Medical Coding Specialist

Instruction Pack 5 | Lessons 26-31

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Instruction Pack 5

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Medical Coding Specialist—Answer Key Pack 5

Integrating ICD-9-CM and CPT Coding Practicum

LESSON 26

Step 1 Learning Objectives for Lesson 26

❒ When you have completed the instruction in this lesson, you will be trained to do the following:

- ☞ Explain and code using the ICD-9-CM coding guidelines.
- ☞ Explain and code using the CPT coding guidelines.
- ☞ Integrate ICD-9-CM and CPT coding.

Step 2 Lesson Preview

❒ In Lessons 11 through 19, you learned how to accurately code diagnoses. In Lessons 21 through 25, you learned how to locate procedures codes for surgery, radiology, pathology, anesthesia and medicine. (We'll explore Evaluation and Management coding in Lessons 27 and 28!) Now let's combine everything you've learned. In this lesson, you'll learn how ICD-9-CM and CPT codes work together. Once again, this lesson is packed full of real-life scenarios to give you practice coding procedures from a physician's dictation! For each scenario, you will have at least one ICD-9-CM and at least one CPT code to record. The exercises in this lesson will give you a good taste of what a Medical Coding Specialist does!

Step 3 ICD-9-CM Coding Review

❒ The *ICD-9-CM* covers diagnostic coding. Let's review the steps for ICD-9-CM coding, as well as some helpful guidelines:

Steps for Assigning Diagnostic Codes

1. Identify the main terms in the diagnostic statement.
2. Locate each main term in the *Index to Diseases* and read any notes that appear with the main term.
3. Refer to any subterms indented under the main term in the *Index to Diseases*.
4. Look at abbreviations, cross-references, symbols and brackets.
5. Choose the tentative code you find in the *Index to Diseases,* Volume 2, then locate and determine the highest level of specificity in the *Tabular List*, Volume 1.
6. Read and use any instructional terms in the *Tabular List* as a guide. Look for INCLUDES and EXCLUDES, notes and other instructional comments at the beginning of each chapter. Also, look at the three-digit code at the beginning of each category or group of codes that you are using within the chapter and check for additional instructions for the group.
7. Assign codes to their highest level of specificity, using the following guidelines:
   - ➲ Assign three-digit codes only when there are no four-digit codes within that category.
   - ➲ Assign a four-digit code only when there is no fifth-digit subdivision for that subcategory.
   - ➲ Assign a fifth-digit to the code for any subcategory for which a fifth-digit subclassification is provided.
   - ➲ Remember to continue coding the dictation until all elements are fully identified before assigning the code.

Outpatient Coding Tips

- ➔ If it is not documented, it did not happen.
- ➔ Do not assume anything.
- ➔ Terms such as *possible*, *suspect*, *probable*. *rule out* or *consistent with* are not assigned codes.
- ➔ Code symptoms only when a definitive diagnosis is not documented.
- ➔ Check with the physician if the information is unclear.
- ➔ For ICD-9-CM codes, you will not record "NEC," "NOS" or check marks.

Step 4 Steps to CPT Coding Review

❒ The *CPT* covers procedural coding. Let's review the steps for CPT coding, as well as some helpful guidelines.

1. Read the documentation and determine the main term. Main terms can be procedures or services, anatomical sites, conditions or diseases, synonyms, eponyms or acronyms.
2. Next, look up the main term in the *CPT Index*. Find the main term and subterms that best represent your procedure.
3. Locate the tentative code or codes in the *CPT Index.*
4. Turn to the main part of the *CPT* to locate the tentative code or codes.
5. Read the guidelines for the section you're using.
6. Read the procedure description to be sure you've found the right code.
7. If there are any symbols next to your code, double-check the legend at the bottom of each page.
8. If necessary, apply a modifier(s) for your code.
9. Read the dictation to identify all procedures, then assign the CPT code(s) and modifier(s), if applicable.

Other Coding Tips

For CPT codes, you will not record the symbols found in the legend of your book. You will not write pathways or code descriptions for either ICD-9-CM or CPT codes. Always remember to read the code descriptions carefully to make sure you have determined the right code.

Step 5 Linking ICD-9-CM and CPT Codes

❒ You know from your studies that diagnostic codes list the problem with the patient. And you know that procedure codes list actions taken to find a diagnosis or treat the problem. As a Medical Coding Specialist, you must make sure that the procedures and diagnoses reported for each medical report match. In other words, they must be linked or integrated. In order to receive reimbursement for a procedure, it must be clear that that procedure is justified by the diagnosis. This is called *medical necessity.* A procedure can be **medically necessary** if certain diagnoses or conditions exist. Let's look at an example.

> SCENARIO: A physician performs a laparoscopic appendectomy on a patient with appendicitis. Appendicitis is the problem, or diagnosis, while the laparoscopic appendectomy is the action taken to solve the problem, or procedure. The appendicitis establishes the medical necessity of the laparoscopic appendectomy.

To code the ICD-9-CM for this example, locate *Appendicitis* in the *Index to Diseases*. Based on the limited information provided, the tentative code is **541**. Turn to the *Tabular List* to determine the highest level of specificity for this code. After reading the code description, you determine **541 Appendicitis, unqualified** is the accurate diagnostic code.

Now, code the CPT by locating the procedure of the *Appendectomy, Laparoscopic* in the *Index*. The tentative code is **44970**. Turn to the main body of the *CPT* to review the guidelines and read the code descriptions. You determine **44970 Laparoscopy, surgical, appendectomy** to be the correct procedure code.

You will record **541** as the ICD-9-CM code and **44970** as the CPT code for this example.

By establishing the relationship between the problem and the procedure, reimbursement for the services is more likely. However, insurance may deny the claim if the ICD-9-CM and CPT codes do not correspond. Let's look at an example of improperly linked codes.

> SCENARIO: A three-view x-ray of a patient's ankle confirms a bimalleolar fracture. The ICD-9-CM submitted for the claim is 824.4 and the CPT submitted is 73130. The diagnosis is correct, but the CPT code description is for a three-view x-ray of the hand. The insurance company will not pay for this service because it is not linked correctly.

Now that you have a good understanding of how ICD-9-CM and CPT codes correspond, you will have a chance to practice your skills. The following scenarios were presented in the Surgery section and should be familiar to you. This allows you to incorporate both sides of coding without being overwhelmed. Without looking back at the surgery section, try your hand at coding the procedure. By coding the ICD-9-CM as well, you will be able to justify the procedure by establishing the medical necessity with the diagnosis.

In most cases, when working as a medical coder, you will apply both the *ICD-9-CM* and *CPT* to your physician's dictation. It's good to get in the habit of coding one type first, followed by the other. Most often, coders prefer coding the diagnosis, then the procedure. This is how the information and answer sheets in this course are formatted. Once you get used to coding both, you will establish your own rhythm of coding. So let's get to the Practice Exercises and see how you do at linking the problem with the procedure!

Step 6 Practice Exercise 26-1

❒ Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

PREOPERATIVE DIAGNOSIS: Inguinal hernia.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: INGUINAL HERNIA REPAIR.

INDICATIONS: The patient is a 16-year-old male who had come in for a sports-related physical. In preparation for football, he has been lifting weights. A week before he was seen, he noticed a bulge in his scrotum. Since the pain was minor, he waited for his scheduled visit with his doctor to have it checked.

PROCEDURE: The patient was placed in a supine position on the table. Following general anesthesia, he was prepped and draped. An incision was made in the abdomen. The abdominal muscles were separated, and the peritoneal cavity was opened. The hernia was located and repaired. The spermatic cord remained intact without injury. The skin was then closed with sutures. There was minimal blood loss. Sutures will be removed in about 1 week. Postoperative care and precautions were explained to the parents.

ICD-9-CM: _____

CPT: _____

Step 7 Review Practice Exercise 26-1

❒ Check your answers with the answer key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have questions.

Step 8 Practice Exercise 26-2

❒ Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

SUBJECTIVE:	Patient sustained a 1.2 cm eyelid laceration and a 3.5 cm forearm laceration following a fall down the stairs at home.
OBJECTIVE:	Patient presented to the emergency department complaining of a wound to the left eyelid and forearm and requested evaluation. After examination of the forearm, eye and eyelid, no foreign body was noted. Eyewash was introduced for approximately 5 minutes to thoroughly clean the eye. The laceration in the left upper eyelid was 1.2 cm in length, while the forearm was 3.5 cm in length. It was felt sutures would provide the best healing for both injuries. A simple repair of the lacerations with 3.0 nylon sutures was made.
ASSESSMENT:	Simple one layer repair of 1.2 cm eyelid laceration and 3.5 cm forearm laceration.
PLAN:	A patch was placed over the eye and prescription drops were given. The patient is to make an appointment with his family physician to be seen in the next 3 days.

Primary ICD-9-CM: _____

Primary CPT: _____

Secondary ICD-9-CM: _____

Secondary CPT: _____

Step 9 Review Practice Exercise 26-2

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have questions.

Step 10 Practice Exercise 26-3

Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

PREOPERATIVE DIAGNOSIS: Cerumen impaction.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: REMOVAL OF IMPACTED CERUMEN.

This pleasant 23-year-old female presents with decreased hearing, ear pain, a plugged feeling and "ringing" in her right ear for approximately one month. She attempted irrigation at home and has not felt relief of any of the symptoms. She denies any history of chronic otitis media or tympanic membrane perforation.

After signing the appropriate consent forms, she was placed in a sitting position with an emesis basin under her right ear. The auricle was pulled up and back. Upon visualization, a right-angle hook was used to remove firm wax. The patient was instructed in the appropriate ways of cleaning her ears. Literature to reinforce the instructions was given to her.

ICD-9-CM: _____

CPT: _____

Step 11 Review Practice Exercise 26-3

❒ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made. Contact your instructor if you have questions.

Step 12 Practice Exercise 26-4

❒ Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

PREOPERATIVE DIAGNOSIS: Stage III chronic pressure ulcer of the right great toe.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: EXCISIONAL DEBRIDEMENT OF SKIN AND SUBCUTANEOUS TISSUE OF RIGHT GREAT TOE.

BRIEF HISTORY: This is a pleasant 86-year-old man with a chronic pressure ulcer of the toe.

PROCEDURE PERFORMED: The patient's foot was prepped with dilute Betadine solution. Following this, the necrotic tissue surrounding the ulcer was sharply excised through the skin and the subcutaneous tissue. The tissue was debrided until it started to bleed around the edge of the ulcer. This procedure was accomplished with minimal local anesthesia and the patient tolerated it with little or no pain. The wound was packed with saline-damp gauze and wrapped with sterile dressings.

ICD-9-CM: _____

_____

CPT: _____

Step 13 Review Practice Exercise 26-4

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have questions.

Step 14 Practice Exercise 26-5

❒ Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

PREOPERATIVE DIAGNOSIS: Multiple masses in lung, right lower lobe.

POSTOPERATIVE DIAGNOSIS: Same, pending pathology.

PROCEDURE PERFORMED: FIBEROPTIC BRONCHOSCOPY WITH TRANSBRONCHIAL BIOPSIES OF RIGHT LOWER LOBE OF LUNG.

PROCEDURE: This 75-year-old male was pre-medicated and then sedated in the preop area. He was then brought to the Endoscopy Suite. After adequate sedation, the bronchoscope was introduced. The distal portion of the trachea, the carina, and all airways were patent. The trachea and the carina were basically normal. The left lung was examined. All segments were patent. No masses were seen. The right lung was then examined. The upper and middle portions of the right lung were patent, and no masses were seen. The lower lobe of the right lung was entered and several masses were encountered. There were excess secretions that appeared thick and discolored. The three largest masses in the lower lobe were excised via biopsy forceps. Hemostasis was maintained with a minimal amount of bleeding. These biopsies were sent for appropriate pathological studies.

ICD-9-CM: _____

CPT: _____

Step 15 Review Practice Exercise 26-5

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor with any questions.

Step 16 Practice Exercise 26-6

❒ Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

PREOPERATIVE DIAGNOSIS: Cystocele.

POSTOPERATIVE DIAGNOSIS: Cystocele with incomplete uterine prolapse. Stress incontinence.

PROCEDURE PERFORMED: COLPOSCOPY.

BRIEF HISTORY: This 32-year-old female was seen by her physician over the past year with symptoms of leakage of urine when coughing, lifting heavy objects, and sneezing. In addition she states she has had numerous bladder infections and painful urination. Her latest Pap smear was abnormal.

PROCEDURE: The procedure was explained to the patient, and a consent form was signed. The patient was placed in the lithotomy position, and the vagina and cervix were exposed using a speculum. The exposed tissues were first wiped with a dry sponge and then washed with a saline solution. The vagina was then visually inspected under magnification. No suspicious looking areas where found. A first-degree prolapse of the uterus was noted. The patient tolerated the procedure well, and surgical options will be explained.

ICD-9-CM: _____

_____

CPT: _____

Step 17 Review Practice Exercise 26-6

❒ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made. Contact your instructor with questions.

Step 18 Practice Exercise 26-7

❒ Read the following operative report to assign the appropriate surgery codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathway.

PREOPERATIVE DIAGNOSIS: Sick sinus syndrome.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: DUAL CHAMBER PACEMAKER AND ATRIAL AND VENTRICULAR LEADS.

INDICATIONS: This patient has been experiencing increasing episodes of sick sinus syndrome. The episodes are not controllable with medication. A dual chamber pacemaker was recommended and discussed with the patient and his family. The patient and his family were informed of all potential complications, including infection, hematoma, pneumothorax, hemothorax, myocardial infarction, and possibly death. They have agreed to the procedure, and the patient signed the consent.

PROCEDURE: The patient was admitted to the cardiac catheterization lab and placed supine on the table. He was prepped, draped, and given local anesthesia. The leads were inserted transvenously through the subclavian vein with the leads positioned in the right atrial appendage for atrial pacing and the right ventricular apex for ventricular pacing. The leads were then attached to the pulse generator, which was inserted into the subcutaneous pocket below the clavicle. The pacemaker was tested and all evidence lead to proper placement with effective pacing. The patient tolerated the procedure very well with minimal blood loss. He was taken to the postanesthesia unit for observation and discharge.

ICD-9-CM: _____

CPT: _____

Step 19 Review Practice Exercise 26-7

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have any questions.

Step 20 Practice Exercise 26-8

❒ Read the following operative report to assign the appropriate surgery codes. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

PREOPERATIVE DIAGNOSIS: Urinary stress incontinence.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: MARSHALL-MARCHETTI-KRANZ WITH BURCH MODIFICATION.

The patient was taken to the operating room, and general endotracheal anesthesia was performed. She was placed in the low lithotomy position in Allen stirrups and prepped and draped in a routine manner with Foley catheter in place. A Pfannenstiel's incision was made with sharp dissection through the fascia. The fascial flaps were reflected and the muscles divided in the midline. The space of Retzius was bluntly dissected free from the posterior symphysis. With one hand in the vagina, the perivaginal tissues were exposed and sutured. Hemostasis was obtained, and sutures were secured to Cooper's ligament to stabilize the anterior vaginal wall. Good hemostasis was confirmed. The bladder was filled to assure its integrity. The incision was then closed with sutures to the fascia. Subcutaneous hemostasis was satisfactory, and the skin was closed with skin staples. Routine dressing was applied. Estimated blood loss was 25 mL. All counts were correct. There was no evidence of hematuria during or at the completion of the procedure. The patient tolerated the procedure well and was taken to the recovery room in satisfactory condition.

ICD-9-CM: _____

CPT: _____

Step 21 Review Practice Exercise 26-8

❒ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made. Contact your instructor with questions.

Step 22 Practice Exercise 26-9

❒ Read the following operative report to assign the appropriate surgery codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathway.

PREOPERATIVE DIAGNOSIS: Sterilization.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: VASECTOMY.

PROCEDURE: Procedure and outcome have been discussed in great detail with patient and his wife. They have agreed to it and understand that a vasectomy is often irreversible. The patient was placed in a supine position, draped, and a local anesthetic was administered. An incision was made on both sides near the root of the penis. The vas deferens was isolated and cut. The ends of the vas were bent back and tightly closed with ligatures and then replaced in the scrotal sac. The skin incision was closed with four sutures. The procedure took 20 minutes and patient went home following 30 minutes in the recovery room.

ICD-9-CM: _____

CPT: _____

Step 23 Review Practice Exercise 26-9

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have any questions.

Step 24 Practice Exercise 26-10

❒ Read the following operative report to assign the appropriate surgery codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathway.

PREOPERATIVE DIAGNOSIS: Leukocytosis.

POSTOPERATIVE DIAGNOSIS: Same, pending pathology.

PROCEDURE PERFORMED: ASPIRATION OF BONE MARROW FROM THE RIGHT ANTERIOR ILIAC CREST.

After adequate general endotracheal anesthesia had been obtained, the patient was placed on the operating table in the supine position. The right anterior iliac crest was prepared in a routine sterile fashion. A needle was inserted in the right anterior crest, and 2.5 mL of bone marrow aspirate was obtained. Appropriate dressing was applied after which the patient was taken to the recovery room in satisfactory condition. There were no operative complications.

ICD-9-CM: _____

CPT: _____

Step 25 Review Practice Exercise 26-10

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor with any questions.

Step 26 Practice Exercise 26-11

❒ Read the following operative report to assign the appropriate surgery codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathway.

PREOPERATIVE DIAGNOSIS: Galactorrhea.

POSTOPERATIVE DIAGNOSIS: Benign tumor of the pituitary gland.

PROCEDURE PERFORMED: CRANIOTOMY FOR EXCISION OF BENIGN PITUITARY TUMOR.

Brief History: The patient is a 49-year-old postmenopausal female, with a history of a radical left mastectomy. Three days following surgery, she noted a white, milky substance leaking from her right nipple. She was instructed to use a breast binder, and when that did not seem to resolve the problem, blood was drawn for prolactin levels. Skull x-rays, AP and lateral cone-down views, excluded a large pituitary tumor. A CT scan revealed a suprasellar tumor. The patient was reassured that most of these tumors are benign, and surgical resection was recommended. It should be noted here that the patient is intolerant of dopamine agonists.

PROCEDURE: Following signed consent, the patient was taken to the operating room, anesthetized, prepped, and draped. The hair on and around the operative site was shaved. The layers of skin, muscle, and membrane were cut away from the skull. A series of burr holes were made into the cranial bone. A Gigil's saw was used between the burr holes using a malleable saw guide. With the skin and flap of the skull hinged back, the tumor was excised and sent for biopsy. Cautery was used for hemostasis. There was minimal bleeding and the patient's vitals remained in a normal range throughout the procedure. The cranial bone was replaced, and the membranes, muscle, and skin were sewn back into position. Sterile dressings were applied, and the patient was discharged to the recovery room.

ICD-9-CM: _____

CPT: _____

Step 27 Review Practice Exercise 26-11

❒ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made. Contact your instructor with questions.

Step 28 Practice Exercise 26-12

❒ You've made it through the Practice Exercises relating to the Surgery section! Linking also applies to the radiology, pathology, anesthesia and medicine sections as well. Before completing this lesson, let's try one more Practice Exercise. This time we'll try a radiology scenario we've seen before, but will link the ICD-9-CM to the CPT code.

Read the following radiology report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathway.

CT ABDOMINAL SCAN WITH CONTRAST

CLINICAL HISTORY: RLQ abdominal pain.

TECHNIQUE: Spiral abdominal CT with oral and intravenous contrast material.

FINDINGS: There is mild thickening of the wall of the terminal ileum. There are an increased number of normal sized mesenteric lymph nodes in the right lower quadrant of the abdomen. The appendix is visualized and is unremarkable. There is trace amount of free fluid in the pelvis. No focal hepatic, splenic or pancreatic abnormalities are seen. Renal uptake of the contrast material is prompt and symmetric and there is no evidence of hydronephrosis. The bladder is unremarkable.

IMPRESSION: Constellation of findings consistent with ileitis that may be due to an infectious process or inflammatory bowel disease. No CT evidence of appendicitis.

ICD-9-CM: _____

CPT: _____

Step 29 Review Practice Exercise 26-12

❒ Check your answers with the Answer Key at the end of this book. Correct any mistakes you may have made. Contact your instructor with questions.

Step 30 Lesson Summary

❒ Linking ICD-9-CM and CPT codes is a fairly simple process as long as you follow the steps to accurate coding. By now you're probably finding the process of coding is straightforward because you're using your books correctly! Being able to understand that the problem is related to the procedure allows for maximum reimbursement of the provider's services. You're on your way to an exciting career as a medical coder!

Step 31 Mail-in Quiz 26

❒ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Quiz Cover Sheet. Use only blue or black ink.

d. **Important!** Please fill in all information requested on your Quiz Cover Sheet or when submitting your Quiz online.

e. Submit your Quiz to the school.

Mail-in Quiz 26

Part 1 Anatomy and Physiology

Choose the best answer from the choices provided. Each item is worth 1 point.

1. Glands are classified regarding _____.

a. how the material that the gland produces is secreted
b. which layer contains the pigment
c. how they developed in the skin
d. how they are produced

2. Sudoriferous glands are also called _____.

a. pores
b. pili glands
c. endocrine glands
d. exocrine glands

3. The stratum germinativum produces epidermal epithelial cells through _____.

a. simple cell division
b. specific gravity
c. special sense organs
d. spondylolysis

4. The skeletal system is composed of three major components: _____.

a. osseous tissue, cartilage and ligaments
b. bone, cartilage and lipids
c. bone, calices and ligaments
d. osseous tissue, cartilage and lipids

5. The ____ tonsils lie at the base of the tongue in the anterior wall of the oropharynx.

a. palatine
b. adenoid
c. pharyngeal
d. lingual

6. The largest artery in the body where the major arteries arise is the _____.

a. arteriole
b. aorta
c. apex
d. ascites

7. The spleen is not responsible for _____.

a. filtering blood
b. producing lymphocytes in the fetus
c. storing platelets
d. saving iron

8. The ____ is not a part of the anatomy of the large intestine.

a. defecation
b. haustrum
c. cecum
d. rectum

9. The test used to detect colon cancer is _____.

a. a barium enema
b. basophil degranulation
c. an Addis
d. bile solubility

10. Finger-like projections extending into the epidermis are ____.

a. dermal papillae
b. the papillary layer
c. vascular
d. phagocytes

11. Stage II of labor is complete with ____.

a. delivery of the placenta
b. the appearance of true uterine contractions
c. vaginal delivery of the neonate
d. all of the above

12. The right and left lobes of the thyroid gland lie on either side of the ____.

a. esophagus
b. thorax
c. xiphoid process
d. trachea

13. Another word for the breakdown of fats and proteins to produce glucose in the liver is ____.

a. glomerulonephritis
b. gluconeogenesis
c. glycogenolysis
d. glycolysis

14. The structures in the CNS are connected and lie in the ____.

a. cranial vault and the spinal canal
b. cranial vault and the medulla oblongata
c. cranial nerves and the spinal nerves
d. cranial nerves and the spinal canal

15. The ____ gives eyes their color.

a. pupil
b. retina
c. iris
d. lens

16. The three structures of the internal ear are the _____.

a. colloid, vestibule and semicircular canals
b. colloid, vestigial organ and semicircular canals
c. cochlea, vestibule and semicircular canals
d. cochlea, vestibule and semilunar canals

17. The olfactory nerves are located in the roof of the _____.

a. mouth
b. inferior vena cava
c. maxilla
d. nasal cavity

18. A virus needs _____ to supply ATP for energy or proteins to build body parts.

a. interferon
b. a cell
c. chemotaxis
d. heat

19. Antibodies bind with _____.

a. a specific antigen
b. any antigen
c. a specific antipyretic
d. any antipyretic

20. Macrophages that develop from WBCs are related to _____.

a. lymphocytes and RBCs
b. lymphocytes and REF
c. myelocytes and WBCs
d. lymphocytes and myelocytes

Part 2 Coding Scenarios

Use the *ICD-9-CM* and *CPT* manuals to determine the correct codes. Each code is worth 4 points.

Mail-in Quiz Scenario 1

PREOPERATIVE DIAGNOSIS: Chronic pyelonephritis.

POSTOPERATIVE DIAGNOSIS: Vesicoureteral reflux.

PROCEDURE PERFORMED: URETHROCYSTOGRAPHY.

BRIEF HISTORY: This 25-year-old male has had a history of long-standing urinary tract infections with multiple recurrences. Urine cultures were positive for Escherichia coli.

PROCEDURE: Consent forms were signed, and the patient was taken to the radiology-procedure suite. He was placed on the combination table and adjusted to allow for the films to be centered at the level of the upper border of the pubic symphysis. He was given mild sedation, prepped, and draped. A catheter was inserted into the urinary meatus through the urethra into the bladder. The bladder was then distended with the contrast material until the patient felt the urge to micturate. Voiding was then recorded on videotape. Vesicoureteral reflux was noted. The patient tolerated the procedure well and was taken to a recovery room. After he was fully awake, he was advised to have the abnormality surgically corrected.

Hint: Code for radiological supervision and interpretation.

21. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 2

PREOPERATIVE DIAGNOSIS: Hallux valgus.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED: REPAIR OF HALLUX VALGUS, KELLER PROCEDURE.

BRIEF HISTORY: This 59-year-old construction worker has been seen over the past six weeks complaining of a painful prominence at the base of his left great toe. He has worn pads over and around the bunion, but the pain is getting worse. Because of his job, metal-toe footwear is required. He has developed calluses over the area. The patient denies having diabetes or a family history of abnormally shaped metatarsal bones.

PROCEDURE: The skin of the left foot was examined and was free from infection. The patient signed the consent forms and opted for general anesthesia. Following sedation, the patient was placed in a supine position on the table. A tourniquet was applied to allow little or no bleeding of the surgical site. The skin of the foot was then thoroughly cleansed with Betadine solution. Sterile towels covered all of the leg other than the surgical site. A 5 cm lengthwise incision was made over the bunion. The bone was exposed just to the inner side of the tendon. The tendon was carefully pulled to one side so that the base of the phalanx bone could be completely severed using an electric rotating saw. Great care was taken while sawing to prevent damage to the tendon on the underside of the toe. Once the base of the phalanx was removed, the exostosis on the side of the metatarsal bone was shaved off with a chisel and mallet to narrow the end of the bone. The ligamentous tissue that overlies the bone on the inner edge of the foot was sutured. The incision site was then sutured and a firm gauze pad was placed between the big toe and the second toe to keep them parallel. The tourniquet was released. Minimal blood loss was noted. The foot was dressed with sterile gauze and taped securely. The patient was then taken to the recovery room in good condition.

22. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 3

PREOPERATIVE DIAGNOSIS: Infertility.

POSTOPERATIVE DIAGNOSIS: Infertility associated with peritubal adhesions.

PROCEDURE PERFORMED: HYSTEROSALPINGOGRAPHY.

BRIEF HISTORY: This 27-year-old woman and her husband of six years have been attempting to conceive a child for the last two years to no avail. After a consultation with a fertility specialist, they have agreed to a hysterosalpingography before attempting any other measures.

PROCEDURE: The patient confirmed that she was seven days post menses. She read and signed the consent form. Following irrigation of the vaginal canal, complete emptying of the bladder, and perineal cleansing, she was placed on the cystoscopic-radiographic table, draped, sedated, and adjusted in the cystoscopic position, with her knees flexed over the leg rests. Following inspection of the preliminary film, and with a vaginal speculum in position, a uterine cannula was inserted through the cervical canal. The attached rubber plug was fitted firmly against the external cervical os. Counter pressure was applied with a tenaculum to prevent reflux of the contrast medium, and the speculum was withdrawn. An opaque medium was introduced via the cannula into the uterine cavity, where it flowed through the fallopian tubes and spilled into the peritoneal cavity. Bilateral peritubal adhesions were noted. The patient tolerated the procedure well and will be discharged to her husband following complete recovery from the sedation.

HINT: Code for radiological supervision and interpretation as well as for the injection portion.

23. ICD-9-CM: _____

_____

CPT: _____

_____

Mail-in Quiz Scenario 4

CC:	Sinus tachycardia.
HX:	This anxious 45-year-old male presents with breathlessness, lightheadedness, and a feeling that his heart is beating too fast.
PROCEDURE:	TWELVE-LEAD ELECTROCARDIOGRAM EVALUATION, INCLUDES TRACING.
	The P waves were 130/min. The atrial depolarization is consistent with origin at the junction of the high right atrium and superior vena cava. Carotid sinus massage temporarily slowed the heart rate, but it returned to a tachycardic level as soon as the carotid sinus pressure was removed.
ASSESSMENT:	Sinus tachycardia.
PLAN:	A cardiology consultation was recommended to further evaluate his cardiac status.

24. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 5

The patient is a 45-year-old female. While attempting to release the blades from an electric knife after carving a turkey, her hand slipped and cut the 2nd digit on her left hand. She immediately applied pressure but was unable to stop the bleeding.

The patient had her last tetanus shot 3 years ago prior to minor surgery. After signing the consent form, she was taken to the procedure room, placed supine on the bed with her left forearm and hand extended on the movable armrest. The wound was noted to be 2 cm in length. A 35 mL syringe with a 19-gauge needle was used to irrigate the wound with saline. The wound was then anesthetized with 1% lidocaine using the aspiration technique first to prevent intravascular injection of the drug. Adison's forceps were used with gentle pressure to decrease trauma when handling the skin edges. A simple repair of the superficial wound was made using 5-0 nylon and a locked-running suture pattern. The suture was secured with Steri-Strips. The patient was instructed to keep the wound dry for at least 24-48 hours and to report any redness or swelling around the wound.

25. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 6

CLINICAL HISTORY/DIAGNOSES: Osteoarthritis of diarthrodial joint, right knee.

PROCEDURE PERFORMED: CELL COUNT, BODY FLUID

Arthrocentesis was performed prior to obtain synovial fluid, specimen #1, right knee noninflammatory articular osteoarthritis.

Synovial fluid is clear, viscous, and amber-colored with a white blood cell count of 1900/mL and a predominance of mononuclear cells. The viscosity was assessed by expressing fluid from the syringe one drop at a time with a stringing effect and a long tail behind each drop. The fluid was not hemorrhagic. These results are consistent with noninflammatory articular osteoarthritis.

26. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 7

ROTATOR CUFF SYNDROME

This 22-year-old female is a member of the tennis team at the college she is attending. She was seen 2 weeks ago and diagnosed with rotator cuff syndrome affecting the supraspinatus muscle. Since her visit she has not played any sports and has been using a sling to rest the shoulder muscle. She has been taking an over-the-counter NSAID and applying moist heat with minimal symptomatic relief.

Because conservative management has not resolved the symptoms, she is seen today for a trigger point injection of the supraspinatus muscle. The patient was seated on the examination table, bent forward, with a patient gown open in the back. The injection site was prepped. A solution of 1 mL of triamcinolone, 40 mg/mL, and 2 mL of lidocaine hydrochloride 2%, was injected into the supraspinatus muscle. There was minimal bleeding, and sterile gauze was secured with a bandage over the site. The patient tolerated the procedure well and was assured the pain should subside within the next 24 to 48 hours. She was also asked to return if she had any redness or swelling at the injection site.

27. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 8

HISTORY

This pleasant 55-year-old male presented to his family doctor with symptoms of a loss of sexual drive and a reduction in the size of his testes. He appears to have an abnormal bronze skin color. Laboratory findings included mildly abnormal liver tests (AST, alkaline phosphatase), elevated plasma iron level with greater than 50% saturation of the transferin, and an elevated serum ferritin. The liver biopsy showed extensive iron deposition in hepatocytes and in bile ducts. The hepatic iron index was greater than 1.9. Studies confirm hemochromatosis and Venesection was strongly recommended.

The Venesection procedure was explained to the patient. He understands that he will require weekly phlebotomy for about 1 or 2 years, after that it will be performed at intervals as required to maintain levels within the normal range. He agreed and signed the consent form.

