

icd 10 code for wellness visit

ICD-10 Code for Wellness Visit: A Comprehensive Guide

Are you searching for the elusive ICD-10 code for a wellness visit? The answer isn't as straightforward as you might think. Unlike many medical procedures and diagnoses, routine wellness visits don't typically receive a specific ICD-10 code. This blog post will unravel the complexities surrounding coding wellness visits, exploring the nuances, offering alternative approaches, and guiding you towards accurate billing and record-keeping. We'll cover why there's no single code, the codes you might use in specific circumstances, and the crucial steps to ensure proper documentation. Let's dive in!

Why There's No Single ICD-10 Code for a Wellness Visit

The primary reason there's no dedicated ICD-10 code for a general wellness visit boils down to the fundamental purpose of the International Classification of Diseases (ICD) system. ICD-10 codes are designed to classify diseases and injuries, not preventative healthcare. A wellness visit focuses on maintaining health, screening for potential issues, and promoting preventative measures. It's not a treatment for an existing condition. Using an incorrect code can lead to inaccurate data, billing issues, and potential audits.

This doesn't mean you should skip coding altogether. Accurate documentation is crucial for tracking patient health, justifying reimbursement, and maintaining regulatory compliance.

Understanding the Role of Evaluation and Management (E&M) Codes

Instead of an ICD-10 code, wellness visits are typically coded using Evaluation and Management (E&M) codes. These codes from the Current Procedural Terminology (CPT) system describe the type and complexity of the physician's services rendered during the visit. The choice of E&M code depends on several factors:

History: The extent of the patient's history taken during the visit (detailed history, expanded problem focused, etc.).

Examination: The complexity of the physical examination performed (comprehensive, expanded problem focused, problem focused, etc.).

Medical Decision-Making: The complexity of the medical decision-making involved (high, moderate, low).

Proper documentation is key to selecting the correct E&M code. Your notes should clearly reflect the level of history, examination, and decision-making involved in the wellness visit. This ensures accurate billing and avoids potential denials.

Circumstances Where ICD-10 Codes Might Be Applicable

While a general wellness visit doesn't typically warrant an ICD-10 code, certain circumstances might necessitate their use. For example:

Screening and preventative services resulting in a diagnosis: If during a wellness visit, a screening test reveals a diagnosis (e.g., hypertension detected during blood pressure screening), then the appropriate ICD-10 code for that diagnosis should be used along with the relevant E&M code. For instance, a diagnosis of hypertension might use code I10.

Addressing specific concerns: If the patient presents with a specific complaint or symptom during a wellness visit, the corresponding ICD-10 code should be applied. For example, a patient expressing concerns about persistent fatigue might warrant a code related to fatigue, although a definitive diagnosis might not be established at that visit.

Follow-up visits: If a patient is undergoing monitoring for a previously diagnosed condition as part of their wellness plan, the relevant ICD-10 code for that condition should be utilized alongside the E&M code reflecting the level of service.

In these cases, it is crucial to accurately document the reason for the visit, the findings, and the diagnostic process. This supports the justification for utilizing both the E&M and ICD-10 codes.

Documentation: The Cornerstone of Accurate Coding

Regardless of whether ICD-10 codes are used, thorough documentation is paramount. Your records should clearly detail:

Reason for the visit: State explicitly that the visit is a wellness check-up or preventative care visit.

History: Record the patient's medical history, including family history and any significant past medical issues.

Examination: Document the physical examination performed, including vital signs, pertinent findings, and any abnormal results.

Assessment and Plan: Outline your assessment of the patient's overall health and any recommendations for future care or follow-up.

Counseling and preventative services provided: Detail any preventative services offered (e.g., immunizations, screening recommendations) and the patient's response.

Complete and accurate documentation not only facilitates accurate coding but also protects you from potential audits and ensures the best possible patient care.

Choosing the Right E&M Code: A Practical Example

Let's imagine a typical wellness visit for a 45-year-old patient. The physician reviews the patient's history (covering past medical issues and family history), performs a comprehensive physical examination (including vital signs, auscultation, etc.), and discusses preventative measures like diet, exercise, and screening recommendations. The medical decision-making is moderate complexity, considering the information gathered and the recommendations given. This scenario might warrant a 99213 or 99214 E&M code (depending on the specific time spent and documentation). Always consult the CPT codebook for the most up-to-date guidelines.

