NR511 Midterm Exam

Week 1

1. Define diagnostic reasoning

Reflective thinking because the process involves questioning one's thinking to determining if all possible avenues have been explored and if the conclusions that are being drawn are based on evidence. *Seen as a kind of critical thinking.

2. Discuss and identify subjective & objective data

- Subjective: What the pt tells you, complains of, etc. *Chief complaint, HPI, ROS
- Objective: What YOU can see, hear, or feel as part of your exam. *lab, data, dx test results.

3. Discuss and identify the components of the HPI

Specifically related to the CC only. Detailed breakdown of CC. OLDCART.

4. Describe the differences between medical billing and medical coding

- Medical coding: The use of codes to communicate with payers about which procedures were performed and why
- Medical billing: Process of submitting and following up on claims made to a payer in order to receive payment for medical services rendered by a healthcare provider.

5. Compare and contrast the 2 coding classification systems that are currently used in the US healthcare system

- CPT codes: Common procedural terminology. Offers the official procedural coding rules and guidelines required when reporting medical services and procedures performed by physician and nonphysician orders.
- ICD codes: International classification of disease. Used to provide payer info on necessity of visit or procedure performed.

6. Discuss how specificity, sensitivity & predictive value contribute to the usefulness of the diagnostic data

- Specificity: The ability of the test to correctly detect a specific condition. If a patient has a condition but test is negative, it is a false negative. If a patient does NOT have a condition but the test is positive , it is a false positive.
- Sensitivity: Test that has few false negatives. Ability of a test to correctly identify a specific condition when it is present. The higher the sensitivity, the lesser the likelihood of a false negative.
- Predictive Value: The likelihood that the pt actually has the condition and is, in part, dependent upon the prevalence of the condition in the population. If a condition is highly likely, the positive result would be more accurate.

7. Discuss the elements that need to be considered when developing a plan

Patient's preferences and actions. Research evidence. Clinical state/circumstances. Clinical expertise.

8. Describe the components of Medical Decision Making in E&M coding

Risk – data – diagnosis. The more time and consideration involved in dealing with a pt, the higher the reimbursement from the payer. Documentation must reflect the MDM!

9. Correctly order the E&M office visit codes based on complexity from least to most complex

New patient:

1. Minimal/RN visit: 99201
2. Problem focused: 99202
3. Expanded problem focused: 99203
4. Detailed: 99204
5. Comprehensive: 99205

Established patient:

6. Minimal/RN patient: 99211
7. Problem focused: 99212
8. Expanded problem focused: 99213
9. Detailed: 99214
10. Comprehensive: 99215

10. Discuss a minimum of three purposes of the written history and physical in relation to the importance of documentation

- Important reference document that vies concise info about the pt's hx and exam findings
- outlines a plan for addressing issues that prompted the visit. Info should be presented in a logical fashion that prominently features all data relevant to the pt's condition
- is a means of communicating info to all providers involved in patient's care.
- is a medical legal document
- is essential in order to accurately code and bill for services

11. Accurately document why every procedure code must have a corresponding diagnosis code

Diagnosis code explains the necessity of the procedure code. Insurance won't pay if they do not correspond.

12. Correctly identify a patient as new or established given the historical information

New patient: If that patient has never been seen in that clinic or by that group of providers OR if the pt has not been seen in the past 3 years

13. Identify the 3 components required in determining an outpatient, office visit E&M code

Place of service, type of service, patient status.

14. Describe the components of Medical Decision Making in E&M coding

Risk – data – diagnosis

15. Correctly order the E&M office visit codes based on complexity from least to most complex

· Repeat of #9?

New patient:

a. Minimal/RN visit: 99201
b. Problem focused: 99202
c. Expanded problem focused: 99203
d. Detailed: 99204
e. Comprehensive: 99205

Established patient:

f. Minimal/RN patient: 99211
g. Problem focused: 99212
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i. Detailed: 99214
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16. Explain what a "well rounded" clinical experience means

Includes seeing kids from birth through young adult visits for well child and acute visits as well as adults for wellness or acute/routine visits. Seeing a variety of patients including 15% of peds and 15% of women's health of total time in the program.

17. State the maximum number of hours that time can be spent "rounding" in a facility

No more than 25% of total practicum hours in the program

18. State 9 things that must be documented when inputting data into clinical encounter

1. Date of service
2. Age
3. Gender and Ethnicity
4. Visit E&M code
5. CC
6. Procedures
7. Tests performed and ordered
8. Dx
9. Level of involvement (mostly student, mostly preceptor, together, etc.)

19. Identify and explain each part of the acronym SNAPPS

- Summarize: present the pt's H&P findings
- Narrow: based on the H&P findings, narrow down to the top 2-3 differentials
- Analyze: analyze the differentials. Compare and contrast H&P findings for each of the differentials and narrow it down to the most likely one.
- Probe: ask the preceptor questions of anything you are unsure of.
- Plan: come up with a specific management plan
- Self-directed learning: an opportunity to investigate more about any topics that you are uncertain of.

