



## Lesson 9 Homework: Evaluation and Management Services

1. Dr. Smith and Dr. Anderson are in the same cardiovascular practice. Dr. Smith is a cardiologist and Dr. Anderson is a cardiovascular surgeon. Dr. Smith has been seeing this Medicare patient for several years and now sends the patient to Dr. Anderson for consideration of a CABG procedure. What series of codes would doctor Anderson use to code the services provided to this patient?
  - a. Established Patient visit: 99211-99215
  - b. Office Consultations: 99242 – 99245
  - c. Inpatient Consultation: 99252-99255
  - d. New Patient visit: 99202-99205
  
2. A physician documents that they spent 13 minutes reviewing the patient's record, 20 minutes with the patient and 7 minutes coordinating a referral, in what instance could this information be used to determine the level of EM code?
  - a. Emergency department services
  - b. Preventive services
  - c. Office or other outpatient services
  - d. Chronic care management services
  
3. Who determines the nature and extent of the history and exam required for an E/M visit, according to the current CPT guidelines?
  - a. The medical coder
  - b. The insurance company
  - c. The treating provider
  - d. The patient
  
4. Who should use the E/M Services Guidelines when selecting a CPT code for a service provided?
  - a. The patient
  - b. The medical coder
  - c. The insurance company
  - d. The reporting physician or QHP
  
5. Which of the following services does not require a face-to-face encounter between the QHP and patient and/or family, according to the E/M coding guidelines?
  - a. Office or Other Outpatient
  - b. Hospital Inpatient and Observation Care Services
  - c. Consultations
  - d. Emergency Department
  
6. Which of the following is required to indicate where the face-to-face encounter occurred, according to the E/M Services Guidelines?



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- a. CPT code
  - b. ICD-10 code.
  - c. Place of Service (POS) code
  - d. Modifier code
7. According to the E/M Services Guidelines, how is a new patient defined?
- a. One who has received any professional services within the last three (3) years from the QHP or another QHP of the exact same specialty and subspecialty in that practice.
  - b. One who has not received any professional services within the last three (3) years from the QHP or another QHP of the exact same specialty and subspecialty in that practice.
  - c. One who has received any professional services within the last year from the QHP or another QHP of the exact same specialty and subspecialty in that practice.
  - d. One who has not received any professional services within the last year from the QHP or another QHP of the exact same specialty and subspecialty in that practice.
8. How many types of MDM are recognized in the Level of MDM table?
- a. One
  - b. Two
  - c. Three
  - d. Four
9. What are the three elements that define Medical Decision Making (MDM)?
- a. Complexity of the Encounter, Data Management, and Patient Risk
  - b. Number of Patients, Amount of Data, and Patient Management
  - c. Number/Complexity of Problems Addressed, Amount/Complexity of Data, and Risk of Complications/Morbidity/Mortality of Patient Management
  - d. Level of Service, Diagnosis Complexity, and Patient Outcome
10. Which of the following is an example of a low complexity MDM presentation according to Column 1 of the Levels of MDM table?
- a. Chronic illness with exacerbation
  - b. Multiple chronic stable conditions
  - c. Acute illness with systemic symptoms
  - d. Self-limited or minor condition
11. Which of the following is an example of a high complexity MDM presentation according to Column 1 of the Levels of MDM table?
- a. Acute uncomplicated illness or injury
  - b. Chronic illness with stable symptoms
  - c. Chronic illness with mild exacerbation
  - d. Chronic illness with severe exacerbation



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12. What are the three categories of data to consider for the second element in column 2 on the Levels of MDM Table?
  - a. Tests, independent interpretation of tests, and orders of tests
  - b. Tests, documents or independent historian, and discussion of management or test interpretation
  - c. Tests, review of prior external note(s), and assessments requiring an independent historian(s)
  - d. Independent interpretation of tests, documents, and discussions of management
  
13. What is the definition of an independent historian according to the E/M GL?
  - a. A physician or other qualified health care professional reporting the E/M services.
  - b. An individual who provides a history in addition to the history provided by the patient.
  - c. An individual who interprets test results that are not reported separately.
  - d. A professional who is involved in the management of the patient but is not a healthcare professional.
  
