The Coding Institute

Part B Insider

News & Analysis on Part B Reimbursement & Regulation

March 16, 2007
Vol. 8, No. 9
Pages 57-64

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American Academy of Professional Coders
CEU APPROVED

QUALITY REPORTING

Can You Hire An Extra Coder For 75 Cents An Hour?

▶ *Doctors question whether 1.5-percent bonus is worth extra work*

The July 1 deadline to start reporting on quality measures for Medicare is roaring closer — but many providers may get out of the that juggernaut.

The Physician Quality Reporting Initiative (PQRI) will pay your practice an extra 1.5 percent of Medicare payments from July to December. In return, you have to report on up to three applicable quality measures for each visit, using "G" codes and Level II codes.

But the 1.5-percent bonus will cover only approximately 10 percent of this program's costs, calculates Easton, CT physician **Stephen Levinson**, author of the **American Medical Association's** *Practical EM: Documentation and Coding Solutions for Quality Health Care*. If a typical physician receives an extra $1,500 for all this work, this translates to 75 cents an hour.

"How many coders can you hire for 75 cents per hour to do the extra work?" Levinson asks.

"For quality care, every visit requires active physician analysis and decision-making," with active documentation, Levinson concludes. "If you are going to load documentation and coding and modifiers for each exception to the [quality] guidelines on top of that, you have a significant administrative cost."

So how can you make the process of coding for the quality demo as painless as possible? There's no easy clear-cut answer yet, says **Collette Shrader**, compliance and education coordinator with **Wenatchee Valley Medical Center** in Wenatchee, WA.

In Shrader's organization, the physicians do their own coding, and then coders match diagnosis codes to procedures and check for Correct Coding Initiative edits.

So the providers will have to add the quality-measure codes to visits, Shrader explains. "We are trying to come up with some way the practitioner can easily do this or we can pull the information from the medical record for him or her."

Start now: One way to prepare for the PQRI expense is to educate your staff on the importance of "accurate and complete ICD-9 coding," says Shrader. Getting ICD-9 codes right is important at any time, but it's especially important for the PQRI. ■

ULTRASOUND

6 Tips To Make Billing The New AAA Screening Easy

▶ *Document your 'Welcome To Medicare' referral*

Your practice may soon be receiving referrals for Medicare's new abdominal aortic aneurysm (AAA) screening service (G0369), which took effect Jan. 1. Will you be ready?

Our experts offer some tips on how to bill this service without worries:

1) **Make sure your patient meets the qualifications** for this one-time exam, advises **Jill Young** with **Young Medical** in East Lansing, MI. To receive coverage, the patients must be "at risk," meaning they have a family history of AAA or are men aged 65 to 75 who have smoked at least 100 cigarettes.

"The required criteria must be documented in the ultrasound report or be reflected in the patient's medical record," adds **Rehna Burge**, radiology and cath lab billing analyst for **North Oaks Medical Center** in Hammond, LA. She advises setting up your scheduling system to check for the criteria before scheduling the patient for the exam.

2) **Document the referral.** You need to receive a referral from a provider that performed the patient's "Welcome to Medicare" exam, according to the **Centers for Medicare & Medicaid Services** (CMS). "Only Medicare beneficiaries who receive a referral for the AAA ultrasound screening as part of the Welcome to Medicare physical exam will be covered for the AAA benefit," CMS cautions.

3) **Get a signed Advance Beneficiary Notice (ABN)** if you can't find out whether your patient actually had the AAA screening before, Burge adds.

4) **Include an appropriate diagnosis code.** Unfortunately, the National Coverage Determination (NCD) for this procedure didn't include a list of covered ICD-9 codes, Burge laments. She recommends trying V81.2 (*Other and unspecified cardiovascular conditions*), but cautions that other sources may suggest other codes.

5) **Don't collect a deductible.** The Medicare deductible doesn't apply to this service, although standard copayments do.

6) **Make sure that primary care physicians** performing the "Welcome to Medicare" exam know to refer patients at risk for AAA to your practice for this screening exam. Three out of four aortic aneurysms are AAAs, and aortic aneurysms account for about 15,000 deaths in the United States every year, CMS notes. Catching AAAs early can make a huge difference in treating them effectively.

