



# Medical Coding and Billing Specialist

Instruction Pack 5

Lessons **36-39**

Explore the possibilities

0205503LB05A-14



**U.S. Career  
Institute®**  
Dream › Learn › Succeed™



# **Medical Coding and Billing Specialist**

## **Instruction Pack 5**

Lesson 36—CPT Coding for Evaluation  
and Management Services

Lesson 37—Comprehensive CPT Evaluation  
and Management

Lesson 38—The Basics of HCPCS Coding

Lesson 39—The Future of Health Care and  
Final Quiz

No part of this document may be reproduced or transmitted in any form or by any means, electronic or mechanical, for any purpose, without the express written permission of U.S. Career Institute.

Copyright © 2013, Weston Distance Learning, Inc. All Rights Reserved.

0205503LB05A-14

## **Acknowledgments**

### **Authors**

Katy Little  
Brenda Blomberg

### **Editorial Staff**

Trish Bowen  
Kimberly Fields  
Kathy DeVault  
Kelly Brown  
Joyce Jeckewicz  
Stephanie MacLeod  
Carrie Williams

### **Design/Layout**

Connie Hunsader  
Sandy Petersen  
D. Brent Hauseman

**U.S. Career Institute**  
Fort Collins, CO 80525  
[www.uscareerinstitute.edu](http://www.uscareerinstitute.edu)

# Table of Contents

## Lesson 36: CPT Coding for Evaluation and Management Services

Step 1: Learning Objectives for Lesson 36 .....	1
Step 2: Lesson Preview .....	1
Step 3: Evaluation and Management Codes.....	1
Step 4: Evaluation and Management Profile.....	2
Steps to Assigning E/M Codes.....	2
Step 5: Classifying Evaluation and Management Procedures.....	3
Place of Service .....	3
Type of Service.....	4
Patient Status .....	4
The <i>CPT Index</i> .....	4
Step 6: Practice Exercise 36-1 .....	5
Step 7: Review Practice Exercise 36-1.....	6
Step 8: Determining Levels of Service .....	6
Key Component Requirements .....	7
Step 9: History Component.....	8
Chief Complaint (CC) .....	8
History of Present Illness (HPI) .....	8
Review of Systems (ROS) .....	9
Past, Family and/or Social History (PFSH).....	10
Determining the History Component.....	10
Example of the History Component.....	11
Step 10: Practice Exercise 36-2 .....	14
Step 11: Review Practice Exercise 36-2.....	15
Step 12: Examination .....	16
Organ Systems Element.....	16
Body Areas Element.....	17
Determining the Examination Component.....	17
Example of the Examination Component.....	18
Step 13: Practice Exercise 36-3 .....	18
Step 14: Review Practice Exercise 36-3.....	19

## **Medical Coding and Billing Specialist**

---

Step 15: Medical Decision Making (MDM).....	19
Number of Diagnosis and Management Options .....	20
Amount and/or Complexity of Data to Be Reviewed.....	20
Risk of Complications and/or Morbidity or Mortality.....	21
The Overall Medical Decision Making Component .....	22
Example of the Medical Decision Making Component .....	23
Step 16: Practice Exercise 36-4 .....	25
Step 17: Review Practice Exercise 36-4.....	28
Step 18: E/M Level of Service.....	28
Example of the Overall Level .....	28
Step 19: Practice Exercise 36-5 .....	29
Step 20: Review Practice Exercise 36-5.....	29
Step 21: Contributing Factors .....	29
Counseling .....	29
Coordination of Care .....	30
Nature of Presenting Problem .....	30
Time .....	30
Step 22: Lesson Summary.....	30
Step 23: Quiz 36 .....	30

### **Lesson 37: Comprehensive CPT Evaluation and Management**

Step 1: Learning Objectives for Lesson 37 .....	1
Step 2: Lesson Preview.....	1
Step 3: Evaluation and Management Subsections.....	1
Office or Other Outpatient Services .....	1
Hospital Observation Services.....	2
Hospital Inpatient Services .....	2
Consultations .....	3
Emergency Department Services .....	3
Critical Care Services.....	4
Nursing Facility Services .....	4
Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services.....	4
Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services.....	5
Home Services .....	5

Prolonged Services .....	5
Case Management Services.....	5
Care Plan Oversight Services.....	5
Preventive Medicine Services .....	6
Non-Face-to-Face Physician Services.....	6
Special Evaluation and Management Services.....	6
Newborn Care Services .....	6
Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services.....	7
Step 4: Practice Exercise 37-1 .....	9
Step 5: Review Practice Exercise 37-1.....	9
Step 6: Coding Steps Review.....	9
Steps for Evaluation and Management Coding.....	10
Steps & Guidelines for ICD-10-CM Codes.....	10
Step 7: Practice Exercise 37-2 .....	10
Step 8: Review Practice Exercise 37-2.....	12
Step 9: Practice Exercise 37-3 .....	12
Step 10: Review Practice Exercise 37-3.....	12
Step 11: Practice Exercise 37-4 .....	12
Step 12: Review Practice Exercise 37-4.....	13
Step 13: Practice Exercise 37-5 .....	13
Step 14: Review Practice Exercise 37-5 .....	14
Step 15: Practice Exercise 37-6.....	15
Step 16: Review Practice Exercise 37-6.....	15
Step 17: Practice Exercise 37-7 .....	15
Step 18: Review Practice Exercise 37-7.....	17
Step 19: Practice Exercise 37-8 .....	17
Step 20: Review Practice Exercise 37-8.....	18
Step 21: Practice Exercise 37-9 .....	19
Step 22: Review Practice Exercise 37-9.....	19
Step 23: Practice Exercise 37-10 .....	19
Step 24: Review Practice Exercise 37-10 .....	20
Step 25: Lesson Summary.....	20
Step 26: Quiz 37 .....	20

## Lesson 38: The Basics of HCPCS Coding

Step 1: Learning Objectives for Lesson 38 .....	1
Step 2: Lesson Preview .....	1
Step 3: History of HCPCS .....	1
Step 4: Practice Exercise 38-1 .....	2
Step 5: Review Practice Exercise 38-1 .....	2
Step 6: Organization of the HCPCS Level II .....	2
Index .....	2
Tabular List .....	2
Appendices .....	5
Step 7: Practice Exercise 38-2 .....	6
Step 8: Review Practice Exercise 38-2 .....	6
Step 9: Lesson Summary .....	7
Step 10: Quiz 38 .....	7
Endnotes .....	7

## Lesson 39: The Future of Health Care and Final Quiz

Step 1: Learning Objectives for Lesson 39 .....	1
Step 2: Lesson Preview .....	1
Step 3: Technology and Health Care: Today .....	1
Step 4: Electronic Health Records .....	3
Step 5: Access the Internet and the Web from a Computer .....	5
The Computer Network .....	6
Step 6: Electronic Coding .....	8
Encoder Programs .....	8
Computer-assisted Coding .....	10
Step 7: Web-based Medical Records .....	11
Step 8: Practice Exercise 39-1 .....	12
Step 9: Review Practice Exercise 39-1 .....	12
Step 10: Lesson Summary .....	12
Step 11: Course Summary .....	12
Step 12: Quiz 39 .....	13
Endnotes .....	13



---

## Answer Key

Lesson 36 .....	1
Practice Exercise 36-1 .....	1
Practice Exercise 36-2 .....	3
Practice Exercise 36-3 .....	6
Practice Exercise 36-4 .....	7
Practice Exercise 36-5 .....	9
Lesson 37 .....	10
Practice Exercise 37-1 .....	10
Practice Exercise 37-2 .....	11
Practice Exercise 37-3 .....	13
Practice Exercise 37-4 .....	13
Practice Exercise 37-5 .....	13
Practice Exercise 37-6 .....	14
Practice Exercise 37-7 .....	16
Practice Exercise 37-8 .....	18
Practice Exercise 37-9 .....	20
Practice Exercise 37-10 .....	20
Lesson 38 .....	22
Practice Exercise 38-1 .....	22
Practice Exercise 38-2 .....	22
Lesson 39 .....	22
Practice Exercise 39-1 .....	22



# Lesson 36

## CPT Coding for Evaluation and Management Services

---

### Step 1: Learning Objectives for Lesson 36

---

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

- 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 factors 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 it's used 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 discover 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 providers for emergency department care, nursing home stays and more. Let's start our exploration of E/M coding by looking at the steps involved.

### 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 need to take a number of different things into consideration. 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 onto 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 you'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 in the *Assignment Pack* into a folder for quick reference. You will use the information every time you code an E/M encounter, in this course 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 and Neonatal 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 provider. 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 if the patient status is 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 health care 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 key 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 36-1

---

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. Write your answers on scratch paper.

**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 36-1

---

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

---

## 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 in your *CPT* education. Don't worry if you're uncertain on some of those steps. You will work through them one step at a time. For now, all you need to know is that in order to narrow down the tentative code range, you 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. (You'll explore 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 minutes 4-6 x a day. Prescribed topical corticosteroid to decrease the inflammation. Contact the office if no improvement in 2 weeks.

# Medical Coding and Billing Specialist

---

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 provider 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, you "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 you'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 provider 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 coding and billing specialist, 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 provider 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.

When the physician documents “noncontributing” in the ROS, the medical coding and billing specialist cannot count that system. Noncontributing doesn’t provide enough information. Did the physician check the system and felt it didn’t contribute to the problem, or was the system not checked altogether? Since you don’t know, you won’t count it.

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

## Medical Coding and Billing Specialist

---

- **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 coding and billing specialist, 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.

## Medical Coding and Billing Specialist

**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 will circle “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 provider 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*.

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*.

## CPT Coding for Evaluation and Management Services

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

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. You'll get there, but first let's check your understanding of the history component with the following Practice Exercise.



## Step 10: Practice Exercise 36-2

---

For the following scenarios, determine the level of service for the history component with the information provided, and write your answers on scratch paper. First, complete the History Component Table following each report. Then, use the Summary History Table to determine the level of service. Use the E/M Audit found in your *Assignment Pack* to assist you.

### 1. EMERGENCY DEPARTMENT 99281-99288

#### HISTORY

##### CHIEF COMPLAINT

Hematemesis x 1 week.

##### HISTORY OF PRESENT ILLNESS

The patient is a 35-year-old Hispanic female who has had hematemesis of coffee-ground material and brown clots for 6 days without bright red blood. She states that approximately 10 days prior to this visit, she had the gradual onset of squeezing epigastric pain which increased with eating. Approximately 3-4 days later, her vomiting started. She initially had trouble keeping solids down but later came to vomit liquids also. The patient denies any change in her bowel or bladder habits, melena or bright red blood per rectum. She states she drinks 6 beers a day and has done so for the past 6 months but has been drinking about 12 beers a day for the last week. She was hospitalized 8 years ago for a similar episode but was not aware of the diagnosis at that time. There was no weight loss with this history.

##### PAST MEDICAL HISTORY

Illnesses: Denies prior tuberculosis, hepatitis, cholecystitis, peptic ulcer disease or other GI disease.

Operations: No prior surgery.

ALLERGIES: NO ALLERGIES TO FOOD OR MEDICATION.

Social history: Alcoholic intake as described above without any use of spirits, wine. The patient denies intravenous drug abuse.

Family history: There is no family history of heart disease, diabetes, bleeding tendencies or thyroid disease.

Gynecological history: Gravida 4, para 4. LMP 4 weeks ago.

##### REVIEW OF SYSTEMS

Except as in the HPI, noncontributory. Note is made of the absence of loss of consciousness, ataxia or other neurological symptoms.

