AAPC

CEMC®

Certified Evaluation & Management Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CEMC®

EVALUATION AND MANAGEMENT

AAPC

Contents

2026 Specialty Study Guide: CEMC® Introduction

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

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CEMC® shows your expertise in evaluation and management coding. 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: CEMC®* 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 CEMC® 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. In addition to this study guide, you will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books. These are the books you will need for your CEMC® exam, as well.

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 show that diagnoses will play a larger role in future reimbursement. It is important to code correctly now, so that you can be prepared for that day.

We will discuss the major topics of diagnosis coding for evaluation and management. The examinee must become familiar with the Official Coding Guidelines for ICD-10-CM. The examinee must know how to select the appropriate ICD-10-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). The examinee must understand the conventions, general coding guidelines, and chapter specific guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume a lion's share of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices. The E/M material will focus on the E/M services 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 evaluation and management will be discussed in this section. Special attention will be 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 RVUs (Relative Value Units) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top 10 Missed Coding Concepts for the CEMC® certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC 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 evaluation and management. The practice exam mimics the format and structure of the CEMC® 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 CEMC® credential:

- CEMC® stands alone as a certification with no prerequisite that the examinee holds a CPC®, COC®, or CIC® credential.
- Exams aptly measure preparedness for real world coding by being entirely operative/physician-note based. These notes are redacted notes from real practices.

The CEMC® 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 Medicare covers the patient, 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
- Incident-to guidelines
- HIPAA regulations
- Split/Shared visits
- Proper use of ABN (Advance Beneficiary Notice)
- 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
  - Laboratory and Pathology
  - Radiology
  - Medicine
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the coding books is essential, as time is an important element in successfully completing the exam. 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: CEMC®* 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 CEMC® 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 in an effort to elevate the standards of medical coding by providing training, 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 be dedicated to providing 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.

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, with no "grace period" to transition to the changes.

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 instructions supplemental to that found in the Tabular List and the Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are used 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 (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. This includes information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

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. Generally speaking, 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 your 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," "consistent with," "compatible 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 diagnostic tests that have been 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 should confirm the order for the physician's reason(s) that the test was ordered.

When you are provided with both a preoperative and postoperative diagnosis, always report the *postoperative* diagnoses codes 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. In such a case, you may still report the shortness of breath as a sign and symptom with pneumonia because the physician has 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) based on the available documentation. For example, a torn meniscus (S83.2-) will become an internal derangement of knee (M23.-) after a defined period.

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 first-listed, with the chronic code 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 describes acute and chronic cholecystitis; two separate codes are not necessary to describe these concurrent conditions.

When selecting from among these codes, read all Includes, Excludes1 and Excludes2 notes to help guide your decision.

Evaluation and Management Coding for Certified E/M 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 correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CEMC™ 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 Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based 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 was 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.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation 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 the 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 back 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.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

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: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 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 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	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

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.

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 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 the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

Introduction

The HCPCS coding system was created in 1983 to translate written descriptions of procedures, services, and supplies into numeric and alphanumeric codes, to facilitate reporting and reimbursement. The HCPCS system has three levels. Level II and III codes are contained in what is commonly called "the HCPCS" code book. There are approximately 5,000 Level II codes, each of which has one alphabetic character followed by four digits. HCPCS contains both permanent national codes that are updated once per year and temporary national codes (which have an initial alphabetic character of Q or F) that are updated mid-year and again at the end of the year. The Level III codes—which are local, rather than national, codes—were mostly eliminated in 2003 with the implementation of HIPAA, which mandated a universal code set.

HCPCS Level I codes comprise the CPT® code book. Within CPT® itself, there are three code categories. The five-digit numeric Category I codes are the most familiar and make up the bulk of the CPT® code book. Category II codes, which contain four digits followed by "F," are supplemental tracking codes. Category III codes, which also contain four digits that are followed by "T," describe emerging technologies. Both Category II and Category III codes have become more extensive in recent years.

The HCPCS system also includes two-digit, numeric or alphabetic modifiers, which may be appended to all category I and category III codes. Some modifiers are merely informational, while others can directly affect reimbursement.