PROCEDURE PERFORMED

The patient was here today for his first treatment. He states he does not have any questions at this time and was ready to begin treatments. Using sterile technique, his first phlebotomy session with 500 mL of blood (about 250 mg of iron) was performed. Following the procedure, the site was negative for abnormal bleeding or hematoma. Sterile gauze secured with tape was placed over the puncture site. Since there were no complications or abnormalities, the patient was discharged and driven home by his very supportive wife.

28. ICD-9-CM: _____

CPT: _____

Mail-in Quiz Scenario 9

PREOPERATIVE DIAGNOSIS: Chronic hepatitis.

POSTOPERATIVE DIAGNOSIS: Chronic viral hepatitis C.

PROCEDURE: NEEDLE BIOPSY OF LIVER, PERCUTANEOUS.

BRIEF HISTORY: This 29-year-old male admits to multiple heterosexual sex partners and recreational intravenous drug use with shared needles for the past 10 years. He thinks he has been diagnosed with hepatitis in the past, but was unsure of when or what type. He presented with symptoms of poor appetite, fatigue, low-grade fever, and some upper-abdominal discomfort. Noted were jaundice, enlarged spleen, spider-like blood vessels in the skin, and fluid retention. A liver biopsy was recommended to obtain hepatic tissue for diagnosis and treatment. Preoperative testing was completed, and there were no contraindications for the procedure.

PROCEDURE PERFORMED: The patient signed the consent form and was taken to the operating room. He was placed on the table in a supine position with a pillow under his left side and his right arm over his head. The site was prepped, draped, and infiltrated with a local anesthetic. A small incision was made between the 6th and 7th intercostal space on the right side. The patient was instructed to hold his breath while the needle was inserted, and a sample of liver tissue was withdrawn. The needle was removed and pressure was held over the site. Minimal bleeding was noted, and sterile gauze was secured over the incision. The sample was taken to the laboratory for an immediate cytohistologic study to determine adequacy of the specimen. The patient tolerated the procedure well and was discharged in 4 hours after being observed for an unremarkable recovery.

29. ICD-9-CM: _____

CPT: _____

Medical Coding Specialist
Mail-in Quiz 26

1. Fill in your **student ID** and your **course code** below.

STUDENT ID NUMBER COURSE CODE

2. Be sure your **name** and **address** are filled in below.
3. **Transfer your answers** to this cover sheet.
4. Write the year of the coding manuals used to complete this quiz: ICD-9 _____ CPT _____.

For School Use Only:
Grade: _____

NAME

ADDRESS

CITY STATE ZIP

U.S. Career Institute
2001 Lowe Street
Fort Collins, CO 80525

CD-2

This Space for Instructor Use

Fold on dotted line

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21. ICD-9-CM: _____

CPT: _____

22. ICD-9-CM: _____

CPT: _____

23. ICD-9-CM: _____

_____

CPT: _____

_____

24. ICD-9-CM: _____

CPT: _____

25. ICD-9-CM: _____

    CPT: _____

26. ICD-9-CM: _____

    CPT: _____

27. ICD-9-CM: _____

    CPT: _____

28. ICD-9-CM: _____

    CPT: _____

29. ICD-9-CM: _____

    CPT: _____

Congratulations!

You have completed Lesson 26

Do not wait to receive the results of your Quiz before moving on.

CPT Coding for Evaluation and Management Services

LESSON 27

Step 1 Learning Objectives for Lesson 27

❒ When you have completed the instruction in this lesson, you will be trained to do the following:

- ☞ Explain why and when Evaluation and Management codes are used.
- ☞ Identify and analyze the types and components of Evaluation and Management codes.
- ☞ Navigate the Evaluation and Management section of the *CPT*.
- ☞ Review the contributing components related to Evaluation and Management.

Step 2 Lesson Preview

❒ Are you ready to finish your exploration of the *CPT* manual? There's only one section we haven't covered: the Evaluation and Management (E/M) section! This section is located at the front of the *CPT* because coders use it the most.

In this lesson, you'll learn what Evaluation and Management codes are, as well as how they're classified. You'll also see how taking a medical history, completing a medical examination, and making medical decisions affect E/M codes. You'll see how contributing components might also be a controlling factor in selecting the level of service. Evaluation and Management coding can be complicated, so this lesson breaks down the process step-by-step. Once you understand all of the parts that make up Evaluation and Management codes, we'll put it all together. Let's begin!

Step 3 Evaluation and Management Codes

❒ How do you code for general office visits and consultations? These items don't really fit into any of the more specialized sections that you've already studied. That was why the Evaluation and Management section was created. This section covers many of the services that aren't actual procedures. It covers encounters between patients and doctors for emergency room care, nursing home stays and more. Let's start our exploration of E/M coding by looking at the steps involved.

The Evaluation and Management section covers physician services.

Step 4 Evaluation and Management Profile

❒ Do you remember from your other *CPT* lessons how some codes featured many different types of information? For example, a radiology code may depend upon the type of procedure, the anatomical location, and the number of times it was done. Or there may be several codes for the same injection depending upon whether it was intravenous, subcutaneous or intramuscular. Evaluation and Management codes are similar in that you, the coder, must take into consideration a number of different things. When coding E/M codes, you need to consider:

- Where the service was provided
- What type of service was provided
- What the patient's status was
- How much of a medical history was taken
- How much of a medical examination was performed
- How complex of a medical decision was made

That's a lot of information to keep in mind! We'll separate it into parts so you can work through the process one step at a time.

Evaluation and Management coding can be broken down into two stages. In stage one you classify the E/M procedure based on the *place of service*, the *type of service* and the *patient status.* Once you've classified your procedure, you can move on to stage two. In stage two, you determine the levels of *history, examination* and *medical decision making* involved. By comparing these levels against the code descriptions in the *CPT*, you can pick the correct E/M code! Let's take a closer look at the steps involved.

Steps to Assigning E/M Codes

The following are the steps to assigning Evaluation and Management codes. Don't worry if you don't understand many of these steps. The remainder of this lesson will explain E/M coding in detail. For now, use this as a road map so you know where we're going.

1. Read the documentation and determine the place of service, the type of service and the patient status.

2. Based on this classification information, locate the tentative code range in the *Index*.

3. Turn to the main part of the *CPT* to locate the tentative code range.

4. Review the guidelines for the section, subsection and heading you're using.

5. Read the code descriptions to be sure you've found the right code range.

6. Determine the individual levels of service for history, examination and medical decision making from the documentation.

7. Assign the code for the overall level of service based on the code description.

Quick Reference Guide to E/M Coding

You might want to flag, laminate, or put the reference pages found after the quiz into a folder for quick reference. You will use the information every time you code an E/M encounter, in this lesson and in the workplace. Using copies of the checklist and the E/M level of service box might assist you when coding on your own. You can choose the references you like for your method of analyzing documentation.

Step 5 Classifying Evaluation and Management Procedures

❒ To begin your search for the accurate E/M code, you must first classify the E/M procedure you are trying to code. The classification system for Evaluation and Management codes has three parts:

1. *Place of Service*
2. *Type of Service*
3. *Patient Status*

Let's take a closer look at each of these parts.

Place of Service

The **place of service** refers to the setting where the services are provided to the patient. The Evaluation and Management section of the *CPT* is divided into the following subsections based on the place of service. The following is a list of these E/M subsections:

1. Office or Other Outpatient Services
2. Hospital Observation Services
3. Hospital Inpatient Services
4. Consultations
5. Emergency Department Services
6. Critical Care Services
7. Nursing Facility Services
8. Domiciliary, Rest Home, or Custodial Care Services
9. Domiciliary, Rest Home, or Home Care Plan Oversight Services
10. Home Services
11. Prolonged Services
12. Case Management Services
13. Care Plan Oversight Services
14. Preventive Medicine Services
15. Non-Face-to-Face Services
16. Special Evaluation and Management Services
17. Newborn Care Services

18. Inpatient Neonatal Intensive Care Services and Pediatric Critical Care Services
19. Complex Chronic Care Coordination Services
20. Transitional Care Management Services
21. Other Evaluation and Management Services

Type of Service

The **type of service** refers to the reason for the evaluation or management service. For example, an **office visit** is a face-to-face meeting between the patient and the doctor. Another example is a *consultation.* A **consultation** is when one physician or other qualified health care professional requests an opinion or advice from another physician or other qualified health care professional.

Patient Status

The **patient status** is identified by one of four categories: *new*, *established*, *outpatient* and *inpatient*. According to the Evaluation and Management Services Guidelines, a "**new patient** is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years." An **established patient**, on the other hand, is one who has received these services within the past three years. A decision tree is found in the *E/M Service Guidelines* to assist in determining new or established.

Let's look at an example to clarify this point. A patient is scheduled to see her dermatologist for a rash. Her physician is called out of the office for an emergency. Another physician in the same specialty and belonging to the same group practice provides the professional service instead. So what is the patient status? In this example, the patient status is an established patient.

Emergency Department Coding Tip

In the emergency department, no distinction is made between new and established patients.

An **outpatient** is one not formally admitted to a healthcare facility, while an **inpatient** has been admitted. The patient status of inpatient or outpatient does not correlate with inpatient or outpatient coding.

Outpatient coding is CPT coding for the professional services provided by the physician. As an outpatient medical coder, you can code for the physician's services for inpatient hospital care.

The *CPT Index*

Now that you can classify an E/M service, let's move on to step two of the E/M coding process: locating the code range in the *Index*. The more you use the *Index*, the more comfortable you'll become with it. Let's walk through an example of this process.

A new patient is seen in the office of an orthopedic specialist for a consultation.

Place of Service: Office

Type of Service: Consultation

Patient Status: New patient

In the *Index* of the *CPT*, use this information to create the coding pathway and locate the tentative code range. The process is identified below.

Coding Pathway: *Consultation, Office and/or Other Outpatient, New or Established Patient*

Code Range: **99241-99245**

> **E/M Coding Tip**
>
> If you are having trouble locating the main term in the *Index*, turn to "Evaluation and Management," and continue your search.

Take a moment to practice creating E/M coding pathways!

Step 6 Practice Exercise 27-1

❒ For the following E/M encounters, use your classifying and coding skills to determine the place of service, the type of service, the patient status, the coding pathway and the tentative code range.

1. **A physician makes a house call to a new patient.**

   Place of Service: _____

   Type of Service: _____

   Patient Status: _____

   Coding Pathway: _____

   Code Range: _____

2. **A patient sees his regular family physician at the office for a sore throat.**

   Place of Service: _____

   Type of Service: _____

   Patient Status: _____

   Coding Pathway: _____

   Code Range: _____

3. **A new patient is seen in the dermatology clinic for acne.**

   Place of Service: _____

   Type of Service: _____

   Patient Status: _____

   Coding Pathway: _____

   Code Range: _____

4. **A patient is seen by her PCP as an inpatient in the hospital for initial care.**

   Place of Service: _____

   Type of Service: _____

   Patient Status: _____

   Coding Pathway: _____

   Code Range: _____

5. **An emergency department physician examines a patient.**

   Place of Service: _____

   Type of Service: _____

   Patient Status: _____

   Coding Pathway: _____

   Code Range: _____

Step 7 Review Practice Exercise 27-1

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have any questions.

Step 8 Determining Levels of Service

❒ Now that you can locate the tentative code range, you're ready for step two. In step two, you narrow down your code range to the correct code. To do this, you examine the three **key components**—history, examination and medical decision making. As a coder, your job is to figure out what *level of service* is documented for each key component. A **level of service** is a measurement of the complexity for an encounter. For example, a level of service for the history component will tell you how extensively the medical history is documented. A level of service for the medical decision making component will tell you the complexity of the decision. Each key component has its own unique set of service levels. Once you have figured out what level of service is performed for each key component, you can use this information to determine the *overall* level of service provided. This will direct you to the correct code to pick.

Got that? (Whew!) Evaluation and Management coding can be tricky. That's why we saved it for last. Don't worry if you're uncertain on some of those steps. We're going to work through them one step at a time. For now all you need to know is that in order to narrow down our tentative code range, we need to know more about the three key components—history, examination and medical decision making.

Key Component Requirements

Most Evaluation and Management classifications incorporate all three key components in their code ranges. In other words, for most E/M codes, you need to examine all three key components. However, this is not always the case. An office visit for an established patient, for example, only requires two components. This is not information you need to memorize. You can find this information by simply reading the code description. Let's look at two code ranges, 99201-99205 and 99212-99215, to see how this works.

In the main body of the *CPT*, find the codes 99201-99205, which code for a new patient seen in an office. Read the beginning of each of the code descriptions. For each code you will note the following description:

> Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

The code description tells you that you must consider all three of the key components when determining the level of service. The rest of the code description will be explained later in this lesson.

Now find the codes 99212-99215, which code for an established patient seen in the office. Read the beginning of each of the code descriptions. For each code you will note the following description:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

You see, the code descriptions in the *CPT* tell you how many key components are considered.

Let's work through an example to show how to find the information for accurate E/M coding. Read through the following SOAP report. As you complete this section on key components, you will see parts of the following SOAP report many times. The report is for an **office visit for a new patient**. Based on this information, you know the code range will be **99201-99205** for this scenario. The first thing you should do when looking at a report is to draw a line, either mentally or physically, to separate fiction from fact. (We'll discuss this more with the history component.)

SUBJECTIVE: A 27-year-old male was hiking in a wooded area over the weekend and developed a pruritic eruption involving his lower extremities. He was wearing shorts during the hike. While they were hiking, the patient's spouse identified the presence of poison oak in the area.

OBJECTIVE: Physical exam reveals erythematous papules on both lower extremities. Some oozing is noted from the papules. There is no infection evident. The patient is afebrile.

ASSESSMENT: Dermatitis due to poison oak.

PLAN: Gauze or thin cloths dipped in water and applied to papules for soothing and cooling for 30 min 4 to 6 times a day. Prescribed topical corticosteroid to decrease the inflammation. Contact the office if no improvement in two weeks.

Look at the line drawn across the SOAP report with the pencil. The history component is based on the information found above that line. The examination component is found in the objective and medical decision making component is based on the entire report.

Let's learn some more about the history component.

Step 9 History Component

❒ The **history component** is the information the patient tells the doctor based on the patient's knowledge. In the SOAP format, the history component is the subjective. The history component is considered fiction, while the examination and medical decision making are considered fact. When reviewing the physician's dictation, we "count" the items documented to determine the level of service for the history component.

The **history component** consists of four elements:

1. Chief complaint (CC)
2. History of present illness (HPI)
3. Review of systems (ROS)
4. Past, family and/or social history (PFSH)

Let's take a closer look at each of the four basic elements of the history component, and then we'll explore how the counting aspect works.

Chief Complaint (CC)

The **chief complaint** is a statement, usually in the patient's own words, describing the symptom, problem or condition that is the reason for this particular encounter. It is often in the first few lines of the dictation but can be found anywhere in the subjective portion of the report. This element is almost always required when determining the level of service. Unlike the other history elements, the information in the CC can be assigned to more than one element.

History of Present Illness (HPI)

In the **history of present illness**, the physician documents the patient's description of the development of the illness. This might begin at the first symptoms or focus on the present condition. This is still subjective information obtained by the verbal communication between the doctor and the patient. Characteristics used in the HPI element cannot be assigned in the Past, Family and/or Social History or the Review of Systems elements. As the medical coder, you will ask yourself the following questions to help determine the HPI characteristics.

- ➲ **Location** — What body location is involved? Is there radiation to parts of the body?
- ➲ **Quality** — Can the condition be described as sharp, burning, dull, radiating or tearing?

- **Severity** — How bad is the pain? There is a recognized pain scale of 1 to 10. Is the condition considered mild, severe, worse, progressing?
- **Associated Signs & Symptoms (AS&S)** — Are there associated manifestations such as swelling, nausea? What other conditions does the patient have?
- **Timing** — How long does it last? Is it intermittent?
- **Duration** — What is the length of the overall problem? When did this problem begin?
- **Context** — In what setting does the problem occur? Are there environmental factors contributing to the problem? In what situation have you had this problem in the past?
- **Modifying Factors** — What helps? How is the problem relieved or worsened?

When the characteristic is addressed in the dictation, you will "count" that toward your HPI element. The CPT code description categorizes the HPI as either *brief* or *extended*. A **brief** HPI indicates that 1 to 3 of the above characteristics are addressed in the dictation. An **extended** HPI indicates that at least 4 characteristics are documented.

HPI Coding Tip

The History of Present Illness is an element of the History Component.

Review of Systems (ROS)

The **review of systems** documents the verbal exchange of information between the doctor and patient. This might be obtained by a series of questions asked by the physician in order to identify signs or symptoms that the patient may be experiencing. A negative statement indicates the physician has considered that system and it should be counted. For instance, when "no abdominal pain" is documented, you will count that towards the gastrointestinal system because the physician has addressed the issue. Anything dictated prior to the examination can be used as the ROS, as long as it hasn't been assigned to HPI or Past, Family and/or Social History.

The following is a list of the systems, as well as some examples found within the systems. Please note, this is not an all-inclusive list.

- **Constitutional** - general appearance, fever, weakness, chills, fatigue
- **Eyes** - conjunctivae, lids, pupils, irises, glasses, contacts, vision
- **Ears, Nose, Mouth, Throat** - head cold, discharge, difficulty swallowing, ear noises, throat pain
- **Cardiovascular** - heart, chest pain, high blood pressure, palpitations
- **Respiratory** - lungs, chest pain, wheezing, dyspnea, sputum, cough, SOB
- **Gastrointestinal** - abdomen, liver, spleen, anus, rectum, nausea, vomiting, appetite, diarrhea, hemorrhoids
- **Genitourinary** - male and female external genitalia, urinary tract, contraception, pregnancy
- **Musculoskeletal** - joint pain, muscle pain, cramps
- **Integumentary** - skin and/or breast, rashes, dryness, eruptions, redness, swelling
- **Neurological** - reflexes, sensation, faintness, tingling, memory loss, headache, weakness, numbness
- **Psychiatric** - judgment, mental status, mood, depression, anxiety
- **Endocrine** - thyroid, diabetes, hormones
- **Hematologic/Lymphatic** - anemic, lymph node, bleeding, bruising
- **Allergic/Immunologic** - allergies, sneezing, itching eyes

The CPT code descriptions categorize the ROS as *problem pertinent*, *extended* or *complete*. A **problem pertinent** ROS indicates one of the systems is documented by the physician. An **extended** ROS indicates the physician documented between 2 and 9 of the systems. Documenting 10 or more systems constitutes a **complete** ROS.

Past, Family and/or Social History (PFSH)

This history element is pronounced "fish." Any information documented prior to the examination and not already assigned to the HPI or ROS elements can be used for the PFSH.

Past history indicates the past medical history of the patient. Prior illness, injury or operations are classified as past medical history. Current medications and allergies are as well. For example, when the documentation indicates "NO ALLERGIES" you can count that towards past history because the physician has addressed the issue of allergies. Age-appropriate immunization status and age-appropriate feeding or dietary status also applies to past history.

Family history is a record of medical events in the patient's family. Health status or cause of death of parents, siblings or children falls into this category. Disease of family members that may be hereditary or provide insight regarding the patient's health are recorded here.

Social history includes marital status, employment, level of education and sexual history. The use of drugs, alcohol or tobacco applies to this category. Again, the statement "denies alcohol use" can count toward the social history.

Determining the History Component

Now that you understand the elements of the history component, let's see how these are used to determine the level of service. There are four levels of service for the history component. The four levels are:

Problem focused: Chief complaint; brief history of present illness or problem.

Expanded problem focused: Chief complaint; brief history of present illness; problem pertinent system review.

Detailed: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patient's problem.

Comprehensive: Chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and/or social history.

As you can see, each level of service has certain requirements. These requirements incorporate not only what history elements were included in an E/M procedure, but to what degree. For example, was a brief or extended history taken for the present illness or problem?

Your goal, as the medical coder, is to code to the highest level of service that is documented. Various methods exist to help you analyze all of this information. The following chart was designed by third-party payers to help you determine the correct history level of service.

Summary History Table				
History	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

As you can see, this chart lays out which history elements are required for each history level of service. It also shows how much information must be included for an element to qualify for a specific level of service. For example, for a Detailed level of service for the history component, the HPI must be extended. For an Expanded Problem Focused level of service for the history component, the HPI only needs to be brief.

In this course, we will refer to this chart when discussing Evaluation and Management codes. When reviewing the documentation you will count the items then circle the corresponding information in the chart. The lowest element will determine your overall history level. Let's work through an example to show how this works!

Example of the History Component

It's time to return to the example of the hiker. You will focus just on the information for the history component. Remember, this is in the subjective section of the SOAP report. You will need to refer back to the list of characteristics for the HPI, systems for the ROS and descriptions of PFSH each time you code from the Evaluation and Management section. Remember, in this example you are dealing with an office visit for a new patient, so codes **99201-99205** will apply. The following is the step-by-step process for determining the level of service for the history component.

> SUBJECTIVE: A 27-year-old male was hiking in a wooded area over the weekend and developed a pruritic eruption involving his lower extremities. He was wearing shorts during the hike. While they were hiking, the patient's spouse identified the presence of poison oak in the area.

Chief Complaint – Why is the patient seeking treatment? In the scenario, it states the patient has a pruritic eruption. You have the chief complaint, so you circle the highest level on the following chart. Why the highest level? Remember, the goal is to code to the highest documented level. "Required" is found on all levels so you circle the highest.

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required

History of Present Illness – The HPI summarizes the patient's signs and symptoms for the encounter. Review the characteristics of HPI to see if any apply. This scenario includes the **location** of the lower extremities, the **duration** since the weekend, and **context** is the wooded area. The HPI is brief (1-3) which appears under Problem Focused and Expanded Problem Focused levels of service. Why limit the level of service to Problem Focused when Expanded Problem Focused is available? The goal is to code to the highest level documented so you circle the "brief" under Expanded Problem Focused.

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4

Review of Systems – The ROS is the verbal exchange of information between the doctor and patient. Again, review the list of systems to categorize the documentation. The scenario indicates a pruritic eruption, which is part of the **Integumentary System**. You've used this for the chief complaint element, but can use it as ROS because the chief complaint is the only element that can be found in more than one element. You cannot count the lower extremity for Musculoskeletal because that is assigned to the HPI element. This is an example of using the information for only one element, with the exception of the CC. The one review of systems is found under Expanded Problem Focused, so you circle that box.

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10

Past, Family and/or Social History – The scenario mentions a spouse, so you know the patient is married. This is part of his social history. Find pertinent 1 of 3 PFSH under Detailed, which you will circle.

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Now you need to put all of this information together to determine the overall history component. CC is Comprehensive; HPI and ROS are Expanded Problem Focused; PFSH is Detailed.

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Turn in your *CPT* to codes 99201-99205 and read the code description specific to the history component of each.

99201 a problem focused history

99202 an expanded problem focused history

99203 a detailed history

99204 a comprehensive history

99205 a comprehensive history

For the history component, majority does not rule. The lowest of all components determines the level of service for the history component. For this scenario, the HPI and ROS determine the level because they are at the **Expanded Problem Focused** level. Which code describes the expanded problem focused history? Based on the code descriptions in the *CPT*, the overall level of service for the history component is **99202**.

One step of the E/M process is complete! You still need to determine the examination and medical decision making levels of service before deciding on the overall level of service. We'll get there, but first let's check your understanding of the history component with the following progress check.

Step 10 Practice Exercise 27-2

❒ For the following scenarios, determine the level of service for the history component with the information provided. First, complete the History Component table following each report. Then, use the summary History table to determine the level of service.

1. EMERGENCY DEPARTMENT 99281-99288

CHIEF COMPLAINT: The patient is admitted to the emergency department after a motorcycle accident (MCA), complaining of right wrist and extreme bilateral leg pain, especially in the right leg.

HISTORY OF PRESENT ILLNESS: The patient was involved in an MCA, wearing a helmet. There is no nausea, vomiting, or change in vision. There was a ten-minute loss of consciousness. There is no complaint of neck, chest, LUE, or back pain.

PAST HISTORY: No smoking, drinking, or IV drug use. Right inguinal bullet removed in 1987. NO ALLERGIES.

REVIEW OF SYSTEMS: No skull or facial tenderness. ROS otherwise noncontributory.

History Component Table		
CC	Describe the symptom, problem, or condition that is the reason for this encounter:	Required
HPI	Location? Quality? Severity? AS&S? Timing? Duration? Context? Modifying Factors?	Number of Characteristics: 1 - 3 = Brief 4 or more = Extended
ROS	Constitutional? Eyes? Ears, Nose, Mouth, Throat? Cardiovascular? Respiratory? Gastrointestinal? Genitourinary? Musculoskeletal? Integumentary? Neurological? Psychiatric? Endocrine? Hematologic/Lymphatic? Allergic/Immunologic?	Number of Systems: 1 = Problem Pertinent 2 – 9 = Extended 10 or more = Complete
PFSH	Past History? Family History? Social History?	Number of Elements: 1 of 3 = Pertinent 2 of 3 = Complete

Summary History Table				
History	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Level of Service for the History Component: _____

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

REASON FOR REFERRAL: Chest pain not relieved with nitroglycerin.

HISTORY OF PRESENT ILLNESS: The patient is a 63-year-old Caucasian male with a 20-year history of hypertension, who complains of chest pain occurring at rest and unrelieved with nitroglycerin. He admits to an admission for heart attack in the past year and a half. Upon this admission, myocardial infarction was ruled out. He was referred to assess coronary anatomy with cardiac catheterization. The patient also complains of paroxysmal nocturnal dyspnea, dyspnea on exertion and orthopnea. There is no hemoptysis, palpitation, murmur, cyanosis, clubbing, or edema. No cough, sputum, claudication.

PAST HISTORY: Habits: Two packs of cigarettes a day x 20 years. Medications: Diltiazem, Isordil, Lasix, KCL. Operations: See HPI. Prior knee surgery. Allergies: NKDA.

FAMILY HISTORY: One brother had an MI, and all sisters have hypertension.

History Component Table		
CC	Describe the symptom, problem, or condition that is the reason for this encounter:	Required
HPI	Location? Quality? Severity? AS&S? Timing? Duration? Context? Modifying Factors?	Number of Characteristics: 1 - 3 = Brief 4 or more = Extended
ROS	Constitutional? Eyes? Ears, Nose, Mouth, Throat? Cardiovascular? Respiratory? Gastrointestinal? Genitourinary? Musculoskeletal? Integumentary? Neurological? Psychiatric? Endocrine? Hematologic/Lymphatic? Allergic/Immunologic?	Number of Systems: 1 = Problem Pertinent 2 – 9 = Extended 10 or more = Complete
PFSH	Past History? Family History? Social History?	Number of Elements: 1 of 3 = Pertinent 2 of 3 = Complete

Summary History Table				
History	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Level of Service for the History Component: _____

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

SUBJECTIVE: The patient is a 2-year-old male. The mother states she was called to pick her son up from the preschool, because he had a low-grade fever, sore throat with blisters in his mouth, and refused to eat.

History Component Table		
CC	Describe the symptom, problem, or condition that is the reason for this encounter:	Required
HPI	Location? Quality? Severity? AS&S? Timing? Duration? Context? Modifying Factors?	Number of Characteristics: 1 - 3 = Brief 4 or more = Extended
ROS	Constitutional? Eyes? Ears, Nose, Mouth, Throat? Cardiovascular? Respiratory? Gastrointestinal? Genitourinary? Musculoskeletal? Integumentary? Neurological? Psychiatric? Endocrine? Hematologic/Lymphatic? Allergic/Immunologic?	Number of Systems: 1 = Problem Pertinent 2 – 9 = Extended 10 or more = Complete
PFSH	Past History? Family History? Social History?	Number of Elements: 1 of 3 = Pertinent 2 of 3 = Complete

Summary History Table				
History	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Level of Service for the History Component: _____

Step 11 Review Practice Exercise 27-2

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes that you may have made. There are various ways to categorize the elements. As long as your overall history level is the same, you're on the right track. Contact your instructor if you have questions on the history component.

Step 12 Examination

❒ The second key component for the Evaluation and Management level of service is the examination. This is a description of the findings from the physician's examination of the patient. Remember, the history component was subjective, or fiction. The examination component is objective, based on factual data the physician has determined.

The examination component consists of two elements:

1. Organ Systems (OS)
2. Body Areas (BA)

Some coders include a third element—General Examination—which covers vital signs and the general appearance of the patient. We will include this information in the Organ Systems element, under the subheading *Constitutional*.

Let's take a closer look at Organ Systems and Body Areas for the examination component!

Organ Systems Element

An **Organ Systems** examination covers the following items:

- **Constitutional**—blood pressure, pulse, respiration, temperature, height, weight, general appearance
- **Eyes**—conjunctivae, eyelids, irises, pupils, PERRLA
- **Ears, Nose, Mouth, Throat**—often referred to as HEENT (head, eyes, ears, nose, throat) but eyes are in a separate system
- **Cardiovascular**—palpation of heart, auscultation of heart (murmurs), pedal pulses, extremity edema, bruits

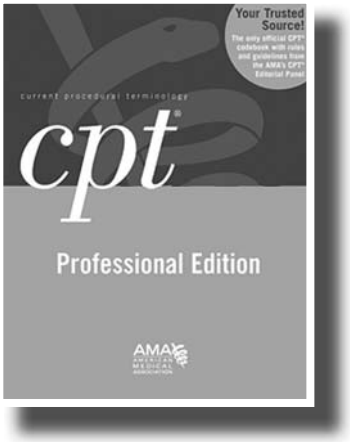
- **Respiratory**—effort, percussion of chest dullness, palpation of chest (tactile), auscultation of lungs (breath sounds, rubs)
- **Gastrointestinal**—mass or tenderness of abdomen, liver and spleen, hernia, anus, perineum, rectum, hemorrhoids, obtain stool sample
- **Genitourinary**—kidney, bladder, ureters, urethra, male and female reproductive systems
- **Skin**—includes glands, edema, rashes, lesions, ulcers
- **Musculoskeletal**—gait and station, digits and nails, misalignment, defects, masses, range of motion, stability, muscle strength and tone
- **Neurological**—sensations, cranial nerves, deep tendon reflexes
- **Psychiatric**—speech, thought process, psychotic thoughts, judgment, orientation to time, place, person, mood, attention span and concentration, memory
- **Hematologic/Lymphatic/Immunologic**—blood, lymph nodes, glands, allergies

The Organ Systems are usually examined using auscultation, percussion or deep palpation.

Body Areas Element

The **Body Areas** element covers the following items:

- Head, Face
- Neck
- Chest, Breast, Axilla
- Abdomen
- Genitalia, Groin, Buttock
- Back, Spine
- Each extremity



You can find a list of the Organ Systems and Body Areas elements in the guidelines of your *CPT*.

The Body Areas are usually examined by visual inspection and/or minimal palpation.

Determining the Examination Component

Determining the level of service for the examination component is straightforward. You just look at the list of Organ Systems and Body Areas then check if they were addressed in the documentation. Only one item in each OS/BA needs to be documented. Documenting the conjunctivae, eyelids and pupils result in the same count as documenting the pupils alone. Note "no abdominal tenderness" would count towards the gastrointestinal system because the organ system was evaluated. As with the history component, there are four examination levels described in the *CPT* manual.

Problem focused: a limited examination of the affected body area or organ system.

Expanded problem focused: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive: a general multi-system examination or a complete examination of a single organ system. *Note: body areas are not counted towards comprehensive.*

The following chart was designed by third-party payers to help you determine the accurate level of service for the examination component.

Summary Examination Table				
Exam	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Let's work through an example using this chart!

Example of the Examination Component

Now it's time to return to the hiker to "count" the examination portion of the SOAP report.

