2013 Final - CPC

10000 Series – Integumentary System

1. Patient presents to the emergency department with multiple lacerations due to a knife fight at the local bar. After examination it was determined these lacerations could be closed using local anesthesia. The areas were prepped and draped in the usual sterile fashion. The surgeon documented the following closures: 7.6 cm simple closure of the right forearm; 5.7 cm intermediate closure of the upper right arm; 4.7 cm complex closure of the right neck; 10.3 cm intermediate closure of the upper chest. What CPT® codes are reported?
   a. 13132, 12035-59, 12004-59
   b. 13132, 12034-59, 12032-59,12004-59
   c. 13132, 12036-59
   d. 13152, 12035-59, 12004-59

2. Patient presents to the operative suite with a biopsy proven squamous cell carcinoma of the left ankle. A decision was made to remove the lesion and apply a split thickness skin graft on the site. The lesion was excised as drawn and documented as measuring 2.4 cm with margins. Using the Padgett dermatone the surgeon harvested a split-thickness skin graft from the left thigh, which was meshed 1.5 x 1 and then inset into the ankle wound using a skin stapler. Xeroform bolster was then placed on the skin graft using Xeroform and 4-0 nylon and the lower extremity was wrapped with bulky cast padding and double Ace wrap. The skin graft donor site was dressed with OpSite. The surgeon noted the skin graft measured 9cm^2 in total. What CPT ® and ICD-9-CM codes are reported?
   a. 15100, 11603-51, 173.72
   b. 15100, 173.72
   c. 15120, 13100-51, 216.7
   d. 15240, 11603-51, 173.72

3. Patient presents with a suspicious lesion on her left arm. With the patient's permission the physician marked the area for excision. The lesion measured 0.9 cm. The wound measuring 1.2 cm was closed in layers using 4-0 Monocryl and 5-0 Prolene. Pathology later reported the lesion to be a sebaceous cyst. What codes are reported?
   a. 11401, 216.6
   b. 12031, 11401-51, 706.2
   c. 13121, 11401-51, 216.6
   d. 11402, 706.2

4. Operative Report:

Pre-Operative Diagnoses:	Basal Cell Carcinoma, forehead Basal Cell Carcinoma, right cheek Suspicious lesion , left nose Suspicious lesion, left forehead
Post-Operative Diagnoses:	Basal Cell Carcinoma, forehead with clear margins Basal Cell Carcinoma, right cheek with clear margins Compound nevus, left nose with clear margins Epidermal nevus, left forehead with clear margins

INDICATIONS FOR SURGERY: The patient is a 47-year-old white man with a biopsy-proven basal cell carcinoma of his forehead and a biopsy-proven basal cell carcinoma of his right cheek. We were not quite sure of the patient's location of the basal cell carcinoma of the forehead whether it was a midline lesion or lesion to the left. We felt stronger about the midline lesion, so we marked the area for elliptical excision in relaxed skin tension lines of his forehead with gross normal margins of 1-2 mm and I marked the lesion of the left forehead for biopsy. He also had a lesion of his left alar crease we marked for biopsy and a large basal cell carcinoma of his right cheek, which was more obvious. This was marked for elliptical excision with gross normal margins of 2-3 mm in the relaxed skin tension lines of his face. I also drew a possible rhomboid flap that we would use if the wound became larger. He observed all these margins in the mirror, so he could understand the surgery and agree on the locations, and we proceeded.

DESCRIPTION OF PROCEDURE: All four areas were infiltrated with local anesthetic. The face was prepped and draped in sterile fashion. I excised the lesion of the forehead measuring 6-mm and right cheek measuring 1.3 cm as I had drawn them and sent in for frozen section. The biopsies were taken of the left forehead and left nose using a 2-mm punch, and these wounds were closed with 6-0 Prolene. Meticulous hemostasis was achieved of those wounds using Bovie cautery. I closed the cheek wound first. Defects were created at each end of the wound to facilitate primary closure and because of this I considered a complex repair and the wound was closed in layers using 4-0 Monocryl, 5-0 Monocryl and 6-0 Prolene, with total measurement of 2.1 cm. The forehead wound was closed in layers using 5-0 Monocryl and 6-0 Prolene, with total measurement of 1.0 cm. Loupe magnification was used and the patient tolerated the procedure well.

What ICD-9-CM codes are reported?

a. 173.31, 232.3, 238.2, 216.3

b. 173.31, 216.3

c. 173.20, 173.40, 216.2, 216.3

d. 172.30, 173.30, 238.2, 239.2

5. Operative Report

Pre-Operative and Post-Operative Diagnosis: Squamous cell carcinoma, left leg
Open wound, right leg
Personal history of squamous cell carcinoma, right leg

INDICATIONS FOR SURGERY: The patient is an 81-year-old white man with biopsy-proven squamous cell carcinoma of his left leg. I marked the areas for excision with gross normal margins of 5 mm, and I drew my planned skin graft donor site from his left lateral thigh. He also had an open wound of his right leg from a squamous cell carcinoma excised four months ago, the skin graft had not taken. We plan on re-skin grafting the area. The patient is aware of all of these markings, and understands the surgery and location..

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room. IV Ancef was given. I used plain lidocaine for his local anesthetic throughout the procedure until the skin grafts were inset. The anterior of his leg and the thigh were infiltrated with local anesthetic. Both upper extremities were prepped and draped circumferentially, which included the left thigh on the left side. I excised the lesion on his left leg as drawn into the subcutaneous fat. Hemostasis achieved with the Bovie cautery. I then excised the wound on his right leg to lower the bacterial counts. I took a 1-2 mm margin around the wound and excised the granulation tissue as well. Hemostasis was achieved using the Bovie cautery. I then changed gloves. A split-thickness skin graft was harvested from the left thigh using the Zimmer dermatome. This was meshed one and a half times one. By this time, the pathology returned showing the margins were clear.
Skin grafts were inset on each leg wound using the skin stapler. Xeroform and gauze bolster was placed over the skin graft using 4-0 nylon. The skin graft donor site was dressed with OpSite. The legs were further dressed with heavy cast padding and the double Ace wrap. The patient tolerated the procedure well.

PROCEDURES: Excision squamous cell carcinoma, left leg with excised diameter of 2.5 cm, repaired with a split-thickness skin graft measuring 5.1 cm^2. Excisional preparation of right leg wound repaired with a split-thickness skin graft measuring 3.2 cm^2.

What CPT® codes are reported?

a. 15100, 11603-51-LT, 15002-5-RT1,
b. 15100, 15100-51-LT, 11603-51-LT, 15002-51-RT
c. 15100, 11403-51-LT, 15100-51-RT
d. 15100, 11603-LT

6. The patient is seen in follow-up for excision of the basal cell carcinoma of his nose. I examined his nose noting the wound has healed well. His pathology showed the margins were clear. He has a mass on his forehead, he says it is from a piece of sheet metal from an injury to his forehead. He has an X-ray showing a foreign body, we have offered to remove it . After obtaining consent we proceeded. The area was infiltrated with local anesthetic. I had drawn for him how I would incise over the foreign body. He observed this in the mirror so he could understand the surgery and agree on the location. I incised a thin ellipse over the mass to give better access to it, the mass was removed. There was a capsule around this, containing what appeared to be a black-colored piece of stained metal , I felt it could potentially cause a permanent black mark on his forehead. I offered to excise the metal, he wanted me to, so I went ahead and removed the capsule with the stain and removed all the black stain. I consider this to be a complicated procedure. Hemostasis was achieved with light pressure. The wound was closed in layers using 4-0 Monocryl and 6-0 Prolene.

What CPT® and ICD-9-CM codes are reported?

a. 10121, 709.4, V90.10
b. 11010, 709.4, V90.10
c. 10121, 729.6, V90.10
d. 11010, 729.6, V90.10

7. The patient is here because the cyst in her chest has come to a head and is still painful even though she has been on antibiotics for a week. I offered to drain it for her. After obtaining consent, we infiltrated the area with 1 cc of 1% lidocaine with epinephrine, prepped the area with Betadine and opened the cyst in the relaxed skin tension lines of her chest, and removed the cystic material. There was no obvious purulence. We are going to have her clean this with a Q-tip. We will let it heal on its own and eventually excise it. I will have her come back a week from Tuesday to reschedule surgery. What CPT® and ICD-9-CM codes are reported?

a. 10040, 706.1
b. 10060, 706.2
c. 10061, 706.2
d. 10160, 786.6

8. Patient has returned to the operating room to aspirate a seroma that has developed from a surgical procedure that was performed two days ago. A 16-guauge needle is used to aspirate 600 cc of non-cloudy serosanguinous fluid. What codes are reported?

a. 10160-78, 998.13
b. 10180-58, 998.12
c. 10140-78, 906.3
d. 10140-58, 729.91

9. A 14-year-old boy was thrown against the window of the car on impact. The resulting injury was a star shaped pattern cut to the top of his head. In the ED, the MD on call for plastic surgery was asked to evaluate the injury and repair it. The total length of the intermediate repair was 5+ 4+ 4+ 5 cm (18cm total). The star like shape allowed the surgeon to pull the wound edges together nicely in a natural Y plasty in two spots. What CPT® code is reported for the repair?

