CBCS Exam Study Guide

1. **2 types of CPT Codes**	*Stand Alone Codes; contain the full description of the procedure for the code *Indented Codes- these are codes listed under associated stand-alone codes. To complete the the description for indented codes, one must refer to the portion of the stand alone code description before the semi-colon
2. **3 sections to Alphabetic Index**	Section 1) Index to diseases Section 2) Table of drugs and chemical Section 3) Index to External Cause of Injury (E Codes)
3. **-24 Unrelated E/M Service by the same physician during a postoperative period**	this is attached to the code of the E/M service provided to a pt during the postop period to indicate that the service is not part of the postoperative care which is usually part of the package of services of the surgery performed. Major surgical procedures will usually have a postop period of 90 days, minor, 10 days. Used only w/ E/M codes
4. **-26 Professional Component**	Most procedures have both professional (physician) and technical components. This modifier is attached to the procedure to indicate that the dr provided only the professional componenet
5. **-32 Mandated Services**	used to indicate that the service provided was required by 3rd party payer, gov, legislative or regulatory body . this does not include second opinion requested by a pt, family member, or another physician
6. **-50 Bilateral Procedure**	used when the same procedure is performed on a mirror-image part of the body
7. **-51 Mulitple Procedure**	used when -more than 1 procedure is performed in the same surgical episode -one code does not describe all of the procedures performed -the secondary procedure is not minor or incidental to the major procedure Ex; **same operation, different site,** multiple operations, same operative session, *procedure performed multiple times
8. **-58 Staged or Related Procedure or Service by the same Physician during the Postoperative Period**	used to explain that the procedure or service done during a postop period was planned at the time of the original procedure. also used if a therapeutic procedure is performed b/c of the findings from a diagnostic procedure
9. **-78 Return to Operating Room for a Related Procedure During the Postoperative Period**	to report a circumstance in which the dr returns to the operating room to address a complication stemming from the initial procedure (third party payers usually pay the surgery portion of the complications surgical package b/c the pt remains in the postop period of the initial procedure. documentation must clearly indicate the reason for the return to the operating room)
10. **79 Unrelated Procedure or Service by the same physician during the postoperative period**	used to indicate that the procedure or service provided during the postop period was not associated w/ the period. payment for the full fee of the subsequent procedure is requested and a new global period starts
11. **-90 reference (outside) laboratory**	used to indicate that the procedure was done by outside lab and not by reporting facililty
12. **-99 Multiple Modifiers**	used to report a procedure or service that has more than one modifier but the payer does not allow the addition of multiple modifiers to the code. is attached to the procedure code and the multiple modifier are listed in block 19 of claim form
13. **a, an**	without
14. **Abduction**	movement away from the midline
15. **Abuse**	incidences or practices, not usually considered fraudulent, that are inconsistent w/ the accepted medical business or fiscal practices in the industry.
16. **Accept Assignment**	mean the provider agrees to accept what the ins co approves as payment in full for the claim

17.	**Add-on codes**	some procedures are carried out in addition to the primary procedure performed. Designated as "add-on" codes w/ a "+" sign and they apply only to procedures performed by same dr to describe additional intraservice work provided. Are never used alone, rather they are always reported in addition to the primary procedure code. All add-on codes are modifier -51 (multiple procedures) exempt
18.	**Adduction**	movement towards the midline
19.	**Albino**	deficient in pigment (melanin)
20.	**-algia**	pain
21.	**Alopecia**	absence of hair form areas where it normally grows
22.	**Alphabetic Index (Volume 2)**	Everything in the Index is listed by condition -that is, diagnosis, signs, symptoms, and conditions such as pregnancy or admission
23.	**Anatomy & Physiology**	A professional medical coder must have knowledge of anatomy & physiology so that coding assignment is quick & accurate.
24.	**Anesthesia**	00100-01999, 99100-99140 (knocked out=0)
25.	**ante**	before
26.	**Anterior, Ventral**	front surface of the body
27.	**anti**	against
28.	**The Appendicular Skeleton**	...
29.	**Appendicular Skeleton**	made up of the shoulder, collar, pelvic, arm & legs
30.	**arth**	cartilage
31.	**Assignment of Benefits**	reimbursement is sent directly from payer to provider
32.	**Axial Skeleton**	consist of the skull, rib cage & spine
33.	**The Axial Skeleton-Skull, Rib Cage, Spine**	...
34.	**Basic Billing & Reimbursement Steps:**	-collect pt info -verify insurances -prepare encounter form (should reflect the diagnosis and services provided to pt, this is used as the basis for billing) -code diagnosis and procedures -review linkage and compliance, review should include the following **appropriateness of the codes** link between the diagnosis and the procedure **payers rules about the diag and proc** documentation of the procedure *compliance w/ regulations -calculate physician charges -prepare claims -transmit claims -payer adjudication, claims received by the payers go through a series of steps to determine whether it should be paid -follow up reimbursement/record retention

35.	**Basic Format of the levels of E&M services**	1) a unique code # is listed 2) the place & type of service is specified 3) the content of the service is defined 4) the nature of the presenting problem(s) usually associated w/ a given level is (are) described 5) time is typically specified in the descriptor of the code
36.	**Benign**	noninvasive, non-spreading, nonmalignant
37.	**Birthday rule**	the plan of the parent whose birthday falls earlier in the year (month and date, not year) is primary to that whose bday falls later in the calender year. If both parents have same birthday, then the plan of the parent who has had the longest coverage is primary. **In case of divorce, the plan of the parent w/ custody of the children is the primary payer unless the divorce settlement states otherwise
38.	**Blue Cross**	covers hospital services, outpatient care, some institutional services and home care
39.	**Blue Cross/Blue Shield Plans**	group of independently licensed local companies, usually nonprofit that contracts w/ dr's and other health entities to provide services to their insured companies and individuals. Most BC/BS plans offer HMO's, PPO's and POS plans
40.	**Blue Shield**	covers physician services, and in some cases, dental, outpatient services and vision care
41.	**Bones**	complete organs made up of connective tissue called OSSEOUS. Inner core of bones is comprised of HEMATOPOIETIC tissue. This is where the red bone marrow manufactures blood cells. Other parts of the bones are storage areas for minerals necessary for growth, ie; calcium and phosphorous
42.	**brady**	slow
43.	**Capitated Rates**	the dr provides a full range of contracted services to covered pt's for a fixed amount on a periodic basis. While guaranteed a fixed amount the dr assumes the risk that the cost of providing the care the pt's may exceed the payment amount. the only additional charge may be a co-payment and a deductible co-insurance
44.	**Carcinoma (Ca) in Situ**	cancer that is localized and has not spread to adjacent tissues or distant parts of the body
45.	**cardi**	heart
46.	**Carpals**	Wrist bones, there are 2 rows of 4 bones in the wrist
47.	**Categories**	are composed of 3 digit codes representing a single disease or condition. the 3 digit code is used only if it is not further subdivided. There are about 100 category codes and most requires a 4th digit (subcategory code) Ex; 242
48.	**Category I Codes**	represents services and procedures widely used by many health care prof in clinical practice in multiple locations and have been approved by the FDA
49.	**Category II Codes**	supplemental codes used for performance measures. Although these codes are intended to facilitate data collection about the quality of care, their use is optional. Cat II codes are published twice a yr, Jan 1st and July 1st
50.	**Category III Codes**	temp codes for emerging technology, services and procedures. If a Cat III code is available, it is reported instead of Cat I unlisted code
51.	**-centesis**	surgical puncture
52.	**cephal**	head
53.	**Cervical**	Neck Bones
54.	**CHAMPVA**	(Civilian Health and Medical Program of the Veteran Affairs) - was created to provide medical benefits to spouses and children of veterans w/ total, permanent service related disabilities or for surviving spouses and children of a veteran who died as a result of service related disability. It is a service benefit therefore no premiums. Members who receive TRICARE do not qualify for CHAMPVA