> OBJECTIVE: Physical exam reveals erythematous papules on both lower extremities. Some oozing is noted from the papules. There is no infection evident. The patient is afebrile.

The physician looked at the extremities and saw oozing. "Skin" found under the Organ Systems counts for one. The physician also notes the patient is afebrile, or doesn't have a fever. This counts as one towards "Constitutional." You have 2 OS/BA documented for this encounter. You will circle 2-4 OS/BA under Expanded Problem Focused.

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Once again, turn to codes **99201-99205** in your *CPT* to determine the code for an expanded problem focused examination. Focus on the exam component in the code description. Based on the code descriptions, the overall level of service for the examination component is **99202**.

It's time to try your hand at determining the level of service for the examination component! We will continue with the examples provided in the previous progress check, but only provide the examination details. Once we complete this, you're on to the medical decision making component. So let's get to it!

Step 13 Practice Exercise 27-3

❒ For the following scenarios, determine the overall level of service for the examination component with the information provided. First, complete the Examination component table below each report. Then, use the Summary Examination Table to determine the level of service.

1. EMERGENCY DEPARTMENT 99281-99288

EXAMINATION	
VITALS:	Pulse: 76. Blood Pressure: 138/80. Respiratory rate: 20. Temperature: 98.
HEENT:	PERRLA. EOMs intact.
CHEST:	No clavicular, sternal, or rib tenderness. HEART: Regular rhythm and rate. LUNGS: Clear to P&A.
ABDOMEN:	Soft and nontender. No organomegaly. No rebound tenderness.
EXTREMITIES:	RUE: 2+ swelling at wrist. Skin intact. Radial pulse is 2+. Positive tenderness at the base of the small metacarpal and anatomic snuff-box. Apposition is 2/5. RLE: Dorsalis pedis and posterior tibial pulses are 2+ and equal bilaterally. Left leg reveals decreased strength with passive resistance. Right leg exam restricted due to severe pain.

Examination Component Table		
Organ Systems	Constitutional? Eyes? Ears, Nose, Mouth, Throat? Cardiovascular? Respiratory? Gastrointestinal? Genitourinary? Skin? Musculoskeletal? Neurological? Psychiatric? Hematologic/Lymphatic/ Immunologic?	Number of Organ Systems Documented
Body Areas	Head, Face? Neck? Chest, Breast, Axilla? Abdomen? Genitalia, Groin, Buttock? Back, Spine? Each Extremity?	Number of Body Areas Documented

Summary Examination Table				
Exam	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Level of Service for the Examination Component: _____

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

PHYSICAL EXAMINATION: Vital signs: Blood pressure: 182/123. Neck: No jugular venous distension. Heart: PMI is at the fifth intercostal space, 2 cm lateral to the midclavicular line. There is a 2/6 systolic ejection murmur best heard in the parasternal border. S1, S2 heard in all areas. Lungs: Clear. Abdomen: Soft, no organomegaly. Extremities: No edema. Pulses: 1+ right femoral, right dorsalis pedis 0, left femoral and dorsalis pedis pulses 2+. Neurologic: No focal defect.

Examination Component Table		
Organ Systems	Constitutional? Eyes? Ears, Nose, Mouth, Throat? Cardiovascular? Respiratory? Gastrointestinal? Genitourinary? Skin? Musculoskeletal? Neurological? Psychiatric? Hematologic/Lymphatic/ Immunologic?	Number of Organ Systems Documented
Body Areas	Head, Face? Neck? Chest, Breast, Axilla? Abdomen? Genitalia, Groin, Buttock? Back, Spine? Each Extremity?	Number of Body Areas Documented

Summary Examination Table				
Exam	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Level of Service for the Examination Component: _____

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

OBJECTIVE: A vesicular exanthema is distributed over the buccal mucosa and palate with similar lesions on the hands and feet, and in the diaper area. Rectal temperature: 103. A rectal swab specimen was positive for Coxsackie A virus.

Examination Component Table		
Organ Systems	Constitutional? Eyes? Ears, Nose, Mouth, Throat? Cardiovascular? Respiratory? Gastrointestinal? Genitourinary? Skin? Musculoskeletal? Neurological? Psychiatric? Hematologic/Lymphatic/ Immunologic?	Number of Organ Systems Documented
Body Areas	Head, Face? Neck? Chest, Breast, Axilla? Abdomen? Genitalia, Groin, Buttock? Back, Spine? Each Extremity?	Number of Body Areas Documented

Summary Examination Table				
Exam	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Level of Service for the Examination Component: _____

Step 14 Review Practice Exercise 27-3

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Again, you may categorize your exam differently, but as long as the overall level is the same, you're doing fine. Contact your instructor if you have questions on the examination component.

Step 15 Medical Decision Making (MDM)

❒ We've analyzed the level of service for the components of history and examination. Now let's discuss the final key component: medical decision making. Information you apply to the medical decision making might be in the examination portion or in the plan. You can use anything in the dictation to determine the medical decision making level.

The medical decision making component consists of three elements:

1. Number of Diagnosis and Management Options
2. Amount and/or Complexity of Data to be Reviewed
3. Risk of Complications and/or Morbidity or Mortality

Let's take a closer look at each of the three basic elements of the MDM component, and then we'll walk through how the process works.

Number of Diagnosis and Management Options

To determine the level of service for decision making for this element you will use the following table. To use the table, you must look at the *problem* and the *plan of action*. The problem is either *new* to the doctor or has already been *established* with the physician. It's not the patient status, but the problem that you are focusing on. A patient presenting a common cold or an insect bite are examples of a "self-limited or minor" problem.

Diagnosis and Management Options Table		
Problem	**Diagnosis/Plan of Action**	**Decision Making**
Self-limited or minor	stable, improving, worsening	**Minimal**
Established w/ Doctor	stable, improved	**Minimal**
Established w/ Doctor	worsening	**Limited**
New to Doctor	no additional work-up planned	**Multiple**
New to Doctor	additional work-up planned	**Extensive**

An **established** problem means the physician has seen the patient for that particular problem before. This could be a patient with a sore throat who is returning to have the condition checked. A **new** problem is one which the doctor is looking at for the first time. Once you know if the problem is new or established, you're ready to consider the progress of the condition. In our example, this would mean asking if the sore throat is stable, improving or worsening. Is it stable or improving? This is **Minimal** for the level of decision making. Or is the sore throat worsening? The level of decision making is **Limited**.

When the problem is new to the doctor, you will determine if additional work-up is planned. The physician might request an x-ray, a culture, a second opinion or might recommend hospitalizing the patient. Whether or not the patient obtains the second opinion does not change the fact that the physician recommends additional work-up. This correlates with an **Extensive** level of decision making. If the physician feels no additional work-up is planned for the condition, the level of medical decision making is **Multiple**.

Emergency Department Coding Tip

Due to the nature of EDs, the emergency department considers all problems as new to the doctor.

Amount and/or Complexity of Data to Be Reviewed

The second element of the MDM component is the data. Documenting a lab test counts toward reviewing data for pathology. The physician does not perform the tests, but documents reviewing the results. Whether you have the results of one pathology test or seven, the score is one. When the documentation indicates the results of one lab and one x-ray, the score is two. The total score determines the level of decision making for this element.

Data to be Reviewed Table

Score	Data Ordered or Reviewed
(1)	Pathology & Laboratory: One or more tests
(1)	Radiology: One or more tests
(1)	Medicine Studies/Tests: One or more studies
(2)	Direct visualization, independent interpretation of specimen, image or tracing previously interpreted by another MD; Each test counts
(1)	Decision to obtain old records
(1)	Additional history from family, caretaker, other
(2)	Review and summarize old records
Total Score	Level of Service for Amount and/or Complexity of Data to be Reviewed
0 to 1	**Minimal or None**
2	**Limited**
3	**Moderate**
4 or more	**Extensive**

Risk of Complications and/or Morbidity or Mortality

The third element of medical decision making is the risk of complications and/or morbidity or mortality. To determine the degree of risk you can use the Table of Risk.

The Table of Risk can be the most challenging. This can be considered a judgment call for the medical coder. However, you must be able to justify your choice for a specific level of service. Understanding whether a chronic illness would be classified with mild or severe exacerbation is a learning process. Read through the table below. Keep in mind, a few examples are listed but it's not a complete list of what may apply.

The level of risk is the far left column. The type of risk is categorized by the **presenting problem**, the **diagnostic procedure(s) ordered** and by the **management options selected.** This element of decision making is determined by the highest level of risk in any one category. The semi-colon indicates an "or" statement. Look at Management Options Selected under **Minimal**. The statement means "rest or gargles or elastic bandage superficial dressing." This table might seem a bit overwhelming, but by walking through the examples and doing the Practice Exercises, you'll get better at using it in no time!

Table of Risk

Level of Risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
Minimal	One self-limited or minor problem	Laboratory tests requiring venipuncture; chest x-ray; EKG/EEG; urinalysis; ultrasound	Rest; gargles; elastic bandage superficial dressing
Low	Two or more self-limited or minor problems; one stable, well-controlled chronic illness; acute uncomplicated illness or injury	Superficial needle biopsies, clinical lab tests with arterial puncture, physiological tests not under stress, non-cardiovascular imaging studies with contrast	Over-the-counter drugs; minor surgery w/no risk factors; IV fluids w/o additives; physical or occupational therapy
Moderate	One or more chronic illnesses with mild exacerbation; two or more stable chronic illnesses; undiagnosed new problem w/uncertain prognosis; acute complicated injury	Diagnostic endoscopies with no identified risk factors; obtain fluid from body cavity (lumbar puncture, thoracentesis)	Minor surgery w/identified risk factors; prescription drug management; IV fluids with additives; closed treatment of fracture or dislocation w/o manipulation
High	One or more chronic illnesses w/severe exacerbation; acute or chronic illness or injuries that pose threat to life or bodily function; abrupt change in neurological status	Cardiovascular imaging studies; cardiac electrophysiological tests; diagnostic endoscopies; discography	Emergency major surgery; parenteral controlled substances; drug therapy requiring intensive monitoring; decision not to resuscitate due to poor prognosis; elective major surgery w/identified risk factors

As a medical coder, you need to put yourself in the physician's shoes. What is the physician's risk in her decision making process for this problem? The risk for an acute uncomplicated injury is low because the risk of infection is low. An acute complicated injury is a moderate level of decision making. As the level of risk for a problem related to the injury rises, so does the risk. If the injury poses a threat to life or bodily function, the level of medical decision making is high. The documentation will assist you in determining if the injury is complicated, uncomplicated or life-threatening.

The Overall Medical Decision Making Component

Now that you can determine the level of service for each element of the medical decision making component, you're ready to put that information together and pick the level of service for the medical decision making component as a whole. To do that, take a look at the following chart created by third-party payers. This chart lists the requirements for each of the four levels of service for medical decision making. These levels are: **straightforward**, **low complexity**, **moderate complexity** and **high complexity**. To qualify for a level of service, two of the three elements must meet or exceed these levels.

Medical Decision Making Summary Table				
MDM	**Straightforward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
Dx/Mgmt	minimal	limited	multiple	extensive
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Let's look at that in more detail. For instance, you have the Dx/Mgmt of limited; the Data at moderate; and Risk at high. You'll drop the lowest, which is the Dx/Mgmt, and use the other two to determine the MDM level. At this point, you'll select the lower of the remaining two, which is the moderate for Data. Your overall MDM is **Moderate Complexity**.

Review the following example to assist you in determining the MDM level.

Example of the Medical Decision Making Component

Let's revisit the injured hiker. This example will focus on the medical decision making portion of E/M coding. Depending on the physician's documenting style, the examination might be used in this step of the E/M process. The exam is included in the examples. Let's continue with the example.

SUBJECTIVE: A 27-year-old male was hiking in a wooded area over the weekend and developed a pruritic eruption involving his lower extremities. He was wearing shorts during the hike. While they were hiking, the patient's spouse identified the presence of poison oak in the area.

OBJECTIVE: Physical exam reveals erythematous papules on both lower extremities. Some oozing is noted from the papules. There is no infection evident. The patient is afebrile.

ASSESSMENT: Dermatitis due to poison oak.

PLAN: Gauze or thin cloths dipped in water and applied to papules for soothing and cooling for 30 min 4 to 6 times a day. Prescribed topical corticosteroid to decrease the inflammation. Contact the office if no improvement in two weeks.

Now let's use this chart with our example.

Number of Diagnosis and Management Options:
Refer to your Diagnosis and Management Options Table.

Problem: the problem is new to the doctor.
Diagnosis/Plan of Action: no additional work-up is planned.
Decision Making: the decision making level is *multiple*.
This is **Moderate Complexity** on the Summary MDM Table.

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Dx/Mgmt	minimal	limited	multiple	extensive

Amount and/or Complexity of Data to be Reviewed:
Refer to your Data to be Reviewed Table.

No labs, no x-rays, no other diagnostic studies. So the score for the data reviewed is zero, which is *minimal or none* level. This is **Straightforward** on the Summary MDM table.

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Data	min/none	limited	moderate	extensive

Risk of Complications and/or Morbidity or Mortality:
Refer to your Table of Risk.

The physician prescribed topical corticosteroid. Any time the physician recommends a prescription, look under Management Options Selected in the Table of Risk. In the Moderate level, the second option indicates "prescription drug management." You might find it helpful to highlight this information for quick reference. So, your risk level is *moderate*.

This is **Moderate Complexity** on the Summary MDM Table.

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Risk	minimal	low	moderate	high

Now let's put the chart together to determine the overall level of service. You see the element of Data is the lowest. You'll recall that to qualify for a level of service two of the three elements must meet or exceed these levels. In other words, you cross out the lowest level, then pick the next highest. Here, the Data element is the lowest. You will cross that out and determine the overall level of service with the remaining two. The level is **Moderate Complexity**.

Summary MDM Table				
MDM	**Straightforward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
Dx/Mgmt	minimal	limited	multiple	extensive
Data	~~min/none~~	limited	moderate	extensive
Risk	minimal	low	moderate	high

Turn in your *CPT* to the **99201-99205** code range so you can assign a specific code for the MDM component. Based on the code descriptions in the *CPT*, the overall level of service for the medical decision making component is **99204**.

The final step in this process of Evaluation and Management coding is to determine the overall level of service. Try your hand at these MDM exercises and then we'll continue to the final step. Now that you understand all of the key components, the final step will be easy!

Step 16 Practice Exercise 27-4

❒ For the following scenarios, refer to the following tables to determine each component. Then, using the Summary MDM table determine the overall level of service for the medical decision making component with the information provided.

Diagnosis and Management Options Table		
Problem	**Diagnosis/Plan of Action**	**Decision Making**
Self-limited or minor	stable, improving, worsening	**Minimal**
Established w/ Doctor	stable, improved	**Minimal**
Established w/ Doctor	worsening	**Limited**
New to Doctor	no additional work-up planned	**Multiple**
New to Doctor	additional work-up planned	**Extensive**

Data to be Reviewed Table	
Score	Data Ordered or Reviewed
(1)	Pathology & Laboratory: One or more tests
(1)	Radiology: One or more tests
(1)	Medicine Studies/Tests: One or more studies
(2)	Direct visualization, independent interpretation of specimen, image or tracing previously interpreted by another MD; Each test counts
(1)	Decision to obtain old records
(1)	Additional history from family, caretaker, other
(2)	Review and summarize old records
Total Score	Level of Service for Amount and/or Complexity of Data to be Reviewed
0 to 1	**Minimal or None**
2	**Limited**
3	**Moderate**
4 or more	**Extensive**

Table of Risk			
Level of Risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
Minimal	One self-limited or minor problem	Laboratory tests requiring venipuncture; chest x-ray; EKG/EEG; urinalysis; ultrasound	Rest; gargles; elastic bandage superficial dressing
Low	Two or more self-limited or minor problems; one stable, well-controlled chronic illness; acute uncomplicated illness or injury	Superficial needle biopsies, clinical lab tests with arterial puncture, physiological tests not under stress, non-cardiovascular imaging studies with contrast	Over-the-counter drugs; minor surgery w/no risk factors; IV fluids w/o additives; physical or occupational therapy
Moderate	One or more chronic illnesses with mild exacerbation; two or more stable chronic illnesses; undiagnosed new problem w/uncertain prognosis; acute complicated injury	Diagnostic endoscopies with no identified risk factors; obtain fluid from body cavity (lumbar puncture, thoracentesis)	Minor surgery w/identified risk factors; prescription drug management; IV fluids with additives; closed treatment of fracture or dislocation w/o manipulation
High	One or more chronic illnesses w/severe exacerbation; acute or chronic illness or injuries that pose threat to life or bodily function; abrupt change in neurological status	Cardiovascular imaging studies; cardiac electrophysiological tests; diagnostic endoscopies; discography	Emergency major surgery; parenteral controlled substances; drug therapy requiring intensive monitoring; decision not to resuscitate due to poor prognosis; elective major surgery w/identified risk factors

1. EMERGENCY DEPARTMENT 99281-99288

CHIEF COMPLAINT:	The patient is admitted to the emergency department after a motorcycle accident (MCA), complaining of right wrist and extreme bilateral leg pain, especially in the right leg.
HISTORY OF PRESENT ILLNESS:	The patient was involved in an MCA, wearing a helmet. There is no nausea, vomiting, or change in vision. There was a ten-minute loss of consciousness. There is no complaint of neck, chest, LUE, or back pain.
PAST HISTORY:	No smoking, drinking, or IV drug use. Right inguinal bullet removed in 1987. NO ALLERGIES.
REVIEW OF SYSTEMS:	No skull or facial tenderness. ROS otherwise noncontributory.
EXAMINATION VITALS:	Pulse: 76. Blood Pressure: 138/80. Respiratory rate: 20. Temperature: 98.
HEENT:	PERRLA. EOMs intact.
CHEST:	No clavicular, sternal, or rib tenderness.
HEART:	Regular rhythm and rate.
LUNGS:	Clear to P&A.
ABDOMEN:	Soft and nontender. No organomegaly. No rebound tenderness.
EXTREMITIES:	RUE: 2+ swelling at wrist. Skin intact. Radial pulse is 2+. Positive tenderness at the base of the small metacarpal and anatomic snuff-box. Apposition is 2/5. RLE: Dorsalis pedis and posterior tibial pulses are 2+ and equal bilaterally. Left leg reveals decreased strength with passive resistance. Right leg exam restricted due to severe pain.
DATA BASE:	X-ray confirms Barton's fracture and anterior dislocation of tibia, proximal end.
IMPRESSION:	1) Barton's fracture, right wrist. 2) Anterior dislocation of tibia, proximal end. 3) Anterior cruciate ligament and lateral collateral ligament laxity in right knee.
PLAN:	Admit for open reduction and internal fixation, right knee, right wrist. Knee immobilizer.

Medical Decision Making Summary Table				
MDM	**Straightforward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
Dx/Mgmt	minimal	limited	multiple	extensive
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Level of Service for the Medical Decision Making Component: _____

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

REASON FOR REFERRAL: Chest pain not relieved with nitroglycerin.

HISTORY OF PRESENT ILLNESS: The patient is a 63-year-old Caucasian male with a 20-year history of hypertension, who complains of chest pain occurring at rest and unrelieved with nitroglycerin. He admits to an admission for heart attack in the past year and a half. Upon this admission, myocardial infarction was ruled out. He was referred to assess coronary anatomy with cardiac catheterization. The patient also complains of paroxysmal nocturnal dyspnea, dyspnea on exertion and orthopnea. There is no hemoptysis, palpitation, murmur, cyanosis, clubbing, or edema. No cough, sputum, claudication.

PAST HISTORY: Habits: Two packs of cigarettes a day x 20 years. Medications: Diltiazem, Isordil, Lasix, KCL. Operations: See HPI. Prior knee surgery. Allergies: NKDA.

FAMILY HISTORY: One brother had an MI, and all sisters have hypertension.

PHYSICAL EXAMINATION: Vital signs: Blood pressure: 182/123. Neck: No jugular venous distension. Heart: PMI is at the fifth intercostal space, 2 cm lateral to the midclavicular line. There is a 2/6 systolic ejection murmur best heard in the parasternal border. S1, S2 heard in all areas. Lungs: Clear. Abdomen: Soft, no organomegaly. Extremities: No edema. Pulses: 1+ right femoral, right dorsalis pedis 0, left femoral and dorsalis pedis pulses 2+. Neurologic: No focal defect.

DATA BASE: EKG: Poor R-wave progression in the precordial leads. Chest x-ray: Cardiomegaly. Cardiac catheterization: Right coronary system: In the right coronary artery was a 70% long midlesion. Left coronary system: There is a distal left main coronary artery disease, about 55%. There was a proximal LAD lesion, 99%. The LAD fills from the collaterals from the circumflex. There is an 80% proximal circumflex lesion with more distal disease, about 40%.

ASSESSMENT:

1) Arteriosclerosis.
2) Hypertension.
3) Coronary artery disease of native vessels.
4) Unstable angina.
5) Congestive heart failure.

RECOMMENDATIONS:

The patient should undergo coronary artery bypass graft as soon as possible with revascularization of the LAD, diagonal, circumflex, and right coronary artery.

Medical Decision Making Summary Table				
MDM	**Straightforward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
Dx/Mgmt	minimal	limited	multiple	extensive
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Level of Service for the Medical Decision Making Component: _____

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

SUBJECTIVE:

The patient is a 2-year-old male. The mother states she was called to pick her son up from the preschool, because he had a low-grade fever, sore throat with blisters in his mouth, and refused to eat.

OBJECTIVE:

A vesicular exanthema is distributed over the buccal mucosa and palate with similar lesions on the hands, feet and in the diaper area. Rectal temperature: 103º F. A rectal swab specimen was positive for Coxsackie A virus.

ASSESSMENT:

Hand, foot and mouth disease.

PLAN:

Tylenol with codeine prescribed for pain and fever. Bed rest. Encourage increase in fluid intake, including milk, liquid gelatin, ice cream, custard or drinks made with syrup of wild cherry (available at pharmacy). Prevent exposure to other infants and young children and any persons with a respiratory illness. Symptoms should subside in 4 to 5 days and he can then return to school.

Medical Decision Making Summary Table				
MDM	**Straightforward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
Dx/Mgmt	minimal	limited	multiple	extensive
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Level of Service for the Medical Decision Making Component: _____

Step 17 Review Practice Exercise 27-4

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes that you may have made. Contact your instructor if you have questions on the medical decision making component.

Step 18 E/M Level of Service

❒ Let's pause and review the steps that got us to this point:

1. Read the documentation and determine the place of service, the type of service and the patient status.

2. Based on this classification information, locate the tentative code range in the *Index*.

3. Turn to the main part of the *CPT* to locate the tentative code range.

4. Review the guidelines for the section, subsection and heading you're using.

5. Read the code descriptions to be sure you've found the right code.

6. Determine the individual levels of service for each key component—history, examination and medical decision making from the documentation.

7. Assign the code for the overall level of service based on the code description.

The classification system provides a code range, but only one code can be applied for the Evaluation and Management service. The key components are evaluated separately to identify the individual levels. The final step is to determine the overall level of the service. In most cases, the CPT code descriptions instruct you to look at all three components and the lowest determines the overall service. Reading the code descriptions in the main body of the *CPT* provides direction. Majority does not rule when selecting the overall E/M level of service. The lowest component brings down the level of service.

In other words, once you know the level of service for each key component, in most cases, simply select the lowest level. This is your overall level of service! The code for that level is your correct Evaluation and Management code.

Example of the Overall Level

Finally, find the E/M code for the hiker's encounter. You've already analyzed the SOAP report and determined the individual component levels. You are coding for an office visit of a new patient, which is the code range 99201-99205. This code range requires that all three components be considered for the overall level of service. The history component is **99202**; the examination is **99202**; and the medical decision making is **99204**. Now you just pick the lowest level. The overall level of service for this encounter is **99202**. Be sure to read the CPT description carefully to determine if 2 or 3 key components are considered.

Step 19 Practice Exercise 27-5

❒ Based on the information obtained from previous Practice Exercises, determine the overall level of service for the following encounters.

1. EMERGENCY DEPARTMENT 99281-99288

history component	**99284**
examination component	**99284**
medical decision making component	**99284**
Overall Level of Service	_____

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

history component	**99243**
examination component	**99243**
medical decision making component	**99245**
Overall Level of Service	_____

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

history component	**99213**
examination component	**99214**
medical decision making component	**99214**
Overall Level of Service	_____

Step 20 Review Practice Exercise 27-5

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made. Contact your instructor if you have any questions.

Step 21 Contributing Factors

❒ When you're coding Evaluation and Management procedures, most of the time you'll only need to use the key components. However, every once in awhile a *contributing factor* will affect the procedure. A **contributing factor** is something which affects the level of service. This may include *counseling*, *coordination of care*, *nature of presenting problem* and *time*. These factors may or may not be part of the patient encounter. Let's take a quick peek at each of these factors!

Counseling

Counseling is a service provided to the patient and/or the patient's family. When counseling the patient or the patient's family is the reason for the service, or consists of more than 50 percent of the total time for the service, counseling is considered to be a component for code assignment. Refer to the E/M Guidelines for a complete list of topics for counseling.

Coordination of Care

Contact with other healthcare providers regarding the patient is **coordination of care**. It might include arranging for a long-term nursing facility. When there is no patient encounter on the day of coordination of care, the service will be reported using case management codes. These case management codes are not always covered by third-party payers.

Nature of Presenting Problem

The **presenting problem** can be considered the chief complaint, or the reason for the encounter. It substantiates a level of service based on the "medical necessity." The severity of the presenting problem may vary during an encounter. Documentation for services need to support the medical necessity by discussing the findings and thought process of the physician when ordering diagnostic or therapeutic services. The five types of presenting problems and definitions are found in the E/M Guidelines.

Time

Time is used to assign an Evaluation and Management code only when the physician spends more than 50 percent of the time face-to-face with the patient and family. The total length of time of the service and the total length of time counseling must be documented. The time indicated with the codes are averages and represent an estimate.

Step 22 Lesson Summary

❒ Way to go! You made it through the final section of the *CPT* manual. Evaluation and Management is a challenge to code, but it is used daily in most physician based coding. It is important that you understand the process and are able to count your way to the accurate level of service. You will find medical coders may categorize the information differently, but the final codes are the same. In the next lesson, you will code the entire process: the E/M code and the diagnosis code(s). If you have questions on E/M, go back and review the information. Your instructors are here to assist you in understanding the materials.

Step 23 Mail-in Quiz 27

❒ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 27

Choose the best answer from the choices provided. Each item is worth 3.33 points.

1. Which is a characteristic found in the HPI element? _____

a. Context
b. Counseling
c. Constitutional
d. Both a and b

2. Which element is part of the medical decision making component? _____

a. Amount and/or complexity of data to be reviewed
b. Risk of complications and/or morbidity or mortality
c. Number of diagnosis and management options
d. All of the above

3. Which is *not* a true statement of time? _____

a. Time is a contributing factor.
b. If you aren't sure of the E/M level, code it based on the time the physician spent with the patient.
c. Time is used to assign an Evaluation and Management code only when the physician spends more than 50% of the time face-to-face with the patient and family.
d. The total length of time of the service and the total length of time counseling must be documented.

4. Marital status, employment, level of education and sexual history are examples of _____.

a. family history
b. medical history
c. social history
d. none of the above

5. Which is an example of a place of service? _____

a. Emergency Department
b. Consultations
c. Office or Other Outpatient Services
d. All of the above

6. A(n) _____ is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

a. new patient

b. established patient

c. outpatient

d. inpatient

7. The decision making level, according to the table for "Diagnosis and Management Options," for an established patient with a new problem with no additional work-up planned, would be _____.

a. minimal

b. limited

c. multiple

d. extensive

8. What level of risk is "diagnostic endoscopies with no identified risk factors" in the Table of Risk? _____

a. Minimal

b. Low

c. Moderate

d. High

9. Which is *not* a true statement of key components? _____

a. All E/M codes require all three key components when determining the level of service.

b. They allow the medical coder to select the appropriate level of service for the encounter by "counting" the information documented.

c. The key components reflect the level of service found in the documentation.

d. History, examination and medical decision making are the three key components.

10. The _____ component consists of chief complaint, history of present illness, review of systems and past, family and/or social history.

a. examination
b. history
c. medical decision making
d. contributing

11. Based on the following question, which HPI characteristic would apply: "In what setting does the problem occur?" _____

a. Context
b. Duration
c. Timing
d. Quality

12. Which is *not* a true statement of the examination component? _____

a. It is based on factual data the physician has determined.
b. The exam contains a description of findings from the physician's examination of the patient.
c. It is subjective or fiction.
d. The organ systems and body areas are elements of the examination component.

13. According to the Table of Risk, what is the level of risk for the decision not to resuscitate due to poor prognosis? _____

a. Minimal
b. Low
c. Moderate
d. High

14. Which is *not* a true statement of the review of systems? _____

a. The ROS might be obtained by a series of questions asked by the physician in order to identify signs or symptoms.
b. It is a verbal exchange of information between the doctor and patient.
c. You obtain this information from the examination portion of the dictation.
d. The ROS is subjective.

15. The _____ refers to the setting where the services were provided to the patient.

a. type of service
b. history
c. place of service
d. condition

16. Based on the following question, which HPI characteristic would apply: "How long does the pain last?" _____

a. Severity
b. Duration
c. Timing
d. Quality

17. Which is a true statement of the chief complaint? _____

a. It is a statement describing the reason for a particular encounter.
b. The chief complaint is the physician's assessment of the problem.
c. It is found in the assessment/impression area of the dictation.
d. This element is rarely required when determining the level of service.

18. In the subjective area of a report, NO ALLERGIES is documented. This information is applied to the _____.

a. past medical history
b. examination
c. review of systems
d. either a or c

19. The classification system for E/M uses _____ to determine a code range.

a. history, examination and medical decision making
b. place of service, type of service and patient status
c. counseling, coordination of care, nature of presenting problem and time
d. condition, symptom and complaint

20. Based on the following question, which HPI characteristic would apply: "What helps?" _____

a. Location

b. Duration

c. Modifying Factors

d. Timing

Use the coding pathway to determine the correct range of codes for the following encounters. Each item is worth 3.33 points.

21. Patient is seen by a cardiologist for an office consultation. _____

a. 99204-99205

b. 99241-99245

22. A new patient is seen at an allergy clinic. _____

a. 99201-99205

b. 99241-99245

23. Inpatient consultation for an established patient _____

a. 99251-99255

b. 99241-99245

24. Rest home visit for a new patient _____

a. 99334-99337

b. 99324-99328

25. Emergency department services _____

a. 99281-99288

b. 99291-99292

Use the following Emergency Department report to answer the following questions. Each item is worth 3.33 points.

HISTORY	
CHIEF COMPLAINT:	Pain and deformity of the distal right forearm.
HISTORY OF PRESENT ILLNESS:	The patient was in good health until today when he fell over a Doberman while walking down a sidewalk. He fell on his outstretched arm, resulting in severe pain and deformity of the distal right forearm.
SOCIAL HISTORY:	Does not smoke, drink or use recreational drugs.
REVIEW OF SYSTEMS:	Noncontributory.
EXAMINATION	
GENERAL:	The patient appears in some distress with acute pain in the distal right forearm. Pulse: 78. Blood pressure 150/88. Temperature: Normal.
HEENT:	PERRLA.
NECK:	Supple.
CHEST:	Clear. No cardiac murmurs. Regular rate and rhythm.
EXTREMITIES:	There is palpable deformity over the distal radius with 1/5 apposition and strength in the right hand and 4+ swelling in the right wrist.
NEUROLOGIC:	Focal neurologic deficit to pinprick at the site of maximal tenderness in the distal right forearm. Decreased DTRs in the RUE.
DATABASE:	X-ray confirms Colles fracture.
ASSESSMENT:	Colles fracture.
RECOMMENDATION:	Refer to Orthopedic Surgery Clinic for reduction and immobilization. Right forearm sling and wrist immobilizer.

