 1 Trauma, in ranges from 100-1000+ beds and large health systems.
- **2011 ACDIS National Conference Poster Presenter**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 8 years Nursing – 30+ years
- **Units/Clinical Strengths:** Medical, Surgical, Cardiac, Neuro, Oncology, Transplant, Ortho, Vascular, Ophthalmology, Emergency, Rehab, CCU, ICU (Cardio-Thoracic, Burn Trauma, Neuro), Pediatric.
- **Systems Experience:** 3M/360, EPIC, Optum CAC, Cerner, Meditech, 3M Encoder, Allscripts, Quadramed, TruCode, QC suite, Excel Office
- **Environment:** Teaching facilities and Level 1Trauma, in ranges from 200-1000 beds and large health systems.
- **Extensive Remote experience**
- **Second Level Review**
- **Auditing and CDI Team Lead experience, with proven effectiveness in remote and consulting roles.**
- **Extensive experience with HACs, PSI's, and APR-DRGs.**
- **Experience with Mortality Review**
- **Two years CDI Team Lead experience includes the creation of orientations and education for physicians, as well as providing ongoing training and education for CDI staff and physicians. Conducted weekly reviews for impact, reconciliation, and compiling reports for management.**
- **Clinical areas of expertise include surgical care, critical care, and cardiac care.**

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Hot Candidates | Continued from page 4

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 8 years Nursing – 11 years
- **Units/Clinical Strengths:** ICU/CCU, Med-Surg, Cardiac/ Telemetry, Neurology, Oncology, Urology, Vascular, Trauma and Psych
- **Systems Experience:** 3M-360(Super-user), 3M encoder, Cerner, JATA, EPIC, MIDAS, Medhost EHR, Allscripts EHR, Meditech EHR, Streamline Health CDI software, McKesson Onecontent & Microsoft Products (Outlook, Word, Excel & PowerPoint)
- **Environment:** Teaching facilities and Level 1 Trauma, in ranges from 400-1000 beds and large health systems.
- **Remote Experience**

SUMMARY

- **Availability:** Immediately
- **Years of Experience:** CDI – 9 Years Clinical – 20+ years
- **Units/Clinical Strengths:** ICU, CCU, Trauma (Pediatric and Acute Care), Surgery, Medical, Cardiac, Neurology, Oncology, Urology, Ortho, Vascular, Pediatrics
- **System Experience:** 3M 360, Cerner, JATA, EPIC, OPTUM 360
- **Environment:** Large Level I Teaching and Trauma
- **Remote Experience**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 5 years Nursing – 7 years
- **Units/Clinical Strengths:** ICU/CCU, Med-Surg, Cardiac/ Telemetry, Neurology, Oncology, Transplants, Urology, Vascular, Orthopedic
- **Systems Experience:** 3M/360 R2, Allscripts, Artifact, Gateway, nThrive, Precyse, Cerner, Citrix, Morcare, Medhost, Clinical View, Access Anywhere & Microsoft Products (Outlook, Word & Excel)
- **Environment:** Teaching facilities and Level 1 Trauma
- **Remote Experience**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 5.5 years Nursing – 9 years
- **Units/Clinical Strengths:** ICU/CCU, Med-Surg, Cardiac/ Telemetry, Neurology, Oncology, Urology, Vascular, Orthopedic, Mom, Babies
- **Systems Experience:** 3M/360 R2, EPIC, Optum 360, EMD, Meditech, Allscripts, Clintrac, Medhost ClinView and AS400 & Microsoft Products (Outlook, Word & Excel)
- **Environment:** Teaching facilities and Level 1 and 2 Trauma, bed sizes ranging 500-600 beds and large health systems.
- **Remote Experience**
- **APR/DRG and MS/DRG Experience**
- **Mortality Reviews**

SUMMARY

- **Availability:** Immediately
- **Years of experience:** CDI – 10 years Nursing – 30 years
- **Units/Clinical Strengths:** ICU/CCU, Trauma, Surgery, Medical, Cardiac/Telemetry, Neurology, Oncology, Urology, Vascular, Obstetrics, Pediatrics, Orthopedic
- **Systems Experience:** Epic, 3M 360, Vizient, Meditech, Allscripts/ Eclipsys, Compass, Optum 360, CAC, Cerner, Microsoft Products (Outlook, Word & Excel)
- **Environment:** Academic/Teaching facility experience, worked in multiple facilities from 1000+ beds to 100+ beds, level 1 trauma

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Hot Jobs

AMN Healthcare Revenue Cycle Solutions has highly qualified professionals ready to jump into your next Case Management, Health Information Management, Cancer Registry, and Trauma Registry challenges. Our Candidates are fresh off of successful assignments and prepared to help you be a success!

