**Course Information Sheet and Course Text Companion**

CRS 211 - Coding Section - Test Coaching/Review for Certification Exam Instructor: Rick Durling

Class Location/Time: HOC 251 / CRS - Tuesdays 1000-1050

Contact by Email: [durlinr@linnbenton.edu](mailto:durlinr@linnbenton.edu) Required Text and Workbook: None

[Schedule of Student Responsibility](https://docs.google.com/spreadsheets/d/1AdLAMKm9PKhzko8Pr7Q59GA2h6v3eYWbJFgYw1N0o78/edit?usp=sharing) [Instructor Schedule/Office](https://docs.google.com/spreadsheets/d/1BvGY3Vc6xFy-anNyykq1L8rsNj5rTJvj2D_RtAHPQJ8/edit?usp=sharing)

Course Responsibilities

All competency assessments will be due on Sunday following the week assigned by 0800 and according to the [Schedule of Student Responsibility](https://docs.google.com/spreadsheets/d/1AdLAMKm9PKhzko8Pr7Q59GA2h6v3eYWbJFgYw1N0o78/edit?usp=sharing).

All of this course will be taught with online components. Ensure your ability to use both MOODLE and ZOOM technology. If you are unsure, please talk to your instructor

**Course Outcomes**

Upon successful completion of this course, the student will be able to research and utilize basic procedural and diagnostic codes. Students will be able to identify these codes from a variety of source documents including, charts, operative notes, E&M records, etc.

**Themes**

Students will focus on themes such as medical necessity, indexing, cross-referencing, specificity, verification, and routine.

**Concepts**

Speed, accuracy, attention to detail, report techniques are common concepts in this course.

**Issues**

Your presence and/or participation is fundamental to meeting the course objectives. Writing Skills, Penmanship, Command of Spoken and Written Language, Attendance, Basic Math. This class has a large ONLINE component. If you are uncomfortable with doing work online, please see me ASAP for assistance. Instructions for online activity must be followed perfectly to avoid mistakes that could cost you points. Claims Processing (taught in CRS 110), differentiating between insurance styles, knowledge of the insurance rules, Spelling, Test Taking.

**Assessment**

Competencies 10 pts each, 100 points Total, 90 pts=A, 80 pts=B, 70 pts=C, 60 pts=D, <60 pts=F

**Assignments**

[Schedule of Student Responsibilities](https://docs.google.com/spreadsheets/d/1AdLAMKm9PKhzko8Pr7Q59GA2h6v3eYWbJFgYw1N0o78/edit?usp=sharing)

Competency assessments are all due by 0800 on Sunday morning, following the week they are assigned. There is no final exam for this course.

**Practice Quizzes**

Practice Quizzes, which are taken on your own anytime after class time. These are designed to check your retention of “key” knowledge areas in coding. These quizzes are not counted for grade; rather, they are designed to assist in demonstrating the points of each module as practice. We will utilize these tests when possible to demonstrate the points of each module during class as well.

**LBCC/Course Academic Dishonesty Policy**

Students at LBCC are responsible for pursuing their studies with honesty and fairness. Acts of academic dishonesty, including such activities as plagiarism or cheating, are regarded by the college as very serious offenses. An instructor has the right to issue an “F” grade for the course

in which the instructor believes the student has cheated or plagiarized and should report all acts of dishonesty to the Assistant Dean of Student Services. Students are encouraged to ask the Writing Desk for a copy of “What’s Plagiarism and How Can you Avoid It?” and to be familiar with “Students’ Rights, Responsibilities, and Conduct.” LBCC Comprehensive Statement of Nondiscrimination.

**Non-Discrimination Policy**

LBCC maintains a policy of nondiscrimination and equal opportunity in employment and admissions, without regard to race, color, sex, marital and/or parental status, religion, national origin, age, mental or physical disability, Vietnam era, or veteran status. Students who may need accommodations due to documented disabilities, or who have medical information which the instructor should know, or who need special arrangements in an emergency, should speak with the instructor during the first week of class. If you believe you may need accommodation services, please contact ODS, 917-4789. If you have documented your disability, remember that you must make your request for accommodations through the ODS Online Services web page every term, in order to receive accommodations. For further information contact the Disability Coordinator at Linn-Benton Community College, RCH-105, 6500 Pacific Blvd. SW, Albany, Oregon 97321, Phone (541)-917-4690 or via Oregon Telecommunications Relay. TTD at 1-800-735-2900 or 1-800-735-1232."

Outline of Materials CRS 211 Test Coaching for Exam

1. Meet a Coder / Basic Humongous Testing
2. Multiple Choice Exams
3. Negotiating and Navigation
4. Cardiology Review
5. Psychology of Testing
6. Anesthesiology Review
7. Lesions and Skin Repair Review
8. Cardiology Review II
9. Applying Modifiers
10. S - N - R

**Lecture Module 1 - Meet a Coder / Exam Prep One**

Classroom Activity: Discussion with past Student

Current Coder Sam Lunde, CPC

**Weekly Work:**

You will hear a lot of advice around the subject of taking large and important exams. Some will be relevant, most will be content-driven or discussing three test-taking subjects: 1. General Rules, 2. How to select the proper answer, 3. Best way to negotiate/navigate through 5 hours and 40 minutes and 150 questions of coding exam. This week we focus on number 1. Before we discuss any sort of specific strategy, the following points are more general and should be established firmly in your brain before we talk about numbers two and three.

**Arrive on time - Not early - Not late**

Arriving on time will help to avoid the "brain pickers," other students who ask you questions right before the test to that you may or may not know the answer to. This can create needless anxiety. Also, being on time avoids the stress that occurs whenever we are late.

**Do a memory dump**

You each will have a unique concoction of competency among the areas of emphasis on the test. Do a complete read-through right away and answer those that simply POP OUT at you first. Spend no more than 30 minutes on this activity. So reading only. No analysis whatsoever.

