Instructor's Manual to Accompany

3-2-1 Code It!

Seventh Edition

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The 2019 versions of CPT, HCPCS Level II, ICD-10-CM, and ICD-10-PCS were used in preparation of this product.

Contents

Preface

This Instructor's Manual is organized into seven sections:

- Section I: Preparing Your Course

Note:

Section I contains sample semester plans and policies for administering exams and grading assignments and exams. Chapter lesson plans that can be modified for individual use are included.

- Section II: Answer Keys to Chapter Exercises and Reviews
- Section III: Answer Keys to Workbook Assignments and Reviews

Note:

Sections II and III are organized according to chapter.

- Section IV: Answer Keys to Workbook Appendices A–D: Coding Patient Records
  - Answer Key to Appendix A: Coding Ambulatory Care Surgery Patient Records
  - Answer Key to Appendix B: Coding Emergency Department Patient Records
  - Answer Key to Appendix C: Coding Physician Office Records
  - Answer Key to Appendix D: Coding Hospital Inpatient Records
- Section V: Answer Key to Workbook Appendix E: Mock Certified Professional Coder (CPC) Certification Examination
- Section VI: Answer Key to Workbook Appendix F: Mock Certification Coding Specialist-Physician (CCS-P) Certification Examination
- Section VII: Answer Key to Workbook Appendix G: Mock Certified Coding Specialist (CCS) Certification Examination

Teaching Tip:

Consider placing a sticky note as a tab at the beginning of each section in the Instructor's Manual.

STUDENT WORKBOOK

The workbook follows the chapter organization of the core textbook and contains application-based assignments. Each assignment contains a list of objectives, an overview of content relating to the assignment, and instructions for completing the assignment. The last assignment in each workbook chapter contains review questions in multiple-choice format to emulate credentialing exam questions. The workbook also contains actual patient records and mock CPC, CCS-P, and CCS certification examinations.

ENCODERPRO.COM EXPERT

Optum360's EncoderPro.com Expert offers a 30-day free trial of their powerful medical coding solution that allows you to look up ICD-10-CM, ICD-10-PCS, CPT, and HCPCS level II codes quickly and accurately. This software can be used to assign codes to any of the exercises in the *3-2-1 Code It!* textbook and workbook.

INSTRUCTOR COMPANION SITE

Additional resources can be found online at **http://login.cengage.com**.

Items listed as Instructor Resources are password-protected. To access the protected Instructor Resources, go to **http://login.cengage.com** to create a unique single-user sign-on. Contact your sales representative for more information.

Note:

Login instructions for Student Resources listed on the Student Companion Site are located in the textbook Preface.

Teaching Tip:

The Instructor and Student Companion Sites also include files that contain updates to the textbook and its supplements, which were changes made to the textbook, workbook, instructor's manual, and/or computerized test bank after publication (e.g., revised codes due to coding updates). You are welcome to email the author at **michelle.ann.green@gmail.com** with questions or comments. The author will respond to your emails, and appropriate corrections will be posted to provide clarification about the textbook and its supplements.

INSTRUCTOR RESOURCES

In addition to this electronic version of the Instructor's Manual, the Instructor Resources contain an online computerized testbank powered by Cognero, and instructor's slides created in PowerPoint®. These supplements are located at the password-protected Instructor Companion Site at **http://login.cengage.com.**

Teaching Tip:

- The Cognero testbank contains multiple choice and completion (coding) questions. Cognero software is available on the Instructor Companion Site to allow you to generate exams quickly, which can be printed, exported and uploaded to a learning management system (e.g., Blackboard), or web-enabled. This means that you can create different versions of the same exam for large classes of students (when students cannot be separated from each other by an empty desk). To save you some time, exported files for Blackboard, Moodle, Angel, Desire2Learn, and Canvas can be downloaded directly from the Instructor Companion Site.
- An *Insurance, Billing, and Coding Curriculum Guide* is also located at the Instructor Companion Site to assist you in developing new academic programs and in modifying existing programs. The guide contains information about the job outlook and salaries for coders, available professional certification examinations, and curriculum coordination (e.g., marketing, student advising, teaching, professional practices, program approval, and program assessment). Content taught in a coding curriculum is linked to AAPC, AHIMA, AMBA, and MAB educational standards. Content is also linked to Cengage Learning products to assist you in selecting textbooks for instruction. Course outlines and course syllabi are included as samples, and they can be modified for your program. (In Adobe® Reader®, click on "File," then "Save as Text" to convert the guide to a document that can be opened in word processing software. All of the formatting will be lost, but you can scroll through the document to locate the content you want to cut/paste and modify to reformat. You might find it easier to print pages from the guide, edit them, and then keyboard new documents for your use.)

