

UROLOGY CODING ALERT

The practical adviser for ethically optimizing coding, reimbursement and efficiency in urology practices

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Reporting 599.7 for Hematuria? Not Anymore ▶ Plus, ICD-9 proposed changes include 3 new urogynecology codes

Every October, you're faced with new ICD-9 codes. They take effect Oct. 1, with no grace period, so now's the time to start preparing. Take a look at these proposed changes that you should plan to incorporate into your superbills.

There may be some changes to the list between now and the end of September, but many of 2009's new additions are already available. Although the new codes for this fall contain relatively few changes for urology, *Urology Coding Alert* homes in on the list of diagnosis code changes most important to you.

Say Goodbye to 599.7

The biggest proposed change for urology is that you'll no longer have ICD-9 code 599.7 (*Hematuria, benign, essential*) to report. This code is scheduled for deletion on Oct. 1. In its place you will have three new ICD-9 codes:

- 599.70 — *Hematuria, unspecified*
- 599.71 — *Gross hematuria*
- 599.72 — *Microscopic hematuria.*

Good News: Codes Are More Specific

Urology coders will frequently use these new diagnostic codes to properly characterize the degree or severity of the hematuria, experts say.

"I think the biggest diagnosis change for our group will be gross hematuria versus microscopic," says **Christy Shanley, CPC**, billing manager for the University of California, Irvine, department of urology. "I believe that they will be used frequently in our practice. This is a good change."

"Hematuria is one of the most frequent conditions warranting referral to urology. The more specific coding can be, the better," adds **Holly Hayataka, MD**, with urology services at The Queens Medical Center in Honolulu, Hawaii. "I believe the new ICD-9 proposals are very good, because the words 'benign' and 'essential' have been deleted. One does not usually know if the hematuria is benign and/or essential until after the complete workup, so 'hematuria, unspecified' is much better."

Update the Kidney Tumor Codes

If your urologist frequently treats kidney problems, starting in the fall you'll be able to be more specific about the type of tumor the patient has. The next ICD-9 update will include two new codes: 209.24 (*Malignant carcinoid tumor of the kidney*) and 209.64 (*Benign carcinoid tumor of the kidney*). These codes are "a nice addition," Shanley says. "Prior to these codes, you would have to code by site, benign or malignant." The new codes help you submit "more defined" diagnosis codes, Shanley adds.

Additionally: If you code for urologists involved in the diagnosis and treatment of endocrine abnormalities and abnormal genitalia, take note of the following proposed additions:

- 259.50 — *Androgen insensitivity, unspecified*
- 259.51 — *Androgen insensitivity syndrome*
- 259.52 — *Partial androgen insensitivity*.

This set of changes also provides further definition and specificity to urology diagnosis coding, Shanley says. The new set of proposed ICD-9 changes deletes the prior code you would have used — 259.5 (*Androgen insensitivity syndrome*).

"The new 259.5x codes are a good thing," Hayataka says. "It allows coding to capture real life more accurately. There are definitely instances when the partial insensi-

tivity code will be more accurate, usually after the completed workup."

Urogynecology changes: For coders working in the urogynecology discipline, you'll want to take note of three new V codes in the proposed lot of codes:

- V88.01 — *Acquired absence of both cervix and uterus*
- V88.02 — *Acquired absence of uterus with remaining cervical stump*
- V88.03 — *Acquired absence of cervix with remaining uterus*.

Other ICD-9 codes of interest to urologists:

- 199.2 — *Malignant neoplasm associated with transplant organ*
- 788.91 — *Functional urinary incontinence*
- 788.99 — *Other symptoms involving urinary system*.

Deletion: As of Oct. 1, you'll replace 788.9 (*Other symptoms involving urinary system*) with 788.99. □

**Have a urology coding question?
Get help from our experts!**

Send your question to the editor, Leesa Israel,
CPC, CMBS, at leesai@elijournals.com
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CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to urology coding, reimbursement and/or compliance to Leesa Israel at Leesa@elijournals.com.