For more information about the AAA screening, read MLN Matters article MM5235 online at www .cms.hhs.gov/MLNMattersArticles /downloads /MM5235.pdf. ■

CCI 13.1

Start Resubmitting Denied Cystourethroscopy, Craniotomy Claims

▶ *You can't use a modifier to override dozens of edits anymore*

Heads up: The Correct Coding Initiative (CCI) has unveiled its latest set of edits. Version 13.1 takes effect April 1, and it includes 1,692 new edits.

CCI version 13.1 also:

• **Deletes 299 edit pairs**, and 212 of those deletions were retroactive to the start of the year, according to **Frank Cohen** with **MIT Solutions Inc.** in Clearwater, FL. That means if you received denials for any of these code pairs since Jan. 1, you can resubmit those claims and get paid.

You can resubmit any denied claims for cystourethroscopy code 52332 along with a dozen other cystourethroscopy codes. Also, CCI 13.1 deletes edits bundling six craniectomy/craniotomy codes with stereotactic body radiation-therapy code 77373. It also deletes edits bundling a few dozen nervous-system surgery codes with stereotactic body radiation-therapy codes 77371-77373.

Finally, 64 pathology and lab testing codes will no longer be bundled with tissue-culture code 87253, and seven of those also will be unbundled from centrifuge-enhanced virus isolation code 87254.

• **Changes modifier indicators for another 132 edit pairs** from "1" to "0," meaning you can no longer override those edits with a modifier. These include edits bundling: laparoscopic enterolysis code 44180 with some surgical codes; surgical anorectal exam code 45990 with a host of digestive-system surgery codes; pelvic exam code 57410 with several female genital system surgery codes; and nursing facility/rest-home visit codes 99307-99310, 99324-99328 and 99334-99337 with observation codes.

In the past, if you had a good reason to bill these code pairs, you could use a modifier to explain why the services were separately identifiable and necessary. But now, Medicare has decided that you can never justify billing them together. ■

CCI 13.1

Don't Bill Chemodenervation With Neurological Testing

▶ *You can't ever bill two hospital visits to the same patient on the same day*

There's no reason you would ever have to bill two "new patient" office visits by the same patient on the same day, but now you won't be able to anyway.

Correct Coding Initiative version 13.1 bundles each new patient visit code from 99201-99205 with every lower-level code in the same series. You can't use a modifier to override those edits.

The same goes for initial observation codes 99218-99220, inpatient consultation codes 99251-99255, domiciliary/rest-home visit codes 99324-99337 and home visit codes 99341-99345.

Also, subsequent hospital care codes 99231-99233 are all bundled with initial inpatient service codes 99221-99223, and no modifier can override those edits either. You also can't bill two different subsequent hospital visit codes for the same patient on the same day.

More new edits:

• **Debridement** codes 11000 and 11040 will become components of dressing codes 16020-16030. Also, **intralesional injection** codes 11900-11901 will become components of chemotherapy codes 96401-96450 and 96542.

• **Fascia lata graft** codes 20920-20922 and tissue graft code 20926 will become components of blepharoptosis repair codes 67901-67902.

• **Proctopexy** codes 45400-45402 and 45540-45550 and **protectomy** code 45397 become components of colectomy codes 44140-44156, 44160, 44204 and 44206-44212. You can override all but a few of these edits with a modifier.

• **Manipulation** codes 45900-45915 become components of chemodenervation code 46505 and ileoanal pouch repair codes 46710-46712.

• **Pelvic exam under anesthesia** code 57410 becomes a component of 51 female genital system surgery codes. You can't use a modifier to override any of these edits.

• **Molecular diagnostic testing** codes 83900 and 83907-83909 become components of infectious agent detection codes 87470-87801 and 87901-87904, except for four codes introduced in 2007.

• **Needle electromyography** codes 95860-95870 and six other neurology testing codes become components of chemodenervation codes 64650-64653. ■

PART B MYTH BUSTER

One Statement Could Rescue Your E/M Coding Levels

▶ *But don't fall into 'double dipping' unless you're sure you can justify it*

Myth: You can't use the same element for both history and review of systems (ROS) unless the doctor notes it twice.

