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Chapter 1 : Delmar's Administrative Medical Assisting : Wilburta Lindh :

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This chapter will assist in accomplishing the following objectives: These codes describe services provided by physicians to evaluate patients and manage their care. Other Preventive Medicine Services. A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. No distinction is made between new and established patients in the emergency department. However, as with most rules, there are exceptions, eg, in the case of visits that consist primarily of counseling or coordination of care. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making, whether or not they are family members eg, foster parents, person acting in locum parentis, legal guardian. A separate code for the office visit is not reported. These patients are there to be observed to determine whether they should be admitted to the hospital, transferred to another facility, or sent home. Since not all hospitals have a specific area designated for observation patients, the patient does not have to be located in an observation area designated by the hospital. Instead, the patient can be designated or admitted as observation status in the medical record. Codes in this category are not used to report hospital observation services involving admission and discharge services provided on the same date. When these codes are reported, it is necessary for all three of the key components to meet or exceed the requirements stated in the code descriptor to qualify for a particular level of service. Code is used to report observation care discharge day management. This code is used by the physician to report final examination of the patient, discussion of the observation stay, instructions for continuing care, and preparation of discharge records. This code is reported only if the discharge from observation status is on a date other than the initial date of observation status. In the event that an observation stay exceeds two days, the appropriate initial observation care code is reported for the initial day, code is reported for the observation care discharge day, and code , Unlisted Evaluation and Management Service, is reported for the observation days in between the initial day and the discharge day. The hospital observation codes are not intended to be used to report physician services related to postoperative recovery of a patient. The global surgical package generally includes those evaluations immediately after surgery. Services include three subcategories of codes: Patients in a partial hospital setting are also included in this range of codes. A partial hospital setting is used for crisis stabilization, intensive shortterm daily treatment, or intermediate-term treatment of psychiatric disorders. These codes are intended to be reported for the first hospital inpatient encounter by the admitting physician. This date may not be the same as the date the patient was actually admitted to the hospital. However, the physician did not have an inpatient encounter with that patient until Thursday morning. Hospital Discharge Services The Hospital Discharge Services codes and are reported for the total time spent by the attending physician for hospital discharge of the patient provided the date of discharge is different from the date of admission. These codes include final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions, and referral forms. The Hospital Discharge Services codes may be used to report discharge services provided to patients who die during the hospital stay. Types of consultations include the following: There is no differentiation between new and established patient visits. When the codes in this subcategory of service are reported, all three key components must meet or exceed the stated requirements to qualify for a particular level of service. Within this series of codes there is no differentiation between new and established patient visits. When the codes in this subcategory are reported, all three key components must meet or exceed the requirements of the code descriptor to qualify for a particular level of service. Only one initial inpatient consultation per admission should be reported by a consultant for a particular patient. When the codes in this subcategory of service are reported, two of the three key components must meet or exceed the requirements of the code descriptor to