26. What is the level of service for the History Component? _____

a. Problem focused
b. Expanded problem focused
c. Detailed
d. Comprehensive

27. What is the level of service for the Examination Component? _____

a. Problem focused
b. Expanded problem focused
c. Detailed
d. Comprehensive

28. What is the level of service for the Medical Decision Making Component? _____

a. Straightforward
b. Low complexity
c. Moderate complexity
d. High complexity

29. What is the overall level of service for this encounter? _____

a. 99282
b. 99283
c. 99284
d. 99285

30. What is the diagnosis code for this encounter? _____

a. 813.41
b. 813.42
c. 813.44
d. 813.51

Congratulations!

You have completed Lesson 27

Do not wait to receive the results of your Quiz before moving on.

Quick Reference Guide to E/M Coding

HISTORY COMPONENT

1. Chief Complaint (CC)

Why is the patient seeking treatment?

2. History of Present Illness (HPI)

Location - What body location is involved? Is there radiation to parts of the body?

Quality - Can the condition be described as sharp, burning, dull, radiating or tearing pain?

Severity - How bad is the pain? There is a recognized pain scale of 1 to 10. Is the condition considered mild, severe, worse, progressing?

AS&S - Are there associated manifestations such as swelling, nausea? What other conditions does the patient have?

Timing - How long does it last? Is it intermittent?

Duration - What is the length of the overall problem? When did the problem begin?

Context - In what setting does the problem occur? Are there environmental factors contributing to the problem? In what situation have you had this problem in the past?

Modifying Factors - What helps? How is the problem relieved or worsened?

3. Review of Systems (ROS)

Constitutional	- general appearance, fever, weakness, chills, fatigue
Eyes	- conjunctivae, lids, pupils, irises, glasses, contacts, vision
Ears, Nose, Mouth, Throat	- head cold, discharge, difficulty swallowing, ear noises, throat pain
Cardiovascular	- heart, chest pain, high blood pressure, palpitations
Respiratory	- lungs, chest pain, wheezing, dyspnea, sputum, cough, SOB, cyanosis

Gastrointestinal	- abdomen, liver, spleen, anus, rectum, nausea, vomiting, appetite, diarrhea, hemorrhoids
Genitourinary	- male and female external genitalia, urinary tract, contraception, pregnancies
Musculoskeletal	- joint pain, muscle pain, cramps, clubbing
Integumentary	- skin and/or breast, rashes, dryness, eruptions, redness, swelling
Neurological	- reflexes, sensation, faintness, tingling, memory loss, headache, weakness, numbness
Psychiatric	- judgment, mental status, mood, depression, anxiety
Endocrine	- thyroid, diabetes, hormones
Hematologic/Lymphatic	- anemic, lymph node, bleeding, bruising
Allergic/Immunologic	- allergies, sneezing, itching eyes

4. Past, Family and/or Social History (PFSH)

Past Medical History - prior illness or injury, operations, current medications, allergies

Family History - health status of parents, siblings, children; disease of family members

Social History - marital status; employment; use of drugs, alcohol, tobacco; level of education; sexual history

EXAMINATION COMPONENT

1. Organ Systems (OS)

Constitutional - blood pressure, pulse, respiration, temperature, height, weight, general appearance

Eyes - conjunctivae, eyelids, irises, pupils, PERRLA

Ears, Nose, Mouth, Throat - often referred to as HEENT (head, eyes, ears, nose, throat) but eyes are in a separate system

Cardiovascular - palpation of heart, auscultation of heart (murmurs), pedal pulses, extremity edema, bruits

Respiratory - effort, percussion of chest dullness, palpation of chest (tactile), auscultation of lungs (breath sounds, rubs)

Gastrointestinal - mass or tenderness of abdomen, liver and spleen, hernia, anus, perineum, rectum, hemorrhoids, obtain stool sample

Genitourinary - kidney, bladder, ureters, urethra, male and female reproductive systems

Skin - includes glands, edema, rashes, lesions, ulcers

Musculoskeletal - gait and station, digits and nails, misalignment, defects, masses, range of motion, stability, muscle strength and tone

Neurological - sensations, cranial nerves, deep tendon reflexes

Psychiatric - speech, thought process, psychotic thoughts, judgment, orientation to time, place, person, mood, attention span and concentration, memory

Hematologic/Lymphatic/Immunologic - blood, lymph nodes, glands, allergies

2. Body Areas (BA)

Head, face

Neck

Chest, Breast, Axilla

Abdomen

Genitalia, Groin, Buttock

Back, Spine

Each extremity

MEDICAL DECISION MAKING COMPONENT

1. Number of Diagnosis and Management Options

Problem	Diagnosis/Plan of Action	Decision Making
Self-limited or minor	stable, improving, worsening	Minimal
Established w/ Doctor	stable, improved	Minimal
Established w/ Doctor	worsening	Limited
New to Doctor	no additional work-up planned	Multiple
New to Doctor	additional work-up planned	Extensive

2. Amount and/or Complexity of Data to be Reviewed

Data to be Reviewed Table	
Score	Data Ordered or Reviewed
(1)	Pathology & Laboratory: One or more tests
(1)	Radiology: One or more tests
(1)	Medicine Studies/Tests: One or more studies
(2)	Direct visualization, independent interpretation of specimen, image or tracing previously interpreted by another MD; Each test counts
(1)	Decision to obtain old records
(1)	Additional history from family, caretaker, other
(2)	Review and summarize old records
Total Score	Level of Service for Amount and/or Complexity of Data to be Reviewed
0 to 1	**Minimal or None**
2	**Limited**
3	**Moderate**
4 or more	**Extensive**

3. Risk of Complications and/or Morbidity or Mortality

Table of Risk			
Level of Risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
Minimal	One self-limited or minor problem	Laboratory tests requiring venipuncture; chest x-ray; EKG/EEG; urinalysis; ultrasound	Rest; gargles; elastic bandage superficial dressing
Low	Two or more self-limited or minor problems; one stable, well-controlled chronic illness; acute uncomplicated illness or injury	Superficial needle biopsies, clinical lab tests with arterial puncture, physiological tests not under stress, non-cardiovascular imaging studies with contrast	Over-the-counter drugs; minor surgery w/ no risk factors; IV fluids w/o additives; physical or occupational therapy
Moderate	One or more chronic illnesses with mild exacerbation; two or more stable chronic illnesses; undiagnosed new problem w/ uncertain prognosis; acute complicated injury	Diagnostic endoscopies with no identified risk factors; obtain fluid from body cavity (lumbar puncture, thoracentesis)	Minor surgery w/ identified risk factors; prescription drug management; IV fluids with additives; closed treatment of fracture or dislocation w/o manipulation
High	One or more chronic illness w/ severe exacerbation; acute or chronic illness or injuries that pose threat to life or bodily function; abrupt change in neurological status.	Cardiovascular imaging studies; cardiac electrophysiological tests; diagnostic endoscopies; discography	Emergency major surgery; parenteral controlled substances; drug therapy requiring intensive monitoring; decision not to resuscitate due to poor prognosis; elective major surgery w/ identified risk factors

History	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3
Exam	**Problem Focused**	**Expanded Problem**	**Detailed**	**Comprehensive**
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS
MDM	**Straightforward**	**Low Complexity**	**Moderate Complexity**	**High Complexity**
Dx/Mgmt	minimal	limited	multiple	extensive
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

HISTORY

Chief Complaint (CC)
History of Present Illness (HPI)
- ❒ Location
- ❒ Quality
- ❒ Severity
- ❒ Associated Signs & Symptoms
- ❒ Timing
- ❒ Duration
- ❒ Context
- ❒ Modifying Factors

Past Medical, Family, Social History (PFSH)
- ❒ Past Medical History
- ❒ Family History
- ❒ Social History

EXAMINATION
Organ Systems (OS)
- ❒ Constitutional
- ❒ Eyes
- ❒ Ears, Nose, Mouth, Throat
- ❒ Cardiovascular
- ❒ Respiratory
- ❒ Gastrointestinal
- ❒ Genitourinary
- ❒ Skin
- ❒ Musculoskeletal
- ❒ Neurological
- ❒ Psychiatric
- ❒ Hematologic/Lymphatic/Immunologic

Body Areas (BA)
- ❒ Head, face
- ❒ Neck
- ❒ Chest, Breast, Axilla
- ❒ Abdomen
- ❒ Genitalia, Groin, Buttock
- ❒ Back, Spine
- ❒ Each Extremity

Review of Systems (ROS)
- ❒ Constitutional
- ❒ Eyes
- ❒ Ears, Nose, Mouth, Throat
- ❒ Cardiovascular
- ❒ Respiratory
- ❒ Gastrointestinal
- ❒ Genitourinary
- ❒ Musculoskeletal
- ❒ Integumentary
- ❒ Neurological
- ❒ Psychiatric
- ❒ Endocrine
- ❒ Hematologic/Lymphatic
- ❒ Allergic/Immunologic

MEDICAL DECISION MAKING

Dx & Management Options
- ❒ Minimal
- ❒ Limited
- ❒ Multiple
- ❒ Extensive

Data Reviewed
- ❒ Minimal or None = 0-1
- ❒ Limited = 2
- ❒ Moderate = 3
- ❒ Extensive = 4

Table of Risk
- ❒ Minimal
- ❒ Low
- ❒ Moderate
- ❒ High

Comprehensive CPT Evaluation and Management

LESSON 28

Step 1 Learning Objectives for Lesson 28

❒ When you have completed the instruction in this lesson, you'll be trained to do the following:

☞ Identify the differences between the E/M codes.

☞ Review the steps to Evaluation and Management coding.

☞ Integrate the *ICD-9-CM* and the E/M codes.

Step 2 Lesson Preview

❒ As you found in the previous lesson, there are many subsections of the Evaluation and Management section. This lesson will take a closer look at the similarities and differences between these subsections. Understanding the subsections will assist you in accurate coding. This lesson also provides plenty of practice with coding E/M services, including coding for the diagnosis! If you have questions along the way, refer back to Lesson 27, use your quick reference guides or contact your instructor. Be sure to use the resources available to assist you with your Evaluation and Management coding.

Step 3 Evaluation and Management Subsections

❒ We've discussed how to use the classification system to locate the tentative code range. We analyzed the key components and how to arrive at the overall level of service. But what exactly is an office visit? Understanding the differences in the E/M subsections will assist you in finding the correct code quickly. Let's take a closer look at the E/M subsections!

Office or Other Outpatient Services

These codes are for office visits and are categorized by the patient status. You'll recall from the last lesson that a new patient is one who has not seen the physician/qualified health care professional or another physician/qualified health care professional in the practice within the last three years. When the documentation indicates "initial office visit," you will be coding for a new patient office visit. Usually more time is required for a new patient. The physician must obtain a history, perform an exam and possibly review data. An established patient, on the other hand, is known to the physician already. The patient's medical records are on file for the physician to review.

The physician must obtain a history, perform an exam and possibly review data.

Hospital Observation Services

Observation services are used for those whose condition is not serious enough to be admitted, but not well enough to go home either. It gives the physician time to monitor the situation to determine if there is a need for further treatment. There are three initial observation codes to designate the beginning of observation status.

When coding for observation, there are some details to keep in mind:

- If a patient is admitted for observation then discharged on the same calendar day, you will use code range **99234-99236** for Observation or Inpatient Care Services.
- When a patient is admitted as an inpatient on the same day as admitted to observation, the observation is not coded. You will only code **99221-99223** for the **Initial Hospital Care**.
- If a patient is seen in the office or emergency department the same day as being admitted for observation, the office service or emergency department service will not be coded.
- If a patient requires additional observation care after the initial service, you will select the appropriate **Subsequent Observation Care** code **99224-99226**.

Let's try coding a patient seen in the emergency department after a car accident. The patient has minor scrapes and bruising with no apparent injuries. The patient complains of a headache and a 10-minute loss of consciousness was noted. The patient is admitted to the hospital for observation in order to rule out a head injury. A comprehensive history and examination were done with the MDM of moderate complexity. The patient remains in observation overnight and is released in good condition the next day.

For this scenario, you will code the initial hospital observation care for one day. To locate the code range **99218-99220** turn to *Hospital Services, Observation, Initial Care*. The comprehensive history and exam with a moderate complexity MDM is a 99219 level of service. The second day the patient was discharged, so you code observation discharge services of 99217. You assign the CPT codes **99219** and **99217** for this encounter.

Hospital Inpatient Services

Codes in this subsection of Evaluation and Management identify the setting where the physician provides the service and identify the status of the patient as an inpatient in the hospital. The patient's inpatient status can be *initial hospital care, subsequent hospital care* or *observation or inpatient care services.* Remember, an inpatient is one who has been formally admitted to a healthcare facility. The first encounter between the patient and admitting physician in the inpatient setting is referred to as **Initial Hospital Care**. During the stay at the hospital, the physician will review medical records and test results as well as any changes in the patient status. These encounters are **Subsequent Hospital Care** and **Observation or Inpatient Care Services** and will be coded when a patient is admitted and discharged on the same day of service.

Hospital Discharge Service is for the physician's time spent during the final discharge. The code includes a final exam, discussion of stay, continuing care instructions, and preparing discharge records, prescriptions and referral forms. The code is based on time. Code 99238 is for discharge time of 30 minutes or less, while 99239 is for more than 30 minutes.

Consultations

A **consultation** is when one physician or other qualified health care professional seeks the opinion or advice of another physician or other qualified health care professional. The request for the consultation may be written or verbal, but it must be documented in the patient's medical records. The consulting physician or other qualified health care professional will send a written opinion back to the requesting physician or other qualified health care professional. Consultations are site specific, either outpatient or inpatient. A consultation initiated by the patient and/or the patient's family will be reported using the appropriate office visit code.

> Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) will no longer recognize consultation codes (99241-99245 and 99251-99255) for Medicare Part B payment. For evaluation services performed in the office or other outpatient settings with dates of service on or after January 1, 2010, physicians and qualified non-physician practitioners should use *CPT* code range 99201-99215 according to current E/M documentation guidelines.

Office or Other Outpatient Consultations

Most outpatient consultations are performed in the provider's office. Outpatient consultations can be found in the hospital observation setting, at a home visit, in a domiciliary or rest home visit or in the emergency department. If, after the initial consultation, the physician initiates a follow-up visit, you would code for an office visit of an established patient. Only when another request for a consultation is obtained can a consultation code be reported again.

Inpatient Consultation

When the opinion or advice regarding a specific problem in the hospital inpatient setting or in a nursing home facility is requested, inpatient consultation will be coded. This E/M code can only be reported once per admission.

Emergency Department Services

Services provided in an emergency department that is part of a hospital and available 24 hours a day will be coded from this subsection. There is no distinction between new and established patients in the ED. Time is not a consideration either. You will not code from this subsection if a patient is seen in the office with a true emergency. These E/M codes are specifically for services provided in the emergency department of the hospital.

There is no distinction between new and established patients in the ED.

Let's look at the code description for 99285.

> Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status.

That's something we haven't discussed before and is a very important statement. If the patient's status is urgent or altered, and the physician is unable to obtain a proper history, this information should be documented in the medical records. This allows you to "count" the history as comprehensive because of the constraints imposed by the urgency of the patient's condition.

Emergency Care Direction

This code is for the physician's or other qualified health care professional's services in providing direction and advice via two-way communication with the ambulance or rescue team as they attend to the patient or are en route to the emergency department. The guidelines provided with this subsection will assist with accurate coding.

Critical Care Services

Critical care services are not site specific, but are usually found in critical care units. This may be the intensive care unit, the respiratory care unit or emergency care unit. Critical care is a service provided by the physician or other qualified health care professionals to critically ill or injured patients. These patients require immediate intervention and life saving measures for illness or injuries that might impair one or more vital organ systems. These services are based on time, which must be documented in the patient's medical records. You will find a helpful chart in the guidelines to this subsection to help you code for the documented time.

Nursing Facility Services

A nursing facility is not a hospital. It provides health care to those who do not meet the criteria for an acute care facility. Nursing facilities were formally called Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs) or Long Term Care Facilities (LTCFs). This subsection consists of four headings: Initial Nursing Facility Care, Subsequent Nursing Facility Care, Nursing Facility Discharge and Other Nursing Facility Services. Let's look at the characteristics of three of these.

- **Initial Nursing Facility Care –** Initial nursing facility will be coded when a patient is admitted to the nursing facility. When a physician or other qualified health care professional provides emergency department services or an office visit, and then admits the patient into a nursing facility, the initial nursing facility is the only service applied for that encounter.

- **Subsequent Nursing Facility Care –** These codes cover services provided on a periodic basis, with no major changes in the patient's condition. This might include management of a chronic condition or treatment of a new problem. The care might include reviewing medical records and diagnostic studies.

- **Nursing Facility Discharge –** Discharging a patient from a nursing facility can include a final exam, discussion of the nursing facility stay, preparation of discharge papers, prescriptions and referral forms. The codes for the service are based on the time spent by the physician or other qualified health care professional during the discharge process.

Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services

Generally, health care services are not provided in a domiciliary, rest home or custodial care service. This type of care provides room, board and other personal assistance services, usually on a long-term basis. The physician or other qualified health care professional is called to evaluate the patient on site. The patient status of new or established classifies the E/M code you will use.

Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services

This subsection describes services to patients who are in a rest home or assisted-living situation but require medical services or care-plan oversights within a 30-day period. Only one physician may report services, and her services should reflect her sole supervisory role. A nursing home or home health agency will only report services when the patient requires recurrent supervision of therapy. If the patient requires infrequent supervision, you cannot report these services separately. Report them with office/outpatient services nursing facility or domiciliary service codes—whichever codes apply.

Home Services

Evaluation and Management services provided by a physician or other qualified health care professional in a private residence will be coded as a Home Service. The codes are classified as new or established based on the patient status.

Prolonged Services

Prolonged physician services can be with or without direct patient contact. These codes are for services that are beyond the usual service provided in an inpatient or outpatient setting. All prolonged services codes are add-on codes and are used in conjunction with other E/M codes. The codes are time based, and documenting the time is necessary.

Prolonged services codes are time-based, add-on codes.

Standby Services

This code covers when a physician or other qualified health care professional is on standby service at another doctor's request. The standby physician cannot be providing services to another patient during this time; she must be available in case her services are needed. These services are reported in 30-minute intervals. The standby services E/M code will only be reported if the standby physician's services were not needed. When the standby services are needed, you will code to the services performed.

Case Management Services

Medical team conferences and anticoagulant management are part of case management services. Time spent by the physician or other qualified health care professionals coordinating a patient's care is coded to this subsection. Documenting the details and time spent are helpful when coding telephone calls.

Care Plan Oversight Services

The physician's management of a complex case might require regular communication with nurses. This E/M code reports the time spent with a particular case over a 30-day period.

Preventive Medicine Services

Routine evaluation and management services for a healthy patient with no complaints are preventive medicine. New patients are noted as initial comprehensive preventive medicine, while periodic comprehensive preventive medicine is for established patients. The codes reflect the age of the patient.

Preventive medicine services do not include immunizations. You will code the vaccines separately from the Medicine section of the *CPT*.

Be sure to note, the guidelines instruct you to code the appropriate Office/Outpatient code (*99201-99215*) in addition to the preventative service if an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine service.

Counseling Factor Reduction and Behavior Change Intervention

Within the preventive medicine subsection you'll find codes for promoting health and preventing illness or injury. While the codes are within the subsection, they are not to be coded in conjunction with a preventive medicine code. They are to be a separate encounter for a specific purpose. Issues include family problems, diet and exercise and substance abuse. The counseling might be individual or group sessions.

Non-Face-to-Face Services

A physician or other qualified health care professional can provide evaluation and management services using a telephone or online communication. There are specific guidelines provided in the *CPT* to review before using these codes. Telephone services are determined by the minutes of the medical discussion, while online evaluation only provides one code to use.

Special Evaluation and Management Services

Evaluation and management services performed to establish a baseline for life or disability insurance are coded from this subsection. The settings are not site specific.

Newborn Care Services

Services provided to newborns in various settings are coded from this section. E/M services for the newborn include material and/or fetal and newborn history, newborn physical exam(s), ordering of diagnostic tests and treatments, meeting with the family and documentation in the newborn medical record. You will select codes based on an initial or subsequent visit, as well as the site of the service.

Delivery/Birthing Room Attendance and Resuscitation Services

Code 99464 is assigned when the delivering physician or other qualified health care professional requests the attendance of a physician during the delivery and the initial stabilization of the newborn. When resuscitation is provided, including positive pressure ventilation and/or chest compressions, you will assign code 99465.

Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services

Services provided to neonatal and pediatric patients during transport and critical care are found under this heading.

Pediatric Critical Care Patient Transport

The E/M codes in this subsection are for the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or injured pediatric patient 24 months of age or younger. Let's analyze that statement. Face-to-face care begins when the physician assumes primary responsibility for the patient and ends when the receiving hospital takes over the care for the patient. Transportation is from the referring hospital to the receiving hospital.

Transportation is from the referring hospital to the receiving hospital.

Refer to the guidelines in this subsection for services performed during the pediatric patient transport.

Code 99466 specifies services for the first 30-74 minutes. Critical care of less than 30 minutes is not included in this subsection. For each additional 30 minutes after the first 74 minutes, code 99467 in conjunction with code 99289. Let's try coding an example for a better understanding of the codes.

> Code a critical care patient transport of a 6-month-old consisting of 134 minutes of physician's attendance and face-to-face care.

First, break the number down to determine the first 74 minutes and the additional minutes. 134-74=60. 60/30=2. So we will code 99466 for the first 74 minutes, and 99467 for each additional 30 minutes. You will record the following for the physician's service: **99466 99467 99467**.

Inpatient Neonatal and Pediatric Critical Care

Although the same definition for critical care services apply for adults, children and neonates, the CPT provides a section specifically for inpatient neonatal and pediatric critical care. **Neonatal** refers to a newborn infant. Extensive guidelines are provided for this subsection. For accurate coding, you should be familiar with the content of the guidelines.

Initial and Continuing Intensive Care Services

Low birth weight (LBW) and very low birth weight (VLBW) infants who are no longer classified as critically ill, but require subsequent care are coded from this subsection. While the infant is no longer critically ill, intensive observation and frequent services only available in the intensive care may be required. These codes identify the present body weight of the infant in grams.

Complex Chronic Care Coordination Services

Patient-centered management and support services provided to patients residing at home or in a domiciliary, rest home or assisted living facilities by physicians or other qualified health care professionals are found in this section of the *CPT*. These services include the following:

- Implementing a care plan directed by the physician or other qualified health care professional
- Coordination of care by multiple disciples and community service agencies
- Management and/or coordination of services for all medical conditions, psychosocial needs and activities of daily living

These services are time based. Codes 99487-99489 are reported only once per calendar month, and should only be reported by one physician or other qualified health care professional. Be sure to read the *CPT* guidelines carefully for accurate reporting of the codes in this section.

Transitional Care Management Services

Transitional care management services, or TCM, are for an established patient during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital or skilled nursing facility/nursing facility to the patient's community setting, which may be to their home, rest home or assisted living facility. TCM begins on the discharge date and continued for the next 29 days. Again, the guidelines will provide you the typical inclusions for this service, and will assist you with accurate coding.

Let's pause and review some of the information you learned about the subsections in the Evaluation and Management section!

Step 4 Practice Exercise 28-1

❒ Match the Evaluation and Management subsection with its description.

1. ____ **Hospital Observation Services**
2. ____ **Hospital Inpatient Services**
3. ____ **Consultations**
4. ____ **Emergency Department Services**
5. ____ **Pediatric Critical Care Patient Transport**
6. ____ **Initial and Continuing Intensive Care Services**
7. ____ **Domiciliary, Rest Home, or Custodial Care Services**
8. ____ **Home Services**
9. ____ **Preventive Medicine Services**
10. ____ **Special Evaluation and Management Services**

a. Evaluation and Management services provided by a physician in a private residence.

b. Low birth weight (LBW) and very low birth weight (VLBW) infants who are no longer classified as critically ill, but require subsequent care.

c. The patient's status can be initial hospital care, subsequent hospital care or observation or inpatient care services.

d. Services for those whose condition is not serious enough to be admitted, but not well enough to go home either.

e. Generally, healthcare services are not provided, while room, board and other personal assistance services are provided.

f. Routine evaluation and management services for a healthy patient with no complaints.

g. The physician's physical attendance and direct face-to-face care during the transport of a critically ill or injured pediatric patient.

h. When one physician seeks the opinion or advice from another physician.

i. Evaluation and management services performed to establish a baseline for life or disability insurance are coded from this subsection.

j. Services must be provided in a hospital.

Step 5 Review Practice Exercise 28-1

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 6 Coding Steps Review

❒ In this lesson, we will provide you plenty of Practice Exercises in relation to coding the diagnosis and E/M service for several different types of encounters. To accurately code the Evaluation and Management service, it is important to follow the steps we discussed. Let's take a moment to review the E/M coding steps, as well as the steps for coding from the *ICD-9-CM*.

Steps for Evaluation and Management Coding

1. Read the documentation and determine the place of service, the type of service and the patient status.
2. Based on this classification information, locate the tentative code range in the *Index*.
3. Turn to the main part of the *CPT* to locate the tentative code range.
4. Review the guidelines for the section, subsection and heading you're using.
5. Read the code descriptions to be sure you've found the right code range.
6. Determine the individual levels of service for history, examination and medical decision making from the documentation.
7. Assign the code for the overall level of service based on the code description.

Steps & Guidelines for ICD-9-CM Codes

1. Identify the main terms in the diagnostic statement.
2. Locate each main term in the *Index to Diseases* and read any notes that appear with the main term.
3. Refer to any subterms indented under the main term in the *Index to Diseases*.
4. Look at abbreviations, cross-references, symbols and brackets.
5. Choose the tentative code you find in the *Index to Diseases,* Volume 2, then locate and determine the highest level of specificity in the *Tabular List*, Volume 1.
6. Read and use any instructional terms in the *Tabular List* as a guide. Look for INCLUDES and EXCLUDES, notes and other instructional comments at the beginning of each chapter. Also, look at the three-digit code at the beginning of each category or group of codes that you are using within the chapter and check for additional instructions for the group.

7. Assign codes to their highest level of specificity, using the following guidelines:
   - Assign three-digit codes only when there are no four-digit codes within that category.
   - Assign a four-digit code only when there is no fifth-digit subdivision for that subcategory.
   - Assign a fifth-digit to the code for any subcategory for which a fifth-digit subclassification is provided.
8. Remember to continue coding the dictation until all elements are fully identified before assigning the code.

Outpatient Coding Tips

- If it is not documented, it did not happen.
- Do not assume anything.
- Terms such as *possible*, *suspect*, *probable*, *rule out* or *consistent with* are not assigned codes.
- Code symptoms only when a definitive diagnosis is not documented.
- Check with the physician if the information is unclear.

Step 7 Practice Exercise 28-2

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

OFFICE VISIT FOR AN ESTABLISHED PATIENT

HISTORY	
CHIEF COMPLAINT:	Daily severe chest discomfort.
HISTORY OF PRESENT ILLNESS:	The patient has had cardiac surgery and a prior myocardial infarction. She rarely has chest pain with her heart disease. For the past week, she has had daily severe discomfort. Nitroglycerin offers no relief for this pain. There has been no shortness of breath, dyspnea, sweating or loss of consciousness.
PAST HISTORY:	Less than half a pack of cigarettes a day. Alcohol and coffee, minimal to none.
MEDICATIONS:	Cardizem 30 mg p.o. t.i.d. Nitrek 6.5 mg p.o. b.i.d.
ALLERGIES:	PENICILLIN AND ERYTHROMYCIN.
REVIEW OF SYSTEMS	
CARDIORESPIRATORY:	No history of hypertension. She has done very well since her cardiac surgery with the exception of recurrent discomfort and some fatigue.
PHYSICAL EXAMINATION	
GENERAL:	This is a charming 59-year-old white female in no acute distress. Pulse: 88, regular. Blood Pressure: 132/80, resting. Respiratory Rate: 20.
CHEST:	There is exquisite costochondral discomfort with myofascial trigger points and two infrascapular points. Heart: PMI at left fourth intercostal space. No bruits present. Rhythm regular without murmur. Lungs: Clear to auscultation and percussion.
EXTREMITIES:	No clubbing or cyanosis. No edema, no deformity. No tenderness or myalgia.
IMPRESSION:	1. Chest pain which does not respond to cardiac medications. Rule out costochondritis or myofascial syndrome. 2. Status post cardiac surgery.
PLAN:	Cardiology consultation for cardiac evaluation.

ICD-9-CM:

_____

_____

CPT:

_____

Step 8 Review Practice Exercise 28-2

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Practice Exercise 28-3

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

> Intensive care unit admits a patient with first- and second-degree burns of the thigh and second-degree burns of the back, 13% of the body surface is involved. The physician is called to ICU to provide care for the patient for one hour.

ICD-9-CM:

_____

_____

_____

CPT:

_____

Step 10 Review Practice Exercise 28-3

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 11 Practice Exercise 28-4

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

GYNECOLOGICAL REPORT

REASON FOR VISIT:	Patient is seen for an initial pelvic examination as part of routine physical before beginning diet and exercise program. The patient is 10 pounds overweight, otherwise feeling fine.
PAST HISTORY:	The patient does not smoke or drink. Usual childhood diseases. No serious illnesses. NO KNOWN DRUG ALLERGIES.
FAMILY HISTORY:	Parents and four siblings alive and well. No family history of breast cancer or uterine cancer.
REVIEW OF SYSTEMS	
GASTROINTESTINAL:	Stools brown. No diarrhea or constipation. No nocturia or hematuria.
GYNECOLOGIC:	Last regular menses two days ago. Sexually active. No birth control methods used. Breast tenderness, only premenstrual.
PHYSICAL EXAMINATION	
GENERAL:	This is a well-nourished, well-developed 26-year-old female in no acute distress. Alert and oriented. Pulse: 80/min. Blood Pressure: 100/80. Respiratory Rate: 20/min. Temperature: 98.6˚F.
NECK:	No thyromegaly.
CHEST:	Clear to auscultation and percussion. Heart: Regular rate and rhythm. Normal heart tones. No murmurs. Breasts: Symmetrical. No masses or discharge.
ABDOMEN:	Soft and slightly full in the suprapubic region. No masses or organomegaly palpated.
PELVIC:	Normal perineum. Bimanual: Uterus nongravid, anteflexed, and anteverted. No enlargement, masses or fixation. No adnexal masses or fixation. Cervical smears obtained. No cervical erosions. No cul-de-sac fluid.
RECTAL:	No blood on the examining glove. Stool guaiac negative.
DATA BASE:	CBC normal. Electrolytes: Na 138, K 4.3, Cl 97, pH 7.4. Pap smear results pending. Stool guaiac negative.
ASSESSMENT:	Normal gynecologic examination.

ICD-9-CM: _____ **CPT:** _____

Step 12 Review Practice Exercise 28-4

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 13 Practice Exercise 28-5

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided.