Reality: As long as the physician documents the item clearly you can count it in both areas. A top **Centers for Medicare & Medicaid Services** (CMS) official, Executive Medical Officer **Barton McCann**, said so in a famous 1998 letter to **Mason Smith** with **Lynx Medical Systems** in Bellevue, WA.

"It is not necessary to mention an item of history twice in order to meet the Documentation Guidelines requirement for the ROS," McCann wrote. "It is important that the information which is provided can be inferred accurately and appropriately by a reviewer to determine level of service and medical necessity."

Evaluation & management documentation guidelines are supposed to help you find the correct level of service and "not to be perceived as a burden to the physician," McCann concluded. You can also find a carrier article on this topic at www.cms.hhs.gov/mcd/viewarticle.asp?article_id=16555&article_version=2&show=all on the CMS Web site.

"Between the now-famous letter from Bart McCann and the guidance available on the CMS Web site," you should be able to defend using the same statement in both history and ROS, says **Eric Sandhusen**, director of reimbursement, HIPAA and fiscal compliance with **Columbia University Department of Surgery**.

For example: A patient presents with several problems, including "chest pain with dyspnea."

"Chest pain and dyspnea can be counted as location and associated signs and symptoms in the history as well as respiratory section of the ROS," says **Patricia Trites** with **Advocates for Documentation Integrity and Compliance** in Augusta, MI.

This issue becomes most controversial in those cases where you need a fourth element in your ROS. In that case, you could consider the phrase "with dyspnea" for your ROS, says **Joan Gilhooly** with **Medical Business Resources** in Evanston, IL.

Caution: Not all carrier medical directors agree with CMS' position on the question of including the same element in history and ROS, notes Gilhooly. You should check with your own carrier before following this advice.

"It's worth asking, 'Do I ever want to be in the position to HAVE to defend this practice?'" says Sandhusen. Some coders take a more conservative position on this issue because they don't want to have to defend themselves in an audit, he explains. Don't start "double dipping" unless you're sure you can justify it.

Also, if the patient shows up with only one complaint, you should not go ahead and use that for both ROS and history, Gilhooly warns. After all, the form wouldn't have a space for "none taken" under ROS if you could just take any element from the history and use it for ROS, she points out.

"You need to have evidence the physician dug deeper," Gilhooly adds. So including just "abdominal pain" in history and ROS is probably not okay, especially if that's the only complaint. But including "abdominal pain, no nausea" in ROS is okay, because that shows the doctor asked an extra question, she says.

Important: You also can't use the same statement twice within history or within ROS, says Sandhusen.

Bottom line: You should get out of the mindset of "looking for words or phrases" to stick into boxes, says Gilhooly. Physicians don't always put E/M documentation in the correct area on the visit notes, and the heading doesn't always tell you where it belongs. "I have seen ROS information in the exam section of the note," she recalls, because sometimes the physician will ask questions while he examines the patient. ■

BILLING

Stop Rushing to Switch Over to the New CMS-1500

▶ *CMS gives you a breather due to incorrect forms*

Don't discard your old CMS-1500 forms just yet.

The **Centers for Medicare & Medicaid Services** granted you a respite and will allow the old version (12-90) until around June 1, not April 1 as originally planned. Next month, Medicare contractors were supposed to accept only the new version (08-05), which accommodates the National Provider Identification (NPI) number.

The delay will give everyone, including providers, clearinghouses and vendors, more time to comply with the new form, cheers **Cyndee Weston**, executive director of the **American Medical Billing Association**. "I am doubtful that some software vendors would have been ready by April 1," she adds. Many of them will welcome the delay.

Also, some carriers might not have been ready to accept the new form, notes **Gary Lindsay** with **Lindsay Technical Consultants** in Mankato, MN.

The problem: Print vendors, specifically the **Government Printing Office** (GPO), are selling incorrectly formatted versions of the revised form, notes **Brian Reitz**, CMS health insurance specialist, in a March 9 Medicare notice.