Level of Service for the History Component: \_\_\_\_\_

### 2. OFFICE CONSULTATION 99241-99245

#### CHIEF COMPLAINT

This 19-year-old female presents today complaining of acne from continually washing area, frequent phone use so the receiver rubs on face and oral contraceptive use. She indicates the problem location is the chin, right temple and left temple locally. She has had this condition for the last 3 months. Severity of condition is worsening.



### PAST HISTORY

Medications: Patient is currently taking Alesse-28 in 20 mcg-0.10 mg tablet, usage started on August 7, 20XX. Medication was prescribed by obstetrician-gynecologist.

Illnesses: Childhood illnesses of chickenpox, measles.

Operations: No previous surgeries.

**ALLERGIES: PATIENT ADMITS ALLERGY TO PENICILLIN RESULTING IN DIFFICULTY BREATHING.**

Social history: Patient admits caffeine use. She consumes 3-5 servings per day. Patient admits alcohol use. Drinking is described as social. Patient admits good diet habits. Patient admits exercising regularly. Patient denies STD history.

Family history: Patient admits a family history of anxiety, stress disorder associated with mother.

Gynecological history: Female reproductive Hx: Birth control pill use. Menses: Onset: 13 years old.

Interval: 22-27 days. Duration: 4-6 days. Flow: Light. Complications: None.

### REVIEW OF SYSTEMS

Integumentary: Positive for periodic reddening of face, acne problems.

Allergic /Immunologic: No allergic or immunologic symptoms.

Constitutional: No fever, headache, nausea or dizziness.

Reference: <http://www.mtsamples.com/site/pages/sample.asp?Type=97-Consult - History and Phy.&Sample=792-Acne Vulgaris - H&P>

**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.

**Level of Service for the History Component:** \_\_\_\_\_

---

## Step 11: Review Practice Exercise 36-2

---

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 medical coding and billing specialists include a third element—General Examination—which covers vital signs and the general appearance of the patient. This information is included 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

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*.

Summary Examination Table				
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! You will continue with the examples provided in the previous progress check, but only provide the examination details. Once you complete this, you're on to the medical decision making component. So let's get to it!

---

### Step 13: Practice Exercise 36-3

---

For the following scenarios, determine the overall level of service for the examination component with the information provided, and write your answers on scratch paper. First, complete the Examination Component Table below each report. Then, use the Summary Examination Table to determine the level of service. Use the E/M Audit found in your *Assignment Pack* to assist you.

#### 1. EMERGENCY DEPARTMENT 99281-99288

##### PHYSICAL EXAMINATION

**GENERAL:** The patient is a well-nourished, well-developed female who appears her stated age of 35 years and appears in no acute distress. The patient is oriented x 3.

**VITAL SIGNS:** Blood pressure: 136/86. Pulse: 72 and regular. Respiratory rate: 16/min.

Temperature: 98.2 °F.

**SKIN:** No spider angioma.

**HEENT:** Mucous membranes moist and pink.

**NECK:** Supple without JVD.

**HEART:** Regular rate and rhythm without murmurs. S1 and S2 are normal.

**LUNGS:** Clear to auscultation.

**ABDOMEN:** Soft. No hepatosplenomegaly or masses.

**RECTAL:** No masses are palpated. However, stool on the examination glove was guaiac positive.

**EXTREMITIES:** No cyanosis, clubbing or edema.

**NEUROLOGIC:** DTRs are intact. Negative Babinski. Heel-to-shin and finger-to-nose intact.

**Level of Service for the Examination Component:** \_\_\_\_\_

### 2. OFFICE CONSULTATION 99241-99245

#### PHYSICAL EXAMINATION

GENERAL: Patient is a 19-year-old female who appears pleasant, in no apparent distress, her given age, well developed, well nourished and with good attention to hygiene and body habits.

SKIN: Examination of scalp shows no abnormalities. Hair growth and distribution is normal. Inspection of skin outside of affected area reveals no abnormalities. Palpation of skin shows no abnormalities. Inspection of eccrine and apocrine glands shows no evidence of hyperidrosis, chromidrosis or bromhidrosis. Face shows keratotic papule.

Reference: <http://www.mtsamples.com/site/pages/sample.asp?Type=97-Consult - History and Phy.&Sample=792-Acne Vulgaris - H&P>

**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 °F. A rectal swab specimen was positive for Coxsackie A virus.

**Level of Service for the Examination Component:** \_\_\_\_\_

---

## Step 14: Review Practice Exercise 36-3

---

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)

---

You've analyzed the level of service for the components of history and examination. Now let's discuss the final key component: medical decision making (MDM). 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 you'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 towards 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	<b>Minimal or None</b>
2	<b>Limited</b>
3	<b>Moderate</b>
4 or more	<b>Extensive</b>

## 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 healthcare document specialist. 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 is not a complete list of what may appear.

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
<i>Minimal</i>	One self-limited or minor problem	Laboratory tests requiring venipuncture; chest x-ray; EKG/EEG; urinalysis; ultrasound	Rest; gargles; elastic bandage superficial dressing
<i>Low</i>	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
<i>Moderate</i>	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
<i>High</i>	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 coding and billing specialist, 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 uncomplicated, complicated 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 entire dictation might be used in this step of the E/M process. 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 minutes 4-6 x a day. Prescribed topical corticosteroid to decrease the inflammation. Contact the office if no improvement in 2 weeks.

Now let's use this chart with the 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.

## Medical Coding and Billing Specialist

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'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 36-4

For the following scenarios, refer to the following tables to determine each component, and write your answers on scratch paper. Then, using the Summary MDM Table determine the overall level of service for the medical decision making component with the information provided. Use the E/M Audit found in your *Assignment Pack* to assist you.

### 1. EMERGENCY DEPARTMENT 99281-99288

#### HISTORY

##### CHIEF COMPLAINT

Hematemesis x 1 week.

##### HISTORY OF PRESENT ILLNESS

The patient is a 35-year-old Hispanic female who has had hematemesis of coffee-ground material and brown clots for 6 days without bright red blood. She states that approximately 10 days prior to this visit, she had the gradual onset of squeezing epigastric pain which increased with eating. Approximately 3-4 days later, her vomiting started. She initially had trouble keeping solids down but later came to vomit liquids also. The patient denies any change in her bowel or bladder habits, melena or bright red blood per rectum. She states she drinks 6 beers a day and has done so for the past 6 months but has been drinking about 12 beers a day for the last week. She was hospitalized 8 years ago for a similar episode but was not aware of the diagnosis at that time. There was no weight loss with this history.

##### PAST MEDICAL HISTORY

Illnesses: Denies prior tuberculosis, hepatitis, cholecystitis, peptic ulcer disease or other GI disease.

Operations: No prior surgery.

ALLERGIES: NO ALLERGIES TO FOOD OR MEDICATION.

Social history: Alcoholic intake as described above without any use of spirits, wine. The patient denies intravenous drug abuse.

Family history: There is no family history of heart disease, diabetes, bleeding tendencies or thyroid disease.

Gynecological history: Gravida 4, para 4. LMP 4 weeks ago.

##### REVIEW OF SYSTEMS

Except as in the HPI, noncontributory. Note is made of the absence of loss of consciousness, ataxia or other neurological symptoms.

##### PHYSICAL EXAMINATION

GENERAL: The patient is a well-nourished, well-developed female who appears her stated age of 35 years and appears in no acute distress. The patient is oriented x 3.

VITAL SIGNS: Blood pressure: 136/86. Pulse: 72 and regular. Respiratory rate: 16/min.

Temperature: 98.2 °F.

SKIN: No spider angioma.

HEENT: Mucous membranes moist and pink.

NECK: Supple without JVD.

HEART: Regular rate and rhythm without murmurs. S1 and S2 are normal.

## Medical Coding and Billing Specialist

---

LUNGS: Clear to auscultation.

ABDOMEN: Soft. No hepatosplenomegaly or masses.

RECTAL: No masses are palpated. However, stool on the examination glove was guaiac positive.

EXTREMITIES: No cyanosis, clubbing or edema.

NEUROLOGIC: DTRs are intact. Negative Babinski. Heel-to-shin and finger-to-nose intact.

### LABORATORY DATA

Sodium 129, potassium 3.5, FBS 81, chloride 113, total bilirubin 0.7, direct bilirubin 0.1, LDH 330, alkaline phosphatase 94, hematocrit stable at 38%.

### IMPRESSION

Upper gastrointestinal bleeding. The etiology is not determined at this time but includes peptic ulcer disease, gastritis, Mallory-Weiss tears or carcinoma.

### PLAN

Ranitidine 50 mg q.8 h., Compazine 10 mg IM q.6 h. p.r.n. for nausea and vomiting. Gastroenterology consultation for gastroscopy. We would like to plan this patient's gastroscopy for as soon as possible, probably tomorrow morning. Obtain serum amylase.

**Level of Service for the Medical Decision Making Component:** \_\_\_\_\_

## 2. OFFICE CONSULTATION 99241-99245

### CHIEF COMPLAINT

This 19-year-old female presents today complaining of acne from continually washing area, frequent phone use so the receiver rubs on face and oral contraceptive use. She indicates the problem location is the chin, right temple and left temple locally. She has had this condition for the last 3 months. Severity of condition is worsening.

### PAST HISTORY

Medications: Patient is currently taking Alesse-28 in 20 mcg-0.10 mg tablet, usage started on August 7, 20XX. Medication was prescribed by her obstetrician-gynecologist.

Illnesses: Childhood illnesses of chickenpox, measles.

Operations: No previous surgeries.

**ALLERGIES: PATIENT ADMITS ALLERGY TO PENICILLIN RESULTING IN DIFFICULTY BREATHING.**

Social history: Patient admits caffeine use. She consumes 3-5 servings per day. Patient admits alcohol use. Drinking is described as social. Patient admits good diet habits. Patient admits exercising regularly. Patient denies STD history.

Family history: Patient admits a family history of anxiety, stress disorder associated with mother.

Gynecological history: Female reproductive Hx: Birth control pill use. Menses: Onset: 13 years old.

Interval: 22-27 days. Duration: 4-6 days. Flow: Light. Complications: None.

### REVIEW OF SYSTEMS

Integumentary: Positive for periodic reddening of face, acne problems.

Allergic /Immunologic: No allergic or immunologic symptoms.

Constitutional: No fever, headache, nausea or dizziness.

### PHYSICAL EXAMINATION

GENERAL: Patient is a 19-year-old female who appears pleasant, in no apparent distress, her given age, well developed, well nourished and with good attention to hygiene and body habits.

SKIN: Examination of scalp shows no abnormalities. Hair growth and distribution is normal. Inspection of skin outside of affected area reveals no abnormalities. Palpation of skin shows no abnormalities. Inspection of eccrine and apocrine glands shows no evidence of hyperidrosis, chromidrosis or bromhidrosis. Face shows keratotic papule.

### IMPRESSION

Acne vulgaris.

### PLAN

Recommended treatment is antibiotic therapy. Patient received extensive counseling about acne. She understands acne treatment is usually long term. Return to clinic in 4 weeks.

Reference: <http://www.mtsamples.com/site/pages/sample.asp?Type=97-Consult - History and Phy.&Sample=792-Acne Vulgaris - H&P>

**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 and feet and in the diaper area. Rectal temperature: 103 °F. A rectal swab specimen was positive for Cocksackie 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 4-5 days, and he can then return to school.

**Level of Service for the Medical Decision Making Component:** \_\_\_\_\_

### Step 17: Review Practice Exercise 36-4

---

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 range.
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 36-5

---

Based on the information obtained from previous Practice Exercises, determine the overall level of service for the following encounters, and write your answers on scratch paper.

### 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	99242
medical decision making component	99244
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 36-5

---

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

---

## 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 that 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 healthcare professionals 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: Quiz 36

---

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the instruction carefully.



