

Research to Another Level: Medical Coding and the Life Care Planning Process: Part I

Ann Maniha, RN, CLCP, CMC

Abstract

This article is the first of a two-part series providing an introduction to medical coding as applied to the life care planning process. The article is designed to identify and define the most common types of medical codes relevant to medical procedures performed in inpatient settings, ambulatory surgical centers (ASC), outpatient hospital settings, and non-facility settings (i.e., physician's office); supplies; equipment; physician fees; allied health professionals; diagnostic testing and hospitalizations involved in one portion of the research process in life care planning. A brief coding bibliography is included to identify specific publications related to each classification of code as well as a reference list at the end of the article that provides contact information for each of the books and databases referenced in the article. In addition, this article will lead into Part 2 of a series of articles that will describe how to research and determine the charge(s) for procedures, physician office visits, and hospitalizations using the relevant codes.

Introduction

An objective for this article is to assist in developing a general understanding of the coding process as related to life care planning, **NOT** to teach the entire coding process. This includes identifying the different classifications of codes and information they represent. The coding process involves identifying the code(s) associated with the service provided. Additionally, the codes provide an in- depth view of how, where and why a procedure is performed, in turn increasing one's knowledge and understanding of the procedure. Coding is a dynamic process continuously changing requiring an individual utilizing the process to remain updated for accuracy. Lastly, this article will help identify the importance of understanding the intricacies involved in determination of charges for items in a life care plan and how coding, if used correctly, may be a benefit to this process of determining charges for life care plan development. It is important to understand the coding process is not a life care planning function per se, but a research tool that can facilitate the process of determining charges for specific items in a life care plan.

As a certified life care planner involved in the development of life care plans, this author never thought that learning the medical coding process would become an area of interest. But as the process of obtaining charges for items in a life care plan became seemingly more and more difficult and hospitals and physicians were giving less and less information in regards to charges, it became clear that coding might be something that would be useful to learn about as a way to enhance one's personal life care planning "tool box." A familiarity with medical codes and what they represent, in addition to how they are applied to services, procedures, items and billing was becoming a necessity more and more every day and that when hospitals and physician offices were contacted for the charge of a procedure, they always seemed to request the code(s) related to the procedure. As a result, this author researched the field and enrolled in training specific to medical coding through a certification program provided by

Practice Management Institute, becoming nationally certified as a Certified Medical Coder (CMC) in 2004. Although there are several training programs and certifications associated with medical coding, the training program undertaken by this author consists of four full days (8 hours per day/1 day per wk) of classroom instruction and hands on coding, with the fifth day being set aside for the certification exam. Maintaining the certification status requires twelve hours per year of continuing education credits. Certification classes can be taken online, in a classroom setting, or through a community college. The CMC and CPC (Certified Professional Coder) are both certifications accepted by Medicare. Since obtaining certification status, this author has been working with the various codes and coding resources in order to increase knowledge and familiarity with the different coding strategies /scenarios. The last four years of medical coding, research associated with the process, and many varied combinations and computations of coding, in addition to an increased knowledge and understanding associated with the procedures, have been a useful resource as applied to developing information associated with charges.

Billing Charges (Billed Amount), Cost and Reimbursement

Although there are rules that are very specific for reimbursement pertaining to Medicare, Workers' Compensation and Private or Group Health Insurance, the life care planner typically does not need to address this area. However, a little background may be helpful. This area involves closely governed rules and regulations associated with the above noted entities. For instance, the above entities do not cover all medical procedures or codes that exist. For example, they may cover a CPT code for Botox injections under a specific ICD-9 CM code (diagnosis) but not under another ICD-9 CM code (diagnosis). To simplify this, consider that some payor sources will cover Botox injections for spasticity but not Botox injections for cosmetic reasons.

In general, there are typically three different and distinct monetary amounts involved when developing charges associated with the codes, billing and reimbursement. First is the billed amount, this is what is actually **charged** to the payor source (billed amount). This is the amount actually charged for the service(s) performed or item(s) provided with no reduction taken. This is the amount the provider has determined will cover his/her costs and provide him/her with a living. It is essentially the same process as a professional (such as a life care planner) would utilize when determining his/her professional fees. The second is the amount the procedure/item **costs**. This involves the actual cost to perform the procedure, such as the cost of overhead, materials utilized, insurance, additional staff, education/expertise involved, and specialty training. No markups have been included in this amount. Third is the **reimbursement amount**. This is the amount the payor actually pays the provider for the service(s) performed depending on the specific rules and regulations of the payor source and any contracts they may have with the service provider. The reimbursement amount will be different depending on the payor source such as specific insurance company plan, Medicare or Workers' Compensation.