Mail: PO Box 413006, Naples, FL 34101-3006
Phone: (800) 508-2582 **Fax:** (800) 508-2592

Editor in Chief: Leesa A. Israel, CPC, CMBS
(Leesa@elijournals.com)

Consulting Editor: Michael A. Ferragamo, MD

Executive Editor: Jerry Salley, CPC
(jerrys@eliresearch.com)

Director of Development:

Bridgett Hurley, JD, MA

President: Samantha Gardiner Saldukas
(sam@medville.com)

Director of Sales: Bill Streight
(bills@medville.com)

Medallion Group Manager: Aleshia Elismond
(elismond@medville.com)

Live Conference Manager: Lacy Keith
(lacyk@medville.com)

Audioconference Director: Tracy L. Thomas
(tracyt@eliresearch.com)

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Test Your Know-How of Stricture Dilation Codes With a Case Study

► *Hint: Learn the modifier 26 guidelines*

If you don't know the proper surgical and radiological codes to report for your urologist's balloon dilation procedures, you could be under-reporting your urologist's services and procedures.

Test yourself by coding this scenario submitted by **Claire Kenny, CPC**, in the urology division of the professional coding department at Lahey Clinic in Burlington, Mass. Start by analyzing the following surgical report (condensed for space purposes) and then compare your coding solution to the expert answer.

Diagnosis (pre- and post-op): Recurrent urethral stricture

Procedure: Cystoscopy, retrograde urethrogram, and urethral balloon dilation

Indications: The patient is a 59-year-old man with history of panurethral stricture of unknown source who is status post a three-stage skin graft urethroplasty in 1980 with graft taken from the right lateral flank. He has since had multiple recurrent strictures requiring 30+ dilations over the past several years.

He also had an episode of retention as well as a recent UTI. The patient has noted a significant decrease in the force and size of his urinary stream and was seen in the office yesterday, at which time the urologist passed a guidewire down the urethra but could not place a dilating balloon over this wire. He now presents for evaluation and dilation under anesthesia.

Procedure: The urologist performed a retrograde urethrogram that showed a stricture in the membranous urethra and a distal pendulous urethra stricture.

Next, the urologist attempted to pass the 17-French cystoscope but was unable to pass the cystoscope beyond the distal pendulous urethra. Therefore, the physician inserted a 4-French open-ended ureteral catheter into the bladder and passed the cystoscope over the ureteral catheter. The patient had a very dense stricture in the distal pendulous urethra, which the urologist navigated with the scope with much difficulty.

The remainder of his pendulous urethra appeared of normal caliber. His prostatic urethra was normal with a normal verumontanum, but a high bladder neck.

Inspection of his bladder revealed multiple trabeculations and several diverticula with the two largest

diverticula on the left posterior bladder wall. He also had some erythematous bullous edema at the bladder neck, which had some erythema. These lesions appeared consistent with inflammation. However, the urologist sent the urine for cytology to rule out a malignancy.

The urologist then removed the cystoscope. Next, he inserted a 9-French urethral balloon dilation catheter, inflating it and leaving it in place.

Coding question: For this procedure, would you report 52281 (*Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female*), or would you report 52000 (*Cystoscopy*), 53600 (*Dilation of urethral stricture by passage of sound or urethral dilator, male; initial*), 51610 (*Injection procedure for retrograde urethrocytography*), 52510 (*Transurethral balloon dilation of the prostatic urethra*), and 74420-26 (*Urography, retrograde, with or without KUB; professional component*)?

"I have been billing 52281 and 74420-26 only and wonder if I'm too cautious," Kenny says.

Answer: Start With the Cysto

CPT coding principles state that you should report only one code if that one code encompasses the multiple procedures or services your urologist performed. Therefore, the first code you should report in this scenario is indeed 52281. This code accurately represents the urologist's work of performing the cystourethroscopy, stricture dilation and the retrograde injection for the urethrocytography.

Next: You should report radiology code 74450 (*Urethrocytography, retrograde, radiological supervision and interpretation*) rather than 74420 for the retrograde urethrogram, says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology, State University of New York, Stony Brook.