Modifiers

Modifier 22 *Increased Procedural Services*

Append modifier 22 to a procedure code when the provider describes the procedure being performed as "above and beyond" the work or circumstances that is normally required within the operative report and there is no other procedure code to describe the extensive services. This modifier is not appended to an E/M code.

Modifier 24 *Unrelated evaluation and management service by the same physician or other qualified healthcare professional during a postoperative period*

Apply this modifier when a patient presents with a new problem within the global period of a procedure. A different diagnosis is necessary to indicate that the E/M service within the global period is not related to procedure. Non-Medicare payers may accept this modifier for a patient visit due to complications from the previous procedure.

Modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service*

This modifier is one of the most commonly used in a primary care setting and is among the most frequently audited modifiers. Modifier 25 does not require a separate diagnosis for the E/M service and the same-day procedure, but the documentation must support the significance and separate work involved in the E/M service. Such a separate service should meet all the audit criteria applied to any other independent E/M service. The provider work dedicated to the E/M service must go beyond what is normally provided with the same-day procedure. Modifier 25 is appended to the E/M code when a significant and separately identifiable E/M service is performed on the same date as a minor procedure (000–010 global days) and other services (xxx global days). The assigned global days can be found in the Physician Fee Schedule Relative Value File at https://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html

Modifier 26 *Professional Service*

This modifier is used to report the physician portion of a radiologic or other diagnostic service that includes both a technical and professional component. Specifically, modifier 26 describes the provider's interpretation and report: This must be a physician interpretation, not merely computerized results. The interpretation and report may be part of the final report but must be documented.

The technical portion of a radiologic or other diagnostic service that includes both a technical and professional component is reported by appending modifier TC *Technical component* to the appropriate CPT® code. Normally, this service accounts for about two-thirds of the total reimbursement for the service, and covers the cost of the technician's work, equipment, supplies, etc.

Modifier 51 *Multiple Procedures*

Modifier 51 is a procedure modifier not applicable to E/M services. Some payers require that you append modifier 51 to the code(s) that describe the second and subsequent same-day

procedures, which are reimbursed at a reduced rate. You should never append modifier 51 to add-on codes (those codes indicated in the CPT® code book with a "+"). Many payers no longer require modifier 51 under any circumstances because payment software can recognize and value multiple, same-day procedures automatically. If your payer does not mandate the use of modifier 51, do not apply it.

Modifier 57 *Decision for Surgery*

Modifier 57 is appended to the E/M service where the decision to perform a major surgery is made on the day of surgery or the day before surgery. This modifier is appended to the E/M code, not the surgical code. Do not append modifier 57 when the E/M is performed on the day of a minor surgery. The more appropriate modifier is 25 if the documentation supports a separately identifiable E/M and a minor procedure.

Modifier 59 *Distinct procedural service*

Append this modifier to identify a procedure that would not normally be reported as separate from another, same-day procedure, but is separate and distinct in the instance. The distinct procedure may occur in a separate site or incision, a different lesion, etc. For example, during colonoscopy, the physician may encounter multiple lesions that require removal by different techniques. You would not report removal by more than one technique for a single lesion, but in this case, there are separate lesions.

CMS instructs that modifier 59 should be used only when a more precise modifier does not apply: Modifier 59 is the "modifier of last resort." Because modifier 59 allows for unbundling, be very careful that the available documentation supports use of the modifier. When NCCI edits apply and allow for a modifier, CMS allows modifier 59 to be appended to a column 1 or column 2 code in the NCCI edits. For the study guide and certification exam, modifier 59 is appended to the column 2 code.

The Global Surgical Package

The "Surgery Guidelines" within the CPT® code book lists those services that CPT® includes in the global surgical package, such as one pre-procedure E/M service on the day of, or day before, the procedure, local anesthesia, and immediate and typical postoperative care. Medicare's list of items included in the global package is more extensive. For example, under CPT® rules, a physician may report an E/M service with modifier 24 when seeing a patient for a complication during the postoperative period. Under CMS guidelines, a visit for any complication during the global period is bundled into the global surgical package.

CPT® does not specify the length of the postoperative period for any individual procedure, whereas CMS defines very precisely—in the Physician Fee Schedule Relative Value File, which is updated annually—the number of postoperative days assigned to each code. Minor surgeries are assigned 000–010 global days. Major surgeries are assigned 090 global days.

