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Clinical Examples Used in this Book
AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides, exams, and workbooks are actual, redacted office visit and procedure notes donated by AAPC members.

To preserve the real world quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.
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Introduction

The medical record is chronological documentation of a patient's medical history and care. Entries are made by all types of providers who provide healthcare services to a patient and include identification information, a patient's health history, medical examination documentation and findings, and test results, among other information. Regulations dictate the privacy of and sharing of this information, as well as what is the required documentation in the medical record. This chapter will discuss the Health Insurance Portability and Accountability Act (HIPAA) and its effect on the medical record, legal requirements for medical records, and basic structure and components of the medical record.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA was enacted on August 21, 1996 to provide rights and protections for participants and beneficiaries of group health plans. Under this law, exclusions for pre-existing conditions were limited, and discrimination against employees and dependents based on their health status were prohibited. HIPAA also established the Healthcare Fraud and Abuse Control Program, a far-reaching program to combat fraud and abuse in healthcare, which includes both public and private health plans.

HIPAA Administrative Simplification provisions required that sections of the law be publicized to explain the standards for the electronic exchange, privacy, and security of health information. Congress did not enact privacy legislation within the specified time governed by HIPAA; therefore, The U.S. Department of Health and Human Services (HHS) developed a proposed rule, which was published and released in final form on August 14, 2002.

Privacy Rule

The Privacy Rule standards address how an individual's protected health information (PHI) may be used. Its purpose is to protect individual privacy, while promoting high quality healthcare and public health and well-being. All covered entities are required to follow the Privacy Rule. Covered entities are defined as health plans, healthcare clearinghouses, and any healthcare provider who transmits health information in an electronic format.

- **Health Plan** covered entities are organizations that pay providers on behalf of an individual receiving medical care. These plans include health, dental, vision, and prescription drug insurers (for example, Health Maintenance Organizations (HMOs), Medicare, Medicaid, and employer, government, and church-sponsored group health plans). There are exceptions:
  - An employer who solely establishes and maintains the plan with fewer than 50 participants is exempt.
  - Two types of government-funded programs are not health plans: food stamps and community health centers.
  - Insurers providing only worker’s compensation, automobile insurance, and property and casualty insurance are not considered to be health plans.

- **All healthcare providers** who electronically transmit health information through certain transactions are covered entities. Some examples of transactions that may be submitted electronically are claim forms, inquiries about eligibility of benefits, and requests for authorization of referrals. Simply using electronic technology, such as sending emails, does not mean a healthcare provider is a covered entity; the transmission must be relating to a standard transaction. The rule applies to all healthcare providers, regardless of whether they transmit the transactions directly, or use a billing service or other third party to transmit on their behalf.

- **Healthcare clearinghouses** include billing services, re-pricing companies, and community health management information systems that process nonstandard information received from another entity into a standard format (for example, data content), or vice versa.

Transactions occur through electronic exchanges, which allow information to be transferred between two parties for specific purposes. A healthcare provider will send a claim to a health plan to request payment for medical services. HIPAA regulations standardized transactions for Electronic Data Interchange (EDI) of healthcare data. These transactions are: claims, encounter information, payment, remittance advice, claims status, eligibility, enrollment, disenrollment, referrals, authorizations, coordination of benefits, and premium payment.

Under HIPAA, electronic transactions must use the adopted standard and adhere to the content and format requirements of ASC X12N or NCPDP (used for certain pharmacy services) for each transaction. An additional rule was adopted to stan-
<table>
<thead>
<tr>
<th>Visit</th>
<th>Date</th>
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<tr>
<td>_____ min</td>
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<tr>
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<td>_____ min</td>
<td>_____ min</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Modalities List each below**

- **Cold packs**
  - 15 min
  - _____ min
  - _____ min

- **Electrical Stimulation**
  - _____ min
  - _____ min
  - _____ min

- **Mechanical Traction**
  - 15 min
  - _____ min
  - _____ min

**Total Time (Code Treatment Time)**

- 90 minutes

**Time IN**

- 9:00

**Time Out**

- 10:30

**PT Initials**

- MR

---

**Physical Therapy Fee Ticket**

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<th>Patient Name</th>
<th>N. Rodriguez</th>
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<tr>
<td>Medical Record Number/Account Number</td>
<td>34789</td>
</tr>
<tr>
<td>Referring Physician</td>
<td>L. Stukey, MD</td>
</tr>
<tr>
<td>Treating Physician</td>
<td>L. Stukey, MD</td>
</tr>
<tr>
<td>Provider</td>
<td>M. Ridenour PT</td>
</tr>
<tr>
<td>Insurance Company</td>
<td>Medicare/UHC</td>
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</table>

**Comments**

---

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<th>Date of Service</th>
<th>Facility</th>
<th>Place of service</th>
<th>CPT® Code</th>
<th>Diagnosis Code(s)</th>
<th>Modifier</th>
<th>Quantity</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/12/20XX</td>
<td>ADT Physical Therapy</td>
<td>11</td>
<td>97530</td>
<td>M54.17</td>
<td>GO</td>
<td>4</td>
<td>$400.00</td>
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<tr>
<td>12/12/20XX</td>
<td>ADT Physical Therapy</td>
<td>11</td>
<td>97010</td>
<td>M54.17</td>
<td>GP</td>
<td>1</td>
<td>$100.00</td>
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<td>M54.17</td>
<td>GP</td>
<td>1</td>
<td>$100.00</td>
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</table>

**Total**

- $700.00

47. When summarizing the findings in the audit report, what issue should be addressed regarding the physical therapist’s documentation?