a. 14041
b. 14040
c. 13121
d. 12035

10. A 63-year-old patient arrives for skin tag removal. As previously noted in her other visit, she has 3 located on her face, 4 on her shoulder and 15 on her back. The physician removes all the skin tags with no complications. What CPT® code(s) should be reported for this encounter?

a. 11201
b. 11201, 11201-51
c. 11200, 11201-52
d. 11200, 11201

20000 Series – Musculoskeletal System

11. This 45-year-old male presents to the operating room with a painful mass of the right upper arm. General anesthesia was induced. Soft tissue dissection was carried through the proximal aspect of the teres minor muscle. Upon further dissection a large mass was noted just distal of the IGHL (inferior glenohumeral ligament), which appeared to be benign in nature. With blunt dissection and electrocautery, the 4-cm mass was removed en bloc and sent to pathology. The wound was irrigated, and repair of the teres minor with subcutaneous tissue was closed with triple-0 Vicryl. Skin was closed with double-0 Prolene in a subcuticular fashion. What CPT® code is reported?

a. 23076-RT
b. 23066-RT
c. 23075-RT
d. 11406-RT

12. The patient has a torn medial meniscus. An arthroscope was placed through the anterolateral portal for the diagnostic procedure. The patellofemoral joint showed grade 2 chondromalacia on the patellar side of the joint only, this was debrided with a 4.0-mm shaver. The medial compartment was also entered and a complex posterior horn tear of the medial meniscus was noted. It was probed to define its borders. A meniscectomy was carried out to a stable rim. What CPT® code(s) is reported?

a. 29880
b. 29870, 29877-59
c. 29881, 29877-59
d. 29881

13. A 3-year-old is brought into the ER crying. He cannot bend his left arm after his older brother pulled it. The physician performs an X-ray to diagnose the patient has a dislocated nursemaid's elbow. The ER physician reduces the elbow successfully. The patient is able to move his arm again. The patient is referred to an orthopedist for follow-up care. What CPT® and ICD-9-CM codes are reported?

a. 24640-54-LT, 832.2, E927.0
b. 24565-54-LT, 832.22, E929.8
c. 24640-54-LT, 832.10, E927.8
d. 24600-54-LT, 832.00, E928.8

14. A 50-year-old male had surgery on his upper leg one day ago and presents with serous drainage from the wound. He was taken back to the operating room for evaluation of a hematoma. His wound was explored, and there was a hematoma at the base of the wound, which was very carefully evacuated.The wound was irrigated with antibacterial solution. What CPT® and ICD-9-CM codes are reported?

a. 10140-79, 998.12
b. 27603-78, 998.59
c. 10140-76, 998.9
d. 27301-78, 998.12

15. A 22-year-old female sustained a dislocation of the right elbow with a medial epicondyle fracture while on vacation. The patient was put under general anesthesia and the elbow was reduced and was stable. The medial elbow was held in the appropriate position and was reduced in acceptable position and elevated to treat non-surgically. A long arm splint was applied. The patient is referred to an orthopedist when she returns to her home state in a few days. What CPT® code(s) are reported?
    a. 24575-54-RT, 24615-54-51-RT
    b. 24576-54-RT, 24620-54-51-RT
    c. 24577-54-RT, 24600-54-51-RT
    d. 24565-54-RT, 24605-54-51-RT

16. A 45-year-old presents to the operating room with a right index trigger finger and left shoulder bursitis. The left shoulder was injected with 1 cc of Xylocaine, 1 cc of Celestone, and 1 cc of Marcaine. An incision was made over the A1 pulley in the distal transverse palmar crease, about an inch in length. This incision was taken through skin and subcutaneous tissue. The Al pulley was identified and released in its entirety. The wound was irrigated with antibiotic saline solution. The subcutaneous tissue was injected with Marcaine without epinephrine. The skin was closed with 4-0 Ethilon suture. Clean dressing was applied. What CPT® code(s) are reported?
    a. 26055-F6, 20610-76-LT
    b. 20552-F6, 20605-52-LT
    c. 26055-F6, 20610-51-LT
    d. 20553-F6, 20610-51-LT

17. A patient presents with a healed fracture of the left ankle. The patient was placed on the OR table in the supine position. After satisfactory induction of general anesthesia, the patient's left ankle was prepped and draped. A small incision about 1 cm long was made in the previous incision. The lower screws were removed. Another small incision was made just lateral about 1 cm long. The upper screws were removed from the plate. Both wounds were thoroughly irrigated with copious amounts of antibiotic containing saline. Skin was closed in a layered fashion and sterile dressing applied. What CPT® code(s) should be reported?
    a. 20680-LT
    b. 20680-LT, 20680-59-LT
    c. 20670-LT
    d. 20680-LT, 20670-59-LT

18. A patient is seen in the hospital's outpatient surgical area with a diagnosis of a displaced comminuted fracture of the lateral condyle, right elbow. An ORIF (open reduction) procedure was performed and included the following techniques: An incision was made in the area of the lateral epicondyle. This was carried through subcutaneous tissue, and the fracture site was easily exposed. Inspection revealed the fragment to be rotated in two places about 90 degrees. It was possible to manually reduce this quite easily, and the manipulation resulted in an almost anatomic reduction. This was fixed with two pins driven across the humerus. The pins were cut off below skin level. The wound was closed with plain catgut subcutaneously and 5-0 nylon for the skin. Dressings and a long arm cast were applied. What CPT® and ICD-9-CM codes are reported?
    a. 24579-RT, 29065-5-RT1, 812.52
    b. 24577-RT, 812.42
    c. 24579-RT, 812.42
    d. 24575-RT, 812.52

19. A patient presented with a closed, displaced supracondylar fracture of the left elbow. After conscious sedation, the left upper extremity was draped and closed reduction was performed, achieving anatomical reduction of the fracture. The elbow was then prepped and with the use of fluoroscopic guidance, two K-wires were directed crossing the fracture site and piercing the medial cortex of the left distal humerus. Stable reduction was obtained, with full flexion and extension. K-wires were bent and cut at a 90 degree angle. Telfa padding and splint were applied. What CPT® code is reported?
    a. 24535-LT
    b. 24538-LT
    c. 24582-LT
    d. 24566-LT

20. A patient presented with a right ankle fracture. After induction of general anesthesia, the right leg was elevated and draped in the usual manner for surgery. A longitudinal incision was made parallel and posterior to the fibula. It was curved anteriorly to its distal end. The skin flap was developed and retracted anteriorly. The distal fibula fracture was then reduced and held with reduction forceps. A lag screw was inserted from anterior to posterior across the fracture. A 5-hole 1/3 tubular plate was then applied to the lateral contours of the fibula with cortical and cancellous bone screws. Final radiographs showed restoration of the fibula. The wound was irrigated and closed with suture and staples on the skin. Sterile dressing was applied followed by a posterior splint. What CPT® code is reported?
    a. 27814-RT
    b. 27792-RT
    c. 27823-RT
    d. 27784-RT

30000 Series – Respiratory, Hemic, Lymphatic, Mediastinum, Diaphragm & Cardiovascular Systems

21. A 20-year-old female, who returned from spring break in Mexico six days ago, presents to the ED with a high fever for three days, a sore throat, general aches and a miserable cough. The ED physician suspects flu and orders a rapid flu test. What ICD-9-CM code(s) should be reported?
    a. 488.19
    b. 487.1
    c. 780.60, 462, 780.96, 786.2
    d. 487.1, 780.60, 462, 786.2

22. 78-year-old patient with bilateral, lower lobe lung cancer has been in the hospital for seven days with a tunneled chest tube in place to drain fluid from the pleural space. The chest tube currently is inserted between the 4th and 5th intercostal space on the left side. There is a very bad infection at the insertion site. The physician removes this chest tube and inserts another chest tube between the 5th and 6th intercostal space on the left side to continue fluid drainage. The tube placed today is just the same as the one removed, only sterile. What CPT® and ICD-9-CM codes are reported?
    a. 32560, 32552-51, 998.89, 162.9
    b. 32550, 32552-51, 996.69, 162.5
    c. 32551, 32552-51, 996.69, 197.0
    d. 32561, 32552-51, 998.89, 162.9

23. A patient underwent bilateral nasal/sinus diagnostic endoscopy. Finding the airway obstructed the physician fractures the middle turbinates to perform the surgical endoscopy with total ethmoidectomy and bilateral nasal septoplasty. What CPT® codes are reported?
    a. 30930, 31255-51, 30520-51
    b. 31255-50, 30520-50-51
    c. 31231, 30130-51, 31255-50
    d. 31255, 30520-51