Submitting incorrect versions of the revised form will delay your payments. Your carrier won't key in a claim using an incorrectly formatted version and will instead return it to you.

To find out if your CMS-1500 version 08-05 is in danger of bouncing back, look at the upper-right corner of the form. Properly formatted claim forms contain approximately a one-quarter inch gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. "If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications," Reitz concludes.

Even with the delay, the new form will have problems, Lindsay notes. There's no space to list the secondary carrier, which all primary carriers require. Physical therapists must list the date of the patient's last X-ray, but there's no space for it. And finally, the carrier's name and address are in the top right-hand corner, which means you can't use a windowed envelope — because the stamp should go in the upper-right corner.

Unresolved issue: "We don't exactly know how the claim form delay will play out with the NPI deadline in May," notes Weston. "It shouldn't be an issue for electronic transactions. But with paper claims, use of old forms without the NPI after the NPI deadline could become an issue." ■

Part B Coding Coach

When Wound Repair Isn't Enough, Turn to Tissue Transfers: 6 Steps Show You How

▶ *You won't report lesion excision separately*

When the surgeon performs an adjacent tissue transfer (for instance, to close a large or irregular wound following lesion removal), you must be sure to add together the area of both the primary and secondary defect to choose the correct code. But that's only the beginning: Successful tissue-transfer coding requires that you follow at least six steps.

1. Differentiate Transfers From Repairs

When reading physician documentation, you must know what separates tissue transfer (14000-14300) from closures as described by repair codes 12001-13160.

In a nutshell: During simple, intermediate or complex repair (12001-13160), the surgeon cleans and sutures the wound. Adjacent tissue transfer involves freeing tissue from around the wound and literally rearranging it to cover the defect.

Recognize the difference: "For adjacent tissue transfer or rearrangement, you should see the surgeon document that the specific defect, excision or laceration needs surrounding tissue rearrangement to accomplish final closure. These include Z-plasty, W or V-Y plasty, rotation flaps, local advancement flaps, and double pedicle flaps," says **John Bishop, PA-C, CPC**, president of **Bishop and Associates** in Tampa, FL. "The original tissue maintains its blood supply and is carefully 'moved' into position for final wound closure."

"The easiest method [to differentiate tissue rearrangement from repair] is to identify whether any of the processes described in the CPT Adjacent Tissue Transfer or Rearrangement section guidelines are described (such as Z-plasty and so on)," says **Terri Brame, CPC, CPC-H**, operations manager for the Division of Clinical Revenue at the **University of Washington** department of surgery. "Another tip is that a 'primary' and 'secondary' defect are addressed."

Finally, unlike repair as described by 12001-13160, the flap creation during tissue transfer results in a "secondary defect" in addition to the "primary defect" of the wound itself.

"The primary defect is the one being repaired, and the secondary defect is the defect created by lifting the adjacent tissue," Brame says.

Important: Surgeons may perform an additional closure or skin graft to repair the secondary defect. Usually, surgeons use tissue transfer to minimize scarring when repairing wounds that are too large or deep for a complex repair.

Tissue Transfer Quick Coding Chart

Location:	Trunk	Scalp, arms, legs
10 sq cm or less	14000	14020
10.1-30 sq cm	14001	14021
Over 30 sq cm	14300	14300
Location:	**Forehead, cheeks, chin, nose, mouth, neck, axillae, genitalia, hands, feet**	**Eyelids, ears, lips**
10 sq cm or less	14040	14060
10.1-30 sq cm	14041	14061
Over 30 sq cm	14300	14300

2. Determine Overall Area And Location

To select the appropriate tissue transfer code, you must determine the total area (in sq cm) of the primary and secondary defects, according to CPT instructions. In addition, you must consider the repair's anatomical location (use the inset chart to find the correct tissue transfer code at a glance).

Example: Your surgeon removes a lesion measuring 2 cm x 2 cm from a patient's right forearm. To repair this primary defect, the surgeon creates a flap measuring 4 cm x 2.5 cm. To determine the total area, add together the area of the primary defect (2 x 2 = 4 sq cm) and the area of the secondary defect (4 x 2.5 = 10 sq cm) for a total area of 14 sq cm. In this case, you should choose 14021 for a repair totaling 14 sq cm on the arm.

