

# Part B Insider

News & Analysis on Part B Reimbursement & Regulation

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## CORRECT CODING INITIATIVE

# You Can Resubmit Dozens of Previously-Bundled 22526 Claims

► **CCI 15.3 retroactively deletes hundreds of edit pairs, but institutes over 18,000 new bundles.**

If you thought the last version of the Correct Coding Initiative (CCI) left no stone unturned in bundling moderate sedation, think again.

CCI's version 15.3, which takes effect Oct. 1, continues the trend, bundling 99148-99150 into most of the other CPT codes, and no modifier can separate the bundles.

**Modifier changes:** CCI 15.3 also ensures that you won't collect when you report thousands of bundles that previously had a "1" modifier (which meant that you could append a modifier to the bundled code and your carrier would possibly reimburse you for both codes).

"In total, there were 73,054 edit pairs reported with a modifier indicator change for this release," said **Frank Cohen, MPA**, senior analyst with MIT Solutions Inc. in Clearwater, Fla., in a Sept. 11 news release. "320 pairs went from an indicator of 0 (can't use a modifier) to 1 (may be able to use a modifier), while the remainder (72,734) went from a 1 to a 0."

Targeted in the change are scores of spine surgery codes. For instance, you can no longer use a modifier to separate the edits bund-

ling 64415-64417 (*Nerve block*) into hundreds of surgical procedures.

**Good news:** On the bright side, CCI deleted 706 edit pairs, meaning that those code pairs are no longer bundled. Even better, 27 of these edit pairs were deleted retroactive to Jan. 1, and 357 pairs were deleted effective April 1. "This means that, if you were denied payment due to these edit pairs in the past, you would likely be able to resubmit the claim for payment at this time," Cohen said in the news release.

**For instance:** The edits bundling venipuncture codes 36400-36406 into 22526 (*Percutaneous intradiscal electrothermal annuloplasty*) have been deleted retroactive to April 1. Plus, the edits bundling IV infusion codes 96360, 96365, 96372, 96374, and 96375 into 22526 were deleted all the way back to their effective date of Jan. 1.

If you plan to resubmit any claims that were denied due to these now-deleted edits, send them with a cover letter explaining why you are doing so, says **Denise Paige, CPC**, secretary of the AAPC's Long Beach chapter. "Otherwise they may be denied as duplicate claims." ■

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## CMS COVERAGE DECISIONS

# MACs Can Make Exceptions to LCDs, CMS Says

► *RACs can only make exceptions to approve claims.*

Local coverage decisions are known by coders as the “final say” from Medicare — if the LCD makes a statement, you can count on your MAC to never veer from that rule.

But CMS has opened the door to giving MACs some wiggle room in adhering to LCDs. Transmittal 302, issued on Sept. 11, notes that MACs “have the authority to apply an exception to the clinical reasonable and necessary requirements described in a n LCD.”

The exceptions must be rare, and the MAC can make them only after thoroughly reviewing a patient’s medical record and analyzing the information.

“Most likely the exceptions to the LCDs would have to be made during the appeal phase,” says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions. “Thorough review of the patient’s medical record is not available in the initial payment phase.”

**Interesting aside:** The transmittal indicates that MACs will create an exceptions report each year, and “if exceptions to LCDs are not rare, the contractor shall reevaluate the LCD clinical criteria.”

In the past, the only way to get an LCD changed was to go to the Carrier Advisory Committee and state your case, Cobuzzi notes. “This new language in the transmittal means that if the LCD is overturned

more often than ‘rarely,’ the MAC should, as a matter of course, do the reevaluation themselves and perhaps change it.”

**RACs:** If you’re nervous about RACs using this new exceptions process to deny your claims at will, take heart: The transmittal notes that “RACs can only use the exceptions process to not deny a claim.”

**What this means:** “Although the transmittal states that certain Medicare contractors (such as affiliated contractors, MACs, and CERT) may use the exceptions process either to approve or to deny a claim, unless directed otherwise by CMS, RACs are only permitted to use the exceptions process ‘to not deny,’ or, put more simply, to approve a claim,” says **Jessica L. Gustafson, Esq.**, with The Health Law Partners, PC in Southfield, Mich.

