Thinking It Through 17.1 page 540
1. [Note that students need to research this question using CPT.]
   The initial visit is coded from range 99221 – 99223, and follow-up visits from range 99231 – 99239. The hospital would not use these codes, because CPT is the required code set for physicians, rather than facilities.

Thinking It Through 17.2 page 550
1. Students may cite differences in the employer’s size, the number of people with whom to interact, and much more specialization in the hospital setting. The instructor may wish to point out that hospital billing departments are often divided either by payer or by alphabetically organized patient groups.

Thinking It Through 17.3 page 552
1. The principal diagnosis is the reason for the admission—diverticulitis with bleeding. A Z code is reported to show that the patient decided not to proceed.

Thinking It Through 17.4 page 555
1. Students may feel more at ease with ICD-10-CM because of familiarity, or they may decide that the inherent logic of building codes is easier to work with.

Thinking It Through 17.5 page 559
1. The Medicare PPS and capitation rates are similar in that both set fixed rates for services. Hospitals are paid after patients are discharged, however, not by prepayment. Also, in the PPS system, the patients’ comorbidities and complications can be reported to increase the reimbursement, while a cap rate must cover all services, regardless of a patient’s relative condition.

Thinking It Through 17.6 page 570
1.  1 Facility name and address
2.  5 Federal tax number
3.  6 Statement covers period (from--through)
4.  8b Patient’s name
5.  9a-e Patient’s address
6.  10 Patient’s birth date
7.  51 Patient’s health plan ID
8.  3a Patient’s control number
9.  11 Patient’s sex
10. 3b Patient’s medical record number
11. 13 Admission hour
12. 14 Type of admission
13. 16 Discharge hour
14. 58 Insured's name
15. 59 Patient's relationship to insured
16. 60 Insured's payer ID number
17. 50 Payer name
18. 42 Revenue code(s)
19. 43 Revenue description
20. 46 Units
21. 47 Charges
22. 67 Principal diagnosis code and POA indicator
23. 76 Attending provider name and ID

ANSWERS TO REVIEW QUESTIONS

Matching page 572

1. C  6. I
2. J  7. G
3. F  8. B
4. A  9. D
5. H  10. E

Multiple Choice page 573

2. C  7. D
3. C  8. A
4. D  9. A
5. C  10. A

Completion page 573

1. DRG: diagnosis-related group
2. PPS: prospective payment system
3. SNF: skilled nursing facility
4. ASC: ambulatory surgical center
5. HHA: home health agency
ANSWERS TO APPLYING YOUR KNOWLEDGE

Case 17.1 page 574
A. adenocarcinoma of the prostate
B. probable acute cholecystitis.
C. principal diagnosis: (probable) bronchiectasis
   procedure: bronchoscopy
   comorbidity: (probable or suspected) pulmonary fibrosis
   complication: post-bronchoscopy fever

Case 17.2 page 574
A. $3,805
B. $3,600
C. Written off
### Case 17.3 Page 575

#### Case Details
- **Patient Name:** KELLY, MARVIN
- **Location:** HARTFORD, CT
- **Hospital:** HANOVER REGIONAL HOSPITAL
- **Address:** 46 STATE ST
- **Phone:** 860-376-2089

#### Charges

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>9171</td>
<td>Nursery/Newborn Level 1</td>
<td>552.00</td>
</tr>
<tr>
<td>0570</td>
<td>Medical-Surgical Supplies</td>
<td>54.44</td>
</tr>
<tr>
<td>0180</td>
<td>Lab</td>
<td>35.09</td>
</tr>
<tr>
<td>0994</td>
<td>Lab-Chemistry</td>
<td>517.04</td>
</tr>
<tr>
<td>0845</td>
<td>Lab-Hematology</td>
<td>72.87</td>
</tr>
<tr>
<td>0919</td>
<td>Lab Pathology-Other</td>
<td>55.28</td>
</tr>
</tbody>
</table>

#### Summary
- **Total Amount:** 2902.72

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**Note:** The image content is a medical bill from a hospital, detailing various charges and payments.
Case 17.3 Notes

- FL 14 (Type of Admission/Visit): Code 4 indicates the patient is a newborn. When code 4 is used, a point of origin for admission code corresponding to newborns must also be used in FL 15 (Point of Origin for Admission or Visit). The code reported in FL 15 is 5, which for newborns indicates that the newborn was born inside this hospital. If the patient were not a newborn, code 5 in FL 15 would indicate the patient was a transfer from an SNF or ICF.

- FL 42 (Revenue Code): With the exception of revenue code 0001, which is reserved for line 23, revenue codes in the UB-04 should be listed in ascending numeric order, as shown in the claim case answer key for case 17.3 above.

- FL 67: In the Patient Services data, the principal diagnosis code on the claim reports POA indicator 1 (Exempt from POA reporting). Because the claim is for a newborn born in the hospital, the newborn’s condition is considered exempt from POA reporting.