The life care planning process involves utilizing the charges billed and not cost or reimbursement rates. This methodology should not be altered because of who the requesting source is. If the life care planner is requested to identify specific reimbursement rates required by rules of the specific jurisdiction in which the life care planner is developing the plan (and associated with state requirements), then it is this author's opinion that a disclaimer should be included in addition to identifying this rate. Identifying the entity's allowable rate, also known as the "reimbursable amount" can be as easy as adding an additional column to the life care

plan charts titled as such.

With regards to billed charges (charges billed), there are common interchangeable terms for this phrase. These can include “billed amount,” “usual or customary,” or “retail.” The billed charge is to represent the charge for the procedure or item before any discount or reduction is applied. In past years, one typically would ask for the “private pay charges;” however, there is wide variability in what “private pay” means and this may no longer be appropriate because most facilities and physicians apply a discount to the “private pay charges.” If care is not taken to identify billed charges, then the potential to utilize discounted charges when costing out a procedure, service, or item in a life care plan will most likely not provide the required amount of funds to appropriately care for the individual over his/her lifetime. When a life care planner is requesting the charge for a service, he/she will need to develop a technique with which they are comfortable. One may discover that this technique may need to be adjusted depending on the source/provider with whom he/she is speaking, but it is important to convey to the provider what the life care planner is actually requesting.

Common Classifications of Codes Defined

The following are the classifications of codes that will be relevant for the life care planning process:

CPT®	Current Procedural Terminology (Copyrighted by and a registered trade mark of the AMA). These are also known as HCPCS Level I.
HCPCS Level II	Healthcare Common Procedural Coding System
MDC	Major Diagnostic Categories
DRG	Diagnostic Related Groups
ICD-9 CM	International Classification of Diseases, 9th revision, Clinical Modification, Volume 1, 2 & 3 (Note: ICD-10 is expected to be released soon.)
ASC	Ambulatory Surgical Center (Free standing outpatient surgical center)
APC	Ambulatory Payment Classification.

Each one of these codes represents different items or services, including location. Although there are times when the codes may cross over into another code's area, for purposes of determining the charge for a service or item in a life care plan, this should not be problematic. An example of this is the HCPCS Level II code may also represent procedures such as administration of vaccines, which there is also a CPT code for. Originally, the HCPCS Level II Code represented many procedures but to bring about continuity (common language associated with coding), the CPT code has been transitioning to take the place of the HCPCS Level II procedure code.

Coding Bibliography

Code Classification	What Items/Services, etc. this Classification of Code Represents	Reference Books	Books/Databases with Fees
CPT (also known as HCPCS Level I) Update yearly	Physician office visits, hospital visits, consultations, etc. Labs Diagnostic medical studies (x-rays, MRIs, etc.) Allied Health Services: Physical therapy Occupational therapy Neuropsychological testing Speech therapy and more	CPT Standard (AMA) CPT Professional (AMA) CPT Expert (Ingenix) CPT Plus (PMIC)	Medical Fees in the United States 2008 (short CPT descriptions) (percentiles) National Fee Analyzer 2008 (long CPT descriptions) (percentiles) Physicians' Fee and Coding Guide 2008 Volume 1 (long CPT descriptions) (ranges lo-hi, not identified in percentiles) Physicians' Fee Reference 2008
HCPCS Level II Update yearly	Durable medical equipment, such as wheelchairs, syringes, oxygen, etc. Drugs Wheelchairs Orthotics/Prosthetics Infusion pumps (Baclofen, etc.) Neurostimulator (device only) Ambulance services Dental services	HCPCS Level II HCPCS Level II Expert HCPCS UnicorMed	HCPCS Level II Fee Analyzer * this book is zip code specific but lists the national fees in percentiles HCPCS Level II Expert * this book will list some commercial costs and the Medicare fees if approved under Medicare * update yearly NU – new RR – rental UE – used (identifies the equipment fees according to these classifications)
ICD-9 CM	Identifies diagnosis or condition of individual (Volume 1 & 2) and procedures (Volume 3)	ICD-9 CM Hospital (Volumes 1, 2 & 3)	* note when the ICD-9-CM manual includes all 3 volumes, this is the hospital version, while the physician's office

