AAPC

CEDC®

Certified Emergency Department Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CEDC®

EMERGENCY DEPARTMENT

AAPC

Contents

2026 Specialty Study Guide: CEDC® Introduction

The *Specialty Study Guide: CEDC®* is designed to help emergency department coders, billers, and other medical office professionals prepare for the CEDC® examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for the emergency department.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and allows you access to continuing education opportunities. The *Specialty Study Guide: CEDC®* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CEDC® examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT® as well as emphasize the importance of correct evaluation and management (E/M) leveling. You will need to use the 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books for the study guide and the CEDC® certification exam.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends indicate that diagnoses will play a larger role in future reimbursement. It is important to code correctly, so you are prepared for that day.

We will discuss the major topics of diagnosis coding for emergency department. The examinee must become familiar with the ICD-10-CM Official Guidelines for Coding and Reporting, know how to select the appropriate ICD-10-CM codes, and be able to properly sequence diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). This year's guidelines can be found at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

The Evaluation and Management (E/M) material will focus on the E/M services for emergency department and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® code book.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to emergency department will be discussed in this section. Special attention is given to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest Relative Value Units (RVUs) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top 10 Missed Coding Concepts for CEDC® certification exam. The list is not presented in a specific order. The information is determined after an evaluation by AAPC's Exam Department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam itself were written by coders with extensive experience in coding for the emergency department. The practice exam mimics the format and structure of the CEDC® certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective specialty disciplines. Here is information on the CEDC® credential:

- CEDC® stands alone as a certification with no prerequisite that the examinee holds a CPC® or COC® credential.
- Exams aptly measure preparedness for "real world" coding by being entirely operative or patient-note based. These operative (op) notes are redacted op notes from real emergency department practices.

The CEDC® examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you sit for this exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that the patient is covered by Medicare, you should follow the CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- EMTALA requirements
- Proper use of an Advance Beneficiary Notice of Noncoverage (ABN) form
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 20000 Series
  - 30000 Series
  - 40000 Series
  - 50000 Series
  - 60000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category II and III codes
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and coding books is essential, as time is an important element in successfully completing the exam. You should approach the exam as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam within the *Specialty Study Guide: CEDC®* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees that pass the CEDC® certification examinations will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly*, and receive a diploma suitable for framing.

About AAPC

AAPC was founded in 1988 to elevate the standards of medical coding by providing certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall provide the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

ICD-10-CM Coding Guidelines for Emergency Department

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics (NCHS) developed ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) in consultation with a technical advisory panel, physician groups, and clinical coders to assure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 1 of each year. There is no grace period allowed for the changes to be implemented.

All versions of the ICD-10-CM code book typically include the ICD-10-CM Official Guidelines for Coding and Reporting. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in the Tabular List and Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that claim (individual dates of service must stand alone), and coders must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as acute when it isn't documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses, in addition to the principal diagnosis, that affect the patient's care.
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, etc.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. When attempting to select an ICD-10-CM diagnosis code, begin by searching for the main term—such as "lesion," "burn," etc. —in the Alphabetic Index. Follow all cross-references and "*see also*" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Be sure to pay close attention to disease definitions, footnotes, color-coded prompts, and other instructions. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first-listed diagnosis should describe the most significant reason for the procedure or visit. The first-listed diagnosis will be reflective of the patient's chief complaint. Relevant co-existing diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding pre-existing conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist, or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis *only* when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with the provider to ensure that the information necessary for proper coding is always noted.

General ICD-10-CM Guidelines

Signs/Symptoms and Confirmed/Unconfirmed Diagnoses

Use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis. Report only confirmed diagnoses. Uncertain diagnoses described as "probable," "possible," "suspected," "likely," "rule out," "compatible with," "consistent with," etc., are not coded. Code the highest level of certainty known, using codes that describe known signs, symptoms, abnormal test results, etc.

For example, if a patient has a breast mass and the provider suspects breast cancer, you should not report breast cancer as the diagnosis. Instead, report the signs and symptoms, such as breast mass, that prompted the exam. If testing later confirms cancer, only then should you report the cancer diagnosis.