Conclusion

Finding the "ICD-10 code for wellness visit" is a misleading quest. Wellness visits, being preventative and focused on health maintenance, are primarily coded using E&M codes. However, ICD-10 codes become relevant if a diagnosis is made during the visit or if the visit is related to the management of a pre-existing condition. Accurate documentation is the key to accurate coding and successful reimbursement. Remember to always consult the most current CPT and ICD-10 manuals for precise coding guidelines.

FAQs

1. Can I use Z codes for a wellness visit? While Z codes represent factors influencing health status, they are generally not appropriate for a standard wellness visit without a specific diagnosis.
1. What if my insurance company requires an ICD-10 code? You should clarify with your insurance provider. They may accept a specific code to process the claim, or they may specifically require the use of E&M codes for wellness visits.
1. How often should I conduct a wellness visit? The frequency of wellness visits varies depending on age, health status, and risk factors. Consult with your patients and refer to relevant guidelines for recommended intervals.
1. What if I discover a new condition during a wellness visit? You would then use both the relevant ICD-10 code for the newly discovered condition, along with the appropriate E&M code for the visit's complexity.
1. Are there specific guidelines for documenting wellness visits? Yes, refer to your professional organization's guidelines and best practices for proper documentation. This ensures compliance and accurate billing.

icd 10 code for wellness visit: ICD-10-CM Official Guidelines for Coding and Reporting - FY 2021 (October 1, 2020 - September 30, 2021) Department Of Health And Human Services, 2020-09-06 These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

icd 10 code for wellness visit: ICD-10-CM: Official Guidelines for Coding and Reporting - FY 2019 (October 1, 2018 - September 30, 2019) Centers for Medicare and Medicaid Services (CMS), National Center for Health Statistics (NCHS), U.S. Department of Health and Human Services (DHHS), 2018-08 These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings.

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impairments arising from a traumatic brain injury.

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identify coding notes and instructions, additional character requirements, codes associated with CMS hierarchical condition categories (HCC), Medicare Code Edits (MCEs), manifestation codes, other specified codes, and unspecified codes. Placeholder X. This icon alerts the coder to an important ICD-10-CM convention--the use of a placeholder X for three-, four- and five-character codes requiring a seventh character extension. Coding guideline explanations and examples. Detailed explanations and examples related to application of the ICD-10-CM chapter guidelines are provided at the beginning of each chapter in the tabular section. Muscle/tendon translation table. This table is used to determine muscle/tendon action (flexor, extensor, other), which is a component of codes for acquired conditions and injuries affecting the muscles and tendons Index to Diseases and Injuries. Shaded guides to show indent levels for subentries. Appendices. Supplement your coding knowledge with information on proper coding practices, risk adjustment coding, pharmacology, and Z codes.

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icd 10 code for wellness visit: Assessing Health Outcomes Among Veterans of Project SHAD (Shipboard Hazard and Defense) National Academies of Sciences, Engineering, and Medicine, Institute of Medicine, Board on the Health of Select Populations, Committee on Shipboard Hazard and Defense II (SHAD II), 2016-02-15 Between 1963 and 1969, the U.S. military carried out a series of tests, termed Project SHAD (Shipboard Hazard and Defense), to evaluate the vulnerabilities of U.S. Navy ships to chemical and biological warfare agents. These tests involved use of active

chemical and biological agents, stimulants, tracers, and decontaminants. Approximately 5,900 military personnel, primarily from the Navy and Marine Corps, are reported to have been included in Project SHAD testing. In the 1990s some veterans who participated in the SHAD tests expressed concerns to the Department of Veterans Affairs (VA) that they were experiencing health problems that might be the result of exposures in the testing. These concerns led to a 2002 request from VA to the Institute of Medicine (IOM) to carry out an epidemiological study of the health of SHAD veterans and a comparison population of veterans who had served on similar ships or in similar units during the same time period. In response to continuing concerns, Congress in 2010 requested an additional IOM study. This second study expands on the previous IOM work by making use of additional years of follow up and some analysis of diagnostic data from Medicare and the VA health care system.