Because the CPT® code book and CMS define the components of the global surgical package differently, and third-party payer guidelines are inconsistent, you should check with your individual payer to determine its rules for the global surgical package.

CPT® Coding for Services and Procedures

Skin Tag Removal

When assigning a CPT® code for removal of skin or fibrocutaneous tags, consider the total number of lesions removed.

- 11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
- +11201 Removal of skin tags, multiple fibrocutaneous tags, any area; each additional 10 lesions, or part there of (List separately in addition to code for primary procedure)

Note that add-on code 11201 applies for each additional 10 lesions or part thereof. If the provider removes 16 lesions, you will report 11200 and 11201. If the provider removed 25 lesions, however, you would still report 11200, 11201.

Lesion Removal

When coding the removal of lesions by excision, the code is selected based on the location of the lesion (for example, neck, face, back) and the type of lesion (for example, malignant or benign). Excision lesion codes are in code range 11400-11646 and defined in the CPT® guidelines as full thickness removal of a lesion of the skin. Each lesion removed is reported separately. For excision of benign or malignant lesions requiring intermediate or complex closures, report separately the appropriate repair closure code. For a benign or malignant lesion excision performed with an adjacent tissue transfer, only report the adjacent tissue transfer code.

Wound Repair

Wound repair codes describe separately reportable or stand-alone services. Note that wound repair is generally included in more extensive procedures. There are three categories of repairs:

- Simple repairs (12001–12021) Includes local anesthesia, and chemical or electrocauterization. Closure with

Top 10 Missed Coding Concepts on CEMC® Examination

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

1. **Split/Shared Visits:** A shared/split visit occurs when an NPP and physician are involved in the same patient case. Per CMS Shared/split visits do not apply in the office setting, only in a facility setting. If performed in the office setting, use incident-to requirements. In the facility setting, if the physician and NPP in the same group performs a face-to-face encounter, the service is billed by either physician or the NPP depending on which one performs the substantive portion (more than half) of the visit.

2. **Teaching Physician Guidelines:** There are two modifiers appropriate for services that involve residents billed by teaching physicians. Modifier GC is reported to identify a resident that is directly involved with the care of the patient. The teaching physician must perform a face-to-face encounter and document the review of the resident's care. The documentation from the resident and the teaching physician are combined to determine the correct E/M code, and modifier GC is appended. If the teaching physician does not perform a face-to-face encounter, the service cannot be coded.

3. **HIPAA Privacy Rule:** Be aware how HIPAA regulations relate to business associates' agreements. When a business associate agreement is signed by a physician practice and an outside audit company, all the employees of the audit company who are authorized, can access the protected health information (PHI) the physician's office provides for review. The audit company must follow all the HIPAA regulations.

4. **Proper ICD-10-CM code selection for follow-up exam:** Follow-up Z code categories Z08, Z09, and Z39 are reported when the condition has been fully treated and no longer exists. When the main reason for an encounter is a follow-up exam with no further treatment for the condition, report the follow-up Z code as the first listed code.

5. **Incident-to Guidelines:** This service is performed by midlevel providers known as NPPs (Non physician Practitioners) which are PAs (Physician Assistants), ARNPs (Advanced Registered Nurse Practitioners) and certified nurse midwives and the service is billed under the physician's national provider identifier (NPI) number,

Incident-to is reported:

- The result of a treatment plan implemented by a physician for an ongoing issue that the patient has previously consulted the physician for. For instance, it could be a follow-up on a diabetes case where the physician has already established a treatment course for the patient.
- That the physician is in the office suite providing supervision (physician does not need to be in the room but must be in the office to bill the services incident-to).

Incident-to is NOT reported:

- If the physician was out of the office seeing patients at the hospital, the services could not be billed because the physician is not providing supervision.
- Incident-to is not recognized in a facility setting.
- If the patient presents with a new problem, it will not fall under the physician's existing treatment plan as it is the first instance of this problem. In such cases, the service would be billed by the Non-Physician Practitioner (NPP).