SECTION

II

Answer Keys to Chapter Exercises and Reviews

CHAPTER

1 Overview of Coding

EXERCISE 1.1 – CAREER AS A CODER

1. c
2. a
3. b
4. c
5. b

EXERCISE 1.2 – PROFESSIONAL ASSOCIATIONS

1. c
2. a
3. b
4. a
5. c

EXERCISE 1.3 – CODING OVERVIEW

1. b
2. a
3. a
4. a
5. a

EXERCISE 1.4 – OTHER CLASSIFICATION SYSTEMS AND DATABASES

1. c
2. g
3. a
4. h
5. f
6. j
7. b
8. e
9. d
10. i

EXERCISE 1.5 – DOCUMENTATION AS BASIS FOR CODING

1. a
2. b
3. b
4. b
5. b

EXERCISE 1.6 – HEALTH DATA COLLECTION

1. management
2. abstracting
3. CMS-1500
4. UB-04 (or CMS-1450)
5. medical

REVIEW

Multiple Choice

1. a
2. d
3. c
4. b
5. b
6. c
7. c
8. d
9. a
10. a
11. c
12. a
13. c
14. b
15. b
16. d
17. b
18. a
19. b
20. c
21. a
22. c
23. a
24. a
25. b

SECTION

III

Answer Keys to Workbook Assignments and Reviews

CHAPTER 1

Overview of Coding

ASSIGNMENT 1.1 – CAREER AS A CODER: INTERVIEW OF A CODING PROFESSIONAL

The student will submit in paragraph format (not Q&A) a two- to three-page word-processed interview of a coding professional. Each paragraph should contain a minimum of three sentences, and the student should write in complete sentences. The paper should contain no typographical or grammatical errors. The last paragraph of the paper should summarize what the student's reaction to the interview was and whether the student would be interested in having this professional's position (along with an explanation of why or why not). Also, the student should "predict the future" by writing about where he or she will be in ten years in terms of employment, family, and so on.

ASSIGNMENT 1.2 – PROFESSIONAL DISCUSSION FORUMS

The student will go to http://list.nih.gov and click on About NIH Listserv to learn all about online discussion forums (listservs). The student will also select a professional discussion forum from Table 1-1 in the Workbook and follow its instructions to become a member. If this assignment is completed by the student outside of class, the instructor can require the student to submit a summary of the experience (or if teaching online, post a discussion).

ASSIGNMENT 1.3 – CODING OVERVIEW: VALIDATING ACCURACY OF ICD-10-CM AND ICD-10-PCS CODES

(Adapted from the American Health Information Management Association.)

Validating ICD-10-CM and ICD-10-PCS Coding Accuracy

1. Code Z85.028 and 0DQ67ZZ are correct. However, code Z43.1 (Encounter for attention to gastrostomy) is missing, and it should be reported first.
2. Code 3E03305 is correct. However, code C40.80 is incorrect because *secondary carcinoma of the bone* is coded as metastatic spread from an unknown primary; therefore, assign C79.51 (neoplasm, bone, malignant secondary) and C80.1 (neoplasm, unknown or unspecific site, malignant primary) (instead of C40.80). Code Z08 is incorrect because it classifies an encounter for follow-up examination after a completed treatment (e.g., chemotherapy) for a malignant neoplasm; this patient has not completed such treatment.

3. Code I50.9 is correct. However, code I25.1 is missing its fifth digit "0" that classifies the native coronary artery site; assign code I25.10 (instead of I25.1).
4. Code N39.0 is correct; however, code B96.20 should be reported as another (additional) diagnosis to describe the *Escherichia coli* infection.
5. Codes O80 and 10E0XZZ are correct. However, code Z37.0 (Single live birth) should also be reported to classify the outcome delivery as a single live birth.