**Read directions carefully**

The directions for a test may seem obvious to some, but to others, there may be valuable information hidden in them. You can facilitate this by knowing the etiquette and rules well before you walk into the testing site.

**Budget time wisely**

Quickly review the test before you begin and decide how much time you will spend on each part of the test. Pay attention to the weight of each section on your grade and make sure you allow enough time for sections that may take more time or are weighted more heavily in the final test grade. It's never fun to arrive at the last page of the test only to find an essay question worth 25 percent of your grade with only a few minutes remaining to complete the test. We will discuss a more specific strategy in week 3.

**Feeling anxious? Practice relaxation**

A number of autogenic relaxation techniques can be useful during a test if you find that anxiety-caused stress is interfering with your performance. Some anxiety is good because it helps us perform better, but at some point, the resultant stress can reduce performance. In week 5 we will address this more specifically.

**Look for cues**

You can look for two answers that are similar, cues from other questions, grammatical matching between the question and answers, and other strategies to give you hints.

**Answer all of the questions**

Some professors give partial credit, so it is important to answer all of the questions even if you are running out of time and can’t answer them fully.

**Do not change answers**

Research has shown that it is best to go with our first instinct when choosing an answer to a question, unless you are very sure the answer you have chosen is wrong.

**Use all of the time available**

If you finish early, go back and review your answers to make sure you haven't skipped a question or made careless mistakes as you responded to the questions.

[CPC Exam Content](https://www.aapc.com/certification/cpc/)

[CPC Practice Exam (20 questions)](http://www.hcpro.com/content/61715.pdf) not all of these apply…. They are the most common questions over 20 years and some are still used while some are revised due to ICD 9. They stopped publishing this list along with other forms of support last year.

[CPC Exam Tips Video](https://youtu.be/rjJ951-YtMU)

**Lecture Module 2 The Multiple Choice Exams**

Many students fail multiple-choice exams because their expectations are that the questions will be straightforward and easily recognized. Most large test creators develop multiple-choice questions by synthesizing material from more than one source creating a dual (or multiple) layered question demanding analysis of the question (and answers) rather than rote memory. The CPC coding certification exam is the quintessential multiple layered question exam; taking information from vastly different sources of our industry including every kind of recognized medical specialty, CMS and other regulatory sources, a procedure manual, a diagnosis manual, and a procedure/supply manual, anatomy, physiology, and medical terminology. This is ultimately significant because each test-taker will possess significantly different competencies utilizing these different sources. That means our ability to analyze each question will vary based on its source. For example, a student with average general coding knowledge but significant knowledge of modifiers, cardiology, and E&M will fare better than a student who is expert in say radiology, anesthesiology, and compliance/regulation, and average coding knowledge. This is because some sources are utilized more heavily than others.

Next we come to the resulting point, on this exam specifically, the average student coming from our program will automatically (with certainty) know the answer to 15 of the 150 questions without any analysis, just based on the fact that their knowledge emphasis matches the blend the creators infused into the question. This leaves analysis as the method of selection for 135 questions. The next part is tricky so stay with me…..

Analyzing the Question: Each question will have 4 *potential* **right** answers. Most test-takers will look hard at all four choices, searching for the one that looks the most correct. If I do that, and the question draws from sources where I have only average knowledge, I have a 25% chance of getting that question right. There is only 1 right answer out of 4. Now follow this…. If I reverse that and look for the *potential* **wrong** answers I increase my odds threefold. There are 3 wrong answers to start with, so selecting the first wrong answer is 75%, the second wrong answer is 66%, and the third wrong answer is 50%. Each of these steps significantly increases my chances of being correct because they all beat the 25% chance I had at the start of this. The one left standing, probably the one answer that I have done the LEAST research on, is almost certainly the right answer. This levels the playing field a bit concerning the multiple sources of information, some which I might excel at; others I might struggle with. But the bar is far lower to climb when I am identifying wrong answers than it is when I try to identify right answers. Consider this the first and perhaps most important lesson for navigating an individual question. We will practice this throughout the term. Most research on your own will show far different instruction on multiple choice questions. Most involve pattern recognition. I believe that is a waste of your time.

**Lecture Module 3 Negotiating and Navigation**

I am going to preface this plan with a caveat…. You won’t like it very much. At first. And some of you may abandon it entirely either before or after starting the test. But for those with the will and patience to see this methodology through, it will pay dividends. This is only a framework afterall. The content knowledge and preparation you have invested in for these past several month will hang on this framework no matter how you construct it. I encourage you to to begin utilizing some of these concepts in your practice testing, coding quizzes, and other courses so that you can be more familiar with it. Don’t worry if at first performance suffers until you get the hang of it. Everything you are doing, and have been doing for several months, still only comes down to two things: 1. Can you pass the AAPC Certification Exam and 2. Can you Get a J-O-B. The second part is probably easier than the first. There is one single student from last year’s cohort that I am helping to prepare for the exam… for the fourth time. But you know what? She has been working as a coder since not long after graduation last year. She has committed to using my method this go-round and I believe she will pass, giving us the first PERFECT YEAR ever in our program. So deal with the discomfort and make this method a new normal for you.

There are 150 questions to answer in 340 minutes making 2 minutes and 15 seconds your time per question. The problem is that while some questions could take only a minute, some questions may take 15 minutes for you to come up with an appropriate response given your skill/competency set. This is normal. In order for this process to work, you must assume that you know enough with your current skill/competency set to get 105 questions correct out of the 150 presented. We have to find a method of triage. Some way to drown out the ***noise*** of those 45 questions and focus on getting all 105 questions right that are within our competency set. This method is structured and precise and involves “passes” through the test; therefore it takes practice so start practicing.