Therefore, unlike other Medicare contractors, RACs may not use the exceptions process to deny claims. “As a practical matter, this means that even if a claim does not fully satisfy all elements set forth in an LCD, the RAC is permitted to apply the exceptions process and approve a claim if the claim appears to be reasonable and necessary after a thorough review of the patient’s medical record and a consideration of other available evidence in medical literature,” Gustafson says.

To read the transmittal, visit [www.cms.hhs.gov/transmittals/downloads/R302PI.pdf](http://www.cms.hhs.gov/transmittals/downloads/R302PI.pdf). ■

## PHYSICIAN ORDERS/REFERRALS

# Next Year, Medicare Will Deny Claims if Referring/Ordering Doc Isn't in PECOS Or Claims System

► **Plus: If your physician isn't 'of the specialty to order or refer,' your MAC will deny your claim starting January 4.**

CMS wants to make sure you're taking PECOS seriously — and the agency is willing to slash your pay to prove it, if necessary.

You probably already know that if your physician performs a service as a result of an order or referral, your claim must include the referring or ordering practitioner's national provider identifier (NPI). What many practices don't realize is that even if the physician has an NPI, he may not necessarily be in the PECOS system, and starting soon, you could face penalties if you perform services referred or ordered by doctors that are not part of PECOS or the MAC's claims system.

**How this happens:** If the referring/ordering doctor has a valid NPI but has not updated his enrollment in the last five years, he may not be in the PECOS system.

### Know the Penalty Phases

CMS has instituted two phases of penalties for practices that report services that are ordered or referred by physicians that aren't in PECOS or the MAC's claims system, according to *MLN Matters* article MM6417:

**Phase 1:** Between Oct. 5 and Jan. 3, 2010, your MAC will search the PECOS system and the MAC's

own claims system for the ordering/referring provider. If the provider is not in PECOS or the claims system “the claim will continue to process and the Part B provider or supplier will receive a warning message on the Remittance Advice,” the *MLN Matters* article advises.

**Phase 2:** After Jan. 4, 2010, CMS will hit you in the pocketbook by denying your claim if your ordering physician isn't part of PECOS or the MAC's claims system.

In fact, even if the ordering doctor *is* part of PECOS or the claims system, “but is not of the specialty to order or refer, the claim will not be paid. It will be rejected,” the *MLN Matters* article warns.

This change will hit specialties that take a lot of referrals the hardest — such as those that perform extensive diagnostic testing or labs, notes **Linda Groves, CPC, CPC-H**, president/CEO of Accutrans Inc., a professional billing company in Painesville, Ohio.

The article outlines which specialties are allowed to refer or order services, and you can read it in its entirety at [www.cms.hhs.gov/MLNMattersArticles/downloads/MM6417.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6417.pdf).

### Keep Track of NPIs

CMS's new penalty phases will mean that your practice has to remain as vigilant as ever in tracking the NPIs of physicians that refer or order services. Although it may sound like an extra step, it could save you time filing appeals later down the road.

“We set up all referring practitioners in our system with their NPI numbers,” says **Connie Stevens**, compliance and reimbursement manager with Wenatchee Valley Medical Center in Washington. “We contact their office for the information and we check the NPPES system to make sure they are registered on that system,” she advises.

If you are part of a specialty where you are subject to an unusual number of physician orders, you may want to put an extra step in place when you accept a physician order, during which you specifically request the physician's NPI.

**NPI registry search:** CMS created a searchable database that allows you to look up a physician's NPI if you can't get it from the practice. To access the registry, visit the CMS Web site at <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>. ■

## PART B REVENUE BOOSTER

# 4 Income Opportunities You Don't Want to Overlook

► **Make sure you aren't bleeding revenue in these areas — it only takes a few minutes to ensure you're collecting your due.**

Medicare coding rules are complex and challenging, but that shouldn't keep you from collecting all of the revenue that you're owed. Follow these four quick tips to make sure you aren't losing cash.

### 1. Update your ICD-9 codes.

It's that time of year when you should be prepping your new superbills so they're ready for the Oct. 1 ICD-9 changes.

