CPMS®

Certified Professional Medical Scribe

STUDY GUIDE

2025

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Introduction

AAPC would like to introduce the Medical Scribe Training: CPMS®. This material was developed to help future healthcare professionals expand their knowledge base, learn a new skill set, and prepare for the Certified Professional Medical Scribe (CPMS®) examination.

AAPC has prepared a program of study aimed at providing the most up-to-date information relating to medical record standards, documentation guidelines, regulatory compliance, and foundations of the revenue cycle.

The Business of Medicine

The business of medicine is highly complex, ever changing, and tightly regulated. Healthcare providers are subject to a myriad of guidelines and requirements, as implemented by insurers and government agencies. These rules cover a wide range of issues, from how providers must handle medical records, to the documented diagnoses or clinical indications a patient must demonstrate if an insurer is to pay for a procedure.

Until the 1940s, healthcare insurance was not commonplace for Americans. During World War II, the Stabilization Act (1942) placed wage and price controls on employers. Congress limited the wages that could be offered but allowed the adoption of employee insurance plans. The 1954 Internal Revenue Code exempted employer contributions to employee health plans from employee taxable income, making health insurance even more appealing.

President Lyndon B. Johnson signed Medicare into law on July 30, 1965 under title XVIII of the Social Security Act. Beneficiaries could sign up for the program on July 1, 1966. U.S. citizens were automatically enrolled in Part A Medicare (which covers hospital stays) at age 65, and had an option to enroll in Part B Medicare, which covers physician services.

The Nixon Administration proposed the Health Maintenance Organization Act of 1973 (P. L. 93–222) to help to control healthcare costs. It authorized $375 million to assist in establishing and expanding health maintenance organizations (HMOs). The act also overrode state laws that prohibited the establishment of prepaid health plans and required employers with 25 or more employees to offer an HMO option if they furnished healthcare coverage to employees. According to the Rand Corporation, HMO enrollment increased from 3 million in 1970 to over 80 million in 1999 (a 12 percent increase, every year).

Preferred Provider Organizations (PPOs) emerged next. A PPO fits within the framework of managed care health insurance. PPOs create a network of doctors, hospitals, and other healthcare providers, and negotiate predetermined fees with a given carrier. PPOs offer members more options, in that members do not have to maintain a primary care physician. A PPO does not require referrals.

The addition of these and other, novel health plans has led to a high level of complexity. Hospitals, clinics, and private physicians' practices must contend with many issues to stay in business. This has led to a greater number of medical professionals with the skill sets necessary to keep the business side of medicine running smoothly.

Medical scribes contribute on the front lines of clinical action to keep things running smoothly. They assist providers in creating medical records and ensure documentation requirements are met in real time. Scribes ease the administrative burden placed on providers, which facilitates better, more efficient patient care.

Scribes in Practice

Patients become frustrated and feel unheard when a physician interacts with a tablet or laptop screen instead of speaking with them directly. This creates patient dissatisfaction which can sometimes lead to diminshed outcomes. Medical scribes intervene to help solve this issue while taking significant paperwork stress off the clinician. Scribes are most effective when they:

- Know, stay current on, and practice established documentation standards and guidelines
- Educate providers on documentation standards and guidelines
- Ensure all services provided are supported by the documentation they create
- Communicate with clinical and billing and coding staff continuously to clarify expectations and solve issues

This course provides the foundational information and concepts for prospective scribes to be successful in passing the CPMS® exam and beginning their career. We go beyond "typing what the Dr. says" to focus on topics essential to understanding medical necessity and the regulations that apply to medical

records and the revenue cycle. Here are the topics we will cover in this training:

- **Healthcare fundamentals of medical terminology, anatomy, and pathophysiology:** To work in healthcare, you must speak the language. As a scribe, you'll be required to hear, understand, and reproduce the clinical language spoken by the physician when you're creating records. Medical terminology gives you basic terms, anatomy provides direction and orientation, and pathophysiology introduces you to some diseases commonly seen in medical practice.
- **Communication:** Communicating with physicians can be intimidating. Getting to know how your providers can most benefit from your help is a critical first step. Good communication with providers is indispensable as a scribe, but don't underestimate the value of communication with the rest of the staff, particularly coders and billers.
- **Compliance:** Healthcare is heavily regulated. Medical records, the ones you'll create as a scribe, have their own content, access, and use requirements. Learn these regulations and how to be compliant and you'll be an asset to your employer.
- **Documentation:** Medical records come in many forms. This chapter includes a survey of medical record types and their content. Documentation for office visits and the structure of evaluation and management services are highlighted and repeated in multiple learning modalities in this chapter because this type of work is the majority of a scribe's workday.
- **Quality measures:** Online reviews of healthcare providers are becoming increasingly significant for patients and for third-party payers. Medicare providers are assigned star ratings based on their patient outcomes, and Medicare is not the only ratings system. Ratings are calculated from predetermined indicators of quality care related to specified diseases, called quality measures. Scribes need to be aware of quality measures to be able to document related clinical information appropriately.
- **Coding and Billing:** Scribes create a work product that moves on to have its content scrutinized and a monetary value assigned. Coders won't hesitate to tell you, "If it's not documented, it didn't happen." Their job relies on your documentation. Scribes need to know why they document the way they do and what happens when the record is complete. In this chapter, the revenue cycle is examined, and coding and billing are explained.
- **Safety:** Healthcare workplace safety and its related regulations are discussed in this chapter.