# Lesson 37

## Comprehensive CPT Evaluation and Management

---

### Step 1: Learning Objectives for Lesson 37

---

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

- Identify the differences between the E/M codes.
- Review the steps to evaluation and management coding.
- Integrate the *ICD-10-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 the previous lesson, use your E/M Audit found in your *Assignment Pack* 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

---

You've discovered how to use the classification system to locate the tentative code range. You 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 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 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.

### 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 his record notes a 10-minute loss of consciousness. 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 the exchange that occurs when one provider seeks the opinion or advice of another provider. The request for the consultation may be written or verbal, but it must be documented in the patient's medical record. The consulting physician will send a written opinion back to the requesting physician. 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) no longer recognizes 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.

Let's look at the code description for 99285.

Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status.

That's something new 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 professional 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 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 physician's time spent during the discharge process.

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

Generally, healthcare 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 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 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.

### 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 physician's 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 preventative medicine service.

## **Counseling Risk 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 Physician Services

A physician 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. You'll find specific codes for inter-professional telephone or internet consultations here as well.

## 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 maternal 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.

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 99466. 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 you 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 disciplines 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 continues 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 37-1

---

On scratch paper, match the *Evaluation and Management* subsection with its description.

- |  |   |
|--|---|
| 1. <b>Hospital Observation Services</b>                      | a. Evaluation and management services provided by a physician in a private residence.   |
| 2. <b>Hospital Inpatient Services</b>                        | b. Low birth weight (LBW) and very low birth weight (VLBW) infants who are no longer classified as critically ill, but require subsequent care. |
| 3. <b>Consultations</b>                                      | c. The patient's status can be initial hospital care, subsequent hospital care or observation or inpatient care services.                       |
| 4. <b>Emergency Department Services</b>                      | d. Services for those whose condition is not serious enough to be admitted, but not well enough to go home either.                              |
| 5. <b>Pediatric Critical Care Patient Transport</b>          | e. Generally, healthcare services are not provided, while room, board and other personal assistance services are provided.                      |
| 6. <b>Initial and Continuing Intensive Care Services</b>     | f. Routine evaluation and management services for a healthy patient with no complaints.   |
| 7. <b>Domiciliary, Rest Home, or Custodial Care Services</b> | g. The physician's physical attendance and direct face-to-face care during the transport of a critically ill or injured pediatric patient.      |
| 8. <b>Home Services</b>                                      | h. Exchanges that occur when one physician seeks the opinion or advice from another physician.  |
| 9. <b>Preventive Medicine Services</b>                       | i. Evaluation and management services performed to establish a baseline for life or disability insurance are coded from this subsection.        |
| 10. <b>Special Evaluation and Management Services</b>        | j. Services must be provided in a hospital.   |

---

## Step 5: Review Practice Exercise 37-1

---

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, you will have 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 you studied. Let's take a moment to review the E/M coding steps, as well as the steps for coding from the *ICD-10-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-10-CM Codes

1. Locate the main term in the *Alphabetic Index*.
2. Refer to any subterms under the main term.
3. look at the punctuation, abbreviation and general notes that may apply.
4. Note the tentative code.
5. Locate the tentative code in the *Tabular List*.
6. Review the general notes, includes and excludes notes.
7. Assign the valid code to its highest levels of specificity.

#### 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 37-2

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

#### OFFICE VISIT FOR AN ESTABLISHED PATIENT

##### HISTORY OF PRESENT ILLNESS

This is a 10-year-old who was found with biliary atresia and underwent a Kasai procedure, but she ended up having a liver transplant. The patient did well after the liver transplant. At this time, there are no complaints and is being seen for a follow-up.

## PAST HISTORY

Medications: Please see the MRC form.

ALLERGIES: THERE ARE NO ALLERGIES.

Social history: The patient lives with the parents and has a good environment.

Family history: Negative for gastrointestinal illness except that a sibling has ulcerative colitis.

Diet: Lactose-limited diet.

## REVIEW OF SYSTEMS

Negative.

## PHYSICAL EXAMINATION

GENERAL: A well-developed, well-nourished child in no acute distress. Measurements: Height 135 cm and weight 28.1 kg.

VITAL SIGNS: Temperature 98.9 and blood pressure 105/57.

SKIN: No unusual lesions.

HEENT: Atraumatic and normocephalic. The pupils are equal, round, and reactive to light. Full EOMs. The conjunctivae and sclerae are clear. The TMs show normal landmarks. The nasal mucosa is pink and moist. The teeth and gums are in good condition. The pharynx is clear.

NECK: Supple without masses.

LYMPHATIC: No adenopathy.

CHEST: Heart: Regular rhythm without murmur. S1 and S2 are normal. The pulses are full and symmetrical bilaterally. Lungs: Clear to auscultation with no retractions.

ABDOMEN: Normal bowel sounds. No hepatosplenomegaly, no masses and no tenderness.

BACK: No scoliosis, hairy patch, lipoma, or sacral dimple.

GENITALIA: Normal female by inspection.

EXTREMITIES: No cyanosis, clubbing, or edema.

NEUROLOGIC: Central nervous system: Developmentally appropriate for age. DTRs are 2+ and symmetrical. The toes are down going bilaterally. Motor and sensory without asymmetry. Cranial nerves 2-12 are grossly intact.

## LABORATORY DATA

Laboratory data indicates tacrolimus 3.1 and negative Epstein-Barr. CMV was not detected.

## IMPRESSION

1. Biliary atresia.
2. Status post orthotopic liver transplantation.

## PLAN

Our plan would be to continue with the medications as follows:

1. Prograf 0.5 mg p.o. b.i.d.
2. Valganciclovir 420 mg p.o. b.i.d.
3. Labs every 2-3 months.
4. To return to clinic in 4 months.

**ICD-10-CM:**

\_\_\_\_\_  
\_\_\_\_\_

**CPT:**

\_\_\_\_\_

### Step 8: Review Practice Exercise 37-2

---

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

### Step 9: Practice Exercise 37-3

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

Intensive care unit admits a patient with 1st- and 2nd-degree burns of the left thigh and 2nd-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 1 hour.

**ICD-10-CM:**

**CPT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Step 10: Review Practice Exercise 37-3

---

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

### Step 11: Practice Exercise 37-4

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

#### GYNECOLOGICAL REPORT

##### HISTORY OF PRESENT ILLNESS

This 38-year-old, gravida 3, para 2, ab 1 white female presents for an initial pelvic examination as part of routine physical exam. Last Pap was a year ago and normal. LMP was August 29, 20XX. Her cycles are usually regular, although that one came about a week early. Her husband has had a vasectomy. Overall, she is feeling well. She notes that a brother who was treated 12 years ago for a brain tumor has had a recurrence and had surgery again.

##### PAST HISTORY

She states that for a while she was really exercising regularly and eating lots of fruits and vegetables. Right now, she is not doing nearly as well. She has perhaps 2 dairy servings daily, trying to cut down. She is not exercising at all, and fruit and vegetable intake varies. She is a nonsmoker. Last cholesterol was in 20XX and was normal. She had a mammogram which was normal recently. She is current on her tetanus update.

## REVIEW OF SYSTEMS

Respiratory: Negative.

Cardiovascular: Negative.

Gastrointestinal: She tends to have a little gas which is worse when she is eating more fruits and vegetables. She had been somewhat constipated, but that is better.

Genitourinary: Negative.

## PHYSICAL EXAMINATION

GENERAL: She is a well-developed, well-nourished, pleasant white female in no distress.

VITAL SIGNS: Her weight was 154 pounds, which is down 2 pounds. Blood pressure 104/66.

NECK: Supple without adenopathy. No thyromegaly or nodules palpable.

CHEST: Heart: Regular rate and rhythm without murmurs. Lungs: Clear to A&P. Breasts: Symmetrical without masses, nipple or skin retraction, discharge or axillary adenopathy.

ABDOMEN: Soft without organomegaly, masses or tenderness.

PELVIC: Reveals no external lesions. The cervix is parous. Uterus is anteverted and normal in size, shape and consistency, and nontender. No adnexal enlargement.

## ASSESSMENT

Normal GYN exam.

Reference: [http://www.mtsamples.com/site/pages/sample.asp?Type=45-Obstetrics / Gynecology&Sample=383-Physical Exam and Pap](http://www.mtsamples.com/site/pages/sample.asp?Type=45-Obstetrics%20Gynecology&Sample=383-Physical%20Exam%20and%20Pap) - 1

ICD-10-CM:

\_\_\_\_\_

CPT:

\_\_\_\_\_

---

## Step 12: Review Practice Exercise 37-4

---

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

---

## Step 13: Practice Exercise 37-5

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

## HOSPITAL DISCHARGE SUMMARY

### DISCHARGE SUMMARY

#### DATE OF ADMISSION

August 5, 20XX

#### DATE OF DISCHARGE

August 9, 20XX

## SPECIAL PROCEDURES AND DIAGNOSTIC TESTS

Open reduction and internal fixation of right olecranon, partial right radial head excised, partial right coronoid process excised.

# Medical Coding and Billing Specialist

---

## HOSPITAL COURSE

The patient is a 26-year-old black male who flew off a motorcycle during a sudden stop, landing on and subsequently injuring his right elbow. Subsequently, the patient complained of pain, tenderness, swelling, decreased range of motion but without any paresthesia or paralysis. On admission, the patient was alert and afebrile. Physical examination was remarkable for only right elbow swelling, diffuse tenderness and decreased range of motion. Neurologic examination and circulation were intact. Plain films demonstrated comminuted olecranon, coronoid and radial head fractures with joint subluxation. The patient was taken to the operating room for open reduction and internal fixation. He tolerated the procedure well. He was treated with Cefadyl 2 gm IV piggyback q.6 h. x 36 hours. He was splinted postoperatively, and a drain was placed at the elbow. Two days later, the drain was removed, and the patient was discharged home in improving condition with the splint still intact and without complication.

## FOLLOW-UP

Thompson Clinic appointment in 1 week. The patient was advised to elevate the right upper extremity and ambulate with a slow but steady gait. The patient was advised of the use and purpose of his pain medication and advised to return sooner if there was a change in the color of or ability to move his fingers.

## CONDITION ON DISCHARGE

Good.

## DISCHARGE DIAGNOSIS

Right elbow radial head fracture, coronoid fracture and olecranon fracture with subluxation of the elbow joint.

## PROGNOSIS

Good with limitation of movement that persists.

## DISCHARGE MEDICATIONS

Tylenol p.r.n. for pain.

## DISCHARGE MANAGEMENT

09:05-09:55 a.m.

**ICD-10-CM:**

**CPT:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

---

## Step 14: Review Practice Exercise 37-5

---

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

## Step 15: Practice Exercise 37-6

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

### 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 3 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 x 1 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-10-CM:

\_\_\_\_\_

CPT:

\_\_\_\_\_

## Step 16: Review Practice Exercise 37-6

---

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

## Step 17: Practice Exercise 37-7

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

### EMERGENCY DEPARTMENT

#### HISTORY

##### CHIEF COMPLAINT

SOB with diaphoresis and EKG en route to hospital showing 3-4 mm ST segment elevations in V4 through V6 with T-wave inversion in V4 through V6 and an inferior wall MI of indeterminate age.

### HISTORY OF PRESENT ILLNESS

This is a 71-year-old female with a long-standing history of hypertension and heart problems since the age of 48 who was admitted to the coronary care unit to rule out acute lateral wall myocardial infarction. She began developing chest pain, shortness of breath and diaphoresis about 5 days ago and was brought by ambulance, where an EKG showed ST elevation and T-wave inversion in V4 through V6 and an inferior wall MI of indeterminate age. She was started on nitrates and diltiazem with relief of her symptoms.