55.	**Chapters**	are the main division on the ICS-9-CM, they are divided into secctions
56.	**Chief Complaint**	brief statement describing the symptom, problem, diagnosis, or condition that is the reason the pt seeks medical care
57.	**cholecyst**	gall bladder
58.	**chondro**	cartilage
59.	**Choose the code that represents the current status of the neoplasm**	a neoplasm code is assigned if the tumor has been removed and pt is still receiving chemotherapy tx or radiation. A V code is assigned if the tumor is no longer present or if the patient is not receiving treatment, but is returning for follow-up care
60.	**Civil Monetary Penalties Law (CMPL)**	law passed by the fed gov to prosecute cases of medicaid fraud
61.	**Claim Status**	Various terms are used to describe the state of submitted forms.
62.	**Clavicle**	or collarbone, is curved horizontal bones that attach to the upper sternum at one end, these bones help stabilize the shoulder
63.	**Clean Claim** has all required fields accurately filled out, contains no deficiencies and passes all edits, the carrier does not require investigation outside of the carrier's operation before paying the claim	
64.	**Coccygeal**	Coccyx (tailbone)
65.	**Coding**	process of converting diagnosis, procedures, and services into numeric and alphanumeric characters
66.	**Coinsurance**	percentage of the cost of covered services that a policyholder or a secondary ins pays. A common payment % for coinsurance is 80/20 which indicates that 20% is the coinsurance for the beneficiary or secondary ins is responsible
67.	**Collagen**	structural protein found in the skin & connective tissue
68.	**Colles Fracture**	the break of the distal end of the radius at the epiphysis often occurs when the pt has attempted to break his/her fall
69.	**colp**	vagina
70.	**Column 1/Column 2 edits (NCCI)**	Identifies code pairs that should not be billed together b/c 1 code (Column 1) includes all the services described by another code (Column 2)
71.	**Commercial Carriers**	-are for profit organizations that operate in the private sector selling different health ins benefits plans to groups or individuals. Most have predefined pt yearly deductibles and coinsurance generally based on the 80/20 split. EX; Aetna, Cigna, Travelers, and Prudential -most have coordination of benefits (COB) clauses to identify the primary and secondary payer responsibility status for dependent children
72.	**Common Prefixes:**	...
73.	**Common Root Words**	...

74.	**Common Suffixes used by Medicare:**	A-Wage earner (upon retirement) B-Spouse of wage earner C-Disabled Child D-Widow HaD- Disabled Adult M- Part B benefits only T- Uninsured and entitled only to health ins benefits
75.	**Communicated Fracture**	the bone is crushed and/or shattered
76.	**Compliance regulations:**	Most billing-related cases are based on HIPPA and False Claims Act
77.	**Complicated Fracture**	the bone is broken and the ends are driven into each other
78.	**Compression Fracture**	the fractured area of the bone collapses on itself
79.	**Consultation**	service performed by a physician whose opinion or advice is requested by another physician in the evaluation or treatment of a pt's illness or suspected problem. The consultation does not assume any responsibility for the pt's care and must send a written report back to the requesting physician
80.	**Contracted Rates w/ MCO's**	phy sicians agree to provide services at a discount of their usual fee in return for a pool of existing pt's
81.	**Coordination of benefits (COB)**	when 2 ins co work together to coordinate payment of the benefits
82.	**co-payment**	cost-sharing requirement for the insured to pay at the time of service. This amount is usually a specific dollar amount
83.	**CPT**	Current Procedural Terminology - codes from CPT code book used to report services and procedures by dr's. The CPT coding sy stem uses a 5 digit numeric system for coding services rendered by dr's. Some codes use a 2 digit modifier to five a more accurate description of the services rendered
84.	**CPT Modifiers**	these are 2 digit add-ons attached to regular codes to tell 3rd party payers of circumstances in which the services or procedures were altered. All modifiers are listed in CPT appendix A. Modifiers relevant to each of the CPT sections are also found in the section guidelines. One must use the modifier that depicts the circumstances most accurately.
85.	**Cranium**	includes following bones *Frontal Bone- forms the anterior part of the skull & forehead *Parietal Bone- Forms the sides of the cranium *Occipital Bone- forms the back of the skull, there is a large hole at the ventral surface in this bone, called the foramen magnum, which allows the brain communication w/ the spinal cord *Temporal Bone- forms the 2 lower sides of the cranium *Ethmoid Bone- forms the roof of the nasal cavity *Sphenoid Bones- anterior to the temporal bones
86.	**Deductible**	a cumulative out-of-pocket amount that must be paid annually by the policyholder before benefits will be paid by the ins co
87.	**derm**	skim
88.	**Describe the 6 columns of the neoplasm table**	...

89.	**Diagnosis suffixes:**	…
90.	**Directional Terms:**	…
91.	**Dirty Claim**	contains errors and omissions, usually these claims do not pass front end edits they are either processed manually for resolving problems or rejected for payment
92.	**Disability Insurance**	defined as reimbursement for income and lost as a result of of a temporary or permanent illness or injury. When pt's are treated for disability diagnosis and other medical problems, separate pt records must be maintained. Disability ins does not pay for healthcare services, but provides the disabled person w/ financial insurance
93.	**Dislocation**	is when the bone is completely out of place
94.	**Distal**	far from the point of attachment to the trunk
95.	**Dorsiflexion**	raising the foot, pulling the toes toward the shin
96.	**dys**	painful, difficult
97.	**-ectomy**	removal, resection, excision
98.	**Electronic Claim**	alternative to paper claim, submitted to payer directly by physician or clearinghouse. Are usually paid faster. Most electronic claims software have self-editing features that detect and report entries that may cause to be rejected, such as invalid codes or incomplete claims
99.	**Eligibility**	the qualify factor or factors that must be met before a pt receives benefits
100.	**-emia**	blood condition
101.	**encounter form**	also called the superbill; it is a listing of the diagnosis, procedures, and charges for a pt's visit
102.	**endo**	inside, within
103.	**enter**	intestine
104.	**epi**	upon, above
105.	**episi**	vulva
106.	**Essential Modifiers**	Terms indented two spaces to the right below the main term called subterms. Are essential modifiers b/c they have bearing on the right selection of the code.
107.	**Established Patient**	Individual who has received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past 3 years.
108.	**Established Patient**	defined as someone who has recieved medical services w/in the last 3 years from the physician or another physician of the same specialty who belongs to the same group practice
109.	**Evaluation and Management (E/M Codes)**	these are listed 1st in the CPT manual b/c they are used by all different specialties. they cover physician services that are performed to determine the best course for pt care.
110.	**Evaluation & Management**	99201-99499 (going to dr feeling 99% leave getting high 5)
111.	**Evaluations & Management Review**	The E&M section include codes that pertain to the nature of the physicians work. Codes depend on type of service, pt status, and place where service was rendured. The E&M section is divided into broad categories such as office visit, hospital visits, and consultations
112.	**Eversion**	turning outward
113.	**ex**	out, out of
114.	**Exclusion and Limitations**	conditions, situations, and services not covered by the ins carrier
115.	**Explanation of Benefits (EOB)**	describes the services billed and includes a breakdown of how the payment is determined (sent to pt)

