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NR511 Midterm Exam 2021/2022

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Week 1

1. Define diagnostic reasoning

Reflective thinking because the process involves questioning one's thinking to determining if all possible avenues have been explored and if the conclusions that are being drawn are based on evidence. *Seen as a kind of critical thinking.

2. Discuss and identify subjective & objective data

- Subjective: What the pt tells you, complains of, etc. *Chief complaint, HPI, ROS
- Objective: What YOU can see, hear, or feel as part of your exam. *lab, data, dx test results.

3. Discuss and identify the components of the HPI

Specifically related to the CC only. Detailed breakdown of CC. OLD CART.

4. Describe the differences between medical billing and medical coding

- Medical coding: The use of codes to communicate with payers about which procedures were performed and why
- Medical billing: Process of submitting and following up on claims made to a payer in order to receive payment for medical services rendered by a healthcare provider.

5. Compare and contrast the 2 coding classification systems that are currently used in the US healthcare system

- CPT codes: Common procedural terminology. Offers the official procedural coding rules and guidelines required when reporting medical services and procedures performed by physician and nonphysician orders.
- ICD codes: International classification of disease. Used to provide payer info on necessity of visit or procedure performed.

6. Discuss how specificity, sensitivity & predictive value contribute to the usefulness of the diagnostic data

- Specificity: The ability of the test to correctly detect a specific condition. If a patient has a condition but test is negative, it is a false negative. If a patient does NOT have a condition but the test is positive, it is a false positive.
- Sensitivity: Test that has few false negatives. Ability of a test to correctly identify a specific condition when it is present. The higher the sensitivity, the lesser the likelihood of a false negative.
- Predictive Value: The likelihood that the pt actually has the condition and is, in part, dependent upon the prevalence of the condition in the population. If a condition is highly likely, the positive result would be more accurate.

7. Discuss the elements that need to be considered when developing a plan

Patient's preferences and actions. Research evidence. Clinical state/circumstances. Clinical expertise.

8. Describe the components of Medical Decision Making in E&M coding

Risk – data – diagnosis. The more time and consideration involved in dealing with a pt, the higher the reimbursement from the payer. Documentation must reflect the MDM!

9. Correctly order the E&M office visit codes based on complexity from least to most complex

New patient:

1. Minimal/RN visit: 99201
2. Problem focused: 99202
3. Expanded problem focused: 99203
4. Detailed: 99204
5. Comprehensive: 99205

Established patient:

6. Minimal/RN patient: 99211
7. Problem focused: 99212
8. Expanded problem focused: 99213
9. Detailed: 99214
10. Comprehensive: 99215

10. Discuss a minimum of three purposes of the written history and physical in relation to the importance of documentation

- Important reference document that vies concise info about the pt's hx and exam findings
- outlines a plan for addressing issues that prompted the visit. Info should be presented in a logical fashion that prominently features all data relevant to the pt's condition
- is a means of communicating info to all providers involved in patient's care.
- is a medical legal document
- is essential in order to accurately code and bill for services

11. Accurately document why every procedure code must have a corresponding diagnosis code

Diagnosis code explains the necessity of the procedure code. Insurance won't pay if they do not correspond.

12. Correctly identify a patient as new or established given the historical information

New patient: If that patient has never been seen in that clinic or by that group of providers OR if the pt has not been seen in the past 3 years

13. Identify the 3 components required in determining an outpatient, office visit E&M code

Place of service, type of service, patient status.

14. Describe the components of Medical Decision Making in E&M coding

Risk – data – diagnosis