24. 55-year-old female smoker presents with cough, hemoptysis, slurred speech, and weight loss. Chest X-ray done today demonstrates a large, unresectable right upper lobe mass, and brain scan is suspicious for metastasis. Under fluoroscopic guidance in an outpatient facility, a percutaneous needle biopsy of the lung lesion is performed for histopathology and tumor markers. A diagnosis of small cell carcinoma is made and chemoradiotherapy is planned. What CPT® and ICD-9-CM codes are reported?
    a. 32098, 77002-26, 162.3, 786.50, 786.39, 784.5, 783.21
    b. 32400, 77002-26, 162.9
    c. 32607, 77002-26, 786.6
    d. 32405, 77002-26, 162.3

25. A surgeon performs a high thoracotomy with resection of a single lung segment on a 57-year-old heavy smoker who had presented with a six-month history of right shoulder pain. An apical lung biopsy had confirmed lung cancer. What CPT® and ICD-9-CM codes are reported?
    a. 32100, 729.5
    b. 32484, 162.3
    c. 32503, 162.3
    d. 19271, 32551-51, 786.50

26. A 3-year-old girl is playing with a marble and sticks it in her nose. Her mother is unable to dislodge the marble so she takes her to the physician's office. The physician removes the marble with hemostats. What CPT® and ICD-9-CM codes are reported?
    a. 30300, 932, E912
    b. 30310, 932, E912
    c. 30150, 932, E915
    d. 30320, 932, E915

27. What is included in all vascular injection procedures?
    a. Catheters, drugs, and contrast material
    b. Selective catheterization
    c. Just the procedure itself
    d. Necessary local anesthesia, introduction of needles or catheters, injection of contrast media with or without automatic power injection, and/or necessary pre-and post injection care specifically related to the injection procedure.

28. In the hospital setting a patient undergoes transcatheter placement of an extracranial vertebral artery stent in the right vertebral artery. Which CPT® code is reported by the physician?
    a. 0075T
    b. 35301
    c. 35005
    d. 0075T-26

29. Catheter advanced from the right femoral vein into the left and right pulmonary artery. The catheter was further negotiated into the right lung lower lobe. Pulmonary angiography performed in all locations, including radiologic supervision and interpretation.
    a. 36015-RT, 36014-59-LT, 75743-26, 75774-26
    b. 36015-50, 36014, 75743-26
    c. 36014-50, 75741, 75774-26
    d. 36015, 36014-59, 75741-26, 75741-59

30. INDICATIONS FOR CORONARY INTERVENTION: Acute inferior myocardial infarction. Documented mildly occlusive plaque with much clot in the right coronary artery.
PROCEDURE: Insertion of temporary pacemaker in the right femoral vein. Primary stenting of the right coronary artery with a 4.5 x 16 mm Express stent. Angio-Seal to the vessels of the right common femoral artery post procedure, and also Angio-Seal of the right common femoral vein.
TECHNIQUE: Judkins percutaneous approach from the right groin with Perclose at the arterial puncture site post procedure.
CATHETERS: #4-French Angio-Jet catheter device, insertion of a #5-French temporary pacing wire, a 4.5 x 16 mm Express stent.
PRESSURES: Aortic Pressure: 107/78

RESULTS:
Coronary stenting procedure of the right coronary artery: The right coronary artery was primarily stented with a 4.5 x 16 mm Express stent. It was expanded to 12 atmospheres. There was no residual stenosis.

IMPRESSION: Successful Angio-Jet and stenting of the distal right coronary artery with no residual stenosis. Angio-Seal to the right femoral vein post procedure.

PROCEDURE: Through the femoral artery sheath, the EBU was advanced to the right coronary. Following this, a PT graphic intermediate wire was used to cross the lesion. Following this, angioplasty of the lesion was performed, utilizing a 2.5 x 20 millimeter CrossSail balloon at multiple sites to ten atmospheres. Following this, there was a fair result; however, there was a significant stenosis and significant calcification at the area, and the decision was made to pursue trying to stent the lesion. Multiple stents were attempted, including a 2.5 x 9 millimeter zipper MX and a 2.5 x 13 millimeter Guidant stent. This was abandoned, and in switching out to a balloon for further ballooning, the patient became hypertensive and with difficulty in terms of her respiratory status. Angiography revealed an occlusion of the mid left anterior descending and thrombus throughout the proximal left anterior descending extending into the left main. Recheck of ACT showed the ACT to be at eight seconds. This likely represented subtherapeutic range for her anticoagulation. A check of her medications revealed that instead of Angiomax, the patient had been given ReoPro without antithrombotic agent. She was therefore given IV heparin up to 12,000 units, and her ReoPro was continued. The lesion was then rewired, and an AngioJet was used to try to suction out this area of thrombus.
Unfortunately, the AngioJet was unable to cross the mid left anterior descending lesion and therefore was somewhat limited in its use for a more distal thrombus, although it did suction out the proximal left anterior descending thrombus. At this point, the patient was emergently intubated, and multiple pressors were started, including dopamine, Levophed, vasopressin, and epinephrine. Following this, a laser was attempted to cross the lesion an excimer laser X80 Spectranetics 0.9 Vitesse; however, this laser was unable to cross the lesion. Therefore, a long balloon, a 2.0 x 40 millimeter CrossSail balloon, was used to cross the lesion and inflate multiple segments of the mid left anterior descending up to a maximum inflation pressure of ten atmospheres. This improved flow, though by no means restored it back to normal. Therefore, following this, longer balloon inflations were performed utilizing a 2.0 x 20 millimeter CrossSail balloon up to fourteen atmospheres for one and a half minutes. This did not improve significantly the flow distally, and therefore the decision was made to try to stent the mid segment with a 2.5 x 9 millimeter zipper MX stent to a maximum inflation pressure of fourteen atmospheres. This resolved the issue in terms of the mid left anterior descending lesion; however, beyond the stent there continued to be residual stenosis, and multiple balloons were used to balloon this up to a 2.5 x 20 millimeter balloon up to fourteen atmospheres. The final result in the left anterior descending revealed a lesion in the mid-left anterior descending that was approximately 40 percent, there was TIMI III flow throughout the proximal and mid left anterior descending. However, at the level of the apex, there was TIMI 0 flow. Throughout the angioplasty, the patient had episodes of bradycardia, and a temporary pacemaker was placed, and this was removed at the end of the procedure.

IMPRESSION: Successful stent to the mid left anterior descending, complicated by thrombotic event in the left anterior descending system. Final result was a successful stent to the mid left anterior descending with residual TIMI 0 flow in the distal left anterior descending. We returned to the right coronary artery and successfully employed a 4.5 x 16 mm Express sent. At the end of the case, an intra-aortic balloon pump was placed in the left femoral artery sheath, and the patient was sent to the Coronary Care Unit on multiple pressors including epinephrine, vasopressin, Levophed, and dopamine.

a. 92928-RC, 92929-LD
b. 92928-RC, 92928-LD, 33967, 92973
c. 92928-RC, 92929-LD, 92973
d. 92928-RC, 92929-LD, 92973-RC

40000 Series – Digestive System

31. A four-year-old patient who accidentally ingests valium found in his mother's purse is found unconscious and rushed to the ED. The child is treated with gastric lavage. What CPT® and ICD-9-CM codes are reported?
a. 43754, 780.09, 969.4, E980.3
b. 43753, 969.4, 780.09, E853.2
c. 43756, 969.4, E980.3
d. 43755, 969.4, E853.2

32. How do you report a screening colonoscopy performed on a 65-year-old Medicare patient with a family history of colon cancer? The patient's 72-year-old brother was just diagnosed with colon cancer. The physician was able to pass the scope to the cecum. What CPT® and ICD-9-CM codes are reported?
a. G0104, V76.41, V10.05
b. G0105, V76.51, V16.0
c. 45378, V76.51, V10.05
d. 45330, V76.41, V16.0

33. 56-year-old patient complains of occasional rectal bleeding. His physician decides to perform a rigid proctosigmoidoscopy. During the procedure, two polyps are found in the rectum. The polyps are removed by a snare. What CPT® and ICD-9-CM codes are reported?
a. 45320, 569.0
b. 45383, 211.3
c. 45309, 45309, 211.3
d. 45315, 569.0

34. 42-year-old patient is brought to the operating room for a repair of a recurrent incarcerated incisional hernia using mesh. What CPT® and ICD-9-CM codes are reported?
a. 49561, 550.91
b. 49566, 553.21
c. 49566, 49568, 553.21
d. 49561, 49568, 551.21

35. 11-year-old patient is seen in the OR for a secondary palatoplasty for complete cleft palate. Shortly after general anesthesia is administered, the patient begins to seize. The surgeon quickly terminates the surgery in order to stabilize the patient. What CPT® and ICD-9-CM codes are reported for the surgeon?
a. 42220-52, 749.00, 780.39
b. 42220-53, 749.01, 780.39
c. 42215-53, 749.01, 780.39
d. 42215-76, 749.00, 780.39

36. A patient is admitted for a simple primary examination of the gastrointestinal system to rule out GI cancer. An upper GI endoscopy is performed that includes the esophagus, stomach, and portions of the small intestine. During the examination, a stricture of the esophagus is identified and subsequently dilated via balloon dilation (20 mm). What CPT® and ICD-9-CM codes are reported?
a. 43235, 151.9, 530.3
b. 43248, 151.9, 530.3
c. 43249, 530.3
d. 43235, 530.3