116.	**Extension**	to increase the angle of the joint
117.	**Facial Bones**	…
118.	**Fee-for-service**	fee that is charged for each procedure or service performed by the physician. This fee is obtained from a FEE SCHEDULE, which is a list of charges or allowances that have accepted for specific medical services. The system in which fee schedules are determined is referred to a USUAL, CUSTOMARY, AND REASONABLE, (UCR)
119.	**Femur**	thighbone
120.	**Fibula**	smaller, lateral leg bone
121.	**Fiscal Intermediary**	an ins co that bids for a contract w/ CMS to handle the medicare program in a specific area
122.	**Fissure-**	groove or crack like sore
123.	**Flat Bones**	are found covering the soft body parts, IE; SHOULDER BLADES, RIBS AND PELVIC BONES
124.	**Flexion**	to decrease the angle of the joint
125.	**Fractures**	broken bone, most occur as a result of trama, however some disease such as cancer or osteoporosis can also cause spontaneous fractures. Can be classified as simple or compound. Simple fractures don't rupture the skin as compound fractures split open the skin allowing for an infection to occur.
126.	**Fraud**	knowingly & intentionally deceiving or misrepresenting info that may result in unauthorized benefits. It is a felony and can result in fines and/or prison.
127.	**Frontal, Coronal**	Vertical plane dividing the body into anterior & posterior portions
128.	**Full ROM**	diathroses are joints that have free movement, Ball-and-socket joints (hip) and hinge joints (knees) are common diathroses joints (synovial joints)
129.	**Gangrene**	death of tissue associated w/ the loss of blood supply
130.	**gastro**	stomach
131.	**Gender rule**	male of household is primary payer
132.	**A geographic practice cost index is applied to account for the economic variation across the different area of the country**	true
133.	**gloss**	tongue
134.	**The Good Samaritan Act**	was developed to protect healthcare professionals from liability of any civil damages as a result of rendering emergency care
135.	**-gram**	record
136.	**-graphy**	process of recording
137.	**Greenstick Fracture**	the bone is partially bent & partially broken, this is a common fracture in children b/c their bones are still soft
138.	**Group Practice**	group of 2 or more physicians and non-physician practitioners legally organized by a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association

139.	**Hair**	composed of tightly fused meshwork of cells filled w/ hard protein called karatin. Has its roots in the dermis & together w/ their coverings, is called HAIR FOLLICES. Main function is to assist in regulating body temp. Holds heat when body is cold by standing on end & holding a layer of air as insulation.
140.	**Hairline Fracture**	a minor fracture appears as a thin line on x-ray; and may not extend completely through the bone
141.	**Hair, Nail & Glands**	...
142.	**Health Care Financing Administration Common Procedure Coding System**	HCPCS Reference Manual
143.	**Health Insurance Portability & Accountability Act (HIPPA)**	Enacted in 1996, created by the Health Care Fraud & Abuse Control Program -enacted to check for fraud and abuse in the Medicare/Medicaid Programs and private payers
144.	**Health Insurance Portability And Accountability Act (HIPPA)**	deals w/ the prevention of healthcare fraud and abuse of patients on Medicare/Medicaid
145.	**Health Practitioner**	includes, but is not limited to, physician assistant, certified nurse-midwife, qualified psychologist, nurse practitioner, clinical social worker, physical therapist, occupational therapist,, respiratory therapist, certified registered nurse anesthetist, or any other practitioner as may be specified
146.	**hemi**	half, partial
147.	**hepato**	liver
148.	**HMO**	Health Maintenance Organization - managed care plan that provides wide range of services to individuals that are enrolled. Generally least costly but most restrictive. Uses a gatekeeper (primary care physician) whom the pt is required to visit initially for any case. If the pt goes to another physician w/o prior approval pcp pt will be responsible for all costs. Physician-Hospital Organization is when physicians, hospitals, and other health care providers contract w/ one or more HMO's or directly w/ employers to provide care.
149.	**How are bones categorized?**	as belonging to either the AXIAL SKELETON or the APPENDICULAR SKELETON.
150.	**How are copayments determined with TRICARE?**	according to 2 programs a) active duty family members b) retirees, their families members and survivors of deceased personnel
151.	**How are muscles attached to bones?**	by strong, fibrous bands of connective tissues called tendons.
152.	**How are payments determined under Medicare's RBRVS?**	by multiplying a code's relative value by constant dollar amount called the conversion factor (multiplier). The conversion factors are determined annually by the CMS in cooperation with congress. The conversion factor varies according to the type of service provided such as medical, surgical, non-surgical

153.	**How are services paid to physicians associated w/ Medicare Part B?**	services are paid according to a fee schedule which is based on the relative value multiplied by the geographical adjustment and conversion factors. All dr's in a given area are paid the same for same service regardless of specialization. However, non par's are paid 5% less for assigned claims. Non PAR's, not accepting assignment, can charge no more than 115% of the participating allowance w/o facing possible Medicare fines and penalties.
154.	**How do individuals that are not eligible for Social Security Obtain Medicare Part A?**	By paying a premium and they must enroll in Part B this is however limited to applicants 65+ and US resident. A deductible is req for each episode of illness and a co-insurance applies for hospitalizations of more than 60 days
155.	**How do you know if an update has been made to the CPT manual?**	**A triangle- represents a change in the code description since the last edition. The change may be minor or significant and it could be an addition, deletion, or revision **2 triangle symbols-represent changes in the text or definition between the triangles **A bullet-represents a new procedure or service code added since the previous addition of the manual **A plus sign-indicates add-on codes **A circle w/ a line through it- represents exemption from use of modifier
156.	**How is a fee schedule determined?**	UCR method, the usual, customary, and reasonable- the carrier compare **the dr's most frequent charge for a given service (the usual)** the average charge of all providers of similar training/experience in a given geographical area (the customary) *the actual charge submitted on a claim (must be reasonable to the provider) *****the lowest amount is used as the basis for payment (the allowed charge)
157.	**How is eligibility for Medicaid classified?**	divided into 2 classifications A) Categorically Needy: 1) families, pregnant women & children 2) Aged and disabled persons 3) Persons receiving institutional or other long-term care in nursing facilities (NF's) and intermediate care facilities (ICF's) B) Medically Needy: 1) medically indigent low-income and families 2)low-income persons losing employer health ins coverage (Medicaid purchase of COBRA purchase)
158.	**How many chapters does the Tabular List(Volume 1) contain?**	17; based on either body system or cause or type of disease
159.	**How many edits does NCCI include?**	2: 1)Column 1/Column 2 (prev called Comprehensive/Component) Edits 2) Mutually Exclusive Edits
160.	**How many layers to the skin?**	3; 1) Epidermis (thin, cellular membrane layer that contains keratin) 2) Dermis (dense, fibrous, connective tissue that contains collagen) 3) Subcutaneous layer (thicker & fatter tissue)
161.	**How many parts to CPT Manual?**	t3; the main text, the appendices and the alphabetic index and is divided into 6 sections; these sections are subdivided into
162.	**How many sections to the CPT Manual?**	8; each section begins w/ guidelines that provide specific coding rules for that section. Guidelines at the beginning of the section are applicable to all codes in the section, while notes that pertain to specific codes appear before or after such codes. Guidelines usually contain definitions of terms, applicable modifiers, subsection info, unlisted services, special reports of info, or clinical samples. The 8 sections are 1)Evaluation & Management (E&M) 2)Anesthesia 3)Surgery 4)Radiology 5)Pathology and Laboratory 6) Medicine 7) Category I codes 8)Category III codes
163.	**How many types of sweat glands?**	2; 1) eccrine sweat glands (most common) 2) apocrine sweat glands (secrete orderless sweat)

