NR511-Final Exam Study Guide

WEEK 1

1. Define diagnostic reasoning

Reflective thinking because the process involves questioning one's thinking to determine 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 data?

What the patient tells you, complains of, etc.
Chief complaint
HPI
ROS

3. Discuss and identify objective data?

What YOU can see, hear, or feel as part of your exam.
Includes lab data, diagnostic test results.
Components of HPI

4. Discuss and identify the components of the HPI

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

5. What is medical coding?

The use of codes to communicate with payers about which procedures were performed and why

6. What is 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.

7. What are CPT codes?

Common procedural terminology
Offers the official procedural coding rules and guidelines required when reporting

medical services and procedures performed by physician and non-physician providers.

8. What are ICD codes?

International classification of disease
Used to provide payer info on necessity of visit or procedure performed.

9. What is 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.

10. What is 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.

11. What is predictive value?

The likelihood that the patient 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.

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

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

13. 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 MDM!
evaluation and management (E&M)

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

New patient:	*Established patient:*
1. Minimal/RN visit: 99201	*Minimal RN visit: 99211*
2. Problem focused: 99202	*Problem focused: 99212*
3. Expanded problem focused: 99203	*Expanded problem focused: 99213*
4. Detailed: 99204	*Detailed: 99214*
5. Comprehensive: 99205	*Comprehensive: 99215*

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

Important reference document that gives 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 the pt's care.
Is a medical-legal document.
Is essential in order to accurately code and bill for services.

16. 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 don't correspond.

17. Correctly identify a patient as new or established given the historical information
If that pt 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.

18. Identify the 3 components required in determining an outpatient, office visit E&M code
Place of service
Type of service
Patient status

19. Describe the components of Medical Decision Making in E&M coding
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Data
Diagnosis
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20. 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 pt's, including 15% of peds and 15% of women's health of total time in the program.

21. 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

22. State 9 things that must be documented when inputting data into clinical encounter
Date of service
Age
Gender and ethnicity
Visit E&M code
CC
Procedures
Tests performed and ordered
Dx

Level of involvement (mostly student, mostly preceptor, together, etc.)

23. What is the first "S" in the SNAPPS presentation?

Summarize: present the pt's H&P findings

24. What is the "N" in the SNAPPS presentation?

Narrow: based on the H&P findings, narrow down to the top 2-3 differentials

25. What is the "A" in the SNAPPS presentation?

Analyze: analyze the differentials. Compare and contrast H&P findings for each of the differentials and narrow it down to the most likely one

26. What is the first "P" in the SNAPPS presentation?

Probe: ask the preceptor questions of anything you are unsure of.

27. What is the second "P" in the SNAPPS presentation?

Plan: come up with a specific management plan

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28. What is the last "S" in the SNAPPS presentation?

Self-directed learning: an opportunity to investigate more about any topics that you are uncertain of.

WEEK 2

1. What is the most common type of pathogen responsible for acute gastroenteritis?
   Viral (can be viral, bacterial, or parasitic), usually **norovirus**

2. Assessing for prior antibiotic use is a critical part of the history in patients presenting with diarrhea. True

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

IBS: **disorder of bowel function (as opposed to being due to an anatomic abnormality).**

Changes in bowel habits (diarrhea, constipation, abd pain, bloating, rectal urgency w/diarrhea).
Symptoms fall into two categories: abd pain/altered bowel habits, and **painless diarrhea. Usually pain is LLQ.**
PE: normal except for tenderness in colon.
Labs: CBC, ESR. Most other labs and radiology/scopes are normal.
Dx made on careful H&P.
May be associated with non-intestinal (extra-intestinal) symptoms (sexual function difficulty, muscle aches/pains, fatigue, fibromyalgia, HAs, back pain, urinary symptoms).
Not associate with serious medical consequences. Not a risk factor for other serious GI dz's.
Does not put extra stress on other organs.
Overall prognosis is excellent.
Major problem: changes quality of life.
Treatment: based on symptom pattern. May include diet, education, pharm (for mod-severe pt's)/other supportive interventions. Usually focuses on lifestyle, diet, and stress reduction. NO PROVEN TREATMENT! Antidiarrheals: use temporarily, reserve for severe. Loperamide (Imodium) or diphenoxylate (Lomotil) 2.5-5mg q6h usually works.
Constipation: high fiber diet, hydration, exercise, bulking agents. If these don't work, intermittent use of stimulant laxatives (lactulose or mag hydroxide); don't use long-term! Linzess (linaclotide), Trulance (plecanatide), and Amitiza (lubiprostone): newer for constipation, work locally on apical membrane of GI tract to increase intestinal fluid secretion and improve fecal transit. Abd pain: dicloclymine (Bentyl), hyoscyamine (avoid anticholinergics in glaucoma and BPH, especially in elderly). TCAs and SSRIs can relieve symptoms in some pt's.
Can be managed by PCP, but if not responsive to tx, refer to GI.

IBD: chronic immunological dz that manifests in intestinal inflammation.