37. A 28-year-old female that had symptoms of RLQ abdominal pain, fever, and vomiting was diagnosed with acute appendicitis. The surgeon makes an abdominal incision to remove the appendix. The appendix was not ruptured. The incision is closed. What are the correct CPT® and ICD-9-CM codes for this encounter?
a. 44950, 540.9
b. 44970, 540.9
c. 44950, 789.03, 780.60, 787.03, 540.9
d. 44970, 541

38. A colonoscopy is performed on a 50-year-old patient with a family history of colon cancer. Found during the procedure were multiple polyps. Two polyps in the transverse colon were removed with hot forceps cautery. Three polyps in the ascending colon were removed via snare. Portions of all polyp tissues were to be sent to pathology. What are the correct CPT® and ICD-9-CM codes for this patient encounter?
    a. 45384 x2, 45385 x3, 211.3, V18.51
    b. 45384, 45385-59, 211.3, V16.0
    c. 45384, 45385-59, 153.6, 153.1, V18.51
    d. 48584 x2, 45385 x3, V16.0

39. 66-year-old female is admitted to the hospital with a diagnosis of stomach cancer. The surgeon performs a total gastrectomy with formation of an intestinal pouch. Due to the spread of the disease, the physician also performs a total en bloc splenectomy. What CPT® codes are reported?
    a. 43622, 38100-51
    b. 43622, 38102
    c. 43634, 38115-51
    d. 43634, 38102-51

40. A patient suffering from cirrhosis of the liver presents with a history of coffee ground emesis. The surgeon diagnoses the patient with esophageal varices. Two days later, in the hospital GI lab, the surgeon ligates the varices with bands via an UGI endoscopy. What CPT® and ICD-9-CM codes are reported?
    a. 43205, 571.6, 456.20
    b. 43244, 571.5, 456.21
    c. 43400, 571.6, 456.21
    d. 43235, 571.5, 454.2

50000 Series – Urinary, Male Genital, Female Reproductive and Endocrine Systems

41. A fracture of the corpus cavernosum penis is repaired. What is the correct code?
    a. 54440
    b. 54420
    c. 54430
    d. 54435

42. Cystoscopy, left ureteroscopy, holmium laser lithotripsy, stone manipulation, stent removal and replacement are performed. The holmium laser was used to break up a cluster of stones at the UP (uteropelvic) junction, which were removed with a basket. Previous CT scan showed stones in the lower pole, it was decided to proceed with ureteroscopy. Left ureteroscope was inserted, confirming multiple stones within the proximal ureter, these were basketed and removed. What CPT® codes are reported for this service?
    a. 52353, 52332-51, 52352-59
    b. 52353, 52000-51, 52352-59
    c. 52310, 52353-51, 52352-59
    d. 52353, 52352-51

43. Circumcision with adjacent tissue transfer was performed. What CPT® code(s) is/are reported for this service?
    a. 14040
    b. 54161-22
    c. 54163
    d. 14040, 54161-51

44. The patient is a very pleasant 72-year-old female noted to have bilateral nephrolithiasis. Her left stones were treated ureteroscopically and her right stone was very large. It was treated with an ureteroscopic procedure. She comes in today for her second ureteroscopic procedure to remove the remaining stone fragments. Right ureteroscopy, laser lithotripsy and right ureteral stent exchange were performed. What CPT® codes are reported for this service?
    a. 52353-58, 52332-58
    b. 52353, 52310, 52332
    c. 52353, 52332-51
    d. 52353-76, 52332-76

45. 67-year-old gentleman with localized prostate cancer will be receiving brachytherapy treatment. Following calculation of the planned transrectal ultrasound, guidance was provided for percutaneous placement of 1-125 seeds into the prostate tissue. What CPT® code is reported for needle placement to insert the radioactive seeds into the prostate?
    a. 55860
    b. 55920
    c. 55875
    d. 55876

46. A woman with abdominal pain and bleeding has a diagnosis of multiple fibroid tumors and undergoes laparoscopic resection without hysterectomy. After the abdomen is entered and inspected it is found she has 5 separate intramural fibroid tumors to be removed. The fibroid tumors are successfully removed, with a total weight of 300 grams. Pathology confirms leiomyoma (myomas or fibroids). What are the CPT® and ICD-9-CM codes reported for this service?
    a. 58146, 218.9
    b. 58546, 218.1
    c. 58545, 218.1
    d. 58140, 218.9

47. A patient presents with cervical cancer, it has spread and metastasized throughout the pelvic area. She receives a total abdominal hysterectomy with bilateral salpingo-oophorectomy, cystectomy and creation of an ileal conduit and partial colectomy. What is/are the CPT® code(s) reported for this service?

a. 58150, 51590, 44140
b. 58152, 44141
c. 58150, 51590, 44140, 58720
d. 58240

48.

Operative Report
Preoperative Diagnosis: L5-S1 degenerative disk disease
Postoperative Diagnosis: Same.

OPERATION:
1. L5-S1 transforaminal lumbar interbody fusion with the Capatone system.
2. Nonsegmental instrumentation with a Spire plate.
3. Lateral arthrodesis with autograft and allograft consisting of Infuse.
4. Use of intraoperative fluoroscopy, less than one hour.

Anesthesia: General endotracheal anesthesia.

DESCRIPTION OF PROCEDURE: The patient was placed in the usual prone position on the Jackson table. After prepping and draping in the usual sterile fashion, and infiltrating the skin subcutaneously with 1% lidocaine with epinephrine, a lineal incision was made in the midline extending from the superior aspect of the spinous process of L5 to the inferior aspect of the spinous process of S1. A subperiosteal dissection of the paraspinous muscles was carried out on the left side to the lateral portion of the lateral facet, on the right side to the medial border of the medial facet.

After obtaining the correct level by fluoroscopy a small laminotomy was carried out on the left side of L5 and a medial facetectomy done with a Midas Rex drill and Kerrisons. The bone dust and bone chips were saved. Once we had exposed the descending S1 root and exiting L5 roots and the thecal sac we protected these with a nerve root retractor. A standard diskectomy was carried out at L5-S1 using various sized curets and pituitary ronguers. Once we had good exposure of the end plates, we distracted the disk space out to 10 mm. An Infuse sponge was then filled with autologous bone dust into a burrito and placed into the disk space towards the anterior portion of the vertebral bodies. This was followed by a 10 x 22 mm Capstone graft which too was filled with an Infuse and autologous bone burrito. Under guidance of the fluoroscopy unit we made sure this was at the anterior portion of the vertebral bodies and in the midline. This confirmed with both the AP and lateral views.

At this point the lamina on the right side of L5 and S1 were decorticated with the Midas Rex drill, and further burritos of Infuse and bone dust were placed over the decorticated regions. The interspinous ligament between L5 and S1 was then removed with a rongeur, and the Spire plate placed under compression over the spinous processes. The set screw was placed and broken off with the attached torque wrench.

At this point we found there was still moderate subcutaneous bleeding, and even though we had Infuse, a Jackson-Pratt drain was placed in the paraspinous muscles and sutured in place with 2-0 silk to the skin. The deep paraspinous muscles and dorsal lumbar fascia were reapproximated with 2-0 Vicryl in a running subcuticular fashion.

Estimated blood loss was 200 cc. Sponge and needle counts were reported to be correct x2. There were no complications from the procedure, and the patient tolerated the procedure well. What CPT® codes are reported?

a. 22612, 63040-51
b. 22558, 63042-51, 22840
c. 22612, 63030-51, 22840
d. 22558, 63030-51, 22840, 22841

49. A patient with uterine prolapse presents for laparoscopic hysterectomy and colpopexy. After induction of general anesthesia the laparoscope is introduced into the abdomen with separate placement of ports for visualization. The surgeons began to tie off the uterine artery when the patient had a sudden drop in blood pressure and could not be stabilized. The procedure was discontinued. No procedures were completed. What are the CPT® and modifier code(s) for this service?

a. 58570-52, 57425-52
b. 58570-53, 57425-53
c. 58570-53
d. 58570-73

50. A 26-year-old gravida 2 para 1 female has been spotting and has been on bed rest. She awoke this morning with severe cramping and bleeding. Her husband brought her to the hospital. After examination, it was determined she has an incomplete early spontaneous abortion. She is in the 12th week of her pregnancy. She was taken to the OR and a dilation and curettage (D&C) was performed. There were no complications from the procedure. She will follow-up with me in the office. She has had four antepartum visits during her pregnancy.
    a. 59812, 637.91
    b. 59812, 59425, 634.91
    c. 58120, 634.91
    d. 58120, 59425, 634.92

60000 Series – Nervous, Eye and Ocular Adnexa, Auditory

51. A 15-year-old has been taken to surgery for crushing his index and middle fingers, injuring his digital nerves. The physician located the damaged nerves in both fingers and sutures them to restore sensory function. What CPT® codes are reported?
    a. 64831, 64872
    b. 64834, 64837-51
    c. 64831, 64837-51
    d. 64831, 64832