164.	**How many Volumes to ICD manual?**	3; *Volume 1- Disease: Tabular List *Volume 2- Disease: Alphabetic Index *Volume 3- Procedures: Tabular list and Alphabetic Index
165.	**How much area does the skin cover?**	an area of 22 sq ft (an average adult). It is the largest organ of the body
166.	**How to ensure you have chosen the correct code?**	First locate the code in the alphabetic index (Volume 2) then cross-reference this code in the Tabular List (Volume 1)
167.	**Humerus**	upper arm bone
168.	**Hypertension table**	found in the Index under the main term "Hypertension" and it contains a list of conditions that are due to or associated with hypertension. The Table classifies the conditions as: -Malignant; an accelerated sever form of hypertension w/ vascular damage and a diastolic pressure of 130mmHg> -Benign; Mild or controlled hypertension & no damage to the vascular system or organs -Unspecified; This is not specified as benign or malignant in the diagnosis or medical record
169.	**hypo**	below, deficient
170.	**hyster**	uterus
171.	**Impetigo**	bacterial inflammatory skin disease characterized by lesion, pustules, and vesicles
172.	**Indemnity Insurance**	also known as a fee-for-service. under this plan, the services that are paid for are listed in the policy and payments are based on the physicians charge for the service. there are no restrictions as to the physicians or hospital the beneficiaries may use and pre-approval of medical visits are not required. Each yr the beneficiary must meet a deductible, after which the benefit may cover for all or part of the charge. Usually a co-insurance for each service applies
173.	**Inferior**	below another structure
174.	**infra**	below
175.	**Inpatient**	term used when a patient is admitted to the hospital w/ the expectation that the pt will stay for a period of 24 hrs or more
176.	**Integumentery Vocabulary**	...
177.	**inter**	between
178.	**Invalid Claim**	contains complete necessary information but is incorrect or illogical in some way
179.	**Inversion**	turning inward

180.	**Ischium**	lower portion of the pelvic bone
181.	**Itemized statement**	statement of the pt's account history, showing dates of service, detailed charges, payment (deductibles, co-pays), the date the ins claim was submitted, applicable adjustments and account balance
182.	**-itis**	inflammation
183.	**Joints**	parts of the body where 2 or more bones of the skeleton join. Different joints have different ROM (range of motion), ranging from no movement at all to full range of movement
184.	**Lacrimal Bones**	paired bones at the corner of each eye that cradle the tear ducts
185.	**lact**	milk
186.	**lapar**	abdomen
187.	**Lateral**	pertaining to the side
188.	**Legal Aspects ... of of Medical Billing & Coding:**	
189.	**Level I Codes**	Consist of codes found in the CPT manual. They have five position numeric codes used to report physicians services rendered to patients.
190.	**Level II Codes (National Codes)**	codes formulated thru the joint efforts of the CMS, the health insurance association of america, and the bcbs association.they are five position alpha-numeric codes for physician and non-physician services not found in the cpt(level 1), start w/ a letter followed by 4 #'s and make up more than 2,400 5 digit alphanumeric codes divided into 22 sections, each covering a related group of items. Most of these items are supplies, materials or injections that are covered by medicare. Some codes are for physicians & non-physician services not found in the CPT (Level I) Ex; E section is for the Durable Medical Equipment category which covers reusable medical equipment ordered by the physician for use in the home, such as wheelchairs or portable oxygen tanks.
191.	**Level III Codes**	codes that were used locally or regionally have been eliminated by the CMS since the implementation of the HIPPA. Some of the codes are now in the Level II
192.	**Level of detail in coding**	a category code is used only if it is not further subdivided. Where subcategory and subclassifaction codes are provided, their assignment is mandatory. A code is invalid if it has not been coded to the level of specificity required for that code.
193.	**Liability Insurance**	a policy that covers losses to a 3rd party caused by the insured, by an object owned by the insured, or on premises owned by insured. Liability ins claims are made to cover the cost of medical care for traumatic injuries, lost wages, and in many cases, remuneration for the "pain and suffering" of the insured party. Most health ins contracts state that health ins benefits are secondary to liability ins.
194.	**Life cycle of Insurance Claims**	I. Claims submission -transmission of claims data either electronically or manually to payers or clearinghouses for processing II. Claims Processing-payers and clearinghouses verify the info found in the submitted claims about the pt and providerIII. Claims Adjudication-process by which the claim is compared to payer edits and the pt's health plan benefits to verify that: -required info is available to process claim -claim is not a duplicate -payer rules and procedures have been followed -procedures performed or services provided are covered benefits
195.	**Limited ROM**	amphiathroses are joints joined together by cartilage that is slightly moveable, such as the vertebrae of the spine or the pubic bone

196.	**Lipocyte**	a fat cell
197.	**lith**	stone
198.	**Location Methods**	The CPT Index is arranged in alphabetic order by main terms which are further divided by subterms. There are 5 location methods; 1)Service or Procedure 2)Anatomic Site 3)Condition or Disease 4)Synonym/Eponym 5)Abbreviation
199.	**Long Bones**	typically very strong, are broad at the ends and have large surfaces for muscle attachment. IE: HUMERUS & FEMUR.
200.	**Lower Appendicular**	can be divided into the pelvis and the lower extremities
201.	**Lower Extremeties**	...
202.	**Lumbar**	Lower Back
203.	**-lysis**	separation, breakdown, destruction
204.	**Macule**	discolored, flat lesion (freckles,, tattoo marks)
205.	**Malignant**	further classified as to primary, secondary or carcinoma in situ
206.	**Malleolus**	ankle
207.	**Mandible**	lower jaw bone
208.	**mast**	breast
209.	**Maxilla**	upper jaw bone
210.	**Medial**	pertaining to the middle of the body
211.	**Medicaid**	a federal program administrated by state gov to provide medical assistance to the needy, each state sets its own guidelines for eligibility and services, therefore benefits and coverage may very widely from state to state
212.	**Medicaid and Medicare (dual coverage)**	if pt has Medicare and Medicaid, medicaid usually pays for the Medicare Part B deductible, coinsurance, and monthly premium amounts.
213.	**Medicaid is the payer of last resort**	True
214.	**Medical Billing & Coding as a Career**	**Claims assistant professional or claims manager,** Coding Specialist, **Collection Manager,** Electronic Claims Processor, **Insurance Billing Specialist,** Insurance Coordinator, **Insurance Counselor,** Medical Biller, **Medical & Financial Records Manager,** Billing & Coding Specialist
215.	**Medical Neccessity**	defined by Medicare as "the determination that a service or procedure rendered is reasonable and necessary for the diagnosis or treatment of an illness or injury"
216.	**Medicare**	is the federall gov's health ins program created by Social Security Act of 1965 titled "Health Insurance for the Aged & Disabled" It is administered by the CMS, formally known as Health Care Financing Administration (HFCA)