Code Classification	What Items/Services, etc. this Classification of Code Represents	Reference Books	Books/Databases with Fees
			version only includes Vol. 1 & 2.
Volume 1	Specific information pertaining to diseases, conditions and injuries. Includes 17 sections/chapters plus 2 supplemental chapters and 5 appendices. Supplemental Chapters: V Codes & E Codes	ICD-9 CM Physicians Office (Vol. 1 & 2) ICD-9 CM Plus (PMIC)	
Volume 2	Alphabetical index for Volume I. (3 sections/chapters)	ICD-9 CM Expert (Ingenix) Easy Coder ICD-9 CM (UnicorMed)	
Volume 3	Classification codes for Procedures performed mainly in an inpatient hospital stay (they are also sometimes used in outpatient hospital facilities)	Easy Coder ICD-9 CM + Vol. 3 (UnicorMed)	
MDC	These are the categories under which the DRGs fall.	Will find in the books pertaining to DRGs	No fee associated with them
DRG	These are mainly used for inpatient stays. They are split into surgical or medical and separated by the different body systems such as cardiovascular, musculoskeletal, etc. Each DRG has ICD-9 CM codes that are associated with it. A ICD-9 CM code may fall under several different DRGs.	DRG Expert DRG Desk Reference DRG Plus	American Hospital Directory HCUP, Healthcare Utilization Project VIMO
ASC	An outpatient category with different levels representing complexity and the amount paid. Utilized in only free standing outpatient surgical centers. Procedures mostly identified by CPT codes.	Outpatient Billing Expert	Outpatient Billing Expert includes Medicare reimbursement fees
APC	An outpatient category associated with groups of CPT codes. Each APC has a group of associated CPT codes they represent. Only utilized in hospital associated outpatient surgery, clinics,	Outpatient Billing Expert APC Manager	Outpatient Billing Expert includes Medicare reimbursement fees. American Hospital Directory

Code Classification	What Items/Services, etc. this Classification of Code Represents	Reference Books	Books/Databases with Fees
	emergency room in addition to others		

Note: The above list of books and databases is not all inclusive and represents many of the books/databases that the life care planner may find useful. All of the above books will have explanations pertaining to their contents and directions in how to use them relevant to the specific codes. A reference list at the end of this article contains contact information for each source in the above tables.

Coding Procedures

A procedure (surgical or medical) involves the following:

1. Physician(s) or individual(s) performing the procedure (CPT code) (When a modifier is applied to the code, the code will provide more specific information in regards to if there is an assistant, co-surgeon, unilateral, bilateral, etc.).
2. Facility or place where the procedure is performed (CPT code, APC, ASC, DRG, ICD-9 CM, Vol. 3)
3. Status of the client in regards to inpatient or outpatient and medical condition at times (DRG, APC, ASC, CPT) (It is important to note that some of the codes such as the DRG, APC or ASC all identify a facility location and are most likely inclusive of all costs except for the physician's fees and anesthesia). Some of the higher priced items such as the Baclofen pump are an additional charge identified by passthrough rules.
4. Supplies/equipment/drug included with the procedure (HCPCS Level II)
5. Reason for performing the procedure, e.g., diagnosis/condition (ICD-9 CM)
6. What was actually performed (CPT code, ICD-9-CM Vol.3)

When coding a procedure, it is important to know the following:

1. What anatomical location is the procedure to be performed?
2. Does this code include bilateral services? Or does the code need to be included twice as in the case of CPT code 20680?
3. Is this an inpatient only procedure?
4. Will the procedure be performed in the physician's office, hospital outpatient surgery (APC), stand alone ambulatory surgical center (ASC), or as an inpatient (DRG)?
5. If the procedure is associated with a graft, does this code include the harvesting of the graft or is this an additional code?
6. Is a co-surgeon or assistant involved?
7. Is this a complex procedure?
8. Are multiple procedures being performed at one time?

Modifiers

The modifiers on the code, CPT or HCPCS Level II, clarify to the payor source who, what, where, complexity level, etc. when the code itself does not identify this information. The code and modifier are used to determine how the procedure(s) will be reimbursed according to reimbursement rules associated with the payor source. Many times the reimbursement rules represent a reduction in payment from the charges for the actual procedure or service, but, as with many rules, there are exceptions to the rules and the modifier can help to identify complexity level or the routine nature of the procedure. Modifiers are defined within the

coding book publications.