qualify for a particular level of service. Follow-up inpatient consultations are visits scheduled to complete the initial consultation and are initiated by the consultant for subsequent consultative visits. If the consultant is unable to finish the initial consultation because, for example, certain test results are not available, then the physician consultant may visit the patient on a date subsequent to the initial consultative visit to complete the initial consultation. The consultant selects the follow-up inpatient consultation code for the services he or she has performed in this subsequent consultative visit. Consultation vs referral From a CPT coding perspective, the terms consultation and referral are not used interchangeably. When a physician refers a patient to another physician, it is not automatically a consultation. Emergency Department Services An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. When the codes in this category of service are reported, all three key components must be met. These codes are not limited to use by emergency department physicians. Time is not a descriptive component for emergency department levels of service because they are typically provided on a variable-intensity basis, often involving multiple encounters over an extended period. Pediatric Patient Transport Services The Pediatric Patient Transport Services codes and are timebased codes reported for pediatric patients 24 months of age or less who are critically ill or injured, who receive face-to-face critical care services delivered by a physician during interfacility transport. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be reported. Pediatric patient transport services involving less than 30 minutes of face-to-face physician care should not be reported with codes and Procedure s or service s performed by other members of the transporting team may not be reported by the supervising physician. Critical care is defined as the direct delivery of medical care for a critically ill or critically injured patient by a physician s. For a given period of time spent, the physician must devote full attention to the patient providing critical care services and cannot provide services to any other patient during the same period. Although critical care is usually given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or emergency care facility, it is not required that the patient is physically located in such an area to receive critical care services. Code is reported once per date for the first 30 to 74 minutes of critical care even if the time spent by the physician is not continuous on that date. Code is used to report additional block s of time of up to 30 minutes each, beyond the first 74 minutes. When critical care services are provided in the outpatient setting, code or is reported regardless of the age of the patient. Services included in the critical care codes are as follows: Codes and are reported per day, for a critically ill inpatient neonate, from birth through 28 days of postnatal age. Codes and are reported for the first day of pediatric and neonatal care services; codes and are reported for subsequent inpatient pediatric and neonatal critical care services. Any services performed that are not listed below may be reported separately. However, other procedures performed as a necessary part of the resuscitation eg, endotracheal intubation, code , are also reported separately when performed as a part of the preadmission delivery room care. To report these procedures separately, they must be performed as a necessary component of the resuscitation and not simply as a convenience before admission to the neonatal intensive care unit. Additional services included in the pediatric and neonatal critical care service codes are as follows: Code describes subsequent intensive care, per day, for the evaluation and management of the recovering VLBW infant present body weight less than grams. There are three subcategories of Nursing Facility Services codes: Three codes describe each of the three events that trigger the performance of a comprehensive assessment by the facility. If the patient is admitted to the nursing facility in the course of an encounter in another site of service, the nursing facility level of service should include the services related to the admission that were provided in the other sites of service as well as in the nursing facility setting, when performed on the same date as the admission or readmission. However, when hospital or observation discharge services performed on the same date as the nursing facility admission or readmission are reported, they may be reported separately. Nursing Facility Discharge Services The Nursing Facility Discharge Services codes and are time based and are intended to be reported for the total duration of time spent by the physician for the final nursing facility discharge of the patient, even if the time spent providing the service is not continuous. Only one code is reported: The attending physician would perform the final examination of the patient pronouncing the patient dead , discussing the nursing facility stay

with family members or others, and preparing discharge records. Note that facility services do not include a medical component. There are separate subcategories of codes for new patient and established patient visits. The term face-to-face refers only to patient face-to-face contact. These are time-based codes and reported for the total duration of face-to-face time spent by a physician providing prolonged services on a given date. Codes and are reported for the office or other outpatient setting. Codes and are reported for the inpatient setting. Codes and are used to report the first hour of prolonged service. These codes may also be used to report a total duration of prolonged service of 30 to 60 minutes on a given date. Prolonged service of less than 30 minutes in total duration on a given date is not reported separately. Codes and are used to report each additional 30 minutes beyond the first hour of prolonged services. These codes may also be used to report the final 15 to 30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not separately reported. The total duration of time spent providing these services on a given date is reported, even if the time spent by the physician on that date is not continuous. Prolonged services of less than 30 minutes in total duration on a given date are not reported. Code must first be reported to report code Code is used to report the first hour of prolonged service on a given date, regardless of the place of service. This code may also be used to report a total duration of prolonged service of 30 to 60 minutes on a given date. It should be reported only once per patient, per date, even if the time spent by the physician is not continuous on that date. Code is used to report each additional 30 minutes beyond the first hour of prolonged physician services, again regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Physician Standby Services The Physician Standby Services code is used to report physician standby services requiring prolonged physician attendance without direct faceto-face patient contact. Physician standby services are provided at the request of another physician. Standby services of less than 30 minutes on a given date are not reported separately. If an additional full 30 minutes of a standby service is provided, it is appropriate to report code for each full 30 minutes of standby service. To report code , the physician must be available to provide care to the patient, but may not actually provide any care. The physician providing the standby services cannot provide care or services to other patients during the period of standby. The Case Management Services codes include two subcategories: Team Conferences and Telephone Calls.