### PAST MEDICAL HISTORY

Illnesses: Peptic ulcer disease, documented by endoscopy. She also had a long-standing history of hypertension. She has a long-standing renal failure, although this has never been clearly documented in her prior hospital records, and her records from Japan are unavailable. She has an aortic aneurysm documented by abdominal CT in her most recent hospitalization at Weston Medical Center, as well as previous cardiac catheterization at that time. There was no history of diabetes, cough, fever, paroxysmal nocturnal dyspnea or hypercholesterolemia.

Medications: The medications she was taking at the nursing home include: Amphojel 30 mL p.o. q.i.d., Carafate 1 g q.i.d., FeSO<sub>4</sub> 325 mg t.i.d., Halcion 0.125 mg p.o. h.s. p.r.n., Pepcid 20 mg 2 q.h.s.

Social history: The patient was born in the United States but lived in Japan most of her life. She has smoked 1 pack per day of cigarettes for a year.

Family history: There is no family history of heart disease.

REVIEW OF SYSTEMS: Except as noted in HPI, noncontributory.

### PHYSICAL EXAMINATION

VITAL SIGNS: Blood pressure: 130/90. Respiratory rate: 20. Heart rate: 95. Temperature: 98.

HEENT: Normocephalic, atraumatic. PERRLA. Fundi positive for AV nicking and narrowing. No flame-shaped hemorrhages are seen.

NECK: Supple. Jugular venous distention at 10 cm. No carotid bruits.

HEART: Soft S1. Normal S2. S3 and S4 present. No murmurs.

LUNGS: Coarse, wet rales to halfway up from the bases.

ABDOMEN: Soft, nontender, without organomegaly. There is a 5-6 cm pulsatile abdominal mass in the right upper quadrant in the midclavicular line, just inferior to the umbilicus.

NEUROLOGIC: No focal abnormalities. Cranial nerves 2-12 are intact.

### DATABASE

The chest x-ray revealed pulmonary edema with a widened mediastinum consistent with a tortuous aorta, unable to rule out a dissection. A chest CT scan revealed evidence of dissection. She was transferred to the coronary care unit for hemodynamic monitoring and possible coronary catheterization.

### IMPRESSION

1. Coronary artery disease with evidence of new inferolateral wall myocardial infarction on electrocardiogram.
2. Peptic ulcer disease, stable on current medications.
3. Probable renal insufficiency. The patient has received contrast this morning for a chest computed tomography scan.
4. Congestive heart failure.



## PLAN

Since the patient has had a previous history of GI bleeding with thrombolytic therapy, we will hold heparin. We will restart nitrates and diltiazem and consider captopril for afterload reduction. We plan to rule out an acute myocardial infarction with serial EKGs and CPK isoenzymes. A gated nuclear study is planned to look for focal areas of akinesia. SMAC with BUN and creatinine to evaluate renal status. Monitor BUN and creatinine q.12 h. in view of the patient's recent contrast dose for cardiac catheterization. We will continue her Lasix therapy as well.

**ICD-10-CM:**

**CPT:**

---

---

---

---

---

---

## Step 18: Review Practice Exercise 37-7

---

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

---

## Step 19: Practice Exercise 37-8

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

### ORTHOPEDIC CONSULTATION REPORT

#### REASON FOR REFERRAL

Patient sent by her physician for a 2nd 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

Medications: Long-term corticosteroid therapy for rheumatoid arthritis. 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 4th, 5th and 6th ribs began 1 week ago spontaneously. No history of trauma.

## Medical Coding and Billing Specialist

---

### PHYSICAL EXAMINATION

GENERAL: This is a 60-year-old, 180-pound white female in moderate distress.

VITAL SIGNS: Pulse: 100 and regular. Blood pressure: 140/110. Respiratory rate: 20, guarded.

Temperature: 99.6 °F.

CHEST: There is pinpoint tenderness over the left 4th, 5th and 6th 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 2-12 are intact.

### DATABASE

A bone survey shows diffuse, widespread changes of rheumatoid arthritis with destruction of taloscaphoid axis and pronation of the right foot. RF factor positive.

### ASSESSMENT

1. Rheumatoid arthritis with severe destructive disease 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-10-CM:

CPT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

---

## Step 20: Review Practice Exercise 37-8

---

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

---

## Step 21: Practice Exercise 37-9

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

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-10-CM:**

\_\_\_\_\_

**CPT:**

\_\_\_\_\_

\_\_\_\_\_

---

## Step 22: Review Practice Exercise 37-9

---

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

---

## Step 23: Practice Exercise 37-10

---

Use your *ICD-10-CM* and *CPT* coding manuals, as well as the E/M Audit, if applicable, found in your *Assignment Pack* to determine the correct codes for the following report.

### 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

Illnesses: The patient experienced similar symptoms 4 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

VITAL SIGNS: Pulse: 168/min. Respiratory rate: 38/min and labored. Temperature: 104.4 °F.

HEENT: Increased nasal discharge. Trachea midline. TMs clear. Pharynx not examined.

NECK: Supple. No jugular venous distention.

## Medical Coding and Billing Specialist

---

CHEST: 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 epinephrine 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-10-CM:

CPT:

\_\_\_\_\_

\_\_\_\_\_

---

## Step 24: Review Practice Exercise 37-10

---

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 and billing specialist career with a specific provider, 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: Quiz 37

---

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the instructions carefully.

# Lesson 38

## The Basics of HCPCS Coding

---

### Step 1: Learning Objectives for Lesson 38

---

When you complete the instruction in this lesson, you will be trained to:

- Describe the history and use of the *HCPCS Level II* manual.
- Explain the organization of the *HCPCS Level II* manual.
- Describe the types of codes found in the *HCPCS Level II* manual.

---

### Step 2: Lesson Preview

---

While the *ICD-10-CM* and *CPT* manuals are the most common manuals in the healthcare profession, there is a third coding manual: *HCPCS Level II*. These codes allow you to code for medical supplies, drugs and special procedures. In this lesson, you'll study the history and purpose of *HCPCS*. Although you don't need the *HCPCS* manual to complete this material, you'll get a brief tour of the manual and learn how to use it

Let's begin by exploring the history of this coding manual.

---

### Step 3: History of HCPCS

---

The **Healthcare Common Procedure Coding System (HCPCS)** was created in 1983 by the Center for Medicare and Medicaid Services (CMS) as a uniform method for health care providers and medical suppliers to report professional services, procedures and supplies. HCPCS codes were mandated by CMS for Part B Medicare services in 1983 and for Medicaid services in 1986. In 1987 HCPCS codes became mandatory for reporting Medicare hospital outpatient services. In addition to these federal programs, HCPCS codes may be required by other payers.<sup>1</sup>

The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA).<sup>2</sup> You're rarely hear the CPT codes references as HCPCS Level I codes.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) when used outside a physician's office. HCPCS Level II codes are alphanumeric, with one letter followed by four numbers. Each subsection in the *HCPCS* manual has its own letter. In addition, each subsection covers a different type of service.

## Medical Coding and Billing Specialist

---

HCPCS codes provide additional information about a patient's procedure or service. 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. Just like the *CPT*, the *HCPCS Level II* manual is updated annually.

Before discussing the organization of the HCPCS manual, let's review the history.

---

### Step 4: Practice Exercise 38-1

---

Determine the term(s) to complete each sentence, and write your answers on scratch paper.

1. HCPCS stands for \_\_\_\_\_ Procedure Coding System.
2. \_\_\_\_\_ developed these codes in 1983.
3. The *HCPCS Level II* is updated every \_\_\_\_\_.
4. While CPT codes represent the procedure, HCPCS codes account for \_\_\_\_\_.

---

### Step 5: Review Practice Exercise 38-1

---

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

---

### Step 6: Organization of the HCPCS Level II

---

The *HCPCS Level II* is designed a lot like the *CPT* or *ICD-10-CM* coding books. It is divided into two sections. The *Index* is arranged alphabetically, while the *Tabular List* is arranged by topic. It also includes appendices.

#### Index

The *Index* is organized alphabetically by main terms. Main terms aren't as straightforward as those found in the *ICD-10-CM* or *CPT*. The main term may be the name of the medical or surgical supply, or it may be listed as the brand names by which the item is known.

Once a tentative code has been located in the *Index*, the code is verified in the *Tabular List* of the manual.

#### Tabular List

Each subsection of the *Tabular List* in the *HCPCS* manual has its own letter. There are 16 subsections and each one of these sections covers a different area of medicine. These include pathology and lab services, drugs administered to patients and more. Now, you'll take a brief look at what you can expect to find in each subsection.

### Transportation Services Including Ambulance and Medical and Surgical Supplies

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 as critical as those needing ALS.

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.

### Enteral and Parenteral Therapy

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.

### Outpatient PPS

The “C” subsection is the outpatient *pass-through-payments section (PPS)*. **Pass-through-payments** are intended to approximate the incremental costs of a new technology.<sup>3</sup> 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.

### Durable Medical Equipment

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.

### Procedures/Professional Services (Temporary)

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.

### Alcohol and Drug Abuse Treatment Services

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.

## Drugs

“J” codes include drugs that ordinarily cannot be self-administered, chemotherapy drugs, immunosuppressive drugs, inhalation solutions and other drugs and solutions. These codes go hand-in-hand with the *CPT* codes listing how a drug was administered. When services involve drugs, both the procedure from the *CPT* and the actual drug used from *HCPCS* are applied.

## Temporary Codes

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.

## Orthotic Procedures and Devices

After the “K” codes comes the “L” subsection, which covers 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. This section also contains codes for prosthetics that a patient may need. This could be a prosthetic leg or hand. Other codes found in this subsection are breast prostheses. This could be a bra for a breast cancer survivor or a silicone implant.

## Medical Services

The codes in this small subsection of “M” cover very specific office services. There are codes for cellular therapy, as well as fabric wrapping of an abdominal aneurysm.

## Pathology and Laboratory Services

*HCPCS Level II* contains some pathology and laboratory codes—in subsection “P”— but most of the lab test codes used are in the *CPT*. This section includes blood products such as whole blood, platelets, plasma or red blood cells. It is used 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.

## Temporary Codes

“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.

## Diagnostic Radiology Services

The “R” subsection has only three codes. These codes show the use of portable radiology equipment.



## Temporary National Codes

All of the codes that you learned about 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 Blue Cross/Blue Shield still uses. Other insurance companies can request that these codes are used, but they are never used for Medicare patients. There are codes for medications, procedures, evaluation and management codes, genetic testing codes and more!

## National T Codes Established for State Medicaid Agencies

“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.

## Vision and Hearing Services

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.

## Appendices

*HCPCS Level II* contains a number of appendices full of useful information. These appendices are used to help find the right code. The contents of the appendices may vary by publisher, but generally, the following information is found in the *HCPCS Appendices*.

**Table of Drugs and Biologicals**—This appendix directs the user to drug titles and the corresponding J code, which you now know are the codes for drugs. Both generic and brand names are listed alphabetically in the *Table of Drugs*.

**Modifiers**—HCPCS has many modifiers that supplement those found in the CPT manual. They help indicate such things as the number of wounds, the type of provider, anatomical sites and various other situations or circumstances.

**New, Changed, Deleted and Reinstated HCPCS Codes**—This is an easy reference for new, changed, deleted or reinstated codes since the last version of the manual.

**Place of Service and Type of Service**—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.

One final note regarding the use of the HCPCS codes: When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, use the CPT code. If, however, the narratives are not identical, use the HCPCS Level II code. Before wrapping up this lesson, let’s pause for another Practice Exercise.

### Step 7: Practice Exercise 38-2

---

Select the best answer from the choices provided, and write your answers on scratch paper.