6. **AMA E/M Guidelines in Selecting the Level for the Risk of Complications and/or Morbidity or Mortality of Patient Management:** Risk is assessed according to the physician's judgment of the patient's likelihood of becoming ill, developing complications, or experiencing mortality between the current visit and the next scheduled encounter. The E/M guidelines clarify that the risk associated with patient management is separate from the inherent risk of the medical condition itself. The level of risk is determined by the provider's management decisions made during the encounter.

7. **AMA E/M Guidelines in Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** For Amount and/or Complexity of Data, whether a test counts toward data depends on whether the test is separately reportable. Ordering, performing, or interpreting diagnostic tests during the encounter does not count toward the E/M data element when the physician separately bills for the test's professional interpretation with a CPT® code. When a provider orders a test that includes a separate interpretation (X-ray, ECG) and it is performed in the office it is presumed that the provider will bill for the test and therefore ordering of a unique test is not counted. Tests that do not require

separate interpretation (such as lab tests that are results only – e.g. rapid strep test) can be counted as ordered or reviewed when they are analyzed as part of the MDM. During a follow-up visit, review of test results ordered at a prior encounter is not counted, because the review was already included with the original order.

8. **Consultation rules according to CPT® and CMS**: A consultation service is performed to provide recommendations for a specific condition or to determine whether the consulting provider will assume responsibility for the patient's ongoing care, either for the entire case or for a particular problem. Under CPT® guidelines, a consultation requires three components: a request from a physician or qualified source, documentation of that request, and a written report sent back to the requesting provider. If any of these elements is missing—such as the absence of a written report— the service cannot be billed as a consultation. CMS no longer reimburses consultation codes, so when documentation indicates the patient is covered by Medicare, office/outpatient E/M codes or hospital care codes must be used instead. Do not assume Medicare coverage based solely on patient age; on the exam, Medicare status will be clearly stated in the case note or question.

9. **Reporting radiology tests performed in the office:** Modifier 26 is appended to report the professional component of a radiologic or other diagnostic service when both a technical and professional component exist. This modifier reflects the provider's interpretation and report, which must be documented and cannot consist solely of computerized findings. Modifier 26 is used when the test is performed at a facility, and the provider is responsible only for interpreting the test. The technical component is reported by appending modifier TC to indicate that the facility supplied and owned the equipment used. When both the technical and professional components are performed in the provider's office the radiology code is reported without a modifier. Documentation must include the ordering diagnosis and the number of views obtained.

10. **AMA E/M Guidelines for Selecting the Level in Number and Complexity of Problems Addressed at the Encounter:** A self-limited or minor problem is a short-term problem expected to resolve with minimal treatment and not expected to affect long-term health.

    Examples:

    - Sore throat / pharyngitis
    - Uncomplicated viral URI ("common cold")
    - Bug bite with mild localized reaction

    When a patient presents with one self-limited/minor problem the level of MDM is straightforward. When a patient has two self-limited/minor problems the level of the MDM is low.

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

CC: Cough, runny nose, fever.

HPI: 15-year-old Friday at home and started developing a productive cough; felt tired and had a clear runny nose. Saturday was feeling much worse. States he laid on the couch all day long, was running fevers on and off. Complains that he would cough so hard his chest would hurt, felt wheezes, and had a fever of 101°F. Felt slightly better yesterday and today, but still has an ongoing cough and feeling of wheezing. Denies gastric problems. All other systems reviewed and are normal. Taking NyQuil prn.

ALLERGIES: NKDA

0: HT 69. WT 171. T 97.3. P 95. 02 sat 97%.

PE:

GENERAL: 15-year-old, age appropriate, appears in no acute distress. A&O x 3. INTEGUMENT: Skin: Pink, warm, dry, and intact. Brisk capillary refill. HEAD: Normocephalic, EARS: TMs: Gray, translucent; light reflex and bony landmarks present bilaterally. External canals normal to examination, NOSE/SINUS: No flaring of nares. Septum: Midline and patent bilaterally. Mucosa: Pink and moist. Clear discharge from the nose, but no sinus tenderness noted to palpation. THROAT/MOUTH: Buccal mucosa: Pink and moist. No lesions. Teeth: Good repair. Tongue: Midline without fibrillation. Uvula: Midline with elevation of soft palate. Gag reflex: Intact. Pharynx: Slightly erythematous. 2+ swelling with postnasal drip noted. Gums: Pink and intact. NECK: Supple without lymphadenopathy. CHEST/LUNGS: Scattered wheezing bilaterally. No rales or rhonchi. No accessory muscle use or retracting. HEART: RRR without murmur, rub, or gallop. ABDOMEN: Soft, nontender, no masses. LAB DATA: Rapid flu screen performed and negative. Rapid strep screen performed and negative. Spent an extended time with this patient. Several minutes longer than usual due to answering questions about how this should impact his football practice.

