2013 Final - CPC

Answers & Rationales

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

   ANS: A
   Rationale: Four lacerations are repaired. The lacerations are separated first by classification (simple, intermediate, complex); then by location. There is one simple closure which is 7.6 for the right forearm (12004). Next the intermediate closures are performed on the arm measuring 5.7 cm and the upper chest measuring 10.3 cm. Trunk (chest) and extremities (arm) are in the same classification and are both intermediate, so the lengths are added together to total 16 cm (12035). The last repair is a complex repair of the neck, 4.7 cm (13132). Subsection guidelines state to append Modifier 59 to indicate that multiple repair procedures are performed.

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

   ANS: A
   Rationale: The excision of the lesion is found by looking in the CPT® Index for Skin/Excision/Lesion/ Malignant, you are referred to code range 11600-11646. The lesion is on the ankle (leg) narrowing the code range to 11600-11606. The lesion is 2.4 cm making the correct code 11603. The guidelines for Excision – Malignant Lesions tell us to report reconstructive closure (15002-15261, 15570-15770) separately. In this case a split thickness skin graft was used. Look in the CPT® Index for Skin Graft and Flap/Split Graft which refers us to code range 15100-15101, 15120-15121. 15100 is the correct code choice. The diagnosis is squamous cell carcinoma. Look in the Neoplasm Table for skin/ankle and there

is a note to "*see also* Neoplasm, skin, limb, lower." Skin/limb/lower gives us a subterm for squamous cell carcinoma (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

ANS: B
Rationale: Understanding a sebaceous cyst is benign, look in the CPT® Index for Skin/Excision/Lesion/Benign referring you to code range 11400-11471. The lesion is coded based on size and location for 11401. The note also indicates the wound was closed in layers allowing for intermediate closure, also coded based on location and size, 12031. In the ICD-9-CM Index, look under Cyst/sebaceous; or Cyst/skin (sebaceous is a nonessential modifier). Both options direct you to 706.2. Verify in the Tabular List.

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

ANS: B

Rationale: For basal cell carcinoma, forehead, look in the ICD-9-CM codebook for the Neoplasm Table, then for Skin/forehead and there is note to "see also Neoplasm, skin, face." Neoplasm, neoplasia/skin/face/basal cell carcinoma refers you to code 173.31. Next, is a basal cell carcinoma, right cheek which also directs you to "see also Neoplasm, skin, face." (173.31). Because both basal cell carcinomas are coded with the same diagnosis code, it is only reported once. In the Index to Diseases, Nevus/compound has a morphology code of /0. Nevus/dermal/and epidermal also has a morphology code of /0. As noted in the Note box under the main term Nevus, morphology codes with a /0 should be coded to "Neoplasm, skin, benign." In the Neoplasm Table, look for skin/nose and skin/forehead both code to skin/face. The code from the benign column is used (216.3). Verify code selection in the Tabular List.

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

ANS: A
Rationale: The first excision is for a malignant neoplasm of the left leg measuring 2.5 cm (11603) and repaired with a split thickness skin graft measuring 5.1 sq cm. The second excision is a surgical wound preparation of an open wound to the right leg (15002) which was repaired with a split thickness autograft measuring 3.2 cm^2. Split thickness autografts are added together for a total graft size of 8.3 cm^2 (15100). Becaluse the original surgery on the right leg was four months ago, this surgery is outside of any global period, so no additional modifier is needed. Modifier 51 is used to indicate multiple procedures.

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

   ANS: C
   Rationale: In CPT® index, see Integumentary System/Removal/Foreign Body, you are directed to code range 10120-10121. The surgeon indicated in the note they considered this incision and removal of foreign body to be complicated leading us to code 10121. In the ICD-9-CM Index to Diseases, see Foreign body/retained/fragments/subcutaneous tissue, you are directed to 729.6. There is no mention of granuloma of the skin making 709.4 incorrect. In the Tabular List, instructions for 729.6 state to use an additional code from V90.01-V90.9 to identify the foreign body. V90.10 indicates a retained metal fragment.

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

   ANS: B

Rationale: The physician performed an incision and drainage (I & D) of a cyst on the chest. To find the code, see the CPT® Index for Incision and Drainage/Cyst/Skin, you are directed to code choices 10040, 10600-10061. 10040 is for acne surgery. 10060-10061 are for I & D of a cyst. Only one cyst was drained making 10060 the correct code. In the ICD-9-CM Index to Diseases, look for Cyst/skin, code 706.2 is indicated. Verification in the Tabular List confirms code selection.