This training was developed to provide the necessary knowledge to prepare the student to take the CPMS® exam and for a career as a professional medical scribe. The course curriculum is presented in chapter format. The curriculum also includes chapter review questions to enhance comprehension of the material covered.

Chapter 1

Medical Terminology and Anatomy Review

Introduction

A thorough knowledge of human anatomy is essential to succeed as a medical scribe, as is the ability to understand medical terminology used to de-scribe and document medical procedures and services. This chapter is not a comprehensive overview of anatomy and medical terms. Rather, it introduces the basic elements of human anatomy and reviews medical vocabulary and terminology.

Medical Terminology

The best way to learn medical terminology is understanding word parts and elements of medical language — root words, prefixes, and suffixes — which serve as the foundation of our medical vocabulary.

Root

The core of any medical term is known as the root or base word. This root stands alone as the primary component of the term. It can be accompanied by a prefix, suffix, or a combining vowel. The root carries the essential meaning of the medical term, and every medical term has at least one root. It's possible for a word to have multiple roots, and a single root can convey different meanings depending on the body system it's referring to.

Root words in medical terminology often use combining vowels to connect the root word with a suffix, or to link two root words together. The most common combining vowels are O and I.

EXAMPLE

Combining vowel between root word and suffix:
Cystoscopy (cyst/o/scopy)

Combining vowel between multiple root words:
Uvulopalatopharyngoplasty (uvul/o/palat/o/pharyng/o/plasty)

Combining vowel between two root words with second root word starting with a vowel:
Gastroenterology (gastr/o/enter/o/logy)

Combining forms are root words with a combining vowel.

Common root words and their combining forms associated with the body systems include:

Integume ntary System

Term	Definition
Derm/o	Skin
Melan/o	Dark, black, melanin
Onych/o	Nail
Trich/o	Hair

Example: Dermabrasion — abrasive treatment to the skin

Musculoskeletal System

Term	Definition
Arthr/o	Joint
Chondr/o	Cartilage
Muscul/o	Muscle
Myel/o	Bone marrow, spinal cord
Oste/o	Bone
Ten/o, tendin/o	Tendon

Example: Osteomyelitis — bone inflammation

Respiratory System

Term	Definition
Bronch/o	Bronchus
Pharyng/o	Pharynx
Pneumon/o	Lung
Pulm/o, pulmon/o	Lungs
Rhin/o	Nose
Trache/o	Trachea

Example: Nasopharyngitis — inflamed nasal and pharyngeal passages, generally from common cold

Cardiovascular System

Term	Definition
Arter/o, arteri/o	Artery
Atri/o	Atrium
Cardi/o	Heart
Phleb/o	Vein
Ven/o, ven/i	Vein
Ventricul/o	Cavity, ventricle

Example: Atrioventricular — referring to chambers of the heart; atria and ventricles

Hemic and Lymphatic Systems

Term	Definition
Hem/o, hemat/o	Blood
Leuk/o, leukocyt/o	White blood cell
Lymphaden/o	Lymph node
Splen/o	Spleen
Thromb/o	Blood clot
Tonsil/o	Tonsil

Example: Thrombocytopenia — blood platelet deficiency

Digestive System

Term	Definition
Bucc/o	Cheek
Cholecyst/o	Gallbladder
Enter/o	Intestine
Gastr/o	Stomach
Gloss/o	Tongue
Hepat/o	Liver
Sial/o	Saliva, salivary gland, salivary duct
Proct/o	Rectum and anus

Example: Hepatosplenomegaly — enlarged liver and spleen

Urinary System

Term	Definition
Cyst/o	Urinary bladder
Nephr/o	Kidney
Pyel/o	Renal pelvis
Ureter/o	Ureter
Urethr/o	Urethra
Urin/o	Urine

Example: Pyelotomy — incision of the renal pelvis

Male Reproductive System

Term	Definition
Epididym/o	Epididymis
Orchi/o, orchid/o	Testis
Prostat/o	Prostate
Test/o	Testis, testicle

Example: Orchiectomy — removal of testicle(s)

Female Reproductive System

Term	Definition
Colp/o	Vagina
Hyster/o	Uterus
Mast/o	Breast, mammary gland
Men/o, mens	Menstruation
Oophor/o	Ovary
Salping/o	Oviduct, tube

Example: Salpingo-oophoritis — inflamed ovaries and oviducts (uterine tubes, fallopian tubes)

Endocrine System

Term	Definition
Adren/o, adrenal/o	Adrenal gland, epinephrine
Endocrin/o	Endocrine glands or system
Pituitar/o	Pituitary gland, hypophysis
Thyr/o, thyroid/o	Thyroid gland

Example: Thyroidectomy — removal of thyroid gland tissue

Nervous System

Term	Definition
Cerebr/o	Cerebrum
Encephal/o	Brain
Mening/o, meninge/o	Meninges
Myel/o	Spinal cord and bone marrow
Psych/o	Mind
Radicul/o	Spinal nerve root

Example: Myelography — diagnostic imaging study on the nerves in and around the spinal canal

Special Senses

Term	Definition
Blephar/o	Eyelid
Corne/o	Cornea
Dacryocyst/o	Lacrimal sac
Myring/o	Tympanic membrane
Retin/o	Retina
Tympan/o	Tympanic cavity (middle ear), tympanic membrane

Example: Myringitis — inflamed tympanic membrane (ear drum)

For radiological studies, the body is often cut along a flat surface called a plane. Frequently used planes include:

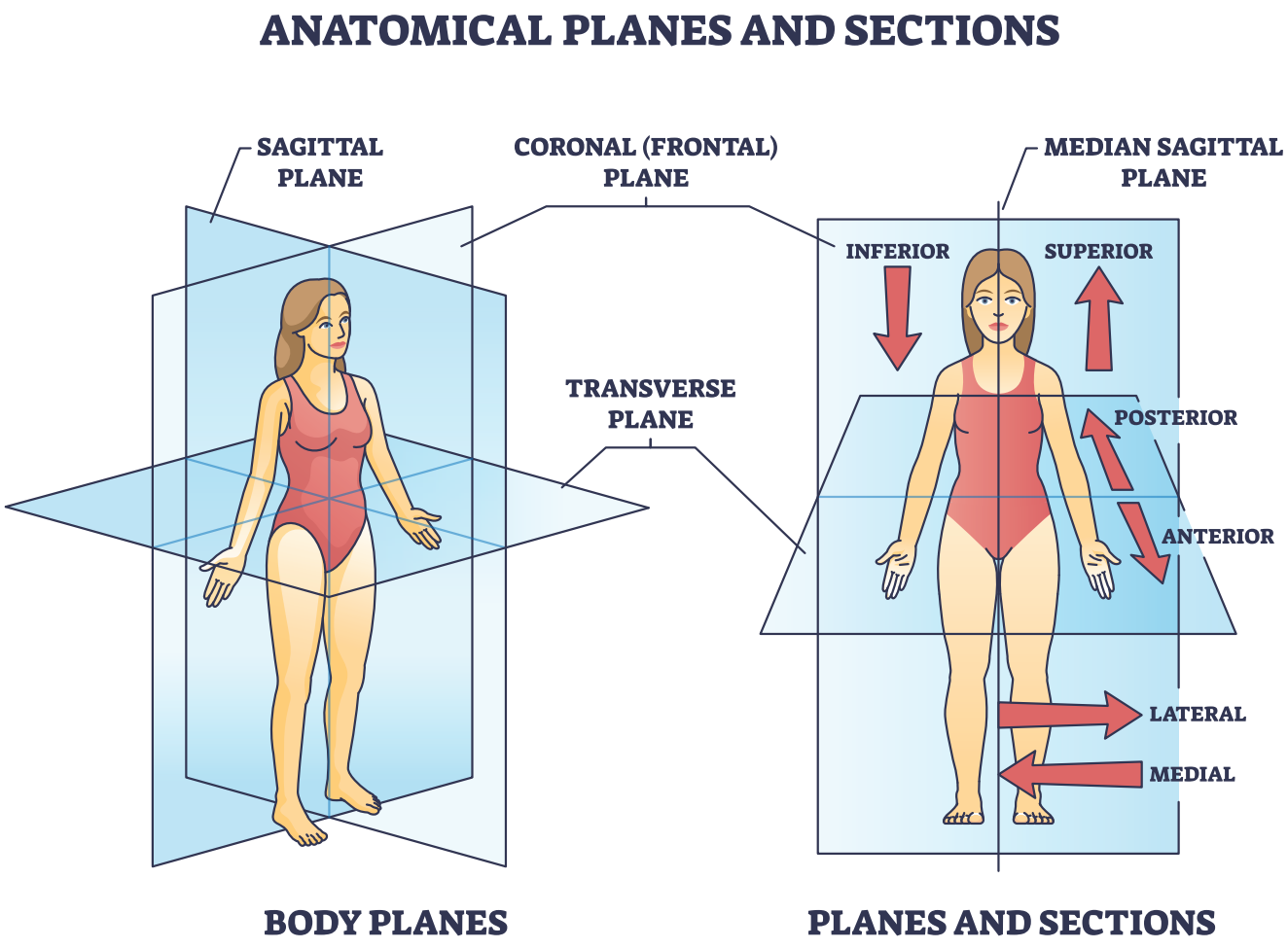
Sagittal—Cuts through the body from front to back and divides the body into right and left sections

Midsagittal—Cuts through the midline of the body from front to back and divides the body into equal right and left sections

Frontal (coronal)—Cuts at a right angle to the midline, from side to side, and divides the body into front (anterior) and back (posterior) sections

Transverse (horizontal) (axial)—Cuts horizontally through the body and separates the body into upper (superior) and lower (inferior) sections

Body Planes



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Structure of the Human Body

The structure of the human body is divided into four categories:

- Cells
- Tissues
- Organs
- Systems

Each structure is a highly organized unit of smaller structures.

Cells

The cell is the basic unit of all living things. Human anatomy is composed of cells varying in size and shape according to function:

- Cell membrane forms the boundary of the cell.
- Cytoplasm makes up the body of the cell.
- Nucleus is the small, round structure in the center of the cell.
- Chromosomes are in the nucleus of the cell; they contain genes that determine hereditary characteristics.

Tissues

Tissue is a group of similar cells performing a specific task:

- Muscle tissue produces movement.
- Nerve tissue conducts impulses to and from the brain.
- Connective tissue connects and supports various body structures: adipose (fat) and osseous (bone).
- Epithelial tissue is found in the skin and lining of the blood vessels, respiratory, intestinal, urinary tracts, and other body systems.

Organs

Organs are two or more kinds of tissue, together performing special body functions. For example, skin is an organ composed of epithelial, connective, and nerve tissue.