1. The **HCPCS** manual is consists of \_\_\_\_\_.
  - a. *Category I, II and III* codes
  - b. seven character codes
  - c. an *Index* and *Tabular List*
  - d. all of the above
2. The \_\_\_\_\_ is/are not part of the **HCPCS** appendices.
  - a. modifiers
  - b. neoplasm table
  - c. place of service
  - d. type of service
3. A main term in the **HCPCS Index** may be \_\_\_\_\_.
  - a. diseases
  - b. brand names
  - c. the name of medical supplies
  - d. either brand names or the name of medical supplies
4. **Transportation codes** show \_\_\_\_\_.
  - a. how critical a patient is
  - b. why a patient is being brought in
  - c. how far the ambulance has traveled
  - d. all of the above
5. **Durable medical equipment** is found in subsection \_\_\_\_\_.
  - a. A
  - b. B
  - c. C
  - d. E

---

### Step 8: Review Practice Exercise 38-2

---

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

### Step 9: Lesson Summary

---

You have made great progress in this lesson! You discovered the history and use of the final coding manual—the *HCPCS Level II*. You know the organization of the manual, as well as a little about each subsection. When you're ready, go ahead and complete the Quiz to reinforce what you've learned in this lesson.

### Step 10: Quiz 38

---

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

### Endnotes

- <sup>1</sup> Review of CPT and HCPCS Level II Code Sets. Advance Healthcare Network, 2003. Web. 7 October 2013.
- <sup>2</sup> HCPCS-General Information. CMS.gov, 2013. Web. 7 October 2013.
- <sup>3</sup> Medicare Reimbursement for Drugs and Devices. Emerging Life Sciences. Web. 7 October 2013.



# Lesson 39

## The Future of Health Care and Final Quiz

---

### Step 1: Learning Objectives for Lesson 39

---

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

- Discuss important trends in the electronic health record.
- Differentiate between encoders and autocoding.
- Summarize the pros and cons of electronic coding.
- Explain key concerns with remote coding.
- Apply your knowledge of EOBs and the claims process.
- Apply diagnostic and procedure codes to scenarios, and create a CMS-1500 form using medical billing software.

---

### Step 2: Lesson Preview

---

From experimental drugs and cutting-edge procedures to computers and the Internet, health care is changing. From the operating room to the front office, every level of medicine is undergoing a revolution. Why? What's driving this change? Technology! Technology is rewriting not only the rules of what is necessary, but what is possible.

In this lesson, we're going to look at how technology is shaping the future of health care. We'll focus on trends in electronic health records and examine what they mean for the healthcare professional. You'll learn about new and upcoming coding tools, such as encoders and computer-assisted coding. You'll also learn more about Web-based medical records.

The healthcare profession is changing. Understanding those changes will help prepare you for success in the years to come.

---

### Step 3: Technology and Health Care: Today

---

The goal of medicine is quality patient care. The backbone of patient care is health information management. Transcriptionists, coders, billers and administrators keep the gears of our health system spinning. Without them, providers wouldn't get paid, medical files couldn't be located, and the system would back up like a traffic jam.

# Medical Coding and Billing Specialist

---

Healthcare professionals, like yourself, are the unsung heroes of health care. They make sure the provider has the medical record when she's examining the patient. They make sure the patient doesn't overpay for services, supplies and advice. They keep an eye out to make sure the diagnosis, the procedure and the bill all match. All in all, they manage the massive amount of information needed by the healthcare industry.

In the past, a medical record was a thick paper file containing notes on all of your visits. Hospitals and physician offices maintained hundreds and thousands of these files which took up a lot of space and time. More importantly, files at one hospital could not easily be shared with another hospital. This was not only a matter of distance. Different providers often used different record formats and filing systems. When the healthcare industry was smaller, this was not a big deal. But now, with health care booming, patients, providers, insurance companies and the government all realize the drawbacks of the old paper system.

The healthcare industry is in the middle of a major shift. On one front they are slowly converting from paper medical files to electronic health records. Top to bottom they are learning to use computers in health information management.

**Health information exchange (HIE)** is the transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.<sup>1</sup> The goal of HIE is to provide safe, timely, efficient and effective access to and retrieval of patient information for providers.

The Institute of Medicine (IOM) originally created the term *CPR (computer-based patient record)* to describe the computerized version of a medical record. The IOM defined the **CPR** as "an electronic patient record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data," with other uses, as well (IOM, 1997).

In 2003, the IOM report established eight core functions that a computer-based patient record should be capable of performing.<sup>2</sup>

1. **Health Information and Data.** The IOM determined that the electronic health record should contain the same items that are found in the paper chart, including problem lists, medications and test results. In addition, the IOM further stated that it should be a well designed interface to enable the provider to review the information efficiently.
2. **Result Management.** This function refers to accessing information easily when and where it is needed. The focus should be on availability, convenience, reliability and ease of use. The provider should be able to access lab or x-ray results any time and from anywhere.

For example, Bonnie had severe pain in the bottom side of her heel for the past two days. The pain is localized to a single location. After exam, the provider has an x-ray taken to rule out a fracture or tumor. Bonnie has the x-ray taken onsite and returns to the exam room. Her provider returns and pulls the image up on her computer. The provider determines there is no sign of a fracture or mass, but suspects a bone spur is causing the pain. Bonnie is provided symptomatic care and is advised that a radiologist will review the x-ray as well, so she'll be called the next day to confirm the diagnosis.

In this case, the electronic health record allowed the provider to import the x-ray. However, the level of access should be considered as well. For instance, the dietitian and pharmacist do not require the same level of access to a patient record.

3. **Order Management.** Computerized entry and storage of data on all medications, tests and other services is an important function of a computer-based patient record. **Computerized provider order entry (CPOE)** refers to any system in which clinicians directly enter medication orders (and, increasingly, tests and procedures) into a computer system, which then transmits the order directly to the pharmacy.<sup>3</sup> The advantages of CPOE include standardized, legible and complete orders, which will reduce medical errors.
4. **Decision Support.** This function of the electronic health record will alert providers and patients to vaccines, screenings and or preventative measures. In addition, it provides warnings and reminders to assist providers in making the decision in patient care. Decision support can aid in: drug interactions/prescriptions/prevention, detection of disease outbreaks, evidence-based guidelines, etc.<sup>4</sup>
5. **Electronic Communications and Connectivity.** This function focuses on patient safety and quality of care. It allows multiple providers in multiple setting to communicate and coordinate care.
6. **Patient Support.** Studies have found that home monitoring and educational materials are directly related to improving the control of a chronic illness, such as diabetes.
7. **Administrative Processes.** Providing better, timelier services to patients also helps the efficiency of a healthcare organization. Electronic health records also assist with billing and claims management. The provider can immediately validate insurance eligibility, as well as obtain authorizations. This function results in more timely payments and less paperwork.
8. **Reporting and Population Health Management.** Computer-based patient records provide a standardized system for reporting requirements for safety and quality that are necessary for state, federal and local entities.

---

### Step 4: Electronic Health Records

---

When the IOM suggested the key functions in 2003, it also established the term electronic health record for this format. Let's look at the alternative terms and requirements of an electronic health record.

**Electronic medical record**, or **EMR**, is another description that is widely used for this type of record. In hospital or office settings, EMR often refers to entire systems that are based on document imaging, or electronic document management systems as a whole. However, a more accurate term for the actual electronic record is **electronic health record**, or **EHR**. The health information management field generally recognizes the distinction between EMR and EHR as the degree of interoperability that each offers. For our purposes, an EHR is defined as follows, according to the Health Information Technology for Economic and Clinical Health (HITECH) component of the American Recovery and Reinvestment Act (ARRA) of 2009:

A **qualified EHR** “includes patient demographics and clinical health information, and has the capacity to provide clinical decision support; support physician order entry; capture and query information relevant to health care quality; and exchange electronic health information with and integrate such information from other sources.”<sup>5</sup>

**Certified EHR** technology “gives assurance to purchasers and other users that an EHR system or module offers the necessary technological capability, functionality and security to help them meet the *meaningful use* criteria. Certification also helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentially and can work with other systems to share information.”<sup>6</sup>

## Medical Coding and Billing Specialist

---

**Meaningful use** generally describes the ability to demonstrate quality improvement through the use of EHRs. However, HITECH identifies three base requirements for meaningful use:

- Use of certified or qualified EHR technology.
- Electronic exchange of health information.
- Use of EHR in reporting on clinical and other quality measures.<sup>7</sup>

The Certified Commission for Health Information Technology (CCHIT) is recognized by the U.S. Department of Health and Human Services as the entity to certify that EHRs support meaningful use.

To ensure meaningful use, data comparability standards are necessary. Data comparability standards make certain the meaning of a term is consistent across all users. Standard vocabulary helps achieve data comparability. Until recently, the specific vendor that developed the EHR software established most vocabularies. However, HITECH requirements demand the use of *controlled vocabulary* to allow for electronic exchange of health information. **Controlled vocabulary** means that a specific set of terms in the EHR's data dictionary must be used.

Providers may use different terms that mean the same thing. For instance, one provider may document a *heart attack*, while another indicates an *MI*, and still another notes a *myocardial infarction*. While these terms mean the same thing to a cardiologist, they are entirely different to a computer. Without standard terminology, it's difficult to gather and retrieve information for research. Controlled vocabulary allows users to index, store and retrieve information from an EHR.

The National Committee on Vital and Health Statistics (NCVHS) was asked to recommend a national standard for vocabulary use in an EHR. The NCVHS recommended that the federal government use the following “core set” of terminologies:<sup>8</sup>

- SNOMED CT—Systematized Nomenclature of Medicine - Clinical Terms
- LOINC—Logical Observation Identifiers Names and Codes
- RxNorm—federal drug terminologies

SNOMED CT presents data in a completely machine-readable format. While the ICD coding database was designed for billing and reimbursement, SNOMED CT is meant to organize the contents of a medical record to capture, encode and use data for clinical care of patients and research. Due to the controlled vocabulary, SNOMED CT can increase quality of care because it allows more accurate descriptions of a patient's medical issues in words physicians understand and doesn't cross into the administrative interpretations of diagnosis codes that are more familiar to coding staff.<sup>9</sup>

**Health Level Seven (HL7)** develops specifications for electronic healthcare information. HL7's mission is to increase the effectiveness and efficiency of healthcare information.



HL7 standards identify types of errors and corrections in an electronic medical record. HL7 has created computer messages to communicate corrections to different computer systems. Let's take a look at a couple of scenarios:

1. To create an addendum: Author dictates additional information as an addendum to a previously transcribed document. A new document is transcribed. This addendum has its own unique document ID that is linked to the original document via the parent ID. Addendum document notification is transmitted. This creates a composite document.
2. To correct errors that were discovered in the original health document that haven't been made available for patient care: Errors, which need to be corrected are discovered in a document. The original document is edited, and an edit notification is sent.<sup>10</sup>

One variation of the EHR is the **personal health record (PHR)**, which is medical information that the patient maintains. The PHR puts control in the consumer's hands. Instead of being a tool for the provider, the health record will become a tool for the patient. In the future, people will have more responsibility for their own well-being. Insurance companies are not the only ones pushing for a shift from doctor as repairman to doctor as coach. Many people see the benefits of healthy living and preventative medicine. The fitness and nutrition industry is growing. So is interest in alternative medicines such as acupuncture and chiropractics. Knowledge is power. Taking personal responsibility for your own health is the first step in the fight against death, disease and aging. Personal health records will be valuable weapons in this fight.

Now, you'll learn about different types of Internet connections and networks.

---

## Step 5: Access the Internet and the Web from a Computer

---

OK, you have a computer and a Web browser; you're viewing Web sites left and right. But how exactly does it happen that these Web pages appear in your browser?

