AAPC

CDEO®

Certified Documentation Expert - Outpatient

STUDY GUIDE

2026

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Chapter 1

Purpose of Clinical Documentation Improvement

This study guide prepares experienced coders and auditors for the Certified Documentation Expert Outpatient (CDEO®) certification exam. Individuals who hold a CDEO® credential are clinical documentation improvement (CDI) experts for outpatient services performed by professional healthcare providers. Throughout this training, CDEO® refers to a clinical documentation specialist in the outpatient setting.

Tested competencies on the CDEO® exam include: the benefits of CDI programs; documentation requirements; quality measures; payment methodologies; and clinical conditions including common signs and symptoms, typical treatment, clinical documentation details, and coding concepts.

Clinical documentation improvement is a proactive measure, which requires consistency and attention to detail. Successful CDI programs do not focus narrowly on maximizing reimbursement; but, instead, focus on documenting the clinical conditions, treatment and management of the conditions, and outcomes of treatment. As reimbursement models shift from fee for service to quality of care and patient outcomes, there is a need to efficiently communicate the quality of care provided and patient outcomes associated with that care.

The growing coding, billing, and auditing workload is reshaping the workflow. In smaller practices, coding and auditing staff also may be responsible to perform CDI (this can be a struggle, if the coding/auditing staff must "wear too many hats"). In large practices or facilities, responsibility for CDI and quality assurance typically is assigned to dedicated staff within the coding and billing departments.

The Professional Side of Clinical Documentation

Changes in healthcare and technology require a central focus on CDI, working prospectively. CDEO®s strive to improve clinical documentation to accurately describe patient care, to adhere to regulatory requirements, and to support services reported. CDEO®s work with everyone who has a role in the documentation process, to develop and monitor CDI policies and procedures.

CDI is important for many reasons. Errors in the medical record can erode patient/provider trust (or worse). Widespread use of the electronic health record (EHR) has allowed "over documentation," cloned medical records, and other compliance failures to flourish. Digitized data and modern computing power allow payers to enforce compliance aggressively using audits, recoupments, and payment denials. You should assume that all clinical documentation will be scrutinized at some point.

The Role of the CDEO®

A CDEO® works with facilities, clinicians, and staff to facilitate excellence and compliance in all medical record entries through the use of internal documentation guidelines. Such guidelines may include:

- The medical record is complete and legible
- The documentation of each patient encounter includes the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the observer
- If not documented, the rationale for ordering diagnostic and other ancillary services can be easily inferred by an independent reviewer or third party with appropriate medical training
- CPT® and ICD-10-CM codes used for claims submission are supported by documentation and the medical record
- Appropriate health risk factors are identified
- The patient's progress, response to and change in treatment, and revised diagnoses are documented

Documentation challenges vary based on the provider/facility type. For example:

- **Inpatient hospital**: Monitoring documentation for multiple providers involved in patient care is a challenge, and maintaining consistent, quality documentation is difficult because deficiencies may not be identified until after the provider has left the facility.
- **Outpatient diagnostic centers**: Often, physicians order tests, but the medical necessity isn't clear.
- **Comprehensive outpatient rehabilitation centers:** The patient care plan must be accurate and updated every 90 days, as required for Medicare patients.
- **Nursing home facilities**: The nursing home is responsible to coordinate care for patients and must ensure proper reimbursement for services performed by other providers.
- **Home healthcare entities:** Obtaining a compliant plan of care from the ordering provider is vital: Without it, services are not justified.

The Quality of Documentation

The medical record serves many purposes. A CDEO® ensures providers are documenting appropriately for all requirements.

Getting Past "Least Expected"

Quality patient care is evident only if it is documented in the medical record. For example, if the provider instructs the patient on risks and benefits of a procedure and how to properly take medication, but fails to document the instructions given and that the patient understood all the instructions, the provider has made himself vulnerable if the patient has an unfavorable outcome.

The Centers for Medicare & Medicaid Services (CMS) documentation guidelines for evaluation and management (E/M) services include the "least expected" documentation to support an encounter. CDI promotes complete and accurate documentation that goes beyond coding and billing, to include:

- Improve the communication and dissemination of information between and across all providers;
- Provide the appropriate treatment, intervention, and plan of care;
- Improve goal setting and evaluation of care outcomes;
- Improve early detection of problems and changes in health status; and
- Provide "evidence" of excellent patient care.

A properly documented medical record also validates place of service; medical necessity for the services provided; billing accuracy; and identity of the provider.

Financial Impact

Deficient medical documentation is a clear indicator that payments may be inaccurate. For example, the patient presents for a follow-up visit for otitis media. The EMR-generated documentation supports a 99214; however, the medical necessity of the service may warrant only a 99212 or 99213. Services coded based on the volume of documentation, rather than the medical necessity of services rendered, can lead to overpayment.