ASSIGNMENT 1.4 – COMPUTER-ASSISTED CODING (CAC)

1. a. **Date of procedure:** August 5, YYYY
   b. **Preoperative diagnosis:** Right anterior cruciate ligament rupture with possible lateral meniscus tea
   c. **Postoperative diagnosis:** Right knee anterior cruciate ligament rupture with lateral meniscus tear
   d. **Procedures** Right knee arthroscopy
   Partial lateral meniscectomy and anterior cruciate ligament reconstruction
   Bone-patellar-bone autograft
   Arthroscopy

NOTE:

The surgeon probably dictated or entered the *Arthroscopy* procedure (as the last line of *Procedures* on the bottom half of the CAC demo application's computer screen) in error because *arthroscopy* is previously stated on line one of *Procedures*.

8. a. S83.509A, S83.289A
   b. S83.289A

NOTE:

- Code S83.289A (tear of lateral cartilage or meniscus of knee current) was selected by the coder as the *admitting diagnosis* (abbreviated as A below the *Admitting Diagnosis* heading in Figure 1-1. The *Admitting Diagnosis* box of the screen indicates that the coder originally deleted S83.289A and then set that code as the admission diagnosis.).
- CAC software also assigned S83.509A (sprain of cruciate ligament of knee) as an admitting diagnosis, but the coder did not "set" that code as the admitting diagnosis. Most likely, review of the patient record face sheet and/or responsible physician's admission note resulted in "tear of lateral cartilage or meniscus of knee current" as the reason for surgical admission/encounter.
- CAC software assigned an *admitting diagnosis* and a *reason for admission* because the software option to capture both of these data elements was selected. In future, the health information director might omit the data capture of one of these elements (e.g., electronic health record entry field *reason for admission* is renamed *admitting diagnosis*).

3. a. S83.509A, S83.289A b. 29881-RT, 29888-RT c. 29875-RT

NOTE:

- CAC software most likely displayed code 29875-RT as Possible, and upon review of patient record documentation (e.g., operative report) the coder deleted the code.
- Although an arthroscopy was performed, it is already included in the first documented procedure (located in the bottom half of the CAC demo application's computer screen).
- The list of procedures (located in the bottom half of the CAC demo application's computer screen) does not include *synovectomy, limited (e.g., plica or shelf resection) (separate procedure)*, which means that procedure was not performed. (In CPT, *separate procedure* is included in parentheses in code descriptions for procedures that are performed as distinct procedures, not in combination with another procedure.)

ASSIGNMENT 1.5 – HEALTH DATA COLLECTION: FACE VALIDITY OF DATA MANAGEMENT REPORTS

(Source: The American Health Information Management Association)

Section A

Service	Discharges	Deaths	Autopsies[1]		Discharge Days	Average LOS[1]	Consults	Medicare Patients		Pediatric Patients	
			#	%				#	Days	#	Days
Medicine	725	40	8	(25%)	6,394	9	717	301	3,104	0	0
General Surgery	280	10	3	30%	2,374	8	184	80	916	0	0
Cardiac Surgery	64	1	1	100%	1,039	16	35	26	431	0	0
Hand Surgery	26	0	0	0%	81	3	2	3	10	0	0
Neurosurgery	94	0	0	0%	1,429	15	39	12	266	4	39
Plastic Surgery	46	0	0	0%	319	7	19	7	97	0	0
Dental Surgery	25	0	0	0%	81	3	46	2	11	1	3
Dermatology	20	0	0	0%	289	14	56	6	83	0	0
Neurology	83	0	0	0%	776	9	183	24	284	0	0
Ophthalmology	87	0	0	0%	352	4	98	51	183	0	0
Orthopedics	216	2	0	0%	1,920	9	64	39	563	1	2
Otolaryngology	139	2	0	0%	705	5	87	16	168	4	7
ICU[2]	(8)	1	1	50%	128	16	1	0	0	8	127
Psychiatry	126	0	0	0%	3,624	29	97	7	317	1	8
Urology	108	1	1	100%	810	8	74	36	318	0	0
Gynecology	184	2	1	50%	853	5	55	11	93	0	0
Obstetrics	451	2	(2)	0%	2,099	5	14	0	0	1	2
SUBTOTAL	2,682	62	17	27%	23,273	9	1,771	621	6,844	20	189
Newborn	310	0	0	0%	1,191	4	0	0	0	0	0
SCN[3]	38	4	1	25%	742	20	0	0	0	0	0
TOTAL	3,030	66	18	27%	25,206	8	1,771	621	6,844	20	189