**Remember:** Your ICD-9 codes prove medical necessity for your claims. Your CPT coding might be completely buttoned-up, but without accurate diagnoses, you can say goodbye to reimbursement.

**Tip:** Now is the time to update your superbills, since the new diagnosis codes take effect on Oct. 1. Purge the outdated codes and print the new ones on your forms.

**2. Stay on top of SNF patient status.** Skilled nursing facilities (SNFs) must consolidate their billing for Medicare beneficiaries who are in a Part B non-covered SNF stay in which their Part A benefits are exhausted. When these patients present to private practices or clinics, you can't bill Medicare directly for certain services, such as the technical component of x-rays.

In these cases, you must bill the physician's x-ray interpretation to

Medicare with modifier 26 (*Professional component*) appended, but bill the technical component directly to the SNF.

**Snafu:** Unfortunately, even if you know these rules, you could still end up dealing with problems when you treat a patient and don't realize that they are a SNF patient.

"It's very frustrating to find out on the back end that a patient was in a SNF when they came to your office even when you have notices posted at your front desk to please tell the receptionist if you are a SNF patient," says **Cindy Bizzle, CPC**, a coder with Specialty Orthopedics.

**Solution:** "When we get a letter from Medicare telling us that a refund is due for a patient being in a SNF, we fax the letter back to Medicare with 'please do immediate offset' written on it," Bizzle says. "This helps stop any interest from accumulating, and the recoup usually comes soon thereafter."

**3. Bill your supplies, when reimbursable.** Medicare includes the cost of most supplies in your pay for the service. For instance, if you perform a biopsy, the tray and bandages that you use are already bundled into the biopsy codes.

However, some supplies, such as casts or splints, can be billable,

depending on the circumstances. CMS has approximately 50 "Q" HCPCS codes that address supply issues with casting/splinting applications.

For instance, if the physician applies a short-leg, fiberglass cast to a 69-year-old patient with fractures of the calcaneus and talus, you should report the appropriate fracture care or casting code, along with Q4038 (*Cast supplies, short leg cast, adult [11 years +], fiberglass*).

**4. Don't wait to get your new physician credentialed.** When you sign a new practitioner on board your practice, don't wait too long before you apply for his NPI.

**Here's why:** You can retroactively bill Medicare for services your physician rendered up to 30 days prior to the date of filing a Medicare enrollment application that the contractor subsequently approves, the Medicare Fee Schedule says.

**What this means:** You have 30 days from the day you submitted the enrollment application to the Medicare carrier and the carrier receives your signed certification via mail, if you're filing via PECOS. If you file via paper application, the filing date is the day the carrier receives your application. ■



## READER QUESTION

# Always Include a Code From the 948.xx Range When Treating Burns

► **Follow the ‘Rule of Nines’ to identify and code the patient’s burns appropriately, based on location.**

**Question:** *When I am coding the diagnoses for burn victims, do I need to include a code from the 948.xx set on every claim?*

**Answer:** Yes, once you locate code(s) to represent the patient’s burn(s), find the appropriate code from 948.xx (*Burns classified according to event of body surface involved*) as a secondary diagnosis. The 948.xx codes can also serve as primary diagnoses when the site of the burn is unspecified, according to ICD-9 2009.

**Reason:** This code helps paint a better picture of the patient’s injuries: the fourth digit in the 948.xx code represents the total body surface area

(TBSA) burned, and the last digit indicates how much of the TBSA suffered third-degree burns.

You’ll employ the “Rule of Nines” to select the fourth and fifth digits. The Rule matches percentages and body areas as follows:

- head and neck, the right arm, and the left arm each equal 9 percent
- the back trunk, front trunk, left leg, and right leg each equal 18 percent (the front and back trunk are divided into upper and lower segments, and each leg is divided into back and front segments, each equaling 9 percent)
- genitalia equal 1 percent.