Inpatient Coder

https://bit.ly/2t8SWd9

Specialty: Inpatient

Location: San Diego, CA

Salary Range: Call for details

Position Summary:
Under indirect supervision, is responsible for accurate coding of all inpatient services, procedures, diagnoses, and conditions, working from the appropriate documentation in the medical record. Classification systems include ICD-10-PCS, CPT, Healthcare Common Procedure Coding System (HCPCS) as well as other specialty systems as required by diagnostic category. All work is carried out in accordance with the rules, regulations, and coding conventions of the American Hospital Association (Coding Clinic), ICD-10-PCS, Centers for Medicare and Medicaid Services (CMS).

Responsibilities and duties include and are not limited to:

- Maintains a working knowledge of ICD-10-PCS coding principles, governmental regulations, official coding guidelines, and third party requirements regarding documentation and billing.
- Assures that all services documented in the patient's chart are coded with appropriate ICD-10-PCS codes. When services/ diagnoses are not documented appropriately, seeks to attain proper documentation in a timely manner according to facility standards.
- Ability to maintain average productivity standards.
- Works the review and CDI queue on a daily basis to ensure all charts that are placed in the review queue are worked, and any corrections are communicated to the facility if necessary.
- The coder is responsible for coding or pending every chart placed in their queue.
- Coders must maintain their current professional credentials.

CDI Specialist

https://bit.ly/2vrDEkh

Specialty: Floor CDI

Location: San Francisco, CA

Salary Range: $93,000 - $100,000 annually

Position Summary:
The Clinical Documentation Specialist is responsible for improving the overall quality and completeness of clinical documentation by expediting clarification to clinical documentation. This is accomplished through ongoing interactions with physicians and other clinical staff to facilitate that the medical documentation in the patient medical record accurately and completely reflects the quality of care rendered to the patient. The accurate and complete medical record documentation will ensure that appropriate reimbursement is received for the level of service rendered to all patients and that information used for measuring and reporting physician and hospital outcomes is correct.

Remote Cancer Registrar

https://bit.ly/315BZgk

Specialty: Cancer Registry

Location: Silvis, IL

Salary Range: Call for details

Position Summary:
The Certified Tumor Registrar is responsible for the review and detailed abstraction of cancer registry data from electronic medical records in compliance with state and national guidelines. Other job duties may include case finding, follow up, reporting, quality assurance, and more. The ideal Cancer Registrar is detail-oriented, committed to high-quality data abstraction, meets both quality and productivity standards, has excellent communication and time management skills, and is highly self-motivated. All Certified Tumor Registrars are expected to abide by regulations as defined by HIPAA.

This position requires: Abstracting at a CoC facility (if applicable), handling case finding, follow up, and other registry duties as required.

Must be a Certified Tumor Registrar and have at least 3 years of experience abstracting in cancer registries, and experience with Metriq is preferred.

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ICD-10-CM Review General Coding Guidelines

By Dee Mandley, RHIT, CCS, CCS-P, CDIP
Content Manager - HIM

Coding professionals are guided by the rules within the ICD-10-CM coding convention first and then by the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines provide direction on how to locate a code by first locating the main term that appears in the diagnostic statement within the codebook index. The code suggested by the index must be verified in the tabular section of the codebook. There are instructional notations within the index and tabular sections that must be followed. You may ask why do we have to validate the code with the tabular section? And the answer is that the index doesn't always provide the full code. For example, there may be a required seventh character that is not noted in the index. Keeping that in mind, a valid diagnosis code is only one that is coded to its's highest level of detail. This level of detail is identified by characters within the code. A valid ICD-10-CM code can be as few as three characters or as many as seven characters depending on the level of detail required by the code category.

