CPT® 2014 Updates: New, Revised, & Deleted Codes
Plus Expert Insight for a Compliant 2014

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Agenda

• An overview of CPT® 2014 changes for major specialties – What’s in & what’s out
  • New edition of CPT® debuts ‘Interprofessional Telephone/Internet’ E/M codes
  • 25% of CPT® changes affect gastroenterology - Prepare for endoscopy, ablation, ERCP changes
  • Fine tune how you report fetal evaluations, fluid collections, and ablation of uterine fibroids
  • New codes for percutaneous patent ductus arteriosus closure and percutaneous septal reduction
  • Educate yourself on shoulder additions
  • Stop reporting 52332 with 52353 starting January 1, 2014
  • Toss out 37204, 37210 for new embolization choices
  • Breast localization devices and biopsy get new codes
  • New codes focus on location, type of anesthesia
  • Learn new details for 69210

• Useful scenarios, tips, examples, and expert insight to ensure you’re on track to apply the changes

• Online tools to help you get up to speed on 2014 CPT® changes
Talking Points of CPT® 2014

• CPT® 2014 will bring 335 code changes for 2014 that include
  • 175 new codes
  • 107 revised codes
  • 53 deleted codes.

Who’s affected: Most of the 335 changes will be found in these subsections: digestive system, molecular pathology, cardiovascular system, complex chronic care coordination services, and transitional care management services.
25% of 2014 CPT® Changes to Affect Gastroenterology

Gastroenterology coders take note: About 25% of these code changes aim to bring the codes you use in line with clinical practice, reflecting advances in endoscopic technology, devices, and techniques.

Further CPT® enhancements for 2014 due to advancements in technology include new and revised codes for

- Breast biopsies and imaging
- Multi-system image-guided catheter drainage
- Cardiology and vascular embolization procedures
Breaking News: New Edition of CPT® Debuts 'Interprofessional Telephone/Internet' E/M Codes

When Medicare stopped paying for consultations in 2010, you probably thought you’d never see another of these codes making its debut in a CPT® book—but that’s exactly what you’ll find when you crack open CPT® 2014.

Effective Jan. 1, CPT® will include four new codes that describe the work of two medical professionals who discuss a patient’s condition via phone or internet, as follows:
99446  Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447  …11-20 minutes of medical consultative discussion and review
99448  …21-30 minutes of medical consultative discussion and review
99449  …31 minutes or more of medical consultative discussion and review
Telephone/Internet E/M Codes

• These new codes are consultative in nature, which means you’ll have to provide a written report back to the requesting physician to qualify for the code, as indicated by the phrase “including a verbal and written report.”

• It’s not clear whether Medicare will include payment for these codes, because they are consultations.
  • Know whether these are payable once the 2014 Medicare Physician Fee Schedule is released.
99481/99482 Replace Category III Codes

- You’ll find two new neonate hypothermia codes among the E/M code changes as well. CPT® 2014 adds the following:
  - +99481 — **Total body systemic hypothermia in a critically ill neonate per day** (List separately in addition to code for primary procedure)
  - +99482 — **Selective head hypothermia in a critically ill neonate per day** (List separately in addition to code for primary procedure).
Delete T Codes for Neonatal Hypothermia

CPT® 2014 deletes two Category III codes you might have used for hypothermia in neonates:

- 0260T — Total body systemic hypothermia, per day, in the neonate 28 days of age or younger;
- 0261T — Selective head hypothermia, per day, in the neonate 28 days of age or younger.
Let’s take a look at how some of the major specialties will be impacted in 2014!
Talking Points for Ob-Gyn

Fine Tune How You Report Fetal Evaluations, Fluid Collections, and Ablation of Uterine Fibroids

Effective January 1, 2014, these areas of your ob-gyn practice will be affected by CPT® changes.