52. A 47-year old female presents to the OR for a partial corpectomy to three thoracic vertebrae. One surgeon performs the transthoracic approach while another surgeon performs the three vertebral nerve root decompressions necessary. How do both providers involved code for their portions of the surgery?
    a. 63087-52, 63088-52 x 2
    b. 63085-62, 63086-62 x 2
    c. 63087-80, 63088-80 x 2
    d. 63085, 63086-82 x 2

53. 26-year-old female with a one-year history of a left tympanic membrane perforation has consented to have it repaired. A postauricular incision was made under general anesthesia. Dissection was carried down to the temporalis fascia and a 3 x 3 cm segment of fascia was harvested and satisfactorily desiccated. The tympanic membrane was excised. Using a high-speed drill a canaloplasty was performed until the entire annulus could be seen. The ossicular chain was examined, it was found to be freely mobile. The previously harvested skin was trimmed and placed in the anterior canal angle with a slight overlapping over the temporalis fascia. Packing is placed in the ear canal, external incisions are closed, and dressings are applied. What CPT® code is reported?
    a. 69436-LT
    b. 69631-LT
    c. 69632-LT
    d. 69641-LT

54. 70-year-old female has a drooping left eyelid obstructing her vision and has consented to having the blepharoptosis repaired. A skin marking pencil was used to outline the external proposed skin incision on the left upper eyelid. The lower edge of the incision was placed in the prominent eyelid crease. The skin was excised to the levator aponeurosis. An attenuated area of levator aponeurosis was dehisced from the lower strip. Three 6-0 silk sutures were then placed in mattress fashion, attaching this attenuated tissue superiorly to the intact tissue inferiorly. This provided moderate elevation of the eyelid. What CPT® code should be reported?
    a. 67904-E1
    b. 67903-E1
    c. 67901-E1
    d. 67911-E1

55. 53-year-old woman with scarring of the right cornea has significant corneal thinning with a high risk of perforation and underwent reconstruction of the ocular surface. The eye is incised and an operating microscope is used with sponges and forceps to debride necrotic corneal epithelium. Preserved human amniotic membrane is first removed from the storage medium and transplanted by trimming the membrane to fit the thinning area of the cornea then sutured. This process was repeated three times until the area of thinning is flushed with surrounding normal-thickness cornea. All of the knots are buried and a bandage contact lens is placed with topical antibiotic-steroid ointment. What CPT® code is reported?
    a. 65780
    b. 65781
    c. 65710
    d. 65435

56. A 60-year-old female with uncontrolled intraocular pressure and early cataracts has been coming in for laser trabeculoplasty. This is her third and last session within the last week for her treatment series. She will be examined over the next three months to ensure the normal inflammations subside. What CPT® code are reported?
    a. 65850
    b. 65855
    c. 65855 x 3
    d. 67145 x 3

57. Parents of a three-year-old male who has chronic serous otitis media in the right ear have consented to surgery. Patient is placed under general anesthesia and the physician makes an incision in the tympanic membrane. Fluid is suctioned out from the middle ear and a ventilating tube is placed in the ear to provide a drainage route to help reduce middle ear infections. What CPT® and ICD-9-CM codes are reported?
    a. 69421-RT, 381.10
    b. 69436-50, 381.4
    c. 69436-RT, 381.10
    d. 69433-RT, 381.01

58. A physician uses cryotherapy for removal trichiasis. What CPT® and ICD-9-CM codes are reported?
    a. 67820, 127.3
    b. 67825, 374.05
    c. 67830, 086.5
    d. 67840, 124

59. A patient receives chemodenervation with Botulinum toxin injections to stop blepharospasms of the right eye. What are the procedure and diagnosis codes?
    a. 64650, 780.8
    b. 67345-RT, 378.10
    c. 64612-RT, 333.81
    d. 64613, 781.93

60. The surgeon performed an insertion of an intraocular lens prosthesis discussed with the patient before the six-week earlier cataract removal (by the same surgeon). What CPT® code is reported?
    a. 66985-58
    b. 66983-58
    c. 66984
    d. 66985

Evaluation & Management

61. 45-year-old established, female patient is seen today at her doctor's office. She is complaining of dizziness and feels like the room is spinning. She has had palpitations on and off for the past 12 months. She reports chest tightness and dyspnea but denies nausea, edema, or arm pain. She drinks two cups of coffee per day. Her sister has WPW (Wolff-Parkinson-White) syndrome. An extended five body area examination is performed. This is a new problem. An EKG is ordered and labs are drawn, and the physician documents a moderate complexity MDM. What CPT® code should be reported for this visit?
    a. 99214
    b. 99215
    c. 99203
    d. 99204

62. 33 year-old male was admitted to the hospital on 12/17/XX from the ER, following a motor vehicle accident. His spleen was severely damaged and a splenectomy was performed.. The patient is being discharged from the hospital on 12/20/XX. During his hospitalization the patient experienced pain and shortness of breath, but with an antibiotic regimen of Levaquin, he improved. The attending physician performed a final examination and reviewed the chest X-ray revealing possible infiltrates and a CT of the abdomen ruled out any abscess. He was given a prescription of Zosyn. The patient was told to follow up with his PCP or return to the ER for any pain or bleeding. The physician spent 20 minutes on the date of discharge.What CPT® code is reported for the 12/20 visit?
    a. 99221
    b. 99231
    c. 99238
    d. 99283

63. 60-year-old woman is seeking help to quit smoking. She makes an appointment to see Dr. Lung for an initial visit. The patient has a constant cough due to smoking and some shortness of breath. No night sweats, weight loss, night fever, CP, headache, or dizziness. She has tried patches and nicotine gum, which has not helped. Patient has been smoking for 40 years and smokes 2 packs per day. She has a family history of emphysema. A limited three system exam was performed. Dr Lung discussed in detail the pros and cons of medications used to quit smoking. Counseling and education was done for 20 minutes of the 30 minute visit. Prescriptions for Chantrix and Tetracylcine were given. The patient to follow up in 1 month. A chest X-ray and cardiac work up was ordered. Select the appropriate CPT code(s) for this visit:.
    a. 99202
    b. 99203
    c. 99203, 99354
    d. 99214, 99354

64. The physician was called to the hospital floor for the medical management of a 56-year-old patient admitted one day ago with aspiration pneumonia and COPD. No chest pain at present, but still SOB and some swelling in his lower extremities. Patient was tachypenic yesterday; lungs reveal course crackles in both bases, right worse than left. The physician writes instructions to continue with intravenous antibiotic treatment and respiratory support He reviewed chest X-ray and labs. Patient is improving and a pulmonary consultation has been requested. What CPT® code is reported?
    a. 99218
    b. 99221
    c. 99232
    d. 99231

65. An established patient presents to the office with a recurrence of bursitis in both shoulders. Range of motion is good and full, but he has tenderness in the subdeltoid bursa. Both shoulders were injected in the deltoid with 120mg Depo-Medrol. What CPT® code(s) is/are reported for this visit?
    a. 99211-25, 20610-50
    b. 99212-25, 20550-50
    c. 99212-25, 20610-50
    d. 20610-50

66. An established 47-year-old patient presents to the physician's office after falling last night at her home when she slipped in water on the kitchen floor. She is complaining of back pain and no tingling or numbness. Physician documents that she has full range motion of the spine, with discomfort. Her gait is within normal limits. Straight leg raising is negative. She requested no medication. It is recommended to use heat, such as a hot water bottle. Doctor's Assessment: Back Strain. What E/M and ICD-9-CM codes are reported for this service?
    a. 99212, 847.9, E888.8, E849.0
    b. 99212, 847.9, E885.9, E849.0
    c. 99213, 846.9, E885.8, E849.0
    d. 99213, 847.9, E888.9, E849.0

67. 5-year-old is brought to the Emergency Department by ambulance, He had been found floating in a pool for an unknown amount of time. EMS started CPR which was continued by the ED physician along with endotracheal intubation and placement of a CVP. The ER physician spent 1 hour with the critically ill patient. The ED physician makes a notation the 1 hour does not include the time for the other separate billable. What CPT® codes should be reported?
    a. 92950, 99291-25, 36556, 31603
    b. 92950, 99291
    c. 92950, 99291-25, 36556, 31500
    d. 92950, 99285-25, 36556, 31500

68. Dr. X asks Dr. Y to look at a 65-year-old male who is in a nursing facility for decubitus ulceration. Dr. Y is unable to obtain history due to current mental status. He obtains a detailed history from Dr. X since the patient is unable to provide a history. A detailed exam along with low MDM is performed. Dr Y. recommends to Dr. X the patient needs to go to the surgical suite for debridement of the ulcerations. Since the patient is unstable at the moment due to elevated blood pressure and a UTI, they decide to delay surgery and to keep monitoring the patient until he stabilizes. Written report is documented. What CPT® code is reported?
    a. 99304
    b. 99234
    c. 99243
    d. 99253