Signs and symptoms are acceptable to report as long as there isn't a more definitive diagnosis to explain the signs and symptoms. If, however, the signs and symptoms are not routinely associated with the more definitive diagnosis, then they should be reported. This rule is similar to the direction given for "unspecified" codes. Unspecified codes are sometimes the best choice to accurately reflect the healthcare encounter because it is not appropriate to assign a specific code when the health record documentation does not support it. For example, pneumonia, unspecified, would be reported when the documentation states simply "pneumonia," a code for Klebsiella pneumonia, wouldn't be assigned as this additional detail was not mentioned.

Assigning codes for acute, chronic, sequela, laterality, and syndromes also have specific instructions for the assignment. In those instances when a condition is documented as both acute (subacute), and chronic and subentries exist for the acute and the chronic condition within the index, the acute (subacute) condition are sequenced first. Sequencing guidance is also provided for residual conditions that remain after the acute phase of an illness or injury. These are known as sequela or late. effects. Sequela conditions can arise right after the illness or injury or appear months or years later. There is no time limit on the use of these codes. The sequencing order is that the condition or nature of the sequela is listed first, followed by the sequela code. The only exception to this rule is when the code for the sequela is followed by a manifestation code. Laterality is a large component of ICD-10-CM, allowing conditions to be coded specifically to the right side, left side, or bilaterally. The guidelines instruct us to assign a separate code for each side when no bilateral option is available. However, when a bilateral condition is present, and the patient is only having one side treated, then we are instructed to assign a diagnosis code for the bilateral condition. When that patient returns to have the other side treated, and the condition on the previous side is no longer present, we should assign a unilateral code. A syndrome is a condition that has many manifestations. If the coding convention does not have a specific code for the syndrome, then we are instructed to code each of the documented manifestations.

A combination code is a single code that combines two diagnoses to report a condition with a manifestation or complication. Sometimes a condition requires more than one code to report the illness fully, and this is known as the multiple coding rules. In this instance, the coding convention provides instructional notes such as "use additional code," implying a secondary code needs to be added. The instructions "code first" and "code, if applicable, any causal condition first" provide sequencing guidance.

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When the documentation states a condition is "impending" or "threatened," we must determine if the condition occurred. If the condition is confirmed, then assign a code for the condition; if not, review the subentries in the index for terms such as "impending" or "threatened." If those terms are not an option, then assign a code for the existing underlying condition. If the documentation supports a condition as "borderline," then that condition is coded unless there is a specific code for borderline listed in the index — for example, borderline diabetes.

There are a few instances where codes can be assigned based on non-provider documentation such as BMI, NIH stroke scale, and skin ulcer stages or depths. A word of caution here – the associated diagnosis for these codes must be documented by the provider. For example, the BMI code cannot be reported if the provider does not document the associated diagnosis of obesity. Documentation regarding complications of care must also be supported by the provider regarding the cause and effect relationship. A coding professional cannot assume that a condition arising after surgery is actually a complication of the surgery.

It is always good to read over the guidelines in their entirety every year in order to stay up to date and refresh your knowledge. See the link below for the official coding guidelines for additional information.

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf

CPT Index Instructions

By Dee Mandley, RHIT, CCS, CCS-P, CDIP
Content Manager - HIM

The CPT codebook is divided into an index and the main text. The index provides a code or code range location and the main text with all code descriptions, which is divided into six sections: Evaluation and Management, anesthesiology, surgery, radiology, pathology, and laboratory, and Medicine. Each section has its own set of guidelines located before the code descriptions and within sections of codes, if necessary. Learning how to use the CPT index is critical in locating the appropriate code.

The main procedure term can be indexed in the following manner; by locating the procedure or service name such as arthroplasty or catheterization; by locating an organ or other anatomical site such as esophagus or coronary artery; by locating a condition such as hematoma or glaucoma; or by synonyms, eponyms, or abbreviations such as Akin Procedure, Gibbons stent, EEG, or TMJ. Once the main term is indexed, a code or a range of codes is typically provided. Each of these codes should be reviewed in the main text to ensure the code accurately identifies the service performed. This is much like indexing code in ICD-10-CM and validating it in the tabular section.