icd 10 code for wellness visit: Improving Diagnosis in Health Care National Academies of Sciences, Engineering, and Medicine, Institute of Medicine, Board on Health Care Services, Committee on Diagnostic Error in Health Care, 2015-12-29 Getting the right diagnosis is a key aspect of health care - it provides an explanation of a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem. According to *Improving Diagnosis in Health Care*, diagnostic errors-inaccurate or delayed diagnoses-persist throughout all settings of care and continue to harm an unacceptable number of patients. It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, providing unnecessary or harmful treatment, or resulting in psychological or financial repercussions. The committee concluded that improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative. *Improving Diagnosis in Health Care*, a continuation of the landmark Institute of Medicine reports *To Err Is Human* (2000) and *Crossing the Quality Chasm* (2001), finds that diagnosis-and, in particular, the occurrence of diagnostic errors-has been largely unappreciated in efforts to improve the quality and safety of health care. Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity. Just as the diagnostic process is a collaborative activity, improving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policy makers. The recommendations of *Improving Diagnosis in Health Care* contribute to the growing momentum for change in this crucial area of health care quality and safety.

icd 10 code for wellness visit: Application of the International Classification of Diseases to Neurology World Health Organization, 1997-10-02 Gives specialists in the clinical neurosciences a detailed and authoritative instrument for coding virtually all recognized neurological conditions. Both neurological diseases and neurological manifestations of general diseases and injuries are included in this comprehensive coding tool. The volume is part of a growing family of specialty-based adaptations of ICD-10 which retain the core codes of the parent classification while providing extended detail at the fifth character and beyond. Now in its second edition ICD-NA has been revised to reflect current clinical concepts in the neurosciences as well as the new coding system introduced with ICD-10. The classification was finalized following extensive consultation with numerous professional organizations and international experts thus ensuring the representation of as many viewpoints as are practical and consistent. While remaining directly compatible with ICD-10 ICD-NA offers clinicians and researchers much greater precision allowing them to match an explicit diagnosis with a detailed code at the five- six or seven-character level. In addition a comprehensive alphabetical index and the extensive use of inclusion and exclusion terms provide considerable assistance in finding the correct category for any condition diagnosed. Apart from these opportunities for recording greater diagnostic detail the direct compatibility with ICD-10 facilitates comparisons between statistics compiled according to ICD-NA and national morbidity and mortality statistics compiled according to ICD-10. These features enhance the flexibility of ICD-NA making it

suitable for use in morbidity statistics hospital record indexing and epidemiological research by government and other health agencies collecting statistical data under relatively few main headings or by individual physicians and researchers requiring a convenient tool for indexing their clinical and teaching material in sufficient detail. The revised classification should also facilitate the collection of epidemiological data comparisons of the prevalence of individual neurological diseases and identification of the risk factors for these diseases at both national and international levels. In addition to the detailed tabular list of neurological and related disorders the volume includes an explanation of the basic principles of classification and instructions for coding morphology codes for neoplasms relevant to neurology and neurosurgery and a 90-page index of diagnostic terms given in standard or official nomenclatures together with synonyms and eponyms.

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icd 10 code for wellness visit: Occupational Therapy Practice Framework: Domain and Process Aota, 2014 As occupational therapy celebrates its centennial in 2017, attention returns to the profession's founding belief in the value of therapeutic occupations as a way to remediate illness and maintain health. The founders emphasized the importance of establishing a therapeutic relationship with each client and designing an intervention plan based on the knowledge about a client's context and environment, values, goals, and needs. Using today's lexicon, the profession's founders proposed a vision for the profession that was occupation based, client centered, and evidence based--the vision articulated in the third edition of the Occupational Therapy Practice Framework: Domain and Process. The Framework is a must-have official document from the American Occupational Therapy Association. Intended for occupational therapy practitioners and students, other health care professionals, educators, researchers, payers, and consumers, the Framework summarizes the interrelated constructs that describe occupational therapy practice. In addition to the creation of a new preface to set the tone for the work, this new edition includes the following highlights: a redefinition of the overarching statement describing occupational therapy's domain; a new definition of clients that includes persons, groups, and populations; further delineation of the profession's relationship to organizations; inclusion of activity demands as part of

the process; and even more up-to-date analysis and guidance for today's occupational therapy practitioners. Achieving health, well-being, and participation in life through engagement in occupation is the overarching statement that describes the domain and process of occupational therapy in the fullest sense. The Framework can provide the structure and guidance that practitioners can use to meet this important goal.