With improved documentation, collections improve. For example, diagnoses reported in the medical record but not reported on the claim form can result in denied claims. Accurate documentation ensures that claims are paid correctly, the first time, reducing the need to re-bill corrected claims or appeal claims held for additional information.

Legal Protection

The details in a well-documented note are a provider's best defense in any legal situation. If the record is deficient, there is no evidence to support a provider's testimony.

Mastering the Documentation Process

To master the documentation process, a CDEO® must:

1. Know the required documentation for the service rendered
2. Educate providers to document services as soon as possible
3. Develop tools to assist with consistency
4. Follow up with auditing
5. Educate providers and staff on requirements

Common deficiencies that are simple to prevent include:

- Sloppy text
- Misspelled words
- Phrases that do not make sense
- Dictation that is not complete
- Skips in the text that indicate the words were not understood
- Incomplete sentences
- Evidence of cloning or copying data from previous dates of service that is not relevant to the current service
- Incorrect dates of service
- Missing dates of service
- Missing dosage and strength of medication ordered
- Missing orders for diagnostic tests

An ongoing chart evaluation process is critical to a successful compliance program. A formal review with a report of findings has a greater impact than communication to the provider on a case-by-case basis. The extent and frequency of chart audits will vary, based on practice needs. The more reviews performed, over time, the less likely you will find major problems.

Best Practices

A CDEO® should monitor the timeliness of documentation. The provider should document during the encounter, or as soon as possible, thereafter. Most practices set a limit (from 24 hours to a few days) for record completion or to authenticate an EHR.

The CDEO® reviews the findings from auditors to determine what should be done to remedy the documentation deficiencies. The responsibilities of the CDEO® and an auditor may overlap; however, there are fundamental differences. An auditor's responsibilities include:

- Review of the record for documentation to support the selected CPT®, HCPCS Level II, and ICD-10-CM codes, and the coding and billing processes, after the claims have been submitted.

End of Chapter Questions

1. What is a disadvantage of the electronic health record with regard to CDI?

   A. Over documentation
   B. Signature of provider unavailable
   C. Limited space for patient's past history
   D. Unable to track payment denials

2. Compliance is achieved in medical record entries through the use of what?

   A. Personnel training
   B. Internal documentation guidelines
   C. Staff meetings
   D. Use of an EHR

3. What are examples of internal documentation guidelines for medical record entries?

   I. Documentation must be in the medical record within one week
   II. Health risk factors must be identified
   III. Documentation must support CPT® and ICD-10-CM codes
   IV. Documentation must be clear why ancillary services are ordered
   V. Notation of patient's age must be documented

   A. I, II, and III
   B. II, III, and IV
   C. III, IV, and V
   D. I, III, and V

4. What facility type must have a compliant plan of care from the ordering provider?

   A. Outpatient diagnostic center
   B. Inpatient hospital
   C. Urgent care facilities
   D. Home healthcare entities

5. A CDI program promotes continuity of care from one provider to another. What affect does this have on patient care?

   A. Prohibits duplicate claim denials
   B. Prohibits patient non-compliance
   C. Improve patient outcomes
   D. Provider communication does not affect patient care.

- **Healthcare providers** who electronically transmit health information through certain transactions are covered entities. Examples of electronically submitted transactions are claim forms, inquiries about eligibility of benefits, and requests for authorization of referrals. Simply using electronic technology, such as sending emails, does not mean a healthcare provider is a covered entity; the transmission must be in connection with a standard transaction. The rule applies to all healthcare providers, regardless of whether they transmit the transactions directly, or use a billing service or other third party to transmit on their behalf. Healthcare providers are defined as providers of services, such as hospitals, and providers of medical or health services, such as physicians, dentists, and other practitioners who furnish, bill, or receive payment for healthcare.
- **Healthcare clearinghouses** include billing services, re-pricing companies, and community health management information systems that process nonstandard information, received from another entity, into a standard (ie, standard format or data content), or vice versa. Usually, healthcare clearinghouses receive individually identifiable information for processing services to a health plan or healthcare provider as a business associate. In these cases, only certain provisions are applicable to the clearinghouses' uses and disclosures of PHI.

Business associates perform certain functions or activities, which involve the use or disclosure of individually identifiable health information on behalf of a covered entity without being a member of the covered entity's workforce.

Business associate services are limited to legal, actuarial, accounting, and consulting, data aggregation, management, administrative, accreditation, or financial services. Examples include claims processing or administration, data analysis, utilization review, billing, benefit management, and re-pricing.

A covered entity can be a business associate of another covered entity. The Health Information Technology for Economic and Clinical Health (HITECH) Act, specifies that an organization that provides data transmission of PHI to a covered entity and that requires access to PHI routinely, such as a Health Information Exchange Organization, will be treated as a business associate.