**Example:** Let’s say a patient has

a severely burned right leg: he has multiple second-degree burns on his front right leg and additional third-degree burns to his back right leg, but no loss of body part. In this instance, you would list the following in this order:

- 945.39 (*Burn of lower limb[s]; full-thickness skin loss [third-degree NOS]; multiple sites of lower limb[s]*) for the third-degree burn
- 945.29 (... *blisters, epidermal loss [second degree]; multiple sites of lower limb[s]*) for the second-degree burn
- 948.10 (... *10-19 percent of body surface; less than 10 percent or unspecified*) to represent TBSA burned. ■

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## PART B CODING COACH

# Play the Lesion Excision Waiting Game Unless Carrier Directs You Otherwise

► *Pathology report can unlock \$57 more for 11620 if it justifies using the malignancy code.*

If recent guidance made you question the MO of waiting for the path report, rest assured you can continue to delay assigning the benign or malignant lesion removal until you have the definitive diagnosis.

A new local coverage determination (LCD) related article “indicated that providers are to bill lesion removals based on what is known at the time of excision, regardless of what the pathology report shows,” points out **Heather Winters, CPC**, at United Cerebral Palsy Association of the North Country in Malone, N.Y. Now that your eyebrows are raised, here’s the scoop.

### Prevent Mislabeling by Waiting for Definitive Diagnosis

Traditionally, experts have recommended waiting for the path report before assigning a benign (11400-11446) or malignant lesion excision code (11600-11646). “You don’t want to call a lesion malignant unless the pathology report does,” says **Jill M. Young, CPC, CEDC, CIMC**, with Young Medical Consulting LLC in East Lansing, Mich.

**Why:** You could mislabel a patient as having a malignancy. The lesion’s appearance may be consistent with a malignancy, but it could ultimately turn out to be benign.

### Play It Safe With Unspecified Dx Under Old NGS Plan

A Medicare contractor for 10 states, however, called for a different approach from this “wait for confirmation” protocol. “If a benign skin lesion excision was performed, report the applicable CPT code, even if final pathology demonstrates a malignant or carcinoma in situ diagnosis for the lesion removed.

The final pathology does not change the CPT code of the procedure performed. To report removal of lesions of uncertain morphology, prior to identification of the specimen, report ICD-9-CM code 239.2 (*Neoplasms of unspecified nature, bone, soft tissue, and skin*), since proper coding requires the highest level of diagnosis known at the time the procedure was performed,” according to the National Government Services Inc. article A47397, “Removal of Benign Skin

Lesions.” (Primary jurisdiction for NGS includes Illinois, Kentucky, Ohio, Wisconsin, Michigan, Virginia, West Virginia, Indiana, Connecticut, and parts of New York.) The document makes the unspecified code the diagnosis to use with a benign excision code, Young explains. Otherwise, the physician could cause these errors:

- If the lesion on visual exam appears consistent with a benign growth but is ultimately malignant, the physician would have still reported a benign lesion excision.

“Lesions that are not known to be malignant at the time of excision are to be coded using the benign lesion removal codes,” Winters explains.

- If visual inspection suggests that the lesion is malignant and the physician calls the lesion malignant but pathology later determines the lesion is actually benign, the patient has been given a risk factor at the insurance level that may not be appropriate. The malignant codes pay more than the corresponding benign codes. Thus, there is a financial incentive to report a malignancy when the lesion is consistent with that assessment, noted **Jean Acevedo**,

## PART B CODING COACH

**LHRM, CPC, CHC, CENTC**, in a question and answer session at The Coding Institute's July 2009 National Coding and Reimbursement Conference in Orlando, Fla.

### Lose \$57 Plus for Refusing to Mislabel

Waiting for the pathology report to come back removes the financial incentive, says Acevedo, president of Acevedo Consulting Incorporated in Delray Beach, Fla. Money is taken out of the equation when office protocol calls for letting the report determine the definitive diagnosis.

But NGS's new policy relied on the physician to call a lesion suspicious of a malignancy as a malignancy. If physicians are not going to give a patient a possibly inappropriate risk factor, their only option under NGS's policy is to report a benign code, Young notes.

**Impact:** "The policy affected payments," Young reports. Physicians can be paid only the lesser payment associated with removing a benign lesion.

**Example:** A benign lesion code for a 0.25 cm excision from the hand pays approximately \$57\* less when reported with the benign code 11420 (*Excision, benign lesion including margins, except skin tag [unless listed else-*

*where], scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less*), rather than the malignant code 11620 (*Excision, malignant lesion including margins, except skin tag [unless listed elsewhere], scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less*). If a physician is not able to call the lesion malignant, he loses that money.