As soon as the proctors say go you will:

**PASS 1** - For the first pass, spend 30 minutes reading every single question but not reading the answers. If you are absolutely positive of the answer, which you will be on perhaps 15 or so questions, read the answers and go ahead and answer it and mark that one completed by putting a checkmark on your test booklet. If you are not absolutely sure, keep reading. This will count as your first “exposure” of that question to your brain. Research and past results both show that for the next 5 hours and 10 minutes your brain will retain about 90% of those questions and continue to work on them even as you begin analyzing other questions.

Progress Check: 30 minutes in, 5 hours and 10 minutes to go, you have 10-20 questions in the win column.

**PASS 2** - On average you will have 135 questions left, some more, some less. In this second pass through the exam, spend no more than one minute per question. This means answering the questions that you can be sure of the answer after careful analysis of the answers, or by looking up just one code of any kind. Only answer the ones you are sure of in one minute or less. Many students buy themselves two little hourglasses, the type you get in some board games; one for 1 minute and 1 for three minutes. Don’t worry or wait if the time is not done, just turn it over when you come to the next question and use the time pieces as a guideline for yourself. Sometimes, after you do this for an hour or so your brain automatically knows the time and you can abandon the timepieces. This focuses your efforts on the low hanging fruit. Perhaps a modifier answers the question, or you can analyze that just one ICD 10 confirmation will make you certain. If you don’t have the answer after a minute, make sure to mark on your test booklet through any of the answers which you know to be incorrect. Those answered should be only the questions that you can be certain you have correct. Surprisingly you will find that this method allows you to answer half of the remaining 135 questions or so. We will use 60 right answers in this pass as our model just to be conservative. If you analyzed 135 questions, the greatest amount of time which that should take is 135 minutes.

Progress Check: 165 minutes into the exam, 175 minutes to go, so less than halfway through and you should have at least 75 questions in the win column with 75 still in question. This means you only need to answer 30 questions correctly in the next 175 minutes.

**PASS 3** - For our third pass, you will do the same as the last pass with modification. Use the 3-minute timer now and look up anything and everything you need to in order to get the question correct. You must also realize that these 75 questions that remain are there for a reason. You have less knowledge in these areas, or the questions representing these areas are tougher than the 75 which you already have correct. This means that additional and focused analysis will be required. If you cannot answer, at least try to mark through at least one answer that you know is incorrect and leave it for pass number four. Although we allow ourselves 3 minutes on each of these; you will find that for the most part you can answer after just a little more analysis or perhaps looking up one additional code, thereby correctly identifying all of the wrong answers. Regardless, stop after 3 minutes if it comes to that and move on. Whatever your blend turns out to be, on average our pass number three takes approximately 110 minutes to complete. This pass has the advantage of collecting more information; and it is also the third time your brain will focus on the question which actually increases the analysis volume for this question. That advantage yields a net average around a 50% success rate.

Progress Check: 275 minutes into the exam, 65 minutes to go, 112 in the win column. This means that the rest is icing on the cake, but still important. Proceed to pass 4.

**PASS 4** - Passes 4 and 5 represent your safety cushion so please do not let off the gas yet. Pass 4 will involve the 30-40 questions still unanswered. Break out your 1 minute timer again. For each remaining question give yourself 1 minute to choose an answer. Consider the answers you have marked as wrong being off the table and choose now between the answers left to each question. At the end of the 1 minute time period or before, select the answer that seems MOST right to you and go with your gut. Not surprisingly, you will still only answer about 25% of these correctly because they fit low in your competency set. But it will still net you more progress….. Speaking of progress….

Progress Check: Out of these remaining questions, you will still probably only get 10-15 correct. But this still means you will have answered correctly on at least 122 questions out of 150 which makes our average for all students using this method a respectable 81.3% and comfortably exceeding the required 70% proficiency.

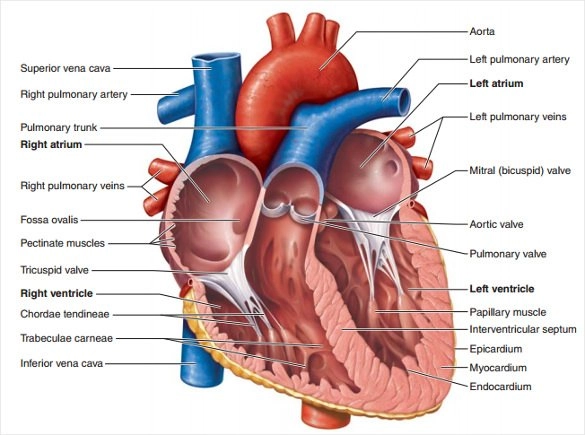
**PASS 5** - Review your answer key, spot check that you have not left any answers blank. If there are still blank answers, answer them with a WAG. Make sure your test is properly documented and wrapped up. Turn it into the proctor and leave with confidence.

It is my hope that this structure provides comfort and security during the exam. But you need to get comfortable before the exam happens. This means trying it out and practicing with it throughout the rest of this term. If you cannot get comfortable with all of it, make your plan to incorporate the parts you are comfortable with into your navigation of the exam. Just remember, the average score of those who stuck rigidly to this method currently stands at 81%. Last year, 18/21 used this method exclusively. None of the three who did not passed the exam on the first try. One of them is still trying and we are crossing our fingers for attempt 4; but a happy ending I am sure….. She will be utilizing this method on the fourth attempt. We have had 7 students since 2000 take the test for a fourth time before the aforementioned student. Six have passed and none have attempted a 5th.

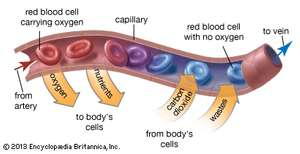
**Lecture Module 4 - Cardiology Review**

The cardiovascular section of the surgical chapter in the CPT is one of the most exciting sections we get to cover. It is cool, hip, interesting, and challenging. The biggest challenge is learning all of the new language, familiarizing ourselves with the physiology; and then reconciling all of that with the modalities and procedures that are conducted in this body system. That is a mouthful. So enjoy the cardiovascular cruise we are about to take.

