nha Corrections

Corrections for Certified Billing and Coding Specialist (CBCS) Study Guide

The dates listed below indicate when the correction was added to this document. These corrections are also made for subsequent printings and within the tutorial version of the book. Implementation of those changes will vary based on deployment schedules for the tutorial updates and depletion of print stock.

Page	Chapter	Description	Date of Change
19	1	Updated image Encounter Form. 99212 Straightforward MDM – 10~~-19~~ min 99213 Low MDM – 20~~-29~~ min 99214 Moderate MDM – 30~~-39~~ min 99215 High MDM – 40~~-45~~ min	2/5/2024
36	2	Updated image 2.9. "Total estimated patient responsibility" is $350.00, not $0.00.	3/9/2023
55	3	3.2 CPT Manual – At A Glance (continued) … #5 80047-89398 0001U-~~0222U~~ **0354U** Pathology & Laboratory … 0042T – ~~0639T~~ **0783T** Category III Codes	3/9/2023
55	3	3.2 CPT Manual – At A Glance (continued) … #5 80047-89398 0001U-~~0354U~~ **0419U** Pathology & Laboratory … 0042T – ~~0783T~~ **0866T** Category III Codes	2/5/2024

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57	3	The level of E/M service reported must be supported by the amount of work documented in the medical record. Keep in mind the foundation of any service performed is medical necessity, not volume of documentation. The level of service performed is driven by the reason for the encounter and measured by the criteria of the code description. ~~The criteria for many E/M codes are the levels of key component(s) documented.~~ **The requirements for E/M services vary based on the type of care. For example, preventive medicine code levels are based on the age of the patient. Other E/M code variables include requirements for time spent or components of care. For codes that are time-based, the time specified in the code description must be met and documented in the encounter note. Codes that are based on the level of medical decision making include a requirement for a medically appropriate history and/or examination. Office visit code requirements offer a choice between documentation of time or medical decision-making level. Emergency department services and nursing facility service codes require documentation of medical decision making.**	2/5/2024

<table>
<tr><th>Page</th><th>Chapter</th><th>Description</th><th>Date of Change</th></tr>
<tr><td>57</td><td>3</td><td>~~Key Components~~

~~History – subjective details about the patient's condition. Elements of history (chief complaint, history of present illness, review of systems and past, family, and social history) are documented according to relevance to the encounter.~~

~~For example, if a patient presents with reports of muffled hearing, their social history is taken because it could be a contributing factor if the patient is subjected to loud noises in their work environment.~~

~~Examination – body areas or organ systems are examined as they relate to the chief complaint. The provider uses the findings to form objective assessments of the patient's condition. The extent of the examination performed (if any) is determined by the provider for each encounter.~~

~~Medical decision making (MDM) – the provider uses the history and exam components to determine a diagnosis or assess the patient's current clinical status of a known diagnosis (e.g., exacerbation versus stable). The elements of MDM are:~~

~~problems addressed during the encounter.~~

~~tests or other data ordered, reviewed, or analyzed during the encounter.~~

~~the associated risk of the patients management decisions made during the encounter.~~

~~While the amount of history and examination performed, as well as the complexity of medical decision-making by the physician, determines the level of code for most E/M codes, some subsections include time-based codes, or codes that can be either component- or time-based—with the determination made by the service provider.~~

~~Examples of E/M subsection requirements~~
<table><tr><th>~~Time-based~~</th><th>~~Component-based~~</th><th>~~Time or Component-based~~</th></tr><tr><td>~~Critical care services~~</td><td>~~Hospital Observation Care~~</td><td>~~Office or Other Outpatient Services~~</td></tr></table></td><td>2/5/2024</td></tr>
</table>