A:

1. Wheezing.
2. Upper respiratory infection.

P:

1. Given Xopenex 1.25 mg nebulizer treatment here, post treatment 02 sat remains at 97%, pulse 105, but wheezing has resolved.
2. Will write for Prednisone 10 mg, 3 tabs po q day x 3 days, 2 tabs po q day x 2 days, 1 tab po q day x 2 days and then stop.
3. Wrote for Albuterol HFA inhaler, 2 puffs every 46 hours prn for wheezing, 1 inhaler, 3 refills.

4. Also wrote for Cefzil 500 mg, 1 tablet b.i.d. for 10 days.
5. Obviously if severe shortness of breath occurs or high fever, go immediately to the Emergency Room for further evaluation. They are agreeable with the plan currently.
6. No school today, may return tomorrow.

Billing Information: This physician labeled his documentation with complete DOS, patient, and signature requirements met. This patient is established with this physician office. He billed a commercial payer 99214. The payer follows Medicare billing rules. AAPC does not ask a coder to make any final determination based on medical necessity. Decisions about what constitutes a medically necessary service should be made only by a practicing physician peer. Please code this service based solely on the documentation using the same rules and logics that are defined by the AMA CPT® E/M guidelines and CPT® code instructions, as applicable to the type of service.

1. The level of service for this encounter is:
   - A. 99211
   - B. 99212
   - C. 99213
   - D. 99214
   - E. 99215

2. The primary diagnosis of this encounter is:
   - A. J06.9
   - B. J98.8
   - C. J22
   - D. J06.9, R06.2

3. How is the extra time coded in this visit?
   - A. 99213, 99417
   - B. 99214-22
   - C. 99215, 99417
   - D. There is no additional service documented

CASE 2

Patient/AGE: XXXX/10-year-old. DOS: 12/23/XX

CC: Patient complains of fever, sore throat, and headache

Temperature, sore throat. Headache, congested, "bad" cough x 5 days, worse at night. Meds: Wellbutrin, Phenergan DM. Denies other respiratory or neurologic complaint.

Physical Exam: Head/Eyes/Ears/Nose/Throat: Exudative tonsillitis, Heart: Normal, Lungs: Clear, Abdomen: Negative, Neuro: Normal, Skin: Normal

Rapid throat culture ordered—if negative, then CBC, possible mono

Version B

CASE 1

CC: Cough, runny nose, fever.

HPI: 15-year-old Friday at home and started developing a productive cough; felt tired and had a clear runny nose. Saturday was feeling much worse. States he laid on the couch all day long, was running fevers on and off. Complains that he would cough so hard his chest would hurt, felt wheezes, and had a fever of 101°F. Felt slightly better yesterday and today, but still has an ongoing cough and feeling of wheezing. Denies gastric problems. All other systems reviewed and are normal. Taking NyQuil prn.

ALLERGIES: NKDA

0: HT 69. WT 171. T 97.3. P 95. 02 sat 97%.

PE:

GENERAL: 15-year-old, age appropriate, appears in no acute distress. A&O x 3. INTEGUMENT: Skin: Pink, warm, dry, and intact. Brisk capillary refill. HEAD: Normocephalic, EARS: TMs: Gray, translucent; light reflex and bony landmarks present bilaterally. External canals normal to examination, NOSE/SINUS: No flaring of nares. Septum: Midline and patent bilaterally. Mucosa: Pink and moist. Clear discharge from the nose, but no sinus tenderness noted to palpation. THROAT/MOUTH: Buccal mucosa: Pink and moist. No lesions. Teeth: Good repair. Tongue: Midline without fibrillation. Uvula: Midline with elevation of soft palate. Gag reflex: Intact. Pharynx: Slightly erythematous. 2+ swelling with postnasal drip noted. Gums: Pink and intact. NECK: Supple without lymphadenopathy. CHEST/LUNGS: Scattered wheezing bilaterally. No rales or rhonchi. No accessory muscle use or retracting. HEART: RRR without murmur, rub, or gallop. ABDOMEN: Soft, nontender, no masses. LAB DATA: Rapid flu screen performed and negative. Rapid strep screen performed and negative. Spent an extended time with this patient. Several minutes longer than usual due to answering questions about how this should impact his football practice.

A:

1. Wheezing.
2. Upper respiratory infection.

P:

1. Given Xopenex 1.25 mg nebulizer treatment here, post treatment 02 sat remains at 97%, pulse 105, but wheezing has resolved.
2. Will write for Prednisone 10 mg, 3 tabs po q day x 3 days, 2 tabs po q day x 2 days, 1 tab po q day x 2 days and then stop.
3. Wrote for Albuterol HFA inhaler, 2 puffs every 46 hours prn for wheezing, 1 inhaler, 3 refills.
4. Also wrote for Cefzil 500 mg, 1 tablet b.i.d. for 10 days.
5. Obviously if severe shortness of breath occurs or high fever, go immediately to the Emergency Room for further evaluation. They are agreeable with the plan currently.
6. No school today, may return tomorrow.

Billing Information: This physician labeled his documentation with complete DOS, patient, and signature requirements met. This patient is established with this physician office. He billed a commercial payer 99214. The payer follows Medicare billing rules. AAPC does not ask a coder to make any final determination based on medical necessity. Decisions about what constitutes a medically necessary service should be made only by a practicing physician peer. Please code this service based solely on the documentation using the same rules and logics that are defined by the AMA CPT® E/M guidelines and CPT® code instructions, as applicable to the type of service.

1. The level of service for this encounter is:

   A. 99211
   B. 99212
   C. 99213
   D. 99214
   E. 99215

2. The primary diagnosis of this encounter is:

   A. J06.9
   B. J98.8
   C. J22
   D. J06.9, R06.2

3. How is the extra time coded in this visit?

   A. 99213, 99417
   B. 99214-22
   C. 99215, 99417
   D. There is no additional service documented

CASE 2

Patient/AGE: XXXX/10-year-old. DOS: 12/23/XX

CC: Patient complains of fever, sore throat, and headache

Temperature, sore throat. Headache, congested, "bad" cough x 5 days, worse at night. Meds: Wellbutrin, Phenergan DM. Denies other respiratory or neurologic complaint.

Physical Exam: Head/Eyes/Ears/Nose/Throat: Exudative tonsillitis, Heart: Normal, Lungs: Clear, Abdomen: Negative, Neuro: Normal, Skin: Normal

Rapid throat culture ordered—if negative, then CBC, possible mono

Rapid throat culture: Positive

Impression: Strep pharyngitis. Penicillin VK 250 mg PO qid

Billing Information: This physician labeled his documentation with complete DOS, patient, and signature requirements met. He has seen this patient before. He billed a commercial payer a 99213 for this service. The payer uses the same rules for preventive medicine reporting as does Medicare. AAPC does not ask a coder to make any final determination based on medical necessity. Decisions about what constitutes a medically necessary service should be made only by a practicing physician peer. Please code this service based solely on the documentation using the same rules and logics that are defined by the AMA CPT® E/M guidelines and CPT® code instructions, as applicable to the type of service.

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

CASE 1

CC: Cough, runny nose, fever. [1]

HPI: 15-year-old Friday was at home and started developing a productive cough; felt tired and had a clear runny nose. Saturday was feeling much worse. States he laid on the couch all day long, was running fever on and off. Complains that he would cough so hard his chest would hurt, felt wheezes, and had a fever of 101°F. Felt slightly better yesterday and today, but still has an ongoing cough and feeling of wheezing. Denies gastric problems. All other systems reviewed and are normal. Taking NyQuil prn.

ALLERGIES: NKDA

O: HT 69. WT 171. T 97.3. P 95. 02 sat 97%.