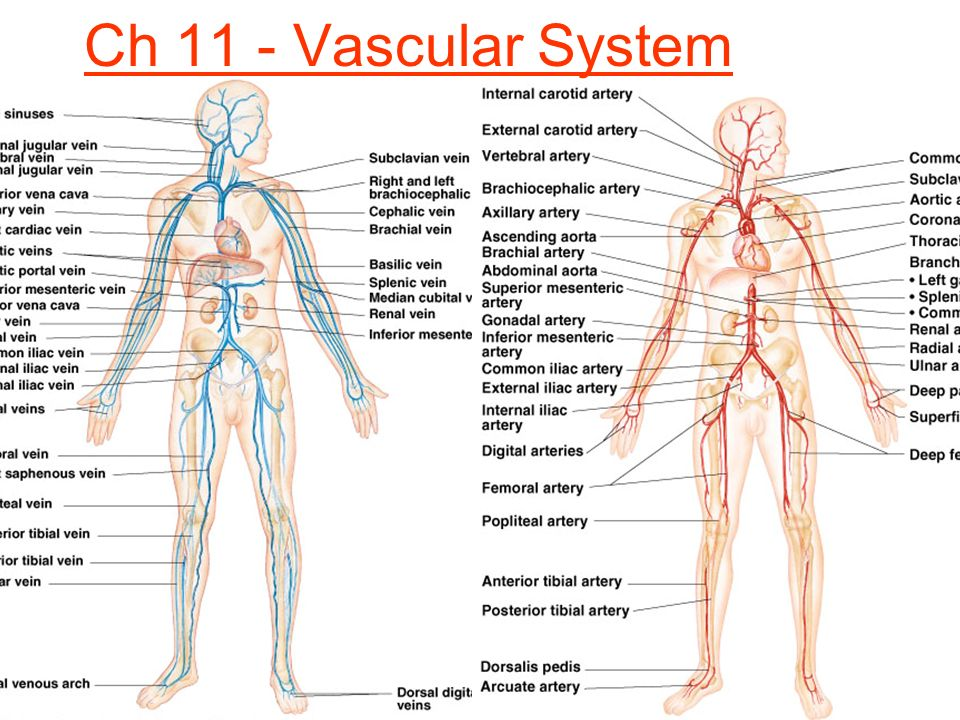
Now remember, the (cardio)(vascular) section is two things….. The heart and the vessels which deliver and retrieve blood from every single living cell in our body. Before we discuss the codes we will do a very very short A&P primer, as some of you may not have completed the medical terminology system study which helps you prepare for this section. But an additional note, there are a half-dozen diagrams prior to the section in your CPT, and at least 3 more in your ICD 10 up front, then several more in the cardio section. Remember this in a pinch when you are trying to figure out what a particular procedure actually is.



Let’s start by picturing a journey. Put on some headphones and sweet music if it helps you travel. We begin in a river, a blue one, filled with blood, called the vena cava. There are two of them, superior and inferior, top and bottom, which collect all of the deoxygenated blood in our venous system, and returns it to the heart in the top right of the four chambers we call the heart. Our river journey, which has a mission, takes us through the vena cava and into the right atrium. The mission is simple. When we begin our journey we have no oxygen on board. We need some… and once we get some we need to repeat the same journey to deliver it back to all those body cells. But we do have something on board when we begin our journey…. CO2 and lots of it weighing down our boat. Back to the journey…. We circulate there momentarily building pressure until the flood gates open below us and the atrium contracts all around us, forcing us into and through a gateway, or valve, which is called the tricuspid (so named because it has three cusps) and down into the right ventricle we go. Once again we float and circulate momentarily while the ventricle, which is like a big muscular sac around us, builds up pressure. All of the sudden another floodgate opens….. This one is called the pulmonary valve. Then, at the same time, the whole ventricle collapses around us in a mighty push and we fly out of the ventricle, through the pulmonary valve, and out into clear smooth water again. This time the river is called the pulmonary artery, it is the only artery in the body that carries only deoxygenated blood. Good thing because we have a bunch of that stuff on board our boat. When we get to the end of this river, we begin to enter smaller and smaller rivers until we come to a very small creek which only really has room for one boat to go through it at a time. This tiny blue waterway is called a capillary.



Turns out that this little creek is just one small blue waterway in a larger cluster of blue and red waterways, together with small airways, called an alveolus. Also turns out that this alveolus is just one of about 600 million in this dude’s lungs. But as we trudge our way through this narrow space we see our chance. There are little holes or windows in the capillary we travel through, and we can dump this CO2 out of the boat and they will just clear through the holes in the capillary. By the time we get out of the little creek we have dumped almost all of our CO2 out of the boat. But the boat isn’t any lighter, and as we look back, somehow the space that used to have all that CO2 is loaded heavy with O2 now. Nothing can be done about that because as soon as we see it we are out of the capillary and into another red river, leading to larger red rivers, and eventually another huge river called the pulmonary vein. We also notice that the water around our boat has turned from blue to red. It should be noted here that this vein is the only vein in the body that carries oxygenated blood. That is of course awesome because we got a ton of it in our boat. Nearing the end of this huge river we see another flood control gate ahead, this one is called the pulmonary valve and we watch it open and close rhythmically as we approach. Eventually we are right up against it again, still carrying our huge load of 02 in the back of the boat, weighing us down. Then the valve opens and we flood out with all the other boats into another huge cave, this one is called the left atrium. We float momentarily while the pulmonary valve above us and a new valve below us opens when the pressure gets to high. The valve below is called the mitral, or bicuspid valve (so named because it has only two cusps, which actually makes it a bit stronger). When it opens we cump out of the left atrium, through the mitral valve, and into another huge cave, the biggest and strongest of all the caves, called the left ventricle. This time we really feel the pressure as it builds before we feel the earthquake which is the left ventricle contraction. Then we blast out through a final valve which is called the aortic valve. Then, at super high speed, we cruise through a short narrow river called the aorta. The pressure now begins to normalize a bit once we clear the aorta. Smooth sailing through the red descending or ascending aortic artery….. It is just dumb luck which one we go through. If we go through the descending, we travel down through this dude’s abdomen, legs, and toes. If we go north, through the ascending aortic artery we travel to the arms, neck, and eventually up into the brain.