When determining charges for procedures and services for a life care plan, it is important to acknowledge that the billing individual will always bill the physician's actual fee (i.e., amount before any deductions have been made), even if it is known that the "reimbursed" amount is to be cut in half, one quarter or some other reduced amount based on the reimbursement rules. When the biller bills for a bilateral procedure where the term bilateral is not included within the code's description, the biller will need to include the charge twice (once for the right and once for the left) at the physician's full fee. If this were not the case, consider that the billing individual happens to bill the physician's fee at 50% of his fee (charge) for the left side and 100% for the right because the procedure performed was a bilateral procedure and not identified as such within the code description. The payor would then reimburse 50% of the already decreased amount (e.g., 50% of 50% is 25% of the physician's fee). The physician would actually be reimbursed 125% instead of 150%, losing 25% of the amount to be reimbursed to him/her. To avoid this from happening, the billing individual will bill the full amount of the physician's fee (charge) twice for the service provided and then to clarify to the payor source, a modifier "50," would be attached to the code to identify that the procedure was bilateral. The payor source would then reimburse 100% of one side (right) and 50% of the other side (left). In other words, the billing individual is not to discount the charge billed prior to submitting the bill to the payor for reimbursement.

Coding tree: The below outline is the author's description of the structure of how the codes relate to one another:

Inpatient:

- MDC
- DRG (Medical or Surgical)
- ICD-9 CM (Vol. 1, diagnosis)
- CPTs
- HCPCS Level II
- ICD-9 CM Vol. 3

Note 1: In relation to costing out hospitalizations, an inpatient procedure, one will still need to add the physician charges to the hospital stay whether it is his/her charge for a surgical procedure, visits, consults, etc.

Note 2: In relation to procedure costs, one will need the facility charge, physician charge, assistant or co-surgeon charge (if applicable), and anesthesia charge added together to represent the procedure charge. Not all procedures performed; will require an anesthesiologist, are performed in a facility or are surgical procedures. When one sees non-facility, this represents the physician's office.

Outpatient: (When hospital outpatient facility utilized)

APC	
CPTs	(will be a classification of code one will most likely see)
ICD-9 CM, Vol. 3	(not utilized as much in outpatient services)
HCPCS Level II	(a classification of code one will most likely see)
ICD-9-CM	(will always be present because it identifies why)

Outpatient: (When free standing outpatient facility utilized)

ASC	
CPTs	(will be the classification of code one will most likely see)
ICD-9 CM, Vol. 3	(not utilized as much in outpatient services)
HCPCS Level II	(a classification of code one will most likely see)
ICD-9-CM	(will always be present because it identifies why)

Physician's Office:

CPT	(what was performed)
HCPCS Level II	(what was utilized in regards to supplies, drugs, devices)
ICD-9 CM	(why the service was performed)

To simplify, when looking for an outpatient procedure use the CPT code and the ICD-9 CM Vol. 3 for inpatient procedures. The physician's part will always be a CPT code.

Quick Summary

In determining the charge for services in a life care plan, the following summary may be helpful:

If you are looking for a:

Diagnosis:
Surgical procedure:

Where you will find it:

ICD-9, Volume 1
CPT or ICD-9–CM Volume 3 associated mainly with inpatient procedures for the hospital, (will see in hospital billing) while the CPT identifies the physician's charge for the surgery (will see in the physician's billing)

Office visit (Dr.)
Durable medical equipment:
Hospitalization
Outpatient procedure:
Lab:
X-rays:
MRIs, CTs
Physical therapy, etc.

CPT
HCPCS Level II
DRG (Medical or Surgical)
APC, or CPT or ASC
CPT
CPT
CPT
CPT

Note: CPT® is a registered trademark and copyright of the American Medical Association.

Conclusion

Medical coding is an ongoing learning process that is continuously changing. The many varied and different codes represent different fees and services. It is important to point out that the overview information presented in this article is with regard to life care planning and not Medicare. Medicare has very specific rules as to what they will cover, how the claim is presented, and how it is processed, including how much they will reimburse to the service provider. In general, Medicare fees are markedly reduced and are not the usual and customary charges billed.

It is hoped that this article has helped to put into perspective the complexities of medical coding as applied to life care planning, and the importance of identifying not only the correct code or codes for a recommended service or procedure, but also the correct charge billed to determine the charge of the service. It may be helpful to consider that the coding process is like painting a picture of the services performed, identifying who is to be involved (physician, assistant, etc.), location (specific area of the body) , where performed (facility), complexity level, reason and specific recommendation, and what was used to paint the picture (equipment/supplies utilized). In addition, understanding the codes and what they represent can also assist the life care planner in reading and comprehending a medical bill.

