Overcoming the Socioeconomic Challenges of a Thyroidology Practice

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Objectives

- Identify components of a successful thyroidology or thyroid-emphasis medical practice
- Identify value of ECNU designation and certification
- Review billing and coding topics related to thyroid sonography and US-guided procedures
Many out there claiming to understand the thyroid gland

**Thyroid 101:**
How to tell if your thyroid is underactive and how certain foods can help!

Looking for a Thyroid-Boosting Supplement that ACTUALLY Works?
If you found this page, you’ve probably searching for an easier way to speed up and maintain a fast and healthy thyroid. See what our research team found out when they dove into the data.

### Part 1: Identify yourself

- Establish yourself as an **expert** in thyroid disease, with genuine credentials, training, and experience
- Endocrinology board certification
- Endocrine Certification in Neck Ultrasound (ECNU)
- Trained and experienced in thyroid FNA (fellowship, Endocrine University, AACE, ATA, ECNU)

### Part 2: Establishing your credentials is important for your patients, colleagues, and insurance carriers, and thus the success of your thyroid practice!
Endocrine Certification in Neck Ultrasound

- ECNU is a professional certification in neck ultrasonography
  - Designates the physician as an expert in diagnostic evaluations of thyroid and parathyroid disorders through the use of U/S and FNA
  - ECNU is recognized by the American Institute of Ultrasound in Medicine (AIUM), a national accreditation body for ultrasonography

https://www.aace.com/ecnu
http://www.aium.org/

Historical perspective: The endocrinologist with an U/S probe!?

- Sonography of the thyroid
  - 1967 – B mode U/S thyroid imaging applied to 194 patients with palpably abnormal thyroid glands, describing 4 distinct "patterns"
  - 1977 – Ultrasound recommended for guidance of thyroid needle aspirations
  - 1986 – Thyroid sonography proves crucial in screening children exposed to high radiation following Chernobyl nuclear disaster
  - Modern day – high resolution sonography is the gold standard for thyroid gland, nodule, parathyroid, and cervical LN evaluation
    - Color and power Doppler, elastography, curvilinear probes, matrix probes

- The endocrinologist
  - Hospital-performed thyroid sonography has been the standard approach, yet endocrinologists are specialists in thyroid anatomy, physiology and disease
  - A clinician!!
    - Detailed history
    - Physical examination
    - Interpretation of detailed lab findings
    - Not a radiologist, but…a thyroid expert

Give him/her an U/S probe!
- Clinician-sonographer = sonologist
Thyroid sonography continues to increase in clinical importance.

- The American Thyroid Association Guidelines for thyroid nodules and differentiated thyroid cancer
  - 2009 Guidelines → 5 references to sonographic characteristics of thyroid nodules or cancer
  - 2015 Guidelines → 100 references to sonographic characteristics of thyroid nodules or cancer
- The thyroid-emphasis ENDOCRINOLOGIST must be highly skilled in sonography of the neck
- Thyroid, parathyroid, and neck sonography is performed regularly

A-mode Imaging
(Amplitude-mode)
A-mode is a method of displaying echoes acquired in 1 dimension in which depth is represented along 1 axis and an echo amplitude is displayed along a perpendicular axis. The image shown is from the original A-mode study by John Julian Wild, MD, PhD, that revealed the differences in echo pattern between a normal stomach wall and a stomach wall infiltrated by cancer.

http://www.aium.org/aboutUs/history/timeline.aspx?decade=1950
Debt of gratitude to AACE

- 1991 AACE founded, first annual meeting 1992 in Orlando, FL.
- 1998 AACE offers the first thyroid ultrasound course, under the direction of Jack Baskin, MD.
- 2002 Thyroid sonography training added to curriculum of annual Endocrine University Program at the Mayo Clinic in Rochester, Minnesota.
- 2002-2008 AACE monitors the increase from 3rd party payers, CMS, and other licensing agencies for regulations and qualifications necessary for imaging procedures by non-radiologist clinicians, and identified the need for endocrinologists to meet compliance standards of the National Commission for Certifying Agencies (NCCA).
- 2008 AACE, in concert with the American Institute of Ultrasound in Medicine (AIUM) develops the Endocrine Certification in Neck Ultrasound program (ECNU).