All along the way we have a choice of detours into little creeks, capillaries, that lead to smaller and smaller structures and eventually individual cells. Those little cell groups have some blue dudes sitting on a dock, waiting for one of us to park so that they can dump their CO2 again, and little red dudes waiting to grab some of our oxygen, which we are only happy to oblige. Because that’s what we are…. A ferry system set up to collect garbage and deliver oxygen. After we dump all of our oxygen and are fully loaded with CO2 again, we head back towards the house (vena cava). The end…..

Now to the coding. Strap it up and get yourself ready for a very important discussion. This section and the E&M section are a bit difficult, but also the most influential sections of the CPT, perhaps followed closely by the medicine section 90,000’s. Let’s start sorta backwards by talking about the ICD 10 manual and cardiovascular/circulatory diagnostic coding. The ICD 10 has several excellent diagrams, an anatomy and physiology review which you should read carefully, and an excellent short discussion of common pathologies. Then come the tabular codes beginning with rheumatic fever (I01) and ending with other and unspecified diseases of the circulatory system (I99). In between are all of the pathologies, their manifestations, complications, and so on; which affect the heart and the vascular system. Make really sure that you drill down to the highest level of specificity (most digits) you can get on each diagnosis. This system, and reimbursement for this system’s procedures in the CPT, link extremely expensive procedures to very specific diagnostic requirements. So therefore we have to expect a good deal of scrutiny when we bill. This means our medical necessity has to be extremely specific and accurate.

**Lecture Module 5 - The Psychology of Test Taking**

As you may remember, we have discussed that if you do not have anxiety leading up to this exam you are simply not human. Think about what anxiety and stress does for us physiologically. It increases blood pressure and well as blood flow. Our adrenal glands provide additional stimulation to our respiratory to our nervous system, cardiovascular system, and respiratory system. The sympathetic nervous system kicks in giving us increased mental and physical capabilities in order to defend ourselves or escape danger. Why on earth would we ever deny ourselves these wonderful weapons when negotiating something so important to us as a career certification exam. So please do not stress about stress. We simply need to find ways to contain and channel that physiological phenomenon into a positive helpmate while we prepare for, and navigate through the CPC exam. Here are some additional links to provide perspective and understanding of how are brain functions during exams; along with some helpful considerations for “channeling” or managing our anxiety.

[Test Taking 101](https://youtu.be/iSAtyliBZcc) video

[Psychology of Test Taking](https://youtu.be/edwmuJqL6KY) video

[Article from the Social Psychology Network](https://www.socialpsychology.org/testtips.htm)

And three miscellaneous concepts covered on last year’s exam……..

[Fair Debt Act](https://www.ftc.gov/enforcement/rules/rulemaking-regulatory-reform-proceedings/fair-debt-collection-practices-act-text)

[TILA](http://files.consumerfinance.gov/f/201503_cfpb_truth-in-lending-act.pdf)

[Business Letter Formats](https://www.gallaudet.edu/tip/english-center/writing/letters/business-letters-formats.html)

**Lecture Module 6 - Anesthesiology Review**

[2018 Anesthesia Base Units](https://docs.google.com/spreadsheets/d/1zXq4EPIIObWk9fmCT12Y7EZ5H93-jhxYL0JGQ5z2L4k/edit?usp=sharing)

[2018 Conversion Factors](https://docs.google.com/spreadsheets/d/1UekBqFjBWwsqR05CrxMe_IUEnVFtEJ-u9n5JqMv6W3Q/edit?usp=sharing) always assume local unless stated otherwise

[2018 Anesthesia Guidelines](https://drive.google.com/file/d/1tm22aSP5ZNpLrSly9iCZ35IBm1acvpvM/view?usp=sharing) (CPT)

[2018 Anesthesia Specific Modifiers (CRNA/Anesthesiologist)](https://docs.google.com/document/d/1uFNcVMJjOmBh3opSoL88YwseGaiKRrZHHNE_z1EOkRM/edit?usp=sharing)

[Medicare Claims Processing Manual](https://drive.google.com/file/d/1PR4Cp9QtvETUgzfwUZLn4C_jAjCsJJeu/view?usp=sharing) (Chapter 12 - Anesthesia)

Coding anesthesia is a very different experience than coding surgery or E&M visits. Anesthesia has a unique blend of anatomical organization and modifiers that you won’t find elsewhere in your CPT manual.

As we begin our adventure we need to stop and spend some time in the [anesthesia guidelines](https://drive.google.com/file/d/1tm22aSP5ZNpLrSly9iCZ35IBm1acvpvM/view?usp=sharing). Take a look at the “time reporting” section of the guidelines.  ***“Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room, or equivalent area; and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.”*** This is an extremely important concept and vital for you to understand as coders assign monetary value to anesthesia procedures by their coding.

**Anesthesia Modifiers**

There are two separate sets of “modifiers” most commonly used for anesthesia coding. The first set are called “physical status modifiers”. These are represented by the letter “P” followed by a number 1 through 6. **All** anesthesia codes will have a “P” modifier in order to be correctly coded. Here is the most important rule of “P coding”: Don’t overthink or interpret the note.

**Physical Status Modifiers**

P1 - “normal healthy patient” - This will be the most commonly used modifier. Patients without specific special mention of disease in the anesthesia procedure notes will be coded as P1.