For outpatient encounters that include diagnostic tests which have been previously interpreted by a physician, and the final report is available at the time of coding, report any confirmed or definitive diagnosis(es) documented in the interpretation. If a definitive diagnosis is known, do not code related signs and symptoms as additional diagnoses; that is, if the test is positive, you report the findings. For tests interpreted as "normal" code the condition, symptom, or sign that necessitated the diagnostic study.

In rare occurrences, a test is ordered without a clear indication of reason, and the ordering physician is not available to gather enough information prior to treating the patient. In such a case, you will want to confirm the order with the ordering provider to obtain the reason(s) for the tests. When you are provided with both a preoperative and postoperative diagnosis, always report the *postoperative* diagnoses if the pre- and postoperative diagnoses differ.

Signs and symptoms attributable to a definitive diagnosis should not be reported separately. Cite additional signs and symptoms beyond the primary diagnosis only when those signs and symptoms are not integral to the disease process. Report only those additional conditions that affect treatment, and that the provider documents for the current visit.

For example, a patient presents with shortness of breath. The next day, the physician determines the patient has pneumonia; but he feels that the shortness of breath may be due to a cardiac condition, not pneumonia. In such case, you may report the shortness of breath as a sign and symptom with pneumonia because the physician has a documented reason to believe that the conditions are unrelated.

Above all, do not extrapolate or assume information. Select codes only from what is apparent in the available documentation.

Acute vs. Chronic

The doctor makes the determination as to when a condition becomes chronic. Coders will select an appropriate code for acute or sub-acute (primary) versus chronic (secondary) conditions based on the available documentation. For example, a torn meniscus (S83.2-) will become an internal derangement of knee (M23.-) after a defined period of time.

If a patient's condition is *both* acute/sub-acute and chronic, and a single code does not describe this combination, the ICD-10-CM code book provides instruction that you would report the acute (sub-acute) code as the first-listed diagnosis, with the chronic code as secondary.

Sequela (Late Effects)

Sequela (late effects) codes are usually reported as secondary diagnoses, with the effect or reason for the visit as primary. There is no time limit (such as 90 days, one year, etc.) in which late effects can occur.

Sequela (late effects) of cerebrovascular disease fall specifically to category I69, which indicate conditions classifiable to I60-I67 (hemorrhage, occlusion, and stenosis, etc.) as the cause of sequela (late effects). Guidelines indicate that the late effects include neurologic deficits caused by cerebrovascular disease and may be present from the onset or may arise at any time after the onset of the condition—classifiable to categories I60-I67. A code(s) from category I69 may be assigned on a health case record with codes from I60-I67 if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.

Some of the codes in category I69 that specify hemiplegia, hemiparesis, and monoplegia also identify whether the dominant or nondominant side is affected. If the dominance is not stated (right-handed, left-handed, or ambidextrous), and the classification does not indicate a default, then the following applies:

- For ambidextrous patients, the default is always dominant.
- If the left side is affected, the default is nondominant.
- If the right side is affected, the default is dominant.

Multiple Conditions Reported with a Single Code

In some cases, ICD-10-CM will employ a single code to describe two or more conditions concurrently, such as a primary diagnosis with an associated secondary process (manifestation), or a primary diagnosis with an associated complication. Code category I12, for instance, describes hypertension with chronic kidney disease. Likewise, K81. 2

Evaluation and Management Coding for Emergency Department Coders

This chapter examines the documentation requirements of the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and to accurately select levels of E/M services for purposes of the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CEDC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M DGs have perhaps inspired more discussion than any other non-clinical topic in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem with this is that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs. These guidelines have been eliminated and are no longer used for leveling an E/M visit.

AMA changed the descriptions of the E/M codes that required the three key components to now require only Medical Decision Making (MDM) or time. In addition, the guidelines for selecting these codes based on MDM are printed in the CPT® code book.

Documentation Guidelines

There are three general principles regarding documentation and to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While a medically appropriate history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT® code book and refer to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

CPT® references that the E/M may be based on MDM or time. However, in the Emergency Department E/M services, time is not a descriptive component. For Emergency Department E/M, MDM is the determining factor.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE:
EMERGENCY DEPARTMENT MDM TO CODE CORRELATION

ED Code	Level of MDM
99281	N/A 99281 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99281.
99282	Straightforward
99283	Low
99284	Moderate
99285	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems Addressed

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter either by history, exam, or medical decision making including diagnostic studies such as lab or radiology studies.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is stated as being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for that encounter.