Chapter 2 : McGraw-Hill Professional

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To get paid, the surgeon must establish that the medical care rendered is not part of the usual postoperative care for the previous surgery. Modifiers , , and cover situations where the surgeon does not provide all the medical care related to the surgery. Physicians, other than the surgeon, may provide and be paid for medical care related to the surgery if the surgeon indicates his service does not include the preoperative or postoperative medical care. Sometimes the doctor performs multiple procedures. Suppose the patient has gall bladder surgery and the doctor also removes nevi from the neck and left thigh, and a basal cell CA of the scalp. You would report the major procedure on the first line, the basal cell CA on the second line, and the nevi on subsequent lines in the order of diminishing significance. The modifier would be used on all but the first service line. Also, each service line must show the appropriate diagnosis code or reference number. Therapeutic surgery includes all related medical care. The modifier is used when there is a separate, postoperative medical service, unrelated to the surgical procedure. If the asthma is unrelated to the surgery, the office visit may be billed as a separate service with modifier Some multiple surgical procedures must be reported without modifier Because these codes are added on to the reporting of another code, they can never be used alone. When printing paper claim forms, be sure that these codes do not roll over to be the only service on another claim form. Codes such as Bone graft, any donor site, minor or small or Injection procedure for myelography are billable but assumed to be related to another reported service. Modifiers increase in importance each year. Be certain you review the modifier sections when you look for changes in procedure codes. When physicians code from a list, they may miss a code that contains multiple services. Encounter forms or coding sheets may state: The description includes codes and Suppose the patient with the abdominal hysterectomy also had a Marshall-Marchetti type procedure. The correct code, , contains all the procedures listed above. Many insurance carriers implement these policies as soon as CMS releases them. The CPT worksheets may require multiple procedure codes, a modifier, or the reporting of quantity. As you complete the worksheets, pronounce the terms. You can increase your vocabulary as you expand your coding skills. Integumentary System These codes include procedures on the skin, subcutaneous and accessory structures, nail, and breast. They cover the removal of lesions, suturing, plastic repairs, burn treatment, and other surgeries. We add together the length of all wounds in the same classification and report the total as a single item. But this rule does not apply to excising multiple lesions as each is reported individually. A ruler with both inches and centimeters will help you report the correct codes for lesions and suturing. Before beginning the worksheets, look at the codes and read the text of the entire integumentary section. You may wish to have a medical dictionary and anatomy reference handy. Benign lesions are listed before malignant; suturing is simple, intermediate, and complex; and the miscellaneous categories list services that do not fit into other sections. The integumentary system ends with procedures on the breast. Watch for worksheet items requiring a modifier, quantity, or multiple codes. Hair transplant, 21 punch grafts Removal of 8 skin tags from left forearm Implant Norplant contraceptive capsules Simple blepharoplasty, right upper lid Reclosure, three surgical wounds Debridement of skin and subcutaneous tissue, left forearm Permanent removal distal half, left great toenail Full thickness graft 2x5 cm. Laser destruction, benign 2 cm. Musculoskeletal System Three worksheets on the musculoskeletal system cover the largest unit in the surgery section. They describe procedures on the supporting structures of the body such as bone, muscle, and tendon. The second worksheet has procedures on the arm, hand and fingers, pelvis and hip joint. The third involves services on the femur, knee, leg, ankle and foot and concludes with casting, strapping, and arthroscopy. The many rules and definitions appearing within the chapter give specific instructions on coding. Note that the service includes the first cast or traction device. This information is repeated at the start of the casting section. There are also modifiers to identify the service as right or left, and ones that identify specific digits. If you believe this is