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icd 10 code for wellness visit: The Best Intentions Committee on Unintended Pregnancy, Institute of Medicine, 1995-06-16 Experts estimate that nearly 60 percent of all U.S. pregnancies--and 81 percent of pregnancies among adolescents--are unintended. Yet the topic of preventing these unintended pregnancies has long been treated gingerly because of personal sensitivities and public controversies, especially the angry debate over abortion. Additionally, child welfare advocates long have overlooked the connection between pregnancy planning and the improved well-being of families and communities that results when children are wanted. Now, current issues--health care and welfare reform, and the new international focus on population--are drawing attention to the consequences of unintended pregnancy. In this climate The Best Intentions offers a timely exploration of family planning issues from a distinguished panel of experts. This committee sheds much-needed light on the questions and controversies surrounding unintended pregnancy. The book offers specific recommendations to put the United States on par with other developed nations in terms of contraceptive attitudes and policies, and it considers the effectiveness of over 20 pregnancy prevention programs. The Best Intentions explores problematic definitions--unintended versus unwanted versus mistimed--and presents data on pregnancy rates and trends. The book also summarizes the health and social consequences of unintended pregnancies, for both men and women, and for the children they bear. Why does unintended pregnancy occur? In discussions of reasons behind the rates, the book examines Americans' ambivalence about sexuality and the many other social, cultural, religious, and economic factors that affect our approach to contraception. The committee explores the complicated web of peer pressure, life aspirations, and notions of romance that shape an individual's decisions about sex, contraception, and pregnancy. And the book looks at such practical issues as the attitudes of doctors toward birth control and the place of contraception in both health insurance and managed care. The Best Intentions offers frank discussion, synthesis of data, and policy recommendations on one of today's most sensitive social topics. This book will be important to policymakers, health and social service personnel, foundation executives, opinion leaders, researchers, and concerned individuals. May

icd 10 code for wellness visit: Registries for Evaluating Patient Outcomes Agency for Healthcare Research and Quality/AHRQ, 2014-04-01 This User's Guide is intended to support the design, implementation, analysis, interpretation, and quality evaluation of registries created to increase understanding of patient outcomes. For the purposes of this guide, a patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes. A registry database is a file (or files) derived from the registry. Although registries can serve many purposes, this guide focuses on registries created for one or more of the following purposes: to describe the natural history of disease, to determine clinical effectiveness or cost-effectiveness of health care products and services, to measure or monitor safety and harm, and/or to measure quality of care. Registries are classified according to how their populations are defined. For example, product registries include patients who have been exposed to biopharmaceutical products or medical devices. Health services registries consist of patients who have had a common procedure, clinical encounter, or hospitalization. Disease or condition registries are defined by patients having the same diagnosis, such as cystic fibrosis or heart failure. The User's Guide was created by researchers affiliated with AHRQ's Effective Health Care Program, particularly those who

participated in AHRQ's DECIDE (Developing Evidence to Inform Decisions About Effectiveness) program. Chapters were subject to multiple internal and external independent reviews.

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icd 10 code for wellness visit: Medicare Essentials Tanya Feke, 2015-03-28 The best-selling Medicare guide is now available with 2015 updates! Written by Tanya Feke MD, a board-certified family physician, Medicare Essentials tells you everything you really need to know about this government program. With experience both caring for patients and working with administrators, she has learned tricks that can save you money and improve your healthcare experience. This book shares the most up-to-date Medicare information with 2015 cost analyses, a review of Medicare's latest preventive screening offerings, and a discussion of Medicare's controversial 2-Midnight Rule. Simple worksheets guide you through the Medicare maze to help you on your way. Let Dr. Feke be your advocate and explain the fine print.