Organizers: Jack Baskin, MD; David S. Baskin, MD; Donald Jones (CEO of AACE); Carmine Valente (CEO of AIUM), and Lenny Greenbaum, MD (former president of AIUM).

Who can become ECNU certified and how?

- Board-certified endocrinologists, cytopathologists, endocrine surgeons, head/neck/ENT surgeons, and radiologists are eligible for application.
- Requirements, in addition to above:
  - Participate in approved thyroid Ultrasound course(s), minimum 15 hours CME credits
  - Attestation of minimum 100 ultrasound studies per year (30% FNA) or 50 studies if in fellowship
  - Pass written certification examination
  - Submit and pass 15 cases including thyroid nodules, malignant lymph nodes, parathyroid adenomas, Hashimoto’s, and FNA.
- Currently 500 ECNU-certified physicians (and counting).
Insurance carriers mandating ECNU certification for reimbursement

- BCBS of Massachusetts
- Horizon BCBS of New Jersey
- Highmark Blue Shield of Pennsylvania
- Health Plan of New York
- Anthem BCBS of Virginia
- Cigna NJ, NY and CT
- Oxford of New Jersey
- Health Care Partners of Nevada (?)

Courtesy of Nickie Mizell, ECNU coordinator

Top 10 reasons for become ECNU certified:

- 10. variable quality of radiology department-performed U/S studies
- 9. review of static / still images often limits quality of interpretation
- 8. Knowledge of the clinical history, lab data, and PE are crucial elements allowing for a more thorough and relevant examination and recs
- 7. performing in-office U/S is logical for the endocrinologist, convenient
- 6. sonography technicians often do not perform lateral neck cervical
- 5. ECNU designation increases patient confidence in YOU
- 4. ECNU designation increases referring provider confidence in YOU
- 3. Most of you are already experts in thyroid and neck U/S and FNA
- 2. Many insurance carriers mandate ECNU certification for reimbursement

1. We are thyroid doctors!!
This “9mm left inferior nodule”

This is NOT a thyroid nodule!

Part 2: obtain ultrasound equipment

- This is the technological pillar of your practice – your THIRD ARM
- You don’t need all the bells and whistles, but the inexpensive and portable “quick scan” machines are NOT ADEQUATE
Many vendors

GE Healthcare Point of Care Ultrasound Choices

GE, GE Monogram, Vscan, Venue 50 and LOGIQ are trademarks of General Electric Company.
Create a great ultrasound report

- Valuable to the patient
- Necessary to the provider
- Mandatory for billing
- Demonstrates your skills

PROCEDURE: US Thyroid

CPT CODE: 76536

COMPARISON: None.

INDICATIONS: Thyroidectomy

TECHNIQUE: High-resolution ultrasound was performed of the thyroid gland.

FINDINGS:
- Right Lobe: Absent
- Left Lobe: Absent
- Isthmus: Absent
- Nodes: None
- Other: None

CONCLUSION: Benign thyroid cyst in the thyroid isthmus.
Post game interview 11/23/14 of Seattle Seahawks running back Marshawn Lynch
Provided 14 answers to 19 questions with a very economical 17 total words spoken.

Answers: “yeah” “No” “Maybe” “I don’t know” “no juice”

The Ultrasound report should be concise!
Not too brief, not too wordy

PROCEDURE: THYROID HEAD AND NECK
CPT CODE: 76938

COMPARISON: IS, THYROID HEAD AND NECK, 7/02/2013, 8:04.


TECHNIQUE: High-resolution ultrasound was performed of the thyroid gland.

FINDINGS:
RIGHT Lobe: Diffuse atrophy. No dominant mass or cyst.
LEFT Lobe: Diffuse atrophy. No dominant mass or cyst.
STIMUS: Diffuse atrophy. No dominant mass or cyst.
NODES: None.
OTHER: None.

CONCLUSION: Atrophic thyroid suggesting chronic thyroiditis. No evidence of thyroid enlargement. No adjacent soft tissue mass or adenopathy.

Recommendations for thyroid nodules:
Consensus statement Society of Radiologists in Ultrasound; Radiology 2005 157:794-800.

Solitary Module
Solid w/ microcalcifications FNA 1 CM or greater
Solid (or mostly solid) FNA 1.5 cm or greater
Mixed solid and cystic FNA 2.0 cm or greater
ADDITIONAL CLINICAL HISTORY: None.