Modifiers: Be sure to append modifier 26 to 74450 to indicate that the urologist only performed the interpretation of the urethrogram. Generally, if a physician conducts diagnostic tests or other services using equipment she doesn't own (like at the hospital), you should append modifier 26 to indicate that she provided only the physician component (the interpretation) of the service, says **Suzan Berman-Hvizdash, CPC, CPC-E/M, CPC-EDS**, physician educator for the University of

(continued on next page)

Pittsburgh and past member of the American Academy of Professional Coders National Advisory Board.

But if the physician does the procedure (in its entirety) in the office with equipment owned by the practice, you don't need a modifier, she adds.

"Code 74420-26 is for the interpretation of a retrograde pyelogram, a radiological study of the kidney pelvis and ureter, not of the urethra," Ferragamo says.

Tip: If the far-left column of the CMS Physician Fee Schedule database lists separate values for the code with modifiers 26 and TC, modifier 26 would be appropriate if your urologist provides only the service's professional component. You can download the fee schedule from the CMS Web site www.cms.hhs.gov/PhysicianFeeSched/.

Avoid Old Codes

Code 52510 represents prostate and prostatic urethra dilation. According to the operative report, the urologist did not perform prostate or prostatic urethra dilation in this case. Therefore, you would not report that code.

Additionally: CPT deleted code 52510 as of January 1, 2008, because this procedure never proved to be clinically effective and urologists rarely performed the procedure to relieve prostatic obstruction, Ferragamo says.

Diagnosis: You should attach ICD-9 code 598.9 (*Urethral stricture, unspecified*) to each of the procedures you report for this case. □

Solidify Postsurgical Coding With 4 Expert Tips

► *Trap: Don't think 58 is just for advanced planning*

Still confused about which postsurgical modifier to use on claims despite the CPT 2008 revisions? You're not the only one.

Despite the fact that CPT 2008 revised the text explaining modifier 58 (*Staged or related procedure or service by the same physician during the postoperative period*), many practices are still confused about how to interpret modifier 58 and when to use it rather than modifier 78 (*Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period*).

Move beyond the confusion and ensure you're coding every postsurgical procedure correctly with these expert tips.

Tip 1: Don't Rely on Planning

This year, CPT advised that you may append modifier 58 to staged or related procedures that were "planned or anticipated" at the time of the original surgery — not just ones that your surgeon planned in advance.

Caution: The new description doesn't mean that you should automatically apply modifier 58 to all foreseen secondary procedures and append modifier 78 for unplanned postsurgical procedures.

Bottom line: You should apply modifier 58 when a procedure or service during the postoperative period is:

- planned prospectively at the time of the original procedure (staged), or
- more extensive than the original procedure, or represents surgical treatment following a diagnostic surgical procedure.

"The current procedure has some connection to the original procedure, be it a more extensive approach to the original procedure or planned services after the original procedure (surgery or therapeutic treatment)," says **Edwina Sprow, CPC**, owner of Sprow Consulting Services based in Phoenix.

Example: The urologist performs a transurethral resection of the prostate (TURP) for benign prostatic hyperplasia (BPH). Because of the large size of the

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prostate gland, the initial procedure is incomplete, and in his op note, the urologist indicates that the patient will need a second-stage TURP to remove more tissue at a later date. The patient returns to the operating room 41 days later for another TURP because of the persistent BPH.

In this case, you report the first TURP using 52612 (*Transurethral resection of prostate; first stage of two-stage resection [partial resection]*). Then, because the urologist said that the patient would require a second-stage resection during the 90-day global period of the first resection, you should code the second TURP as 52614 (*Transurethral resection of prostate; second stage of two-stage resection [resection completed]*). Append modifier 58 to indicate a staged procedure and ensure full payment for the second TURP within the 90-day global of the first.

Important: Payers require that documentation in the initial op note should indicate that a second staged procedure will be necessary. This prospectively indicates the anticipated staged procedure.

Key: The patient's condition, rather than the results of a previous surgery, dictates the need for additional procedures. You should not use modifier 58 if the patient needs a follow-up procedure to correct surgical complications that arise from the initial surgery.