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<table>
<tr><th>Page</th><th>Chapter</th><th>Description</th><th>Date of Change</th></tr>
<tr><td>61</td><td>3</td><td>
<table>
<tr><td>ALPHA</td><td>NUMERIC</td><td colspan="4">ALPHA OR NUMERIC</td><td>~~ALPHA~~</td></tr>
<tr><td>S</td><td>4</td><td>0</td><td>0</td><td>2</td><td>1</td><td>A</td></tr>
<tr><td colspan="3">CATEGORY</td><td colspan="3">SUB-CATEGORY ~~SUBCLASSIFICATIONS~~</td><td>EXTENSION</td></tr>
<tr><td colspan="3">Three-character categories are diseases, injuries, external causes, and factors that influence health and encounters for health services.</td><td colspan="3">The fourth through sixth characters specify clinical details such as anatomic site, acuity, laterality, and manifestations.</td><td>The 7th character extension defines the episode of care (initial, subsequent, sequela), or other characteristic required for a category.</td></tr>
</table>
</td><td>2/5/2024</td></tr>
<tr><td>69</td><td>3</td><td>Challenge
Match the description with the correct CPT modifier.
1. 26 A. Increased Procedural Service
2. 22 B. Professional component
3. 57 C. Decision for surgery
4. 59 D. Distinct Procedural Service
1, B; 2, A; 3, C ~~D~~; 4, D ~~C~~</td><td>2/18/2022</td></tr>
<tr><td>73</td><td>3</td><td>• ~~CPT category II code 3046F: Most recent hemoglobin A1c level greater than 9.0%~~
• CPT category II code 3044F: Most recent hemoglobin A1c (HbA1c) level less than 7.0%
• ~~CPT category II code 2089F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%~~
• CPT category II code 3051F: Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
• CPT category II code 3052F: Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%
• CPT category II code 3046F: Most recent hemoglobin A1c level greater than 9.0%</td><td>3/9/2023</td></tr>
</table>

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Page	Chapter	Description	Date of Change
90	4	CHALLENGE Match the Medicare appeal level with the correct description. … ~~1, D; 2, E; 3, A; 4, C; 5, B~~ **1, C; 2, B; 3, D; 4, A; 5, B**	10/2/2023
104	Case Studies	CHALLENGE ~~The patient has a $35 copay, a remaining balance of $50 on the annual deductible and the allowed charges for the biopsies will be $425. Recall that the plan pays 80/20. Which of the following is the total patient responsibility for this encounter?~~ ~~A. $85~~ ~~B. $170~~ ~~C. $510~~ ~~D. $300~~ ~~B is correct. The total patient responsibility is $170.00 for this encounter. The calculation is as follows: $35 for the encounter copay, plus $50 for the remaining deductible and $85 for 20% coinsurance for the biopsies. $85 is incorrect because the total includes only the copay and the remaining deductible. $510 is incorrect because it adds the copay, remaining deductible and all of the allowed charges. $300 is incorrect because the calculation is the 80% coinsurance the insurance will pay after the remaining deductible is subtracted.~~ **According to the scenario above, the patient has a $35 copay, a remaining balance of $50 on the annual deductible, and the allowed charges for the biopsies will be $425. Recall that the plan pays 80/20 after the deductible has been applied to the charges. Which of the following is the total patient responsibility for this encounter?** **A: $85** **B: $160** **C: $510** **D: $300** **B is correct. The total patient responsibility is $160.00 for this encounter. The calculation is as follows: $35 for the encounter copay, plus $50 for the remaining deductible and $75 for 20% coinsurance for the biopsies. $85 is incorrect because the total includes only the copay and the remaining deductible. $510 is incorrect because it adds the copay, remaining deductible, and all of the allowed charges. $300 is incorrect because the calculation is the 80% coinsurance the insurance will pay after the remaining deductible is subtracted.**	3/9/2023

Page	Chapter	Description	Date of Change
118	Coding Scenarios	9. Chronic care management services, total monthly time of ~~15~~ **20** minutes	3/9/2023
125	Coding Scenarios	3. CPT codes: 99213-25; 72100; 11200 ICD-10-CM codes: M54.5**0**; L91.8 HCPCS codes: L0627 Journey: M54.5**0**: Pain, low back L91.8: Tag, skin 99213: Evaluation and Management, office and other outpatient visit, established patient 72100: Radiology, diagnostic imaging, spine and pelvis 11200: Skin, removal, skin tags L0627: Orthotic devices, lumbar	3/9/2023
143-146	Quizzes	Numbering of Quiz 3 items corrected to begin at 1 instead of at 16.	4/22/22