2015 Update on AHA Coding Clinic for ICD-10-CM and ICD-10-PCS
Part Two

Wednesday, August 26, 2015
12:00 pm CST

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Overview

- Revision of ventriculoperitoneal shunt
- Skin sparing mastectomy
- Robotic-assisted laparoscopic hysterectomy converted to open procedure
- Alcohol abuse and withdrawal
- Glasgow coma scales
- Heart failure with pleural effusion
- Revision of femoropopliteal bypass graft
- Total knee revision
- Reverse total shoulder arthroplasty
- Revision of femoral head and acetabular liner
- Total hip replacement surgery using stem cell autograft
- Coronary artery intervention site
- Nontraumatic acute liver injury
- Urinary calculi fragmentation and evacuation
- Decompression laminectomy
- Uterine artery embolization
Revision of Ventriculoperitoneal Shunt

- Patient with congenital hydrocephalus
- Status post VP shunt
- Admitted due to shunt failure
- Surgery to replace shunt
  - Distal end removed and replaced
  - What is PCS code – is this considered a drainage device?
Revision of Ventriculoperitoneal Shunt (cont.)

• VP shunt
  – Drains extra fluid from brain into peritoneal cavity
    • Fluid is then absorbed
  – Has three basic parts
    • Ventricular catheter
    • Shunt valve
    • Distal catheter
Revision of Ventriculoperitoneal Shunt (cont.)

- Ventricular catheter
  - Placed into fluid part of brain
  - Fluid drains through catheter into the valve
- Valve
  - One way valve
  - Controls rate of flow
- Distal Catheter

Revision of Ventriculoperitoneal Shunt, (cont.)

- Not classified as a drainage device
  - Drainage – taking/letting out fluids/gases
- Initially placed to reroute contents of cerebral ventricle to another location
  - Bypass – altering the route of passage of the contents of a tubular body part
    - The device placed in the initial root operation “bypass” is “synthetic substitute”
    - Sites of revision: peritoneal cavity and subcutaneous tissue of periauricular area
Revision of Ventriculoperitoneal Shunt, (cont.)

• Assign codes:
  – **0WWG4JZ**, Revision of synthetic substitute in peritoneal cavity, percutaneous endoscopic approach
  – **0JWS0JZ**, Revision of synthetic substitute in head and neck subcutaneous tissue and fascia, open approach

*Coding Clinic, Second Quarter 2015* pages 9-10

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Skin-Sparing Mastectomy

• Patient with history of breast cancer
• Admitted for skin-sparing mastectomy
  – technique that preserves as much of the breast skin as possible
  – the tumor, clean margins, nipple, areola, fat and other tissues that make up the breast are removed
  – breast tissue is removed through the small opening that is created
Skin-Sparing Mastectomy (cont.)

• Entire breast removed via electrocautery
• Resection or excision of breast?
  – Resection: cutting out or off, without replacement, all of a body part
  – Excision: cutting out or off, without replacement, a portion of a body part
• Assign code:
  – **0HT0ZZ**, Resection of right breast, open approach
  – Nipple removal is not coded separately

Coding Clinic, Fourth Quarter 2014 page 34

Robotic-Assisted Laparoscopic Hysterectomy

• Patient with endometrial carcinoma
• Attempted robotic-assisted laparoscopic hysterectomy
  – Attempt made to mobilize uterus
  – Uterine vessels could not be safely visualized
• Converted to open total abdominal hysterectomy (TAH) with bilateral salpingo-oophorectomy
Robotic-Assisted Laparoscopic Hysterectomy (cont.)

• How is the attempted robotic-assisted laparoscopic hysterectomy, converted to open TAH coded?
  – Guideline B3.2d: multiple procedures are coded if the intended root operation is attempted using one approach, converted to different approach
  – Guideline B3.3: Discontinued procedure

• If the intended procedure is discontinued:
  – Code to approach ultimately used
  – Additionally, “inspection” coded with approach value of the attempted approach
    • OUT90ZZ, Resection of uterus, open approach
    • OUT70ZZ, Resection of bilateral fallopian tubes, open approach
    • OUT20ZZ, Resection of bilateral ovaries, open approach
    • UTC0ZZ, Resection of cervix, open approach
    • 0UJD4ZZ, Inspection of uterus and cervix, percutaneous endoscopic approach
    • 8E0W4CZ, Robotic assisted procedure of trunk region, percutaneous endoscopic approach

Coding Clinic, Frist Quarter 2015 pages 33-34
Alcohol Abuse and Withdrawal

• Patient admitted in withdrawal and physician documents alcohol abuse.