**\*Note:** Figures based on the 2009 Medicare Physician Fee Schedule that assigns 2.88 relative value units (RVUs) to 11420 and 4.46 RVUs to 11620 — a difference of 1.58 RVUs or approximately \$56.99 nationally using the 2009 conversion factor of 36.0666. You can use these rates to compare private payers' fees.

The policy caused such an uproar that NGS removed the paragraphs pertaining to coding for excision of benign vs. malignant skin lesions from the article as of July 1, 2009. "Providers are encouraged to code according to the coding instructions applicable to their various practice situations," according to NGS ([www.ngsmedicare.com/NGSMedicare/lcd/L27362\\_active\\_sia.htm](http://www.ngsmedicare.com/NGSMedicare/lcd/L27362_active_sia.htm)).

### Follow Path Report Unless Your Policy Differs

Some insurers agree that a "wait and confirm" approach is the way to go. The LCD for WPS calls for assigning the excision codes using the diagnosis of the tissue pathology report, Young reports. "The WPS policy is in direct opposition to the one NGS put out." You've got to know your carrier's guidelines. If your contractor does not have an established policy, or your practice does not participate in Medicare, check your office policy, Young recommends.

Does your compliance plan call for following ICD-9 guidelines in the absence of other policies? You've struck gold with this "wait for path" support from Chapter 2: Neoplasms (140-239) General Guidelines: "To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in situ, malignant, or of uncertain histologic behavior." ■

*Got a question for our experts?*

*Send it to editor Torrey Kim, CPC, at*

*Torrey@partbinsider.com.*

## PHYSICIAN NOTES

# Durable Medical Equipment Competitive Bidding Deadline Is Less Than a Month Away

► **Plus: CMS determines that negative pressure wound therapy systems don't warrant their own HCPCS code.**

Suppliers waiting for the onset of competitive bidding now have a firm deadline for the program. CMS will begin accepting bids for durable medical equipment in nine metro areas starting Oct. 21, CMS's Competitive Bidding Implementation Contractor said on its Web site.

The bid window will be open for 60 days, and CMS will announce the bid rates and begin contracting with suppliers in June of next year, the CBIC said. The program will go into effect in January 2011. Suppliers can begin signing up for bid system user IDs and passwords on Aug. 17, according to CMS estimates.

There are a few changes from the original Round One bid, CMS noted in a release. Puerto Rico will now be excluded from the bid areas, and negative pressure wound therapy

items and Group 3 complex rehabilitative power wheelchairs will be excluded from the list of bid items. Otherwise the bid areas and items remain the same.

*You can access more bidding information, including the detailed timeline and entire slate of educational sessions and materials, at [www.dmecompetitivebid.com](http://www.dmecompetitivebid.com).*

### In other news ...

• **The research on negative pressure wound therapy (NPWT) has just been completed by CMS and the Agency of Healthcare Research and Quality, and NPWT proponents may not like the findings.**

“The available evidence does not support significant therapeutic

distinction of a NPWT system or component of a system,” CMS said. In other words, no one NPWT system or part deserves its own HCPCS code.

NPWT applies a localized vacuum to draw the edges of the wound together while providing a moist environment to promote rapid wound healing. NPWT is based on two theories: (1) the removal of excess interstitial fluid decreases edema and concentrations of inhibitory factors and increases local blood flow; and (2) stretching and deformation of the tissue by the negative pressure can disturb the extracellular matrix and introduce biochemical responses that promote wound healing.

*The study backing up CMS' decision can be accessed online at [www.ahrq.gov/clinic/ta/negpresswtd/npwtd01.htm](http://www.ahrq.gov/clinic/ta/negpresswtd/npwtd01.htm).* ■



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**Torrey Kim, CPC**  
Editor-in-Chief  
[torrey@partbinsider.com](mailto:torrey@partbinsider.com)

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Consulting Editor

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The Coding Institute, 2272 Airport Road S., Naples, FL 34112 Tel: (800) 508-2582 Fax: (800) 508-2592

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