Section B

Discharge Disposition	# of Patients
Against medical advice	15
Home	2,850
Home health care	10
Skilled nursing facility	37
Rehabilitation facility	39
Other hospital	13
Expired	(65)
TOTAL	3,030

Section C

Results	# of Patients
Discharged alive	2,964
Not treated	0
Diagnosis only	0
Expired over 48 hours	54
Expired under 48 hours	12
TOTAL	(3,029)

Section D

Type of Death	Number of Deaths	Autopsies	
		#	%
Anesthesia	0	0	0%
Postoperative	8	2	25%
Medical examiner	4	3	75%
Stillbirths	4	3	75%
TOTAL	16	8	50%

[1]Round up mathematical calculations to the whole number (e.g., 8.82 is reported as 9).
[2]ICU is the abbreviation for intensive care unit, where patients who need constant monitoring receive care.
[3]SCN is the abbreviation for special care nursery, where premature infants, twins, triplets, and so on, receive care.

Section A

Under the Deaths column of the table (Column 3, Row 16), the number of ICU deaths should be 2. RATIONALE: Because the Autopsies # data column is accurate and the subtotal of deaths is 62, there is an incorrect data entry in a cell above the Total row. Upon review of the data in each row for Autopsies, # and %, the calculated ICU autopsies percentage is 50%, which means that there were 2 ICU deaths.

Under the Autopsies column of the table (Column 4, Row 4), the Autopsies % for the Medicine service should be 20%. RATIONALE: The Autopsies % in the Medicine service data cell is incorrect because $(8 \div 40) \times 100 = 20\%$ (not 25%). (The number 40 in the formula represents the number of Medicine deaths, located in Column 3.)

Under the Autopsies column of the table (Column 4, Row 18), the Autopsies % for the Obstetrics data cell should be 100%. RATIONALE: The Autopsies % in the Obstetrics service data cell is incorrect because $(2 \div 2) \times 100 = 100\%$.

Section B

Under the Discharge Disposition section of the table (Column 2, Row 3, bottom left), the total expired should be 66. The total expired is correctly reported as 66 in the top portion of the table. (All data located in subtotal and total rows in the upper portion of the spreadsheet are correct.)

Section C

The Results, # of Patients, Total (Column 5, Row 10, bottom middle) should be 3,030 because 2,964 + 54 + 12 = 3,030, which also matches the total in the top portion of the table (Column 1) and the bottom portion of the table (Column 1).

ASSIGNMENT 1.6 – PHYSICIAN QUERY PROCESS

To:	Dr. Trevors
From:	Lisa Dubois (Coder04)
Date:	May 8, YYYY
Subject:	Query about patient record number 987654

Patient Name	**Patient Record Number**
Marian Reynolds	987654
Date of Encounter	**Location**
May 4, YYYY	Medical Center
Reason for Query	
Inadequate documentation	
Query or Comment	
Documentation indicates patient received intravenous fluids for the nursing diagnosis of dehydration. Would it be appropriate to document a diagnosis for coding? If so, add an addendum to the patient record. Thank you. LD	
Provider Reply	

ASSIGNMENT 1.7 – DOCUMENTATION AS A BASIS FOR CODING: DETERMINING MEDICAL NECESSITY

1. e
2. b
3. a
4. c
5. g
6. i
7. j
8. f
9. h
10. d

ASSIGNMENT 1.8 – OTHER CLASSIFICATIONS, DATABASES, AND NOMENCLATURES: SNOMED CT

1. a
2. c
3. d
4. c
5. a

REVIEW

Multiple Choice

1. b
2. c
3. b
4. d
5. b
6. a
7. d
8. d
9. d
10. b
11. a
12. a
13. c
14. b
15. b
16. b
17. d
18. a
19. d
20. b