• Index entry:
  – Alcohol
    • withdrawal F10.239
      – F10.239, Alcohol dependence with withdrawal, unspecified
        » There is an Excludes 1 note at category F10.23-, Alcohol dependence with withdrawal
          • Excludes alcohol dependence with intoxication (F10.22-)

Alcohol Abuse and Withdrawal (cont.)

• Question: How is alcohol abuse with withdrawal coded in ICD-10-CM?
  – ICD-10-CM:
    • Alcohol withdrawal categorized as alcohol dependence, by default
    • Combination code for alcohol dependence with withdrawal
    • Query for clarification
Glasgow Coma Scales

• Used to assess degree of consciousness
• Scoring is determined by three factors:
  – Amount of eye opening
  – Verbal responsiveness
  – Motor responsiveness
• Coma codes (subcategory **R40**) can be used in any setting, but mainly used by trauma registries

Glasgow Coma Scales (cont.)

• Sequenced after the diagnosis code
• One code from each subcategory is needed to complete the scale
• At minimum, record initial score
  – Multiple scores may be assigned, if desired
• Scores:
  – Total: **R40.24-**, Glasgow coma scale, total score
  – Individual: **R40.21-R40.23**
Glasgow Coma Scales (cont.)

• Individual score codes:
  – R40.21, Coma scale, eyes open
    • R40.211-, Coma scale, eyes open, never
    • R40.212-, Coma scale, eyes open, to pain
    • R40.213-, Coma scale, eyes open, to sound
    • R40.214-, Coma scale, eyes open, spontaneous
  – R40.22, Coma scale, best verbal response
    • R40.221-, Coma scale, best verbal response, none
    • R40.222-, Coma scale, best verbal response, incomprehensible words
    • R40.223-, Coma scale, best verbal response, inappropriate words
    • R40.224-, Coma scale, best verbal response, confused conversation
    • R40.225-, Coma scale, best verbal response, oriented

• Individual score codes, (cont.)
  – R40.23, Coma scale, best motor response
    • R40.231-, Coma scale best motor response, none
    • R40.232-, Coma scale, best motor response, extension
    • R40.233-, Coma scale, best motor response, abnormal
    • R40.234-, Coma scale, best motor response, flexion withdrawal
    • R40.235-, Coma scale, best motor response, localizes pain
    • R40.236-, Coma scale, best motor response, obeys commands
Glasgow Coma Scales (cont.)

• Total score codes:
  – **R40.24**, Glasgow coma scale, total score
    • **R40.241**, Glasgow coma scale score 13-15
    • **R40.242**, Glasgow coma scale score 9-12
    • **R40.243**, Glasgow coma scale score 3-8
    • **R40.244**, Other coma, without documented Glasgow coma scale score, or with partial score reported

Glasgow Coma Scales (cont.)

• Questions:
  – Can individual Glasgow coma score (GCS) codes be assigned based on documented numeric values rather than description of codes?
    • GCS eye subscore - 3
    • GCS verbal subscore - 4
    • GCS motor subscore - 6
  – When reporting GCS, can a total score be calculated if only individual scores are documented?
Glasgow Coma Scales (cont.)

• Answer:
  – Documentation clearly shows ratings are specific scores or numeric values for the GCS, appropriate to report codes from categories R40.21-, R40.22- and R40.23-.
  – Code R40.24-, Glasgow coma scale, total score is NOT assigned if the individual scores are documented.
  – There is a 7th character for these codes.
    • Indicates when the scale was recorded
    • Should match for all three codes

Polling Question #1

The ICD-10-CM Coding Guidelines state that the coma scale codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected.

Will your facility be reporting the coma scale codes?

A. As individual scores
B. Only the total score code
C. We will not be reporting these codes
D. Haven't decided if we will report these codes
Heart Failure with Pleural Effusion

• Heart failure:
  – I50.9, Heart failure unspecified
  – Nothing to indicate if code J91.8, Pleural effusion in other conditions classified elsewhere, can be assigned as an additional code.
  – However, at category J91, there is an excludes 2 note for “pleural effusion in heart failure.”

Heart Failure with Pleural Effusion (cont.)

• Previous advice
  – Pleural effusion in CHF is usually minimal
  – Addressed by aggressively treating the CHF
  – Not coded separately
• Is code J91.8 assigned for pleural effusion due to CHF?
• How is pleural effusion in CHF coded?
Heart Failure with Pleural Effusion (cont.)

• **J91.8**, is assigned only if specifically evaluated or treated.
• Again, this is a condition that is commonly seen with CHF.
• Usually minimal and not addressed other than by treating the CHF.
• However, if the pleural effusion requires either therapeutic intervention or diagnostic testing, appropriate to separately report.