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GENERAL: 15-year-old, age appropriate, appears in no acute distress. A&O x 3. INTEGUMENT: Skin: Pink, warm, dry, and intact. Brisk capillary refill. HEAD: Normocephalic, EARS: TMs: Gray, translucent; light reflex and bony landmarks present bilaterally. External canals normal to examination, NOSE/SINUS: No flaring of nares. Septum: Midline and patent bilaterally. Mucosa: Pink and moist. Clear discharge from the nose, but no sinus tenderness noted to palpation. THROAT/MOUTH: Buccal mucosa: Pink and moist. No lesions. Teeth: Good repair. Tongue: Midline without fibrillation. Uvula: Midline with elevation of soft palate. Gag reflex: Intact. Pharynx: Slightly erythematous. 2+ swelling with postnasal drip noted. Gums: Pink and intact. NECK: Supple without lymphadenopathy. CHEST/LUNGS: Scattered wheezing bilaterally. No rales or rhonchi. No accessory muscle use or retracting. HEART: RRR without murmur, rub, or gallop. ABDOMEN: Soft, nontender, no masses. LAB DATA: Rapid flu screen performed and negative. Rapid strep screen performed and negative. [2] Spent an extended time with this patient. Several minutes longer than usual due to answering questions about how this should impact his football practice.

A:

1. Wheezing.
2. Upper respiratory infection. [3]

P:

1. Given Xopenex 1.25 mg nebulizer treatment here, [4] post treatment 02 sat remains at 97%, pulse 105, but wheezing has resolved.
2. Will write for Prednisone 10 mg, 3 tabs po q day x 3 days, 2 tabs po q day x 2 days, 1 tab po q day x 2 days and then stop. [5]
3. Wrote for Albuterol HFA inhaler, 2 puffs every 46 hours prn for wheezing, 1 inhaler, 3 refills.
4. Also wrote for Cefzil 500 mg, 1 tablet b.i.d. for 10 days. [6]
5. If severe shortness of breath occurs or high fever, go immediately to the Emergency Room for further evaluation. They are agreeable with the plan currently.
6. No school today, may return tomorrow.

Billing Information: This physician labeled his documentation with complete DOS, patient, and signature requirements met. This patient is established with this physician office. He billed a commercial payer 99214. The payer follows Medicare billing rules. AAPC does not ask a coder to make any final determination based on medical necessity. Decisions about what constitutes a medically necessary service should be made only by a practicing physician peer. Please code this service based solely on the documentation using the same rules and logics that are defined by the AMA CPT® E/M guidelines and CPT® code instructions, as applicable to the type of service.

[1] Chief Complaint.

[2] Data: Two point of care (POC) labs performed in office.

[3] Primary Diagnosis.

[4] MDM: Nebulizer treatment given in office.

[5] MDM: Prescription drug management.

[6] MDM: Prescription drug management.

1. **Answer:** C. 99213

   Rationale: This is an established patient. According to the AMA CPT® E/M Guidelines, the overall MDM is low, based on the following elements:

   Number and complexity of problems addressed at the encounter: Low – This is an acute, uncomplicated illness or injury.

   Amount and/or complexity of data to be reviewed and analyzed: Limited – POC labs are considered in the MDM even if billed by the provider. Rapid tests are considered POC tests.

   Risk of complication and/or morbidity or mortality: Moderate – Prescription drug management.

2. **Answer:** A. J06.9

   Rationale: The patient has wheezing and a URI, which typically occurs together when the patient has lung impairment, like asthma. Wheezing is not a choice here, but upper respiratory infection is. Look in the ICD-10-CM Alphabetic Index for Infection/respiratory (tract)/upper NOS referring you to J06.9. Remember, the sequencing that a physician does on his documentation of diagnoses is not necessarily the sequencing that is done in ICD-10-CM coding.

3. **Answer:** D. There is no additional service documented

   Rationale: The physician documents, "Several minutes longer than usual due to answering questions about how this should impact his football practice." Without the total time spent documented, it is inappropriate to code for a prolonged service (99417) or select the E/M code based on time. To use time as the criteria for selecting an E/M level, the provider must document the total time spent in patient care on the date of the encounter.

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