3. Consider Each Repair Separately

When reporting tissue transfers, you should consider and code each repair individually, Brame says.

Source of confusion: CPT treats all wound repairs (12001-13160) at the same level of severity (simple, intermediate or complex) and anatomic subcategory as a single, cumulative wound. Therefore, coding for wound repair as described by 12001-13160 often means that you'll use a single code to describe repair of more than one wound.

This is not true of adjacent tissue transfers, however.

Bottom line: For each repair by adjacent tissue transfer, you will report one code. Even if the surgeon uses more than one type of flap to close a defect, you should report each flap separately based on the defect's size.

Exception: You should consider a double-advancement flap as a single procedure, even though it involves creating two flaps.

Example: The surgeon removes two lesions from the right forearm and closes each wound using tissue transfer and a secondary defect of 12 sq cm, for a total of 17 sq cm.

Comments? Suggestions? Contact Charlie Kupperman, Executive Editor, at 1-888-219-0355 or charlie@partbinsider.com.

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The second closure involves a primary defect of 7 sq cm and a secondary defect of 15 sq cm, for a total of 22 sq cm. In this case, you would choose two units of 14021 rather than a single unit of 14300 because you should report each adjacent tissue transfer separately, even if they occur in the same anatomical region.

4. Include Lesion Removal

You should not report benign or malignant lesion excision (11400-11646) separately when claiming adjacent tissue transfer. Rather, you should consider the lesion removal as included in (bundled to) the tissue transfer, Bishop says. Both CPT and **Centers for Medicare & Medicaid Services** guidelines (as set forth in the National Correct Coding Initiative [NCCI]) confirm this practice.

Example: The surgeon excises a carcinoma of the face (11643, *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm*). She closes the excision using adjacent tissue transfer (14040). In this case, you should report 14040 only. The lesion excision (11643) is included in the tissue transfer.

"Staged" exception: If the surgeon performs an excision on a separate (earlier) day from the tissue transfer, you may report the procedures separately. This can occur, for instance, if the surgeon wishes to wait for the pathology report to be sure the margins are clear before closing the operative wound.

But if the tissue transfer occurs during the excision's 10-day global period, you must append modifier 58 (*Staged or related procedure or service by the same physician during the postoperative period*) to the tissue transfer code.

What about separate locations? NCCI includes a modifier indicator of "1" for the edits bundling 11400-11646 to 14000-14350. You may use modifier 59 (*Distinct procedural service*) to override the edits when the lesion excision and adjacent tissue transfer occur at different locations, or during separate, distinct operative sessions, says **Barbara J. Cobuzzi,** president of **CRN Healthcare Solutions** in Tinton Falls, NJ.

Example: The surgeon performs a single excision on the right forearm, along with lesion excision followed by adjacent tissue transfer at another location near the elbow.

In this case, you should report the lesion excision followed by adjacent tissue transfer using the appropriate tissue transfer code only (for example, 14021).

You may report the lesion excision only in a separate location using the appropriate lesion excision code (for example, 11601, *Excision, malignant lesion including margins, trunk, arms or legs; excised diameter 0.6 to 1.0 cm*) with modifier 59 appended.

5. Include Repairs And Debridement, Too

In addition to lesion excision, you should also bundle into adjacent tissue transfers any repairs (12001-13160) or debridement (11000-11042) for the same lesion or injury, Brame says. NCCI bundles 12001-13160 and 11000-11042 to 14000-14300, as outlined in the introductory material of Chapter 3 ("Integumentary System") and supported by code pair edits elsewhere. Different location allows for separate payment: If the repair and tissue transfer occur at different locations, you can report the repair separately.

Example: The surgeon removes a lesion from the patient's left cheek, which requires a flap repair. At the same time, he closes a nearby but separate 2.5-cm wound by intermediate repair. In this case, you can report the flap repair (14040) separately from the intermediate repair (12051, *Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less*). Remember that the flap repair includes the lesion excision at the same site.

