Study Guide:

CEMC™

Evaluation and Management

2012

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ISBN 978-1-935809-85-2

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2012 Specialty Study Guide: CEMC™ Introduction

The *2012 Specialty Study Guide: CEMC™* is designed to help evaluation and management coders, billers, and other medical office professionals prepare for the CEMC™ examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for evaluation and management.

Health care in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CEMC™ is the best defense for you, and also helps your employer. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and allows you access to continuing education opportunities. The *2012 Specialty Study Guide: CEMC™* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CEMC™ examination.

We will review the importance of using the coding guidelines within ICD-9-CM and CPT® as well as emphasize the importance of correct evaluation and management (E/M) leveling. In addition to this study guide, you will need 2012 versions of ICD-9-CM, CPT®, and HCPCS Level II codebooks. These are the books you will need for your CEMC™ exam, as well.

ICD-9-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determine health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-9-CM coding. Regulatory trends show that diagnoses will play a larger role in reimbursement in the future. It's important to code correctly so you are prepared for that day.

We will discuss the major topics of diagnosis coding for evaluation and management. The examinee must become familiar with the Official Coding Guidelines for ICD-9-CM. The examinee must know how to select the appropriate ICD-9-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). Due to publishing constraints, the current year's codebook will always have last year's guidelines. This year's guidelines can be found at www.cdc.gov/nchs/data/icd9/icd9cm_guidelines_2011.pdf. The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-9-CM manual.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the E/M material will focus on the E/M services, and underscore the importance of modifier use. An understanding of the E/M guidelines and subsection notes is an important foundation for accurate code selection. The examinee must understand the 1995 and 1997 CMS Documentation Guidelines. A copy of both sets of guidelines are permitted during the CEMC™ certification exam.

Reproduced on the last page of this chapter is an audit tool that is useful when leveling an office visit. You can use this tool when you reach the practice exam at the end of this booklet. You may also bring the audit tool of your choice to the CEMC™ certification exam.

CPT® Coding

Surgical procedures specific to evaluation and management will be discussed in this section. Special attention will be paid to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor intensive procedures. The codes with the highest RVUs (Relative Value Units) are sequenced first.

Practice Exam

The practice exam and the exam itself were written by coders with extensive experience in evaluation and

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ICD-9-CM Coding Guidelines

Introduction to ICD-9-CM Coding Guidelines

ICD-9-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Health care providers must begin using the most recent ICD-9-CM code revisions on Oct. 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-9-CM manual typically include the ICD-9-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information, and provide instruction supplemental to that found in Volumes 1 (Tabular List for Numerical Codes) and 2 (Alphabetic Index to Diseases) of the ICD-9-CM manual.

ICD-9-CM codes are "utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of health care costs," according to the Official Guidelines. Ongoing, case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-9-CM code assigned must be supported by documentation linked to that particular claim (individual dates of service must "stand alone"), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as "acute" when it isn't documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-9-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, the use of fourth and fifth code digits, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-9-CM

Use the alphabetic index (Vol. 2) and tabular list (Vol. 1) of the ICD-9-CM manual together. When attempting to select an ICD-9-CM diagnosis code, begin by searching for the main term—such as "lesion," "burn," etc.—in Volume 2. Follow all cross-references and "see also" entries. When you have located the code you are seeking, turn to that code in Volume 1. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instruction. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. Generally speaking, the first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis *only* when that chronic condition is treated, or becomes an active factor in the patient's care.

Always select ICD-9-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for myocardial infarction (MI) requires

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guidelines state that when coding for multiple burns, you should "sequence first the code that reflects the highest degree of burn when more than one burn is present." In addition:

- When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.
- When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.
- When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.
- Report a non-healing burn, or burn necrosis, as an acute burn condition.

You should use codes from the 948 series as a secondary diagnosis with codes 940-947. Category 948 *requires* both fourth and fifth code digits, which describe the percentage of the body burned and the percentage of the body affected by third-degree burns, respectively. Apply the "rule of nines," as described in the ICD-9-CM manual, to determine the percentages of the body affected.

Poisoning

The first question you should ask when selecting a code for poisoning by drugs, medicinal, and biological substances (960-979) should always be: How did it happen? That is, was the substance properly, or improperly administered? A patient may have an adverse reaction to a properly administered drug, which requires different coding than if a drug was given in error. When sequencing codes, always report the poisoning code first, followed by a code for the manifestation. For a diagnosis of drug abuse or dependence to the substance, report the abuse or dependence code as an additional diagnosis.

