CODING / COMPLIANCE POST TEST
Emergency Medicine
New and Reappointments

Please return to:
Your Departmental Credentialing Coordinator
along with your New/Reappointment Application Packet:

Name: ________________________________
Signature: ______________________________

Number Correct: __________________________ of 10 Date: __________________________

CODING CATEGORIES AND LEVEL OF SERVICE

1. True/False. Critical care reimbursement is diagnosis-related so it is important to document with precision the extent of injury or illness requiring the advanced level of care.

2. Complexity of medical decision making is quantified based on the documentation of:
   a. the number of diagnostic and/or management options
   b. the amount and complexity of data reviewed (including old medical records or gathering history from someone other than the patient)
   c. the risk to the patient of the illness or injury or the proposed treatment or diagnostic tests
   d. a and b
   e. all three above
   f. any two of the three listed above

3. True/False. All three components: history, physical exam and medical decision making must be documented at the level of evaluation and management service billed.

4. True/False. When injury or illness acutely impairs one or more vital organ systems and the physician note establishes the necessity for critical care services, the amount of time spent in the care of the patient must be recorded in the note to bill for critical care services.
5. True/False. A medical student may document the review of systems and past, family and social history portions of the history, but the physician may only use that work if she references review of the information.

MEDICARE TEACHING PHYSICIAN GUIDELINES – WORKING WITH RESIDENTS

6. True/False. Medicare pays residents (and some fellows) through Medicare Part A and therefore does not pay for services they provide if there is no demonstrated participation by a teaching physician.

7. For time-based codes, such as critical care, the teaching physician must:
   a. be physically present for the entire period of time for which the claim is made and must personally document his/her presence for the entire time being billed.
   b. be present for the key portions of the service and the resident may document his/her presence.
   c. be present for the key portions of the service and must personally document his/her presence.

8. Medicare’s documentation requirements can be met by:
   a. co-signatures and statements such as “agree with above,” or “seen and agree.”
   b. a full note by teaching physician or documentation in addition to the resident/fellow’s note by the teaching physician that demonstrates his/her participation in the required key elements of the history, exam and medical decision making.
   c. a computer-generated note, initiated by a teaching physician stating, “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s finding and plans as written.”
   d. b or c

9. True/False. The following is considered an acceptable teaching physician attestation for an Emergency Medicine patient.

   “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”
10. Which of the following situations may require refunding and possibly payment of a fine to the federal government?
   
   a. The teaching physician sees a Medicare patient, discusses the patient with the resident and co-signs the resident note.
   
   b. The physician performed what was medically necessary and billed the patient. The documentation did not include all the details of the exam to support the billed level of service.
   
   c. The policy of the division is to perform a comprehensive exam and history on each patient and all patients are billed for a high level of service
   
   d. a and b
   
   e. b and c
   
   f. all of the above