<u>Week 2</u>

1. Identify the most common type of pathogen responsible for acute gastroenteritis

Bacteria: Staphylococcus
Viral: Norovirus (Norwalk virus) in adults and Rotavirus in Peds up to 2 yrs old.

2. Recognize that assessing for prior antibiotic use is a critical part of the history in patients presenting with diarrhea

Due to Risk for C Diff infection

3. Describe the difference between Irritable Bowel Disease (IBS) and Inflammatory Bowel Disorder (IBD)

IBS (Irritable Bowel Disease)

- a disorder of bowel function, not from anatomic abnormality;
- characterized by alternating bowel pattern, constipation and diarrhea;
- associated symptoms include abdo pain relieved w/defecation, bloating, rectal urgency w/diarrhea;
- Extra-intestinal symptoms: pain on intercourse or lack of libido, muscles aches&pain, fatigue, fibromyalgia syndrome, headache, back pain, urinary symptoms (urgency, hesitancy, bladder spasm);
- Not associated with serious medical consequences; tend to live long;
- Does not put stress on other organs (heart, liver, kidney)
- Major problem of IBS: the quality of life that people suffer

Inflammatory Bowel Disorder (IBD)

- A chronic immunological disease that manifests in intestinal inflammation.
- Characterized by exacerbations and remissions throughout lifetime.
- UC and CD -- most common

4. Discuss two common Inflammatory Bowel Diseases

Ulcerative colitis (UC):

- the thinner mucosa of the rectum and sigmoid colon become inflamed, which results in friability, erosions, and bleeding.
- More in male (age 10-40)
- Involved in the rectosigmoid areas, crypt abscess development
- Sx: bleeding, cramping, urge to defecate d/t mucosa destruction
- Tenderness LLQ or across the entire abdomen, often accompanied by guarding and abdo distension;
- Stools --watery diarrhea w/ blood and mucus d/t loss of absorptive surface
    - Fecal leukocytes almost always present
    - Mild form < 4 BM per day, relieved w/defecation, no associated systemic sx

- Moderate (4-6 BM/day), ↑ blood and mucus, systemic sx (tachy, fever, wt loss)
- Severe -- (6-10/day), abdo tenderness, symptoms of anemia, hypovolemia, and impaired nutrition, --risk for perf colon

Crohn's disease (CD):

- An inflammatory process that begins in the submucosa of the intestine and gradually spreads to involve the mucosa and serosa.
- Can involve all or any layer of the bowel wall and portion of GI tract from mouth to anus (about 80% small bowel involvement and 20% of the colon).
- More in female (age 15-25, 50-80)
- Greater risk for colorectal cancer
- Skipped lesions --some haustral segments are affected while others are not.
- cobblestone appearance--inflamed tissue is surrounded by scar tissue.
- Transmural inflammation -- serosal inflammation cause bowel loops to adhere to one another leads to obstruction, fistulas, and shortening of the bowel.
- Tenderness RLQ or mass
- Sx: abdo cramping, fever, anorexia, weight loss, spasm, flatulence,
- Stools contain blood, mucus, and/or pus
- Symptoms tend to increase during stress or after meals consisting of poorly tolerated fatty, spicy, or dairy.
- Steatorrhea- fatty stools d/t insufficient absorption of bile salt
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5. Discuss the diagnosis of diverticulitis, risk factors, and treatments

- Diagnosis = occurs when a patient's diverticulosis becomes inflamed and when the projection becomes eroded it can progress to the point of eruption causing left lower quad pain and tenderness, fever, change in bowel habits (usually diarrhea), N/V, mass, rebound tenderness with involuntary guarding and rigidity, occult blood. If there is a fistula, UA may show increased WBC and RBC, urine culture may be positive.
- Risk Factors = low fiber diet, hypertrophy of the segments of the circular muscle of the colon, chronic constipation and straining, irregular and uncoordinated bowel contractions, obesity, and weakness of the bowel muscle brought on by aging. Directly related to the suspected causes of the disease: older than age 40, low-fiber diet, previous diverticulitis, and the number of diverticula present in the colon.
- Treatments = metronidazole 500mg TID x 10-14 days along with Ciprofloxacin 500mg BID or trimethoprim/sulfamethoxazole DS 160/800 BID. Close office follow up should occur upon completion of abx therapy as complications such as abscess and perforation can occur.

6. Identify the significance of Barrett's esophagus

Thought to be caused by chronic GERD. Gastric contents are so irritating, an inflammatory response is established in the esophagus. Erosion occurs due to increased blood flow due to inflammation. As the erosion heals, the body replaces the normal squamous epithelium with metaplastic columnar epithelium (Barrett's epithelium) containing goblet and columnar cells.