217.	**Medicare Part A**	aslo called the Hospital Insurance for the Aged and Disabled. It covers institutional providers for inpatient, hospice, and home health services, such as the following -a bed pt in a hospital -pt's in a psych hospital -bed pt's in a nursing facility -pt's receiving home health care services -terminally ill pt who has <6 to live and needs hospice care -terminally ill pt who needs respite care
218.	**Medicare Part B**	referred to as Supplementary Medical Insurance (SMI). coverage is a supplement of Part A, which covers medical expenses, clinical lab services, home health care, outpatient hospital treatment, blood, and ambulatory surgical services.
219.	**Medicare Part C**	Medicare Managed Care Plans (formally Medicare Plus (+) Choice Plan) was created to offer a # of healthcare services in addition to those available under Part A & Part B. The CMS contracts w/ managed care plans or PPO's to provide Medicare benefits. A premium similar to Part B may be required for coverage to take affect
220.	**Medicare Part D**	Prescription Drugs- enacted by the Medicare Prescription Drug, Improvement and Modernization Act in Dec 2003 and began implementation in Jan 2006 where Medicare beneficiaries can enroll in the Medicare Prescription drug plan. the beneficiaries have the choice of among several plans that offer drug coverage for which they pay a monthly premium
221.	**Medicare's Resource Based Relative Vale Scale (RBRVS) Payment Schedule**	under this schedule a procedure's relative value is the sum total of 3 elements 1) Work; represents the amount of time, intensity of effort, and medical skill required of the dr 2) Overhead; practice costs related to the performing of the service 3) Malpractice: cost of medical malpractice insurance -medical malpractice insurance that covers the insured only for those claims made while the policy is in force is called claims-made coverage
222.	**Medicine (except anesthesiology)**	90281-99199, 99500-99602 (RPM-789, M=9)
223.	**Med Term**	...
224.	**-megaly**	enlargement
225.	**Melanin**	major skin pigment
226.	**Metacarpals**	the 5 radiating bones in the fingers. These are the bones in the palm of the hand.
227.	**Metatarsal**	midfoot bone
228.	**-meter**	measure
229.	**Multigravida**	a pregnant woman who has had at least one previous pregnancy
230.	**Muscle Actions**	...
231.	**Muscles**	Muscle is tissue comprised of cells. Have the ability to contract & relax.
232.	**The Musculoskeletal System**	includes bones, muscles & joints. Acts as a framework for the organs, protects many of those organs, and also provides the body w/ the ability to move
233.	**Mutually Exclusive Edits (NCCI)**	ID's code pairs that, for clinical reasons, are unlikely to be performed on the same pt on the same day
234.	**myo**	muscle

235.	**Nails**	cover & protect the dorsal surface of the distal bones of the fingers & toes. Part that is visible is nail body, nail root is under skin @ the base of the nail and nail bed is the vascular tissue under the nail that appears pink when the blood is oxygenated or blue/purple when it is oxygen deficient.
236.	**nat**	birth
237.	**neo**	new
238.	**Neoplasm Table**	this is located in the Index under the main term "Neoplasm" and is organized by anatomic site. Each site has 6 columns w/ 6 possible codes determined by whether the neoplasm is malignant, benign, of uncertain behavior or of unspecified nature
239.	**New Patient**	Individual 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 3 years.
240.	**New Patient**	defined as one who has not received medical services w/in the last 3 years
241.	**Nodule**	solid, round or oval elevated lesion more than 1 cm in diameter
242.	**Non-covered benefit**	any procedure or service reported on the ins claims that is not listed in the payer's master benefit list. This will result in the denial of the claim. Providers may be able to recover the charges from the pt
243.	**Nonessential Modifers**	the main term may be followed by these in paranthesis, their presence or absences does not have an effect on the the selection of the code listed for the main term
244.	**No ROM**	most synarthroses are immovable joints held together by fibrous tissue
245.	**oligo**	scanty, little
246.	**-oma**	tumor, mass
247.	**oophor**	ovary
248.	**-osis**	abnormal condition
249.	**oste**	bone
250.	**Other CPT Codes**	*Add-on codes- used for procedures that is always performed during the same operative session as another surgery in addition to the primary service/procedure and is never performed separately *Modifiers-provide the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed by the definition of the code
251.	**Outpatient**	pt who receives treatment in any of the following settings: -phy sicians office -hospital clinic, emergency department, hospital same day surgery unit, ambulatory surgical center (pt is released w/in 23 hrs) -hospital admission for observation
252.	**Palatine bones**	Make up part of the roof of the mouth
253.	**pan**	all
254.	**Paper Claim**	traditional method used by providers for submission of charges to ins co's. The most commonly used form is the CMS-1500. Few plans will still accept the physicians encounter forms or superbill and Medicare will only accept claims on the CMS-1500
255.	**para**	beside
256.	**Patella**	kneecap
257.	**Pathologic Fracture**	any fracture occurring spontaneously as a result of disease

258.	**Pathology and Laboratory**	80048-89356 (RPM-789; P=8)
259.	**-pathy**	disease condition
260.	**The Patient Care Partnership (Patients Bill of Rights)**	was developed to promote the interests and well being of the pt's and residents of the healthcare facility. This bill has still not become law
261.	**Patient Confidentiality**	All pt's have right to privacy & all info should remain privileged. Only discuss pt info when necessary to do job. Obtain a signed consent form to release medical info to ins co or other individual.
262.	**Peer Review Organization (PRO)**	a state based group of physicians working under gov guidelines to review the cases and determine their appropriateness and quality of professional care
263.	**Pelvis**	superior & widest bone
264.	**per**	through
265.	**-pexy**	surgical fixation
266.	**Phalanges**	finger bones, each finger has 3 phalanges, except for the thumb. The 3 phalanges are the proximal, middle and a distal phalanx. The thumb has a proximal and distal
267.	**Phalanx**	toe bones, 14 in all (2 in great toe, 3 in each of the other toes)
268.	**Physician**	a doctor of medicine or osteopathy, dental medicine, dental surgery, podiatric medicine, optometry, or chiropactic medicine legally authorized to practice by the state in which he/she performs
269.	**Physician's Identification Numbers**	-State license #, dr must obtain this # in order to practice w/in a state -Employer Identification # (EIN), also known as federal tax identification #, used by IRS -SS#, typically not used on claim form unless provider does not have (EIN) -Provider Identification # (PIN), # assigned by ins co to a physician who renders services to pt's -Unique Provider Identification # (UPIN), # assigned to the physician by medicare -performing Provider Identification provider # (PPIN), dr has a separate PPIN for each group office/clinic in which he/she practices. In the medicare program, in addition to a group #, each member of a group is issued a 8-character PPIN -Group Provider Number, # is used instead of the individual dr's # for the performing provider who is a member of a group practice that sub,its claims to ins co under the group name
270.	**Plantar Flexion**	lowering the foot, pointing the toes away form the shin
271.	**-plasty**	surgical repair
272.	**pneum**	lung
273.	**poly**	many
274.	**Polyp**	benign growth extending from the surface of the mucous membrane
275.	**POS**	Point-of-service- managed care plan that gives beneficiaries the option whom to see for service. If the beneficiary see provider w/in network they will receive benefits similar to HMO but if they choose to see a provider not in the network, the POS will still pay for the services but at a rate significantly lower than the in network dr and difference will be billed to pt
276.	**Posterior, Dorsal**	back side of the body
277.	**PPO**	Preferred Provider Organization- basically same as HMO however PPO's charge a higher premium than HMO's in exchange for more flexibility & more options for beneficiaries, No gatekeeper and pt choose dr they want to see as long as they are in network, if pt chooses to see dr not in network they will shoulder all costs.