happening in your office, talk to the doctor and get this clarified before billing the service. The musculoskeletal system is arranged by body site, from the top down, from the center out. After the general procedures, it is organized: Forearm and wrist Hand and fingers Pelvis and hip joint Femur and knee joint Leg and ankle joint Foot Each body site section follows this organization: Manipulation Arthrodesis Amputation Miscellaneous Note how many worksheet items in the musculoskeletal section contain the diagnosis. Watch for items that need multiple procedure codes, right, left, finger and toe modifiers, or quantity specified. Respiratory System From nosebleed and tonsillectomy to removal of a lung, this section covers procedures associated with the nose, sinuses, larynx, trachea, bronchi, lungs, and pleura. In this system we are introduced to endoscopy. Note that when a surgical or therapeutic endoscopy is performed, the appropriate sinusotomy, diagnostic endoscopy, and inspecting all sinuses is included. This is another example of correct coding, or bundling of services. This endoscopy section had significant changes in both the and editions of CPT. Codes revised in were deleted in and replaced with new codes. Things have been fairly stable since then. Cardiovascular System This section lists the surgical procedures on the vascular and cardiac systems; the heart, veins, and arteries. The instructional introductory paragraphs refer to first, second, and third order vessels and vascular families, and the injection procedures for arteriography. This manual is available from: Aortic procedures include the sympathectomy, if performed. Diagnostic cardiac catheterization is in the Medicine section. Review the extensive explanation of pacemaker and cardioverter-defibrillator services. Coronary bypass grafting, both venous and arterial, is complex and requires careful reading. Watch out for worksheet item 3. Move slowly and carefully through this CPT section. Hemic and Lymphatic - Mediastinum and Diaphragm These combined, small sections include procedures on the spleen, bone marrow, lymph nodes and channels, mediastinum, and diaphragm. Compared to the cardiovascular section, this one is easy. Watch for these notations as you code this worksheet. Digestive System This system covers procedures on the mouth, salivary glands, pharynx, adenoids, tonsils, esophagus, stomach, intestines, appendix, rectum and anus, liver, biliary tract, pancreas, abdomen, peritoneum, omentum, and hernia repair. This diverse section contains endoscopic procedures and refers to the related radiographic supervision and interpretation service. Remember that surgical endoscopy includes diagnostic endoscopy. Watch for multiple codes and the item that requires a modifier. Urinary System This section includes the procedures on the kidney, ureter, bladder, and urethra. Also transplant services, including the harvesting of the kidney. Urinary endoscopy and other procedures identify special bundling instructions. Read the worksheet items carefully. Urethra and ureter can look similar in some forms of the words. Note the different codes for male and female. One worksheet item has two possible codes. What else do you need to know to find the exact code? Subsequent urethral stricture dilation, male, age 27 Transurethral resection of prostate Closure of traumatic kidney wound Infant meatotomy Cystourethroscopy, fulguration of 1. Male Genital System These codes identify procedures on the penis, testis, epididymis, tunica vaginalis, scrotum, vas deferens, spermatic cord, seminal vesicles, and prostate. Watch for the worksheet item that has two possible answers. Intersex, Female Genital, and Maternity This section defines intersex surgery; procedures on the vulva, perineum and introitus, vagina, cervix and corpus uteri, oviduct, ovary, and in vitro fertilization. Also included are the services related to delivery, antepartum, and postpartum care. With CPT , the laparoscopy codes were given new numbers and moved to the specific body system for that service. There are several options for endoscopy in this section. You may need to read the procedure notes to code the vulvar surgery as simple, radical, partial, or complete. Note the services included in the prenatal or antepartum care. Would you bill inpatient medical care for the time your patient is hospitalized for delivery? No, not for the usual care associated with delivery, but you could report additional care for other complications. Also, another physician, following the patient for an unrelated difficulty, such as a cardiac problem, would bill for regular medical care unrelated to the delivery. Examine the instructions on partial prenatal care. Abortions may be spontaneous, missed, septic, or induced. Some worksheet items may require multiple codes or quantity indicators. Endocrine and Nervous Systems Procedures on the thyroid, parathyroid, thymus and adrenal glands, carotid body, skull, meninges and brain, spine and spinal cord, extracranial and peripheral nerves, and autonomic nervous system; destruction by neurolytic agent, neuroplasty, and neurorrhaphy are included on this worksheet.