_Coding Clinic, Second Quarter 2015 pages 15-16_
Root Operation – “Revision”

• Correcting a malfunctioning/displaced device
  – Always involves a device
• Revision can include correcting a malfunctioning device by taking out and/or putting in part of the device
• Site of procedure:
  – In/on a body part
• Examples: Adjustment of pacemaker lead, adjustment of hip prosthesis

Other Examples of Revision Surgery

• Open revision of right hip replacement, involving recementing of prosthesis
• Adjustment of position, pacemaker lead in left ventricle, percutaneous
• Revision of VAD reservoir placement in chest wall, causing patient discomfort
Scenario 1 - Revision of Femoropopliteal Bypass Graft

Patient status post femoropopliteal bypass (fem-pop) presents with graft occlusion. Open thrombectomy with trimming and reanastomosis of existing fem-pop autologous bypass graft.

04WY07Z Revision of autologous tissue substitute in lower artery, open approach

Coding Clinic, First Quarter 2015 pages 36-37

Root Operation – “Replacement”

• Putting in device that replaces a body part
  – Always involves a device
• Site of Procedure
  – Some/all of a body part
• The body part may have been taken out or replaced, or may be taken out, physically eradicated, or rendered nonfunctional during the Replacement procedure.
  – Removal procedure is coded for taking out the device used in a previous replacement procedure.
• Examples: Total hip replacement, bone graft, and free skin graft
Other Examples of Replacement Surgery

- Excision of abdominal aorta with gortex graft replacement
- Tendon graft to right ankle using cadaver graft
- Mitral valve replacement using porcine valve

Root Operation – “Removal”

- Taking out or off a device from a body part
- If taking out a device and putting in a similar device is done with an external approach:
  - Code the procedure to the root operation “Change”
    - Otherwise, the procedure for taking out the device is coded to the root operation – “Removal.”
    - Procedure for putting in the new device is coded to the root operation performed.
- Examples: drainage tube removal, cardiac pacemaker removal, cement spacer removal, fixation hardware removal
Scenario 2 - Total Knee Revision

Patient with painful right total knee arthroplasty presents for revision. Old components removed and new tibial and femoral components were inserted and cemented.

0SRCOJ9  Replacement of right knee joint with synthetic substitute, cemented, open approach

0SPC0JZ  Removal of synthetic substitute from right knee joint, open approach

Scenario 2 - Total Knee Revision (cont.)

• Coder’s responsibility to determine what the health record documentation equates to in PCS terms.
• Providers are not expected to use the terms in PCS code descriptions.
• Coder not required to query when the correlation between the documentation and PCS terms is clear.
• Although revision may be documented in the operative note:
  – ICD-10-PCS defines revision as correcting the position or function of a previously placed device
  – Without taking out and putting a whole new device in its place
  – Complete redo of a procedure is coded to the root operation performed:
    • In this example, both removal and replacement carried out.
Scenario 3 - Reverse Total Shoulder Arthroplasty

Patient undergoes reverse total shoulder arthroplasty. At surgery, rotator cuff repaired, and the biceps tendon tenodesed and secured with sutures. To achieve additional external rotation strength, the latissimus muscle was harvested and transferred around the humerus and secured to the greater tuberosity.

**ORRJ00Z**  
Replacement of right shoulder joint with reverse ball and socket, synthetic substitute, open approach

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Scenario 4 - Revision of Femoral Head and Acetabular Liner

Patient admitted for revision of right hip arthroplasty. The right ceramic head and acetabular liner were replaced due to excessive wear.

**OSRR03A**  
Replacement of right hip joint, femoral surface with ceramic synthetic substitute, uncemented, open approach

**OSUA09Z**  
Supplement right hip joint, acetabular surface with liner, open approach

**OSP90JZ**  
Removal of synthetic substitute from right hip joint, open approach

**OSP909Z**  
Removal of liner from right hip joint, open approach

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*Coding Clinic, Second Quarter 2015 pages 19-20*
Scenario 5 - Total Hip Replacement Surgery Using Stem Cell Autograft

Patient developed avascular necrosis and arthritis following left hip fracture, status post open reduction with internal fixation. Currently undergoing left total hip replacement, and bone marrow harvest from the proximal femur. Stem cell autograft was then placed in the deep tissue and the subcutaneous tissue.

Scenario 5 - Total Hip Replacement Surgery Using Stem Cell Autograft (cont.)