TECHNIQUE: Real-time sonographic imaging of the thyroid, including color flow imaging, was performed by the sonographer. Multiple representative static images were saved for review.

FINDINGS:

Right Lobe: 4.2 x 1.6 x 1.1 cm. Heterogeneous appearance with multiple nodules.

Right Lobe Modules: Oval modules extending from upper to middle pole measuring 3.8 x 1.2 x 1.0 cm and is complex. Solid nodules in the upper to middle pole measuring 1.8 x 0.6 x 0.8 cm and 1.2 x 0.6 x 0.2 mm.

Left Lobe: 4.6 x 1.7 x 1.3 cm. Heterogeneous appearance of multiple nodules.

Left Lobe Modules: Elongated oval module measuring 2.7 x 0.6 x 0.7 cm is complex with calcifications. Solid nodule in the upper to middle pole measuring 0.8 x 0.4 x 0.3 mm.

Isthmus: 2.0 mm.

Adjacent Tissues: Normal.

Other: None.

IMPRESSION:
1. Multiple complex to solid nodules bilaterally likely reflecting multinodular goiter. The complex nodule in the LEFT however does appear to have calcifications. Given the size of some of the nodules, further imaging with nuclear medicine scanning or short-term follow-up may be helpful.
Your Ultrasound report - summary

COMPONENTS
- Clinic logo and name
- Patient demographic information
- Indication for study and ICD-10 code
- Measurements in 3 dimensions
- Commentary on thyroid echogenicity and vascularity
- Detailed commentary on abnormal findings / nodules
  - Size, shape, echogenicity, borders, vascularity, elastography
  - Presence or absence of halo, microcalcifications, macrocalcifications, etc
- Commentary on cervical lymph nodes
- Impression and specific recommendations
- Signature

TIPS
- Provide a “clean report” free of redundancy, spelling errors or grammatical errors
- Be concise – not overly brief (Marshawn Lynch) nor overly wordy (you are not writing a book)
- Don’t bury your report in your clinic note between your PE and the assessment – this should be a stand-alone report
- Send it out – CC PCP and referring provider

Consider Nuclear Endocrinology, in your office!

- I-123 uptake studies and I-131 administration (no scans)
- Pros:
  - Comprehensive thyroidology
  - Efficiency / convenience for pt
  - Potential financial benefit, if high volume
- Cons:
  - Need for certification (RAM license)
  - Cost of equipment (>20,000)
  - Paperwork, site inspections (the government!)
Radioactive materials (RAM) license

Radioactive materials license
► Issued to your clinic or to the facility where you have privileges, by the NRC or the “agreement state”
► Allows the facility to order, receive, possess and use radioactive materials (for medical purposes)

Be an Authorized User
► Authorized Users are physicians listed on the radioactive materials license who are authorized to prescribe and administer particular radiopharmaceuticals for specific diagnostic or therapeutic procedures

As an authorized user...

You CAN
► Perform thyroid uptake studies (I-123, I-131)
► Perform radioactive treatment for hyperthyroidism
► Perform radioactive treatment for thyroid cancer

You can NOT
► Perform thyroid scans
► This will require 800 hours for the imaging component of your license
► Or you could go back and complete a fellowship in...

To become an authorized user, you will need 80 hours of classroom instruction – radiation safety and physics AACE can help!
What you will need (to buy!)

- Uptake probe
  - $10,000-$14,000
- Dose calibrator
  - $6,500
- Survey meter (Geiger counter)
  - $1,000
- Neck Phantom
  - $300
- Film badge
  - $500 / year

SIMPLE “HOT LAB” LAYOUT

Courtesy of Woody Sistrunk, MD
Question: I want to administer I-131 to my hyperthyroid patients. What next?