14. What does the term "risk" refer to in the context of MDM guidelines?
  - a. Risk from the condition when appropriately managed
  - b. Risk from the condition when inappropriately managed
  - c. Risk from diagnostic procedures and treatments
  - d. Risk from the patient's overall health status
  
15. Which of the following is an example of a decision associated with moderate risk of morbidity from additional diagnostic testing or treatment?
  - a. Decision re: emergency major surgery
  - b. Drug therapy requiring intensive monitoring for toxicity.
  - c. Decision re: elective major surgery w/o risk
  - d. Diagnosis or treatment significantly limited by social determinants of health.
  
16. What is the definition of risk as used in the E/M guidelines?
  - a. The probability and/or consequences of an event
  - b. The level of morbidity associated with a procedure or treatment.
  - c. The level of complication associated with a patient's condition.
  - d. The potential for a patient to experience harm during management.
  
17. What affects the assessment of level of risk according to the E/M guidelines?
  - a. The clinician's experience and training
  - b. The clinician's specialty
  - c. The nature of the event under consideration
  - d. The patient's medical history
  
18. According to the E/M guidelines, what is the basis for determining the level of risk in MDM?



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- a. Probability and/or consequences of an event
  - b. Severity of the patient's condition
  - c. Likelihood of success of treatment
  - d. Complexity of the diagnostic tests required.
19. Which of the following is an example of a high-risk situation in MDM according to the Levels of MDM Table in the E/M guidelines?
- a. Prescription drug management
  - b. Decision re: minor surgery with identified risks
  - c. Decision re: elective major surgery w/o risk
  - d. Decision not to resuscitate or to de-escalate care because of poor prognosis.
20. Based on CPT, which of the following is true about time-based reporting for E/M services?
- a. Emergency department services require time to be documented in the code descriptor.
  - b. Total encounter time includes F2F time with the patient and non-F2F time personally spent by clinical staff on the date of the encounter.
  - c. Clinical staff time is counted as part of countable time.
  - d. Shared and/or split visits are reported without summing the time personally spent by the physician and QHP responsible for assessing and managing the patient.
21. Based on information in CPT, which of the following is a rule for time-based coding?
- a. Apply this method to all visits regardless of the length of the encounter.
  - b. Count all time spent by the clinician dedicated to this patient on the date of service, including time spent performing separately reimbursable services.
  - c. Use unlisted codes frequently to report unusual services.
  - d. Reserve time-based reporting for time-consuming encounters such as hospital follow-ups, complex illnesses, and extensive prescription work.
22. How many elements on the Levels of MDM table must be captured to support the complexity indicated when calculating MDM?
- a. 1/3 elements
  - b. 2/3 elements
  - c. 3/3 elements
  - d. 4/4 elements
23. What are the four things that should be documented when a consultation is performed?
- a. The consultation request, the reason for the request, the patient's insurance information, the consultant physician's license number
  - b. The consultation request, the reason for the request, the services rendered, the consultant physician's favorite color.
  - c. The consultation request, the reason for the request, the services rendered, the report from the consultant physician.



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- d. The consultation request, the reason for the request, the patient's favorite color, the report from the consultant physician
24. How are the codes for inpatient or observation consultations selected?
- a. Based on the patient's insurance information
  - b. Based on the number of consultations performed
  - c. Based on the total encounter time or level of MDM
  - d. Based on the consultant physician's license number
25. What is the main difference between CPT codes 99221-99239 and office visit services?
- a. CPT codes 99221-99239 are for hospital inpatient and observation care services, while office visit services are for outpatient services.
  - b. CPT codes 99221-99239 are for initial and subsequent visits, while office visit services are categorized as new or established patient visits.
  - c. CPT codes 99221-99239 are identified by an admit and discharge on the same day, while office visit services are not.
  - d. CPT codes 99221-99239 require the use of total time or MDM for code selection, while office visit services do not.