• Bone marrow was procured from the operative site in the area of the hip replacement procedure.
  – Do not code the use of bone marrow.
  – In ICD-10-PCS, locally harvested tissue is not coded separately.
Polling Question #2

Choose which surgery is coded to the root operation Revision in ICD-10-PCS?

A. Surgery to replace the migrated portion of a ventriculoperitoneal shunt that has become free of its connection and migrated into the abdomen.

B. Abdominal wall herniorrhaphy, open, using synthetic mesh

C. Tendon graft to right ankle using cadaver graft, open

D. Left total hip arthroplasty with bone marrow harvest from the proximal femur

E. Temporary pacemaker removal following coronary artery bypass graft

Nelly Leon-Chisen, RHIA
Director, Coding and Classification
Coronary Artery Intervention Site

B3.6b
Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of a coronary artery (e.g., left anterior descending).

Source: ICD-10-PCS Official Guidelines for Coding and Reporting

Coronary Artery Intervention Site (cont.)

• A coronary intervention “site” refers to each distinct lesion treated, unless a single lesion extends into more than one artery.
Coronary Artery Intervention Site – Example #1

• Multiple drug-eluting stents placed percutaneously in three distinct lesions, in three separate coronary arteries:
  – First diagonal (D1) branch of the left anterior descending (LAD)
  – Left circumflex (LCX), and
  – Right coronary artery (RCA)

• **027234Z**, Dilation of coronary artery, three sites, with drug-eluting intraluminal device, percutaneous approach

Coronary Artery Intervention Site – Example #2

• Patient had one long mid-to-distal lesion in the left anterior descending (LAD) coronary artery treated percutaneously with two drug-eluting stents.

• **027034Z**, Dilation of coronary artery, one site with drug-eluting intraluminal device, percutaneous approach.
  – ICD-10-PCS currently does not capture number of stents classified to the same device value used to treat a single coronary artery lesion

**Coding Clinic**, Second Quarter 2015, pages 3-4
Coronary Artery Intervention Site – Example #3

• Lesion proximal left anterior descending (LAD) artery treated percutaneously with one drug-eluting stent
• Lesion distal LAD artery treated with one non drug-eluting stent
  – Two distinct lesions in the same coronary artery (LAD) were treated. These lesions are considered two coronary sites.
  – Since different types of stents were inserted, two codes with the body part value of one coronary artery site are assigned, to show the type of stent used.

Coronary Artery Intervention Site – Example #3 (cont.)

• **027034Z**, Dilation of coronary artery, one site with drug-eluting intraluminal device, percutaneous approach
• **02703DZ**, Dilation of coronary artery, one site with intraluminal device, percutaneous approach
Coronary Artery Intervention Site – Example #4

• Lesion within the left anterior descending (LAD) coronary artery extended into a branch artery of the LAD at the bifurcation
• Two drug-eluting stents were placed percutaneously, one in the LAD and one in the branch
  • Are branches considered separate coronary artery sites?

Coronary Artery Intervention Site – Example #4 (cont.)

• In this case, the branch is not coded as a separate coronary artery site. According to the procedure report, the lesion extended from the LAD to the branch.
  – If the lesion in the branch had been a separate lesion than the one in the LAD, then the body part value would be coded as two coronary sites.
• 0270346, Dilation of coronary artery, one site, bifurcation, with drug-eluting intraluminal device, percutaneous approach.
Coronary Artery Intervention Site – Example #5

- Percutaneous transluminal coronary angioplasty (PTCA) of the right coronary artery (RCA)
  - Two drug-eluting stents
- PTCA of proximal and mid-portion of the left anterior descending (LAD) coronary artery
  - Three drug-eluting stents overlapping from the proximal to the mid-LAD

Coronary Artery Intervention Site – Example #5 (cont.)

- **027134Z**, Dilation of coronary artery, two sites with drug-eluting intraluminal device, percutaneous approach.
  - Two distinct sites were dilated, the right coronary artery and the left anterior descending coronary artery.
  - Since all of the stents placed were drug-eluting, they can be captured with a single code.
Polling Question #3

A drug eluting stent and a non-drug eluting stent are inserted in a single site. How is this reported?

A. Drug eluting stents are reported separately from non-eluting stents, two codes are reported.

B. One code for both stents is reported as a non-eluting stent.

C. One code for both stents is reported as a drug-eluting stent.

Nontraumatic Acute Liver Injury

- Diagnosis: Acute liver injury and acute nonviral hepatitis
- Nontraumatic acute liver injury
  - Code to exact nature of liver problem
  - If etiology unknown, query provider
- In this example, “Acute hepatitis, nonviral”
  - Assign K72.00, Acute and subacute hepatic failure without coma
Urinary Calculi Fragmentation and Evacuation

• Index:
  – “Lithotripsy, with removal of fragments – see Extirpation.”