Author's Note: Part 2 of this two-part series of articles will address coding of procedures and hospitalizations.

Resource List**Coding Publications:**

- CPT® 2008 Standard Edition (AMA) <https://catalog.ama-assn.org>. List price: \$71.95, 2009 \$74.95
 - CPT 2008 Professional Edition (AMA) <https://catalog.ama-assn.org>. List price: \$99.95, 2009-\$102.95
 - 2008 Current Procedural Coding Expert (Ingenix) <http://www.shopingenix.com>. List price: \$82.95, 2009-\$89.95. Contact Lance Morely, Ingenix account manager, 800-678-8398, Option 4, extension 23281 and inform him that you are a life care planner for potential discounts.
 - CurrentProceduralCodingExpert.com (Ingenix) <http://www.shopingenix.com>. List price: \$74.95
 - CPT® Plus! 2008 (PMIC) <http://pmiconline.stores.yahoo.net/>. List Price: \$69.95
 - CPT® Reference of Clinical Examples: Official Scenarios for Correct Coding, <https://catalog.ama-assn.org>. List Price \$99.95
 - Procedural Coding Professional 2008 <http://www.codingbooks.com>. List price: \$89.95 (The Medical Management Institute/MMI)
 - AMA HCPCS 2008 Level II, <https://catalog.ama-assn.org>. List Price: \$94.95
 - HCPCS Level II 2008 Professional (MMI) <http://www.codingbooks.com>. List Price: \$89.95
 - Ingenix HCPCS 2008 Level II, <https://catalog.ama-assn.org>. List Price: \$99.95
 - 2008 HCPCS Level II Expert (Ingenix) <http://www.shopingenix.com>. List price: \$99.95
 - HCPCSExpert.com (Ingenix) <http://www.shopingenix.com>. List price: \$69.95
 - HCPCS 2008, (PMIC) <http://pmiconline.stores.yahoo.net/>. List price: \$67.95
 - HCPCS 2008 e-Book PDF format. <http://pmiconline.stores.yahoo.net/>. List price: \$47.95
 - HCPCS UnicorMed <http://www.unicormed.com>. List price: \$84.95
 - ICD-9-CM, Volumes 1,2 &3, Professional for Hospitals and Payers (MMI) (Spiral) 2008. List Price: \$99.95
 - ICD-9 CM 2008 Hospital/Payer Edition, Volume 1,2 & 3 (PMIC). List Price: \$89.95
 - ICD-9 CM 2008 Hospital/Payer Edition, Volume 1,2 & 3, e-Book PDF format. List Price: \$62.95 (CD)
 - 2008 ICD-9 CM Expert for Physicians (Ingenix) Vol. 1 & 2. List price: \$95.95
 - 2008 ICD9 Professional for Physicians (Ingenix) Vol. 1 & 2. List price: \$86.95
 - ICD9Expert.com/physicians (Ingenix) <http://www.shopingenix.com>. List price: \$79.95 (online)
 - Easy Coder ICD-9 CM (UnicorMed) <http://www.unicormed.com>. List price: \$62.00
 - Easy Coder ICD-9 CM + Vol. 3 (UnicorMed) <http://www.unicormed.com>. List price: \$72.00
 - 2008 DRG Expert (Ingenix) <http://www.shopingenix.com>. List price: \$99.95, 2009-\$119.95
-