Assess Your 2014 Fetal Evaluation Codes

- Ob-Gyns can use the plasma of pregnant women for noninvasive prenatal testing that uses cell free fetal DNA to screen for fetal aneuploidy. Now you’ll have a CPT® code to report this:
  - 81507 (Fetal aneuploidy [trisomy 21, 18, and 13] DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy).
Changes for Ob-Gyn

**Revision:** In addition, you’ll see the descriptor for 84112 revised as follows (emphasis added): *Evaluation of cervicovaginal fluid for specific amniotic fluid protein(s) (eg, placental alpha microglobulin-1 (PAMG-1)[PAMG-1], cervicovaginal secretionplacental protein 12 [PP12], alpha-fetoprotein), qualitative, each specimen.*

The ob-gyn would order this test to reflect PAMG-1 when he wants to determine whether fetal membranes have ruptured.

*Note:* This code is not a CLIA-waived or PPMP test, and therefore, the ob-gyn would not be billing for this service.
CPT® Updates, Deletes, and Revises Surgical Offerings

- New code for surgery - **10030** (*Image-guided fluid collection drainage by catheter [e.g., abscess, hematoma, seroma, lymphocele, cyst], soft tissue [e.g., extremity, abdominal wall, neck], percutaneous*)
  - This code could help you code these procedures when your physician needs to drain fluid using catheterization.

- You also can add these codes to your 2014 coding possibilities:
  - **49405** (*Image-guided fluid collection drainage by catheter [e.g., abscess, hematoma, seroma, lymphocele, cyst]; visceral [e.g., kidney, liver, spleen, lung/mediastinum], percutaneous*)
  - **49406** (*... peritoneal or retroperitoneal, percutaneous*)
  - **49407** (*... peritoneal or retroperitoneal, transvaginal or transrectal*).
Ob-Gyn Changes

Deletion:

- **58823** *(Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous [e.g., ovarian, pericolic]*) makes an exit; report this procedure as **49407**.
- Strike **13150** *(Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less)* from your coding options.

Revision:

Subtle revision of “e.g.” changing to “i.e.” in **15777** *(Implantation of biologic implant [e.g., acellular dermal matrix] for soft tissue reinforcement (i.e., breast, trunk) [List separately in addition to code for primary procedure])*.
4. Watch Out for Vaccine Codes

- Several new vaccine codes will be published in CPT® 2014.
- The main code that is new to most coders is 90673 (Influenza virus vaccine, trivalent, derived from recombinant DNA [RIV3], hemagglutinin [HA] protein only, preservative and antibiotic free, for intramuscular use).
- Other codes include:
  - 90686 — Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use
  - 90688 — Influenza virus vaccine, quadrivalent, split virus, when administered to individuals 3 years of age and older, for intramuscular use.

To get details about the new vaccine codes, visit

Anesthesia: New Codes Focus on Location, Type of Anesthesia

You’ll have six new Category II possibilities to report in certain situations:

- **0581F** — Patient transferred directly from anesthetizing location to critical care unit (Peri2) [ASA]
- **0582F** — Patient not transferred directly from anesthetizing location to critical care unit (Peri) [ASA]
- **4554F** — Patient received inhalational anesthetic agent (Peri2) [ASA]
- **4555F** — Patient did not receive inhalational anesthetic agent (Peri2) [ASA]
- **4559F** — At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (Peri2) [ASA]
- **4560F** — Anesthesia technique did not involve general or neuraxial anesthesia (Peri2) [ASA].
Prepare for Endoscopy, Ablation, ERCP Changes

Get ready to overhaul your endoscopic coding, thanks to upgrades in CPT® 2014. Watch for scope type and route used for entry to correctly code these services.

Delve Deeper Into Documentation For Esophagogastroduodenoscopies

- Use a new code range 4319X for any esophagogastroduodenoscopy procedures performed using a rigid scope through the oral route.
- Two codes in the 4319X range will be used for esophagogastroduodenoscopy procedures that are performed using the nasal route and a flexible scope.
Gastroenterology

Documentation clues: You will have to review the procedure note for indications that your gastroenterologist used a rigid scope or a flexible scope for the procedure.