Toxic Effects

Toxic effects (980–989) are different than poisonings in that they refer to substances chiefly non-medicinal in source. These codes exclude burns from chemical agents, localized toxic effects indexed elsewhere, and respiratory conditions due to external agents. When reporting toxic effects, you should also use an additional code as a secondary diagnosis, to specify the nature of the toxic effect.

V Codes

V codes describe "classification of factors influencing health status and contact with health services." More specifically, V codes describe encounters in which there is not anything specifically wrong with the patient, although the patient may have a history of a condition or been exposed to possible danger (such as a patient who has been exposed to AIDS but does not show any current symptoms). V codes fall into a variety of categories, including most prominently:

- **Contact/Exposure:** The patient is a potential carrier of disease, or has been exposed to hazardous materials (eg, V87.1x *Contact with and [suspected] exposure to hazardous aromatic compounds).*
- **Innoculations/Vaccinations.**
- **Status:** The patient has the sequelae or residual of a past disease or condition.
- **History (of):** This can include either personal history (V10-V15, a past medical condition that no longer exists and for which the patient is not receiving treatment, but that has a potential for recurrence) or family history (V16–V19.8, a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of contracting the disease).
- **Screening:** Codes V72–V82 describe testing for disease in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease; conditions discovered during a screening visit may be assigned as a secondary code.
- **Observation:** Codes V29 *Observation and evaluation of newborns for suspected condition not found* and V71 *Observation and evaluation for suspected conditions not found* are used in limited

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An Overview of the Anatomy of the DGs

There are three general principles regarding documentation and to ensure that credit can be thoroughly verified. It is important to follow these rules of thumb.

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

There are three main components that are used to measure the level of E/M work documented. These components are the primary focus of this chapter. They are:

1. History
2. Exam
3. Medical decision making

There are additional components which include analyzing the necessity of the service comparative to the nature of the presenting problem and crediting time spent in counseling and coordination of care when the needs of the patient are not reflected by a standard history and physical. For instance, when a patient is given a new diagnosis of cancer, time drives the level of service. Time and activities must be documented to support the variation from component base leveling. We will discuss selecting E/M codes based on time later in this chapter.

The three key components are each divided into specific elements. Since coding relies on counting subjective elements, the correct interpretation requires consistency, citable references, a logical argument and, ultimately, medical necessity. For certification exam purposes, you are required to assign the E/M code based on the three key components or time when appropriately documented. AAPC does not expect examinees to select the E/M code based on medical necessity for exam purposes. However, when selecting E/M codes for payers, medical necessity is the overarching requirement. Although a high level service may be supported by documentation of the three key components, it may not be medically necessary to perform all elements.

History Component

There are four levels of history: problem focused, expanded problem focused, detailed, and comprehensive. The history component consists of a chief complaint; history of present illness (HPI); review of systems (ROS); and past, family, and social history (PFSH). The chief complaint is required for all levels of history and is the reason why the patient is presenting for care. In some cases the patient may not have a complaint. In those cases, the provider should document what the patient presents for. Examples include annual exam, well child checkup, or follow-up for diabetes management. If documentation shows that the provider is unable to obtain a history from the patient or other source, for example, if the patient is unconscious, the overall level of medical necessity and the work of the provider are not penalized by the fact that the physician could not obtain a history from the patient. When unable to obtain a history from the patient or other source, the provider must indicate the reason why he could not obtain the history. For example, the provider can document "patient unconscious and unable to provide history." If the provider summarizes additional history supplied by a family member or a caregiver, that can be given credit in the medical decision making component and we will be discussing that later in this chapter.

The ROS and PFSH from an earlier encounter can be updated without complete re-documentation for most payers. It is necessary for the provider to indicate the new status of the history and to leave an audit trail regarding where the original documentation is stored. Physicians should be cautioned that although a comprehensive history may be performed, a comprehensive history is not always medically necessary or billable.

History of Present Illness

The HPI is a chronological description of the development of the patient's present illness from the first sign or symptom or from the previous encounter to the present.

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Behavior change intervention services are provided to patients who have already developed the risky behavior.

Smoking cessation (quitting smoking) counseling, and alcohol and substance abuse counseling are found in the behavior change intervention codes. The codes are selected based on the substance and the amount of time spent with the patient.

E/M Selected Based on Time

In some cases, the encounter does not require the provider to perform a history, exam, and MDM. During some encounters, counseling, or coordinating care takes up the majority of the visit with the patient. In those cases, the provider can select the E/M code based on time. In the CPT® book, each E/M code is given an amount of time. For example, on 99213 "Physicians typically spend 15 minutes face-to-face with the patient and/or family."