- A. Contact RSO for local hospital or facility and ask to become an authorized user and be placed on the RAM license
- B. Complete 80 hour radiation physics and radiation safety course, pass exam, document 3 supervised administration cases, apply to become an authorized user on the RAM license
- C. Purchase dose calibrator, survey meter, uptake probe, and neck phantom, apply to NRC to be an authorized user then for “hot lab” license
- Complete 800-hour nuclear medicine course through AACE, document 6 supervised cases (3 low dose, 3 high dose), then apply to become an authorized user on the RAM license

Answer

- A. Contact RSO for local hospital or facility and ask to become an authorized user and be placed on the RAM license
- B. Complete 80 hour radiation physics and radiation safety course, pass exam, document 3 supervised administration cases, apply to become an authorized user on the RAM license
- C. Purchase dose calibrator, survey meter, uptake probe, and neck phantom, apply to NRC to be an authorized user then for “hot lab” license
- Complete 800-hour nuclear medicine course through AACE, document 6 supervised cases (3 low dose, 3 high dose), then apply to become an authorized user on the RAM license
Financials

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>Medicare allowable</th>
</tr>
</thead>
<tbody>
<tr>
<td>78012</td>
<td>Thyroid uptake</td>
<td></td>
</tr>
<tr>
<td>79005</td>
<td>I-131 administration</td>
<td></td>
</tr>
</tbody>
</table>

Part 3: know how to bill and code properly

- The financial success of your practice depends on it
**Disorders of the thyroid (ICD-10)**

**E00-E07, E20-21, E89, C73**

- E00  Congenital iodine-deficiency
- E01  iodine-deficiency related thyroid disorders
- E02  subclinical iodine-deficiency hypothyroidism
- E03  Other hypothyroidism
- E04  Other non-toxic goiter
- E05  Thyrotoxicosis
- E06  Thyroiditis
- E07  Other disorders of the thyroid

- E20  hypoparathyroidism
- E21  hyperparathyroidism
- E89  post-procedural hypothyroidism
- C73  malignant neoplasm of the thyroid gland

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**Be more specific**

<table>
<thead>
<tr>
<th>Good</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperparathyroidism (E20)</td>
<td>Primary Hyperparathyroidism (E21.0) FHH (E83.52)</td>
</tr>
<tr>
<td>Hypothyroidism (E03)</td>
<td>Hashimoto’s thyroiditis (E06.3) Post-surgical hypothyroidism (E89.0)</td>
</tr>
<tr>
<td>Hyperthyroidism (E05)</td>
<td>Graves’ disease (E05.00) Toxie multinodular goiter without crisis or storm (E05.20)</td>
</tr>
</tbody>
</table>

*3-digit codes are not sufficient to bill*

**ICD-10 Official Guidelines for Coding and Reporting 2016, Chapter 4**
Thyroid cancer: currently being treated or personal history only?

Current malignancy or treatment
► “When a primary malignancy has been excised but further treatment such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.”
► C73 Malignant neoplasm of thyroid gland

Personal history of malignancy
► “When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code for category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of malignancy.”
► Z85.850 Personal history of malignant neoplasm of thyroid

Documentation must support

ICD-10 Official Guidelines for Coding and Reporting 2016, Section I, Chapter 2, letter m.

Thyroid Ultrasound
Physician Fee Schedule

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>Medicare allowable</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>76536*</td>
<td>U/S, soft tissues of head and neck, with images</td>
<td>$117.80</td>
<td>0.56</td>
</tr>
<tr>
<td>76942</td>
<td>U/S guidance for needle placement</td>
<td>$51.58</td>
<td>0.67</td>
</tr>
</tbody>
</table>

*“TC” modifier = technical component  
*“26” modifier = professional component  
*No modifier = includes both
**Thyroid Nodule FNA Physician Fee Schedule**

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
<th>Medicare allowable</th>
<th>Work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021</td>
<td>FNA w/o image</td>
<td>$124.96</td>
<td>1.27</td>
</tr>
<tr>
<td>10022</td>
<td>FNA with image</td>
<td>$143.22</td>
<td>1.27</td>
</tr>
<tr>
<td>60100</td>
<td>Core biopsy</td>
<td>$115.29</td>
<td>1.56</td>
</tr>
</tbody>
</table>

Medicare allowable = maximum amount that MC will reimburse for a specific service

WRVU = work relative value unit, or the CMS-determined cost for providing a service

**UG FNA – billing codes**

- Thyroid, parathyroid, cervical lymph node FNA:
  - CPT code 76942
  - Identifies ultrasound guidance
  - Only use once per encounter for Medicare/Medicaid, even if multiple lesions were sampled by FNA
  - For each nodule / lesion FNA:
    - CPT code 10022
    - Identifies FNA procedure
    - Modifier 59 if 2nd nodule FNA in the same lobe which identifies the procedure as “distinct or independent”

- Chart documentation should include:
  - Indication for procedure (ICD-10)
  - Patient consent, signed
  - Location / site
  - Procedure description
FNA example #1

- Right thyroid nodule
- FNA performed under US guidance
- 4 passes made*

Question: what billing codes should be used for this procedure?