UC and Crohn's are most common.

UC: mucosal surface of colon is inflamed, resulting in friability, erosions, bleeding. Usually occurs in rectosigmoid area, but can involve entire colon. Ulcers form in eroded tissue, abscesses form in crypts, become necrotic and ulcerate, mucosa thickens/swells, narrowing lumen. Pt's are at risk for perforation. Symptoms: bleeding, cramping, urge to defecate. Stools are watery diarrhea with blood/mucus. Fecal leuks almost always present in active UC. Tenderness usually in LLQ or across entire abd.
Crohn's: inflammation extends deeper into intestinal wall. Can involve all or any layer of bowel wall and any portion of GI tract from mouth to anus. Characteristic segmental presentation of dz'd bowel separated by areas of normal mucosa ("skipped lesions"). With progression, fibrosis thickens bowel wall, narrowing lumen, leading to obstructions, fistulas, ulcerations. Pt's are at greater risk for colorectal cancer. Most common symptoms: cramping, fever, anorexia, wt loss, spasms, flatulance, RLQ pain/mass, bloody/mucus/pus stools. Symptoms increase with stress, after meals. 50% of pt's have perianal involvement (anal/perianal fissures).
Inflammation can lead to bleeding, fever, increased WBC, diarrhea, cramping. Abnormalities can be seen on cross-sectional imaging or colonscopy.
No single explanation for IBD. Theory: viral, bacterial, or allergic process initially inflames small or large intestine, results in antibody development which chronically attack intestine, leading to inflammation. Possible genetic predisposition.
Dx made by H&P correlated with symptoms, must exclude infectious cause for colitis. Primary dx tools: sigmoidoscopy, colonoscopy, barium enema w/small bowel follow-through, CT.
Tx is very complex, managed by GI.
Drugs: 5-aminosalicylic acid agents have been used for >50yrs, but have shown to be of little value in CD; still used as first attempt for UC. Antidiarrheals w/caution (constipation). Don't use in acute UC or if toxic megacolon. Corticosteroids used when 5-ASA not working. If corticosteroids don't work, use immunomodulators (azathioprine, methotrexate, 6-mercaptopurine), but can cause bone marrow suppression and infection. Newer class: anti-TNF (biologic response modifiers) for mod-severe dz. Remicade (infliximab), Humira (adalimumab), Entyvio (vedolizumab); can increase risk of infection.

4. Discuss two common Inflammatory Bowel Diseases
UC and Crohn's are most common.

5. Discuss the diagnosis of diverticulitis, risk factors, and treatments

Subjective:
S/S of infection (fever, chills, tachycardia)
Localized pain LLQ
Anorexia, n/v
If fistula present, additional s/s will be present associated w/affected organ (dysuria, pneumaturia, hematachzia, frank rectal bleeding, etc)

Objective:
Tenderness in LLQ
Maybe firm, fixed mass at area of diverticuli
Maybe rebound tenderness w/involuntary guarding/rigidity
Hypoactive bowel sounds initially, then hyperactive if obstructive process present
Rectal tenderness
+occult blood

Diagnostics:
Mild-moderate leukocytosis
Possibly decreased hgb/hct r/t rectal bleeding
Bladder fistula: urine will have increased WBC/RBC, culture may be +
If peritonitis, blood culture should be done (for bacteremia)
Abd XR: perforation, peritonitis, ileus, obstruction
CT may be needed to confirm

6. Identify the significance of Barrett's esophagus.

A condition in which the esophageal lining is replaced by a tissue resembling intestinal lining. Squamous lining of lower esophagus turns into columnar epithelium (goblet cells).

Average age of onset: 55

1.6 – 6.8% of persons affected (5-10% of people with GERD get Barrett's esophagus).

Risk Factors:

- GERD
- Obesity
- Smoking
- Age
- Gender
- Ethnicity

Signs/Symptoms:

1. Long-term indigestion-heart burn, fullness, bloating, belching
2. difficulty swallowing food
3. losing symptoms of GERD without doing anything

Diagnosis:

Upper endoscopy & biopsy if cells are present

How to tx:

Medications (acid suppressing (proton pump inihibitors)

Endoscopic ablative therapies

Endoscopic mucosal resection

Esophagectomy

Increases Risk of BE:

- H. pylori
- NSAIDS and aspirins
- Diet and nutrition

Decreases Risk of BE:

- Folate
- Vitamin E
- Intake of Lutein

7. What is best test for diagnosing GERD?

24 pH probe

- Probe through nose, sits in esophagus for 24 hours
- Constantly monitors pH

Heartburn is typical symptom. Usually occurs 30-60 min after meals and with reclining. Burning chest pain and regurgitation are common. Pain may be relieved by antacids.
Most have no structural defects
Non-GI symptoms included asthma, chronic cough, laryngitis, sore throat or non-cardiac chest pain.

8. Risk factors of GERD:

Obesity
Pregnancy
Smoking
Collagen Vascular Disease
ETOH use
Hiatal Hernia
Gender (more common in males)