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

ANS: A
Rationale: The provider performed a puncture aspiration of a seroma (clear body fluid built up where tissue has been removed by surgery). In the CPT® Index, see Seroma, your only option is Incision and Drainage (or I & D)/Skin. This is not an incision and drainage, but a puncture aspiration. Code 10160 is the correct code for the puncture aspiration. Even though it does not specifically state "seroma" it is the code to report. This is not a staged return to the operative suite for the puncture aspiration of the seroma. Modifier 78 is used because the patient is returning to the operative suite with a complication in the global period. The diagnosis is reported as a post-operative complication. In the ICD-9-CM Index to Diseases, Seroma indexes to 998.13. Verification in the Tabular List confirms code selection.

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

ANS: D
Rationale: Subsection Guidelines in the Adjacent Tissue Transfer or Rearrangement state that these codes are not to be used when the repair of a laceration incidentally results in a configuration such as a Y plasty. Look in the CPT® Index for Repair/Skin/Wound/Intermediate. Instructions in the subsection guidelines for Repair state to add up all the lengths when in the same repair classification and anatomical sites grouped together into the same code descriptor. Based on the documentation, the total length is 18 cm. An intermediate repair of this length on the top of the head would be reported with code 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

ANS: D

Rationale: Look in the CPT® Index for Removal/Skin Tags. Based on the documentation, the total number of skin tags removed is 22. Code 11200 is reported for the removal of "up to and including 15 lesions." Notice the wording for 11201 "… each additional 10 lesions, or part thereof." The words "part there of" in the code description means you do not need to have a complete total of 10 skin tags to report the add-on code. The add-on code can be reported if the additional skin tags are 10 and under; so it is not necessary to append modifier 52 to this add-on code.. Code 11201 is an add-on code and modifier 51 Multiple procedures exempt.

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

ANS: A

Rationale: The 4-cm mass was removed from the soft tissue of the shoulder. To access the mass, the provider had to go through the proximal aspect of the teres minor muscle. The mass was located distal to the inferior glenohumeral ligament (IGHL). Masses that are removed from joint areas as opposed to masses removed close to the skin require special knowledge and become more of an orthopedic concern due to joint involvement. Therefore, it is reported from codes within the musculoskeletal section. Code 23076 is used because dissection was carried through the proximal aspect of the teres minor. In the CPT® Index, look for Excision/Tumor/Shoulder directing you to 23071-23078.

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

ANS: D

Rationale: In the CPT® Index, look for Arthroscopy/Surgical/Knee. You are referred to 29871-29889. Review the codes to choose appropriate service. 29881 is the correct code since the tear was in the "medial meniscus". A meniscectomy as well as debridement with a shaver (or chondroplasty) were performed. 29877 would not be reported as this is covered with code 29881. 29880 is not appropriate as the procedure would have had to be performed on both the medial and lateral compartments. The surgery started out as a "diagnostic procedure," but changed when the physician decided to perform surgical procedures on the knee, rather than only examining the knee for diagnostic purposes.

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
c. 24640-54-LT, 832.10, E927.8

b. 24565-54-LT, 832.22, E929.8
d. 24600-54-LT, 832.00, E928.8

ANS: A
Rationale: In the CPT® index, look up Elbow/Dislocation/Closed Treatment. You are referred to 24600-24605, and 24640. Review the codes to choose appropriate service. 24640 is the correct code to report treatment of a dislocated nursemaid's elbow with manipulation. Modifier 54 is used to report that the ED physician performed the surgical portion of the service only. The patient is referred to an orthopedist for follow-up care. Modifier LT is appended to indicate the procedure was performed on the left side.

In the ICD-9-CM Index to Diseases, look up Nursemaid's/elbow. You are referred to 832.2. Review the code in the tabular section to verify accuracy. According to ICD-9-CM guidelines: A dislocation not indicated as closed or open should be classified as closed. In the ICD-9-CM Index to Diseases (Alphabetic Index) to External Causes of Injury and Poisoning, Section 3, look up Pulling,injury/due to/sudden strenuous movement. You are referred to code E927.0. Review the code in the Tabular List to verify accuracy.