The Internet does not exist in one location. It exists in shared locations between hundreds of millions of computers, servers and networks. For example, Erik in Denmark may publish the photographs he took on his recent trip to Thailand. Xing Mao in China may publish statistics on the ratios of female and male children that families in the United States adopt. And Gabriela in Chile may publish a daily **blog** (short for **Web log**, which is like an online diary) that describes her life in South America, including sales information for the handmade products from her alpaca, sheep and goat farm.

So where is all of this information? Well, remember that each of these Web pages is published on the World Wide Web, which exists on the Internet. You, Erik, Xing Mao and Gabriela can view these Web pages—and all the others that people everywhere write—anytime you want, as long as you have access to the Internet.

Before you learn about the computer network, let's look at the language of the Internet. Many know that **HTML (Hypertext Markup Language)** was designed to display data and is the most widely used language for Web-based documents. A document using HTML contains embedded tags that provide guidance to HTML viewers (usually called Web browsers) as to how to display the document and connect it to other documents.<sup>10</sup>

# Medical Coding and Billing Specialist

HTML has its advantages and disadvantages:

Advantages	Disadvantages
Linkability—data is hyperlinked, letting you move from one site to another	Intelligibility—limited in how well data knows itself
Simplicity—it's easy to learn and to display	Adaptability—limited in data changes in response to environmental changes
Portability—it's portable over networks, operating systems and languages	Maintainability—limited in ease of data maintenance

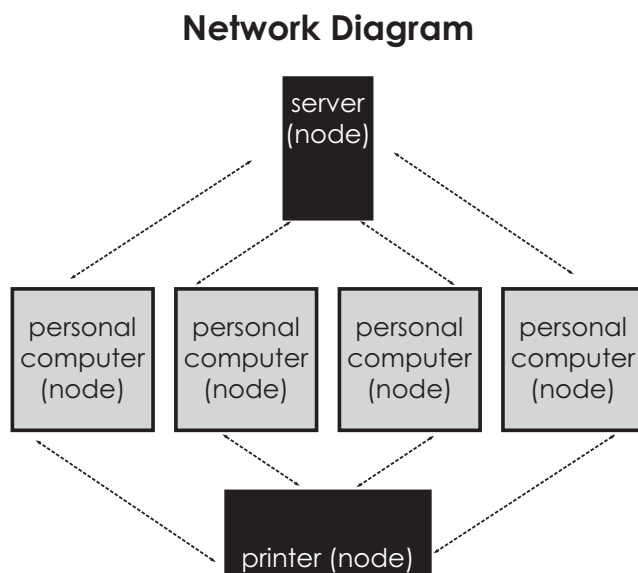
Basically, the HTML format is not interoperable, which means that data cannot be shared across organizations. EHRs don't just "contain" or transmit information, they also compute with it—for example, a qualified EHR will not merely contain a record of a patient's medications or allergies, it will also automatically check for problems whenever a new medication is prescribed and alert the clinician to potential conflicts. HTML is unable to compute. **XML (Extensible Markup Language)** was designed to overcome this limitation, which improves the functionality of the Web by letting you identify your information in a more accurate, flexible and adaptable way. XML is the language of EHRs.

## The Computer Network

To access the information on the Internet, your computer must be part of a network. A network is a system of computers and/or servers, printers and databases that communications lines connect. All computers, servers, printers or databases connected to one network are called nodes. All nodes have the means to share information and communicate with one another.

### Types of Networks

Networks exist so that different computers can rely on one another to perform functions like storing, sending and retrieving information.



To access the information on the Internet, your computer must be part of a network.

There are four basic types of computer networks.

1. **Client/Server Network**—One or more computers (called clients) are connected to one another and to a central computer or mainframe (called a server). We'll talk about servers in more detail in a moment, but first, let's look at an example of a client/server network.

A manufacturing plant in Michigan makes engines for hybrid vehicles. All of the conveyer belts that move the engines throughout the plant are connected to a central computer. Based on signals from other, smaller computers at different workstations, the central computer knows how fast or how slow to run the conveyer belts. It even knows when to turn the conveyer belts off if there is an emergency or a breakdown in one area of the plant. These computers are on a client/server network.

2. **Peer-to-Peer Network**—Two or more computers are connected to one another and share information without the presence of a server.

Let's say that Cody and Ben are college roommates, and both young men use Mac Book laptops with iTunes and iPods. Cody has a great collection of more than four thousand listening hours of Classic Rock, Pop and Indie Rock music, while Ben has a substantial amount of rare Jazz and Blues recordings. They've decided to set up a peer-to-peer network so they can easily share music files without violating copyright laws.

3. **LAN Network**—LAN stands for **local area network**. Such a network consists of one or more computers in a home or office that are connected to one another and a server. They are a self-contained network with a gateway or link to the Internet. Let's study an example.

Martin is a freelance graphic designer and avid photographer who runs his own business from the comforts of his home office. Martin uses three printers, a copier, a laptop computer and a large desktop computer with a huge flat screen monitor for his work. Meanwhile, his wife owns a laptop, and his daughters share a desktop computer and printer in their bedroom. Martin and his family's computers all have Internet access, and they are connected to one server (and one back up server) that he keeps in the basement. This arrangement is an example of a LAN.

4. **WAN Network**—WAN stands for **wide area network**. Such a network consists of two or more LANs in several different buildings that are connected to one another.

An example of a WAN might be an international broadcasting company that has offices in the United States, Canada, Panama, Brazil, Great Britain, Germany, France, Spain, Poland, Saudi Arabia, Sri Lanka, South Korea, the Philippines and New Zealand. Each of these offices contain multiple LANs, but the LANs are connected into a larger WAN to facilitate faster e-mail communication and to share full access to photographic images and video footage database files.

## Servers

A **server** is a data resource that other computers access for information. Some people call a server a **host computer**, and that analogy works well when you think about the functions a server performs. For example, when you host a party, you make introductions among your guests. You refill the drinks, make important announcements and manage the music or overall atmosphere at the party. A server operates in much the same way. Since the server is a host to the computers attached to its network, the server relays information, transfers files, delivers programs and awaits and fulfills the requests of its client computers.

## Step 6: Electronic Coding

---

**Electronic coding** uses computers to speed up the coding process. As technology develops, more and more computers will be used in coding. While this may alter some of your responsibilities, it is important to know everything you're learning in this program. With more computers helping in the health information department, healthcare document specialists will act more as editors to the computer's coding.

There are several different levels of electronic coding: *encoder programs*, *computer-assisted coding* and *NLP autocoding*. Let's take a look at each.

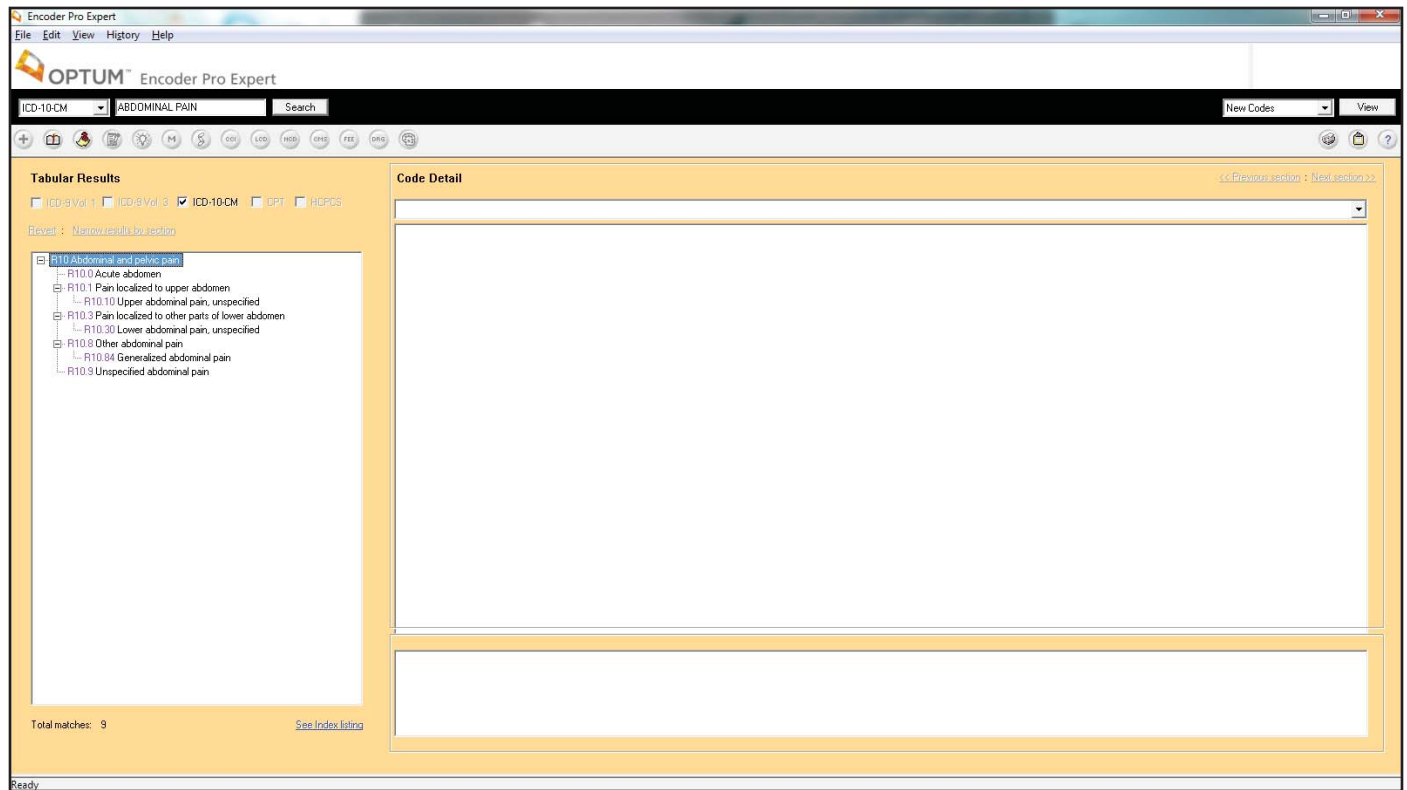
### Encoder Programs

An **encoder** is an interactive computer program that helps you assign codes. With this program, the user inserts a keyword and then selects different sections, subsections, headings, subheadings and code listings related to that keyword. Think of this type of encoder as a computer-version of your *ICD-10-CM*, *CPT* and the *HCPCS* manual, all rolled into one. This encoder assists you in navigating your codes quickly and with the click of a button. You will receive a demonstration CD-ROM of one of these encoders later in the course. You'll also receive a supplement showing you how to use it like a pro.