You Be the Coder

Lesion Resection and Fulguration of Bleed

Question: *I need to code the following procedure for my urologist: He performed a cystoscopy using a 21 French scope that revealed a large median lobe and some friable bulbous type lesions (questionable tumors) coming off the interior portion of the bladder/median lobe of the prostate. He had noticed this area was bleeding during a prior in-office cystoscopy. Using a 24 French resectoscope, he completely resected the lesions and a large portion of the median lobe of the prostate. He then evacuated the chips using the Ellik evacuator. He was able to control all bleeding and identify the ureteral orifices prior to the resection. He resected the majority of the median lobe in the process of resecting these lesions.*

Florida Subscriber

Answer: See page 54. □

Tip 2: OR Isn't a Requirement

Your urologist does not need to return the patient to the operating room (OR) for you to use modifier 58, says **Denae M. Merrill, CPC-E/M**, owner of Merrill Medical Management in Saginaw, Mich. The physician may provide a postoperative procedure or service, for instance, in his office or other outpatient setting. In all cases, however, the same physician must provide both the initial service/procedure and the follow-up procedure that requires modifier 58.

Tip 3: 'More Extensive' Doesn't Equal More Complex

Don't be confused by "more extensive": A "more extensive" procedure to which you append modifier 58 doesn't need to be more complex or time-intensive than the original procedure (although it can be). Rather, the urologist's subsequent procedure need only be more extensive than the work he performed during the initial procedure. Here again, however, the patient's condition — not complications from the initial surgery — must drive the decision to perform an additional procedure.

"'More extensive' is an important set of words," Merrill says. "What they are talking about is when a patient first has a simple-type procedure and that doesn't 'fix' the problem, so they take the patient back for a more complex-type procedure."

Explanation: Modifier 58's descriptor refers to when the patient undergoes a procedure that fails to completely correct the problem, and then the patient requires a more extensive procedure during the global of the first procedure. An example would be an extracorporeal shock wave lithotripsy (50590) that does not completely fragment a renal pelvic calculus followed by a "more invasive" procedure, a percutaneous nephrostolithotomy (50081), to completely fragment and remove the stone. The proper coding would be 50590 and 50081-58.

Important: If you're using modifier 58 due to "more extensive" reasons, ensure that your urologist has clearly documented the reasons in the additional procedure's note, Sprow says.

Tip 4: Turn to 78 for Complications

Unlike modifier 58, you should apply modifier 78

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when conditions arising from the initial surgery (complications) — rather than the patient’s condition — call for a related procedure.

Example: The urologist performs a distal ureterectomy, ureteroscopy and ureteral reimplantation of the left ureter for a lower ureteral carcinoma. Eight days later, the patient has severe gross hematuria with clots requiring a return to the OR where the urologist performs a cystogram and fulguration of a bleeding vessel within the bladder at the ureteroneocystotomy, ureteral reimplantation site.

For the second surgery, report 52214-78 (*Cystourethroscopy, with fulguration [including cryosurgery or laser surgery] of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands*). Because your urologist had to perform the second surgery due to a complication resulting from the first surgery, you need to append modifier 78 to indicate that your physician performed surgery in the operating room to correct a complication from a prior procedure.

Next, report 51600-78 (*Injection procedure for cystography or voiding urethrocytography*) for the cystogram. If the patient’s medical record shows documentation that the physician not only performed the cystogram

and but also interpreted the results, you should also report 74430 (*Cystography, minimum of three views, radiological supervision and interpretation*).

Append modifier 26 (*Professional component*) to 74430 to indicate that you are only billing for the professional component — the cystogram’s interpretation.