Per CPT® guidelines, "*The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms that are likely to represent a highly morbid condition may "drive" MDM even when the ultimate diagnosis Is not highly morbid.*"

Top 10 Missed Coding Concepts on CEDC® Exam

The concepts discussed are not in a particular order. The tips provided below are based on AAPC Exam Department observations of the most missed coding concepts.

1. **Modifier 57:** When the decision to perform a major procedure is performed on the day before, or same day as, the major procedure, report modifier 57 with the E/M code in addition to the major surgical procedure code. Major procedures are assigned 90 global days. In the emergency department, the most common major procedure performed is fracture care. Documentation needs to support that the ED provider performed the major procedure to report modifier 57 on the E/M code.

2. **Open versus closed fracture care:** Open fracture care is reported when the provider creates an opening to expose the bone to treat the fracture. This type of procedure is not performed in the ED. The patient is taken to an operating room. The patient may present with an open fracture (bone pierces the skin) that is treated with closed fracture care. For example, the bone is manipulated back in place, the wound is repaired, and a cast is applied. The treatment performed dictates the type of fracture care reported, not the patient's diagnosis.

3. **Requiring anesthesia versus without anesthesia:** Some procedures in CPT® have a selection "with anesthesia" and "without anesthesia." To select codes that require anesthesia, general, regional, or monitored anesthesia care are required. Moderate/conscious sedation (MCS) is not considered anesthesia. When MCS is performed, select the CPT® code option "without anesthesia." For example, a closed treatment of a shoulder dislocation on a 13-year-old, performed with 30 minutes of moderate conscious sedation by the treating physician with a trained observer, is reported 23650, 99152, 99153.

4. **Debridement:** CPT® 11000 is reported for the debridement of extensive infected or eczematous skin conditions that involve only the surface layers of the skin (epidermis and possibly dermis) over a wide area, without an open wound. In contrast, 11042 is used for open wound debridement that involves removal of skin and subcutaneous tissue (and includes the epidermis and dermis, if performed).

5. **Cardiography:** ECG codes 93000-93010 are differentiated by which part of the procedure the physician is reporting. Modifiers 26 or TC are not used with these codes. When reporting the ED physician interpretation for an ECG, report code 93010 without a modifier 26.

6. **Fracture Care Treatment:** The ED provider can report a CPT® code for fracture care treatment when documentation confirms that the ED provider personally performed the treatment. However, if another provider, such as an orthopedic provider, is called to the ED to treat the fracture, the ED provider will report only the appropriate ED E/M code, the orthopedic provider reports the CPT® code for the fracture care treatment.

7. **Understand AMA E/M Guidelines for Selecting the Level for the Risk of Complications and/or Morbidity or Mortality of Patient Management:** Risk is evaluated based on the physician's assessment of the patient's potential for illness, complications, or death between the current encounter and the next scheduled visit. According to the Evaluation and Management (E/M) guidelines, the **risk of complications, morbidity, or mortality** associated with **management decisions** is distinct from the inherent risk of the **medical condition itself**. The level of risk is determined by the provider's clinical decision-making during the encounter, including diagnostic testing and treatment choices. It also encompasses management options that were considered but ultimately not selected, as discussed with the patient and/or family.

8. **Reviewing AMA E/M Guidelines for Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** Extensive level needs 2 out of 3 categories:

   - Category 1
   - Category 2
   - Category 3

   For example, if the provider orders/reviews 3+ unique tests (Category 1) and discusses treatment/management of the patient with another provider (Category 3) you meet the requirements to report an extensive level.

9. **GE vs GC modifier:** These modifiers are reported when services are provided by teaching physicians in conjunction with resident services. The teaching physician will append modifier GC *Service has been performed in part by a resident under the direction of a teaching physician* whenever a resident is involved with the care. Modifier GE *Service has been performed by a*

resident without the presence of a teaching physician under the primary care exception is appended to the code to indicate the service was provided without the presence of the teaching physician. Modifier GE is not applicable in the Emergency Department.