P2 - “A patient with mild systemic disease” - Actually, this should be interpreted just a bit. What we really mean here is: A patient with disease that is not specifically or equivalently described as severe. Think about the difference.

P3 - “A patient with severe systemic disease”. - This one is a bit tricky because how often does the provider actually document the word severe? Equivalent verbiage would be malignant, intractable, or uncontrolled; but be careful that you, as a coder, don’t interpret a group of reported symptoms or conditions as severe.

P4 - “A patient with severe systemic disease that is a constant threat to life” - Again, this is not a judgement call for us as coders. If the provider does not document this, we should not interpret it either. Only use this modifier if clearly stated by provider in documentation.

P5 - “A moribund patient who is not expected to survive without the operation” - Just like the rest, this is not interpreted by us. It must be specifically stated by the provider in documentation to be coded.

P6 - A declared brain-dead patient whose organs are being removed for donor purposes.

Generally, **an additional unit will be allowed for P2-P5,** but generally not for P1 or P6. It is important to note that if multiple anesthesia risk modifiers are billed (Physical Status Modifiers and [**Qualifying Circumstances Modifiers**](https://hmsa.com/portal/provider/zav_pel.ph.ANE.600.htm)) payment will be made up to the modifier with the highest unit value. No payment will be allowed to the Qualifying Circumstances Modifier when billed in combination with a Physical Status Modifier (P2-P5) that is of equal unit value.

**CRNA/Anesthesiologist Specific Modifiers**

Part of the world of anesthesia within health care includes the partnership between anesthesiologists (MD or DO) and certified nurse anesthetists (CRNA). CRNA’s are qualified and legally able to provide anesthesia to patients during procedures. Sometimes this will be supervised; and this supervision has different coding implications depending upon how many cases are being supervised. Here are the code extenders (modifiers) that apply to this situation, along with an explanation for each.

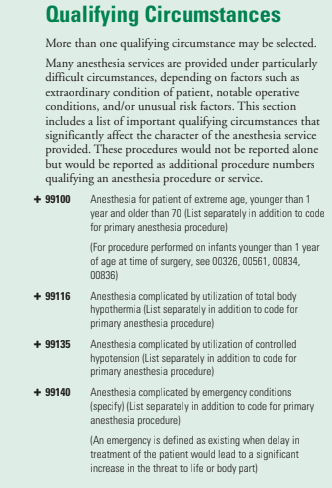
|  |  |
| --- | --- |
| * Modifier | * Description |
| * AA | * Anesthesia services performed personally by anesthesiologist |
| * AD | * Medical supervision by a physician: more than four concurrent anesthesia procedures. |
| * QK | * Medically directed by a physician: two, three, or four concurrent procedures |
| * QY | * Anesthesiologist medically directs one CRNA |
| * QX | * CRNA service: with medical direction by a physician |
| * QZ | * CRNA service: without medical direction by a physician |

* The following modifiers can be reported in the 2nd position under appropriate circumstances in addition to one of the previous anesthesia modifiers:

|  |  |
| --- | --- |
| * Modifier | * Description |
| * QS | * Monitored anesthesia care service |
| * 23 | * Unusual anesthesia * Note: When using modifier 23, appropriate documentation must be submitted with the claim. |

**Qualifying Circumstance Codes (modifiers)**

Our last set of “modifiers” aren’t really modifiers at all in the true sense of the word. However, they function like modifiers, so you may often hear them referred to as such. QC codes are formatted in two distinct ways. First, they are formatted like a regular CPC tabular section code, with 5 numeric digits. Second, all of them have the “+” indicator, so they are also considered add-on codes. Remember that add-on codes cannot be appended with a -51 modifiers.



99140 will be the modifier/extender code you will utilize the most out of this group. Roughly 25-40% of your anesthesia codes will utilize this modifier as it should be used for any patient who is over 70 or under 1 year of age. The 99100 modifier adds 1 base unit to whichever anesthesia code to which it is attached. You can find a link to all of the base units [HERE](https://docs.google.com/spreadsheets/d/1zXq4EPIIObWk9fmCT12Y7EZ5H93-jhxYL0JGQ5z2L4k/edit?usp=sharing). Modifier codes are sometimes used to signal abnormal circumstances related to anesthesia care. These 5-digit qualifying circumstances codes are recognized as modifiers when they are billed as separate line items in order to report services that were provided under unusually difficult circumstances (i.e. unique operative conditions, extenuating issues with [the patient’s condition](https://mbmps.com/abcs-physical-status-modifiers/), etc.).

## **Qualifying Circumstances Modifiers for Anesthesia Risk**

The following codes are recognized as anesthesia modifiers when reported properly.

**99100 – Unit value = 1**

Administration of anesthesia to a patient younger than age 1 or older than age 70.

**99116 – Unit value = 5**

Administration of anesthesia complicated by utilization of total-body hypothermia.

**99135 – Unit value = 5**

Administration of anesthesia complicated by utilization of controlled hypotension.

**99140 – Unit value = 2**

Administration of anesthesia complicated by emergency conditions only. An “emergency” is defined as delay in treatment of the patient that would lead to a significantly heightened increase in the threat to life or body part.

One thing of note is that [if multiple anesthesia risk modifiers are billed](https://mbmps.com/anesthesia-billing/), payment will be made as far up as the highest unit value modifier. When billed in conjunction with a Physical Status Modifier of equal unit value, no payment is allowed to the Qualifying Circumstances Modifier.

## **How to Document**

For CPT codes 99116 and 99135, anesthesia records should be submitted. For CPT code 99140, the indications for performing the service should be recorded directly on the CMS 1500 claim form. Block 19 may be used to record risk indications, and EMC providers can enter indications in the Comments field.

When using an anesthesia risk modifier, the anesthesiologist may use Block 19 for provide indications or supporting information. Anesthesia risk modifiers may be reported in Block 24D of the CMS 1500 claim form. Enter the applicable anesthesia CPT code on the first line, followed by modifier codes. Then, report the charge for the service on the same line in box 24F, and put the time units in box 24G.