Systems

Systems are groups of organs working together to perform complex body functions. For example, the nervous system is made up of the brain, spinal cord, and nerves. Its function is to coordinate and control other body parts.

Medical Terms Related to Cells and Tissues

Nucleus—Small, round structure within the cell containing chromosomes and nucleoplasm (DNA [deoxyribonucleic acid] and RNA [ribonucleic acid]).

Chromosome—Linear strand made of DNA carrying genetic information.

Gene—Specific segment of base pairs in chromosomes; functional unit of heredity.

Body Cavities

The body is not a solid structure. It has five cavities, each of which contains an orderly arrangement of internal organs.

Dorsal cavity includes:

- Cranial cavity: The space inside the skull, or cranium, containing the brain.
- Spinal (vertebral canal) cavity: The space inside the spinal column containing the spinal cord.

Ventral cavity includes

- Thoracic, or chest cavity: The space containing the heart, lungs, esophagus, trachea, bronchi, and thymus.
- Abdominal cavity: The space containing the lower portion of the esophagus, the stomach, intestines (excluding the sigmoid colon and rectum), kidneys, liver, gallbladder, pancreas, spleen, and ureters. The abdomen can be divided into four sections: right upper quadrant (RUQ), left upper quadrant (LUQ), right lower quadrant (RLQ), and left lower quadrant (LLQ). For example, the spleen is located in the left upper quadrant of the abdomen.
- Pelvic cavity: The space containing the urinary bladder, certain reproductive organs, part of the large intestine, and the rectum.

Membranes

Membranes line the internal spaces of organs and tubes opening to the outside, and line body cavities. There are five types of membranes: mucous membranes, serous membranes, synovial membranes, meninges, and the cutaneous membrane.

Mucous membranes—These line the interior walls of the organs and tubes opening to the outside of the body, such as those of the digestive system. These membranes are lined with epithelium and are involved in absorption and secretion. The mucous membrane is composed of epithelium overlaying a layer of connective tissue called lamina propria. Not every mucous membrane secretes mucus.

Serous membranes—These line cavities, including the thoracic cavity and internal organs (eg, heart). They consist of a layer of simple squamous epithelium overlaying a layer of loose connective tissue. Serous membranes support internal organs and compartmentalize the large cavities to hinder spread of infection. For example, the lungs are covered by pleura and the heart is covered by pericardium.

Synovial membranes—Composed of connective tissue, these membranes are found lining the cavities of joints. Their function is to produce synovial fluid, which is released

Chapter 3

Effective Communication

A proficient scribe must understand the complexities of provider communication, understanding both what is being stated to them and how to effectively communicate in return to ensure that the note and visit are streamlined for both the provider and the patient. This chapter will cover the key steps in the communication process, when to communicate, and how to go above expectations when helping a provider communicate with patients.

Communication, An Overview

In the *Oxford Dictionary of English*, communication is defined as, "The successful conveying or sharing of ideas and feelings." The key word in this definition is successful. The role a CPMS® plays in a medical clinic is enormous. Physicians rely on their scribes to record key information from the discussions in the patient rooms, provide test results and communication from other physicians at a moment's notice, remind them of issues that need to be addressed at each visit, provide any answers a physician may need in a timely manner, and much more. Scribes are the backbone of an efficient, well-functioning visit, allowing the doctor to keep all attention on the patient A CPMS® knows when to speak up in every situation to ensure that the visit is documented in a concise, clear, and legible manner, along with verifying all necessary tests are ordered, all patient questions are addressed, and anyone who needs to review the chart later can find all information easily.

Understanding the Mindset of a Physician

Communicating effectively with physicians requires an understanding of their needs, wants, and mindset.

Doctors are trained to take responsibility for patient lives, constantly making decisions aimed at optimal patient outcomes. They continuously sort and prioritize information, often under intense intellectual, physical, and emotional stress. With a belief that there's no room for error in patient care, physicians aim to meet patients' expectations for perfection.

Many doctors find it difficult to accept that despite their hard work and effort for patients, it may not align with the compliance requirements of documentation related to coding, billing, and accurate payment. This discrepancy can create obstacles in the working relationship between a documentation specialist and a physician, potentially leading to communication issues if the specialist is unaware of the conflict.

When communicating with a physician, consider that during indoctrination to medical training and the Hippocratic Oath, the primary focus is on the patient above all else. There is little or no mention of the business of medicine in most medical schools.

Effective Communication

Remember, communication is the process of conveying information, thoughts, and feelings between people through speaking, writing, or body language. Effective communication requires that transmitted content is received and understood by someone in the way it was intended. The goals of effective communication include creating a common perception, changing behaviors, and acquiring information.

When you confront difficult issues, listening is more important than talking or other forms of expression. To effectively listen, try to be at ease and avoid interrupting the speaker, if possible.

Active listening has several benefits, including:

- Helping you assess a situation more effectively and accurately
- Allowing the speaker to clarify thoughts and feel heard
- Diffusing emotions that can present large roadblocks to thinking effectively

In addition to listening, effective communication includes speaking and expressing your thoughts in a clear, true, and non-defensive manner. When speaking, use "I" statements, and avoid statements that sound blaming or accusing. "I" statements communicate your thoughts and keep you responsible for your part of the communication.

The following are blocks to effective communication:

- Me-too-ism, such as, "that's nothing; let me tell you what happened to me!" These statements make the speaker feel unheard.
    - As a medical scribe, there is no need to share your own health woes with the patient as this is not pertinent to their visit and only works to dismantle any trust that has been established between the patient and the physician.