A contract is required between business associates to impose specified written safeguards on the individually identifiable health information used or disclosed by the business associate. The contract must describe the permitted and required uses of PHI by the business associate, limit the business associate from using or further disclosing the PHI (except where permitted by contract or required by law), and require the business associate to follow appropriate safeguards to prevent use or disclosure of the PHI, except as expressly defined in the contract. Covered entities may not contractually authorize a business associate to make any use or disclosure of PHI that violates the Privacy Rule.

SAMPLE BUSINESS ASSOCIATE AGREEMENT PROVISIONS

Words or phrases contained in brackets are intended as either optional language or as instructions to the users of these sample provisions.

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Healthcare Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Covered Entity].

(c) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware; [The parties may wish to add additional specificity regarding the breach notification obligations of the business associate, such as a stricter time frame for the business associate to report a potential breach to the covered entity and/or whether the business associate will handle breach notifications to individuals, the HHS Office for Civil Rights (OCR), and potentially the media, on behalf of the covered entity.]

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create,

practices may never fully implement all of the components." Based on the practice's specific history with billing problems and other issues, the practice should begin by adopting only those components most likely to provide an identifiable benefit.

The CPG lists potential benefits of a compliance program for individual and small group practices as:

- Increasing accuracy of documentation;
- Increasing the speed and optimization of proper payment of claims;
- Minimizing billing mistakes;
- Reducing the chances that an audit will be conducted by CMS or the OIG; and
- Avoiding conflicts with the Self-referral and Anti-kickback statutes.

The document also lists four risk areas for individual and small group practices indicated by the OIG. The risk areas are:

- Coding and Billing:
  - Billing for items or services not rendered or not provided as claimed
  - Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary
  - Double billing resulting in duplicate payment
  - Billing for non-covered services as if covered
  - Knowing misuse of provider identification numbers, which results in improper billing
  - Unbundling (billing for each component of the service instead of billing an all-inclusive code)
  - Failure to properly use coding modifiers
  - Clustering
  - Upcoding the level of services provided
- Reasonable and Necessary Services: Physicians should be able to order any tests, including screening test, they believe are appropriate for the treatment of their patients, but practices should be aware that Medicare will only pay for services that meet the Medicare definition of reasonable and necessary
- Documentation: Medical record documentation verifies that a claim for payment is accurate, as submitted. The medical record may be used to validate: the site of the service; the appropriateness of the services provided; the accuracy of the billing; and the identity of the provider of service
- Improper Inducements, Kickbacks, and Self-Referrals:
  - Financial arrangement with outside entities to whom the practice may refer federal healthcare program business
  - Joint ventures with entities supplying goods or services to the physician practice or its patients
  - Consulting contracts or medical directorships
  - Office and equipment leases with entities to which the physician refers
  - Soliciting, accepting, or offering any gift or gratuity of more than nominal value to or from those who may benefit from a physician practice's referral of federal healthcare program business

An appendix at the end of the CPG lists four additional risk areas for physicians, with examples:

- Reasonable and Necessary Services:
  - Advanced Beneficiary Notices (ABNs)
  - Certificates of Medical Necessity (CMNs)
  - Billing for non-covered services as if covered
- Physician Relationships with Hospitals:
  - The Emergency Medical Treatment and Active Labor Act (EMTALA)
  - Teaching physicians
  - Gainsharing arrangements and CMPs for hospital payments to physicians to reduce or limit services to beneficiaries
  - Physician incentive arrangements
- Physician Billing Practices:
  - Third-party billing services
  - Billing practices by non-participating physicians
  - Professional courtesy
- Other Risk Areas:
  - Rental of space in physician offices by persons or entities to which physicians refer
  - Unlawful advertising

Appendix B, *Criminal Statutes*, describes frequently cited criminal statutes related to healthcare fraud and abuse.

Appendix C, *Civil and Administrative Statutes*, describes frequently cited civil and administrative statutes related to healthcare fraud and abuse.

Appendix D lists OIG HHS contact information, and Appendix E lists carrier contact information.

Compliance Program Guidance for Hospitals

The CPG for hospitals was originally issued in the *Federal Register* on February 23, 1998; and supplemental guidance was issued in the Federal Register on January 31, 2005. Potential benefits of a compliance program listed for hospitals are:

Provider Options - RAC Overpayment Determination

	Discussion Period	Rebuttal	Redetermination
Which option should I use?	The discussion period offers the opportunity for the provider to provide additional information to the RAC to indicate why recoupment should not be initiated. It also offers the opportunity for the RAC to explain the rationale for the overpayment decision. After reviewing the additional documentation submitted the RAC could decide to reverse their decision. A letter will go to the provider detailing the outcome of the discussion period.	The rebuttal process allows the provider the opportunity to provide a statement and accompanying evidence indicating why the overpayment action will cause a financial hardship and should not take place. A rebuttal is not intended to review supporting medical documentation nor disagreement with the overpayment decision. A rebuttal should not duplicate the redetermination process. (See 42 CFR 405.374-375)	A redetermination is the first level of appeal. A provider may request a redetermination when they are dissatisfied with the overpayment decision. A redetermination must be submitted within 30 days to prevent offset on day 41.
Who do I contact?	Recovery Audit Contractor (RAC)	Claim Processing Contractor	Claim Processing Contractor
Timeframe	Day 1 - 30	Day 1-15	Day 1-120 Must be submitted within 120 days of receipt of demand letter. To prevent offset on day 41 the Redetermination must be filed within 30 days.
Timeframe Begins	Automated Review: Upon receipt of the Initial Findings Letter (IFL) Complex Review: Upon receipt of Review Results Letter	Date of Demand Letter	Upon receipt of Demand Letter
Timeframe Ends	Day 30 (offset begins on day 41)	Day 15	Day 120

Source: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/ProviderOptionsChart_508cleared_7-28-2017.pdf

FY 2020 Total Corrections by RAC Region/Contract and Type of Claim (Dollar Amounts and Number of Claims)

RAC Regions	Type of Claim	Collected Overpayments	Number of Claims with Collected Overpayments	Restored Underpayments	Number of Clams with Restored Underpayments	Total Corrected Amount	Total Number of Corrected Claims
Regions 1-5	Part A	$157,601,755.14	35,471	$18,208,733.86	5,922	$175,810,489.00	41,393
	Part B	$22,685,397.07	79,832	$1,461,359.58	8,178	$24,146,756.65	88,010
	DME	$39,963,604.44	95,798	$0	0	$39,963,604.44	95,798
Sub Totals		***$220,250,756.65***	***211,101***	***$19,670,093.44***	***14,100***	***$239,920,850.09***	***225,201***

Source: https://www.cms.gov/files/document/fy-2020-medicare-ffs-rac-report-congress-appendices.pdf

Status Indicators

Global surgery status indicators for surgical CPT® codes (10000–69999) are assigned based on risk factors associated with medical procedures. The status indicators can be found on the National Physician Fee Schedule Relative Value File found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

An excerpt is provided below:

HCPCS	MOD	DESCRIPTION	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC
11006		Debride genit/per/abdo m wall	0	0	0	0	2
11008		Remove mesh from abd wall	ZZZ	0	0	0	0
1101F		Pt falls assess- docd le1/yr	XXX	0	0	0	9
11010		Debride skin at fx site	10	0.1	0.8	0.1	2
11011		Debride skin musc at fx site	0	0	0	0	2
11012		Deb skin bone at fx site	0	0	0	0	2
11042		Deb subq tissue 20 sq cm/<	0	0	0	0	2
11043		Deb musc/fascia 20 sq cm/<	0	0	0	0	2
11044		Deb bone 20 sq cm/<	0	0	0	0	2
11045		Deb subq tissue add-on	ZZZ	0	0	0	0

- 000: Endoscopies or minor procedures with preoperative, and postoperative relative values on the day of the procedure, only, are reimbursable. E/M services on the same day of the procedure generally are not payable. (e.g., CPT®, 43255, 53020, 67346).
- 010: Minor procedures with preoperative relative values on the day of the procedure, and postoperative relative values during a 10-day postoperative period, are reimbursable services. E/M services on the day of the procedure and during the 10-day postoperative period are not reimbursable. (e.g., CPT® 17261, 40800, 64612).
- 090: Major procedures with one-day preoperative period and 90-day postoperative period are a component of global package of the major procedure. E/M services on the day prior to the procedure, the day of the procedure, and during the 90-day postoperative period are not reimbursable. (e.g., CPT® 21048, 32664, 49591).
- MMM: Maternity codes; the usual global period concept does not apply. (e.g., CPT® 59400, 59612).
- XXX: The global concept does not apply to this code. (e.g., E/M services, Anesthesia, Laboratory and Radiology procedures) (CPT® 10021, 36593, 38220, 44720).
- YYY: These are unlisted codes, and subject to individual pricing. (e.g., CPT® 19499, 20999, 44979).
- ZZZ: Represents add-on codes. They are related to another service and are always included in the global period of the primary service. (e.g., CPT® 27358, 44955, 67335).

Other columns to indicate the percentage of payment for the preoperative, intraoperative, and postoperative components of the global package. This information is useful for many reasons. The number of global days assigned to a code will assist the CDEO in knowing services that are part of the surgical package are not billed and paid separately. Also, it is important to monitor the global days to make sure that when the global period is over, services are billed and paid correctly.

EXAMPLE

On March 1st, a patient underwent an aspiration of a bone cyst reported with code 20615, which is assigned 10 global days. The patient presents for a follow up visit on March 15th.

In this case, the follow-up visit is reported separately with the appropriate E/M code based on the documentation and medical necessity because the visit occurred outside of the global period. If the follow-up visit occurred within the 10-day global period, the service can be reported with 99024 for internal tracking.