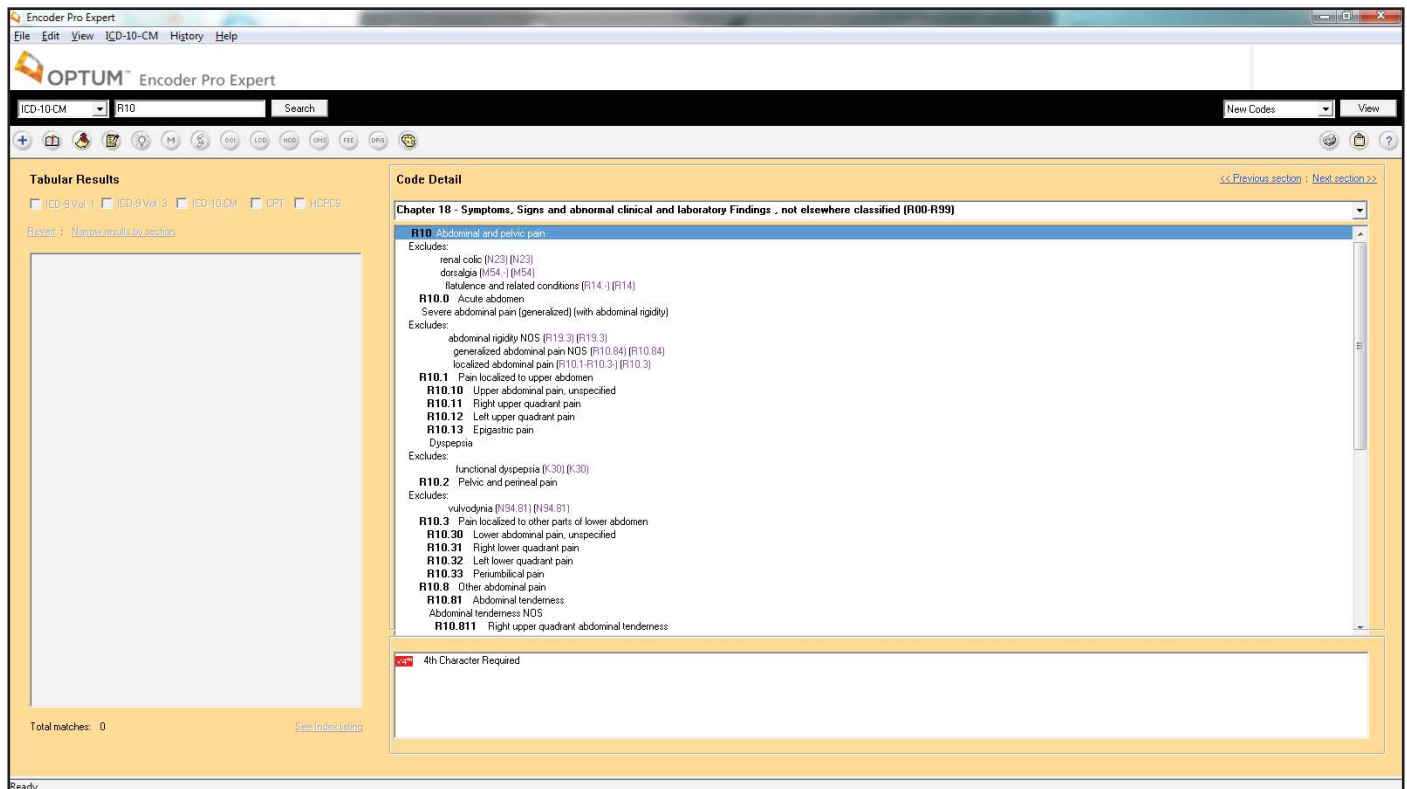
However, using an encoder program doesn't mean you don't need to be familiar with coding rules and the manuals. You need to have a clue to locate the accurate code! For many coders, the encoder program is more useful as a verification tool. For example, let's say you're looking up the code for abdominal pain. If you use this as the basis for your encoder search, you are likely to get so many potential codes that you'll have a hard time narrowing it down to the right one.

One of the benefits of using encoders is efficiency. And when it comes to coding, efficiency equals money.

Look at the following example. A search in the *ICD-10-CM* for *Abdominal pain* retrieved several code categories.

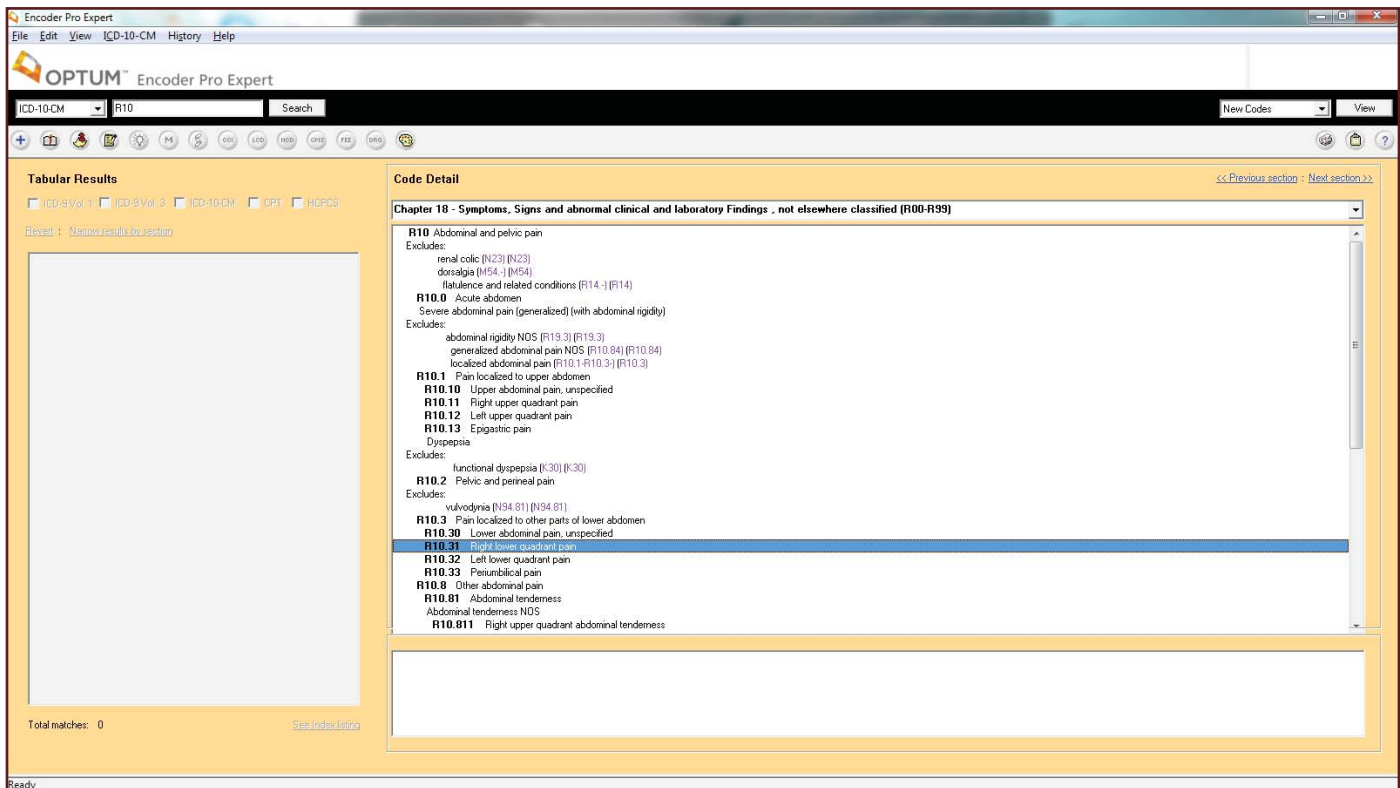


Let's narrow down our search. If you already know that the code for abdominal pain starts with R10, you can use the encoder to fine-tune your search. Here's an example using the encoder in that way.



# Medical Coding and Billing Specialist

If you are unsure of the correct fifth digit to use for RLQ (right lower quadrant), just scroll down the list like the example below. Do you see the code R10.31? Great!



## Computer-assisted Coding

After encoders, the next level of technology is computer-assisted coding (CAC). CAC uses a computer to assign an actual code. Whereas an encoder determines the best code, a computer-assisted program is programmed to pick codes itself. The computer can do this in one of two ways: by using inputted information or by finding the diagnosis and procedure in the chart itself. Let's examine how each of these methods work.

The most common automated coding systems require a user to input data. The user will read a medical chart and figure out the diagnoses and the procedures. Next she will type this information into the computer-assisted program. The computer uses logic and coding rules programmed into its memory to code the diagnoses and the procedures. Of course, this system isn't perfect. CAC programs are not advanced enough to handle rules which can be interpreted in several different ways. Not all codes are black and white; however, CAC software can draw the user's attention to any codes it has trouble with. This is where you, the healthcare professional, come in!

The second type of CAC software is much more advanced than the first. Some medical providers use a software called **natural language processing (NLP)**, which can read and translate English. Instead of having to input the diagnoses and procedures to be coded, the entire medical chart can be uploaded into the NLP autocoder. This program will read the chart, pick out the diagnoses and procedures, and then assign the appropriate code.



But how accurate is it? Today, NLP technology is not advanced enough to rival the accuracy of an experienced, human coder. However, NLP software is getting better. Instead of using a rigid set of rules to program the computer-assisted coding, NLP uses complex statistical methods to predict how an experienced human would code the information. Using statistics gives NLP autocoders flexibility, as well as the ability to improve. Like a human, the more the NLP software translates and codes, the better it gets. Like standard computer-assisted programs, NLP software can alert the user when it is unsure about a code. In fact, because it uses statistics, it can say exactly how unsure it is.

But NLP technology isn't perfect. There is more to coding than just connecting the dots! While the NLP autocoding software companies are touting their programs as the next wave in health information management, not everyone is so sure. Many providers are skeptical and question just how valid the programs are. It doesn't matter how fast the programs are if they aren't accurate enough.

What does computer-assisted coding mean for the coding healthcare professional? Will they be replaced by computers? The answer is no, although there will be some changes. Computers will eventually take over much of the manual work of assigning simple codes and transcribing basic medical reports. Computer-assisted coders will zip through the easy and routine codes. However, healthcare professionals will still be needed to tackle all of the challenging reports which stump the computer. And with medicine constantly evolving, there will always be plenty of exciting and new charts to code.

In addition, healthcare professionals may be responsible for managing these programs and their coded data. They may be in charge of quality-control, security, and monitoring the regular additions, deletions, and changes to the code sets. It is an exciting time to be a healthcare professional. You're getting in on the first wave of a whole new system!

---

### Step 7: Web-based Medical Records

---

One of the advantages of being a healthcare professional is that you may work from home. With **Web-based medical records**, the medical record is an encrypted file so unauthorized people can't read it and e-mails it to a secure computer server. The chart is given a digital certificate. A digital certificate is like an electronic lock. Only the person with the right electronic key—such as a password—can open it. When a chart is stored on the server and assigned to a medical coding and billing specialist, it is given a digital certificate that only that healthcare professional can open.

You can either work with the medical chart while it is saved on the server, or you may download the file and work with it after disconnecting from the Internet. The latter is more secure because there are less opportunities for hackers to break in and view the information. Once you're done, you e-mail the chart back to the server and delete the information from your computer.

Security is a very important issue for Web-based medical records. This is especially true with all of the security guidelines mandated by HIPAA. In addition to encryption and digital certificates, physical security is important. The computer you use for home coding shouldn't be used for non-work activities (like Internet shopping). The system should be protected by a password, and others should not have access to it. Some remote companies and agreements stipulate that management can inspect the home office at any time to ensure that security is being maintained.

Now, let's review what you've learned with a Practice Exercise.

### Step 8: Practice Exercise 39-1

---

On scratch paper, identify four trends in the technology of health care.

### Step 9: Review Practice Exercise 39-1

---

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

### Step 10: Lesson Summary

---

Computers are revolutionizing health care. With electronic health records, they're helping ensure consistent, quality care. With personal health records, computers empower people to manage their own health. On the coding front, they improve accuracy with encoders and speed with computer-assisted coding (CAC) programs. Natural language programming (NLP) will free healthcare professionals up to focus more on managing medical information. The Internet allows more and more people to work safely and efficiently from home. All in all, computers are the future. The change to a fully-electronic health information system will be slow. But it will come, and health care will never be the same. And you will be on the front line of this exciting technology!

### Step 11: Course Summary

---

You've made it! This is your last lesson! You discovered different types of insurance and know how to complete the CMS-1500, which is the most common claim form. You've studied the *ICD-10-CM* and *CPT* manuals and know the format of the *HCPCS* coding manual. Congratulations on a job well done!

Now, you will complete a comprehensive exam that allows you to apply all of your medical coding and billing knowledge. There are six parts to the test.