- Moralizing, preaching, and being judgmental. Recognize that the speaker may say something that offends your value system. Set aside judgment so you can listen.
  - This will happen; a patient will say something with conviction that may cause severe stress, emotional pain, or anger. It is imperative that the scribe remain calm, collected, and, most of all, quiet in these situations. It will not help anyone if a comment is escalated into a verbal argument and completely dismantles the patient's confidence in both the physician and their clinic, also like meaning their quality of care will drop significantly due to their perception of the attack. The patient's health needs must come above all else.
- Giving advice when it is not asked for.
  - This is especially important to avoid as a scribe as sometimes the patient sees a person in the medical clinic and takes your word as medically sound. This can lead to them ignoring a request from their trained medical staff in lieu of following what has been said by the scribe, even if in passing. Always remember, you are an extension of the physician and, therefore, can be seen as such by a patient.
- Consolation comments, such as "it's going to be all right," that may sound patronizing.
  - Patients will ask for your opinion from time to time. It is imperative that you avoid giving it and instead politely remind them that you have no medical training to be able to comment and that it is best to stick to the physician's thoughts on the topic.
- Arguing or disagreeing with the speaker.
  - Once again, this disrupts the care and should be avoided no matter what personal opinions may be on the topic discussed.
- Analyzing or interrupting.

Body Language

Communication is not just words: A lot of communication is non-verbal.

Controlling your body language can help to ensure effective communication. There is evidence to suggest mimicking the body stance and pose of the person you are conversing with may subconsciously put them at ease. This holds true whether you are communicating with providers, employees, patients, etc.

EXAMPLE

The following body language examples indicate how certain postures or actions may be perceived:

Fiddling: You are bored or impatient.

Clock watching: You are anxious to move on to something else.

Tapping: You are impatient or nervous.

Too much eye contact: You are aggressive.

Hunched posture: You lack confidence.

Arms crossed: You are defensive.

Touching your face: You are timid.

Rubbing your nose: You are lying.

No eye contact: You have low interest or lack confidence.

Stereotyping and Communication

Webster defines the word stereotype as follows: "Something conforming to a fixed or general pattern; especially an often oversimplified or biased mental picture held to characterize the typical individual of a group."

Stereotyping can adversely affect communication or enhance communication within a healthcare setting, depending on perception and use. The following are three ways stereotyping affects our communication daily, either consciously or unconsciously. Becoming aware of these issues can help us recognize them in our communication style or approach and help us to prepare our responses with more confidence.

- Power differential/class: One individual may view another individual's position as higher or lower than theirs. One individual may see this power differential as educated versus uneducated. Yet another may look at the power differential from a perspective of administration versus staff.

  In power differential stereotyping, this difference — real or perceived—can cause an individual to cower or power during a session of communication, resulting in ineffective communication patterns.
- Cultural competence/ethnicity-race: This form of stereotyping is legally wrong; however, this still may be an underlying issue when it comes to effective communication. One must be aware of cultural issues in the workplace. Education on how to effectively communicate with persons of differing cultures is available and should be studied and cultivated by administration in the workplace. For instance, direct

Chapter 3 Review Questions

1. Which one of the following is the primary role of a scribe in a medical clinic?
   A. To make sure all documentation requirements related to coding and billing are met.
   B. To order and provide test results from the patient's visit to other physicians.
   C. To ensure the visit is documented in a clear, concise, and legible manner.
   D. To remind physicians of issues that need to be addressed on the patient's next visit.

2. What is the appropriate response for a medical scribe when a patient says something offensive or distressing?
   A. Engage in a verbal argument indicating why you agree or disagree.
   B. Stay calm, collected, and quiet, prioritizing the patient's health needs.
   C. Walk out of the room and request you no longer scribe for the patient.
   D. Wait for the physician to leave to talk to the patient on the offense.

3. Which of the following body language postures indicates a lack of confidence?
   A. Fiddling
   B. Clock watching
   C. Hunched posture
   D. Rubbing your nose

4. In the context of power differential stereotyping, which of the following best describes a potential impact on communication patterns?
   A. It can lead to ineffective communication patterns due to perceived power differences.
   B. It enhances communication between individuals of different ranks.
   C. It only affects communication between individuals of the same rank.
   D. It has no effect on communication between individuals or positions held in an office/clinic.

5. What is an appropriate approach when initiating a difficult conversation?
   A. Start the conversation immediately without checking if the other person is ready, having a statement prepared to ensure your points are heard first.
   B. Begin the conversation by asking if it's a good time to talk, prepare a concise statement, and listen to the other person's response.
   C. Begin the conversation with a list of questions, listen to the to the person's response, and then be ready to defend your answer to the same questions.
   D. Prepare a long, detailed statement to start the conversation and immediately start the conversation with detail, explaining the reward and risk.

6. What is the first step a scribe should take when establishing a working relationship with a provider?
   A. Review clinic software and templates.
   B. Discuss the provider's preferences in documentation.
   C. Arrive early at the clinic and review the patient list.
   D. Establish a rapport with the provider.

7. Which of the following is NOT a recommended practice for conducting and documenting verbal queries during a patient's encounter?

   A. Interrupting patient conversations and provider workflow for queries.

   B. Including a brief summary of the conversation, the diagnosis or procedure in question, and the supporting clinical indicators in the documentation.