Chapter 3 : How to Export Access Data to Excel using VBA

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This includes the written and lab simulation final. Blinn College Policies Blinn College policies on civility, class attendance; scholastic integrity; students with disabilities; final grade appeals; and electronic devices as stated in the Blinn College Faculty Handbook, Blinn College Catalog and specific technical program handbooks. All policies, guidelines and procedures in the Faculty Handbook, the Board Policy and Administrative Procedure Manuals are applicable to this course. Civility Statement Members of the Blinn College community, which includes faculty, staff and students, are expected to act honestly and responsibly in all aspects of campus life. Blinn College holds all members accountable for their actions and words. Therefore, all members should commit themselves to behave in a manner that recognizes personal respect and demonstrates concern for the personal dignity, rights, and freedoms of every member of the College community, including respect for College property and the physical and intellectual property of others. This statement reflects step one in a possible four step process. Attendance Policy The College District believes that class attendance is essential for student success; therefore, students are required to promptly and regularly attend all their classes. There are four forms of excused absences recognized by the institution: Other absences may be excused at the discretion of the faculty member. A student enrolled in a developmental course is subject to College District-mandated attendance policies. Failure to attend developmental classes shall result in removal from the course as defined by the College District. Scholastic Integrity Blinn College does not tolerate cheating, plagiarism, or any other act of dishonesty with regard to the course in which you are enrolled. In a case of scholastic dishonesty, it is critical that written documentation be maintained at each level throughout the process. It is the responsibility of faculty members to maintain scholastic integrity at the College District by refusing to tolerate any form of scholastic dishonesty. Adequate control of test materials, strict supervision during testing, and other preventive measures should be utilized, as necessary, to prevent cheating or plagiarism. If there is compelling evidence that a student is involved in cheating or plagiarism, the instructor should assume responsibility and address the infraction. Students with Disabilities Non-Discrimination Statement Blinn College does not discriminate against qualified individuals with disabilities in the recruitment and admission of students, the recruitment and employment of faculty and staff, or the operation of any of its programs and activities, as specified by applicable federal laws and regulations. Students should make arrangements for disability service directly with each campus on which they attend classes. Students enrolled on the Brenham, Schulenburg, and Sealy campuses should contact for more information. Students on the Bryan Campus should contact Designated parking spaces, ramps, handicapped restroom facilities, elevators, and assistance from College employees are readily available on all campuses. Services for Students with Documented Disabilities Students with documented disabilities must self-identify and provide current, appropriate documentation of the disability to the Office of Disability Services ODS prior to receiving services. Students are encouraged to contact this office as early as possible to initiate services. Direct services to students with disabilities are provided in the following areas: A 5 point penalty will be assessed per each tardy for lab competency exams. A 10 point deduction will be assessed the first day an assignment is late with additional 5 points every day thereafter. There are no make-up quizzes given. A grade of zero will be recorded for each missed quiz. If you miss your scheduled lab simulation time you will have to meet with instructor to schedule another time. A deduction of 5 points will be applied as well for unexcused absences. A grade of zero will be recorded for an exam not completed within the 10 day time period. Please note on the schedule the weeks in which both labs meet together on the same day. If the student needs to change a lab day or will be absent from lab, they must arrange to switch with another student and inform the instructor at least one day prior to the lab. Please refer above for policy on tardiness to lab competencies. Failure to perform these duties during the assigned weeks will result in 5 points lab grade deduction for each

student per each assignment. Absolutely no exposures allowed without an instructor present. All laboratory equipment phantoms, electronics, patient care items, etc. Any type of equipment or room malfunction or damage noted or observed by students must be reported to instructor. This is to ensure that the proper protocols and steps to fix equipment are taken, which then assures the safety and security of all students and instructors utilizing the lab. Violation of this policy will result in a written citation with a 5 point deduction from the final course grade. Please turn off or silence any watch alarms, cell phones, etc. Cell phones must be kept in bags at all times, unless instructed otherwise by professor.

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