Good practice: If the medical record does not clearly indicate the reason for the subsequent surgery, you should check with your urologist prior to selecting a modifier. □

READER QUESTIONS

Get Paid for Codes That You Can’t Unbundle

Question: *Is there a way of billing for a stent removal on one side and a ureteroscopy on the opposite side? The Correct Coding Initiative (CCI) bundles two codes — 52310 and 52353, for example — and does not allow coders to break the bundle using any modifier. I come across many procedure codes that CCI says I can never report together, but my urologist performs the procedures on different ureters or kidneys. Is there any way to code for these sorts of procedures and get the reimbursement the doctor deserves?*

Hawaii Subscriber

Answer: The Correct Coding Initiative (CCI) establishes edits for Medicare, and if the patient’s carrier is Medicare, you may have some difficulty collecting payment for the procedures you have asked about. As you state, CCI bundles 52310 (*Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder [separate procedure]; simple*) and 52353 (*Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy [ureteral catheterization is included]*) with an edit indicator of 0, meaning that you can never bypass this edit with any modifier.

Suggested coding: Despite the CCI bundle, experts suggest that you first report 52353 with modifier LT (*Left side*) appended for the left-side ureteroscopy and stone fragmentation. You’ll attach diagnosis code 592.1 (*Ureteral calculus*). Then, report 52310 with both modifier 59 (*Distinct procedural service*) and modifier RT (*Right side*) for the removal of the right-side ureteral stent. With this code, submit diagnosis code 939.0 (*Foreign body in urethra and bladder*). Modifier 59 indicates that you intend to break the bundle that CCI puts in place.

Why: Some private carriers that do not follow the

You Be the Coder

Lesion Resection and Fulguration of Bleed

Answer: First, report 52612 (*Transurethral resection of prostate; first stage of two-stage resection [partial resection]*) for the transurethral resection of the prostatic median lobe. Attach 600.01 (*Hypertrophy [benign] of prostate with urinary obstruction*) as the diagnosis code.

Also report 52234 (*Cystourethroscopy, with fulguration [including cryosurgery or laser surgery] and/or resection of; SMALL bladder tumor[s] [0.5 up to 2.0 cm]*) for the resection of the tumor at the bladder neck.

Diagnosis warning: The diagnosis code for this portion of the procedure is 239.4 (*Neoplasms of unspecified nature; bladder*) because you do not yet know the pathology of these bladder neck lesions. Remember that 239.4 is a payable diagnostic code indicating medical necessity. □

CCI may reimburse you for the two procedures when you use modifiers 59 and LT/RT. Medicare as well as some private carriers, however, will strictly follow the CCI. In these cases, the payer will deny one of the codes, usually 52310.

Appeal: Because the urologist should be reimbursed since the procedures involve two different, separate parts of the urinary tract — the right and left sides — you should be able to successfully appeal this denial with complete and detailed documentation. You will need to be persistent in your appeals, however.

Change Your Coding When Doctor Changes Tubes

Question: *A patient presented with previously placed nephrostomy tube and a 3-cm renal pelvic stone within the same kidney. The urologist performed an antegrade pyelogram and after removing the nephrostomy tube used a Bard X-Force balloon to dilate the nephrostomy tract under fluoroscopy.*

Then the physician prepared the nephroscope, removed the balloon and used the nephroscope. Using the Cyperwand lithotripter, he fragmented the stone using ultrasound and sucked out the fragments. Fluoroscopy revealed a small stone burden left, so the urologist used a cystoscope, a rigid nephroscope and grasping forceps to remove the fragments. He used a 22-french foley as a follow-up nephrostomy tube for postoperative drainage, and performed a second antegrade pyelogram to confirm tube position. He did not place a stent. Are 50394 and 50561 the only codes to use?

California Subscriber

Answer: No. You should report four codes for this procedure. First, for the fragmentation of the renal calculus and fragment removal, report 50081 (*Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm*).

Next, submit 50394 (*Injection procedure for pyelography [as nephrostogram, pyelostogram, antegrade pyeloureterograms] through nephrostomy or pyelostomy tube, or indwelling ureteral catheter*) for the nephrostogram and antegrade pyelogram. Then, report 50398 (*Change of nephrostomy or pyelostomy tube*) for the changes of the nephrostomy tube.