   C. Developing good communication with the provider for real-time verbal queries.

   D. Submitting the documented conversation either electronically in the patient's health record or attaching it to the paper chart for the physician to review and sign.

8. Which query allows the physician to clarify the documentation to support their clinical decision making?

   A. Multiple choice query

   B. Yes/no query

   C. Open query

   D. Verbal query

9. What is the purpose of a medical scribe querying a physician?

   A. To challenge the physician's diagnosis

   B. To assist with the accuracy of the medical record

   C. To make sure the documentation supports payers' guidelines

   D. To assist the physician in the medical queries for the patient

10. What is the best method to comply with HIPAA when sending a query?

    A. Through the physician's personal email

    B. Include it in the patient's medical chart

    C. Through the physician's personal cell phone

    D. Verbal queries without documentation

Chapter 5

Medical Record Standards and Documentation Guidelines

Introduction

A medical record is a chronological account of a patient's health history and care, documented by various healthcare providers. It includes identification details, health history, examination documentation, and test results like labs and X-rays. A scribe's role is to accurately and promptly record the clinician's work, adhering to office/clinic guidelines. Due to the sensitive information in medical records and their various uses, including legal, there are strict rules around their privacy, sharing, and required documentation.

Accuracy

Accuracy in medical records is crucial for patient care and regulatory adherence. Additionally, it is a legal document often shared among healthcare professionals and insurers. Spelling accuracy matters as errors can lead to significant mistakes. Spell-check functions may alter correctly spelled words, so always review your work thoroughly before finalizing or approving the note.

Ancillary Services Clinical Indicators

The physician will receive new patient material on the first office visit and may receive multiple records for a patient prior to their next visit. The additional records can be from orders they have given for laboratory or radiology testing. Labs and radiology are ancillary services. These reports should be reviewed for any acute results and an appropriate plan implemented according to office policy and clinical protocols.

Medical scribes use the following reports to extract pertinent information:

- Medication list — Provided by patient on first visit. Some electronic medical record (EMR) platforms are able to link directly to pharmacy data.

*Do not assume! Clarify with your clinician which diagnosis corresponds to each medication. For example, don't assume a diabetes diagnosis for patients taking metformin. There are other conditions for which this medication is prescribed.

Common medications and associated conditions

Brand Name	Generic Name	Classification	Conditions Used to Treat
Abilify	Aripiprazole	Antipsychotic	Bipolar disorder, schizophrenia
Actos	Pioglitazone	Diabetes medication	Diabetes mellitus
Albuterol	Albuterol inhalant	Bronchodilator	Asthma, chronic obstructive pulmonary disease (COPD), respiratory failure
Ambien	Zolpidem	Sedative/hypnotic	Insomnia
Amoxicillin		Penicillin antibiotic	Bacterial infections
Aspirin	Salicylate	Pain medication	Pain, fever, inflammation
Ativan	Lorazepam	Antianxiety	Anxiety
Augmentin	Amoxicillin	Penicillin antibiotic	Bacterial infections
Azithromycin		Antibiotic	Bacterial infection
Cardizem	Diltiazem	Calcium channel blockers	Hypertension
Celebrex	Celecoxib	Antiarthritic	Arthritis
Cipro	Ciprofloxacin	Anti-infective	Infection
Codeine		Narcotic, opiate	Pain
Coumadin	Warfarin sodium	Anticoagulant	Deep vein thrombosis
Crestor	Rosuvastatin	Statin	Cholesterol management
Diflucan	Fluconazole	Antifungal	Oral thrush
Enalapril	Enalapril systemic	Angiotensin converting enzyme (ACE) inhibitor	Hypertension and congestive heart failure (CHF)

Brand Name	Generic Name	Classification	Conditions Used to Treat
Epogen	Epoetin alfa	Protein	Anemia, human immunodeficiency virus
Flagyl	Metronidazole	Antibiotic	Bacterial infection, *Clostridium difficile*
Fosamax	Alendronate	Bisphosphonates	Osteoporosis
Glucophage	Metformin	Antihyperglycemic	Diabetes mellitus
Heparin		Anticoagulant	Prevent blood clots, flush intravenous catheter
Hydrochlorothiazide - HCTZ		Diuretic	Hypertension, edema caused by heart failure, kidney failure, cirrhosis
Keppra	Levetiracetam	Antiepileptic	Seizures, epilepsy
Lactulose		Synthetic disaccharide	Constipation, hepatic encephalopathy
Lantus	Insulin glargine	Insulin	Diabetes mellitus
Lasix	Furosemide	Diuretic	CHF, edema, acute renal failure
Lexapro	Escitalopram	Antidepressant	Depression
Lipitor	Atorvastatin	Statin	Cholesterol management
Lisinopril		ACE inhibitor	Hypertension
Motrin	Ibuprofen	Analgesic, nonsteroidal anti-inflammatory drug	Inflammation, fever
Neurontin	Gabapentin	Antiepileptic	Neuropathy
Nexium	Esomeprazole	Antacid	Gastroesophageal reflux disease (GERD)
Norvasc	Amlodipine	Calcium channel blockers	Hypertension, angina, coronary artery disease
Nystatin		Antifungal	Yeast infection
Percocet	Acetaminophen and oxycodone	Narcotic, opiate	Pain relief
Plavix	Clopidogrel	Antiplatelet	Blood clots
Prednisone		Corticosteroid	Anti-inflammatory
Premarin		Conjugated estrogens	Hormone replacement
Prilosec	Omeprazole	Antacid	GERD
Protonix	Pantoprazole	Proton pump inhibitor	Inhibits gastric acid secretion
Seroquel	Quetiapine	Antipsychotic	Bipolar disorder, schizophrenia
Singulair	Montelukast	Leukotriene inhibitor	Asthma, allergies
Synthroid	Levothyroxine	Hormone replacement	Hypothyroid
Tamiflu	Oseltamivir	Antiviral	Influenza virus A and B
Tissue plasminogen activator - TPA		Thrombolytic agent	Myocardial infarction , stroke, peripheral vascular disease
Toprol	Metoprolol	Beta blocker	Hypertension
Tylenol	Acetaminophen	Pain medication	Pain reliever, fever reducer
Valtrex	Valacyclovir	Antiviral	Herpes viral infection
Vicodin	Hydrocodone	Narcotic, opiate	Pain
Xanax	Alprazolam	Benzodiazepine	Anxiety
Zocor	Simvastatin	Statin	Cholesterol management
Zofran	Ondansetron	Serotonin receptor antagonist	Nausea and vomiting
Zoloft	Sertraline	Antidepressant	Depression