In CPT, indented sub-terms in the index are known as modifying terms. These modifying terms need to be completely reviewed to choose the appropriate procedure code. The main term Arthroscopy has the first level indented modifying terms of Diagnostic, Surgical, and Unlisted, followed by third-level modifying terms for the specific joint.

The cross-reference term "see" appears throughout the index and is listed with the main term directing the code search to another main term. For example, Arthroplasty, Shoulder – See Repair, Shoulder.

Reviewing and understanding how to reference codes in the CPT index is an important first step in being a successful outpatient surgery coding professional.

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ICD-10-PCS – PCS Body Part Review

By Dee Mandley, RHIT, CCS, CCS-P, CDIP
Content Manager - HIM

Understanding anatomy is critical when assigning ICD-10-PCS codes. The PCS coding system contains numerous definitions and anatomical references necessary to correctly assign procedure codes. The ICD-10 procedural coding system has its own unique set of guidelines for each of the seven characters that make up a valid code. The body part character is the fourth character with specific guidance regarding body part consideration. When we think of body parts' we think of the heart, lung, arm, foot, etc. In PCS, the "body part" value can represent a specific component of an organ and not the whole organ. For example, a body part value may be assigned to a lobe of the lung rather than the whole lung. This detail is necessary when only a portion of a body part is the focus of a procedure. The guidelines also clarify that if there isn't a specific value for a particular component of an organ, then the body part value for the entire body part is chosen.

Often times the prefix "peri" will be used in procedural notes to describe the site of the procedure. It is the coder's responsibility to understand human anatomy well enough to understand the exact site of the procedure and what is being referred to with the suffix "peri." Coding procedures done on tubular body parts is another area of general coding guidance. Here guidelines state to assign the body part value corresponding to the furthest anatomical site from the point of entry.

Body parts with branches such as nerves and arteries are assigned the body part value to the closest proximal branch. Proximal meaning closest to the point of origin. Here is where knowing how to utilize the body part key in Appendix D is a necessity. This key is useful for many reasons but especially when it refers to branches or arteries and nerves. For example, if the documentation states the mandibular nerve, the body part key tells us that the closest proximal branch is the trigeminal nerve and to choose that body part value for the procedure.

The PCS coding system includes body part values for bilateral structures; however, if a bilateral option is not available, then separate codes are reported for the right and left structure. When procedures are being performed on fingers and toes, and there isn't a specific value for fingers and toes, we are directed to choose the hand or foot body part value.

Since the intestinal tract goes from the esophagus to anus, it is divided into upper and lower intestinal tracts. Sometimes the coder is led to a PCS table with body part values only for upper or lower intestinal tract posing a dilemma to build the code. The guidelines provide the answer describing the upper as the esophagus down to and including the duodenum and the lower as the jejunum down to and including the rectum and anus.

Coronary arteries are identified in PCS with the body part value based on the number of coronary arteries involved in the procedure. For example, the value two has been assigned to the coronary artery, three arteries in the PCS Bypass table 021. This is so one procedure code can be assigned when the same procedure is done to multiple arteries, including the same device and qualifier values.

Interested in getting a discount on your annual AAPC membership? See below for details on how to join our corporate membership.

- All active full-time AMN RCS consultants are eligible to be added to our corporate AAPC membership.
- The discounted membership fee is $145 per year, and it is deducted from your annual $350 education allowance. If you have already used your education allowance on other expenses, the amount will be deducted from your paycheck.
- If you would like to take advantage of this benefit, please email **RCSEducation@amnhealthcare.com** with your request. Please be sure to include your AAPC member ID in the email.

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About AMN Healthcare

AMN Healthcare is the leader and innovator of healthcare workforce, staffing, and revenue cycle services to healthcare facilities across the nation. AMN provides unparalleled access to the most comprehensive network of quality healthcare professionals. With insights and expertise, AMN helps providers optimize their workforce to successfully reduce complexity, increase efficiency, and improve patient outcomes.