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

ANS: D
Rationale: In the CPT® Index, look for Hematoma/Leg, Upper. You are referred to 27301. Verify the code for accuracy. Modifier 78 is appended to 27301 to indicate that an unplanned procedure related to the initial procedure was performed during the postoperative period. In the ICD-9-CM Index to Diseases, look for Complications/surgical procedures/hematoma. You are referred to 998.12. Review the code in the Tabular List for accuracy.

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
c. 24577-54-RT, 24600-54-51-RT
b. 24576-54-RT, 24620-54-51-RT
d. 24565-54-RT, 24605-54-51-RT

ANS: D
Rationale: In the CPT® Index, look for Fracture/Humerus/Epicondyle/Closed Treatment. You are referred to code 24560-24565. Review the codes to choose the appropriate service. 24565 is the correct code to report an epicondyle fracture manipulated (reduced) without a surgical incision to perform the procedure. In the CPT® Index, look for Dislocation/Elbow/Closed Treatment. You are referred to 24600,24605. Review the codes to choose appropriate service. 24605 is the correct code because the patient was put under general anesthesia to perform the procedure. Modifier 54 is used to report the physician performed the surgical portion only. The patient is referred to an orthopedist for follow up or postoperative care. Modifier 51 is used to report multiple procedures were performed. Append modifier RT to indicate the procedure is performed on the right side.

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

ANS: C

Rationale: In the CPT® Index, look for Trigger Finger Repair. You are referred to 26055. Review the code to verify accuracy. In the CPT® Index, look for Injection/Joint. You are referred to 20600-20610. Review the codes to choose appropriate service. 20610 is the correct code since the shoulder was injected. Modifier F6 is used to report the right index finger that was repaired. Modifier LT is used to indicate the left shoulder joint. Modifier 51 is used to indicate multiple procedures were performed.

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

ANS: A

Rationale: When reporting the removal of hardware (pins, screws, nails, rods), the code is selected by fracture site, not the number of items removed or the number of incisions that are made. To report 20670 or 20680 more than once, there would need to be more than one fracture site involved. In this case, there is only one fracture site even though two incisions are made. We know the removal is deep because the screws were in the bone. In the CPT® Index, look for Removal/Implantation. The correct code is 20680. Modifier LT is appended to indicate the procedure is performed on the left side.

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

ANS: C

Rationale: As noted in ICD-9-CM Tabular List at the beginning of Chapter 17, a comminuted fracture is a closed fracture; therefore, a comminuted lateral condyle fracture is listed as 812.42. In the ICD-9-CM Index to Diseases, look up Fracture/humerus/external condyle directing you to 812.42. The fracture procedure code is found in the CPT® Index for Fracture/Humerus/Condyle/Open Treatment 24579. The manipulation is included in 24579. The application of the first cast is always bundled with the 24579 and not reported separately.

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

    ANS: B
    Rationale: This is a supracondylar fracture of the elbow repaired by percutaneous fixation. In the CPT® Index, look for Fracture/Humerus/Supracondylar/Percutaneous Fixation, 24538. Modifier LT is appended to indicate the procedure is performed on the left side.

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

    ANS: B
    Rationale: In the CPT® Index, look for Fracture/Fibula/Open Treatment 27784, 27792, 27814. 27784 reports open treatment of a proximal fibular fracture or shaft fracture. The correct code is 27792, Open treatment of a distal fibular fracture which includes internal fixation. Modifier RT is appended to indicate the procedure is performed on the right side.

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

    ANS: C

Rationale: According to the ICD-9-CM Official Coding Guidelines Section I.B.6, signs and symptoms are reported when a related definitive diagnosis has not been established. The flu was suspected but not established therefore we code the patient's presenting symptoms. In the Index to Diseases, see Fever directing you to 780.60. She also has a sore throat, in the Index to Diseases, look up Pharyngitis directing you to code 462. In the Index to Diseases, look up Cough directing you to 786.2. Verify these codes in the Tabular List.

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

    ANS: B
    Rationale: Code 32552 represents the indwelling tunneled chest tube removal and code 32550 the insertion of a new indwelling catheter/tube. In the Index to Diseases, look up Catheterization/Pleural Cavity which directs you to 32550-32552. Read both codes to confirm the selections.
    The infection at the insertion site of the chest tube is indexed under Complications/infection/due to (presence of) any device, implant, or gaft/catheter NEC, directing you to code 996.69. The ICD-9-CM code for the lung cancer is found using the Neoplasm Table.Look up lung/lower lobe. In the malignant primary column we are directed to code 162.5. Verification in the Tabular List confirms code selection.