A. Total duration of time is not documented in the medical record.
B. Time in and out is not documented on the encounter form.
C. 97014 is not supported in the documentation.
D. 97010 is not supported in the documentation.
48. **Answer:** C. Incorrect modifier appended to 97530.

**Rationale:** GO is appended to 97530, which represents services delivered under an outpatient occupational therapy plan of care. GP represents services delivered under a physical therapy plan of care.

---

**CASE 10**

PATIENT: J. Nichols  
DATE: 4/13/20XX  
REFERRING PHYSICIAN: Stephen Klein, M.D.

CHIEF COMPLAINT: **Chronic UTIs**

**HISTORY OF PRESENT ILLNESS:** Ms. Pinkston is a 29-year-old young lady referred to us by Dr. Klein for evaluation of the above and advice on treatment. She states that she underwent a C-section in 20XX, which was complicated by a reaction to the epidural as well as a post-op hematoma. It has resulted in decreased sensation of her bladder filling. She has mild urge incontinence and urgency, which was preceded by a stress incontinence that she has not been treated for. This has also resulted in a urinary tract infection about once a month. She seemed to be doing timed voiding on her own to decrease the amount of urine and to have fewer accidents. She says she has good stream when she voids. She feels like she does not completely empty. She has had no dysuria, frequency, or hematuria but does have nocturia three times a night. Thus Dr. Klein referred her to us for evaluation of the infections and urinary incontinence. She has no history of stones, sexually transmitted disease, or family history of any urologic problems.

**PAST MEDICAL HISTORY:** Significant for depression.

**PAST SURGICAL HISTORY:** Tonsillectomy, adenoidectomy, C-section and myringotomy tubes.

**MEDICATIONS:** Zoloft

**ALLERGIES:** STADOL, MORPHINE, LATEX, RELPAX

**SOCIAL HISTORY:** She is married and is a medical assistant at Max’s Dermatology. She does not smoke. Drinks occasionally. No history of alcohol abuse. Exercises regularly.

**FAMILY HISTORY:** Significant for hypertension.

**REVIEW OF SYSTEMS:** Please refer to the chart unless otherwise stated.


**LABS:** Urinalysis ordered.

**ASSESSMENT/PLAN:** We will have her obtain a MESA symptom score, voiding diary, and a local cystourethroscopy. We will obtain her records from Dr. Maddox for further evaluation and review.

Electronically signed by: Dan Brown, M.D., F.A.C.S.

Board Certified Urologist
4/13/20XX

Stephen Klein, M.D.
4444 SW ABC Trail
Colorado Springs, CO 29192

Dear Dr. Klein:

I appreciate your request to evaluate Sherry P for her chronic UTIs and urinary incontinence. She was seen today in my office. A brief summary and recommendations are as follows:

We will have her undergo some routine testing including a cystourethroscopy. We will obtain her records from her gynecologist and make further recommendations at that time.

Thank you again for your kind request for evaluation. I appreciate your gesture and will keep you updated regarding her urological progress.

Sincerely,

Dan C. Brown, M.D., F.A.C.S.

Patient Name J. Nichols
Medical Record Number/Account Number 0987654321
Treating Physician Dan C. Brown, MD
Referring Physician Stephen Klein, MD
Insurance Company Medicare

Office Coding Fee Ticket

<table>
<thead>
<tr>
<th>Date of Surgery</th>
<th>Facility</th>
<th>Place of service</th>
<th>CPT® Code</th>
<th>Diagnosis Code(s)</th>
<th>Modifier</th>
<th>Quantity</th>
<th>Fee</th>
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<tr>
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<td></td>
<td>99243</td>
<td>N39.0, N39.3</td>
<td>1</td>
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<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$175.00</td>
</tr>
</tbody>
</table>

\[1\] Chief complaint—chronic UTIs.
\[2\] Noted as a referral.
\[3\] Request for consult.
\[4\] ROS: Genitourinary.
\[5\] HPI: Context.
\[6\] HPI: Quality.
\[7\] HPI: Location.
\[8\] HPI: Severity.
\[9\] HPI: Associated Signs & Symptoms.
\[10\] HPI: Duration.
\[11\] ROS: Genitourinary.
\[12\] PFSH: Personal history.