10. **ED provider reporting Hospital Inpatient E/M Codes:** There are times when an ED provider is called up to the hospital floor, such as the ICU, to provide services to a patient. The ED E/M code is not reported, instead a Hospital Inpatient and Observation Care Services E/M code is reported.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

HPI: A 59-year-old patient presents to the emergency department with hip pain and inability to bear weight. The patient reports that he was kneeling over his dog when he felt a pop and some pain in his left hip. The patient has had three previous episodes of hip dislocation. He denies any distal neurologic complaint. There was no other injury.

PFSH:

Surgical History: Bilateral hip replacements.

Social History: Lives with family.

Physical Exam: Vital Signs: Reviewed nurse's notes.

Patient Status: Alert and cooperative.

Neck: FROM, nontender, no lymphadenopathy.

Lungs: Clear to auscultation and breath sounds equal, no wheezes, rales, or rhonchi.

Heart: Regular rate and rhythm without murmurs, ectopy, gallops, or rubs.

Abdomen: No tenderness; Normal bowel sounds.

Back: No costovertebral, paravertebral, intervertebral, or vertebral tenderness or spasm.

Extremities: Left lower extremity is medially rotated and mildly shortened. Distal neurovascular status is intact.

Skin: Normal.

Neurological: Awake, alert, oriented x3 and cooperative. Sensory and motor functions appear intact.

Intervention: Initial plain films demonstrate posterior dislocation. IV and analgesia. After consent was obtained, patient was prepared for procedural sedation and reduction of hip dislocation. IV Midazolam, 2 mg, as well as 50 mcg of fentanyl was administered for moderate conscious sedation. Closed reduction of left hip was accomplished with axial traction in the flexed hip position x1 attempt. Patient tolerated procedure well. The independent observer (RN) was present and documented the moderate sedation template. Total moderate conscious sedation intraservice time was 35 minutes. On recovery from sedation, patient states that he feels significantly better. Distal neurovascular status remains intact.

Significant Diagnostic Findings:

Imaging: Initial plain films demonstrate posterior dislocation. Post reduction film well limited by single view, strongly suggests relocation. Reevaluation: NAD. Vital signs stable. Feels better. Patient has full range of motion of the left hip without pain; states that he feels significantly better.

Ortho Consult: This case was discussed with Dr. X. He agrees to outpatient follow up tomorrow.

Diagnosis: Hip dislocation.

1. In addition to the E/M code, what is the CPT® coding for this patient encounter?

   A. 27265, 99152, 99153
   B. 27266
   C. 27265
   D. 27232, 99156, 99157, 99157

2. Does the surgical first listed CPT® code require a modifier, and if so, which modifier?

   A. 25
   B. 54
   C. 57
   D. No modifier needed

CASE 2

HPI: A 61-year-old female with a complaint of postmenopausal vaginal bleeding for 2 days. C/O pelvic pain for 1 day. Mother had endometrial cancer. Patient states that she had this problem and was seen initially 3 years ago. Had biopsy and Pap. Pap negative, biopsy showed polyp. No dysuria, no fever, no nausea, or vomiting.

ROS:

Constitutional: Negative. Nausea: Negative.

Headache: Negative.

GI: Negative.

Respiratory: Negative. Vaginal Discharge: Negative.

Cardiovascular: Negative.

GU: Mild pelvic cramping, no vaginal discharge

PFSH:

Medical: HTN, DM Type 1.

Surgical: Cholecystectomy.

Family: DM-Father; Endometrial cancer-mother

Social: Alcohol: Denies. Tobacco: Uses tobacco products occasionally.

Drugs: Denies.

Physical Examination:

General Appearance: No acute distress.

Abdominal: Soft nontender.

External Genitalia: No rash. No lesions.

Vagina: No bleeding at this time. No Discharge.

Cervix: Speculum exam: Appears closed, no active bleeding, no tissue seen at OS.

Uterus: Normal.

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

HPI: A 59-year-old patient presents to the emergency department with hip pain and inability to bear weight. The patient reports that he was kneeling over his dog when he felt a pop and some pain in his left hip. The patient has had three previous episodes of hip dislocation. He denies any distal neurologic complaint. There was no other injury.