69. An established patient presents to the clinic today for a follow-up of his pneumonia. He was hospitalized for 6 days, on IV antibiotics. He was placed back on Singulair and has been doing well with his breathing since then. An expanded problem focused exam was performed. Records were obtained from the hospital and the physician reviewed the labs and X-rays. The patient was told to continue antibiotics for another two weeks to 20 days, and the prescription Keteck was replaced with Zithromax. Patient to return to the clinic in two weeks for recheck of his breathing and re-X-ray then. What CPT® code should be reported?
    a. 99214
    b. 99242
    c. 99335
    d. 99213

70. A 90-year-old female was admitted this morning from observation status for chest pain to r/o angina. A cardiologist performs a comprehensive history and comprehensive exam. Her chest pain has been relieved with the nitroglycerin drip given before admission and she would like to go home. Doctor has written prescriptions to add to her regimen. He had given her Isosorbide, and she is tolerating it well. He will go ahead and send her home. We will follow up with her in a week. Patient was admitted and discharged on the same date of service. What CPT® code is reported?
    a. 99235
    b. 99217
    c. 99238
    d. 99221

Anesthesia

71. 5- year-old patient is experiencing atrial fibrillation with rapid ventricular rate. The anesthesia department is called to insert a non-tunneled central venous (CV) catheter. What CPT® code is reported?
    a. 00400
    b. 36555
    c. 36556
    d. 36557

72. A 43-year-old patient with a severe systemic disease is having surgery to remove an integumentary mass from his neck. What CPT® code and modifier are reported for the anesthesia service?
    a. 00300-P2
    b. 00300-P3
    c. 00322-P3
    d. 00350-P3

73. An 11-month-old patient presented for emergency surgery to repair a severely broken arm after falling from a third story window. What qualifying circumstance code(s) may be reported in addition to the anesthesia code?
    a. 99100
    b. 99116
    c. 99140
    d. 99100, 99140

74. 59-year-old patient is having surgery on the pericardial sac, without use of a pump oxygenator. The perfusionist placed an arterial line. What CPT® code(s) is/are reported for anesthesia?
    a. 00560
    b. 00560, 36620
    c. 00561
    d. 00562

75. 74-year-old patient is undergoing surgery under monitored anesthesia care. The surgeon has determined the procedure will be markedly invasive. What modifier(s) is/are appropriate for Medicare?
    a. QS
    b. G8
    c. G9
    d. G8 and QS

76. A 72-year-old patient is undergoing a corneal transplant. An anesthesiologist is personally performing monitored anesthesia care. What CPT® code and modifier(s) are reported for anesthesia?
    a. 00144
    b. 00144 AA
    c. 00144 AA QS
    d. 00144 QK QS

77. A CRNA is personally performing a case, with medical direction from an anesthesiologist. What modifier is appropriately reported for the CRNA services?
    a. QX
    b. QZ
    c. QK
    d. QS

78. An anesthesiologist is medically supervising six cases concurrently. What modifier is reported for the anesthesiologist's service?
    a. AA
    b. AD
    c. QK
    d. QX

Radiology

79. A patient was admitted to observation status after losing control and crashing his motorcycle into the guardrail on the highway. The patient was unconscious; a CT scan of the brain without contrast and the chest is performed. It revealed a fracture of the skull base with no hemorrhage in the brain. There was no puncture of the lungs. Three views of the right and left sides of the ribcage reveal fractures of the third and fifth rib. What CPT® and ICD-9-CM codes are reported?
    a. 70460-26, 71260-26, 71101-26, 803.00, 807.02, E815.0, E846.5
    b. 70450-26, 71275-26, 71101-26, 803.06, 807.09, E812.2, E849.5
    c. 70450-26, 71250-26, 71101-26, 801.09, 807.02, E816.2, E849.5
    d. 70450-26, 71250-26, 71110-26, 801.06, 807.02, E815.2, E849.5

80. A 41-year-old male is in his doctor's office for a follow up of an abnormality, which was noted, on an abdominal CT scan. He is to have a chest x-ray due to chest tightness. He otherwise states he feels well and is here to go over the results of his chest X-ray (PA and Lateral) performed in the office and the CT scan performed at the diagnostic center. The results of the chest X-ray were normal. CT scan was sent to the office and the physician interpreted and documented that the CT scan of the abdomen showed a small mass in his right upper quadrant. What CPT® codes are reported for the doctor's office radiological services?
    a. 71020-26, 74150-26
    b. 71020, 74150
    c. 71020-26, 74150
    d. 71020, 74150-26

81. A patient has a history of chronic venous embolism in the superior vena cava (SVC) and is having a radiographic study to visualize any abnormalities. In outpatient surgery the physician accesses the subclavian vein and the catheter is advanced to the superior vena cava for injection and imaging. The supervision and interpretation of the images is performed by the physician. What codes are reported for this procedure?
    a. 36010, 75827-26
    b. 36000, 75820-26
    c. 36000, 75827-26
    d. 36010, 75820-26

82. 70-year-old female presents with a complaint of right knee pain with weight bearing activities. She is also developing pain at rest. She denies any recent injury. There is pain with stair climbing and start up pain. An AP, Lateral and Sunrise views of the right knee are ordered and interpreted. They reveal calcification within the vascular structures. There is decreased joint space through the medial compartment where she has near bone-on-bone contact, flattening of the femoral condyles, no fractures noted. The diagnosis is right knee pain secondary to underlying localized degenerative arthritis. What CPT® and ICD-9-CM codes are reported?

a. 73560, 715.96
b. 73562, 715.96, 719.46
c. 73562, 715.36
d. 73565, 715.36, 719.46

83. Myocardial Perfusion Imaging—Office Based Test
Indications: Chest pain.
Procedure: Resting tomographic myocardial perfusion images were obtained following injection of 10 mCi of intravenous Cardiolite. At peak exercise, 30 mCi of intravenous Cardiolite was injected, and post-stress tomographic myocardial perfusion images were obtained. Post stress gated images of the left ventricle were also acquired.
Myocardial perfusion images were compared in the standard fashion.
Findings: This is a technically fair study. There were no stress induced electrocardiographic changes noted. There are no significant reversible or fixed perfusion defects noted. Gated images of the left ventricle reveal normal left ventricular volumes, normal left ventricular wall motion, and an estimated left ventricular ejection fraction of 50%.
Impression: No evidence of myocardial ischemia or infarction. Normal left ventricular ejection fraction. What CPT® code is reported?

a. 78451
b. 78451, A9500
c. 78453
d. 78451, A9500 x 30

84. After intravenous administration of 5.1 millicuries Tc-99m DTPA, flow imaging of the kidneys was performed for approximately 30 minutes. Flow imaging demonstrated markedly reduced flow to both kidneys bilaterally. What CPT® code is reported?

a. 78710
b. 78701
c. 78708
d. 78725

85. An oncology patient is having weekly radiation treatments with a total of seven conventional fractionated treatments. Two fractionated treatments daily for Monday, Tuesday and Wednesday and one treatment on Thursday. What radiology code(s) is/are appropriate for the clinical management of the radiation treatment?

a. 77427
b. 77427 x 7
c. 77427 x 2
d. 77427-22

86. Magnetic resonance imaging of the chest is first done without contrast medium enhancement and then is performed with an injection of contrast. What CPT® code(s) is/are reported for the radiological services?

a. 71550, 71551
b. 71552
c. 71555
d. 71275

87. A CT scan confirms improper ossification of cartilages in the upper jawbone and left side of the face area for a patient with facial defects. The CT is performed with contrast material in the hospital. What CPT® code is reported by an independent radiologist contracted by the hospital?

a. 70460-26
b. 70481-26
c. 70487-26
d. 70542-26

88. A patient is positioned on the scanning table headfirst with arms at the side for an MRI of the thoracic spine and spinal canal. A contrast agent is used to improve the quality of the images. The scan confirms the size and depth of a previously biopsied leiomyosarcoma metastasized to the thoracic spinal cord. What CPT® and ICD-9-CM codes are reported?

a. 72255, 239.7
b. 72157, 237.5
c. 72070, 192.2
d. 72147, 198.3

Laboratory and Pathology

89. A patient has partial removal of his lung. The surgeon also biopsies several lymph nodes in the patient's chest which are examined intraoperatively by frozen section and sent with the lung tissue for Pathologic examination. The pathologist also performs a trichrome stain. What CPT® codes are reported for the lab tests performed?
    a. 88309 x 2, 88313
    b. 88309, 88305, 88313, 88331
    c. 88307, 88305x2, 88332
    d. 88309, 88307, 88313

90. A couple with inability to conceive has fertility testing. The semen specimen is tested for volume, count motility and a differential is calculated. The findings indicate infertility due to oligosoermia. What CPT® and ICD-9-CM codes are reported?
    a. 89310, 89320, V26.21
    b. 89257, 606.9, V26.21
    c. 89320, 606.1
    d. 89264, 606.1