- A. 76536 and 76942
- B. 76942 and 10021
- C. 76942 and 10022
- D. 60100
Answer

- A. 76536 and 76942
- B. 76942 and 10021
- C. 76942 and 10022
- D. 60100

FNA example #1

- Right thyroid nodule
- FNA performed under US guidance
- 4 passes made*

*The unit of service for fine needle aspiration (CPT codes 10021 and 10022) is for the separately identifiable lesion. If a physician performs multiple "passes" into the same lesion to obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for separate aspiration(s) of a distinct separately identifiable lesion. Source: CHAP3-CPTcodes10000-19999_final103115.doc; Revision Date: 1/1/2016

Translation: you do not bill for the number of needle passes performed on a given nodule. Whether you make one pass or 6, if into the same nodule, you can only use 10022 once.
FNA example #2

- US FNA of right and left thyroid nodules
- 4 passes made into each nodule

Question: what billing codes should be used for this procedure?

- A. 76942 (x 2) and 10022 (x 2)
- B. 10021 and 10022
- C. 76942 and 10022-RT and 10022-LT
- D. 76942 and 10022 and modifier 59
Answer

- A. 76942 (x 2) and 10022 (x 2)
- B. 10021 and 10022
- C. 76942 and 10022-RT and 10022-LT
- D. 76942 and 10022 and modifier 59

FNA example #2

- UG FNA of right and left thyroid nodules
- 4 passes made into each nodule
- 76942
- 10022 – RT
- 10022 – LT

- Do not code 76942 twice!
- Can only be used once for the entire encounter, regardless of how many UG FNA procedures or passes are made
- Must use RT and LT modifiers to identify different site or separate lesion
FNA example #3

- UG FNA of two left nodules and one right thyroid nodule
- 4 passes made into each nodule for 12 needle passes total

Question: what billing codes should be used for this procedure?

- A. 76942 (x 2) and 10022 (x 3)
- B. 10021 and 10022 and 10023
- C. 76942 and 10022-RT and 10022-LT (x 2)
- D. 76942 and 10022-RT and 10022-LT and 10022-59-LT
Answer

- A. 76942 (x 2) and 10022 (x 3)
- B. 10021 and 10022 and 10023
- C. 76942 and 10022-RT and 10022-LT (x 2)
- D. 76942 and 10022-RT and 10022-LT and 10022-59-LT

FNA example #3

- UG FNA of two left nodules and one right thyroid nodule
- 4 passes made into each nodule for 12 needle passes total
- 76942
- 10022 – RT
- 10022 – LT
- 10022 – 59 – LT

Application of these modifiers may prevent erroneous denials of claims for procedures performed on different anatomical sites.
Rapid on-site evaluation (ROSE)

**Why?**
- Assures sufficient FNA sampling
- Expedites care via reduced likelihood of repeat FNA on future date, may reduce number of needle passes
- Improves patient satisfaction
- Immediate clinician feedback
- Efficiency is vital given the high prevalence of thyroid nodules – ideal to maximize care on initial visit
- It’s cost effective and puts the patient first!
- This is an adequacy assessment, NOT a diagnostic interpretation which is done later by a certified cytopathologist

Repeat: onsite specimen adequacy assessment is NOT a diagnostic cytologic interpretation!

Rapid on-site smear evaluation

**What you will need:**
- Basic microscope
- Diff Qwik or similar stains
- CLIA certification*
- A few extra minutes!

**How to code:**
- CPT code 88172 for first evaluation
- CPT code 88177 for repeat evaluation(s)
88172: The bad news...

- Unfortunately...in 2013, CMS reversed a prior 2011 decision for onsite cytology evaluation to be a CLIA-waived test.
- This effectively restricts this SIMPLE and VALUABLE activity to cytologists only.
- Oddly, CMS will cover a repeat FNA procedure on a separate date of service at higher financial cost and higher patient inconvenience.
- This makes no sense.