HOSPITAL DISCHARGE SUMMARY

ADMITTING DIAGNOSIS:	1. Hypertension 2. Polyuria 3. Muscular weakness
HISTORY OF PRESENT ILLNESS:	This is a 44-year-old woman with a 20-year history of hypertension, controlled with medication with increasing doses. She has had a two-year history of polyuria and progressive muscular weakness.
LABORATORY FINDINGS:	Serum potassium 2.6, Aldosterone level is 112. CT scan shows a mass in the right adrenal gland measuring 3 x 4 cm.
HOSPITAL COURSE:	After admission and initial evaluation, the patient was referred for elective right adrenalectomy, which she underwent without complications. Her postoperative course has been remarkable for fluctuations in her serum potassium, which has been mostly hypokalemic and which has responded well to supplementation. Additionally, she has polyuria. Urine osmolality and electrolytes are pending. This is decreasing, and with return of bowel function yesterday, she is being started back on oral intake today. Discussion centered on differential of polyuria and possibility of obligatory polyuria secondary to chronic potassium loss.
DISPOSITION:	Discharged to home on fifth postoperative day. Return to clinic in two weeks for blood pressure check.
CONDITION ON DISCHARGE:	Improving.
DISCHARGE DIAGNOSIS:	1. Conn's syndrome. 2. Aldosterone-secreting adrenal cortical adenoma, status post right adrenalectomy.
PROGNOSIS:	Good.
DISCHARGE MEDICATION:	Vicodin 1 tab q.4h. for pain.
DISCHARGE MANAGEMENT:	09:05 – 09:55 am

ICD-9-CM:	**CPT:**
_____	_____
_____	
_____	

Step 14 Review Practice Exercise 28-5

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 15 Practice Exercise 28-6

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided.

INITIAL OFFICE VISIT

SUBJECTIVE: Two weeks ago the mother of this 7-year-old female noted a low-grade fever, headache and stuffy nose lasting three days. A couple of days after symptoms subsided, patient noticed a bright red rash on her face. Patient now presents with similar rash on trunk, arms, and legs, times one week.

OBJECTIVE: Temperature 100.7˚F. Physical examination reveals net-like rash on face, trunk, arms, and legs.

ASSESSMENT: Patient has fifth disease.

PLAN: Plenty of bed rest. Drink lots of clear fluids and take acetaminophen as needed to reduce fever. Call office if rash does not begin to clear within 10 days.

ICD-9-CM: _____

CPT: _____

Step 16 Review Practice Exercise 28-6

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 17 Practice Exercise 28-7

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided.

INITIAL INPATIENT CONSULTATION

REASON FOR REFERRAL:	Evaluation of cellulitis secondary to burn injury.
HISTORY OF PRESENT ILLNESS:	This 30-year-old male was in the shower, and he burned the posteromedial upper arm with hot water. In spite of local treatment initiated after an emergency department visit, he developed increasing cellulitis.
PAST HISTORY:	No medications. Denies history of diabetes. NO KNOWN ALLERGIES.
REVIEW OF SYSTEMS:	Noncontributory.
EXAMINATION:	The patient is afebrile. The right upper arm is swollen, erythematous, and warm. There is a second- and third-degree burn measuring 20 cm x 7 cm on the posteromedial upper arm. One-third of the area had ruptured bullae, and the remainder is covered by a black eschar.
DATA BASE:	White blood cell count 20,200.
ASSESSMENT:	Second- and third-degree burn, right upper arm, with cellulitis.
RECOMMENDATIONS:	Debride eschar. Continue Silvadene dressing t.i.d. Agree with IV antibiotics.

ICD-9-CM:	**CPT:**
_____	_____
_____	
_____	
_____	

Step 18 Review Practice Exercise 28-7

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 19 Practice Exercise 28-8

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided.

ORTHOPEDIC CONSULTATION REPORT

REASON FOR REFERRAL:	Patient sent by her physician for a second opinion for her continuous pain in her right ankle and foot.
HISTORY OF PRESENT ILLNESS:	This patient has severe arthritic destructive disease in the left subtalar joint. She cannot walk because of continuous pain in the ankle and foot. Any inversion or eversion causes immediate severe discomfort. The patient has had long-standing, severe osteoporosis and rheumatoid arthritis. In addition, she has been on long-term steroid therapy. The patient has spontaneously fractured ribs with delayed healing.
PAST HISTORY:	Long-term corticosteroid therapy for rheumatoid arthritis.
MEDICATIONS:	Currently, prednisone 40 mg daily p.o.
ILLNESSES:	Rheumatoid arthritis, osteoporosis.
ALLERGIES:	NO ALLERGIES TO FOOD OR MEDICATION.
SOCIAL HISTORY:	The patient was employed as a plumber until the age of 50 when progressive arthritis limited her ability to continue working.
FAMILY HISTORY:	There is no family history of cancer, diabetes. A paternal uncle and a sister have RA.
REVIEW OF SYSTEMS	
CARDIORESPIRATORY:	Pleuritic pain and dyspnea and focal pain over the left fourth, fifth and sixth ribs began one week ago spontaneously. No history of trauma.
PHYSICAL EXAMINATION	
GENERAL:	This is a 60-year-old, 180-lb white female in moderate distress. Pulse: 100 and regular. Blood pressure: 140/110. Respiratory Rate: 20, guarded. Temperature: 99.6°F.
CHEST:	There is pinpoint tenderness over the left fourth, fifth and sixth ribs in the left midaxillary line. Heart: PMI left midclavicular line. Regular rate and rhythm without murmurs. Lungs: Clear.
NEUROLOGIC:	There is a decrease in sensation in the right ankle and foot. Cranial nerves II-XII are intact.
DATA BASE:	A bone survey shows diffuse, widespread changes of rheumatoid arthritis with destruction of taloscaphoid axis and pronation of the right foot.
ASSESSMENT:	1. Rheumatoid arthritis with severe destructive diseases of the subtalar joint, right ankle and foot. 2. Spontaneous pathologic fractures, left ribs 4-6. 3. Osteoporosis.
RECOMMENDATIONS:	The severe pain and limitation of motion of right foot argues in favor of triple arthrodesis with bone graft from the right iliac crest to the right subtalar joint and transfer of the peroneal tendons of the right ankle. It is well known that the patient has severe osteoporosis and spontaneously fractured ribs. However, because of the severity of the destruction of the right ankle, arthrodesis is recommended at this time. A written report will be sent to the referring physician.

ICD-9-CM: **CPT:**

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Step 20 Review Practice Exercise 28-8

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 21 Practice Exercise 28-9

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

A 5-year-old female is seen and counseled by her family physician for a well-child exam. Details of the examination are documented. After her exam she received immunizations administered by the nurse for DtaP (diphtheria, tetanus toxoid, and acellular pertussis).

ICD-9-CM: **CPT:**

_____ _____

_____

_____

Step 22 Review Practice Exercise 28-9

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 23 Practice Exercise 28-10

❒ Read the following report to assign the appropriate codes for each dictation. Record the ICD-9-CM code(s) and CPT code(s) in the spaces provided. For future reference, you may want to record the coding pathways.

EMERGENCY DEPARTMENT REPORT.

CHIEF COMPLAINT:	Respiratory distress and fever x 12 hours.
HISTORY OF PRESENT ILLNESS:	This 20-month-old Caucasian male began coughing yesterday late afternoon. Fever and coughing were aggravated in the evening. Patient was given Tylenol and slept well. Today at 8:00 a.m., the patient showed respiratory distress and increased mucous secretions.
PAST HISTORY:	The patient experienced similar symptoms four months ago, but they were relieved spontaneously. The patient is the product of a normal spontaneous vaginal delivery. Birth weight: 6 pounds 1 ounce.
ALLERGIES:	NONE.
FAMILY HISTORY:	No family history of maternal or paternal diabetes, hypertension or tuberculosis.
REVIEW OF SYSTEMS:	Noncontributory.
PHYSICAL EXAMINATION	
CONSTITUTIONAL:	PULSE: 168/min. RESPIRATORY RATE: 38/min and labored. TEMPERATURE: 104.4ºF.
HEENT:	Increased nasal discharge. Trachea midline. TMs clear. Pharynx not examined.
NECK:	Supple. No jugular venous distention.
HEART:	Sinus rhythm with tachycardia. No murmurs.
LUNGS:	There is inspiratory wheezing and respiratory retraction bilaterally. Tachypnea is present. There are bilateral rhonchi. No areas of consolidation.
ABDOMEN:	Soft and flat. No organomegaly.
EXTREMITIES:	No venous distention.
NEUROLOGIC:	No neurologic deficits. Moves all extremities well.
IMPRESSION:	Croup. Rule out epiglottitis.
PLAN:	NPO. Lateral neck film to rule out subglottic edema. Thirty percent oxygen mist tent. Racemic Eepinephrine 0.125 mL in 2.5 mL normal saline. Tylenol p.r.n. for fever. Intubation precautions until radiographic evidence of subglottic edema is excluded.

ICD-9-CM: _____

CPT: _____

Step 24 Review Practice Exercise 28-10

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 25 Lesson Summary

❒ You've made it through the comprehensive E/M Practice Exercises! The process of coding Evaluation and Management is a tedious one, but, with practice, it does become easier. Once you begin your medical coding career with a specific physician, you will become comfortable with the dictation style. As you are able to find the information quickly, your coding will be faster as well. You might even find yourself memorizing the information so you don't have to reference the charts as much! This will come by using the information daily. Until that time, be sure to use your reference materials for accurate coding.

Step 26 Mail-in Quiz 28

❒ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instructions and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Quiz Cover Sheet. Use only blue or black ink.

d. **Important!** Please fill in all information requested on your Quiz Cover Sheet or when submitting your Quiz online.

e. Submit your answers to the school.

Mail-in Quiz 28

Read the following medical records. Use the *ICD-9-CM* to assign all necessary diagnostic codes. Use the *CPT* to determine the correct code from the E/M section. Apply modifiers if applicable. Each code is worth 3 points. E/M codes with key components are worth 4 points.

1. Scenario 1

INITIAL OFFICE VISIT

HISTORY	
CHIEF COMPLAINT:	One-month history of increasing ethanol use, nausea, vomiting, diarrhea, abdominal pain and increasing girth.
HISTORY OF PRESENT ILLNESS:	The patient is a 52-year-old Caucasian man with a history of ethanol abuse since age 15. He was hospitalized for two months for alcoholic liver disease. He states that he started drinking one month ago and wants to stop drinking secondary to the above complaints. He also complains of hot and cold flashes. He denies history of upper GI bleeding, hematomas, hematochezia, melena. No history of withdrawal seizure or PUD or pancreatitis.
PAST HISTORY:	Except as noted in the HPI, status post ventral hernia repair and gout x 4 years.
MEDICATIONS:	Lasix and antacids.
ALLERGIES:	NO KNOWN DRUG ALLERGIES.
FAMILY HISTORY:	No family history of diabetes, hypertension, coronary artery disease or carcinoma.
REVIEW OF SYSTEMS:	
HEENT:	Intermittent epistaxis x 1 month.
CARDIORESPIRATORY:	Chronic cough productive of white sputum. Hypertension for many years, treated with Lasix.
GASTROINTESTINAL:	As noted in HPI.
GENITOURINARY:	Occasional nocturia.
MUSCULOSKELETAL:	Joint pain, swelling, and back pain secondary to gout.
PHYSICAL EXAMINATION	
GENERAL:	The patient is a well-developed obese male in no acute distress with ketotic breath.
HEENT:	PERRLA. Funduscopic exam shows anterior narrowing bilaterally.
HEART:	Regular rate and rhythm. The PMI is at the fifth intercostal space at the midclavicular line. No murmur or bruits are heard.

LUNGS:	Normal to inspection, palpation, percussion and auscultation.
ABDOMEN:	There is 1+ right upper quadrant and periumbilical tenderness without rebound or guarding. There is a reducible ventral hernia present. Normal bowel sounds. The liver edge is 9 cm below the right costal margin. The spleen is not palpable. There is shifting dullness present and a questionable fluid wave present.
RECTAL:	The stool is guaiac negative.
EXTREMITIES:	There is trace edema in both ankles. There is no clubbing, cyanosis, deformity or tenderness. Range of motion is normal. No ulcers or trophic changes are present. The pulses are 2+ and equal bilaterally.
NEUROLOGIC:	Unremarkable.
IMPRESSION:	1. Alcoholic liver disease, rule out hepatitis. 2. Doubt delirium tremens. 3. Hypertension. 4. Reducible ventral hernia. 5. Rule out pancreatitis. 6. Asymptomatic gout.
PLAN:	Serial blood pressure sitting and recumbent; SGOT, SGPT, LDH, alkaline phosphatase, serum amylase and urinalysis; abdominal sonography to rule out ascites. Give thiamine and folic acid supplements and continue Lasix for ascites. Consider abdominocentesis for protein and culture if ascites is present.

ICD-9-CM:	**E/M:**
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_____	
_____	

2. Scenario 2

UROLOGY OFFICE CONSULTATION REPORT

REASON FOR REFERRAL:	Probable systemic lupus erythematosus.
HISTORY OF PRESENT ILLNESS:	Patient was told she had SLE in 1998.
PAST HISTORY:	
ILLNESSES:	Lupoid hepatitis, 1998.
OPERATIONS:	Renal biopsy. Hepatic biopsy.
REVIEW OF SYSTEMS:	
HEENT:	Conjunctivitis and iritis.
CARDIORESPIRATORY:	Pleuritic chest pain.
GASTROINTESTINAL:	Vague abdominal pain.
GENITOURINARY:	Edema.
PHYSICAL EXAMINATION:	
GENERAL:	The patient is a 50-year-old female with obvious pedal edema.
CHEST:	
HEART:	RRR.
LUNGS:	Clear.
BREASTS:	Normal.
ABDOMEN:	Hepatomegaly. No shifting dullness or fluid waves.
EXTREMITIES:	There was 3+ pitting edema in both lower extremities.
DATABASE:	Sodium 135, potassium 4.6, calcium 7.6, phosphorus 2.7, total protein 4.5, albumin 1.9, BUN 25, creatinine 1.1, uric acid 5.2. Hemoglobin 13.6, hematocrit 42.1, sedimentation rate 35. WBCs 5,600 with 86 segs, 0 bands, 12 lymphs, MCV 93. The 24-hour urine protein is 10.57 gm, creatinine 828 mg. Q-panel: The 5'-nucleotidase was elevated at 12.98, anti-DNA negative, anticentromere negative, anti-smooth muscle negative, ANA positive at 195, anticardiolipin antibody normal and mitochondrial antibody normal.
ASSESSMENT:	1. Abnormal antinuclear antibody positive for lupus. 2. Nephrosis.
RECOMMENDATIONS:	Nephrology consultation for evaluation of renal status.

ICD-9-CM: **E/M:**

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3. Scenario 3

	ESTABLISHED PATIENT OFFICE VISIT
PROBLEM	Acute chest pain.
SUBJECTIVE:	The patient has long-standing osteoporosis and rheumatoid arthritis, under treatment with prednisone 40 mg p.o. daily. Yesterday, she experienced the onset of severe left chest pain in the left midaxillary line. She has had pleuritic pain and dyspnea since that time. There is no history of trauma. In addition, there is pain in the right ankle.
OBJECTIVE:	There is pinpoint tenderness in the midaxillary line over ribs 4-6. There is 3/5 limitation of motion of right ankle secondary to pain. Inversion-eversion motion 3/5. The femoral, popliteal, posterior tibial, dorsalis pedis pulses are full and equal bilaterally. The Achilles tendon reflexes are equal bilaterally. There is pronation deformity of the right ankle and minimal swelling of the right ankle. The tibiotalar joint appears to be well maintained. The taloscaphoid area has more swelling.
ASSESSMENT:	1. Rule out spontaneous rib fractures. 2. Rheumatoid arthritis. 3. Osteoporosis.
PLAN:	Rib series and rib taping if fractures are present. Bone survey with attention to the right ankle and foot. Orthopedic consultation for evaluation of right ankle and foot.

ICD-9-CM:

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E/M:

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4. Scenario 4

CHIEF COMPLAINT:	The patient is seen for an initial office visit complaining of a rash and itch in the left groin.
HISTORY OF PRESENT ILLNESS:	The patient indicates he has had jock itch in the past and was treated with ketoconazole.
PAST MEDICAL HISTORY:	Splenectomy at age 10 secondary to trauma. NO ALLERGIES.
REVIEW OF SYSTEMS:	Noncontributory.
EXAMINATION:	The patient is a 26-year-old male who appears well developed and well nourished. Vital signs normal.
HEENT:	PERRLA. EOMs intact.
HEART:	Normal.
CHEST:	Clear.
ABDOMEN:	NBS. No organomegaly.
GENITALIA:	Secondary dermatitic changes in the left inguinal fold are seen with lichenification. Diffuse erythema.
RECTAL:	Normal. Stool guaiac negative.
NEUROLOGIC:	DTRs intact.
IMPRESSION:	1. Tinea cruris.
	2. Cannot exclude candidiasis or dermatophyte infection.
PLAN:	Microsize griseofulvin 250 mg p.o. t.i.d. Wood's light examination. Culture for yeast infection to rule out Candida.

ICD-9-CM: _____

E/M: _____

5. Scenario 5

DISCHARGE SUMMARY

ADMITTING DIAGNOSIS:	Intermittent claudication
HISTORY OF PRESENT ILLNESS:	The patient was admitted with intermittent pain with walking and claudication after one block of walking. Cardiac exam revealed regular sinus rhythm with no murmurs, gallups, or rubs. Femoral, popliteal, posterior tibial, and dorsalis pedis pulses are 1+ on the left and 0 on the right. There was a 10 cm pulsatile mass in the periumbilical region of the abdomen.
LABORATORY DATA:	Aortic sonography shows a large aortic aneurysm that extends from at least the level of the diaphragm to the renal arteries. Thoracoabdominal CT demonstrated an aneurysm, extending from the aortic valve to the level of the renal arteries. EKG normal. Doppler 2D echocardiogram normal.
HOSPITAL COURSE:	On the third hospital day, a type I aortic aneurysm repair with graft replacement was performed. The postoperative course was uneventful.
DISPOSITION:	Discharged to home with visiting nurse daily to monitor peripheral pulses. Return to Cardiovascular Surgery Clinic in seven days.
DISCHARGE DIAGNOSIS:	1. Thoracic and abdominal aortic aneurysm, sparing the renal arteries; status post graft replacement. 2. Diffuse atherosclerotic disease without clinical evidence of coronary artery disease.
PROGNOSIS:	Good.
DISCHARGE MEDICATIONS:	Inderal 20 mg 1 p.o. q.i.d.
DISCHARGE MANAGEMENT:	4:15 p.m. – 4:43 p.m.

ICD-9-CM:

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E/M:

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6. Scenario 6

ORTHOPEDIC OFFICE CONSULTATION

SUBJECTIVE: The patient is a 37-year-old male with a history of Hansen's disease, lepromatous type. He has been on dapsone therapy 100 mg daily. A few days ago, he had started on thalidomide 100 mg q.d. as well. Today he complains of swollen and painful right knee along with possible subjective fever, although he denies any history of trauma, shaking chills, or sexual activity other than with his spouse and denies other joints involved.

OBJECTIVE: Physical exam reveals a male in no acute distress. Blood pressure: 130/90. Temperature: 98°F. Pulse: 80. Respirations 20. Chest is clear. Cardiovascular examination: Regular rate and rhythm. Abdomen: Positive bowel sounds. Nontender. Extremities: No cyanosis, clubbing, or edema. Scattered hyperpigmented macular lesions on the arms, trunk, and lower extremities. Musculoskeletal examination reveals a large, erythematous, tense effusion of the right knee with markedly decreased range of motion of the right knee. No other signs of synovitis or arthralgias are noted. Neurological exam was intact with the exception of scattered paresthesias in the lower and upper extremities. X-ray results from PCP show a very large effusion on the right knee.

ASSESSMENT: Right knee arthritis, probably secondary to Hansen's disease.

PLAN: A written report will be sent to PCP. Recommend arthrodesis and culture of right knee effusion.

ICD-9-CM: _____

E/M: _____

7. Scenario 7

EMERGENCY DEPARTMENT

CHIEF COMPLAINT:	Intermittent headaches for the past two weeks and vomiting and lethargy for the last day.
HISTORY OF PRESENT ILLNESS:	This is a 5-year-old male with myelomeningocele, ventriculoperitoneal shunt with four previous revisions. The last one was three years ago. He is currently under treatment for a UTI with Septra. For the last two weeks, the patient has had intermittent headaches relieved by Tylenol. He has had vomiting and lethargy for the last 24 hours. There is no history of fever, urinary tract symptoms, or diarrhea. No loss of consciousness, seizure activity or visual changes.
PAST HISTORY:	Immunizations are up to date including diphtheria, tetanus, and polio. Product of a cesarean section for breech, remaining in Neonatal ICU for 22 days. A VP shunt was placed for congenital hydrocephalus. The patient was not intubated. Repair of myelomeningocele and vesicostomy. Ventriculoperitoneal shunt revision performed four times. NO ALLERGIES.

SOCIAL HISTORY:	In special school, normal development. Walks with braces.
EXAMINATION	
GENERAL:	Sleepy, arousable, appropriate.
VITAL SIGNS:	Pulse: 68. Blood pressure: 108/62. Respiratory rate: 32 Temperature: 99.8°F. Weight: 18 kg.
HEAD:	Reservoir firm.
EYES:	PERRL. EOMs full.
EARS:	Tympanic membranes clear.
NOSE:	Clear.
NECK:	Supple.
HEART:	Regular rate and rhythm without murmurs.
LUNGS:	Clear.
ABDOMEN:	Soft, normal bowel sounds. Vesicostomy. No hepatosplenomegaly. Back: Well-healed myelomeningocele repair scar.
EXTREMITIES:	Warm. Pulses 2+. Capillary refill less than 2 sec.
NEUROLOGIC:	Moves all extremities, alert when aroused. DTRs 2+. Negative Babinski.
IMPRESSION:	1. Hydrocephalus with probable ventriculoperitoneal shunt malfunction in a child with closed fontanelle. 2. Potential for rapid deterioration with increasing hydrocephalus. 3. Urinary tract infection due to Escherichia coli.
PLAN:	Recommend neurosurgery consultation. Repeat urine culture, electrolytes, WBC with differential. NPO maintenance fluid, cardiac monitor. Continue Bactrim suspension.

ICD-9-CM:	**E/M:**
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8. Scenario 8

OFFICE VISIT

SUBJECTIVE: Patient returns with increasing malar rash. She complains of decreased strength in both wrists and elbows with minor pain in these joints. She has noticed a change in her personality, becoming more combative recently.

OBJECTIVE: This is an anxious 53-year-old female. The physical exam reveals 2/5 strength in both elbows and wrists. The triceps and biceps reflexes are 1+ bilaterally. There is an erythematous butterfly-shaped rash overlying the malar eminence of the face.

ASSESSMENT: The physical findings suggest systemic lupus erythematosus. Other possibilities include fibrositis, dermatomyositis, aseptic meningitis and rheumatoid arthritis.

PLAN: Recommend hospital admission for ANA, RA factor, hypercoagulation panel, thyroid panel, PT, PTT, lumbar puncture, lupus anticoagulation factor and electromyogram. Patient requests a second opinion and a consultation appointment is scheduled with the office of Dr. Jones. Feldene is prescribed for symptomatic relief.

ICD-9-CM: _____ **E/M:** _____

9. Scenario 9

A 23-year-old female has chronic diarrhea associated with abdominal pain, fever, anorexia, weight loss, and right lower quadrant fullness. She has had some previous workup for this condition as an outpatient and is now being admitted to the hospital for a barium enema and upper GI series with small bowel follow-through. The physical examination noted fever, RLQ abdominal pain, and chronic diarrhea. After completing a detailed history and examination, the gastrointestinal findings indicate leukocytosis and mild anemia. This suggests the presence of regional enteritis. The medical decision making was low complexity. The patient should expect a short stay in the hospital while determining the cause of her symptoms. Her admitting diagnosis is leukocytosis and mild anemia.

ICD-9-CM: _____ **E/M:** _____

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10. Scenario 10

A physician is called to ICU to provide care for a 15-year-old female with acute respiratory failure from asthma. The physician provides critical care support for one hour until the patient is stable.

ICD-9-CM: _____ **E/M:** _____

_____

Medical Coding Specialist
Mail-in Quiz 28

1. Fill in your **student ID** and your **course code** below.

STUDENT ID NUMBER _____ COURSE CODE _____

2. Be sure your **name** and **address** are filled in below.
3. **Transfer your answers** to this cover sheet.
4. Write the year of the coding manuals used to complete this quiz: ICD-9 _____ CPT _____.

For School Use Only:
Grade: _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

U.S. Career Institute
2001 Lowe Street
Fort Collins, CO 80525

CD-2

This Space for Instructor Use

Fold on dotted line

1. Scenario 1

ICD-9-CM:

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E/M:

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2. Scenario 2

ICD-9-CM:

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E/M:

_____

3. Scenario 3

ICD-9-CM:

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E/M:

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4. Scenario 4

ICD-9-CM:

_____

E/M:

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5. Scenario 5

ICD-9-CM:

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E/M:

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6. Scenario 6

ICD-9-CM:

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E/M:

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7. Scenario 7

ICD-9-CM:

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E/M:

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8. Scenario 8

ICD-9-CM:

_____

E/M:

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9. Scenario 9

ICD-9-CM:

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E/M:

_____

10. Scenario 10

ICD-9-CM:

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E/M:

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Congratulations!

You have completed Lesson 28

Do not wait to receive the results of your Quiz before moving on.

Coding Resources

Step 1 Learning Objectives for Lesson 29

❒ When you have completed the instruction in this lesson, you will be trained to do the following:

- ☞ List professional coding organizations and the services they offer.
- ☞ Explain credentialing and how it relates to coding.
- ☞ Explain the importance of professional liability insurance.
- ☞ Identify helpful coding-related print and Internet publications.

Step 2 Lesson Preview

❒ Imagine yourself on the first day of your new job as a Medical Coding Specialist. Picture yourself reading through exciting medical reports and using your *ICD-9-CM* and *CPT* to find the right code for each report. You've learned both diagnostic and procedural coding. You've practiced with both the *ICD-9-CM* and *CPT*. You're getting more and more comfortable with medical terminology and human anatomy. You can code for surgery, anesthesia, radiology, pathology and medicine. You've learned a lot!

In this lesson, we're going to step back from the "How to code" aspect of your training and take a look at your future career. As a medical coder, the *ICD-9-CM* and the *CPT* aren't your only allies. There are many organizations and resources available to help you succeed. This lesson is full of information to help you find the information and guidance you need. We'll compare the professional organizations that cater to coders. We'll discuss credentialing and certification options. We'll peruse the print and online resources that can help you stay abreast of changes in the coding field. In fact, you might be surprised at all the help that's out there for you!

Step 3 Associations for Professional Coders

❒ As you already know, medical coding is an essential component of the healthcare field. Over the years, a number of professional organizations have been created to help medical coders succeed. These organizations provide educational resources, community ties, job support and more. In the following sections, we'll take a look at some of the more prominent coding associations and the services they offer.

The American Health Information Management Association (AHIMA)

The American Health Information Management Association (AHIMA) is a membership organization representing more than 64,000 healthcare professionals. It provides reliable and valid information for all areas of health management. AHIMA began in 1928 as the Association of Record Librarians of North America (ARLNA). The purpose of this organization was to "elevate the standards of clinical records in hospitals and other medical institutions." This organization has undergone several name changes over the years. It became AHIMA in 1991.

AHIMA offers a number of services to their members. Among them are:

- Coding certification exams
- Communities of Practice
- Careers Assist: Job Board
- *Perspectives of AHIMA*
- *Journal of AHIMA*

The AHIMA provides reliable and valid information for all areas of health management.

American Health Information Management Association (AHIMA)
233 N. Michigan Avenue, 21st Floor
Chicago, IL 60601-5809
Phone: (312) 233-1100 or (800) 335-5535
Fax: (312) 233-1090
Email: info@ahima.org
Web: www.ahima.org

We'll discuss many of these services later in the lesson.

American Academy of Professional Coders (AAPC)

The American Academy of Professional Coders (AAPC) was founded in 1988 as the American Academy of Procedural Coders. The goal of the original organization was to provide education, recognition and certification for physician-practice procedural coders. The AAPC also sought to raise the procedural coding standards.

As you can see, the AAPC specializes in CPT coding. However, it has broadened its focus to include hospital coding and has introduced some aspects of inpatient procedure coding into its curriculum and testing services. Today, the AAPC represents coders who work for physicians, clinics, hospitals, outpatient facilities, payers and consulting firms. All in all, the AAPC has more than 118,000 members worldwide. Nearly 78,000 of those members are certified by the AAPC. Membership is open to not just coders, but billers and other medical information workers as well.

The AAPC offers the following coding-related services and programs:

- Coding certification exams and study guides
- Examination review classes
- Coding education
- An annual conference
- Local chapters
- AAPC publications

American Academy of Professional Coders (AAPC)
2480 South 3850 West, Suite B
Salt Lake City, UT 84120
Phone: 800-626-CODE (800-626-2633)
Fax: 801-236-2258
Email: info@aapc.com
Web: www.aapc.com

AAPC Career Edge

AAPC's Career Edge is a resource for coding jobs. It's a good place to both find jobs and keep an eye on what's in demand. Career Edge includes Coder's Connection classified advertising options on both the AAPC Web site and in the AAPC news magazine.

American Medical Association (AMA)

The American Medical Association (AMA) is a major professional organization in the world of health care. The AMA speaks out on important issues like patient rights and the health of the nation. They also created and maintain the *CPT*. The AMA Web site features a variety of valuable resources for the medical coder. Some of the AMA resources that you might find helpful include:

- CPT code information, including revisions
- CPT licensing
- Annual CPT educational symposium
- *CPT Assistant* coding journal
- *Journal of the American Medical Association (JAMA)*
- AMA Code of Medical Ethics

American Medical Association (AMA)
515 N. State Street
Chicago, IL 60654
Phone: 800-621-8335
Web: www.ama-assn.org

American Hospital Association (AHA)

The American Hospital Association (AHA) serves hospitals, healthcare networks, patients and communities. The AHA represents these people and organizations in the development of national healthcare policy. Some of the AMA resources you might find helpful include:

- Publications covering healthcare legislation
- Research on healthcare services and information management

American Hospital Association (AHA)
115 N. Walker Drive
Chicago, IL 60606
Phone: 312-422-3000 or (800) 424-4301
Fax: 312-422-4796
Web: www.aha.org

Step 4 Credentialing

❒ You've probably heard people use the term *credentials* before. Most likely, the word came up in a conversation about someone's qualifications for a job. In a market where there are so many people offering similar services, credentials help people let their customers know they are qualified to do a certain job. There are credentials for teachers, for home repair people, for attorneys and more! There are also credentials for medical coding specialists like you.

Think of all you have learned in your Medical Coding Specialist course! Just a short time ago, you probably knew very little about coding as a profession. Soon you will have all of the knowledge and experience you need to confidently begin your new career. Completing this course to become a medical coding specialist is the foundation upon which you will develop your professional skills.

Many medical coding specialists decide that credentialing is a good way to grow professionally and keep their skills up to date. Some employers require it, although not all. What's more important is that you can prove that you can do the work. Your USCI Medical Coding Specialist Diploma will help you do just that. Nonetheless, credentialing is a growing trend. Credentialing validates your skills and knowledge and sometimes allows for job advancement opportunities—and pay increases!

Whether or not you go for credentials is up to you. If you don't want to do it now, you can take that leap anytime in the future. There are still plenty of coding opportunities out there for uncredentialed coders!

However, to give you a taste of the credentialing, let's review some of the credentials you can get.

Coding Credentialing and Certification Options

Don't let all of the different acronyms confuse you. These are all just credentials to show you know how to code. A **credential** is a title you can add to your name and resume, as in Jane Smith, CCS. A **certificate** is a piece of paper that proves you have earned a credential or passed a course of study.

AHIMA offers three coding certification exams: *Certified Coding Associate (CCA), Certified Coding Specialist (CCS),* and *Certified Coding Specialist—Physician-based (CCS-P).* AAPC offers three exams: *Certified Professional Coder (CPC), Certified Professional Coder—Hospital (CPC-H)* and *Certified Professional Coder—Payer (CPC-P).*

So, let's take our tour of the coding credentials!