278.	**pre**	before, in front of
279.	**Pre-authorization**	requirement for some health ins plans to obtain permission for a service or procedure before it is done. It indicates that a specific procedure or service is deemed "medical necessary"
280.	**Pre-certification**	to determine coverage for a specific treatment such as surgery, hospitalization or tests, under the insured's policy
281.	**Pre-determination**	to determine the pt's benefits and the maximum dollar amount that the ins company will pay. Often the 1st step of the ins verification process, it is completed prior to the first visit
282.	**Preferred Provider Plan**	the type of plan a patient may have where they can see providers outside their plan, the pt is responsible for higher portion of the fee
283.	**Premium**	the cost of ins coverage paid annually, semi-annually or monthly to keep a policy in effect
284.	**Primary Malignancy**	the original cancer site. Malignant tumors are considered primary unless documented as secondary or mastastic
285.	**Procedural Suffixes:**	...
286.	**Pronation**	turning the palm or foot downward
287.	**Protraction**	moving a part of the body forward
288.	**Proximal**	near the point of attachment to the trunk
289.	**pseudo**	false
290.	**Pubic Bone**	lower anterior part of the bone
291.	**Qualified diagnosis**	working diagnosis which is not yet established
292.	**Radiology (including nuclear medicine and diagnostic ultrasound)**	77010-79999 (RPM-789)
293.	**Radius**	lateral lower arm bone (in line w/ the thumb)
294.	**Reasons for Documentation**	Important that every pt seen by dr has comprehensive legible documentation about pt's illness, treatment, & plans for following reasons: *Avoidance of denied or delayed payment by ins co investigating the medical necessity of services *Enforcement of medical record-keeping rules by ins co requiring accurate documentation that supports procedure & diagnosis codes. *Subpoena of medical records by state investigators or the court for review *Defense of professional liability claim
295.	**Rejected Claim**	requires investigation and needs further clarification
296.	**Relative Value Payment Schedule Method**	involves the use of relative value scales which assign a relative weight to individual services according to the basis for the scale. Services that are more difficult, time consuming, or resource intensive to perform typically have higher relative values than other services
297.	**Remittance Advice**	an electronic or paper-based report of payment sent by the payer to the provider
298.	**Retention Of Medical Records**	Is governed by state & local laws & may vary from state-to-state. Most dr are required to retain records indefinitely, deceased pt records should be kept for @ least 5 years

299.	**Retraction**	Moving a part of the backward
300.	**rhin**	nose
301.	**Rib Cage**	There are 12 pairs of ribs. The 1st 7 pairs join the sternum anteriorly through the cartilaginous attachments called COSTAL CARTILAGE. The TRUE RIBS #'s 1-7 attach directly to the sternum in the front of the body. The FALSE RIBS, #'s 8-10 are attached to the sternum by cartilage. Ribs 11 & 12 are FLOATING RIBS, b/c they are not attached at all
302.	**Rotation**	revolving a bone around its axis
303.	**-rrhagia**	bursting forth of blood
304.	**-rrhapy**	suture
305.	**-rrhea**	discharge, flow
306.	**Sacral**	Sacrum
307.	**Sagittal**	vertical plane dividing the body into right & left sides
308.	**salping**	fallopian tubes
309.	**Salter-Harris Fracture**	a fracture of the epiphyseal plate in children
310.	**Scapula**	or shoulder blades are flat bones that help support the arms
311.	**-sclerosis**	hardening
312.	**-scopy**	to view
313.	**-scopy**	visual examination
314.	**SEBACEOUS GLANDS**	located in the dermal layer of the skin over the entire body, expect for palm of hands and soles of feet. Secrete oily substance called SEBUM. SEBUM CONTAINS LIPIDS THAT HELP LUBRICATE THE SKIN & MINIMIZE WATER LOSS. It is the overproduction of sebum during puberty that contributes to acne in some people
315.	**SEBACEOUS (OIL) GLANDS & SUDDORIFERIOUS (SWEAT GLANDS)**	produce secretions that allow the body to be moisturized or cooled.
316.	**Secondary Malignancy**	cancer that has metastasized (spread) to a secondary site either adjacent or remote region of the body
317.	**Section 1: Index to diseases**	each term is followed by the code or codes that apply to that term
318.	**Section 2: Table of Drugs and Chemicals**	contains a list of drugs & chemicals w/ the corresponding poisoning code and E codes. The E codes are used to explain the circumstances surrounding the poisoning which may be: -Accident: Poisoning was due to accidental overdose, wrong substance taken, accidents in use of drugs and biologicals, external causes of poisoning classifiable to 980-989 -Therapeutic Use: instances when a correct substance properly taken is the cause of an adverse effect -Suicide Attempt: the poisoning was self-inflicted -Assault: poisoning was inflicted by another person w/ intent to kill or injury -Understand: poisoning cannot be determined whether intentional or accidental

319.	**Section 3: Index to External Cause of Injury (E codes)**	this is the index for the E codes. It classifies in alphabetical order, environment events and other conditions as the cause of injury and other adverse effects.
320.	**Sections**	composed of a group of 3 digit categories representing a group of conditions or related conditions, they are divided into categories
321.	**Sequencing the diagnosis**	the diagnosis, condition, or other reason for the encounter or visit shown in the medical record to be chiefly responsible for the services provided is listed first. Coexisting conditions that were treated or medically managed or influenced by the pt during the encounter are listed as additional codes. (Conditions that were previously treated and no longer exist are not coded.) If personal history or family history has an impact on current care or influence treatment, history code may be assigned as a secondary code
322.	**Sesamoid Bones**	small, rounded bones that resemble a sesame seed. they are found near joints and increase the efficiency of muscles near a joint. IE, KNEE CAP
323.	**Short Bones**	are small w/ irregular shapes, they are found in wrist and ankle
324.	**Skull**	made up of 2 parts, the cranium and the facial bone
325.	**Some of the Services covered by Medicaid**	-inpatient hospital services -outpatient hospital services -Physician services -emergency service -prenatal care -vaccines for children -cosmetics procedures necessitated by an injury (elective cosmetic procedures are not included) -family planning and supplies
326.	**Spinal/Vertebral Column**	is divided into 5 regions from the neck to the tailbone. There are 26 bones in the spine & are referred to as the VERTABRAE
327.	**Sprains, strains and dislocation/subluxation**	SPRAIN is a traumatic injury to the joint involving the soft tissue, soft tissue includes the muscles, ligaments and tendons.
328.	**The St. Anthony Relative Value for Physicians (RVP)**	unlike the RBRVS the RVP has no geographical adjustment factor or individual RVU component to calculate. However, for each category of procedures, a separate conversion factor must be developed
329.	**stomat**	mouth
330.	**-stomy**	opening
331.	**Strain**	lesser injury, usually this is a result of overuse or overstretching
332.	**sub**	under
333.	**Subcategories**	provide a 4th digit code (one digit after the decimal point) which is more specific that category code (3 digit) in terms of causes, site, manifestation of the condition. This must be used in available. Ex; 242.0
334.	**Subclassification**	provides a 5th digit code which gives the highest specificity of description to a condition. Use of it is mandatory when available. A code not reported to the full # of digits required is invalid ex; 242.01
335.	**Subluxation**	bone is partially out of joint
336.	**SUDDORIFEROUS GLANDS**	sweat glands that are tiny, coiled gland found on almost all body surfaces. They are most numerous in the palms and soles of feet. Coiled sweat glands originate in the dermis and straighten out to extend up through the epidermis. Tiny opening at surface is called a PORE.