88172 – cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis; first evaluation; each site.

Reimbursement

- Atrio - $66.79
- Health Net MedAdvantage - $63.81
- Lifewise - $107.17
- Medicare - $56.63
- Moda/OOS - $128.80
- OHP Allcare - $97.95
- OHP Jackson Care Connect - $54.36
- PacificSource - $135.15
- Providence Health Plan - $136.74
- Regence BCBS - $123.97
- Regence MedAdvantage - $65.12
Case example

- 53 year old female is referred for evaluation of a neck lump
- She also reports mild, intermittent difficulty swallowing
- A full history is taken with emphasis on:
  - Family history of thyroid malignancy or related genetic syndromes
  - Personal history of exposure to ionizing radiation
  - Symptoms (dysphagia, dysphonia, dyspnea)
- Physical examination is performed with emphasis on the thyroid gland, cervical lymph nodes and cardiovascular examination
- Laboratory interpretation: TSH
- Medical decision: thyroid U/S is needed with possible FNA, depending on sonographic features

Case example (continued)

- In-office Neck/Thyroid sonogram is performed
  - Thyroid gland is measured ant/mid/lateral and sup/mid/inferior for each lobe, and AP isthmus measurement
  - Careful attention to identified thyroid nodule(s) with images demonstrating Doppler flow, nodule borders, elastography (if available), and any other abnormal findings (i.e. microcalcifications)
  - 3 dimensions are measured for each nodule (Long x AP x transverse)
  - Evaluation of cervical lymph nodes is made
- A detailed Ultrasound report is constructed, separate from the physical exam and other chart notes, summarizing findings and providing specific recommendations
Case example (continued)

- A suspicious right nodule is identified and FNA is considered warranted
- Patient consent is obtained
- FNA is performed under dedicated U/S guidance
- A small sample is air-dried then stained for rapid on-site evaluation of adequacy by microscope
- Procedure is completed
- Post-procedure instructions are given and arrangements are made for follow up and communication of FNA findings and actions based on those findings

Putting it all together...

- E&M code: 99203-99205
- Ultrasound: 76536*
- US guidance of needle placement: 76942*
- FNA: 10022
- Rapid on-site assessment of adequacy: 88172*

*see next slide
!see prior slides
Coding Alert

Effective January 1, 2016, CPT® codes 76536 and 76942 cannot be billed together at the same patient encounter unless performed at separate anatomic sites.

Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) added a new procedure to procedure (PTP) edit to the National Correct Coding Initiative (NCCI) that affects Medicare reimbursement if a physician performs guidance for needle placement (CPT® code 76942) and a diagnostic head and neck ultrasound (CPT® code 76536) at the same patient encounter. The new edit was put into place because CMS indicated that evaluation of a patient's anatomic region and guidance for a needle placement procedure in that radiologic modality at the same patient encounter are not separately reportable services. AACE has recently sent comments to NCCI strongly opposing this PTP edit explaining the undue hardships this will pose to both patients and the endocrinologists who treat them.

AACE is currently working with other organizations to reverse this NCCI PTP edit decision.

Commercial carriers who follow Medicare’s NCCI edits could have this edit as well. AACE encourages members to review contracts at the beginning of each year and watch reimbursements. Please alert your coding, billing and collection staff.

Coding and billing take home points

- Documentation matters
- Educate staff, be educated by them
  - Sometimes correctly-coded services are not billed/correctly and services are written off unnecessarily
  - Codes change annually, maintain most up-to-date information/books
- Use modifiers correctly
- If not certain, inquire and clarify – don’t repeat the same mistake over and over again
Endocrine Toolkit for Success offers coding guidelines and crosswalks from ICD9 to ICD10 codes:
https://www.aace.com/resources/endocrine-survival-toolkit

Coding, Billing and Practice Management
https://www.aace.com/advocacy/socioeconomics

Coding Inquiries

Hassle Factors

American Association of Clinical Endocrinologists
AACE Coding Information Service
Due to the abundance of coding requests received in the AACE office, responses can take up to 7 Business Days following the initial receipt of this request.
Please mail or email a copy of this completed form along with supporting documentation to:
AACE
Socioeconomics & Member Advocacy
245 Riverside Avenue, Suite 200 • Jacksonville, Florida 32202
(904)403-7878 • Endcoding@aace.com

ALL REQUESTS MUST BE TYPED OR PRINTED. ILLEGIBLE APPLICATIONS MAY BE RETURNED.