PFSH:

Surgical History: Bilateral hip replacements. [1]

Social History: Lives with family.

Physical Exam: Vital Signs: Reviewed nurse's notes.

Patient Status: Alert and cooperative.

Neck: FROM, nontender, no lymphadenopathy.

Lungs: Clear to auscultation and breath sounds equal, no wheezes, rales, or rhonchi.

Heart: Regular rate and rhythm without murmurs, ectopy, gallops, or rubs.

Abdomen: No tenderness; Normal bowel sounds.

Back: No costovertebral, paravertebral, intervertebral, or vertebral tenderness or spasm.

Extremities: Left lower extremity is medially rotated and mildly shortened. Distal neurovascular status is intact.

Skin: Normal.

Neurological: Awake, alert, oriented x3 and cooperative. Sensory and motor functions appear intact.

Intervention: Initial plain films demonstrate posterior dislocation. IV and analgesia. After consent was obtained, patient was prepared for procedural sedation [2] and reduction of hip dislocation. IV Midazolam, 2 mg, as well as 50 mcg of fentanyl was administered for moderate conscious sedation. [2] Closed reduction of left hip was accomplished with axial traction in the flexed hip position x1 attempt. [3] Patient tolerated procedure well. The independent observer (RN) was present and documented the moderate sedation template. Total moderate conscious sedation intraservice time was 35 minutes. [2] On recovery from sedation, patient states that he feels significantly better. Distal neurovascular status remains intact.

Significant Diagnostic Findings:

Imaging: Initial plain films demonstrate posterior dislocation. Post reduction film well limited by single view, strongly suggests relocation. Reevaluation: NAD. Vital signs stable. Feels better. Patient has full range of motion of the left hip without pain; states that he feels significantly better.

Ortho Consult: This case was discussed with Dr. X. He agrees to outpatient follow-up tomorrow.

Diagnosis: Hip dislocation.

[1] Indication of prior arthroplasty was performed on patient.

[2] Moderate conscious sedation.

[3] Successful reduction of the hip arthroplasty.

1. **Answer:** A. 27265, 99152, 99153

   Rationale: You should select the closed treatment of post hip arthroplasty dislocation as the patient has a history of prior hip replacements. The dislocation was successfully reduced through manual manipulation.

   When assigning moderate conscious sedation (MCS) codes, you need to determine who performs both the sedation and the procedure to ensure proper code selection. In this case, the ED provider performed the MCS as well as the dislocation reduction procedure. Therefore, report code 99152 for the initial 15 minutes and the add-on code 99153 for each additional 15 minutes. MCS should not be reported for fracture codes that specify the service as performed "with anesthesia."

2. **Answer:** B. 54

   Rationale: Modifier 54 is necessary as this procedure has a 90-day global period, and the patient will be having aftercare (postoperative management) by following up with orthopedics.

CASE 2

HPI: A 61-year-old female with a complaint of postmenopausal vaginal bleeding for 2 days.[1] C/O pelvic pain for 1 day. Mother had endometrial cancer. Patient states that she had this problem and was seen initially 3 years ago. Had biopsy and Pap. Pap negative, biopsy showed polyp. No dysuria, no fever, no nausea or vomiting.

ROS:

Constitutional: Negative. Nausea: Negative.

Headache: Negative.

GI: Negative.

Respiratory: Negative.

Cardiovascular: Negative.

GUy: Mild pelvic cramping, no vaginal discharge

PFSH:

Medical: HTN, DM Type 1.

Surgical: Cholecystectomy.

Family: DM-Father; Endometrial cancer-Mother

Social: Alcohol: Denies. Tobacco: Uses tobacco products occasionally.

Drugs: Denies.

Physical Examination:

General Appearance: No acute distress.

Abdominal: Soft nontender.

External Genitalia: No rash. No lesions.

Vagina: No bleeding at this time. No Discharge.

Cervix: Speculum exam: Appears closed, no active bleeding, no tissue seen at OS.

Uterus: Normal.

Adnexa: Bilateral, no tenderness.

Neurological: Alert and oriented x3.

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