When selecting an E/M based on time, the provider must document the total time spent as well as that more than 50 percent of that time was spent counseling or coordinating care. The provider must also include what the physician counseled the patient on or what care was coordinated.

In the office and outpatient setting, time is defined as face-to-face time. In the inpatient setting, time is defined as unit/floor time.

Case Example

Patient here today because of a football injury, parent thought it would get better but it has just got worse. Patient has problem with his right shoulder. He was tackled in football practice and landed on shoulder.

Subjective

CC: Shoulder injury

HPI: Has pain in the right shoulder since a football tackle.

ROS:

Const: Denies chills, fatigue, fever, and weight change. General health stated as good.

Eyes: Denies visual disturbance.

CV: Denies chest pain and palpitations.

Resp: Denies cough, dyspnea, and wheezing.

GI: Denies constipation, diarrhea. Dyspepsia. dysphagia, hematochezia. Melena, nausea, and vomiting.

GU: Urinary: denies dysuria. Frequency, hematuria, incontinence.

Musculo: Denies arthralgias, andmyalgia.

Skin: Denies rashes.

Neuro: Denies neurologic symptoms.

Current Meds: None

Allergies: NKDA

Objective

BP: 118/78 Pulse; 76 T: 98.0

Exam:

Const: Appears obese. No signs of apparent distress present. ENMT: Auditory canals normal. Tympanic membranes are normal. Nasal mucosa is pink and moist. Dentition is in good repair. Posterior pharynx shows no exudate, irritation, or redness. Neck: Palpation reveals no lymphadenopathy. No masses appreciated. Thyroid exhibits no thyromegaly. No JVD. Resp: Respiration rate is normal. No wheezing. Auscultate good airflow. Lungs are clear bilaterally. CV: Rate is regular. Rhythm is regular. No heart murmur appreciated. Extremities: No clubbing, cyanosis, or edema. Right shoulder is tender. No obvious deformation. Decreased ROM in abduction and extension. Abdomen: Bowel sounds are normoactive. Palpation of the abdomen reveals no CV, no tenderness, muscle guarding, rebound tenderness or tenderness. No abdominal masses. No palpable hepatosplenomegaly. Musculo: Walks with a normal gait. Skin: Skin is warm and dry.

Assessment: Joint pain in the shoulder region.

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Content and Documentation Requirements

General Multi-System Examination

System/Body Area	Elements of Examination
Constitutional	■ Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff) ■ General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Eyes	■ Inspection of conjunctivae and lids ■ Examination of pupils and irises (eg, reaction to light and accommodation, size, and symmetry) ■ Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth, and Throat	■ External inspection of ears and nose (eg, overall appearance, scars, lesions, masses) ■ Otoscopic examination of external auditory canals and tympanic membranes ■ Assessment of hearing (eg, whispered voice, finger rub, tuning fork) ■ Inspection of nasal mucosa, septum, and turbinates ■ Inspection of lips, teeth, and gums ■ Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx
Neck	■ Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) ■ Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	■ Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) ■ Percussion of chest (eg, dullness, flatness, hyperresonance) ■ Palpation of chest (eg, tactile fremitus) ■ Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)

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- Education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous five
- Education, counseling, and referral, including a written plan provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits

You should report an IPPE visit using G0402 *Initial Preventive Physical Examination (IPPE).*

Impacted Cerumen Removal

Cerumen removal is a service that is bundled according to the NCCI. If you perform this procedure the same day as an E/M service, it is bundled in. This is a code for removal of impacted cerumen. This is not for just cerumen. To report this code the use of instrumentation is required. This is not for an irrigation to remove cerumen. This procedure code description includes one or both ears. Do not report modifier 50 when performed on both ears.

Lesion Removal

When coding the removal of lesions, the code can be selected based on the location of the lesion, the technique used for the removal, and the type of lesion.

Skin tag removals are common procedures. 11200 report the first 15 lesions. 11201 is reported for each additional 10 lesions or part thereof. If we had 17 skin tags, we would report 11200 and 11201. If we had 30 lesions. We would report 11200 for the first 15, 11201 for the next 10, and 11201 for the last five.

When reporting destructions we need to know the type of lesion. If it is premalignant, benign, or malignant. We also need to know the number of lesions destroyed. For example, if we destroyed three premalignant lesions, we would report 17000 for the first lesion and 17003 with two units for the second and the third lesions. If we destroyed three benign lesions we would report 17110. For malignant lesion destruction, we need to know the location and size of the lesion. For example, a 2.5 cm lesion on the patient's arm would be reported with 17263. Destruction can be performed via laser surgery electrosurgery, cryosurgery, chemosurgery, and surgical currettement. If the lesion is destroyed, there is no pathology report, and therefore, we would be coding from the physician's interpretation of what the lesion was. The code for the destruction of a malignant lesion is selected based on the size of the lesion destroyed. The destruction of premalignant or benign lesions are coded based on the number of lesions destroyed.