1) Physician Name __________________________ Office Contact __________________________
Street __________________________ City ______ State ______ Zip __________
Phone ( ) __________________________ Fax ( ) __________________________ E-mail __________________________

2) Type of Code (Mark appropriate box)

3) Request (Please attach request if additional space is required)

Coding questions?
Maybe AACE can help...
Sign up for Endonomics

Endonomics™ is currently a free monthly electronic newsletter for participants of AACE’s Practice Support Network. Endonomics™ includes physicians, non-physician practitioners, practice managers, office administrators, coders, billers, collectors and other business office staff. It educates, informs, and alerts you & your staff of important information required to achieve a compliant, successful and profitable endocrinology office. Endonomics™ includes important coding tips, opportunities for improved accuracy in billing, ICD 10 tips, Medicare updates, and office management pearls. Subscribers to Endonomics™ receive notifications regarding upcoming endocrine specific webinars, coding courses and other important publications.

If you or your staff are not currently part of the Practice Support Network and would like to join, go to https://www.aace.com/advocacy/socioeconomics/endonomics to be added to the database.

And remember- it’s FREE!

Still want more knowledge on coding?

2016 ENDOCRINE-SPECIFIC CODING EDUCATION

Designed for Physicians, Non-Physicians, Practitioners and Staff

For more information or to register, visit
https://www.aace.com/advocacy/socioeconomics/courses/coding-courses

Bridge the Gaps in Endocrine Coding
AACE Your E/M Coding
June 10 & 11
Justin Gables Center
11 Davis Place
Boston, MA 02215

Coding Essentials for Endocrine Coding
AACE Your E/M Coding
July 11-12
Hampton Inn & Suites
Wrentham, MA

Bridge the Gaps in Endocrine Coding
AACE Your E/M Coding
October 20-21
University of Texas Health Science Center
San Antonio, TX 78229

Coding Essentials for Endocrine Coding
AACE Your E/M Coding
November 14-15
Hyatt Place Atlanta Airport
Atlanta, GA 30329

Still want more knowledge on coding?
Workflow

- Office staff preparation for FNA procedures is crucial
  - Office staff prepare pathology requisition form (patient demographics and insurance information), patient consent form, and sets out slides and all needed supplies prior to physician-patient encounter
  - Trained / experienced medical assistant (I have 2 in my office, primary and secondary; nobody else!)
- Generally 3-5 needle passes per thyroid nodule for sufficient sampling and molecular markers, and maximum of 2 nodules / lesions per encounter (for time management and patient comfort)
- ROSE

Example
Part 5: run a comprehensive thyroid practice (part 1)

- The patient comes first
  - Staff and physician triage consult in advance of appointment
  - Additional lab testing in advance, if needed
  - Staff preparation for FNA procedure if this is possible or likely (crucial)
  - Detailed neck ultrasound at initial visit
  - FNA on first visit, if indicated
  - Rapid on-site cytology evaluation
  - Clinic or hospital uptakes and I-131 treatment

- Consultation with colleagues
  - Consult letter with detailed U/S report with recommendations
  - Cancer conference or Tumor board
  - Hospital consults, curb-side consults

- Education
  - Patient education materials and resources
  - Lectures, presentations, round table discussions in community
  - AACE or other professional society involvement

- Research

Putting it together a day in the life

- Consult triage
  - I do not make patients with newly-diagnosed thyroid nodules wait 5 months for an appointment, strive to see the same week
  - Trained medical assistant screens consults, anticipates procedures

- Procedures
  - Some physicians will not perform the FNA procedure on visit #1 but will reschedule the patient to a “procedure day”
  - If FNA of a thyroid nodule, cervical lymph node, or parathyroid gland is deemed appropriate, I will usually do this on the same visit (I am not comfortable asking patients who traveled great distances to come back another day)

- The Ultrasound study
  - Variable length, but usually can be done properly in 10 minutes

- Iodine-131
  - Uptake studies occasionally done in the endocrinologist office
  - I am a fan of this – we are the thyroid specialists
  - Not always logistically practical, or economical (very practice dependent)