Certified Coding Associate (CCA)

The **Certified Coding Associate** (**CCA**) is an entry-level coding credential. If you are a new coder without much experience, you can immediately demonstrate your mastery of entry-level coding skills by earning the CCA. Earning a CCA also demonstrates a commitment to coding. It is a good starting point for coding credentials.

To take the CCA certification exam you must have a U.S. high school diploma or equivalent educational background. It is recommended that you have completed a formal coding training program, such as the one you're almost finished with! It is also recommended, although not required, that you have experience in hospital-inpatient and ambulatory-care medical coding. AHIMA notes that previous examination results indicate that persons who have three or more years of coding experience are more likely to pass the exam.

To download a free, comprehensive *Certified Coding Associate Handbook*, go to AHIMA's Web site. The handbook can be found at www.ahima.org/certification/documents/CCAhandbook.pdf. This handbook also explains the CCA exam process in detail.

Certified Coding Specialist (CCS)

Certified Coding Specialists (**CCS**) are skilled professional coders with solid experience classifying medical data from patient records. They generally come from a hospital setting. CCSs must be experts in the diagnostic and procedural coding systems. They must also be fluent in medical terminology, disease processes and pharmacology.

Examples of CCS level work include preparing coded data for Medicare and Medicaid recipients on the behalf of hospitals and medical providers. This data is also used by researchers and public health officials to monitor patterns and explore new interventions.

The CCS certification exam evaluates the individual's proficiency in coding. On top of entry-level coding skills, the CCS exam covers some information management skills. You would consider getting a CCS certification after you have experience in coding inpatient records. Experience coding the hospital portion of ambulatory surgery and emergency room care is also helpful. AHIMA recommends at least three years of experience before taking the CCS exam.

Certified Coding Specialist—Physician-based (CCS-P)

The third type of credentialing offered by AHIMA is the **Certified Coding Specialist—Physician-based** (**CCS-P**). CCS-P coding practitioners have expertise in physician-based settings. This can include doctors' offices, group practices, specialty centers and multi-specialty clinics. CCS-P coders have in-depth experience with diagnostic and procedural codes. They also are experts in health information documentation.

With the growth of managed care, the future looks good for this specialty. So if you develop solid experience and proficiency coding in a doctor's office, clinic or similar setting, you might want to consider obtaining the CCS-P certification to attest to your ability.

Certified Professional Coder (CPC)

The **Certified Professional Coder** (**CPC**) is the American Academy of Professional Coder's main coding certification. The CPC exam tests the student on diagnostic and procedural codes. In addition to the codes, CPCs have to keep current with compliance and reimbursement policies, as well as updating office forms and fee schedules based on code changes. CPCs can also take care of denied claims.

To become a CPC, two years of coding experience is recommended. However, you can waive one year of experience with successful completion of this course! You're almost halfway there.

Certified Professional Coder – Hospital (CPC-H)

The second credential offered by the AAPC is the **Certified Professional Coder – Hospital** (**CPC-H**). This credential focuses on hospital outpatient coding services. The exam covers the diagnostic and procedural coding systems.

Just like the regular CPC credential, a CPC-H should have at least two years of coding experience. You can also waive a year of that experience when you pass your Medical Coding Specialist course. On top of coding, CPC-Hs often are involved with the health information management aspect of health care. While some may code full time, many are experienced enough to help out where needed.

Certified Professional Coder-Payer (CPC-P)

The CPC-P demonstrates a coder's aptitude, proficiency and knowledge of coding guidelines and reimbursement methodologies for all types of services from the payer's perspective. Claims reviewers, utilization management, auditors, benefits administrators, billing service, provider relations, contracting and customer service staff can each benefit their practice with the CPC-P credential.

The CPC-P certification exam certifies that the successful candidate has the knowledge and skills to adjudicate provider claims effectively. The exam will test the examinee's basic knowledge of coding-related payer functions with emphasis on how those functions differ from provider coding. The relationship between coding and payment functions will be explored in depth.

The CPC-P exam consists of two parts, testing coding accuracy and reimbursement methodologies. The Medical Coding Concepts section will test the examinee's understanding of medical terminology, anatomy and diagnostic and procedural coding concepts. The Reimbursement Methodologies section will cover physician reimbursement, inpatient payment systems, outpatient payment systems, health insurance concepts and HIPAA.

This information is taken from: http://www.aapc.com/certification/cpc-p.aspx.

AAPC Apprentice Certifications

Many new coders have the education and basic knowledge to pass either the CPC or the CPC-H exams but not the required amount of experience. This is common with entry-level coders. To help these people out, the AAPC has created new credentials: the **Certified Professional Coder – Apprentice** (**CPC-A**), **Certified Professional Coder – Hospital – Apprentice** (**CPC-H-A**) and the **CPC-P-A**. If you successfully pass the test, you will be awarded these apprentice certifications. Like all of the other certifications, you will have to complete Continuing Education Units (CEUs). When you have completed the required work experience and submitted documentation for that work, your credentials will be upgraded to the full CPC, CPC-H or CPC-P!

ICD-10-CM Proficiency

As we continue our journey toward ICD-10 implementation, certified coders will need to show their proficiency in the new coding system. For holders of an American Academy of Professional Coders (AAPC) credential, all certified coders will have the opportunity to take the ICD-10 proficiency exam. The 75-question test will be a timed, online proficiency exam. The test will be open book, and coders have the opportunity to take it twice for the fee. AAPC will require its certified coders to pass this test to retain their certification.

For holders of a credential from the American Health Information Management Association (AHIMA), continuing education hours with ICD-10-CM/PCS content will be required, as applicable and relevant to the specific AHIMA credential(s) held by the individual. AHIMA certified professionals are required to participate in a predetermined number of mandatory baseline educational experiences specific to ICD-10-CM/PCS. These specific CEUs will count as part of the total required CEUs, by credential, per CEU cycle. So for example, if you hold an RHIA credential with AHIMA, you are required to have at least six CEUs dedicated to ICD 10-CM/PCS; 12 for the CCS-P credential; 18 for the CCS credential and so forth.

Certificants who hold more than one AHIMA credential are required to report only the highest number of CEUs from among all credentials held. For example, if an individual has both an RHIA and CCS, he or she would normally report 50 CEUs per recertification cycle, and 18 of those CEUs will be required to cover ICD-10-CM/PCS. AHIMA certified professionals may begin earning ICD-10-specific CEUs after January 1, 2011.

This information is taken from: http://blogs.hcpro.com/icd-10/.

You can contact either AHIMA or the AAPC for more information on all of these certifications. Before you move on to legal issues and coding resources, let's review what you've learned.

Step 5 Practice Exercise 29-1

❒ Match the acronym with its full name.

1. _____ **AHIMA**
2. _____ **AAPC**
3. _____ **AMA**
4. _____ **AHA**
5. _____ **CCA**
6. _____ **CCS**
7. _____ **CCS-P**
8. _____ **CPC**
9. _____ **CPC-H**
10. _____ **CPC-A**
11. _____ **CPC-H-A**

a. American Hospital Association
b. Certified Coding Specialist
c. American Health Information Management Association
d. Certified Professional Coder—Apprentice
e. American Medical Association
f. Certified Professional Coder—Hospital
g. Certified Coding Associate
h. American Academy of Professional Coders
i. Certified Professional Coder—Hospital—Apprentice
j Certified Professional Coder
k. Certified Coding Specialist—Physician-based

Step 6 Review Practice Exercise 29-1

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 7 Professional Liability Insurance

❒ When you begin your career as a professional medical coding specialist, you might be a self-employed contractor with a doctor's office or healthcare facility. Or you might work as an employee for a doctor or an outpatient facility. Whatever the case, as a professional coder you will be responsible for many decisions related to medical codes. Because of this, you are partially responsible for financial reimbursement for medical services provided to patients. Although it's not an everyday event, in today's medical environment of high costs and frequent lawsuits, an unintentional but significant error in your work could put you at risk for malpractice.

This is not meant to scare you. However, lawsuits are a growing trend in many professions today. Healthcare and medical coding are no exception. The best defense against a lawsuit is being properly trained and having *professional liability insurance*. You've taken the right step on the education front, so let's focus on liability.

Professional liability insurance is just what it sounds like. It's insurance to protect you if anyone decides to sue you for malpractice. In terms of coding, this might be because of some coding-related error. If you are sued, professional liability insurance typically pays for legal fees, court costs, court judgments and even out-of-court settlements. As those who have been sued for medical malpractice will tell you, the investment in liability insurance is worth the cost for the security and peace of mind it provides. Understand that if you are an employee, your employer should already have insurance. You won't need to worry about being protected. However, if you decided to form your own coding business, you would need to arrange for your own liability insurance.

Professional liability insurance is a wise investment for self-employed coders.

There are a number of sources you can contact to find out more about professional liability insurance. First, check with the American Health Information Management Association (AHIMA), the American Academy of Professional Coders (AAPC) and the American Medical Association (AMA). All of these organizations offer liability insurance packages to their members.

The obvious benefit of getting your insurance coverage from one of these organizations is that they are experts in your profession. They will be able to help you with the details of liability insurance for healthcare workers and medical coders.

The various medical coding resources we introduce in the following sections are also valuable sources of information on liability insurance.

Step 8 Coding Publications and Online Resources

❒ Whether you're just embarking on your coding career or are an experienced coder, you will need to be up to date on coding developments. You will always rely on resources to help you find codes and information on healthcare issues. Why are resources so important to coders? First because it is not humanly possible to remember every diagnostic or procedural code. Also, new and revised codes are published annually. Resources serve a number of functions:

- Reference books allow you to store the codes you don't use every day.
- Resources can provide you with the information right now, when you need it.
- Resources serve as a valuable support system if you are working independently as a coder or don't otherwise have much contact with other coders where you work.

The following organizations and resources will be very helpful to you in your new career. Consider them as a starting point from which to develop your own pool of coding resources. They will give you a good idea of what's available. You will recognize some of the organizations from earlier in the lesson; others will be new to you. You will also learn about other resources as you become more involved in the professional network of medical coders through these references and through your work. Some of your best resources may turn out to be experienced colleagues!

Should I Buy Reference Books?

Many new coders wonder if they should buy their own set of reference books. The answer is not yet. Wait and see where you will be working. If you work for a facility, you will more than likely have access to many of them through your work there. The facility will also make sure you have up-to-date code books, which will save you a lot of money!

American Academy of Professional Coders (AAPC)

AAPC Publications

Member of the AAPC, receive various publications to keep up-to-date on healthcare trends. These publications include *Coding Edge, EdgeBlast* and *BillingInsider.*

- *Coding Edge* is a monthly print publication that is written by and for members of the AAPC. Articles include issues facing the coding industry and updates on emerging trends and concerns. Members of the AAPC can subscribe to the coding news magazine.
- *EdgeBlast* is a newsletter distributed by e-mail twice a month to AAPC members. It includes summaries and links to important articles.
- *BillingInsider* is an e-newsletter available to members and nonmembers. Topics relate to the billing side of the medical practice.

American Health Information Management Association (AHIMA)

AHIMA Publications

AHIMA provides both online and in print publications relating to the healthcare field. These publications include the *Journal of AHIMA* and *Perspectives in HIM*. In addition, members have access to an online tool for healthcare professionals.

AHIMA's *Communities of Practice* (*CoP*) is an online tool that AHIMA members use to network, share, problem-solve and stay informed of the latest trends in HIM-related topics. This growing professional network provides answers, support and career advice using the latest technology.

The *Journal of AHIMA* is a monthly journal that includes both coding-specific and general health information management related articles. It also includes tips for on-the-job solutions and practical guidance on regulations, policies and procedures. This journal is available to nonmembers by subscription.

Perspectives in Health Information Management is a scholarly, peer-reviewed research journal that aims to advance health information management practice and encourage interdisciplinary collaboration between healthcare professionals and others in disciplines supporting the advancement of the management of health information. It's an online journal that is free to members and nonmembers.

AHIMA e-Newsletters

AHIMA e-newsletters are primarily for members of AHIMA. You can find a complete listing of the e-newsletters on the AHIMA Web site.

- *Academic Advisor* is a quarterly e-newsletter for HIM educators.
- *CodeWrite* is a monthly e-newsletter containing coding, reimbursement and compliance information.
- Members receive *AHIMA Advantage* electronically six times each year. This publication includes healthcare and AHIMA news. In addition, members receive *AHIMA Advantage E-Alerts* weekly, which deliver news summaries on industry, AHIMA and government news related to healthcare. Members can view the most recent issue on the *CoP*.

American Medical Association (AMA)

The AMA produces the *CPT Assistant*, the *Journal of the American Medical Association* and a slew of coding reference material, including express reference cards, specialty coding references and electronic data files of technical coding manuals.

The *CPT Assistant* is a monthly newsletter only available to AMA members. It provides detailed articles, commentaries and updates to keep your claims system running.

The *Journal of the American Medical Association* (*JAMA*) has been published continuously since 1883. It is an international peer-reviewed general medical journal published 48 times per year.[9] Its objective includes publishing original, important, valid, peer-reviewed articles on a diverse range of medical topics.

American Hospital Association (AHA)

The *Coding Clinic* is quarterly publication that provides official coding guidelines and advice. A subscription allows you to access past issues for updates about coding-specific conditions or procedures.

You can find out more about *Coding Clinic* by calling (800) 242-2626 or by checking out the AHA Web site at www.aha.org.

OptumInsight

OptumInsight, previously Ingenix, publishes many of the coding manuals. In addition, OptumInsight offers a comprehensive mix of coding, billing, reimbursement and compliance products in a wide array of formats and services. These include Web-based tools, books, desktop software and print and electronic updates.

Among the many publications that might be of particular interest to you as a healthcare document specialist are:

- *Coder's Dictionary*. This dictionary is written by coders for coders. It includes definitions for medical nomenclature, eponyms, new technology and acronyms.
- *DRG Expert.* The nation's DRG information experts bring you this annual book organized by Major Diagnostic Category (MDC) for accurate assignment of DRGs and maintenance of the highest level of data quality. This book is for those who need to either accurately assign DRGs or verify DRG information.
- *Uniform Billing Expert*. This reference tool assists in managing the constant changes to Medicare billing and reimbursement. It provides information about UB-04 billing rules and requirements.
- *Outpatient Billing Expert*. This reference applies to hospital outpatient departments and free-standing ambulatory surgical centers. It provides guidance to improve reimbursement and reduce denied claims.
- *Coder's Desk Reference for Diagnoses.* This reference allows you to better understand the clinical meanings behind codes. It provides coding tips and includes coding scenarios to demonstrate the application of the codes.
- *Coder's Desk Reference for Procedures.* This manual helps you identify the differences between CPT codes that seem very similar.

OptumInsight
2525 Lake Park Blvd.
Salt Lake City, UT 84120
(801) 464-3649
www.optumcoding.com

Just Coding Web Site

Just Coding

The *Just Coding* Web site provides answers to coding questions, access to coding articles and discussion groups, a free e-newsletter, job opportunities and a number of links to other helpful Web sites. Among the useful tools and links are the following:

- Continuing Education credits via articles, quizzes or Webcasts
- Coding and reimbursement updates
- Boot Camps, conferences and Webcasts
- Coding guidance, practice questions and expert analysis
- CPC practice exam and Job Board

JustCoding.com
75 Sylvan Street
Suite A-101
Danvers, MA 01923
(800) 650 6787
www.justcoding.com

National Institute of Health (NIH)

The National Institute of Health is the steward of medical and behavioral research for the United States. NIH funds scientific studies at universities and research institutions across the country. NIH is made up of 27 Institutes and Centers, each with a specific research agenda, often focusing on particular diseases or body systems.

If you visit the NIH Web site and enter a search on "medical coding", you will find a wide range of resources. There are publications, reports and research documents available, all related to coding. In the field of medical coding, the impact of ongoing medical research is great. As you know, the coding manuals are constantly being updated and revised to reflect new information that becomes available in medicine. The NIH is one of the primary resources for the details of such research.

National Institute of Health (NIH)

9000 Rockville Pike

Bethesda, MD 20892

Phone: 301-496-4000

Web: www.nih.gov

Web site for locating topic-specific toll-free NIH phone numbers: www.nih.gov/health/infoline.htm

Other Coding Resources

A number of other companies and organizations provide a variety of healthcare professional resources. Here are a few that you might want to check out as you develop your network of resources.

For The Record

For The Record is published biweekly and provides reliable information on a range of health information issues. The subscription is free to members of the AACP and some members of AHIMA. The magazine is available in print, digital or both. For more information, visit the Web site at www.fortherecordmag.com or call (800) 278-4400.

Advance for Health Information Professionals

Advance for Health Information Professionals offers a free e-newsletter that provides an editorial advisory board, hands-on help and CCS prep information. You'll also receive notices on free Advance Job Fairs and job postings. The Web site for this publication is http://health-information.advanceweb.com. To subscribe by phone, call (800) 355-1088.

MedicalCoding.net

MedicalCoding.net was founded in 2001. It is a subsidiary of Provistas, Inc. *MedicalCoding.net* presents a variety of medical coding, billing and compliance books, eBooks, data files, claims forms and software to complement Provistas' educational and consulting programs. Provistas is focused on providing Medicare compliance solutions to hospital and physician-practice clients. You can also subscribe to e-mail news at the Web site www.medical-coding.net or call (888) 288-2043.

The Coding Institute

The Coding Institute is a national newsletter publishing company. This group offers a wide range of medical specialty newsletters, coding bulletins, audio conferences, video coding series, CDs, print transcripts and online discussion groups. Contact *The Coding Institute* for information about free, sample newsletters at (800) 508-2582 or www.codinginstitute.com.

RAmEX Ars Medica, Inc.

RAmEX Ars Medica, Inc. distributes medical multimedia materials for professionals, including healthcare document specialists. Resources include medical CD-ROMs, medical videos, medical books, medical journals, medical slides, medical audio tapes and other medical software covering a broad range of medical fields and topics. You can find out more about RAmEX Ars Medica products by visiting the Web site at www.ramex.com or calling (800) 633-9281.

Online Medical Dictionaries

If you have Internet access, perhaps you've discovered the handiness of online dictionaries. Many of them are even free! In particular, the medical dictionaries listed below can be an excellent source of information and support. Some of these Web sites include a variety of medical information and resources in addition to the dictionary. Take a few minutes to visit each Web site and bookmark them for future reference.

- www.online-medical-dictionary.org
- www.medical-dictionary.com
- www.medic8.com/MedicalDictionary.htm
- www.medterms.com
- www.medicinenet.com
- www.sciencekomm.at/advice/dict.html

Coding Discussion Groups

We've already referred to a couple of medical coding discussion groups previously in the lesson. For example, AHIMA's Communities of Practice and the Just Coding Web site. Your coding know-how and contact list will grow as you actively participate in some of these online groups. Here are some links to a couple of other discussion groups you may find helpful.

- The Coding Institute: www.codinginstitute.com/links/Discussion_Groups/more2.html
- Medical Coding Zone: www.pub169.ezboard.com/bmedicalcodingzone

Step 9 Career Opportunities and Job Listings

❒ Now the section you've been waiting for: job listings! You've probably already been thinking about possible job opportunities for when you finish your studies. You may have even checked out some Web sites or coding publications. In addition to any local opportunities in doctors' offices or medical facilities, you can find a number of possible leads through the Internet. We've already covered several of these—the AHIMA job bank, the AAPC Career Edge job listings and the Just Coding Web site. There are many more online possibilities.

After you've checked out these three, you may want to see if any of the other resources listed in this lesson include job listings or links to Web sites with job listings. Discussion groups are also an excellent starting place for your job search. Established coders can give you job-hunting advice and recommendations, on and offline. When it comes to finding work, networking is a must. You can also do a general Internet search using a search engine like Google, Yahoo and Ask.

The following is an example from an actual Web site of one company that offers a placement service for medical coding jobs:

Brown Consulting Associates, Inc.
P.O. Box 468
Twin Falls, Idaho 83303
Phone: (208) 736-3755
Fax: (208) 736-1946
Web: http://medicalcodingjobs.com

Welcome to the original and most complete medical-coding specific Web site, which instantly links employers with skilled medical coding professionals from around the nation.

Medicalcodingjobs.com is quickly becoming the nation's best resource for locating and hiring medical coders. The site is viewed daily by professional coders in search of new and challenging opportunities.

Employee Applicants may search the job openings 24 hours a day free of charge. All qualified candidates are encouraged to post a free, detailed profile on the site listing their skills and qualifications. These confidential postings are available to subscribing companies only. To post your listing simply click on the "New Employees" link.

Employers can join the growing number of hospitals and physician offices and clinics who are utilizing Medicalcodingjobs.com to attract and locate professional coders subscribing to this site. One annual subscription fee provides your company with the ability to post unlimited job openings and have unlimited access to the Medicalcodingjobs.com database of 1,200 qualified candidates. There are no other fees or costs associated with the site. To become a subscribing company, click the "New Employers" link on the left.

The Instant E-mail option is available to all Employee Applicants and Subscriber Companies. This option immediately sends the detailed information to all Employee Applicants when a new company or job is added. The Instant E-mail option also allows Subscriber Companies as well as Employee Applicants to individually and confidentially communicate with each other regarding job openings posted on this site.

This is the most complete and cost effective resource for staffing your company's medical coding department! Now let's get started! Use the navigation bars to the left to view our site and learn more about medicalcodingjobs.com.

A note of caution: if you seek the help of a professional employment company to find a job, be sure to ask up front about any fees. Some companies charge for their job-hunting services, and sometimes these fees can be quite high. You want to know before you say yes whether or not their services and the likelihood of your finding a job with them are worth the cost.

Step 10 Practice Exercise 29-2

❒ Match the coding resource with the company or organization where you can find it. Some answers may be used more than once.

1. ____ ***The Academy CODING EDGE***
2. ____ **The *CPT Assistant***
3. ____ ***Coding Clinic***
4. ____ ***Coder's Desk Reference for Diagnoses***
5. ____ ***Coder's Desk Reference for HCPCS Level II***
6. ____ ***Coder's Desk Reference for Procedures***
7. ____ ***Advance* magazine**

a. Ingenix
b. AHIMA
c. AMA
d. AAPC
e. AHA

Step 11 Review Practice Exercise 29-2

❒ Check your answers with the Answer Key at the back of this book. Correct any mistake you may have made.

Step 12 Lesson Summary

❒ You've probably heard the expression "the more you know…" When it comes to medical coding, that saying is exactly right. As a coder, you must keep up to date with coding regulations, medical advances and professional trends. The resources in this lesson are your Yellow Pages, grapevine and encyclopedia, all rolled into one. Whether you're searching for information on the latest coding changes or listings for available jobs, these resources are a great place to start. As you explore these resources and network with other coders, you'll no doubt find other resources you like.

Don't feel overwhelmed. There's more information in these resources than anyone could read through. What's important is that you know where to begin your search if you have any questions. You've learned more than enough about coding in this course to begin your career!

One final note: Website addresses and phone numbers change frequently. The addresses and numbers listed in this lesson were current at the time of printing, but they may change in the future. You may want to keep a list of your favorite resources and update the contact information regularly.

Step 13 Mail-in Quiz 29

❒ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 29

Choose the best answer from the following choices. Each item is worth 6.67 points.

1. The two main associations for coders are _____.

a. AHIMA and AHA
b. AMA and AHA
c. AAPC and AHIMA
d. AHA and AAPC

2. AHIMA's Communities of Practice is a(n) _____.

a. networking tool to meet other coders and find information
b. online store to purchase coding manuals
c. collection of practice exams for the CCS exam
d. group of healthcare providers who advise AHIMA members

3. The AAPC offers ____ as a coding-related service.

a. AHIMA journal
b. Career Edge job listing
c. CPT licensing
d. CPT Assistant coding journal

4. Credentials can help you ____.

a. find work
b. get promoted
c. get raises
d. all of the above

5. Entry-level coders can earn a(n) ____.

a. CCA
b. CPC-H
c. AMA
d, CCS

6. CCSs must be ____.

a. experts in the diagnostic coding system
b. fluent in medical terminology
c. experts in the procedural coding system
d. all of the above

7. Professional liability insurance protects you if you ____.

a. get hurt on the job
b. accidentally hurt someone on the job
c. make a mistake and get sued
d. are robbed

8. Professional liability insurance is ____.

a. required by law for all coders
b. recommended for all self-employed coders
c. a waste of money
d. automatically provided to all credentialed coders

9. Which of the following is not a reason for using coding resources? _____

a. Reference books allow you to store the codes you don't use every day.

b. Resources can provide you with the information right now, when you need it.

c. Resources answer coding questions which come up, so you don't have to know the steps for diagnostic and procedural coding.

d. Resources serve as a valuable support system if you are working independently as a coder or don't otherwise have much contact with other coders where you work.

10. You can find a list of reference tools for coders recommended by the Office of the Inspector General at which Web site? _____

a. www.ingenix.com

b. www.justcoding.com

c. www.codinginstitute.com

d. www.medicalcodingjobs.com

11. To find out about current medical research being conducted by the government, you could go to _____.

a. www.ramex.com

b. www.medterms.com

c. www.medical-coding.net

d. www.nih.gov

12. _____ is a national medical newsletter publishing company.

a. Provistas

b. The Coding Institute

c. RAmEx Ars Medica, Inc.

d. None of the above

13. www.medterms.com, www.medicinenet.com and www.sciencekomm.at/advice/dict.html are all _____.

a. discussion boards

b. online publications

c. medical dictionaries

d. liability insurance providers

14. Networking is useful for _____.

a. locating jobs

b. finding answers for coding questions

c. neither a nor b

d. both a and b

15. The AHIMA job bank, the AAPC Career Edge job listings and the Just Coding Web site are _____.

a. great places to begin looking for a coding job

b. only open to experienced coders

c. your final resort in your job search

d. generally unhelpful resources

Congratulations!

You have completed Lesson 29

Do not wait to receive the results of your Quiz before moving on.

HCPCS Coding

LESSON 30

Step 1 Learning Objectives for Lesson 30

❒ When you have completed the instruction in this lesson, you will be trained to do the following:

- ☞ Discuss the history and purpose of *HCPCS*.
- ☞ Explain how the *HCPCS* manual is structured.
- ☞ Explain how to code for supplies using *HCPCS* manual.
- ☞ Discuss the *HCPCS* modifiers.

Step 2 Lesson Preview

❒ As a medical coding specialist, most of the time you'll be using the *ICD-9-CM* and *CPT* manuals to code diagnoses and procedures. However, there is a third coding manual: *HCPCS Level II*. These codes allow you to code for medical supplies and special procedures. In this lesson, you'll learn about the history and purpose of *HCPCS*. You'll also get a tour of the *HCPCS* manual and learn how to use it.

Step 3 History of HCPCS

❒ HCPCS codes were actually first developed by the insurance company Blue Cross/Blue Shield (BC/BS). BC/BS wanted more information from the medical providers than they could get from *CPT* codes. BC/BS wanted to know if a stent was used during a cardiac catheterization and if the doctor used a plaster cast or a fiberglass cast to stabilize a fracture. To gather this information, BC/BS developed a set of codes which would become *HCPCS Level II*. Not only did this code set contain codes for supplies, but it listed additional procedures not included in the *CPT*.

This worked great for Blue Cross/Blue Shield, but then other insurance companies started coming up with their own set of codes for supplies. Pretty soon, medical coders and billers had to deal with many different systems for all of the different insurance companies. Needless to say, this caused a lot of problems and headaches. Pretty soon, Medicare noticed what was happening and decided that they would develop a nationwide standard for supply and additional procedure codes.

HCPCS stands for **Healthcare Common Procedure Coding System**. The Centers for Medicare and Medicaid Services (CMS) developed these codes in 1983 and update the codes every year. Like the *ICD-9-CM* and *CPT*, it is important to always work from the most current edition. In this course, we will refer to HCPCS Level II, 2013 published by Optum.

Why Use HCPCS?

HCPCS codes are very important in the medical billing process. HCPCS codes help the provider describe exactly what was done to a patient during their visit or stay. While the *CPT* focuses on the procedure, *HCPCS* allows the provider to account for gauze, sutures, syringes and other supplies used during procedures. While the *CPT* includes codes for the administration of drugs, *HCPCS* includes codes for the actual drugs themselves. By using HCPCS codes, the provider can be more fully reimbursed.

HCPCS codes cover medical supplies.

Step 4 How the *HCPCS* Manual Is Designed

- *HCPCS Level II* is designed a lot like your *CPT* or your *ICD-9-CM* coding books. It is divided into two sections. You have an *Index*, which is arranged alphabetically, and a *Tabular List*, which is arranged by topic. In each book, the *Tabular List* is broken down differently:
  - In the *ICD-9-CM*, the *Tabular List* is broken down by body system.
  - In the *CPT*, the *Tabular List* is broken down by procedure.
  - In the *HCPCS Level II*, the *Tabular List* is broken down by the service.

HCPCS codes are alphanumeric. This means that they include both letters and numbers. HCPCS codes are made up of one letter and four numbers, such as G0168. Each subsection in the *HCPCS* manual has its own letter. In addition, each subsection covers a different type of service.

Later in the lesson, we'll take a closer look at the services covered in the *HCPCS Level II*. But first, let's take a look at the steps for HCPCS coding.

Step 5 Steps for HCPCS Coding

❒ At the front of the *HCPCS Level II* manual, you'll find instructions on how to code for HCPCS. While there are some differences, you'll be familiar with many of these steps from all of your *ICD-9-CM* and *CPT* practice. Let's walk through the steps:

1. First, read through the documentation and identify the services or supply received.
2. If a procedure is not listed in the *CPT* or if you're coding for supplies, look up the term in the *Index* of the *HCPCS Level II*. The term could be a drug administered, such as Lasix, or a supply, such as crutches.
3. Locate a tentative code or codes.
4. Turn to the *Tabular List* of the manual and locate your tentative code or codes.
5. Read through the code descriptions for all tentative codes.
6. Check for color bars, notes, symbols and references.
7. Review the appendices for the reference definitions and other guidelines for coverage issues that apply.
8. Determine whether any modifiers should be used.
9. Assign the correct code.

As you can see, coding for HCPCS is similar to coding diagnoses or procedures. First you locate the terms, and then you find them in the *Index*. In the *Index* you'll find a list of tentative codes which you find in the *Tabular List*. Once you find your tentative codes, you read the descriptions and all the guidelines, notes and information affecting that code. Then, after adding any modifiers, you're ready to assign your code!

Color Bars, Notes, Symbols and References

Depending on the publisher, the bottom of each page of the *Tabular List* of the *HCPCS* coding manual will have reference symbols that will help you understand some of the billing subtleties of each code.

Once you begin coding for a physician's office or outpatient facility, you will be able to identify the patient's insurance carrier. The **red bar** at the bottom of each *Tabular List* page indicates services that are not covered by Medicare.

The **yellow colored bar** indicates services that are subject to carrier discretion. The medical coding or billing specialist will need to check with the specific insurance carrier if one of these codes is assigned for services provided.

The **blue bar** indicates that there are special coverage instructions. Sometimes you will find CIM (*Coverage Issues Manu*al) and MCM (*Pub 100 Medicare Carriers Manual*) **reference numbers** may be included after the code descriptions. You can locate the crosswalks for these reference numbers in *Appendix 4 - PUB 100/NCD Reference.* The publications can be found on the CMS Web site: www.cms.hhs.gov/manuals.

Some codes can only be billed in a certain quantity, such as supplies for durable medical equipment. The symbol for quantity alert is a **white box outlined in red with a red check** inside. It will be found to the left of the code number.

Some of the symbols below you will recognize from your previous studies:

● New Code

○ Recycled/Reinstated Code

▲ Revised Code

In the following example a **line** has been drawn through the code indicating that it is no longer used. ~~K0652 Skin protection wheelchair seat cushion, width less than 22 in., any depth~~

There are also the traditional male and female symbols to help medical coders know if the service is appropriate for a patient of a certain gender.