- The currently-used code range 43200-43232 will henceforth cover procedures that are performed using a **flexible** scope performed through the **oral** route.

Watch descriptor changes: Code descriptors for 43235-43259 eliminate the words, “Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate” which will now read, “Esophagogastroduodenoscopy, flexible, transoral.”
Capture new codes for ablation and stent placements

You will stop using these codes:

- 43219
- 43228
- 43256
- 43258

Watch out for more new codes

- New codes for dilation of the esophagus during an esophagoscopy or an esophagogastroduodenoscopy; transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance; and endoscopic mucosal resection.
  - **Stop** reporting codes for surgical dilation procedures using a balloon or a dilator, namely 43456 – **now deleted**
Check for changes to ERCP Codes

• Descriptor changes to currently used endoscopic retrograde cholangiopancreatography (ERCP) codes

• **Stop** using these CPT® codes in your gastroenterology practice:
  
  ➢ **43267** (Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube)
  
  ➢ **43268** (...with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct)
  
  ➢ **43269** (...with endoscopic retrograde removal of foreign body and/or change of tube or stent)
  
  ➢ **43271** (...with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct[s])
  
  ➢ **43272** (...with ablation of tumor[s], polyp[s], or other lesion[s] not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique)
Orthopedics

Educate Yourself on These Shoulder Additions

Orthopedic surgeons will benefit from two new codes that describe shoulder prosthesis removals, as follows:

- **23334** — *Removal of prosthesis, includes debridement and synovectomy when performed; humeral or glenoid component*
- **23335** — *... humeral and glenoid components (e.g., total shoulder)*

- These shoulder prosthesis removal codes will offer more specificity than the previous options, which included **23331** and **23332**, both of which will be deleted effective Jan. 1.

- With these deletions and additions, you’ll also have new code **23333** (*... deep [subfascial or intramuscular]*).
Revision: In addition, you should pay attention to the revised descriptors to **24160** (Implant removal–Removal of prosthesis, includes debridement and synovectomy when performed; elbow joint humeral and ulnar components) and **24164** (... radial head).

Orthopedic coders also won’t want to miss those changes related to radical resection, chemodenervation, and phone/Internet codes!
See What’s in Store for Cardiology...

CPT® 2014 gets in line with clinical practice by adding new codes for percutaneous patent ductus arteriosus closure and percutaneous septal reduction.

- CPT® 2014 adds 93582 (Percutaneous transcatheter closure of patent ductus arteriosus) to represent closing a patent ductus arteriosus (PDA) by a percutaneous approach. This addition may prove useful for many cardiology coders.

- Another percutaneous cardiac surgery code added is 93583 (Percutaneous transcatheter septal reduction therapy [e.g., alcohol septal ablation] including temporary pacemaker insertion when performed).
Top Changes for Cardiology

- Toss out 37204, 37210 for new embolization choices and in their place, see four new codes – 37241, 37242, 37243, 37244.
- Turn to new code 37217 for Retrograde Carotid or Innominate Stent Placement.
- Do away with 37205-+37208 to make room for new intravascular stent codes.
  - In their place, you have new codes 37236-+37239, which bundle in stent placement, radiological supervision and interpretation, and (if performed) same-vessel angioplasty.
CPT® 2014 clarifies the definitions of cardiac device skin pocket codes by removing the term “revision” and focusing specifically on “relocation.” The updated code definitions remove the crossed out text and add the underlined text:

- **33222, Revision or relocation** of skin pocket for pacemaker
- **33223, Revision** Relocation of skin pocket for cardioverter-defibrillator.
Urology: Stop Reporting 52332 with 52353

A new code will change your cystourethroscopy + lithotripsy + stent coding.