For situations that require the use of an anesthesia risk modifier, enter the 5-digit risk modifier code on the second line and report the charge for the modifier on the same line in box 24F.

**Placing a Value on Anesthesia Procedures**

According to [Current Procedural Terminology (CPT) guidelines](http://engage.ahima.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=9af2a07d-26e1-4694-b1de-a4c59d0dbc30), anesthesia time begins when the provider – the anesthetist – starts preparation for the patient, either in the operating room or another similar area. Note that time spent reviewing medical records before the surgery is *not* billable. This is a part of preoperative valuation, which is already calculated into the base units.

Anesthesia time ends whenever the provider is no longer personally attending the patient, and when the patient is safely placed into post-anesthetic supervision.

The proper way to report anesthesia time is to record it in minutes. One unit of time is recorded for each 15-minute increment of anesthesia time. For example, a 45-minute procedure, from start to finish, would incur three units of anesthesia time. Being exact is required, since Medicare pays to one-tenth of a unit. Do not estimate the time or round up or down inappropriately. For example, for a 63-minute procedure, one would receive 4.2 time units (four time units x 15 minutes plus 1/5th of a time unit, or 0.2).

Using time units calculated from anesthesia time, one can calculate reimbursement for a procedure using a certain formula.

For anesthesiologists or CRNAs directly performing anesthesia:

**(Time Units + Base Units + (additional from Both Modifier Types)) X Conversion Factor = Allowable Unit Charge**

For anesthesiologists medically directing anesthesia:

**((Time Units + Base Units) X (Conversion Factor)) x ½ or (50%) = Allowable Unit Charge**

**Lecture Module 7 - Lesions and Skin Repair Review**

The excision subsection and the skin repair subsection are the top two targets for coding in integumentary. It will be important to understand the 51 and 59 modifiers to master this section. You may want to actually skip down to that part of the lecture down towards the bottom of the document.

There are four main criteria to selecting the proper lesion excision code. Behavior, body area, size, and closure/repair. Behavior is simple, it is either malignant or it’s not, which means it is benign. Then have body area, body areas are grouped like this:

11400 - 11406 Trunk, arms or legs

11420 - 11426 Scalp, neck, hands, feet, genitals

11440 - 11446 Face, ears, mucous membranes, eyelids, nose and lips

11450 - 11451 Allilary

11462 - 11463 Inguinal (crotch)

11470 - 11471 Perianal, perineal, or umbilical

Once you select the proper behavior and body area, then you just code to the proper size and you’re all set to select the code. To get the size, take the largest diameter, add the margin size by two if there is one, then you get a total size. So if you have a 2 cm lesion with 1 cm margins, your total size will be 4 cm because there is a margin on both sides. Margins are the amount of healthy tissue which might be removed out and around the lesion itself. Let’s try one of each to see if you got it, and don’t worry, you will get plenty of practice.

Benny Benign had 2 lesions, one malignant one benign. The 2.6 cm benign lesion on his leg was removed without margins and simple closure. The 1.4 cm malignant lesion on his ear was removed with .5 cm margins and simple closure. Find ICD10 and CPT codes with the proper modifier.

Michael Malignant had three benign lesions removed, a 2 cm no margin lesion on his scalp, a 2.5 cm 1 cm margins lesion on his chest, and a 1 cm with .5 cm margins on his scrotum. Find the proper CPT, ICD10 and don’t forget the modifiers.

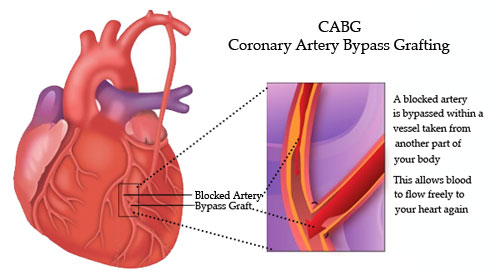
Answers: Benny - 11643, 11403-51, C44.201, D23.70; Michael - 11406, 11422-59, 11422-59, D23.5, D23.4, D29.4

(further explanation: The use of modifier -51 with Benny is because the second procedure was ***different*** (remember that was our key word for -51) than the first one. The use of modifier -59 on the second and third procedure with Michael is because the second two procedures were really the ***same*** (remember that was our key word for -59) as the first procedure.)

[Skin Study Sheet](https://docs.google.com/document/d/1kXdj-0TH3-NNW3hMfYP5mpYGaBoiUh64DVGhAZCGc4o/edit)

**Lecture Module 8 - Cardiology Review II**

**Venous Grafting Only for Coronary Artery Bypass 33510 - 33513**



Veins are more pliable, more flexible, and more adaptable than arteries. But they are also designed to hold less pressure than an artery. If the resulting pressure from a bypass is projected to be within the limits of a vein, usually harvested from the leg or arm, this bypass vessel is usually selected first; and you would code from this section. The harvested vein is then attached both above and below the obstruction to revascularize the portion of heart which had been starving for oxygenated blood flow. The main code for this set is 33510 which represents a single cardiac artery bypass using a vein obtained from the arm, leg, or another site. Most often, the vein of choice is the saphenous vein from either leg. This is a very superficial vein, the longest in our body, which runs up the entire back of your leg. If a lower extremity vein is harvested for grafting, that is included in the code for this subsection. If an upper extremity vein is harvested, add-on code 35500, and if it is the femoropopliteal vein, add code 33572. After code 33510 in this subsection, the other three 5 codes represent 2-6 venous grafts performed at the same operative session.

**Combined Arterial-Venous Grafting for Coronary Bypass 33517-33530**

When we use both arterial and venous grafts, we always code the arterial graft first as primary procedure, and then add a “combined” code from this section to represent the number of added venous grafts. For example, if we are doing one arterial coronary bypass graft and one venous graft bypass, we would code 33533, 33517.