• Root operation “Extirpation” -- Removal of solid matter includes any previous fragmentation of the solid matter prior to its removal.
  – Fragmentation is inherent to extirpation
  – Objective is to remove solid material such as a foreign body, thrombus, or calculus from the body part.
  – Body part value is based on the location of the stone at the beginning of the procedure.

Urinary Calculi Fragmentation And Evacuation - Example #1

• Transurethral removal calculus left renal pelvis via ureteroscopy.
  – Stone initially fragmented by laser lithotripsy, and some of the remaining fragments were removed endoscopically by basket via the bladder.
    • Calculus was moved from one site to another during treatment
  – OTC48ZZ, Extirpation of matter from left kidney pelvis, via natural or artificial opening endoscopic

Coding Clinic, Second Quarter 2015, pages 7-8
Urinary Calculi Fragmentation And Evacuation - Example #2

• First admission
  – Staghorn stone of the left kidney and a left ureter stone without obstruction or hydronephrosis.
  – Extracorporeal shock wave lithotripsy (ESWL) of the left kidney and left ureter calculi.
    • Stone fragments removed from both sites endoscopically via basket, and ureteral stent placed.
    • Calculi at two different body sites, and both were treated with extirpation.

Urinary Calculi Fragmentation and Evacuation - Example #2 (cont.)

• First admission (cont.)
  – N20.2, Calculus of kidney with calculus of ureter
  – 0TC18ZZ, Extirpation of matter from left kidney, via natural or artificial opening endoscopic
  – 0TC78ZZ, Extirpation of matter from left ureter, via natural or artificial opening endoscopic
  – 0T778DZ, Dilation of left ureter with intraluminal device, via natural or artificial opening endoscopic

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Urinary Calculi Fragmentation and Evacuation - Example #2 (cont.)

• Second Admission
  – Fragmented portion of left stone had not passed in urine. Now in the bladder, causing pain.
  – Bladder stone fragmented using extracorporeal shock wave lithotripsy (ESWL), and removed endoscopically via basket.

Urinary Calculi Fragmentation And Evacuation - Example #2 (cont.)

• Second Admission (cont.)
  – **N21.0**, Calculus in bladder, as the principal diagnosis
  – **OTCB8ZZ**, Extirpation of matter from bladder, via natural or artificial opening endoscopic
    • Body part value is based on the location of the stone at the start of the procedure.

*Coding Clinic*, Second Quarter 2015, pages 8-9
Decompressive Laminectomy

• Index:
  – Laminectomy – see Excision

• Coding Clinic, Fourth Quarter 2013, page 116
  – Root operation “Excision” for decompressive laminectomy procedures

• Clarification Second Quarter 2015, page 30
  – Decompressive laminectomy is done to release pressure and free up the spinal nerve root. Therefore the appropriate root operation is “Release.”

Decompressive Laminectomy (cont.)

• Open complete decompressive laminectomy of L3-L4, superior partial laminectomy of L5, and inferior partial laminectomy of L2.
  – 01NB0ZZ, Release lumbar nerve, open approach

Coding Clinic, Second Quarter 2015, page 34
Multiple Decompressive Cervical Laminectomies

• Diagnosis: Cervical myelopathy
• Surgery: Open total decompressive laminectomy of C3, C4, C5 and partial decompression of C6.
  – How many ICD-10-PCS codes?
  – Count each vertebral level decompressed separately?

Multiple Decompressive Cervical Laminectomies (cont.)

• Laminectomy performed to release the spinal cord
  – Cervical spinal cord is classified as a single body part.
  – By convention, vertebral level (C3, C4, and so on) used to identify specific area along the spinal cord, but each designation is not a separate and distinct body part.
  – The vertebral level designations of the cervical spinal cord do not constitute separate and distinct body parts anatomically, therefore the multiple procedures guideline B3.2b does not apply
• **00NW0ZZ**, Release cervical spinal cord, open approach

*Coding Clinic, Second Quarter 2015, pages 21-22*
Uterine Artery Embolization

- Right uterine artery embolization
- Gelfoam used intraluminally to embolize the uterine artery
  - Cut into pledgets, inserted in a syringe, and injected into the vessel to occlude it.
  - When used in this way, Gelfoam is coded as an intraluminal device.
  - 04LE3DT, Occlusion of right uterine artery with intraluminal device, percutaneous approach

Coding Clinic, Second Quarter 2015, page 25
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Nelly Leon-Chisen, RHIA
Program Chairperson
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