91. In a legal hearing to determine child support there is a dispute about the child's paternity. The court orders a paternity test, and a nasal smear is taken from the plaintiff and the child. The plaintiff is confirmed as the father of the child. Choose the CPT®, ICD-9 codes and modifiers for the paternity testing.
    a. 89190-32, V26.39
    b. 86910-32, V70.4
    c. 86900, V70.4
    d. 86910, V26.39

92. A virus is identified by observing growth patterns on cultured media. What is this type of identification is called?
    a. Definitive
    b. Qualitative
    c. Quantitative
    d. Presumptive

93. A breast biopsy is performed on a mass and the surgeon requests a frozen section examination of the specimen to determine whether more extensive resection is appropriate. The frozen section reveals no indications of malignancy. No other specimen is obtained but the remainder of the biopsy specimen is sent for further testing and examination, including decalcification. The results indicate breast fibrosclerosis only. What CPT® and ICD-9-CM codes are reported?
    a. 88331, 88313, 611.72
    b. 88305, 88331, 88311, 610.3
    c. 88307, 88331, 793.81
    d. 88307, 88305, 88331, 88313, 610.3

94. A major university medical center has an International Clinic specializing in treating individuals who move to the USA bringing with them diseases and conditions native to their home countries. A Brazilian woman presents to this clinic with complaints of hematuria and fatigue. Urine analysis with microscopy identifies eggs in the urine and further testing identifies Schistosomiasis through presumptive identification with inoculation and dissection. What CPT® and ICD-9-CM codes are reported?
    a. 87003, 81000, 120.0
    b. 87003, 81007, 599.70, 780.79
    c. 87001, 81007, 120.0
    d. 87001, 81000, 599.70, 780.79

95. Flow cytometry is performed for DNA analysis. What CPT® code is reported?
    a. 88182
    b. 88184
    c. 88187
    d. 88189

96. A urine pregnancy test is performed by the office staff using the Hybritech ICON (qualitative visual color comparison test). What CPT® code is reported?
    a. 84703
    b. 84702
    c. 81025
    d. 81025, 36415

97. Mr. Bowen is having a pre-employment physical (screening). His doctor ordered the following serum blood tests: CBC, automated comprehensive metabolic panel, and a thyroid stimulating hormone (TSH) assay. A urine drug screen for multiple drug classes was also collected. Code the services for these labs.
    a. 80050, 80100
    b. 80048, 81000
    c. 80050-26, 80100-26
    d. 80053, 84443, 80100

98. A couple has been trying to conceive for nine months without success. Preliminary studies show the woman ovulates and the husband's sperm count is good. A sperm sample is submitted for both a post coital Huhner test and a hamster penetration test. Report the codes.
    a. 89300, 89320
    b. 89310, 89330
    c. 89300, 89329
    d. 89325, 89260

Medicine

99. A patient with Sickle cell anemia with painful sickle crisis received normal saline IV, 100 cc per hour to run over 5 hours for hydration in the physician's office. She will be given Morphine & Phenergan, prn (as needed). What codes are reported?
    a. 96360, 96361 x 4, J7050 x 2, 282.62
    b. 96360 x 5, J7050, 282.60
    c. 96360, 96361 x 3, J7030, 282.62
    d. 96360, J7030, 282.69

100. A patient with bilateral sensory hearing loss is fitted with a digital, binaural, behind the ear hearing aid. What HCPCS Level II and ICD-9-CM codes should be reported?
    a. V5140, 389.11, V53.2
    b. V5261, V53.2, 389.11
    c. V5140, 389.22
    d. V5261, V72.11, 389.11

101. Mrs. Mertz goes to the procedure room to have a permanent pacemaker implanted. She is given a mild sedative and the area just under the right clavicle is prepped and draped in a sterile manor. An incision is made to create a pocket for the pulse generator. A venogram is shot through an indwelling antecubital IV and a catheter is threaded from the pocket into the right subclavian vein. The catheter is advanced into the right atrium under fluoroscopic guidance. Using the Seldinger technique the catheter is withdrawn over a guide wire and a 32 FR Medtronic pacing wire is threaded back over the guide wire and into the right atrium under fluoroscopy. The guide wire is removed and the pacing tip is screwed into the myocardium. Thresholds are tested for sensing and capture. The lead is attached to the pulse generator and placed into the pocket. The pocket is closed with interrupted 4-0 Prolene. Choose the correct code(s).
    a. 93288 –26, 33249
    b. 33206, 36140-51, 93288 –26, 75820 – 26
    c. 33206, 75820 – 26
    d. 33206, 33212-51

102. 42-year-old patient presented to the urgent care center with complaints of slight dizziness. He had received services at the clinic about 2 years ago. The patient related this episode happened once previously and his 51-year-old brother has a pacemaker. A chest X-ray with 2 views and an EKG with rhythm strip were ordered (equipment owned by the urgent care center). The physician detected no obvious abnormalities, but the patient was advised to see a cardiologist within the next 2 - 3 days. The physician interpreted and provided a report for the rhythm strip and Chest X-ray. What CPT® and ICD-9-CM codes are reported for the physician employed by the urgent care center who performed a Level 3 office visit in addition to the ancillary services?
    a. 99213-25, 71020, 93040, 780.4
    b. 99213-25, 71020-26, 93042, 780.4
    c. 99283-25, 71010-26, 93010, 780.5
    d. 99203-25, 71010, 93000, 786.50

103. 55-year-old male has had several episodes of tightness in the chest. His physician ordered a PTCA (percutaneous transluminal coronary angioplasty) of the left anterior descending coronary artery. The procedure revealed atherosclerosis in the native vessel. It was determined a stent would be required to keep the artery open. The stent was inserted during the procedure.
    a. 92928-LD, 414.01
    b. 92920-LD, 92929-59, 414.06
    c. 92920-LD, 92928, 414.01, 414.06
    d. 92920-LD, 92928-59, 414.01

104. A pregnant female is Rh negative and at 28 weeks gestation. The child's father is Rh positive. The mother is given an injection of a high-titer Rho (D) immune globulin, 300 mcg, IM. What CPT® and ICD-9-CM codes are reported?
    a. 90384, 96372, 656.13
    b. 90386, 96372, 656.13
    c. 90384, 90471, 773.0
    d. 90386, 90471, 773.0

105. A patient with hypertensive end stage renal failure, stage V, and secondary hyperparathyroidism is evaluated by the physician and receives peritoneal dialysis. The physician evaluates the patient once before dialysis begins. What CPT® and ICD-9-CM codes are reported?
    a. 90945, 401.9, 585.5, 588.81
    b. 90947, 403.91, 588.81
    c. 90945, 403.91, 585.6, 588.81
    d. 90947, 403.91, 585.5

106. A patient with congestive heart failure and chronic respiratory failure is placed on home oxygen. Prescribed treatment is 2 L nasal cannula oxygen at all times. A home care nurse visited the patient to assist with his oxygen management. What CPT® and ICD-9-CM codes are reported?
a. 99503, 428.0, 518.83
b. 99503, 428.9, 518.82
c. 99504, 428.40, 518.83
d. 99503, 428.0, 518.82

107. A therapist in a residential care facility works with a non-verbal autistic child, age 4. In this session, the therapist uses drawing paper and washable markers. The therapist sat with the child and began to draw on a sheet of paper. She gave paper and markers to the child and encouraged the child to draw. The session lasted 30 minutes.
a. 90875, 90832, 299.00
b. 90880, 299.00
c. 90882, 299.00
d. 90880, 299.90

108. A patient had several panic attacks at work disturbing to her co-workers. She had been unable to explain any particular reason for her behavior. Her employer requested she be referred for counseling. After several sessions, her psychiatrist provided reports for her primary care physician and her insurer about her status and prognosis. What CPT® and ICD-9-CM codes are reported for the preparation of the report?
a. 90889, 300.01
b. 90887, 300.00
c. 90885, 300.01
d. 90889, 300.23

Medical Terminology

109. A dacryocystectomy describes:
a. Excision of the lacrimal sac
b. Excision of the sclera
c. Excision of the cornea
d. Excision of the pupil

110. The meaning of the root "blephar/o" is:
a. Choroid
b. Sclera
c. Eyelid
d. Uvea

111. The meaning of heteropsia (or anisometropia) is:
a. Blindness in half the visual field
b. Double vision
c. Unequal vision in the two eyes
d. Blindness in both eyes

112. The radiology term "fluoroscopy" is described as:
a. Technique using magnetism, radio waves and a computer to produce images
b. An X-ray procedure allowing the visualization of internal organs in motion
c. A scan using an X-ray beam rotating around the patient
d. Use of high-frequency sound waves to image anatomic structures

113. Sialography is an X-ray of :
a. Sinuses
b. Liver
c. Salivary glands
d. Ventricles of the brain

114. A projection is the path of the X-ray beam. If the projection is front to back it would be:
a. Lateral
b. Recumbent
c. Decubitis
d. Anteroposterior

115. Cytopathology is the study of:
a. Tissue
b. Cells
c. Blood
d. Organs

116. The process of preserving cells or whole tissues at extremely low temperatures is known as:
a. Cryotherapy
b. Cryopexy
c. Cryalgesia
d. Cryopreservation