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Without Answers Nelly Leon-Chisen, 2014-08 The ICD-10-CM and ICD-10-PCS Coding Handbook is the only guide published in collaboration with the Central Office on ICD-10-CM/PCS of the American Hospital Association. Handbook content reflects 2014 versions of the Official Guidelines for Coding and Reporting. Its format and style of presentation follows that of previous editions inspired by the Faye Brown approach to coding instruction. The text leads students to logical answers and provides primary supporting sources. This logical approach has enabled the Handbook to become the most popular textbook for hospital and physician office coder training. Exercises are presented in clear, technically correct language that progresses from easy to more difficult. Exercise answers in the case summaries list assigned and appropriately sequenced codes, followed by a comments section that explains how codes were assigned and why other codes were not assigned. Each chapter includes an overview that highlights important points, as well as learning outcomes and terms to know features that help readers understand and absorb new information. A Remember... feature provides sidebar comments or facts that alert readers to special information or perspectives. Expanded indexes enhance the speed of finding and applying new information.

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guidelines should be used as a companion document to the official version of the ICD-10- CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO). These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

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necessary for correct documentation of physical therapy services, provide guidance for readers in their ethical responsibility to quality record-keeping, and deliver the mechanics of note writing in a friendly, approachable tone. Featuring the most up-to-date information on proper documentation and using the International Classification of Functioning, Disabilities, and Health (ICF) model as a foundation for terminology, the Third Edition includes expanded examples across a variety of practice settings as well as new chapters on: Health informatics Electronic medical records Rules governing paper and electronic records Billing, coding, and outcomes measures Included with the text are online supplemental materials for faculty use in the classroom. An invaluable reference in keeping with basic documentation structure, *Physical Therapy Documentation: From Examination to Outcome*, Third Edition is a necessity for both new and seasoned physical therapy practitioners.

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how best to diagnose, treat, and manage your patient based on the history of present illness, review of systems, relevant history, and physical examination findings. This workbook will ask probing questions to help you determine differential and most likely diagnoses, diagnostic tests to order, and appropriate patient management strategies using relevant and timely references to support your decisions. The organization of each case study simulates the patient care journey from chief complaint to outcome. Serving as a virtual clinical preceptor, this workbook can be used independently or in a classroom setting. It is accompanied by a robust online student supplement that provides answers to all questions, real outcomes of the cases, and valuable personal insights from the authors on how the patient was successfully managed. Not only will this workbook help you work through patient cases clinically, it will also share important, but often overlooked, bedside manner skills needed to successfully communicate with and care for your patients. Covering conditions across all organ systems and across the lifespan, this workbook is organized by chief complaint, providing an authentic perspective on what to expect in the patient care environment. It even includes information on pathophysiology and how to use ICD-10 and CPT (E/M) codes in your documentation. The book uniquely weaves together both the science and art of medicine by including personal insights into quality and compassionate care. Key Features Provides real-life patient cases from an interprofessional author team of physician assistants, nurse practitioners, and physicians Uses a templated case study design and critical thinking exercises to help you methodically work through various patient scenarios Teaches clinical and bedside manner skills imperative for delivering quality patient care Covers patients across the lifespan, including pediatric, adolescent, adult, and geriatric populations Offers additional insight on patient education, medical and legal concerns, and interprofessional collaboration Includes a robust online student supplement with valuable insights from the authors on how they successfully managed the cases Provides instructors with a table of contents that is filterable by chief complaint, diagnosis, patient population, and organ system *Details changed to protect patient information.

icd 10 code for wellness visit: Advanced ICD-10 for Physicians Including Worker's Compensation and Personal Injury Eugene Fukumoto, 2017-07-28 ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization. It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury of diseases. The code set allows more than 14,000 different codes and permits the tracking of many new diagnoses. The U.S. has used ICD-10-CM (Clinical Modification) since October, 2015. This national variant of ICD-10 was provided by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics, and the use of ICD-10-CM codes are now mandated for all inpatient medical reporting requirements. This book is for physicians, practice managers and all others who need learn ICD-10. It's designed for the clinician to learn how to put their diagnosis into a code and not rely on staff or computer software programs to decide it form them. ICD-10 is a complex system of coding and Medicare and third party insurers have been lenient giving providers a year to get used to the coding system. As a result, physicians and their staff have become very complacent regarding proper coding. However, Medicare and third party insurers will soon begin to deny claims which are not coded correctly, which in turn will cost physician groups time and money. This book focuses on Worker's Compensation and Personal Injury, a very large segment of the healthcare industry and is a new area to ICD-10. The diagnosis coding for injuries is much different than for Medicare or group insurance and unless the physicians and their staff learn how to use it properly, they risk losing income for themselves and worse, they risk losing the case for the patient.

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