337.	**Superior**	above another structure
338.	**Supination**	turning the palm or foot upward
339.	**Supplementary Classification Codes**	...
340.	**supra**	above, beyond
341.	**Surgery**	10021-69990 (Surgery always want to feel 100%)
342.	**Surgical Package**	also called "global surgery" includes a variety of services rendered by a surgeon which includes the following: -surgical procedure performed -local infiltratration, metacarpal/metatarsal/digital block or topical anesthesia -Preoperative E/M services; on day immediately prior to the day of the procedure -immediate postoperative care -Normal, uncomplicated postop care
343.	**Synovial Joints**	free moving joints, are surrounded by joint capsules. Many of the synovial joints have BURSAE-SACS OF FLUID THAT ARE LOCATED BETWEEN THE BONES OF THE JOINT AND THE TENDONS THAT HOLD THE MUSCLES IN PLACE.
344.	**Tarsal**	hind foot bone
345.	**tetra**	four
346.	**-therapy**	treatment
347.	**Thoracle**	Upper Back
348.	**Tibia**	shin
349.	**-tomy**	incision, to cut into
350.	**Transverse, Cross-sectional**	Horizontal plane dividing the body into upper & lower portions
351.	**TRICARE**	regionally managed health care program for active duty and retired members of the armed forces, their families and survivors. It is a service benefit and contains no premium. TRICARE is the new title for CHAMPUS program (Civilian Health and Medical Program of the Uniformed Services)
352.	**Ulcer**	open sore on the skin or mucous membrane
353.	**Ulna**	lower medial arm bone
354.	**Unauthorized Benefit**	procedure or service provided w/o proper authorization or was not covered by a current authorization. The claim is denied and the provider cannot bill the pt for the charges
355.	**Uncertain Behavior**	uncertain whether benign or malignant, borderline malignancy
356.	**Unlisted Procedures**	Procedures considered experimental, newly approved, or seldom used may not be listed in the CPT manual. Can be coded as unlisted procedures. they are located at the end of the subsections or subheadings. when unlisted procedure code is reported must be described in the accompanying documentation
357.	**Unspecified Nature**	a neoplasm is identified; however, no nature of the tumor is documented in the diagnosis of the medical record
358.	**Upper Appendicular Skeleton**	includes the shoulder girdle which is made up of the SCAPULA, CLAVICLE, & UPPER EXTREMITIES

359.	**Upper Extremities**	consist of the following:
360.	**Vesicle**	small collection of clear fluid; blister
361.	**VI. Payment**	once the claim is approved for payment, a remittance advice (RA) is sent to the provider and an explanation of benefits (EOB) is mailed to the policyholder
362.	**Volume 1-Index to Diseases, Tabular List**	contains the disease and condition codes and the descriptions, also contains the V codes and E codes
363.	**Volume 2-Index to Diseases, Alphabetic Index**	the is the alphabetic index of Volume 1; use this first then volume 1 to confirm codes
364.	**Volume 3-Procedures**	contains codes for surgical, therapeutic, and diagnosis procedures, used primarily in hospitals
365.	**Vomer**	bone that forms posterior/inferior part of the nasal septal wall between the nostrils
366.	**What 3 ways can an individual obtain health insurance?**	1)Group Ins-when a group of employees & their dependents are insured under 1 group policy issued to the employer. Generally the employer pays the premium or portion of premium and the employee pays the difference. 2)Personal Insurance- an insurance plan issued to an individual. premium rates are usually higher than group rates and service availability is lessened w/ this type of coverage 3)Pre-paid health plan- pre-determined set of benefits covered under one set annual fee
367.	**What are BC/BS plans reimbursement methodologies?**	physician reimbursement had been based on the UCR method but more plans have adapted the RBRVS method while some are using capitated rates.
368.	**What are bones connected to one another by?**	by fibrous bands of tissues called LIGAMENTS
369.	**What are circumstances when V codes are used?**	*When a person who is not currently sick encounters health services for some specific reason such as to act as an organ donor or receive a vaccination. (IE; V59.3 is the code for donor of bone marrow) *When a person w/ a resolving disease or chronic condition presents for specific treatment of that disease or condition. (IE; V56.0 is used for extracorporeal dialysis) *When a circumstance may influence the pt's health status but is not a current illness (IE; V16.3 is used for family history of coronary artery disease) *To indicate the birth status of a newborn (IE; V30.0 is uused for a newborn male born in the hospital by c-section)
370.	**What are common forms of fraud?**	billing for services not furnished, unbundling, & misrepresenting diagnosis to justify payment
371.	**What are E codes?**	Supplementary Classification of External Causes of Injury and Poisoning -supplementary classification codes used to describe the reason of EXTERNAL CAUSE of injury, poisoning and other adverse effects. Can be found in both Volumes ! & 2.
372.	**What are examples of Abuse?**	submitting a claim for services/procedures performed that is not medically necessary, and excessive charges for services, equipment or supplies.
373.	**What are Medical Ethics?**	Standards of conduct based on moral principle. They are generally accepted as a guide for behavior towards pt's, dr's, co-workers, the gov, and ins co's.
374.	**What are Medicare Health Insurance Claim Numbers (HCIN'a)?**	issued by CMS and are usually SS #'s with letter (alpha) or letter/number (alphanumeric) suffixes.

375.	**What are muscles attached to the bone by?**	tendons
376.	**What are the 2 major sections of a claims form?**	-Blocks 1-13, refers to pt info -Blocks 14-33, refers to physician info
377.	**What are the 2 provisions of HIPPA?**	Title I: Insurance Reform Title II: Administrative Simplification
378.	**What are the 3 different functions of the human muscles?**	1) allow the skeleton to move 2) responsible for movement of organs 3) to pump blood to the circulatory system
379.	**What are the 3 types of plans covered under TRICARE?**	1) Standard- fee-for service, cost-sharing plan 2) Extra- preferred provider organization 3) Prime- health maintenance organization plan w/ a point of service option ***All have annual deductibles, w/ the exception of PRIME
380.	**What are the 5 types of benefits offered?**	1) Medical treatment 2) Temporary disability 3) Permanent disability 4) Vocational rehabilitation 5) Death benefits for survivors
381.	**What are the key components of E/M?**	a; history -chief complaint -History of present illness (HPI) -review of systems (ROS) -Past, family and social history (PFSH) b;physical examination c;medical decision making complexity
382.	**What are the possible consequences of inaccurate coding and incorrect billing?**	**delayed processing & payment of claims** reduced payments, denied claims **fine and/or imprisonment** exclusion from payer's programs, loss of dr's license to practice med
383.	**What are V codes?**	Supplementary Classification of Factors Influencing Health Status and Contact of Health Services-supplementary classification code used to identify health care encounters that occur for reasons other that illness or injury or to indentify pt's whose illness is influenced by special circumstances or problems. Can be found in both Volume 1 & Volume 2
384.	**What codes are used to classify environmental events, circumstances, and conditions as the cause of injury, poisoning & other adverse effects and capture how the injury or poisoning happened, the intent and the place where the event happened?**	E codes
385.	**What does acting within ethical behavior boundaries mean?**	carrying out one's responsibilities w/ integrity, dignity, respect, honesty, competence, fairness, & trust.
386.	**What does Medical Necessity edit check for?**	-procedure codes match the diagnosis code -procedure are not elective -procedures are not experimental -procedures are essential for treatment -procedures are furnished at an appropriate level
387.	**What % does Medicare pay?**	80%
388.	**What do the codes range from? (ICD-Volume 1)**	001-999
389.	**What format does CPT coding system use and why?**	Indented format, to save space