Anatomy

117. Which part of the brain controls blood pressure, heart rate and respiration?
   a. Cortex
   b. Cerebrum
   c. Cerebellum
   d. Medulla

118. What are chemicals which relay, amplify and modulate signals between a neuron and another cell?
   a. Neurotransmitters
   b. Hormones
   c. Interneurons
   d. Myelin

119. Which of the following conditions results from an injury to the head? The symptoms include headache, dizziness and vomiting.
   a. Meningitis
   b. Parkinson's disease
   c. Concussion
   d. Epilepsy

120. Lacrimal glands are responsible for which of the following?
   a. Production of tears
   b. Production of zonules
   c. Production of vitreous
   d. Production of mydriatic agents

121. Which of the following does NOT contribute to refraction in the eye?
   a. Aqueous
   b. Macula
   c. Cornea
   d. Lens

122. A patient diagnosed with glaucoma has:
   a. A lens that is no longer clear
   b. Bleeding vessels on the retina
   c. Abnormally high intraocular pressure
   d. Corneal neovascularization

123. Which of the following is true about the tympanic membrane?
   a. It separates the middle ear from the inner ear
   b. It separates the external ear from the middle ear
   c. It sits within the middle ear
   d. It sits within the inner ear

124. Which of the following is true about the function of the cochlea?
   a. It helps with balance and sound transmission
   b. It helps with balance only
   c. It transmits sound only
   d. Its function is to excrete cerumen (wax) to help keep the ear clean

ICD-9-CM

125. 45-year-old female with malignant Mullerian duct cancer is receiving her first treatment of chemotherapy. What diagnosis codes should be reported?
   a. V58.11, 184.8
   b. 198.82, V58.11
   c. V58.11, 221.8
   d. 184.8, V58.11

126. What diagnosis codes should be reported for pyoderma caused by MSSA?
   a. 686.00, 041.89
   b. 686.09, 041.11
   c. 686.00, 041.11
   d. 041.89, 686.09

127. 2-year-old comes into the ED for not moving his right arm. He was playing with his brother and his arm was pulled and has not moved it since then. The condition is diagnosed as a nursemaid's elbow. Which code is correct to report?
   a. 832.00
   b. 832.2
   c. 832.09
   d. 832.01

128. The patient was given thrombolytic therapy for an acute myocardial infarction (STEMI) of the anterolateral wall which converted to a NSTEMI. What ICD-9-CM code should be reported?
   a. 410.00
   b. 410.11
   c. 410.70
   d. 410.80

129. An HIV positive patient was admitted with skin lesions on the chest and back. Biopsies were taken, and the pathologic diagnosis was Kaposi's sarcoma. Leukoplakia of the lips and splenomegaly were also noted on physical examination. Discharge diagnoses: (1) HIV infection, (2) Kaposi's sarcoma, back and chest, (3) leukoplakia (4) splenomegaly. What ICD-9-CM code should be reported?

a. 042, 176.0, 528.6, 789.2
b. V08, 176.0, 789.2, 528.6
c. 042, 176.0, 528.6, 789.2, V08
d. 528.6, 176.0, 789.2, V08

130. An elderly male patient presents to the ED complaining of a high-fever the day prior to the encounter and of extreme lethargy. He has a history of benign hypertension which has been elevated. On arrival he was examined and admitted, with possible septic urinary tract infection and concern for his elevated blood pressure. Pseudomonas showed in the urine culture and IV antibiotics were administered. During the course of the day, his fever decreased and his lethargy improved. He was noted to have gross hematuria. As the IV fluids were decreased, he resumed his usual hypertensive state. On the next hospital day, the urine was clear and he was discharged on oral antibiotics, with septicemia ruled out. What ICD-9-CM codes should be reported?

a. 041.7, 995.91, 599.71, 401.1
b. 599.0, 041.7, 599.71, 401.1
c. 041.7, 599.0, 401.9, 599.71
d. 599.71, 041.7, 599.0, 401.9

131. Friends brought a young male with type 1 diabetes to the emergency department, in a comatose state. He was admitted with ketoacidosis and was resuscitated with saline hydration via insulin drip. After regaining consciousness, the patient reported that the morning of admission he was experiencing nausea and vomiting and decided not to take his insulin because he had not eaten. He was treated with intravenous hydration and insulin drip. By the following morning, his laboratory work was within normal range and he was experiencing no symptoms. What ICD-9-CM codes should be reported?

a. 250.11, 780.01, V58.67
b. 250.13, 786.01, V58.67
c. 250.33, V58.67
d. 250.31, V58.67

132. A young female, was brought to the clinic by her sister. She has had periods of severe depression for many years and is on Lithium Her physician also manages her depression, hypothyroidism, and migraine headaches. Additional medications are Synthroid and Midrin.. During the past week, she became manic, running all her credit cards to the limit, getting inappropriately involved in a friend's suicide attempt, quitting her job, and trying to take over the pulpit at church. On the day of the clinic visit, she threatened to strike the telephone repairman with a lead pipe. She was admitted for Lithium adjustment. Diagnoses are: Manic bipolar depression, hypothyroidism and migraine. What ICD-9-CM codes should be reported?

a. 296.80, 244.8, 346.90
b. 296.20, 244.9, 346.90
c. 296.41, 244.1, 346.90
d. 296.40, 244.9, 346.90

133. A 14-year-old male patient was injured while skateboarding. The injuries included a fracture of the femur shaft with multiple significant abrasions of the thigh. What ICD-9-CM codes should be reported?

a. 821.01, E885.2, E006.0
b. 821.00, E885.2, E006.0
c. 821.00, 919.0, E886.0, E006.0
d. 821.01, 916.0, E888.8, E006.0

134. 40-year-old woman, 25-weeks-pregnant with her second child, is seeing her obstetrician. She is worried about decreased fetal movement. During the examination the obstetrician detects bradycardia in the fetus. What ICD-9-CM codes should be reported?

a. 659.73, V23.82
b. 779.81, 656.63
c. 648.63, V23.82
d. 659.73, 659.63

135. Ten days following a below-the-knee amputation, the patient sees her physician. The physician notes that the amputation stump is not healing and is infected. What ICD-9-CM code(s) should be reported?

a. 998.59, V49.70
b. 997.62
c. 998.89, V49.70
d. 897.1

HCPCS

136. How many days does it take for CMS to implement HCPCS Level II Temporary Codes that have been reported as added, changed, or deleted?
a. 365
b. 90
c. 30
d. 60

137. What temporary HCPCS Level II codes are required for use by Outpatient Prospective Payment System (OPPS) Hospitals?
a. C codes
b. G codes
c. H codes
d. Q codes

138. If a CPT® code and a HCPCS Level II code exist for the same service, which should you report?
a. The HCPCS Level II code.
b. The CPT® code.
c. Report both.
d. It depends on the payer.

139. A patient is seen in the physician's office for a 2,400,000 U injection of Bicillin LA. What is the code to represent this drug?
a. J2540 x 4
b. J0561 x 24
c. J2510 x 4
d. J0558 x 24

140. What is the correct HCPCS Level II code for a removable metatarsal foot arch support which is premolded?
a. L3050
b. L3060
c. L3080
d. L3090

Coding Guidelines

141. What is the appropriate modifier to use when two surgeons perform separate distinct portions of the same procedure?
a. 66
b. 80
c. 62
d. 59

142. What hernia repair codes can be reported with add-on code 49568?
a. 49555-49557
b. 49654-49659
c. 49560-49566
d. 49570-49572

143. How are new additions and revisions indicated in your CPT® codebook each year?
a. Italic print
b. Red print
c. Green print
d. Bold print

144. What modifier would be used to report the termination of a surgery following induction of anesthesia due to extenuating circumstances or those that threaten the well being of the patient?
a. Modifier 52
b. Modifier 22
c. Modifier 53
d. Modifier 54

145. What is the correct CPT® code for the extensive excision of nasal polyps?
a. 30020
b. 30100
c. 30110
d. 30115

Practice Management

146. The 2012 OIG Work Plan prioritizes which of the following topics for review?
a. Dystrophic nail care
b. Lesion removal
c. E/M services during the global surgery periods
d. Fracture repair

147. The Medicare program is made up of several parts. Which part is most significant to coders working in physician offices and covers physician fees without the use of a private insurer?
a. Part A
b. Part B
c. Part C
d. Part D

148. When are providers responsible for obtaining an ABN for a service not considered medically necessary?
    a. After providing a service or item to a beneficiary
    b. Prior to providing a service or item to a beneficiary
    c. During a procedure or service
    d. After a denial has been received from Medicare

149. What form is used to send a provider's charge to the insurance carrier?
    a. UB-04
    b. CMS-1500
    c. ABN
    d. Provider reimbursement form

150. If an NCD doesn't exist for a particular service/procedure performed on a Medicare patient, who determines coverage?
    a. To determine new codes under Current Procedural Terminology (CPT)
    b. Centers for Medicare & Medicaid Services (CMS)
    c. Medicare Administrative Contractor (MAC)
    d. The patient