When the patient has been partially vaccinated for COVID-19 by the Centers for Disease Control and Prevention (CDC) recommendations in effect at the time of the encounter, code Z28.311, Partially vaccinated for COVID-19, may be assigned.

Chapter 2: Neoplasms (Codes C00–D49)

To properly code neoplasms, the medical record must indicate if the neoplasm is benign, in situ, malignant, or of uncertain histologic behavior. If there is a malignancy, the secondary (metastatic) site should also be reported.

Codes should be selected from the Table of Neoplasms in ICD-10-CM. ICD-10-CM guidelines state, "If the histology (cell type) of the neoplasm is documented, that term should be referenced first, in the main section of the Index, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate."

When a primary malignancy is still present, or is still being treated, it needs to be coded as still existing. If a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85 *Personal history of malignant neoplasm,* indicates the former site of the malignancy. This seems straightforward, but many factors must be considered in the office/facility; for example, whether certain drugs are regarded as prophylactic versus treatment.

Some forms of cancer are prone to recur or tend to have a familial predominance. Any family or personal history of skin cancers should always be documented and reported.

Non-Melanoma Skin Cancer

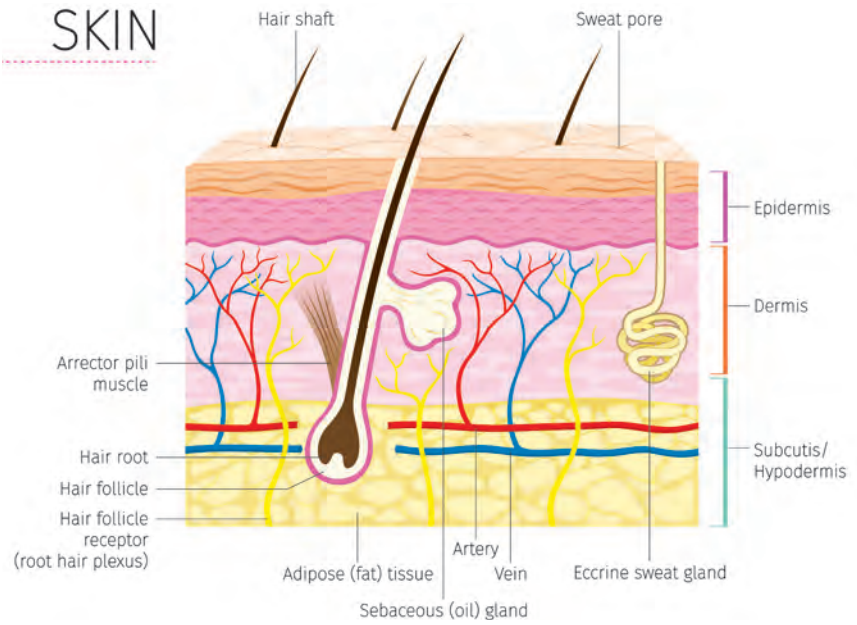
The skin is the largest organ system of the body. It is made up of two layers – the epidermis and the dermis. The epidermis has four to five layers that are called stratum—the Stratum Corneum, Stratum Lucidum, Stratum Granulosum, Stratum Spinosum, and Stratum Basale. The stratum basale is the layer of reproducing cells that lie at the base of the epidermis and receives its nourishment from dermal blood vessels.

The epidermis contains mostly dead cells and has no blood vessels. The basal layer of the epidermis contains melanocytes, which are cells that produce melanin, a dark brown pigment. The difference in people's skin color comes from the amount of melanin the melanocytes produce and distribute.

The epidermis is important as it protects against water loss, mechanical injury, chemicals, and microorganisms.

The dermis has two layers (Papillary Dermis and Reticular Dermis) and lies under the epidermis. The dermis contains structures that nourish and innervate the skin. They are: nerves/nerve endings, cutaneous blood vessels, hair, nails, and glands. The dermis binds the epidermis to underlying tissues and consists of connective tissue with collagen and elastic fibers within a gel-like ground substance.

Beneath the skin is the subcutaneous tissue. It contains fat and connective tissue that houses the larger blood vessels and nerves. The subcutaneous layer assists in regulating the temperature of the skin itself and the body. The size of the subcutaneous tissue varies throughout the body and from person to person.



Source: stock.adobe.com

Non-melanoma skin cancers include basal cell carcinoma, squamous cell carcinoma, and Merkel cell carcinoma.

Basal Cell Carcinoma (BCC)

BCCs are the most common type of skin cancer, occurring in approximately 80 percent of cases of skin cancer. BCC begins in the basal cells, which are the cells in the epidermis that produce new skin cells as old ones die. BCCs most often occur on the sun-exposed areas of the body, especially the head and neck. Anyone with a history of sun exposure can develop BCC.

Category C44 has the codes for basal cell carcinomas. The 5th character 1 in the code category indicates the type of carcinoma as basal cell.