DURABLE MEDICAL EQUIPMENT E0100-E9999

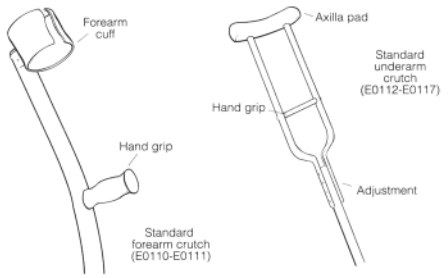
E codes include durable medical equipment such as canes, crutches, walkers, commodes, decubitus care, bath and toilet aids, hospital beds, oxygen and related respiratory equipment, monitoring equipment, pacemakers, patient lifts, safety equipment, restraints, traction equipment, fracture frames, wheelchairs, and artificial kidney machines.

CANES

Y **E0100** **Cane, includes canes of all materials, adjustable or fixed, with tip**
White canes for the blind are not covered under Medicare.
MED: 100-2,15,110.1

Y **E0105** **Cane, quad or 3-prong, includes canes of all materials, adjustable or fixed, with tips**
MED: 100-2,15,110.1

CRUTCHES



Y ☑ **E0110** **Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips**
MED: 100-2,15,110.1

Y ☑ **E0111** **Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips**
MED: 100-2,15,110.1

Y ☑ **E0112** **Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips**
MED: 100-2,15,110.1

Y ☑ **E0113** **Crutch, underarm, wood, adjustable or fixed, each, with pad, tip, and handgrip**
MED: 100-2,15,110.1

Y ☑ **E0114** **Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips, and handgrips**
MED: 100-2,15,110.1

Y ☑ **E0116** **Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each**
MED: 100-2,15,110.1

Y ☑ **E0117** **Crutch, underarm, articulating, spring assisted, each**
MED: 100-2,15,110.1

E ☑ **E0118** **Crutch substitute, lower leg platform, with or without wheels, each**
Medicare covers walkers if patient's ambulation is impaired.

WALKERS

Y **E0130** **Walker, rigid (pickup), adjustable or fixed height**
MED: 100-2,15,110.1

Y **E0135** **Walker, folding (pickup), adjustable or fixed height**
Medicare covers walkers if patient's ambulation is impaired.
MED: 100-2,15,110.1

Y **E0140** **Walker, with trunk support, adjustable or fixed height, any type**
MED: 100-2,15,110.1

Y **E0141** **Walker, rigid, wheeled, adjustable or fixed height**
Medicare covers walkers if patient's ambulation is impaired.
MED: 100-2,15,110.1

Y **E0143** **Walker, folding, wheeled, adjustable or fixed height**
Medicare covers walkers if patient's ambulation is impaired.
MED: 100-2,15,110.1

Y **E0144** **Walker, enclosed, 4 sided framed, rigid or folding, wheeled with posterior seat**
MED: 100-2,15,110.1

Y **E0147** **Walker, heavy duty, multiple braking system, variable wheel resistance**
Medicare covers safety roller walkers only in patients with severe neurological disorders or restricted use of one hand. In some cases, coverage will be extended to patients with a weight exceeding the limits of a standard wheeled walker.
MED: 100-2,15,110.1

Y **E0148** **Walker, heavy-duty, without wheels, rigid or folding, any type, each**

Y **E0149** **Walker, heavy-duty, wheeled, rigid or folding, any type**

ATTACHMENTS

Y ☑ **E0153** **Platform attachment, forearm crutch, each**

Y ☑ **E0154** **Platform attachment, walker, each**

Y **E0155** **Wheel attachment, rigid pick-up walker, per pair**

Y **E0156** **Seat attachment, walker**

Y ☑ **E0157** **Crutch attachment, walker, each**

Y ☑ **E0158** **Leg extensions for walker, per set of 4**

Y ☑ **E0159** **Brake attachment for wheeled walker, replacement, each**

COMMODES

Y **E0160** **Sitz type bath or equipment, portable, used with or without commode**
Medicare covers sitz baths if medical record indicates that the patient has an infection or injury of the perineal area and the sitz bath is prescribed by the physician.

Y **E0161** **Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)**
Medicare covers sitz baths if medical record indicates that the patient has an infection or injury of the perineal area and the sitz bath is prescribed by the physician.

Y **E0162** **Sitz bath chair**
Medicare covers sitz baths if medical record indicates that the patient has an infection or injury of the perineal area and the sitz bath is prescribed by the physician.

Special Coverage Instructions | Noncovered by Medicare | Carrier Discretion | ☑ Quantity Alert | ● New Code | ○ Recycled/Reinstated | ▲ Revised Code

notes

symbols

color bar

Details of the legend can be found in the introduction section of the HCPCS manual. Many of the symbols and edits are used by medical coders who work for providers who specialize in certain types of service, such as providing medical equipment or skilled nursing facilities.

Appendices

HCPCS Level II contains a number of appendices full of useful information. These appendices are used to help you find the right code. Again, the contents may vary by publisher. Let's take a quick peek at each one and see how to use it.

- **Appendix 1—Table of Drugs**
  This appendix directs the user to drug titles and the corresponding J code. Both generic and brand names are listed alphabetically in the *Table of Drugs*. A *Physicians' Desk Reference* (PDR) is a good resource for the medical coder when using this appendix. The unit column in this table refers to the standard minimum usage for each drug. The drug table also references the route of drug administration by the use of acronyms. The definition of each acronym is found in the introduction section of *Appendix 1 – Table of Drugs*. With a few exceptions, oral administration is not included because this type of drug is usually provided by a pharmacy after a visit to the physician.

- **Appendix 2—Modifiers**
  Appendix 2 contains numerous HCPCS modifiers. They help the medical coder indicate such things as the number of wounds, the type of provider, anatomical sites and various other situations or circumstances. If the modifier applies, it must be included.

- **Appendix 3—Abbreviations and Acronyms**
  Appendix 3 includes abbreviations and acronyms included in the HCPCS code description. If you are unsure of how to interpret an acronym, you can refer to this appendix for clarification.

- **Appendix 4—Pub 100**
  Appendix 4 references revisions made by CMS to the HCPCS codes and their definitions. You will also find text to match Medicare PUB 100 reference numbers that are included with some of the HCPCS codes.

- **Appendix 5—New, Changed, Deleted, and Reinstated HCPCS Codes for 2013**
  This appendix is self-explanatory and is an easy reference for new, changed, deleted or reinstated codes.

➲ **Appendix 6—Place of Service and Type of Service**
The final appendix in the *HCPCS* manual contains place of service and type of service codes. The codes in this section appear on the CMS-1500 claim form to specify the entity or facility that provided services. Place of Service codes are two-digit numbers, while the Type of Service codes are alphanumerical and contain two or three digits. Type of Service codes are also known as BETOS (Berenson-Eggers Type of Service) codes, and they apply to established clinical categories.

Now let's take a closer look at the subsections found in the *HCPCS Level II*.

Step 6 Sections of the *HCPCS* Manual

❒ Each subsection of the *Tabular List* in the *HCPCS* manual has its own letter. There are 16 subsections: A, B, C, E, G, H, J, K, L, M, P, Q, R, S, T and V. Each one of these sections covers a different area of medicine. These include dental services, pathology and lab services, drugs administered to patients and more. Let's take a brief look at what you can expect to find in each subsection.

A

The "A" subsection has two parts: transportation codes and medical and surgical supply codes. Transportation codes are used by ambulance services to show how critical a patient is, why a patient is being brought in, and how far they had to travel to reach the patient. There are two major types of patients for ambulance services: patients requiring *BLS* and patients requiring *ALS*. **BLS** stands for basic life support. **ALS** stands for advanced life support. Patients needing BLS are not critical, while patients needing ALS are.

Medical and surgical supply codes include listings for all kinds of things a surgeon may use on a patient during surgery. These codes also include supplies a patient may need after surgery, such as a Foley catheter: **A4312 Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way, all silicone**.

B

Subsection "B" consists of Enteral or Parenteral Feeding Therapy. This subsection includes codes for supplies, formulas and nutritional solutions related to feeding therapy. Feeding therapy is the procedure where a provider injects nutrients into a patient who is unable to eat on her own. One supply you might code from this subsection is a nasogastric tube: **B4081 Nasogastric tube with stylet**.

C

The "C" subsection is the outpatient *pass-through-payments section (PPS).* **Pass-through-payments** are important because they show the CMS how and when new technology is being used. HCPCS codes from this section also allow for additional reimbursement for technology that is being provided that does not yet have a permanent CPT or HCPCS code, and has been proven to benefit the patient as well as the medical provider. Typically Medicare has not paid for these services in the past, but now recognizes efficacy. Using codes from this section allows CMS to provide additional reimbursement to the provider if medical necessity has been established. Pass-through-payment codes can be used in conjunction with ambulatory payment classifications (APC's) used by hospitals for billing outpatient services.

E

The "E" subsection lists durable medical equipment. This is where a physician, hospital or nursing home can get reimbursement for crutches, walkers, bathtub rails and more. These codes are mainly supply codes. For example, if a patient visits the doctor because of an asthma attack, the doctor may need to use a nebulizer by an IPPB (Intermittent Positive Pressure Breathing) machine. If so, the doctor can charge an **E0500 IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source**.

G

The codes in the "G" subsection are temporary codes for procedures and professional services. These codes are used for procedures that would normally be coded in the *CPT* but for which there aren't any *CPT* codes.

H

Not only does *HCPCS* have codes for supplies, but it also has codes for therapies and treatment services for alcohol and drug abuse. These are your "H" codes. In addition to alcohol and drug abuse treatment, these codes cover foster care and mental health services. For example, the foster care child code is **H0041 Foster care, child, nontherapeutic, per diem**.

Be careful when you assign detox codes. Not just anyone can assign detox codes. To code detox procedures, a facility must be a specially licensed facility that treats these types of patients. If a patient presents to the ED who has Acute Alcohol Intoxication—diagnosis code 305.00—and the physicians treat for detox by giving the patient fluids, the ED cannot code for detox. They can only code for the infusion.

J

"J" codes are used a lot. They are drug codes. These codes go hand-in-hand with the *CPT* codes listing how a drug was administered. When coding for services involving drugs, you will code the procedure from the *CPT* and the actual drug used from the *HCPCS.*

Let's look at an example.

This 22-year-old female is a member of the tennis team at the college she is attending. She was seen two weeks ago and diagnosed with rotator cuff syndrome affecting the supraspinatus muscle. Since her visit she has not played any sports and has been using a sling to rest the shoulder muscle. She has been taking an over-the-counter NSAID and applying moist heat with minimal symptomatic relief.

Because conservative management has not resolved the symptoms, she is seen today for a trigger point injection of the supraspinatus muscle. The patient was seated on the examination table, bent forward, with a patient gown open in the back. The injection site was prepped. A solution of 10 mg of triamcinolone, and 2 mL of lidocaine hydrochloride 2%, was injected into the supraspinatus muscle. There was minimal bleeding and sterile gauze was secured with a bandage over the site. The patient tolerated the procedure well and was assured the pain should subside within the next 24 to 48 hours. She was also asked to return if she had any redness or swelling at the injection site. The *ICD-9-CM*, *CPT* and *HCPCS* codes for this patient encounter are:

	20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
726.10	J3490	Injection, lidocaine HCl for intravenous infusion, 10 mg.
	J3301	Injection, triamcinolone acetonide, not otherwise specified, 10 mg.

K

There are two subsections of temporary supply codes in *HCPCS.* The first subsection is the "K" codes. These temporary codes cover durable medical equipment. These codes are used to measure the use of durable medical equipment. Based on how this equipment is used, the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) may either delete this code or add it to the "E" section of HCPCS codes.

L

After the "K" codes comes the "L" subsection: Orthotic Procedures and Devices. Orthotic procedures are services dealing with adjustments to the musculoskeletal system. One reason adjustments may be made is to treat scoliosis. In this case, you may code **L1000 Cervical-thoracic-lumbar-sacral Orthosis (CTLSO) (Milwaukee), inclusive of furnishing initial orthosic, including model**. This section also contains codes for prosthetics that a patient may need. This could be a prosthetic leg or hand. An example of one of these codes is **L5974 All lower extremity prostheses, foot, single axis ankle/foot**.

Other codes that you'll find in this subsection are breast prostheses. This could be a bra for a breast cancer survivor or a silicone implant.

M

The codes in this small subsection cover very specific office services. There are codes for cellular therapy, as well as fabric wrapping of an abdominal aneurysm.

P

HCPCS Level II contains some Pathology and Laboratory codes—in subsection "P"—but most of the lab test codes you'll use are in the *CPT.* This section includes blood products such as whole blood, platelets, plasma or red blood cells. You will use it to identify the products that are given along with a transfusion code from the *CPT.* Also included are HCPCS codes for Papanicolaou smears and some chemistry and microbiology tests.

Q

"Q" codes are the second subsection of temporary codes. "Q" codes are mainly new medication and drug codes. When most new medications hit the market, their codes are listed in this subsection. This allows the CMS to review how a new medication is being used before adding it to the "J" codes.

R

The "R" subsection has only three codes. These codes show the use of portable radiology equipment. For example, in this subsection you'll find **R0076 Transportation of portable EKG to facility or location, per patient**.

S

All of the codes that we have discussed up to now are known as the National Medicare Codes. These need to be used when billing all Medicare patients. The "S" subsection is the Temporary National Codes (Non-Medicare) section. These are codes that Medicare will not pay but which Blue Cross/Blue Shield still uses. Medicaid and other insurance companies can request that you use these codes, but you can never use these codes for Medicare patients. This section is an all-inclusive section. There are codes for medications, procedures, evaluation and management codes, genetic testing codes, and more!

T

"T" codes are used by Medicaid to show if a patient's home is suitable for living. A home may be too dangerous if someone who just had a knee amputation lives in a house full of stairs. If there is doubt, Medicaid may send out a Registered Nurse to evaluate the patient's house.

This subsection also includes codes for substance abuse treatments and training-related procedures.

V

The final subsection – "V" codes – cover vision and hearing services and supplies. The vision section shows what type of lenses a patient may need. There are codes for contact lenses, bifocals and more. The hearing section includes codes for hearing screenings, hearing aids and other hearing services.

"V" codes cover vision and hearing services and supplies.

Step 7 Practice Exercise 30-1

❒ Determine the nine steps to correct HCPCS coding:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

Step 8 Review Practice Exercise 30-1

❒ Check your answers with the Answer Key at the back of this book. Correct any mistakes you may have made.

Step 9 Lesson Summary

❒ This lesson completes your training as a medical coding specialist! After this Quiz, you'll be ready for your final lesson—a comprehensive coding practicum that brings together everything you've learned. After that, you'll be ready to market your new skills and find a job as a professional coder. You've worked hard to reach this point. Take a moment to pat yourself on the back. Treat yourself to a reward! You're doing great!

Step 10 Mail-in Quiz 30

❒ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instruction and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Scanner Answer Sheet included. Use only blue or black ink on your Scanner Answer Sheet.

d. **Important!** Please fill in all information requested on your Scanner Answer Sheet or when submitting your Quiz online.

e. Submit your answers to the school via mail, fax or, to receive your grade immediately, submit your answers online at www.uscareerinstitute.edu.

Mail-in Quiz 30

Choose the best answer from the following choices. Each item is worth 6.67 points.

1. HCPCS codes were first developed by _____.

a. Medicare
b. Medicaid
c. Blue Cross/Blue Shield
d. AHIMA

2. HCPCS codes are revised every _____.

a. six months
b. year
c. two years
d. five years

3. HCPCS stands for _____.

a. Health Coverage Providers Coding System
b. Healthcare Common Procedure Coding System
c. Health Company Payment Contracting Service
d. Healthcare Coding Patient Coverage System

4. *HCPCS Level II* codes for _____.

a. diagnoses
b. surgical procedures
c. anatomy
d. supplies

5. The *HCPCS* manual contains _____ sections.

a. one
b. two
c. three
d. four

6. HCPCS codes are listed _____.

a. alphabetically
b. numerically
c. alphanumerically
d. numeribetically

7. To find the scientific name of a drug, you would use _____.

a. Appendix 3
b. Appendix 2
c. Appendix 1
d. Appendix 4

Match the *HCPCS* subsection with the code descriptions.

8. B _____

9. H _____

10. K _____

11. L _____

a. Orthotic Procedures
b. Enteral or Parenteral Feeding Therapy
c. Temporary codes for durable medical equipment
d. Therapies and treatment services for alcohol and drug abuse

Match the code description with the *HCPCS* subsection. Some answers may be used more than once.

12. _____ Specific office services

13. _____ Pass-through-payments

14. _____ Surgical supplies

15. _____ Transportation

a. subsection A

b. subsection C

c. subsection E

d. subsection M

Congratulations!

You have completed Lesson 30

Do not wait to receive the results of your Quiz before moving on.

Putting It All Together — Final Practicum

LESSON 31

Step 1 Learning Objectives for Lesson 31

❒ When you have completed the instruction in this lesson, you will be trained to do the following:

☞ Apply your medical terminology and anatomy knowledge to medical coding.

☞ Code for medical diagnoses and procedures.

Step 2 Lesson Preview

❒ You've made it! This is your last lesson as a medical coding student. After this, you'll be ready to work as a professional medical coding specialist! You've learned all about medical terminology and anatomy. You've studied the *ICD-9-CM, CPT* and *HCPCS* coding manuals. Congratulations on a job well done!

Your final lesson is a comprehensive final exam to bring all of your medical coding knowledge together. There are four parts to the test. Part 1 addresses coding concepts for the *ICD-9-CM, CPT* and *HCPCS*. Part 2 allows you to code for diagnoses, and Part 3 gives you real-world scenarios to code like a professional coder. Finally, Part 4 gives you the chance to review E/M coding.

You're going to do great!

Step 3 Mail-in Quiz 31

❒ Follow the steps to complete the Quiz.

a. Be sure you've mastered the instructions and the Practice Exercises that this Quiz covers.

b. Mark your answers on your Quiz. Remember to check your answers with the lesson content.

c. When you've finished, transfer your answers to the Quiz Cover Sheet. Use only blue or black ink.

d. **Important!** Please fill in all information requested on your Quiz Cover Sheet or when submitting your Quiz online.

e. Submit your answers to the school.

Mail-in Quiz 31

Part 1 Coding Concepts for *ICD*, *CPT* and *HCPCS*

Choose the best answer from the following choices. Each item is worth 1 point.

1. Which is *not* a true statement of ICD-9-CM coding? _____

a. Do not assume anything.

b. Code symptoms to substantiate the final diagnosis.

c. If it's not documented it didn't happen.

d. Check with the physician if the information is unclear.

2. CPT main terms can be _____.

a. conditions

b. eponyms

c. procedures

d. all of the above

3. For HCPCS Level II coding, once you've determined whether any modifiers should be used you should _____.

a. check for color bars, symbols, notes and references

b. assign the code

c. determine the highest level of specificity in the *Tabular List*

d. assign a fifth-digit subclassification from the *Index to Diseases*

4. For ICD-9-CM sequencing, _____ coding means that two or more codes are necessary to fully describe the patient's condition.

a. coexisting
b. mandatory
c. multiple
d. combination

5. Once you've located the tentative code or codes in the *CPT Index*, the next step is to _____.

a. record the code or code range provided
b. turn to the main part of the *CPT* to locate the tentative code or codes
c. determine the highest level of specificity in the *Tabular List*
d. none of the above

6. _____ is broken down by the services and not by body system.

a. *HCPCS*
b. *ICD-9-CM*
c. *CPT*
d. All of the above

7. Once you've located the tentative code in the *ICD-9-CM Index to Diseases*, the next step is to _____.

a. assign the code
b. determine the highest level of specificity in the *Tabular List*
c. turn to the main body of the *CPT* to read the code description
d. assign a fifth-digit subclassification from the *Index to Diseases*

8. In which book does the black circle or bullet represent a new code? _____

a. *HCPCS*
b. *ICD-9-CM*
c. *CPT*
d. All of the above

9. The linking of ICD-9-CM and CPT codes _____.

a. establishes medical necessity by corresponding the problem with the procedure
b. is not necessary for reimbursement from insurance carriers
c. requires each procedure to be linked to at least one ICD-9-CM code
d. both a and c

10. For E/M coding, once you've read the code descriptions to be sure you've found the right code range, what's the next step? _____

a. Assign the code range for the encounter.

b. Determine the level of service based on the contributing component of time.

c. Determine the individual levels of service for history, examination and medical decision making from the documentation.

d. Use your best judgement to determine the correct code.

11. According to the final rule released by the _____, *ICD-10* codes will be applied to all services provided on or after October 1, 2014.

a. Department of Health and Human Services

b. Centers of Medicare and Medicaid

c. American Medical Association

d. American Health Information Management Association

12. One section of the *ICD-10-CM* is arranged numerically within 21 separate chapters according to _____.

a. body system or condition

b. condition or eponyms

c. body system or nature of injury and disease

d. nature of injury and disease and condition

13. According to the *ICD-10-CM* Conventions, a three-digit category without further sub-classification is equivalent to a(n) _____.

a. procedure

b. valid three-digit code

c. invalid code

d. valid code when additional characters are added

14. _____ in the *ICD-10-CM* may be synonyms or provide a list of various conditions included within a code classification.

a. Inclusion terms

b. Excludes2

c. Main terms

d. Eponyms

15. Excludes2 in the *ICD-10-CM* means _____.

a. "not coded here"

b. "not otherwise specified"

c. "not included here"

d. "not elsewhere classifiable"

16. In the *ICD-10-CM*, the _____ identifies the services as an initial or subsequent encounter, or sequela.

a. modifier
b. extension
c. category
d. dummy-place holder

17. In the *ICD-10-CM*, the _____ is an alphabetical list of terms and their corresponding code.

a. *Neoplasm Table*
b. *Tabular List*
c. *Index to External Causes*
d. all of the above

18. In the *ICD-10-CM*, _____ enclose supplementary words that may be present or absent in the statement of a disease without affecting the code number to which it is assigned.

a. brackets
b. colons
c. parentheses
d. slanted brackets

19. _____ characters of the *ICD-10-CM* represent the etiology, anatomical site or the severity of the condition.

a. The first three
b. The fourth, fifth and sixth
c. The seventh and first
d. All

20. _____ are used in both the *Index* and the *Tabular List* of the *ICD-10-CM* to enclose supplementary words.

a. Parentheses
b. Colons
c. Brackets
d. Slanted brackets

Part 2 ICD-9-CM Coding

Read the following scenarios. Use your *ICD-9-CM* to assign the accurate diagnosis code(s). Each code is worth 2 points.

21. Type 2 diabetes with ketoacidosis

_____

22. Decubitus ulcer of the left hip, Stage II

_____

_____

23. Alzheimer's dementia with behavioral disturbance

_____

_____

24. Swelling of the knee joint

_____

25. Streptococcal sepsis

_____

_____

26. Septic shock with acute kidney failure

_____

_____

_____

27. Cough caused by URI

_____

28. Continuous dependency of alcohol

_____

29. First-degree burn of the forearm and second-degree burn of the hand affecting 7% of the total body surface area

_____

_____

_____

30. Hypertensive cardiovascular disease with CHF

_____

_____

31. Lung cancer that has metastasized to the brain

_____

_____

32. Disseminated lobar pneumonia

_____

33. Choledocholithiasis with acute cholecystitis

_____

34. Cesarean delivery due to breech presentation causing an obstruction and resulting in a single liveborn male. Code for the delivery.

_____

_____

_____

Part 3 Coding Scenarios

Read the following medical reports. Use your *ICD-9-CM* and *CPT* to assign the accurate diagnosis and procedure codes. Record the codes on the lines following each report. Note: E/M codes do not apply, and E-codes are not necessary. Each code is worth 2 points.

35. Scenario 1

HISTORY: The patient is a 32-year-old male who presented with a red-colored, 2 cm conical-shaped nodule on the back of his neck. He claims it grew in size within the past 24 hours. He had a boil in the same spot six months ago and it required removal. Fluctuant was felt with palpation. Severe pain was noted with slight pressure. He denies a history of diabetes mellitus or use of immunosuppressive drugs. Due to the excessive pain and reoccurrence of this furuncle, incision and drainage was recommended.

PROCEDURE: The patient signed the consent form and was taken to the procedure room. Using sterile technique, the posterior neck was prepped, draped, and anesthetized with 1% lidocaine. The lesion was lanced resulting in rapid resolution and reduction of pain. Pressure was held on the site with minimal bleeding noted. Betadine ointment was applied, and it was then covered with gauze and secured with tape. A sample of the fluid was sent to the laboratory. The patient will return in 3-5 days for a wound check.

ICD-9-CM: _____

CPT: _____

36. Scenario 2

HISTORY: The patient is a 5-year-old female who was practicing for a ballet recital. As she was completing a pirouette, she twisted her knee and fell to the ground. To ensure that permanent damage had not occurred, the orthopedist felt a diagnostic arthroscopy of her knee should be done.

PROCEDURE: After full explanation of the procedure, the parents signed the consent form. The patient was escorted into the procedure room by her parents where she was sedated. The incision site was prepped and draped. Injection of a saline solution distended the joint. The arthroscope was advanced into the joint through a small skin incision. The exploration revealed a torn lateral meniscus. A meniscal repair was then scheduled. The arthroscope was removed. Minimal bleeding was noted and the site was covered with sterile dressing. The patient tolerated the procedure well and was taken to the operating room for further care.

ICD-9-CM: _____

CPT: _____

37. Scenario 3

HISTORY: This very pleasant 69-year-old male suffered an embolic stroke 11 months ago. He has been in an assisted-care facility for the past 10 months. Redness was noted in his right thigh extending to the toes. He complains of tenderness around the area and a dull, aching pain in his leg when walking that is not relieved with rest. There is also pain when raising his leg and flexing his foot.

PROCEDURE: Consent forms were signed, and a venous occlusion plethysmography of both legs was performed. Deep vein thrombosis of the lower right extremity was noted. Further review of his chart will determine treatment. A physical therapy consult will be ordered.

ICD-9-CM: _____

CPT: _____

38. Scenario 4

HISTORY: The patient is a 12-year-old female who was at baseball practice when she was hit in the nose with the softball. After 20 minutes, the team nurse was unable to control the bleeding. Her father then took his daughter to the emergency department.

PROCEDURE: After being admitted and consent forms signed, the physician determined her nose is negative for a fracture. The patient was diagnosed with epistaxis. Anterior, simple packing with gauze was inserted into the right nostril to apply constant pressure. The patient was advised to avoid touching or blowing her nose. The packing can be taken out slowly and gently within the next 6-8 hours. If bleeding persists, she should return to the emergency department or contact her physician.

ICD-9-CM: _____

CPT: _____

39. Scenario 5

SUBJECTIVE: The patient, a 22-year-old female, stubbed her toe on her son's highchair. After 24 hours of dull throbbing pain, she decided to have it checked.

OBJECTIVE: The right great toe appeared swollen, discolored, and was sensitive to touch. The radiologist reviewed the x-ray which revealed a fractured great toe. The physician strapped the great toe to the second toe.

ASSESSMENT: Fractured right great toe.

PLAN: Patient to keep foot elevated as much as possible. Ibuprofen every 4-6 hours as needed for pain.

ICD-9-CM: _____

CPT: _____

Part 4 E/M Coding Scenarios

Read the following scenarios. Use your *ICD-9-CM* and *CPT* to assign accurate diagnoses (no E-codes required) and E/M codes. Record the codes on the lines following each scenario. Each code is worth 1 point.

40. Scenario 1

Bobby was playing softball when he misjudged the ball, and it hit him in the nose. He was taken to the emergency department at the hospital. Dr. Jones performed a detailed history and an expanded problem focused exam, with a moderate complexity medical decision making. Bobby was diagnosed with a nasal contusion and released.

ICD-9-CM: _____

E/M: _____

41. Scenario 2

Chester has an appointment for a check-up on his asthma. He is wheezy and having labored breathing. His established physician performs an expanded problem focused history and exam. No further treatment is recommended. Chester is to return in three months for a check-up on his asthma.

ICD-9-CM: _____

E/M: _____

42. Scenario 3

Kathy, a 33-year-old established patient, sees Dr. Owens in her office for what she thinks is a sinus infection. Her history is documented as problem focused, while the exam is expanded problem focused with a decision making of moderate complexity. Her diagnosis is acute maxillary sinusitis.

ICD-9-CM: _____

E/M: _____

43. Scenario 4

Franco, a new patient to the office, went to see Dr. White complaining of pain in his upper arm. He had been experiencing some muscle weakness and had difficulty getting out of the bathtub. Franco also has a rash and fever. Dr. White documents a detailed history and exam because of Franco's past medical history of rheumatoid arthritis. The medical decision making was of moderate complexity. Dr. White diagnosed Franco with infective myositis in the upper arm.

ICD-9-CM: _____

E/M: _____

44. Scenario 5

Jerry called his doctor when he had a sudden onset of nausea, abdominal cramping and bloody diarrhea with mucus. Dr. Smart had Jerry come to the office right away, and Dr. Smart documented an expanded problem focused history and performed a detailed examination. The medical decision making was moderate complexity. Dr. Smart determined Jerry had food poisoning. Jerry was sent home to rest. Dr. Smart told Jerry that the symptoms should subside within five to seven days. Jerry was told to watch for dehydration and to call immediately if he felt he was not getting any better.

ICD-9-CM: _____

E/M: _____

Medical Coding Specialist
Mail-in Quiz 31

1. Fill in your **student ID** and your **course code** below.

STUDENT ID NUMBER _____ COURSE CODE _____

2. Be sure your **name** and **address** are filled in below.
3. **Transfer your answers** to this cover sheet.
4. Write the year of the coding manuals used to complete this quiz: ICD-9 _____ CPT _____.

For School Use Only:
Grade: _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

U.S. Career Institute
2001 Lowe Street
Fort Collins, CO 80525

CD-2

This Space for Instructor Use

Fold on dotted line

Part 1

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

Part 2

21. Type II diabetes with ketoacidosis

_____

22. Decubitus ulcer of the left hip, Stage II

_____

_____

23. Alzheimer's dementia with behavioral disturbance

_____

_____

24. Swelling of the knee joint

_____

25. Streptococcal sepsis

_____

_____

26. Septic shock with acute kidney failure

_____

_____

_____

27. Cough caused by URI

_____

28. Continuous dependency of alcohol

_____

29. First-degree burn of the forearm and second-degree burn of the hand affecting 7% of the total body surface area

_____

_____

_____

30. Hypertensive cardiovascular disease with CHF

_____

_____

31. Lung cancer that has metastasized to the brain

_____

_____

32. Disseminated lobar pneumonia

_____

33. Choledocholithiasis with acute cholecystitis

_____

34. Cesarean delivery due to breech presentation causing an obstruction and resulting in a single liveborn male. Code for the delivery.