In the healthcare industry, quality service and positive cash flow are crucial. Proper management of claim submissions to third-party payers is key to this. The process of collecting accurate patient data, billing, submitting claims, following up on accounts receivable, and creating patient statements is known as revenue cycle management.

Medical scribes play a unique role at the intersection of clinical encounters and the initiation of the billing cycle. Billing involves much more than selecting the appropriate codes to include in a claim form. There are several considerations for effectively managing the revenue cycle process in medical office. Identifying the best methods and tools to achieve your objectives is often referred to as best practices. Let's look at some roles in the medical office and some of the best practices that make them effective in the revenue cycle.

Front Office

The front office has the initial contact with the patient and plays a vital role in customer service, optimizing physician time, and claim quality assurance. This requires customer service training as well as cross-training between front office staff members.

Below are some best practice suggestions for front office staff.

Prior to patient arrival

- Gather as much information as possible at the time the patient appointment is made. At a minimum, patient name, address, date of birth, and insurance information should be obtained during initial appointment contact.
- Offer new patient packets online or via email before the appointment, including registration and financial responsibility forms, health histories, etc. This speeds up the registration process. Technology allows practices to perform tasks online, like reviewing systems, obtaining past family and social history, and verifying insurance eligibility.
- Before a patient's appointment, verify their insurance eligibility and benefits. As insurance plans grow more complex, understanding these benefits and the patient's financial responsibility is beneficial for the medical practice. Reach out to patients with insurance verification issues.

Patient Appointment Arrival

- Assign a staff member in the practice to greet new patients and inform them about the practice's policies.
- Verify identification (ID) and receipt of forms. Scan or copy current insurance cards and ID. Ensure forms like assignment of benefits, release of information, and privacy practices are signed. Provide an ABN if Medicare may not cover the service. Some EHR systems can integrate these forms.
- Ask open-ended questions to allow for fewer patient errors. Simply asking the patient, "Has anything changed?" is never enough, and this should be discouraged in your office. Example: Upon check-in, the receptionist needs to ask the patient, "What is your current address?" instead of, "Do you still live at 1300 E. Jackson Street, Anywhere, USA?"
- Always collect copays and deductibles at each visit. Offices should establish and display their payment policies, notifying patients that payments are due on the service date. Without a date-of-service payment collection process, the subsequent collection cost can be high. Consider using credit card machines that allow debit cards to reduce bank processing fees.
- Display policies on payments and collections. When the patient knows what to expect from the office, and that payment is requested at every visit, the patient comes prepared to cover these costs at the time of service.
- Have readily available (displayed, if possible) lists of insurance companies with which the practice participates and a working knowledge of the level of participation in the practice.
- Know your patient demographics. Providing wifi in the waiting room can be incredibly convenient for some people. Patients remain loyal to practices that make it easy for them to visit.

Back Office

Ancillary Staff

While physicians are primarily responsible for medical documentation, it is crucial for ancillary staff to have basic billing and coding training. They perform billable services

like venipuncture, injections, X-rays, and lab services, which must be documented. Therefore, all service-providing staff should understand proper documentation and coding to ensure all services are recorded. For instance, when administering a vaccine, the type, dose, and administration route must be documented. Ancillary staff play a key role in ensuring ordered services are accurately documented and reported to insurance carriers.

Understanding regulations for coding evaluation and management (E/M) and other office services is crucial due to the high percentage of office visits. Scribes' completed documentation from office visits generally goes to certified coders. For scribes, knowledge of coding is required — but not at the same level as if they were coding. The practice manager is responsible for making sure the ancillary staff (e.g., medical assistants, scribes, nurses, etc.) is trained to document services appropriately for coding and billing.

Coding and Billing Departments

A medical coder's main duty is to review clinical documentation and assign the correct CPT®, ICD-10-CM, and HCPCS Level II codes to all billable services. Medical billers create and submit claims based on these codes to insurance companies, ensuring the practice receives the maximum and most suitable reimbursement. It's crucial for coding and billing departments to be cross-trained. Billers need a good understanding of coding guidelines to effectively handle denials. Coders should be familiar with the payer contracts and specific guidelines, understand bundling issues, and know the proper documentation requirements for billing compliance. This knowledge overlaps significantly with the responsibilities of medical scribes. Sometimes, the coder and biller may be the same individual. Regardless of your practice's staffing, it's beneficial to familiarize yourself with the coders and billers and use them as a resource.