**Arterial Grafting for Coronary Artery Bypass 33533-33548**

This bypass stuff sounds highly technical and hard to code. Mostly it is just scary because you think you won’t understand it. But as you jump in and try it, you find it is much easier than it sounds. All coronary bypasses are performed on native coronary arteries, not on veins. So all coronary bypasses are arterial in that sense. But when we refer to an arterial or venous graft, we are referring to the harvested section of vessel we are going to use to bypass it, not the occluded vessel itself. So now we come to the arterial grafts. This code set represents procedures that use only arterial grafts, harvested usually from adjacent sites including the internal mammary artery, gastroepiploic artery, epigastric artery, radial artery (from the arm); and the only one that gets coded separately is the radial artery harvest 35600. Again the first code, 33533 is the main code for one arterial bypass graft on one occluded vessel. Below that you can find codes for additional bypass grafts at the same operative session and a few more procedures that may accompany or be performed in place of a graft. Remember that sometimes we need to code for the use of both arterial and venous grafts. In that case, code from this subsection first, then add the appropriate combined code from 33517-33530.

**Lecture Module 9 - Applying Modifiers Review**

[**Resource 1**](https://www.medicalbillingandcodingonline.com/cpt-modifiers/)

[**Resource 2**](http://www.tagolden.com/Modifiers%20Best%20List.pdf)

[**Resource 3**](https://youtu.be/LhRu_ZSKcqA)

**Discussion**

Simply put, modifiers may be the biggest, most widespread, key to success on the national exam. Approximately 50%, or 75 questions on the national exam will involve the use of modifiers. Modifiers come in all shapes and sizes from CPT (level I) modifiers, HCPCS (level II) modifiers, all sorts of anesthesia modifiers, as well as modifiers (sorta) as 7th digit extensions off of ICD10 codes even though they aren’t really true modifiers. I do not ask you to memorize a single CPT or ICD10 code for the national exam because they are so easy to access. You may say the same thing about modifiers…. Why memorize them if they can be easily looked up? The answer is simple….. Time.

Challenging an exam that relies so heavily on time to be our enemy, every second we can save by knowing something without looking it up is key and crucial. This term you have seen increasing focus on modifiers as tools to help us answer individual questions. Therefore it shouldn’t surprise you to hear that at least 30 questions on the national exam may be answered WITHOUT looking anything up simply because you know the meaning of the modifiers used in the answer choices.

Your challenge for the last few weeks of study of this term is to ensure that you know your modifiers. Begin with focus on the level I (cpt) modifiers found inside of the cover on your CPT manual. Once you have mastered these to about 90%, focus on the level II modifiers listed in the same place, then move on to all types of anesthesia modifiers. You will find these easier to memorize than you think. Please spend at least one study session doing this memory work before attempting this week’s practice quiz. The practice quiz will be open all term long and you can come back to practice with it several times during the rest of the term.

This week’s practice quiz randomly selects modifiers from each of the procedural contexts discussed above. Though you will only get 10 questions each attempt, plan to make a few attempts as their are a total of 20 questions loaded and each time you take it you should get a few different questions.

**Lecture Module 10 - S-N-R**

In an exam situation, where success is crucial to career, most folks revert to freshman college student mode; because it is the only thing they know. This usually involves staying up late and studying for more than half of that 24 hour period, attempting to cram, or re-cram, as much information as possible into their brains. Alcohol and/or caffeine often accompany this mad dash to the finish line. The hope, of course, is to temporarily store all of the information necessary to be successful on the exam. This despite the fact that study after study shows that this type of pre-exam routine actually diminishes performance on the exam. Examinees employing this strategy usually do worse than examinees who do nothing at all to prepare for their exam in the last 24 hours. When they sit down to take the exam, they are generally fatigued, undernourished, anxious, and overwhelmed, and perhaps dehydrated to boot.

A counterintuitive approach has been shown time after time in large studies to be more effective in preparing for a crucial exam in the last 24 hours leading up to exam time. This involves making the commitment not to study at all for the entire day prior to the exam. Instead, details such as nutrition heavy in protein, normalized blood sugar, volume of quality sleep, and relaxation have all contributed much more positively to exam success than a more normal approach.

If you think about it, it all makes perfect sense. If you haven’t learned what is necessary in a nine-month program of education, no amount of studying in the last 24 hours is going to help anyway. Also, “cramming” or extended, fatigued study sessions generally produce less than a 10% retention rate after 24 hours. So studying during this period is not beneficial anyway. The biggest indicators to success in a crucial exam are in order as follows:

1. **S**leep
2. **N**utrition
3. **R**elaxation

Perhaps you needed somebody to tell you that….. SLEEP - EAT - RELAX is the best advice you can possibly follow in the 24 hours leading to an exam.

1. Follow your normal routine for sleep on a school day.
2. Eat lots of animal or plant based protein to feed your brain and provide more sustained energy.
3. Avoid alcohol but consume anything else that helps you relax and does not leave a residual effect for the next day. If alcohol is how you normally recreate, consume the smallest amount possible that allows you continue functioning normally. Build in time for the day before to do something fun and relaxing. Hiking, sightseeing, reading for pleasure, according to your interest. Do not schedule appointments, duties, or any extra responsibilities for the day before the exam. Make it a day that you get to be good to yourself.
4. Let me reiterate just for emphasis…. The last day to study for the exam is June 20th, or two days before you take it. Even this day should be light and general and not focused on any particular coding competency.

Finally, it is important to mention that you have all the answers when you walk in the door. They are contained in those three books you are carrying. Your performance on this exam is not linked to how much of that material you know; but rather on how well your brain can access it. So ***brain fitness*** is FAR more important than a little more knowledge ever will be. That is the basis of all of the above instruction in module 10.

Now go and kick some AAPC Exam ASSSSSSS!!!!!!