- Unlike other specialties, urology coders won’t have a slew of changes to learn. There are seven code changes that pertain to urology:
  - Five new codes
  - Two deleted codes

- Get to know 52356: According to experts, new code 52356 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent [eg, Gibbons or double-J type]) will have significant impact on urology practices.
Example:

- **Old way:** Currently when you bill for ureteroscopic fragmentation of a renal pelvic or ureteral stone followed by a double J stent insertion, you report 52353 and 52332. These two codes are separately billable and payable.

- **New Way:** As of Jan 1, for the same procedures, you’ll only be able to bill 52356.

- **Note:** If your urologist performs the cystourethroscopy with lithotripsy but does not place a stent, you’ll still report just 52353.

*Plus, CPT® 2014 has also deleted codes 50021 and 58823. These codes have been replaced by 49405, 49406, and 49407.*
The most significant change for ENTs is with 69210

**Current descriptor:** “Removal impacted cerumen (separate procedure), 1 or both ears.”

**Revised descriptor:** “Removal impacted cerumen requiring instrumentation, unilateral” (underlining added for emphasis).

**Impact:** Three important revisions to the descriptor are worth noting and will make a difference in your coding:

- The specification that the code requires instrumentation
- The designation as a unilateral code (instead of for one or both ears, as in previous years)
- The separate procedure designation was removed.
CPT® 2014 will also introduce three new Category II codes related to dysphagia (787.20) for tracking measures.

- 3759F — Patient screened for dysphagia, weight loss, and impaired nutrition, and results documented (ALS) [AAN]
- 3760F — Patient exhibits dysphagia, weight loss, or impaired nutrition (ALS) [AAN]
- 3761F — Patient does not exhibit dysphagia, weight loss, or impaired nutrition (ALS) [AAN]
Pediatric Practices Can Expect...

Apart from the new vaccine and 'Interprofessional Telephone/Internet' E/M Codes, there are several other changes that will impact pediatricians.

For instance:

- Cerumen Removal is Now Strictly Unilateral (also see slide 28)

For those practices that have struggled with the question of how to report cerumen removal when it involves both ears, the answer is now clear:

- You’ll need to append a bilateral modifier (modifier 50) to 69210
- Although the descriptor for this code used to say “one or both ears” it now specifically states “unilateral.”
CPT® will also eliminate the vague code 92506 (Evaluation of speech, language, voice, communication, and/or auditory processing) that you’ve been using to evaluate patients’ speech issues.

Instead, 2014 will bring heightened specificity to these options, with the following new codes:

- 92521 – Evaluation of speech fluency (eg, stuttering, cluttering)
- 92522 – Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)
- 92523 – With Evaluation of language comprehension and expression (eg, receptive and expressive language)
- 92524 – Behavioral and qualitative analysis of voice and resonance
Major Changes Eyeing Family Practices

1. Look for New E/M Codes For Consults (See details in previous slides)
2. Observe Changes to Vaccination Codes (See previous slides)
3. Understand Descriptor Changes to Cerumen Removal (See previous slides)
4. Upgrade to New Code for Ultrasound Wound Care Therapy:

If your clinician is performing the application of a low frequency ultrasound device for wound care, you had to use the Category III code 0183T to report the procedure in 2013. In CPT® 2014, you will have a new option as the old Category III code 0183T will be deleted, and in its stead, you will have a new Category I CPT® code to report the procedure:

97610, Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.
Ophthalmology Practices Will See...

New codes:

- **0329T**: Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report
- **0330T**: Tear film imaging, unilateral or bilateral, with interpretation and report
- **66183**: Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

Revised codes:

- **65778**: Placement of amniotic membrane on the ocular surface for wound healing; self-retaining without sutures
- **65779**: Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured
### Oncology: Breast Localization Devices And Biopsy Get New Codes In 2014

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<td>Biopsy, breast, with placement of breast localization device[s] [e.g., clip, metallic pellet], when performed, and imaging of the biopsy specimen, when performed, percutaneous</td>
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Q. A 26-year-old male came to physician for removal of cerumen. Physician removed impacted cerumen from both ears with the help of curette. How will you report this procedure?