Capture the urologist's reading of the nephrostogram and antegrade pyelogram using 74425 (*Urography,*

antegrade [pyelostogram, nephrostogram, loopogram], radiological supervision and interpretation). Append modifier 26 (*Professional component*) to indicate that your physician only read and interpreted the study.

Use Radical Coding for Missing Components

Question: *How should I code a LT-hand assisted radical laparoscopic nephrectomy of the left kidney with partial removal of ureter in which the urologist did not remove adrenal gland? The diagnosis the physician indicated is malignant renal mass.*

Texas Subscriber

Answer: When your urologist performs a radical laparoscopic nephrectomy, including the removal of Gerota's fascia and the perinephric fat, but does not also perform an adrenalectomy, the American Urological Association has instructed that you should still code for the radical laparoscopic nephrectomy using 50545 (*Laparoscopy, surgical; radical nephrectomy [including removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy]*).

Keep in mind: When the surgeon performs a hand-assisted procedure, you won't report any additional codes. Payers consider the hand in the wound an extra portal site not necessitating an additional CPT code or modifier.

You should report diagnosis code 189.0 (*Malignant neoplasm of kidney ... except: penis*) for this procedure.

Second-Stage TURP Warrants Altered Codes

Question: *The urologist did a TURP one day and then had to go back unexpectedly two weeks later and do another TURP to remove residual obstructing tissue because the patient could not void. Should I consider this a second-stage TURP even though the physician did not mention the second procedure in his original operative note? The second procedure was still within the 90-day global period of the first.*

Virginia Subscriber

Answer: The coding for the second procedure will depend on whether you have already coded and billed for the initial transurethral resection of the prostate (TURP).

If you have already reported and billed for the initial

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TURP using 52601 (*Transurethral electro-surgical resection of prostate, including control of postoperative bleeding, complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included]*), you should report the second TURP with 52614 (*Transurethral resection of prostate; second stage of two-stage resection [resection completed]*) because 52601 is a “once in a lifetime” procedure per patient, so you can only bill this procedure once for a patient.

Don't forget: Append modifier 58 (*Staged or related procedure or service by the same physician during the postoperative period*) to 52614 indicating that although the urologist did not anticipate a staged procedure, the patient needed a second TURP. The diagnosis would be the same for both procedures: 600.01 (*BPH with urinary obstruction*).

If you have not already coded for the initial TURP, use 52612 (*Transurethral resection of prostate; first stage of two-stage resection [partial resection]*) for the first procedure and 52614-58 for the second TURP.

— *Answers to Reader Questions and You Be the Coder* contributed by **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology, State University of New York, Stony Brook. □

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Past President, American College of Medical Practice Executives
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Coastal Georgia College

Michael A. Ferragamo Jr., MD, FACS

Clinical Assistant Professor of Urology
State University of New York Medical College

Morgan T. Hause, CCS, CCS-P

Compliance and Privacy Officer
Urology of Indiana LLC

Margie Irvin, RN, CRLS

Regional Vice President, Integrated Health Services (IHS) Lithotripsy Division
Allied Section Chair of Governmental Affairs and Reimbursement for the American Lithotripsy Society
CEO, Bay Area Renal Stone Center, Fla.

Marta Krissovich, MS, RN, NP, CNS, CCCN

Society of Urologic Nurses & Associates, Calif.

Maggie M. Mac, CMM, CPC, CMSCS

Consulting Manager
Pershing, Yoakley & Associates, Fla.

Janet McDiarmid, CMM, CPC, MPC

CEO, McDiarmid Consultants LLC
Past President
American Academy of Professional Coders
National Advisory Board

David J. McLeod, MD

Residency Program Director and Director of Urologic Oncology
Walter Reed Army Medical Center, Washington, D.C.

Ron Nelson, PA-C

Clinical Practitioner
Reimbursement Policy Analyst
President, Health Services Associates, Mich.
Past President, American Academy of Physician Assistants

Lynn R. Rogers

Office Manager
Professional Economics Ltd., Ind.
Member, Healthcare Billing and Management Association

Laura Siniscalchi, RHIA, CCS, CCS-P, CPC

Manager, Deloitte & Touche