EXAMPLE

70-year-old patient presents with a history of basal cell carcinoma of the right thigh two years ago. She complains of 2 months of crusting on the right nasal tip. Patient with a long history of sun exposure with multiple bad sunburns. Biopsy reveals new basal cell carcinoma of the nasal tip. The patient will undergo Mohs surgery.

C44.311 Basal cell carcinoma of skin of nose

Z85.828 Personal history of other malignant neoplasm of skin

Squamous Cell Carcinoma (SCC)

SCC begins in the squamous cells, which compose most of the skin's epidermis. They are the second most common type of skin cancer. SCCs occur on all areas of the body, but most often on sun-exposed areas of the body (e.g., rim of the ear, lower lip, face, bald scalp, neck, hands, arms, and legs). They tend to grow and spread more than BCCs, are more likely to invade fatty tissues beneath the skin, and are more likely to metastasize to the lymph nodes or other parts of the body.

Category C44 includes codes for squamous cell carcinoma, broken down in the same way as melanoma and Merkel cell carcinomas. The 5th character 2 in the code category indicates the type of carcinoma as squamous cell.

EXAMPLE

A patient had a suspicious lesion removed from the back of his right hand. The patient is informed that the biopsy results confirm squamous cell carcinoma.

C44.622 Squamous cell carcinoma of skin of right upper limb, including shoulder

NOTE: Many codes in the subcategories for skin cancer do not follow the laterality pattern (1=right, 2=left, 3=bilateral).

Merkel Cell Carcinoma (MCC)

MCC is a rare form of skin cancer that develops from the neuroendocrine cells (hormone-making cells in the skin). MCC is thought to be caused from sun exposure and Merkel cell polyomavirus (MCV). MCV is a common virus that usually causes no symptoms. In rare cases, changes in the virus' DNA can lead to Merkel cell carcinoma. Merkel cell carcinomas often metastasize to the lymph nodes and internal organs, and tend to recur.

Category C44 contains codes for basal cell, squamous cell, other, and unspecified malignant neoplasms of the skin. The subcategories break down by type of malignancy, site, and laterality (when applicable). Category C4A contains codes for Merkel cell carcinoma. The subcategories break down by site and laterality (when applicable).

The subcategories and codes for C4A are as follows:

C4A.0- Merkel cell carcinoma of lip

C4A.1- Merkel cell carcinoma of eyelid, including canthus

C4A.2- Merkel cell carcinoma of ear and external auricular canal

C4A.3- Merkel cell carcinoma of other and unspecified parts of face

C4A.4- Merkel cell carcinoma of scalp and neck

C4A.5- Merkel cell carcinoma of trunk

C4A.6- Merkel cell carcinoma of upper limb, including shoulder

C4A.7- Merkel cell carcinoma of lower limb, including hip

C4A.8 Merkel cell carcinoma of overlapping sites

C4A.9 Merkel cell carcinoma, unspecified

EXAMPLE

A 75-year-old male patient presents with a rapidly enlarging mass near his upper lip. He is fair skinned and lives on a farm, using no sun protection other than a baseball cap. The mass has been rapidly increasing in size for the past 2 months. After diagnostic testing, he is diagnosed with Merkel cell carcinoma of the peri-oral area.

C4A.39 Merkel cell carcinoma of other parts of face

Lung Cancer

Lung cancer is the second most common cancer among both men and women in the United States, but it is the leading cause of cancer death among both sexes. The number one risk factor for lung cancer is cigarette smoking. There are two main types of lung cancer, named for the kinds of cells and how the cells look microscopically. Small cell carcinoma includes oat cell cancer and combined small cell carcinoma. Non-small cell cancer includes squamous cell carcinoma (also called epidermoid carcinoma), large cell carcinoma, and adenocarcinoma.

Codes for lung cancer are broken down by morphology, site, and laterality, except C34.2 *Malignant neoplasm of middle lobe, bronchus or lung* because only the right lung has a middle lobe. Subcategories that breakdown by laterality are:

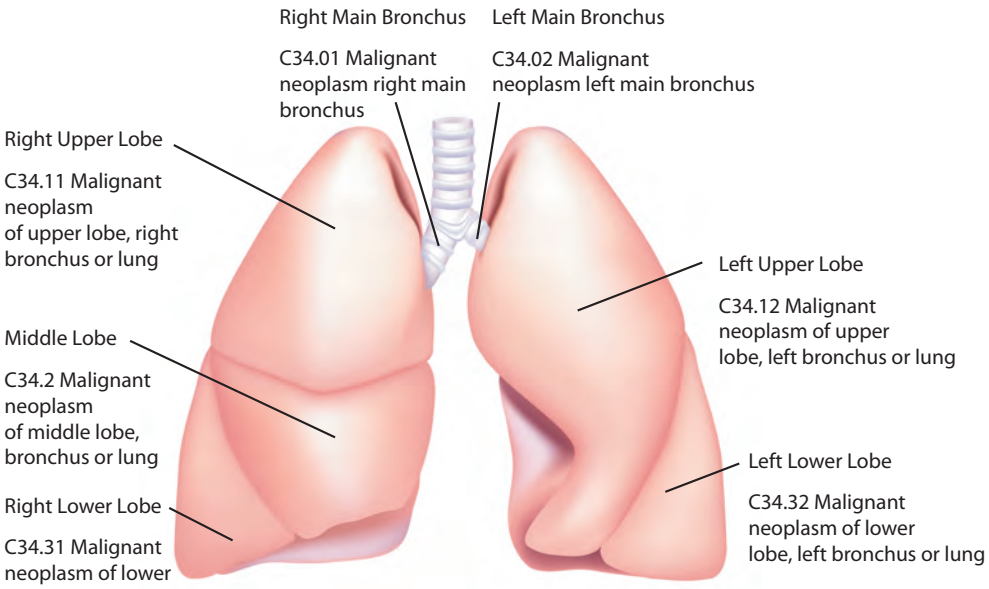
C34.0- Malignant neoplasm of main bronchus

C34.1- Malignant neoplasm of upper lobe, bronchus or lung

C34.3- Malignant neoplasm of lower lobe, bronchus or lung

C34.8- Malignant neoplasm of overlapping sites of bronchus and lung

C34.9- Malignant neoplasm of unspecified part of bronchus or lung



Source: AAPC

The code for carcinoid tumor of the lung, C7A.090 has no specific site or laterality contained within the code.

Secondary malignant neoplasms are broken down by laterality.

EXAMPLE

A patient with cancer in the lower lobe of his left lung presents for lobectomy.

C34.32 Malignant neoplasm of lower lobe, left bronchus or lung

Breast Cancer

According to the Centers for Disease Control, breast cancer is the most common cancer among women. Ductal carcinoma is the most common type of female breast cancer. Breast cancer in males is uncommon, making up less than one percent of all cases of breast cancer. The codes are broken down by specific site (upper-outer, lower-inner, etc.), laterality, and gender. For every code for female breast cancer, there is a matching code for male breast cancer.

Selecting the Level of Medical Decision Making (MDM)

Number/Complexity of Problems Addressed - **Nature of Presenting Problem (Table A)**	
Minimal	☐ 1 Self-limited/minor problem
Low	☐ 2+ Self-limited/minor problems ☐ 1 Stable, chronic illness ☐ 1 Stable, acute illness ☐ 1 Acute, uncomplicated illness/injury ☐ 1 Acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
Moderate	☐ 1+ Chronic illnesses w/ exacerbation, progression, or Tx side effects ☐ 2+ Stable, chronic illnesses ☐ Undiagnosed problem w/ uncertain prognosis ☐ Acute illness w/ systemic symptoms ☐ Acute complicated injury
High	☐ Chronic illness w/ severe exacerbation, progression, or Tx side effects ☐ Acute/chronic illness/injury that poses threat to life or bodily function ☐ INITIAL NURSING FACILITY CARE ONLY: Multiple morbidities requiring intensive management

Amount and/or Complexity of **Data to be Reviewed and Analyzed (Table B)**				
Category 1	QTY:____ Review of prior external note(s) from each unique source QTY:____ Review of the result(s) of each unique test QTY:____ Ordering of each unique test			
Independent Historian (IH)	Assessment requiring independent historian(s) (Category 2 for Limited; Category 1 for Moderate/High)			
Category 2	Independent interpretation of a test performed by another physician/other QHP (not separately reported)			
Category 3	Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reported)			
Total	0 or 1	1 of 2	1 of 3	2 of 3
	1-Category 1	2-Category 1 IH	3-Category 1/IH 1-Category 2 1-Category 3	3-Category 1/IH 1-Category 2 1-Category 3
Data Level	Minimal or None	Limited	Moderate	Extensive

Risk of Complications and/or Morbidity or Mortality of **Patient Management (Table C)**	
Minimal	☐ Minimal risk of morbidity from additional diagnostic testing or treatment *Examples:* *Rest, gargles, elastic bandages, superficial dressings*
Low	☐ Low risk of morbidity from additional diagnostic testing or treatment *Examples:* *OTC drugs without complications from drug interactions or co-morbidities, minor surgery w/o identified risk factors, PT/OT therapy, IV fluids w/o additives*
Moderate	☐ Moderate risk of morbidity from additional diagnostic testing or treatment *Examples:* *Prescription drug management* *Decision regarding minor surgery w/ identified patient or Tx risk factors* *Decision regarding elective major surgery w/o identified patient or Tx risk factors* *Diagnosis or Tx significantly limited by social determinants of health*
High	☐ High risk of morbidity from additional diagnostic testing or treatment *Examples:* *Drug therapy requiring intensive monitoring for toxicity* *Decision regarding elective major surgery w/ identified patient or treatment risk factors* *Parenteral controlled substances* *Decision regarding emergency major surgery* *Decision regarding hospitalization or escalation of hospital-level care* *Decision not to resuscitate or to de-escalate care because of poor prognosis*