_____

_____

_____

Part 3

35. Scenario 1

ICD-9-CM: _____

CPT: _____

36. Scenario 2

ICD-9-CM: _____

CPT: _____

37. Scenario 3

ICD-9-CM: _____

CPT: _____

38. Scenario 4

ICD-9-CM: _____

CPT: _____

39. Scenario 5

ICD-9-CM: _____

CPT: _____

Part 4

40. Scenario 1

ICD-9-CM: _____

E/M: _____

41. Scenario 2

ICD-9-CM: _____

E/M: _____

42. Scenario 3

ICD-9-CM: _____

E/M: _____

43. Scenario 4

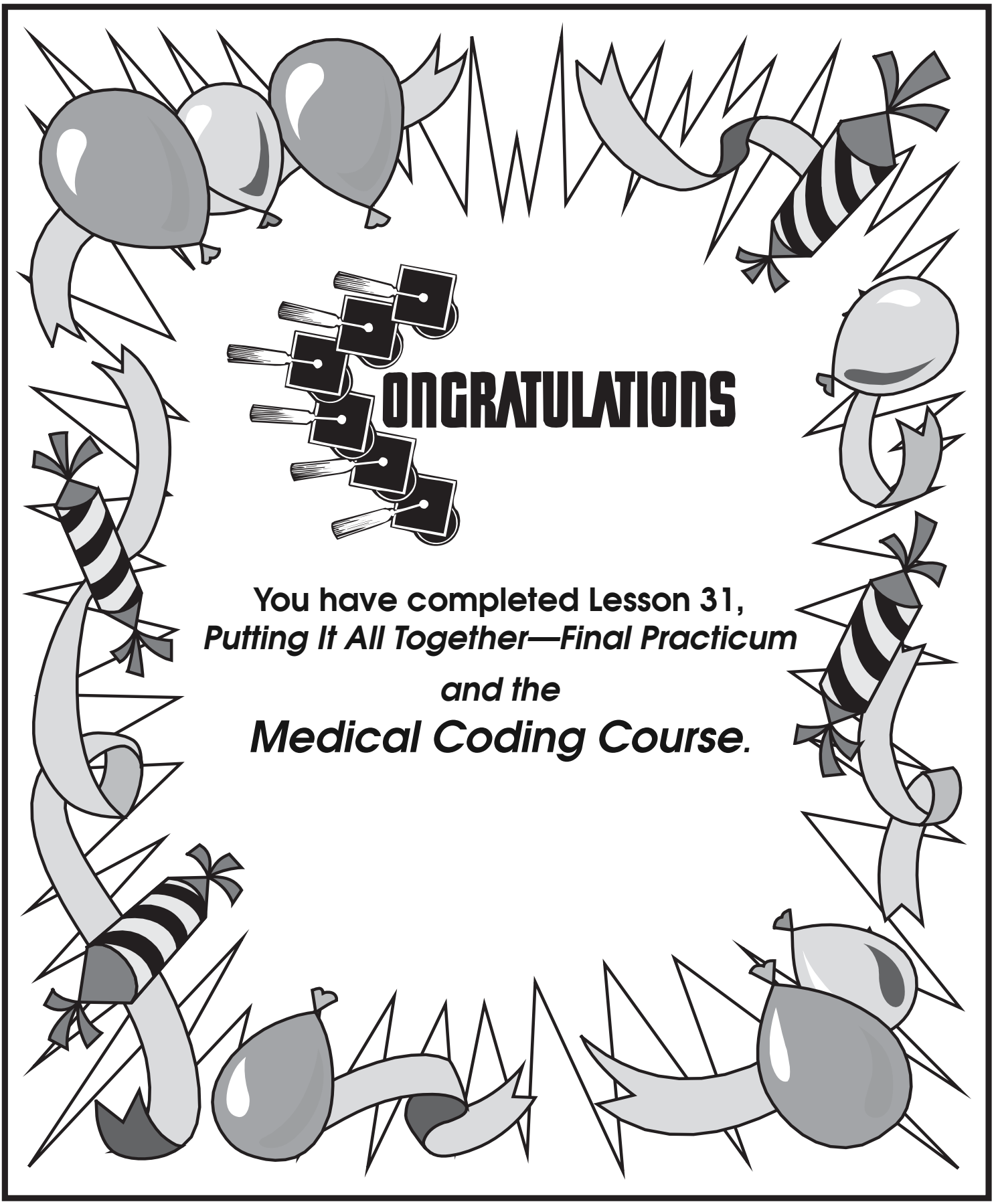
ICD-9-CM: _____

E/M: _____

44. Scenario 5

ICD-9-CM: _____

E/M: _____



You have completed Lesson 31,
Putting It All Together—Final Practicum
and the
Medical Coding Course.

Medical Coding Specialist
Answer Key
Pack 5

ANSWER KEY

Practice Exercise 26-1

Record codes: **550.90** **49505**

ICD-9-CM Coding pathway: Hernia, inguinal 550.9

Fifth-digit subclassification 0 = unilateral or unspecified (not specified as recurrent)

Tabular List: 550.90 Inguinal hernia, without mention of obstruction or gangrene, unilateral or unspecified (not specified as recurrent)

CPT Coding pathway: Hernia Repair, Inguinal 49491, 49495-49500, 49505

Code description: 49505 Repair initial inguinal hernia, age 5 years or older; reducible

Practice Exercise 26-2

Record codes: **881.00** **12002**

870.0 **12011-59**

ICD-9-CM Coding pathway: Laceration - *see also* Wound, open by site
New Pathway: Wound, open, forearm 881.00

Tabular List: 881.00 Open wound of elbow, forearm, and wrist, Without mention of complication, forearm

CPT Coding pathway: Skin, Wound Repair, Simple 12001-12021

Code description: 12002 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

Secondary Codes:

ICD-9-CM Coding pathway: Laceration, eyelid NEC, skin (and periocular area) 870.0

Tabular List: 870.0 Laceration of skin of eyelid and periocular area

CPT Coding pathway: Skin, Wound Repair, Simple 12001-12021

Code description: 12011-59 Simple repair of superficial wounds of face, ears, eyelids, nose lips and/or mucous membranes; 2.5 cm or less – Distinct Procedural Service

Practice Exercise 26-3

Record codes: **380.4** **69210**

ICD-9-CM Coding pathway: Impaction, cerumen 380.4

Tabular List: 380.4 Disorders of external ear, Impacted cerumen

CPT Coding pathway: Cerumen, Removal 69210

Code description: 69210 Removal impacted cerumen (separate procedure), 1 or both ears

Practice Exercise 26-4

Record codes: **707.09** **11042**
707.23

ICD-9-CM Coding pathway: Ulcer, pressure, other site 707.09

Tabular List: 707.09 Chronic ulcer of skin, Pressure ulcer, Other site

ICD-9-CM Coding pathway: Ulcer, pressure, stage, III 707.23

Tabular List: 707.23 Pressure ulcer stage III

CPT Coding pathway: Debridement, Skin, Subcutaneous Tissue 11042-11047

Code description: 11042 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

Practice Exercise 26-5

Record codes: **786.6** **31628**

ICD-9-CM Coding pathway: Mass, lung 786.6

Tabular List: 786.6 Swelling, mass, or lump in chest

CPT Coding pathway: Bronchoscopy, Biopsy 31625-31629, 31632-31633

Code description: 31628 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

Practice Exercise 26-6

Record codes: **618.2** **57420**

625.6

Primary ICD-9-CM Coding pathway: Cystocele, female, with uterine prolapse, incomplete 618.2

Tabular List: 618.2 Genital prolapse, Uterovaginal prolapse, incomplete

Secondary ICD-9-CM Coding pathway: Incontinence, stress (female) 625.6

Tabular List: 625.6 Pain and other symptoms associated with female genital organs, Stress incontinence, female

CPT Coding pathway: Colposcopy, Vagina 57420-57421

Code description: 57420 Colposcopy of the entire vagina, with cervix if present

Practice Exercise 26-7

Record codes: **427.81** **33208**

ICD-9-CM Coding pathway: Syndrome, sick, sinus 427.81

Tabular List: 427.81 Cardiac dysrhythmias, Other specified cardiac dysrhythmias, Sinoatrial node dysfunction

CPT Coding pathway: Pacemaker, Heart, Insertion 33206-33208

Code description: 33208 Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular

Practice Exercise 26-8

Record codes: **625.6** **51840**

ICD-9-CM Coding pathway: Incontinence, stress (female) 625.6

Tabular List: 625.6 Pain and other symptoms associated with female genital organs, Stress incontinence, female

CPT Coding pathway: Marshall-Marchetti-Krantz Procedure 51840-51841, 58152, 58267, 58293

Code description: 51840 Anterior vesicourethropexy, or urethropexy (eg, Marshall-Marchetti-Krantz, Burch); simple

Practice Exercise 26-9

Record codes: **V25.2** **55250**

ICD-9-CM Coding pathway: Sterilization, admission for V25.2

Tabular List: V25.2 Encounter for contraceptive management, Sterilization

CPT Coding pathway: Vasectomy 55250

Code description: 55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)

Practice Exercise 26-10

Record codes: **288.60** **38220**

ICD-9-CM Coding pathway: Leukocytosis 288.60

Tabular List: 288.60 Leukocytosis, unspecified

CPT Coding pathway: Aspiration, Bone Marrow 38220

Code description: 38220 Bone marrow; aspiration only

Practice Exercise 26-11

Record codes: **227.3** **61546**

ICD-9-CM Coding pathway: Tumor, benign–*see* Neoplasm, by site, benign

New pathway: Neoplasm, pituitary (gland), Benign 227.3

Tabular List: 227.3 Benign neoplasm of other endocrine glands and related structures, Pituitary gland and craniopharyngeal duct (pouch)

CPT Coding pathway: Pituitary Gland Tumor, Excision 61546-61548, 62165

Code description: 61546 Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach

Practice Exercise 26-12

Record codes: **789.03** **74160**

ICD-9-CM Coding pathway: Pain, abdominal 789.0

Fifth-digit subclassification 3 = right lower quadrant

Tabular List: 789.03 Abdominal pain, right lower quadrant

CPT Coding pathway: Abdomen, CT Scan 74150-74178, 75635

Code description: 74160 Computed tomography, abdomen; with contrast material(s)

Practice Exercise 27-1

1. A physician makes a house call to a new patient.

Place of Service: **House**

Type of Service: **House Call visit**

Patient Status: **New Patient**

Coding Pathway: **House Calls, New Patient**

Code Range: **99341-99345**

2. A patient sees his regular family physician at the office for a sore throat.

Place of Service: **Office**

Type of Service: **Office Visit**

Patient Status: **Established Patient**

Note: Regular family physician indicates the patient is an established patient.

Coding Pathway: **Office and/or Other Outpatient Services, Office Visit, Established Patient**

Code Range: **99211-99215**

3. A new patient is seen in the dermatology clinic for acne.

Place of Service: **Office**

Note: Dermatology clinic is a specific type of office.

Type of Service: **Office Visit**

Patient Status: **New Patient**

Coding Pathway: **Office and/or Other Outpatient Services, Office Visit, New Patient**

Code Range: **99201-99205**

4. A patient is seen by her PCP as an inpatient in the hospital for initial care.

Place of Service: **Hospital**

Type of Service: **Initial Care**

Patient Status: **Inpatient**

Coding Pathway: **Hospital Services, Inpatient Services, Initial Care, New or Established Patient**

Code Range: **99221-99233**

5. An emergency department physician examines a patient.

Place of Service: **Emergency Department**

Type of Service:

Patient Status:

Note: Emergency Department does not take new or established into consideration.

Coding Pathway: **Evaluation and Management, Emergency Department**

Code Range: **99281-99288**

Practice Exercise 27-2

1. EMERGENCY DEPARTMENT 99281-99288

CC	leg pain	required
HPI	Location – leg Severity – extreme AS&S – wrist pain Context – motorcycle accident	4 = extended
ROS	Eyes – no change in vision Gastrointestinal – no nausea Neurological – loss of consciousness Musculoskeletal – no skull tenderness Allergic/Immunologic – no allergies	5 = extended
PFSH	Medical history – bullet removed Social history – no smoking	2 = complete

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Level of Service for the History Component: Detailed **99284**

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

CC	chest pain	required
HPI	Location – chest AS&S – dyspnea on exertion Context – occurring at rest Modifying Factor – nitroglycerine	4 = extended
ROS	Cardiovascular – no palpitation Respiratory – no cough Musculoskeletal – no clubbing Integumentary – no edema Allergic/Immunologic – allergies NKDA	5 = extended
PFSH	Medical history – knee surgery Family history – brother w/ MI Social history – smokes	3 = complete

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Level of Service for the History Component: Detailed **99243**

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

CC	sore throat	required
HPI	Location – throat AS&S – blisters	2 = brief
ROS	Constitutional – fever ENMT – mouth Gastrointestinal - refuses to eat	3 = extended
PFSH	Social history – preschool	1 = pertinent

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

Level of Service for the History Component: Expanded Problem Focused **99213**

Practice Exercise 27-3

1. EMERGENCY DEPARTMENT 99281-99288

   Constitutional – Pulse

   Eyes – PERRLA

   Cardiovascular – Regular rhythm and rate

   Respiratory – Clear to P&A

   Gastrointestinal – Soft

   Skin – Skin intact

   Musculoskeletal – Tenderness at metacarpal

   Each Extremity – Leg exam

8 OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Note: Comprehensive is not documented because it indicates 8 organ systems. Each Extremity is a body area, not an organ system. Only 7 organ systems are documented.

Level of Service for the Examination Component: Detailed **99284**

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

   Constitutional – Blood pressure

   Cardiovascular – Murmur

   Respiratory – Clear

   Gastrointestinal – Abdomen soft

   Skin – Edema (negative)

Neurological – No focal defect

Neck – No jugular venous distension 7 OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Level of Service for the Examination Component: Detailed **99243**

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

Constitutional – rectal temperature

Mouth – vesicular exanthema

Gastrointestinal – rectal swab

Skin – lesions on hands

Genitalia, groin, buttocks – diaper area 5 OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Level of Service for the Examination Component: Detailed **99214**

Practice Exercise 27-4

1. EMERGENCY DEPARTMENT 99281-99288

Number of Diagnosis and Management Options:

The problem is new to the doctor. Additional work-up is planned. The decision making level is extensive, which is **High Complexity**.

Amount and/or Complexity of Data to be Reviewed:

X-rays results are documented for a score of 1. The decision making level is minimal or none level, which is **Straightforward** medical decision making.

Risk of Complications and/or Morbidity or Mortality:

The physician requests to admit the patient for minor surgery with identifiable risk factors. The risk level is moderate, which is a **Moderate Complexity**.

Determine the overall level. The element of Data is the lowest. Cross that out and determine the overall level of service with the remaining two.

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Dx/Mgmt	minimal	limited	multiple	extensive
Data	~~min/none~~	limited	moderate	extensive
Risk	minimal	low	moderate	high

Level of Service for the Medical Decision Making Component: Moderate Complexity, **99284**

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245

Number of Diagnosis and Management Options:

The problem is new to the doctor. Additional work-up is planned. The decision making level is extensive, which is **High Complexity**.

Amount and/or Complexity of Data to be Reviewed:

X-ray	1
EKG/Cath	1
Total Score	2

The score for the data reviewed is two for a limited level, which is **Low Complexity** medical decision making.

Risk of Complications and/or Morbidity or Mortality:

The presenting problem is one or more chronic illnesses with severe exacerbation. The risk level is high, which is a **High Complexity**.

Determine the overall level. The element of data is the lowest. Cross that out and determine the overall level of service with the remaining two.

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Dx/Mgmt	minimal	limited	multiple	extensive
Data	min/none	limited	moderate	extensive
Risk	minimal	low	moderate	high

Level of Service for the Medical Decision Making Component: High Complexity, **99245**

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215

Number of Diagnosis and Management Options:

The problem is new to the doctor. No additional work-up is planned. The decision making level is multiple, which is **Moderate Complexity**.

Amount and/or Complexity of Data to be Reviewed:

One pathology test for a score of 1. The level is minimal or none level, which is **Straightforward** medical decision making.

Risk of Complications and/or Morbidity or Mortality:

The management options selected is prescription drug management. The risk level is moderate, which is a **Moderate Complexity**.

Determine the overall level. The element of Data is the lowest. Cross that out and determine the overall level of service with the remaining two.

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
Dx/Mgmt	minimal	limited	multiple	extensive
Data	~~min/none~~	limited	moderate	extensive
Risk	minimal	low	moderate	high

Level of Service for the Medical Decision Making Component: Moderate Complexity, **99214**

Practice Exercise 27-5

1. EMERGENCY DEPARTMENT 99281-99285
   history component 99284
   examination component 99284
   medical decision making component 99284
   based on lowest of three key components **99284**

2. CARDIOLOGY OFFICE CONSULTATION 99241-99245
   history component 99243
   examination component 99243
   medical decision making component 99245
   based on lowest of three key components **99243**

3. OFFICE VISIT, ESTABLISHED PATIENT 99211-99215
   history component 99213
   examination component 99214
   medical decision making component 99214
   based on lower of two key components **99214**

Practice Exercise 28-1

1. d Services for those whose condition is not serious enough to be admitted, but not well enough to go home either.

2. c The patient's status can be initial hospital care, subsequent hospital care or observation or inpatient care services.

3. h When one physician seeks the opinion or advice from another physician.

4. j Services must be provided in a hospital.

5. g The physician's physical attendance and direct face-to-face care during the transport of a critically ill or injured pediatric patient.

6. b Low birth weight (LBW) and very low birth weight (VLBW) infants who are no longer classified as critically ill, but require subsequent care.

7. e Generally, healthcare services are not provided, while room, board and other personal assistance services are provided.

8. a Evaluation and Management services provided by a physician in a private residence.

9. f Routine evaluation and management services for a healthy patient with no complaints.

10. i Evaluation and management services performed to establish a baseline for life or disability insurance are coded from this subsection.

Practice Exercise 28-2

786.50 99214

V45.89

ICD-9-CM Pathway: Pain, chest 786.50
Tabular List: 786.50 Chest pain, unspecified
ICD-9-CM Pathway: Status, postsurgical V45.89
Tabular List V45.89 Other postprocedural status, Other
CPT Coding Pathway: Office and/or Other Outpatient Services, Office Visit, Established Patient 99211-99215

HISTORY

CC		chest discomfort	required
HPI	Location	chest	
	Severity	severe	
	Duration	past week	
	Modifying Factors	Nitroglycerine	4=extended
ROS	Constitutional	fatigue	
	Cardiovascular	hypertension	
	Respiratory	shortness of breath	
	Integumentary	sweating	
	Neurological	loss of consciousness	
	Allergic/Immunologic	penicillin allergy	6=extended
PFSH	Past Medical history	cardiac surgery	
	Social history	smokes	2=complete

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

HISTORY COMPONENT: **DETAILED, 99214**

EXAMINATION

Constitutional – pulse

Cardiovascular – regular rhythm

Respiratory – clear to ausculation

Skin – edema

Musculoskeletal – clubbing

Psychiatric – no acute distress

Chest, Breast, Axilla – costochondral discomfort 7 = OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

EXAMINATION COMPONENT: **DETAILED, 99214**

MEDICAL DECISION MAKING

Number of Diagnosis and Management Options

The problem is new to the doctor and additional work-up is planned. The decision making level is extensive, which is **High Complexity.**

Amount and/or Complexity of Data to be Reviewed

No data is reviewed. The decision making level is minimal or none level, which is **Straightforward** medical decision making.

Risk of Complications and/or Morbidity or Mortality

The presenting problem is an undiagnosed new problem with an uncertain prognosis. The risk level is moderate, which is a **Moderate Complexity.**

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
dx/mgmt	minimal	limited	multiple	extensive
data	~~min/none~~	limited	moderate	extensive
risk	minimal	low	moderate	high

MDM COMPONENT: **MODERATE COMPLEXITY, 99214**

Overall level of service for the encounter is 99214.

Practice Exercise 28-3

945.26 **99291**

942.24

948.10

ICD-9-CM Coding pathway: Burn, thigh, second degree 945.26
Tabular List: 945.26 Burns of lower limb(s), Blisters, epidermal loss [second degree], thigh [any part]
ICD-9-CM Coding pathway: Burn, back, second degree 942.24
Tabular List: 942.24 Burn of trunk, Blisters, epidermal loss [second degree], back [any part]
ICD-9-CM Coding pathway: Burn, extent (percent of body surface), 10-19 percent 948.1 ✓
Fifth-digit 0 = less than 10 percent or unspecified as third degree
Tabular List: 948.10 Burns classified according to extent of body surface involved, 10-19 percent of body surface, less than 10 percent or unspecified as third degree
CPT Coding pathway: Critical Care Services 99291-99292
99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

Practice Exercise 28-4

V72.31 **99385**

ICD-9-CM Coding pathway: Examination, gynecological V72.31
Tabular List: V72.31 Gynecological examination, Routine gynecological examination
CPT Coding pathway: Preventive Medicine, New Patient 99381-99397
99385 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years

Note: You will code to new patient since it was an initial visit.

Practice Exercise 28-5

255.12 99239

227.0

V45.89

ICD-9-CM Coding pathway: Syndrome, Conn 255.12
Tabular List: 255.12 Disorders of adrenal glands, Conn's syndrome
ICD-9-CM Coding pathway: Adenoma – *see also* Neoplasm, by site, benign
New pathway: Neoplasm, adrenal (cortex), Benign 227.0
Tabular List: 227.0 Benign neoplasm of other endocrine glands and related structures, Adrenal gland
ICD-9-CM Coding pathway: Status, postoperative V45.89
Tabular List: V45.89 Other postprocedural status, Other
CPT Coding pathway: Discharge Services, Hospital 99238-99239
99239 Hospital discharge day management; more than 30 minutes

Practice Exercise 28-6

057.0 99202

ICD-9-CM Coding pathway: Disease, fifth 057.0
Tabular List description: 057.0 Erythema infectiosum [fifth disease]

Coding Pathway: Office and/or Other Outpatient Services, Office Visit, New Patient 99201-99205

CC		rash	required
HPI	Location	face	
	Quality	bright red	
	Duration	1 week	4=extended
	Context	symptoms subsided	
ROS	Constitutional	fever	
	Ears, Nose, Mouth, Throat	nose stuffy	
	Integumentary	rash	3=extended
PFSH	N/A		0=N/A

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

HISTORY COMPONENT: **EXPANDED PROBLEM FOCUSED, 99202**

EXAMINATION

Constitutional - temperature

Skin – net-like rash

2 = OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

EXAMINATION COMPONENT: **EXPANDED PROBLEM FOCUSED, 99202**

MEDICAL DECISION MAKING

Number of Diagnosis and Management Options
The problem is new to the doctor and no additional work-up is planned. The decision making level is multiple, which is **Moderate Complexity.**
Amount and/or Complexity of Data to be Reviewed
No data is reviewed. The decision making level is minimal or none level, which is **Straightforward** medical decision making.
Risk of Complications and/or Morbidity or Mortality
The physician recommends over-the-counter drugs. The risk level is low, which is a **Low Complexity.**

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
dx/mgmt	minimal	limited	multiple	extensive
data	~~min/none~~	limited	moderate	extensive
risk	minimal	low	moderate	high

MDM COMPONENT: **LOW COMPLEXITY, 99203**

Overall level of service for the encounter is 99202.

Practice Exercise 28-7

943.33 **99252**

948.00

906.7

682.3

ICD-9-CM Coding pathway: Burn, arm, upper, third degree 943.33
Tabular List: 943.33 Burn of upper limb, except wrist and hand, Full-thickness skin loss [third degree NOS], upper arm
ICD-9-CM Coding pathway: Burn, extent, less than 10 percent 948.0
Fifth-digit 0 = less than 10 percent or unspecified (third degree burn)
Tabular List: 948.00 Burns classified according to extent of body surface involved, Burn [any degree] involving less than 10 percent of body surface
ICD-9-CM Coding pathway: Late, effect(s) (of), burn, extremities 906.7
Tabular List: 906.7 Late effects of injuries to skin and subcutaneous tissues, Late effect of burn of other extremities
ICD-9-CM Coding Pathway: Cellulitis, arm 682.3
Tabular List: 682.3 Other cellulitis and abscess, Upper arm and forearm

CPT Coding pathway: Consultation, Inpatient 99251-99255

CC		cellulitis	required
HPI	Location	arm	
	Severity	increasing	
	AS&S	cellulitis	
	Context	hot water	4=extended
ROS	Endocrine	diabetes	
	Allergic/Immunologic	no allergies	2=extended
PFSH	Past Medical history	no medication	1=pertinent

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

HISTORY COMPONENT: **DETAILED, 99253**

EXAMINATION

Constitutional – afebrile

Skin – swollen

Each extremity – visualizing burns on arm

3 = OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

EXAMINATION COMPONENT: **EXPANDED PROBLEM FOCUSED, 99252**

MEDICAL DECISION MAKING

Number of Diagnosis and Management Options
The problem is new to the doctor and additional work-up is planned. The decision making level is extensive, which is **High Complexity.**
Amount and/or Complexity of Data to be Reviewed
One lab reviewed for WBC. The decision making level is minimal or none level, which is **Straightforward** medical decision making.
Risk of Complications and/or Morbidity or Mortality
The physician recommends IV fluids with additives. The risk level is moderate, which is a **Moderate Complexity.**

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
dx/mgmt	minimal	limited	multiple	extensive
data	min/none	limited	moderate	extensive
risk	minimal	low	moderate	high

MDM COMPONENT: **MODERATE COMPLEXITY, 99254**

Overall level of service for the encounter is 99252.

Practice Exercise 28-8

714.0 **99243**

718.97

733.19

733.00

ICD-9-CM Coding pathway: Arthritis, rheumatoid 714.0
Tabular List: 714.0 Rheumatoid arthritis
ICD-9-CM Coding pathway: Destruction, joint (*see also* Derangement, joint)
New pathway: Derangement, joint, foot 718.97
Tabular List: 718.97 Unspecified derangement of joint, ankle and foot
ICD-9-CM Coding pathway: Fracture, pathologic (cause unknown), specified site 733.19
Tabular List: 733.19 Pathologic fracture, Pathologic fracture of other specified site
ICD-9-CM Coding pathway: Osteoporosis (generalized) 733.00
Tabular List: 733.00 Osteoporosis, unspecified
CPT Coding pathway: Consultation, Office 99241 - 99245

CC		pain ankle	required
HPI	Location	foot	
	Severity	severe	
	AS&S	arthritic destructive disease	
	Modifying Factors	inversion	4=extended
ROS	Cardiovascular	pleuritic pain	
	Respiratory	dyspnea	
	Musculoskeletal	rib fracture	
	Allergic/Immunologic	no allergies	4=extended
PFSH	Past Medical history	rheumatoid arthritis	
	Social history	plumber	3=complete
	Family history	sister with RA	

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

HISTORY COMPONENT: **DETAILED, 99243**

EXAMINATION

Constitutional – pulse

Cardiovascular – regular rhythm

Respiratory – clear

Musculoskeletal – rib tenderness

Psychiatric - moderate distress

Neurological – decreased sensation

6 = OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

EXAMINATION COMPONENT: **DETAILED, 99243**

MEDICAL DECISION MAKING

Number of Diagnosis and Management Options
The problem is new to the doctor and additional work-up is planned. The decision making level is extensive, which is **High Complexity.**
Amount and/or Complexity of Data to be Reviewed
A bone scan is reviewed, which is a score of 1. The decision making level is a minimal or none level, which is **Straightforward** medical decision making.
Risk of Complications and/or Morbidity or Mortality
The presenting problems consist of one or more chronic illnesses with mild exacerbation. The risk level is moderate, which is a **Moderate Complexity.**

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
dx/mgmt	minimal	limited	multiple	extensive
data	~~min/none~~	limited	moderate	extensive
risk	minimal	low	moderate	high

MDM COMPONENT: **MODERATE COMPLEXITY, 99244**

Overall level of service for the encounter is 99243.

Practice Exercise 28-9

V20.2 **99393**

90700

90471

ICD-9-CM Coding pathway: Examination, health (of), child, routine V20.2
Tabular List: V20.2 Routine infant or child health check CPT Coding pathway: Preventive Medicine 99381-99397
99393 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedure, established patient; late childhood (age 5 through 11 years)
CPT Coding pathway: Vaccines, Diphtheria, Tetanus, Acellular Pertussis (DTaP) 90700
90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use
CPT Coding pathway: Administration, Immunization, One Vaccine/Toxoid, with Counseling 90460
90460 Immunization administration through 18 years of age via any route of administration, when counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

Practice Exercise 28-10

464.4 **99284**

ICD-9-CM Coding pathway: Croup 464.4
Tabular List: 464.4 Croup
CPT Coding Pathway: Evaluation and Management, Emergency Department 99281-99288

CC		respiratory distress	required
HPI	Severity	increasing	
	AS&S	mucous	
	Duration	yesterday	
	Modifying Factors	Tylenol	4=extended
ROS	Constitutional	fever	
	Respiratory	cough	
	Allergic/Immunologic	none	3=extended
PFSH	Past Medical history	same symptoms 4 mo ago	
	Family history	no diabetes	2=complete

History	Problem Focused	Expanded Problem	Detailed	Comprehensive
CC	required	required	required	required
HPI	brief 1 to 3	brief 1 to 3	extended 4	extended 4
ROS	N/A	pertinent 1 system	extended 2 to 9	complete 10
PFSH	N/A	N/A	pertinent 1 of 3	complete 2 of 3

HISTORY COMPONENT: **DETAILED, 99284**

EXAMINATION

Constitutional – pulse

Ears, Nose, Mouth, Throat – nasal discharge

Cardiovascular – sinus rhythm

Respiratory – wheezing

Gastrointestinal – soft

Musculoskeletal – venous distension

Neurological – no defects

Neck – supple

8 = OS/BA

Exam	Problem Focused	Expanded Problem	Detailed	Comprehensive
	1 OS/BA	2-4 OS/BA	5-7 OS/BA	8 OS

Note: Comprehensive is not documented because it indicates 8 organ systems. The neck is a body area, not an organ system. Only 7 OS are documented.

EXAMINATION COMPONENT: **DETAILED, 99284**

MEDICAL DECISION MAKING

Number of Diagnosis and Management Options
The problem is new to the doctor and additional work-up is planned. The decision making level is extensive, which is **High Complexity.**
Amount and/or Complexity of Data to be Reviewed
An x-ray is ordered which is a score of 1. The decision making level is limited level, which is **Straightforward** medical decision making.

Risk of Complications and/or Morbidity or Mortality
The presenting problem is an undiagnosed new problem with an uncertain prognosis. The risk level is moderate, which is a **Moderate Complexity.**

MDM	Straightforward	Low Complexity	Moderate Complexity	High Complexity
dx/mgmt	minimal	limited	multiple	extensive
data	min/none	limited	moderate	extensive
risk	minimal	low	moderate	high

MDM COMPONENT: **MODERATE COMPLEXITY, 99284**

Overall level of service for the encounter is 99284.

Practice Exercise 29-1

1. **c** American Health Information Management Association
2. **h** American Academy of Professional Coders
3. **e** American Medical Association
4. **a** American Hospital Association
5. **g** Certified Coding Associate
6. **b** Certified Coding Specialist
7. **k** Certified Coding Specialist—Physician-based
8. **j** Certified Professional Coder
9. **f** Certified Professional Coder—Hospital
10. **d** Certified Professional Coder—Apprentice
11. **i** Certified Professional Coder—Hospital—Apprentice

Practice Exercise 29-2

1. *The Academy CODING EDGE*	**d**	AAPC
2. The *CPT Assistant*	**c**	AMA
3. *Coding Clinic*	**e**	AHA
4. *Coder's Desk Reference for Diagnoses*	**a**	Ingenix
5. *Coder's Desk Reference for HCPCS Level II*	**a**	Ingenix
6. *Coder's Desk Reference for Procedures*	**a**	Ingenix
7. *Advance* magazine	**b**	AHIMA

Practice Exercise 30-1

1. **First, read through the documentation and identify the services or supply received.**
2. **If a procedure is not listed in the *CPT* or if you're coding for supplies, look up the term in the *Index* of the *HCPCS Level II*.**
3. **Locate a tentative code or codes.**
4. **Turn to the *Tabular List* of the manual and locate your tentative code or codes.**
5. **Read through the code descriptions for all tentative codes.**
6. **Check for color bars, notes, symbols and references.**
7. **Review the appendixes for the reference definitions and other guidelines for coverage issues that apply.**
8. **Determine whether any modifiers should be used.**
9. **Assign the correct code.**