A. **69210-50**

**Descriptor:** *Removal impacted cerumen requiring instrumentation, unilateral.*

Q. A patient suffered from neck pain. Physician ordered X-ray cervical spine 3 views. X-ray was performed in physician office and cervical spondylosis was diagnosed. How will you report the CPT® code for radiological services?

A. **72040-26**

**Descriptor:** *72040-Radiologic examination, spine, cervical; 2 or 3 views.*
Q. A physician performed ERCP for removal of stent from pancreatic duct in a 55-year-old female having chronic pancreatitis. What is the appropriate CPT® code for the procedure?

A. 43275

 Descriptor: Endoscopic retrograde cholangiopancreatography (ercp); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)

Q. Which is the new code added in 2014 that represents Trichomonas vaginalis amplified probe technique?

A. 87661

 Descriptor: Trichomonas vaginalis, amplified probe technique
Q. A 28-year-old male came to physician complaining of shoulder pain. Patient explained that he had several metal shavings embedded in his shoulder from a work accident 2 weeks ago. X-ray confirmed presence of foreign body in shoulder region. Physician performed an incision into the shoulder and through the fascia and muscle to visualize the foreign body. He excises the foreign body using forceps. Which CPT® code will you use for the procedure?

A. 23333

Descriptor: Removal of foreign body, shoulder; deep (subfascial or intramuscular)
Q. A 40-year-old male presents to the emergency room in shock following a car accident. CT exam shows a complex left pelvic fracture and large left pelvic hematoma with active extravasations of contrast material. Surgeon used fluoroscopic guidance for emergency embolization to correct active extravasations. Which CPT® code represents the service referred to the patient?

A. 37244

Descriptor: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation.
Upcoming Challenges

Starting January 1, 2014, you’ll come across a lot of tough and difficult to understand coding scenarios such as the above. And if you’re not well-versed with the changes, your claims could be denied, and you and your practice could miss out on deserved reimbursement.

Not sure how to get a grip on the 2014 changes?
Tools to Tackle CPT® 2014 Changes

Learning the CPT® 2014 changes can be a breeze with the right resources by your side.
Where to find them?

If you’re looking for some easy and affordable tools to help you get up to speed on the changes, SuperCoder is a good place to be.

For instance, you can turn to Fast Coder, a compliance-boosting online resource, which will help you learn CPT® 2014 changes in a snap.
This online resource can help you...

- **Get CPT® code details instantly** – including new, revised, and deleted codes.

- **CPT 2014 Button**: Instantly access the new, revised, and deleted codes with the help of the CPT® 2014 Button.

- **Get official guidelines shown per code**: No need to flip from a code to the start of a subsection to locate applicable guidelines. Essential instructions from CPT® coding guidelines are shown with each code.

- **Master CPT® guidelines**: Shows all instances of the searched code(s) and/or keyword(s) appearing in the searched codeset's official guidelines, such as when 69210 appears in guidelines of CPT® codes.
You can even...

- **Get upcoming and historical Info** for the CPT® code(s) and/or keyword(s) entered.
- Get the Coding Institute’s written simple explanations containing CPT® codes or keywords searched.
- Click the Tools tab to search codes details without going to a code's details page.
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- Quickly spot CPT® guideline changes by looking for green SuperCoder Text.
- See the code’s allowed physician modifiers by clicking on the Modifiers – P button.
With Fast Coder you also get:

**LCD and NCD Lookup:** Get LCD policies with hyperlinks and NCDs containing ICD-9-CM codes at CPT® code level.

- **CPT® <-> HCPCS Crosswalk:** Identify drugs associated with CPT® procedure codes

- **CCI Edits Checker:** Adhere to CCI edits thanks to same-view descriptors and RVUs sorted in descending value order. Now this tool has an advanced version – New Upgraded CCI Edits Checker - that gets you locality, facility, and adjusted RVUs.

For details visit:  
**http://www.supercoder.com/cpt-codes/**
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