Medical Decision Making (MDM) (Table D)					
Final Results of Tables A, B, C = Level of Medical Decision Making (MDM) **Must consider 2 of the 3 MDM elements for the overall MDM level** • Use any two components that meet or exceed • Drop the lowest one					
Table A	Number/Complexity of Problems Addressed	Minimal	Low	Moderate	High
Table B	Amount and/or Complexity of Data to be Reviewed and Analyzed	Minimal or none	Limited	Moderate	Extensive
Table C	Risk of Complications and/or Morbidity or Mortality of Patient Management	Minimal	Low	Moderate	High
MDM Level		Straightforward	Low	Moderate	High

Time-Based Coding

Elements of Time	
Provider time includes the following activities, when performed: *Preparing to see the patient, such as reviewing the patient's record *Obtaining and/or reviewing separately obtained history *Performing a medically appropriate history and examination *Counseling and educating the patient, family, and/or caregiver *Ordering medications, tests, or procedures *Referring and communicating with other healthcare providers when not separately reported *Documenting clinical information in the electronic or other health record *Independently interpreting results when not separately reported *Communicating results to the patient/family/caregiver *Coordinating the care of the patient when not separately reported	Do NOT count time on the following: *Time spent on performing any service that is reported separately *Travel *Teaching that is general and not limited to discussion that is required for the management of a specific patient
Total Encounter Time: _____	**E/M Code: _____**

Prolonged Services - Physician or Other Qualified Healthcare Professional					
E/M Code	**Time**	**Report E/M code only**	**99417 x 1**	**99417 x 2**	**99417 x 3 or more for each additional 15 min.**
98003	60+	Less than 75 minutes	75-89	90-104	105+
98007	40+	Less than 55 minutes	55-69	70-84	85+
98011	60+	Less than 75 minutes	75-89	90-104	105+
98015	40+	Less than 55 minutes	55-69	70-84	85+
99205	60+	Less than 75 minutes	75-89	90-104	105+
99215	40+	Less than 55 minutes	55-69	70-84	85+
99245	55+	Less than 70 minutes	70-84	85-99	100+
99345	75+	Less than 90 minutes	90-104	105-119	120+
99350	60+	Less than 75 minutes	75-89	90-104	105+
99483	60+	Less than 75 minutes	75-89	90-104	105+

E/M Code	Time	Report E/M code only	99418 x 1	99418 x 2	99418 x 3 or more for each additional 15 min.
99223	75+	Less than 90 minutes	90-104	105-119	120+
99233	50+	Less than 65 minutes	65-79	80-94	95+
99236	85+	Less than 100 minutes	100-114	115-129	130+
99255	80+	Less than 95 minutes	95-109	110-124	125+
99306	50+	Less than 65 minutes	65-74	75-89	90+
99310	45+	Less than 60 minutes	60-74	75-89	90+

Practice Questions' Answers and Rationales

Purpose of CDI

1. **Answer:** D

   Rationale: Quality patient care is evident only if it is documented in the medical record. CMS documentation guidelines for E/M services include the "least expected" documentation to support an encounter. CDI promotes complete and accurate documentation that goes beyond coding and billing, to include:

   - Improve the communication and the dissemination of information between and across all providers of services which can improve patient outcomes.
   - Provide the appropriate treatment, intervention, and plan of care.
   - Improve goal setting and evaluation of care outcomes.
   - Improve early detection of problems and changes in health status; and
   - Provide "EVIDENCE" of excellent patient care.

   A properly documented medical record also validates place of service; medical necessity for the services provided; billing accuracy, and; identity of the provider.

2. **Answer:** A

   Rationale: A CDEO's responsibilities include reviewing the medication list and making sure the lists are updated. At each visit, the list should be updated to indicate whether the prescription is still current and accurate.

3. **Answer:** A

   Rationale: Reviewing documentation for completeness is a primary role of a documentation specialist. If the patient had an undocumented allergy to penicillin, the patient could be prescribed a life-threatening medication.

Provider Compliance and Communication

4. **Answer:** D

   Rationale: HIPAA regulations require a provider's office to use the best means possible to keep data secure.

5. **Answer:** A

   Rationale: Maintaining an acronym and abbreviation list will help reduce the documentation burden for providers. This also helps coders when reviewing documentation to appropriately assign the correct codes.

6. **Answer:** B

   Rationale: The physician query is used to clarify documentation by clarifying conflicting, ambiguous, or incomplete information about significant conditions or procedures in the medical record of the patient. In addition to obtaining clarification, the query may serve as an educational tool to improve physician documentation and the coders' understanding of clinical scenarios.

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