CHILDREN’S HOSPITAL OF PITTSBURGH
CONTINUITY CLINIC CURRICULUM
Billing & Coding Conference CME Quiz
Week of August 14, 2017

Instructions to receive credit for completion:

If you are CME eligible: Please print and complete this quiz, using black ink. Fax your completed quiz to 412-692-5946. Individuals who answer 5 or more questions correctly will receive 1.0 CME credit. NOTE: You must submit the quiz by the end of this month to be awarded credit.

If you are a resident log into Med Hub to record module completion

Name: (Please print) __________________________ Office phone: _______________ Social Security# _______________

Last 5-digits of

Circle the single best answer for each question.

1. For coding purposes, a patient is billed as a “new patient” if he/she:
   a. Has been seen by your practice in the newborn nursery, but not previously in your office
   b. Has been seen at one of your satellite offices, but not previously in your main office
   c. Was seen in the emergency department, but not previously in your office
   d. Has not been seen in your office for the past 2 years

2. At the PCC, an attending preceptor must go into the room and examine the patient:
   a. For visits with E & M billing code levels 3, 4, and 5
   b. For visits with E & M billing code levels 4 and 5
   c. For all PL-1 visits
   d. For all patients new to your practice

3. If a child is scheduled for a routine check-up but has acute medical problems which preclude provision of health supervision care, how should this visit be coded for billing?
   a. Code with the appropriate preventive medicine code
   b. Code with the preventive medicine code, and add an E & M visit code and diagnoses to signify the complexity of the visit
   c. Code with the preventive medicine code, and add an E & M modifier and the diagnoses
   d. Use E & M code 9921X and mark the diagnoses; do not use the preventive medicine codes

4. For procedures, one of the following is true:
   a. Vision and hearing screening are considered part of routine care, so they are not billed
   b. Developmental screening is considered part of routine care, so it is not billed
   c. Cerumen removal which is performed bilaterally can be charged twice
   d. Since it is often not clear what insurance will cover, document and order all procedures performed

5. Diagnoses can be coded for a visit:
   a. If you review the problem and write for refills related to the diagnosis
   b. If there is a complaint of ear pain but no diagnosis of otitis media, then bill as “r/o otitis media”
   c. If the child with a diagnosis of asthma has URI symptoms and no wheezing at the time of the visit, then asthma can be coded as the primary diagnosis
   d. If there is no clear-cut diagnosis at an acute visit, then the diagnosis becomes “well child”

6. For E & M coding, which one of the following statements is true?
   a. A visit during which a nurse alone sees a patient can not be billed with an E & M code
   b. It is important to “down-code” to protect yourself against insurance audits
   c. The complexity of the problem primarily determines the coding level
   d. If time is used for determining the E & M code, such as for a counseling visit, it is not necessary to mark the amount of time spent with the patient for coding purposes