Code Sets

The Health Insurance Portability and Accountability Act (HIPAA) law mandates standardization of all electronic data interchange formats related to health information. Healthcare providers use HIPAA-compliant codes to denote procedures, services, and diagnoses for each patient visit. The following are standardized coding formats that are used for all claims submitted by medical providers:

ICD-10-CM

(International Classification of Diseases, Tenth Revision, Clinical Modifications)

Diagnosis codes: ICD-10-CM codes represent the diagnosis or reason a service is performed.

ICD-10-CM codes are three to seven alphanumeric characters.

ICD-10-PCS

(International Classification of Diseases, Tenth Revision, Procedure Coding System)

Procedure codes: These codes represent procedures performed at inpatient hospital facilities. These codes are only submitted by facilities. Professional services are not reported with ICD-10-PCS codes.

The format for ICD-10-PCS procedure codes is seven characters with no decimal.

CPT®

(Current Procedural Terminology)

Procedure codes: CPT® codes represent procedures performed and billed by physicians and nonphysician practitioners (NPPs). CPT® codes are maintained and updated by the American Medical Association (AMA) annually. They are divided into three categories:

Category I — These five-digit codes have descriptors which correspond to a procedure or service. Codes range from 00100-99499. They are divided into six sections: Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine.

Category II — These are five-character alphanumeric codes, ending with F, that supplement Category I codes. While optional, they offer valuable data for performance measurement and patient care. Category II codes aid in collecting quality of care data.

Category III —Temporary codes are used for emerging technology, procedures, and services for data collection and evaluation. If a new procedure lacks a Category I code, but is in Category III, the Category III code must be used.

Modifiers — In some instances, providers may need to provide extra details about a performed procedure by adding a modifier to the CPT® code. These modifiers, which can be either alphabetic or numeric, always consist of two characters.

Modifiers indicate that a service or procedure has been modified or altered. There are two types of modifiers:

Pricing modifiers: Affect payment of service, will determine allowance of service billed, and should be placed in the first modifier field.

Information modifiers: Provide additional information, may state whether a service is medically reasonable and necessary, and should be used in the second, third, or fourth field, if a pricing modifier is being used.

HCPCS Level II

(Healthcare Common Procedure Coding System)

Practice Examination

Medical Terminology

1. Which of the following medical terms is related to the condition of stiffening of a joint in the musculoskeletal system?
   A. Arthroplasty
   B. Ankylosis
   C. Myopathy
   D. Osteopenia

2. What is the medical terminology used to describe a condition where the patient experiences a ringing in the ears?
   A. Tinnitus
   B. Vertigo
   C. Diplopia
   D. Labyrinthitis

3. A patient is diagnosed with menorrhagia. What does the patient have?
   A. Absence of menstruation
   B. Painful or difficult menstruation
   C. Excessive blood flow during menstruation
   D. Normal menstruation

Anatomy

4. Which three layers make up the heart?
   A. Epicardium, myocardium, and endocardium
   B. Duodenum, jejunum, and ileum
   C. Dermis, epidermis, and stratum
   D. Medial, lateral, and subacromial

5. The conjunctiva is in which organ system?
   A. Gastrointestinal
   B. Respiratory
   C. Urinary
   D. Eyes

6. Which one of the following is NOT part of the endocrine system?
   A. Adrenal glands
   B. Pancreas
   C. Gallbladder
   D. Thyroid gland

Appendix B

Chapter Questions–Answers and Rationales

Chapter 1

1. **Answer:** B. It is used to link the root word with the suffix or another root word.

   Rationale: A combining vowel is used in medical terminology to link the root word with the suffix, or one root word to another root word. It also makes medical terms easier to pronounce. The most common combining vowels are O and I. While occasionally these vowels might be dropped, such as when the suffix begins with a vowel, the combining vowel is always placed between two root words, even when the second root word begins with a vowel. Therefore, option B is the correct answer.

2. **Answer:** C. - ectomy

   Rationale: The suffix "-ectomy" is used to denote the surgical removal of body structures. In contrast, "-otomy" refers to the incision or cutting into a body structure, and "-ostomy" refers to the surgical creation of an opening. Understanding these differences can help eliminate confusion in medical terminology.

3. **Answer:** A. Lateral

   Rationale: Lateral means toward the side of the body. The term deep is used to describe a position that is closer to the center of the body. Proximal means nearer to the point of attachment or a given reference point. Distal is farther from the point of attachment or from a given reference point.

4. **Answer:** C. Ophthalmoscope

   Rationale: An ophthalmoscope is a medical instrument used by healthcare professionals to examine the interior structures of the eye, including the retina and optic nerve.

5. **Answer:** D. Urticaria

   Rationale: Urticaria, also known as hives, is a skin condition characterized by the sudden appearance of itchy, red, raised welts on the skin. Pruritus is for severe itching. Tinea refers to a ringworm.

6. **Answer:** B. Bradycardia

   Rationale: Bradycardia is the medical term used to describe a slower-than-normal heartbeat. On the other hand, palpitations refer to a feeling of a rapid, fluttering, or pounding heart. Tachycardia is the term for a faster-than-normal heart rate. Endocarditis is an inflammation of the inner layer of the heart, often due to a bacterial infection.

7. **Answer:** C. Endocrine

   Rationale: The thyroid is a part of the endocrine system. This system includes all the glands in the body that produce hormones, which are chemicals that regulate many of our body's functions.

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