- 2008 DRG Expert e-Book (Ingenix) <http://www.shopingenix.com>. List price: \$99.95, 2009-\$119.95
 - 2008 DRG Desk Reference (Ingenix) <http://www.shopingenix.com>. List price: \$199.95
 - 2008 DRG Desk Reference eBook (Ingenix) <http://www.shopingenix.com>. List price: \$199.95
 - DRG Guide Book 2008 (MMI) List price: \$89.95, 2009. List Price: \$99.95
 - DRG Plus, 2008 <http://pmiconline.stores.yahoo.net/>. List Price: \$99.95
 - Outpatient Billing Expert (Ingenix) <http://www.shopingenix.com>. List price: \$199.95
 - APC Manager now OPPS Manager (Ingenix) <http://www.shopingenix.com>. List price: \$229.95
 - Medical Fees in the United States 2008 e-Book PDF Format. List Price: \$99.95 (CD) PMIC. Contact John Santiago, 800-633-7467, extension 2536, and inform him that you are a life care planner for potential discounts.
 - Medical Fees in the United States 2008. List Price: \$149.95 (Soft bound book) PMIC
 - 2008 National Fee Analyzer (Ingenix) <http://www.shopingenix.com>. List price: \$159.95
 - Physicians' Fee and Coding Guide 2008 Volume 1 <http://www.coderscentral.com>. List price: \$169.95
 - Physicians' Fee Reference 2008 (Wasserman) <http://www.ndas.com>. List price: \$139.00
 - 2008 HCPCS Level II Fee Analyzer (Ingenix) <http://www.shopingenix.com>. List price: \$249.95
 - HCUP, Healthcare Utilization Project, <http://hcupnet.ahrq.gov/>
 - VIMO, <http://www.vimo.com/hospital/cost.php> or <http://www.vimo.com> (search the site)
 - American Hospital Directory, <http://www.ahd.com>, \$355.00 per year for life care planners. Otherwise \$395.00
 - American Medical Association, <https://catalog.ama-assn.org>
 - Free ICD-9-CM and DRG Coding on the Internet, <http://icd9coding.com>. PMIC and Medical Coding & Compliance Solutions, LLC (MCCS) are pleased to provide the health care industry free use of our ICD-9-CM/DRG coding software, powered by FLASH CODE.
 - Flash Code Provider Internet Version <http://pmiconline.stores.yahoo.net/flashcode.html>. List Price: \$279.95
 - Coders' Almanac for Diagnosis 2008 (MMI) <http://www.codingbooks.com>. List price: \$99.95
 - Coders' Almanac for Procedures 2008 (MMI) <http://www.codingbooks.com>. List price: \$99.95
 - Coders' Almanac for Terminology 2008 (MMI) <http://www.codingbooks.com>. List price: \$99.95
 - CodeItRightOnline (compliance) <http://www.codingbooks.com>. List price: \$399.95 per year
-

- CodeItRightOnline <http://www.codingbooks.com>. List price: \$149.95 per year
- Ingenix EncoderPro.com Professional <http://www.shopingenix.com>. List \$559.95 per year
- Ingenix EncoderPro.com <http://www.shopingenix.com>. List price: \$289.95 per year
- Ingenix EncoderPro.com Expert <http://www.shopingenix.com>. List price: \$949.95 per year
- BC Advantage (magazine, \$45 per yr) <http://www.billing-coding.com>

Author's Note: Most likely, any one of the providers for the above coding publications can obtain different publishers' products. In the author's experience, PMIC and Ingenix will usually give a discounted price for life care planners. It is suggested that the life care planner research the different sites and compare.

Websites

AMA:	https://catalog.ama-assn.org
PMIC:	http://pmiconline.stores.yahoo.net/
Ingenix:	http://www.shopingenix.com
The Medical Management Institute (MMI):	http://www.codingbooks.com
UnicorMed	http://www.unicormed.com
Mag Mutual	http://www.coderscentral.com

Information pertaining to medical coding certifications

- Practice Management Institute, <http://www.pmiMD.com>, 800-259-5562, CMC Certification \$999.00
- 2008 Coding Certification Boot Camps, 1-800-334-5724, option 2, <http://www.codingbooks.com>, \$1,395.00 with \$300.00 discount if register 60 days early. Note: Coding Certification Boot Camp is the ONLY training course that prepares you to take both the American Academy of Professional Coders (AAPC) Certified Professional Coder Exam and the Association of Registered Health Care Professionals (ARHCP) Registered Medical Coder Exam. You can choose to test for one or both certifications.
- American Academy of Professional Coders, <http://aapc.com>, 800-626-2633 (CPC, certified professional coder). Offers online and classroom study.
- American Health Information Management Association (CCS, certified coding specialist), <http://www.ahima.org>, 800-335-5535.

About the Author

Ann Maniha is a registered nurse (1975), certified life care planner (1998) and certified medical coder (2004). She maintains a private consulting practice in Houston, Texas, where she provides research assistance, develops life care plans for individuals with disabilities and/or chronic health needs and sells her life care planning software, "Life Care Planning for the PC." Ann frequently offers assistance in medical coding procedures, has presented on the topic at various national conferences, and is the process of developing a program to assist life care planners and researchers with how to utilize the medical coding process.