- Part 1 covers what you've just learned about the future of health care.
- Part 2 allows you to demonstrate your understanding of EOBs and the billing process.
- Part 3 covers ICD-10-CM coding for diagnostic statements.
- Part 4 gives you real-world scenarios to code both the ICD-10-CM and CPT.
- Part 5 allows you the chance to review E/M coding, as well as apply diagnostic codes.
- Part 6 covers creating the CMS-1500 claim form using MedLook billing software.

You're going to do great!



## Step 12: Quiz 39

---

Once you've mastered the course content, locate this Quiz in your *Online Course* or your *Assignment Pack*. Read and follow the Quiz instructions carefully.

### Endnotes

- <sup>1</sup> "Health information exchange (HIE)." Search Health IT, May 10, 2012. Web. 4 October 2013.
- <sup>2</sup> "Core Functions of an EHR." EHR Scope, July 14, 2009. Web. 4 October 2013.
- <sup>3</sup> "Computerized Provider Order Entry." Agency for Healthcare Research and Quality. Web. 4 October 2013.
- <sup>4</sup> "Core Functions of an EHR." EHR Scope. July 14, 2009. Web. 4 October 2013.
- <sup>5</sup> "Frequently Asked Questions on HITECH Provider Incentives Under Medicare." Minnesota e-Health, 18 June, 2009. Web. 4 October 2013.
- <sup>6</sup> "Overview." Centers for Medicare & Medicaid Services, 9 April, 2012. Web. 4 October 2013.
- <sup>7</sup> "Frequently Asked Questions on HITECH Provider Incentives Under Medicare." Minnesota e-Health, 18 June, 2009. Web.
- <sup>8</sup> Lumpkin, John. "Letter to The Honorable Tommy G. Thompson." 5 Nov., 2003. Web. 4 October 2013.
- <sup>9</sup> Fluckinger, Don. "SNOMED CT will be coming to EHR systems and patient records near you." TechTarget, n.d. 4 October 2013.
- <sup>10</sup> "XML vs. HTML: A Publishing Comparison." United States Bureau of the Census's Statistical Compendia Branch, July 19, 2002. Web. 4 October 2013.



# Pack Five

## Medical Coding and Billing Specialist

### Answer Key

---

#### Lesson 36

---

#### Practice Exercise 36-1

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**

## **Medical Coding and Billing Specialist**

---

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 36-2

There are various ways to categorize the history elements. As long as your overall history level is the same, you're on the right track.

### 1. EMERGENCY DEPARTMENT 99281-99288

CC	hematemesis	required
HPI	Location—epigastric Quality—squeezing AS&S—vomiting Duration—6 days Modifying factor—increase with eating	4 = extended
ROS	Gastrointestinal—bowels Gastrourinary—bladder Neurological—no loss of consciousness Allergic/Immunologic—no allergies	4 = extended
PFSH	Medical history—denies tuberculosis Family history—no heart disease Social history—drinks beer	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 **99284**

## Medical Coding and Billing Specialist

### 2. OFFICE CONSULTATION 99241-99245

CC	acne	required
HPI	Location—chin Severity—worsening Duration—3 months Modifying factor—oral contraceptives	4 = extended
ROS	Constitutional—no fever Gastrointestinal—no nausea Integumentary—reddening of face Neurological—no headache Allergic/Immunologic—penicillin	5 = extended
PFSH	Medical history—birth control Family history—anxiety Social history—caffeine use	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 36-3

### 1. EMERGENCY DEPARTMENT 99281-99288

Constitutional—Vital signs  
ENMT—Moist mucous membranes  
Cardiovascular—Regular rhythm and rate  
Respiratory—Clear to auscultation  
Gastrointestinal—Soft  
Skin—No spider angioma  
Neurological—DTRs intact  
Neck—Supple  
Extremity—no clubbing

9 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 and each Extremity are body areas, not organ systems. Only 7 organ systems are documented.*

Level of Service for the Examination Component: Detailed **99284**

### 2. OFFICE CONSULTATION 99241-99245

Constitutional—No apparent distress  
Skin—Keratotic papule  
Hematologic/Lymphatic/Immunologic—glands  
Head/Face—palpation of skin

4 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: Expanded Problem Focused **99242**



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 36-4

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:

Lab 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 provides a prescription drug. 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**

## Medical Coding and Billing Specialist

---

### 2. OFFICE CONSULTATION 99241-99245

#### Number of Diagnosis and Management Options:

The problem is new to the doctor. No 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 to be reviewed. The level is minimal or none, which is *Straightforward* medical decision making.

#### Risk of Complications and/or Morbidity or Mortality:

The management option 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, **99244**

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 36-5

1. EMERGENCY DEPARTMENT 99281-99288

history component	99284
examination component	99284
medical decision making component	99284
based on lowest of three key components	<b>99284</b>

2. OFFICE CONSULTATION 99241-99245

history component	99243
examination component	99242
medical decision making component	99244
based on lowest of three key components	<b>99242</b>

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	<b>99214</b>

## Lesson 37

---

### Practice Exercise 37-1

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. Exchanges that occur 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 37-2

**K83.1** Atresia, bile, acquired *see* Obstruction, bile duct; Obstruction, bile duct

**Z94.4** Transplant(ed) (status), liver

**99213** Office and/or Other Outpatient Services, Office Visit, Established Patient 99211-99215

### HISTORY

CC		transplant followup	required
HPI	Location	liver	
	Context	transplant	2=brief
ROS	Allergic/Immunologic	none	1=pertinent
PFSH	Family history	ulcerative colitis	
	Social history	lives with parents	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: **EXPANDED PROBLEM FOCUSED, 99213**

### EXAMINATION

Constitutional—vital signs

Eyes—PERRLA

ENMT—nasal mucosa pink

Cardiovascular—regular rhythm

Respiratory—clear to auscultation

Gastrointestinal—no masses

Genitourinary—normal bowel sounds

Skin—no unusual lesions

## Medical Coding and Billing Specialist

Musculoskeletal—no clubbing

Neurological—DTRs

Psychiatric—no acute distress

Hematologic/Lymphatic—no adenopathy

Neck—supple

Chest, Breast, Axilla—costochondral discomfort

Genitalia, Groin, Buttock—normal female by inspection

Back, Spine—no scoliosis

15 = OS/BA

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

### EXAMINATION COMPONENT: COMPREHENSIVE, 99215

#### MEDICAL DECISION MAKING

##### Number of Diagnosis and Management Options

The problem is established with the doctor and is stable, improved. The decision making level is minimal, which is **Straightforward**.

##### Amount and/or Complexity of Data to be Reviewed

One lab 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 management options selected is prescription drug management. 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

*Note: Either Dx/Mgmt or Data can be crossed out.*

### MDM COMPONENT: STRAIGHTFORWARD, 99212

Overall level of service for the encounter is 99213. Remember, for an established patient, you only need to consider 2 of the 3 key components.

## Practice Exercise 37-3

**T24.212A** Burn, thigh, left, second degree; initial encounter

**T21.24XA** Burn, back, second degree; initial encounter

**T31.10** Burn, extent (percent of body surface), 10-19 percent, with 0-9 percent third degree burns

**99291** Critical Care Services, Evaluation and Management 99291-99292; first 30-74 minutes

## Practice Exercise 37-4

**Z01.419** Examination, gynecological

**99385** Preventive Medicine, New Patient 99381-99397; new patient; 18-39 years

*Note: You will code to new patient since it was an initial visit.*

## Practice Exercise 37-5

**S52.121A** Fracture, traumatic, radius, head—*see* Fracture, radius, upper end;  
Fracture, traumatic, radius, upper end, head (displaced); right; initial  
encounter for closed fracture

**S52.041A** Fracture, traumatic, coronoid process—*see* Fracture, ulna, upper end,  
coronoid process; Fracture, traumatic, ulna, upper end, coronoid process  
(displaced); right; initial encounter for closed fracture

**S52.021A** Fracture, traumatic, olecranon—*see* Fracture, ulna, upper end, olecranon  
process; Fracture, traumatic, ulna, upper end, olecranon process  
(displaced); right; initial encounter for closed fracture

**S53.101A** Subluxation, elbow (traumatic); right; initial encounter

**V28.9XXA** *External Causes:* Accident, transport, motorcyclist, non collision accident;  
initial encounter

*Note: Discharge summary is for the entire encounter, which was  
active treatment for the injury.*

**99239** Discharge Services, Hospital 99238-99239; 99239 Hospital discharge day  
management; more than 30 minutes

## Practice Exercise 37-6

**B08.3** Disease, fifth

**99202** 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 37-7

- I25.10** Disease, artery, coronary  
**I21.09** Infarct, myocardium, ST elevation, inferior (inferolateral)  
**K27.9** Ulcer, peptic  
**I50.9** Failure, heart, congestive

**99284** Evaluation and Management, Emergency Department 99281-99288

CC	SOB	required
HPI	Location—chest AS&S—diaphoresis Duration—5 days Modifying Factor—relief with nitrates/ diltiazem	4 = extended
ROS	Constitutional—no fever Cardiovascular—MI Respiratory—SOB Genitourinary—renal failure Endocrine—no diabetes Allergic/Immunologic—no hypercholesterolemia	6 = extended
PFSH	Medical history—peptic ulcer disease Family history—no heart disease Social history—cigarettes	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

HISTORY COMPONENT: **DETAILED, 99284**

EXAMINATION

Constitutional—vital signs

Eyes—PERRLA

Cardiovascular—no murmurs

Respiratory—course, wet rales

Gastrointestinal—soft

Neurologic—cranial nerves intact

Neck—supple

Abdomen—mass

8 = OS/BA

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

*Note: 8 OS/BA but cannot be Comprehensive because not all are organ systems.*

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**

One lab, one radiology and one medicine for a score of three. The decision making level is moderate level, which is **Moderate** medical decision making.

**Risk of Complications and/or Morbidity or Mortality**

An acute or chronic illness that poses threat to life or bodily function. The risk level is **high** which is **High 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: **HIGH COMPLEXITY, 99285**

Overall level of service for the encounter is 99284.

## Practice Exercise 37-8

**M05.871** Arthritis, rheumatoid, seropositive, specified, ankle; right

**M24.871** Destruction, joint (*see also* Derangement, joint, specified type NEC); Derangement, joint, specified type NEC, foot joint; right

**M84.48XG** Fracture, pathological, rib; subsequent encounter for fracture with delayed healing

**M81.0** Osteoporosis

**99243** Consultation, Office and/or Other Outpatient 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 37-9

**Z00.129** Examination (routine), child

**99393** Preventive Medicine, Established Patient 99382-99397; late childhood (age 5 through 11 years)

**90700** Vaccines, Diphtheria, Tetanus, Acellular Pertussis (DTaP)

## Practice Exercise 37-10

**J05.0** Croup

**99284** 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.

## Lesson 38

---

### Practice Exercise 38-1

1. HCPCS stands for **Healthcare Common** Procedure Coding System.
2. **CMS** developed these codes in 1983.
3. The *HCPCS Level II* is updated every **year**.
4. While CPT codes represent the procedure, HCPCS codes account for **supplies**.

### Practice Exercise 38-2

1. The *HCPCS* manual is consists of **c. an *Index* and *Tabular List***.
2. The **b. neoplasm table** is/are not part of the *HCPCS* appendices.
3. A main term in the *HCPCS Index* may be **d. either brand names or the name of medical supplies**.
4. Transportation codes show **d. all of the above**.
5. Durable medical equipment is found in subsection **d. E**.

## Lesson 39

---

### Practice Exercise 39-1

1. **Electronic health records will replace paper health records.**
2. **People will use personal health records and take more responsibility for their health and well-being.**
3. **Providers will move toward an electronic document management system based on computers.**
4. **Electronic coding will complete many of the easy, simple coding tasks.**