390.	**What is a clearinghouse?**	an entity that receives transmission of claims for dr's offices, separate the claims by carriers and performs software edits on each claim to check for errors. One this process is complete, the claim is then sent to proper ins carrier. The dr pays the clearinghouse a fee for their services. A result of the review is sent back to the claims preparer using and audit/edit report
391.	**What is a Medical Record & what is it comprised of?**	documentation of the pt's social & medical history, family history, physical exam findings, progress notes, radiology & lab results, consultation reports and correspondence to pt- Is the foremost tool of clinical care and communication.
392.	**What is a medical report?**	part of the medical record & is a permanent legal document that formally states the consequences of the pt's exam or treatment in letter or report form. IT IS THIS RECORD THAT PROVIDES INFO NEEDED TO COMPLETE THE INS CLAIM FORM.
393.	**What is a method use to minimize danger, hazards, & liabilities associated w/ abuse?**	Risk Management
394.	**What is an Advance Beneficiary Notice?**	a document provided to a Medicare beneficiary by a provider prior to a service being rendered letting the beneficiary know of his/her responsibility to pay if Medicare denies the claim
395.	**What is Employee Liability?**	"Errors & Omissions Insurance"-protection against loss of monies caused by failure through error or unintentional omission on the part of the indv or service submitting the claim. *** **Some dr's contract w/ a billing service (clearinghouse) to handle claims submission, & some agreements contain a clause stating that the dr will hold the co harmless from "liability resulting from claims submitted by the service for any account", means dr is responsible for mistakes made by billing service, errors & omissions is not needed in the instance.** *****However, if dr ever asks the ins biller to do the least bit questionable, such as write of pt's balances for certain pt's automatically, make sure you have a legal document or signed waiver of liability relieving you of responsibility for such actions.
396.	**What is Employer Liability?**	Means physicians are legally responsible for their own conduct and any actions of their employees (designee) performed w/in the context of their employment. Referred to as "vicarious liability. A.K.A "respondent superior"-"let the master answer". Means employee can be sued & brought to trial
397.	**What is Health Insurance?**	A contract between a policyholder (one who purchases the contract) and an insurance carrier to reimburse the policy holder of all or most medical expenses
398.	**What is Medigap?**	Medicare Supplemental Insurance-to pay for medical services and items not covered by Medicare and Medicare's coinsurance and deductible. Medigap is a private insurance designed to help pay for those amounts that are typically the pt's responsibility under Medicare. there are several standard Medigap policies established by the federal gov w/ the ins industry
399.	**What is the 1st body system for which medical procedures are described in the CPT manual?**	The Integumentary System (the skin and it's accessory organs) Integument means covering. It is a complex system of specialized tissues containing glands, nerves and blood vessels.
400.	**What is the eponychium?**	the cuticle at the lower part of the nail sometime referred to as such

401.	**What is the False Claims Act (FCA)?**	Federal law that prohibits submitting a fraudulent claim or making a false statement or representation in connection w/ a claim. Also protects & rewards whistle-blowers.
402.	**What is the fibrous covering of muscles called?**	the fascia and the aricular cartilage, covers the end of many bones and serves as a protective function.
403.	**What is the main function of the skin?**	To protect the deeper tissues from excessive loss of minerals, heat & water. It also provides protection form diseases by providing a barrier. It accomplishes its diverse functions w/ assistance from the hair, nails and glands.
404.	**What is the moon like white area of the nail called?**	lunula
405.	**What is the National Correct Coding Initiative (NCCI)?**	Developed by CMS to promote the national correct coding methodologies & to control improper coding that lead to inappropriate payment of Part B health ins claims.
406.	**What is Title II of HIPPA?**	Administrative Simplification-goal is to focus on the health care practice setting to reduce administrative cost & burdens. Has 2 parts-1) development and implementation of standardized health-related financial & administrative activities electronically 2) Implementation of privacy & security procedures to prevent the misuse of health info by ensuring confidentiality
407.	**What is Title I of HIPPA?**	Insurance Reform-primary purpose is to provide continuous ins coverage for worker & their dependents when they change or lose jobs. Also **Limits the use of preexisting conditions exclusions** Prohibits discrimination from past or present poor health **Guarantees certain employees/indv the right to purchase new health ins coverage after losing job** Allows renewal of health ins cov regardless of an indv's health cond. that is covered under the particular policy.
408.	**What organ secretes hormones?**	the adrenal glands, they secrete epinephrine & steriods
409.	**What out of pocket costs for beneficiaries are associated w/ Medicare part B?**	Contains an annual deductible that must be met b4 benefits begin, beneficiaries pay 20% of the Medicare approved amount for services after the deductible has been met. Premiums are usually deducted from the monthly SS check.
410.	**What portion of services do the beneficiary pay?**	20%, deductible, premiums, and for non-covered services
411.	**What should be done in absences of payer provided instructions for completing claim form?**	Instructions on the claim form
412.	**Wheal**	Smooth, slightly elevated, edematous (swollen) area that is redder or paler than the surrounding skin
413.	**/When is the ICD manual updated**	Annually, Usually in October

414.	**When may providers use PHI (Protected Health Information) w/o specific authorization under the HIPPA Privacy Rule?**	When using for TPO, Treatment (primarily for the purpose of discussion of pt's case w/ other dr's) Payment (providers submit claims on behalf of pt's) & Operations (for purposes such as training staff & quality improvement)
415.	**Which volume(s) are used in the inpatient and outpatient settings (physician office)?**	Volume's 1 & 2
416.	**Who assigns NPI#'s & what are they?**	The CMS assigns a standard unique identifier known as National Provider Identifier (NPI).
417.	**Who audits claims?**	State & federal agencies as well as private ins co's
418.	**Who covers cost of Workers Compensations?**	employers pay for premiums, the amount of which will depend on the specific job, occupational category, and level of risks
419.	**Who developed HCPCS & What is it?**	The CMS developed Healthcare Common Procedure Coding System (HCPCS) which is a collection of codes for procedures, supplies, products, and services that may be provided to Medicare/Medicaid beneficiaries and also to those enrolled in a private health ins program. Codes are divided into 2 levels:
420.	**Who has the task of investigate and prosecuting health care fraud & abuse?**	The Office of Inspector General (OIG)
421.	**Who is Medicare available to?**	-persons aged 65 or older, retired on Social Security Benefits -spouses of a person paying into the Social Security System -those who received social security disability payments for 24 months -those diagnosed w/ end stage renal disease (ERSD) -kidney donors to ERSD pt's (all expenses related to kidney transplant are covered) -retired federal employees of the Civil Service Retirement System (CSRS)
422.	**Who** The American Medical Association (AMA) and they update it annually withe a new one coming out each November & **publishes CPT** becoming effective on January 1st of the following calender year **and updates it?**	
423.	**Workers Compensation**	is a state required ins plan, the coverage of which provides benefits to employees and their dependents for work related injury, illness or death. Each state has established minimum # of employees required before this laws comes into effect. Further, not all states offer WC plans
424.	**Zygoma**	cheekbone