Trigger Point Injections

Trigger point injections are focal, discrete spots of hypersensitive irritability identified within bands of muscle. These points cause local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers. The physician identifies the trigger point injection site by palpation or radiographic imaging and marks the injection sire. The needle is inserted and the medication is injected into the trigger point. The codes are selected based on the number of muscles injected not the number of injections performed. 20552 is used to report injection of single or multiple trigger points in one to two muscles. 20553 is used to report single or multiple trigger points in three or more muscles.

Venipuncture

Venipuncture is the collection of venous blood. Many payers bundle this service with E/M codes so make sure you check your payer policies. In CPT® Assistant, there is a notation that says, "in addition, the 99000 codes handling and/or conveyance for transfer could be reported when the physician's office centrifuges the specimen." It should be considered when specimens are prepared and packaged for outside laboratories.

Radiology Services

These codes are selected based on the anatomic site of the X-ray, the number of views, and sometimes the types of views. When a CT scan or MRI is performed, the codes are selected based on whether they are performed with contrast, without contrast, and with and without contrast. Contrast codes are used when the contrast is

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CEMC™ Practice Exam

Case 1

CC: Cough, runny nose, fever.

HPI: 15-year-old Friday was at home and started developing a productive cough; feeling tired and had a clear runny nose. Saturday was feeling much worse. States he laid on the couch all day long, was running fevers on and off. Complains that he would cough so hard his chest would hurt, felt wheezes and had a fever of 101. Felt slightly better yesterday and today, but still has an ongoing cough and feeling of wheezing. Denies gastric problems. All other systems reviewed and are normal. Coming in for evaluation of the same. Taking NyQuil prn.

ALLERGIES: NKDA

0: HT 69. WT 171. T 97.3. P 95. 02 sat 97%.

PE:

GENERAL: 15-year-old, age appropriate, appears in no acute distress. A&O x 3. **INTEGUMENT:** Skin: Pink, warm, dry, and intact. Brisk capillary refill. HEAD: Normocephalic, EARS: TMs: Gray, translucent; light reflex and bony landmarks present bilaterally. External canals normal to examination, NOSE/SINUS: No flaring of nares. Septum: Midline and patent bilaterally. Mucosa: Pink and moist. Clear discharge from the nose, but no sinus tenderness noted to palpation. THROAT/MOUTH: Buccal mucosa: Pink and moist. No lesions. Teeth: Good repair. Tongue: Midline without fibrillation. Uvula: Midline with elevation of soft palate. Gag reflex: Intact. Pharynx: Slightly erythematous. 2+ swelling with postnasal drip noted. Gums: Pink and intact. NECK: Supple without lymphadenopathy. CHEST/LUNGS: Scattered wheezing bilaterally. No rales or rhonchi. No accessory muscle use or retracting. HEART: RRR without murmur, rub, or gallop. ABDOMEN: Soft, nontender, bowel sounds to all four quadrants. LAB DATA: Rapid flu screen performed and negative. Rapid strep screen performed and negative. Spent an extended time with this patient. Several minutes longer than usual due to answering questions about how this should impact his football practice.

A:

1. Wheezing.
2. Upper respiratory infection.

P:

1. Given Xopenex 1.25 mg nebulizer treatment here, post treatment 02 sat remains at 97%, pulse 105, but wheezing has resolved.
2. Will write for Prednisone 10 mg, 3 tabs po q day x 3 days, 2 tabs po q day x 2 days, 1 tab po q day x 2 days and then stop.
3. Wrote for Albuterol HFA inhaler, 2 puffs every 46 hours prn for wheezing, 1 inhaler, 3 refills.
4. Also wrote for Cefzil 500 mg, 1 tablet b.i.d. for 10 days.
5. Obviously if severe shortness of breath occurs or high fever, go immediately to the Emergency Room for further evaluation. They are agreeable with the plan at this time.
6. No school today, may return tomorrow.

Billing information: This physician labeled his documentation with complete DOS, patient, and signature requirements met. This patient is established with this physician office. He billed a commercial payer 99214. The payer follows Medicare billing rules. AAPC does not ask a coder to make any final determination based on medical necessity. Decisions about what constitutes a medically necessary service should be made only by a practicing physician peer. Please

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