6. Report Surgical Prep, Grafts Separately

Bishop confirms that when your surgeon uses a skin graft to close a secondary defect, you may report the procedure in addition to the tissue transfer:

- 15100-15136 for autologous skin grafts
- 15150-15157 for autologous tissue-cultured epidermal grafts
- 15040 for autologous keratinocytes and dermal tissue harvesting for tissue-cultured skin grafts
- 15170-15176 for acellular dermal replacement.

In addition, you may report surgical preparation of the recipient site, when required, using the following codes (as appropriate to location and total area prepared):

- 15002 — *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children*
- +15003 — *… each additional 100 sq cm or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure)*
- 15004 — *Surgical preparation or creation of recipient site by excision of open wounds, burn eschar or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children*
- +15005 — *… each additional 100 sq cm or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure)*.

Specifically, CPT 2007 instructs, "Codes 15002-15005 describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft."

What constitutes site prep that warrants billing 15002-15005? According to the Sept. 1997 *CPT Assistant*, "Usually, the untreated site contains uneven layers or multiple layers that pose a problem, not only facilitating the connection of the surfaces (to maximize graft survival) but accommodating the graft to cause minimal visualization of the graft site." ■

PHYSICIAN NOTES

NPIs Won't Replace Medicare Numbers

▶ *Get ready for more paperwork headaches under a dual number system for surveys*

Think the National Provider Identifier (NPI) numbers required in May will simplify your Medicare paperwork? Think again.

After the NPI implementation, the **Centers for Medicare & Medicaid Services** will continue to issue and use Medicare/Medicaid Provider Numbers, CMS says in a March 2 memo to state survey agencies (S&C-07-16).

New name: To decrease confusion between the new numbers, CMS will call the Medicare Provider Number the "Centers for Medicare & Medicaid Services Certification Number," or CCN.

The Health Insurance Portability & Accountability Act (HIPAA) requires providers to use NPIs on all HIPAA-regulated transactions, such as claims, by May 23. But CMS will use the new CCN on all Survey and Certification and patient assessment transactions, the memo specifies.

"In some activities, both numbers will be used," CMS says. You can review the memo online at www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-16.pdf.

In other news:

• CMS is reviewing all Medicare policies on erythropoiesis stimulating agents (ESAs) after the **Food and Drug Administration** (FDA) issued some new warnings regarding their use. CMS also opened a National Coverage Analysis (NCA) on the use of ESAs for conditions other than end-stage renal disease (ESRD). CMS hopes to have a national coverage determination (NCD) on ESAs soon.

• Medicare spending will outpace the growth of the economy and other government spending over the next few decades, warns a March 8 letter from the **Congressional Budget Office**. Slowing spending could involve providing incentives for doctors to follow quality standards or grouping doctors into "multispecialty units" that would share some responsibility for each patient's care and make more money if they save the government money.

• CMS posted a new letter with information about the Physician Quality Reporting Initiative (PQRI) at www.cms.hhs.gov/mlnmattersarticles/downloads/mm5558.pdf. Also, **Research & Markets** posted a new report on "Weighing the Benefits of Partici-pation" in the PQRI online at www.researchandmarkets.com/reports/c51618.

• CMS also posted a guide to rural health for providers and suppliers at www.cms.hhs.gov/MLNProducts/downloads/MedicareRuralHealthGuide.

• An increasing number of cancer survivors and slower growth in the pool of oncologists will result in a shortage of 2,500 to 4,800 cancer doctors by 2020, according to a new study commissioned by the **American Society of Clinical Oncology**. The **Association of American Medical Colleges Center for Workforce Studies** conducted the study, published in ASCO's *Journal of Oncology Practice*. ■

PART B Insider

Published 35 times annually by *The Coding Institute*.
Subscription rate is $549.

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Part B Insider (USPS 023-079) (ISSN 1559-0240) is published the 1st, 2nd, and 3rd week of each month except the publishing date the week New Years by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Rd, Durham, NC 27713. Subscription price is $549. Periodicals Postage is paid at Durham NC 27705 and additional entry offices. Ride-Along enclosed. POSTMASTER: Send address changes to Part B Insider, P.O. Box 413006, Naples, FL 34101-3006.

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