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

    ANS: B
    Rationale: According to the CPT® guidelines for coding of endoscopies, a surgical sinus endoscopy includes a sinusotomy and diagnostic endoscopy. In the Index, look up Ethmoidectomy/Endoscopic directing you to 31254-31255. Code 31255 represents a total ethmoidectomy. In the Index, look up Septoplasty, this directs you to code 30520. The fracturing of the turbinates is inclusive to the procedures and not reported separately, since the physician is fracturing the turbinates to perform the ethmoidectomy. Modifier 50 indicates these procedures were both performed bilaterally and modifier 51 is reported with code 30520 to indicate multiple procedures performed at same session, for maximum reimbursement.

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

    ANS: D

Rationale: In the CPT® Index, look up Biopsy/Lung/Needle. This directs you to code 32405. Code 77002 is the appropriate code for the fluoroscopic guidance as indicated by the parenthetical statement under code 32405 and by reviewing the code descriptor for 77002. Modifier 26 is appended to report the professional component.
We have a diagnosis of small cell carcinoma of the lung which is code 162.3. In the Index, go to the Neoplasm Table and look under lung/upper lobe and the "Primary" column code 162.3 is listed. The signs and symptoms are no longer codes since we do have this definitive diagnosis (ICD-9-CM Guidelines Section I.B.6) Brain metastasis is suspected but not confirmed so it would not be reported. The chemotherapy is planned but not performed so it would not be reported either.

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

    ANS: B
    Rationale: A segment of the lung is removed. In the CPT® Index, look up Removal/Lung/ Single Segment. This directs you to code 32484.
    We have a confirmed diagnosis of apical lung cancer, a cancer in an upper lobe, which is code 162.3. The term apical means the tip of a pyramidal or rounded structure, so apical lung cancer means the tumor/cancer is located at the top or upper lobe of the lung. We find this by looking in the Neoplasm Table under lung/upper lobe. In the primary malignant column we are directed to code 162.3.

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

    ANS: A
    Rationale: Since the marble is a foreign body, look in the CPT® Index for Nose/Removal/Foreign Body. Here you are directed to use code 30300.
    For the ICD-9-CM code first look up in the Index to Diseases Volume 2 Foreign Body/entering through orifice/nose or nostril. This directs us to code 932.The E code is indexed in the Index to External Causes under Foreign Body, object or material/air passage/nose (with asphyxia, obstruction, suffocation) directing you to code E912.Verify codes in the Tabular List..

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.

    ANS: D
    Rationale: CPT® guidelines under Vascular Injection Procedures indicate the above-listed in d as being included.

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

    ANS: D
    Rationale: This is a Category III code. Look in the CPT® index under Stent/Placement/Transcatheter/Intravascular/Extracranial, and you are referred to 0075T-0076T. When you check these codes, you see S&I is included; therefore, modifier 26 reports the professional service.

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

    ANS: A
    Rationale: Look in the CPT® index for Pulmonary Artery/Catheterization, you are referred to 36013-36015. 36015-RT reports the second order selective catheterization of the right pulmonary artery; 36014-59-LT reports the first order selective catheterization in a different family of the left pulmonary artery. Look in the CPT® index for Angiography/Pulmonary, and you are referred to 75741-75746, 93568. Code 75743-26 reports bilateral pulmonary angiography, and 75774 reports the additional angiography after the basic study of the right and left pulmonary arteries. This is found in the CPT® index under Angiography/Other Artery 75774.

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

ANS: B

Rationale: Only one base code can be reported per major coronary artery. In this case angioplasty and stent placement was performed in the right coronary artery (92928-RC) and in the left anterior descending (92928-LD) Look in the CPT® index for Coronary Artery/Angioplasty/with Stent Placement 92928-92929. A thrombectomy was performed by AngioJet in the LD, 92973. Look in the CPT index for Coronary Artery/Thrombectomy 92973. A temporary pacemaker was inserted through the femoral vein; however it is bundled with the cardiac catheterization. At the end of the procedure, an intra-aortic balloon pump was inserted, 33967. This is found in the CPT® index under Insertion/Balloon/Intra-Aortic 33967, 33973.

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

    ANS: B
    Rationale: Code 43753 is the correct CPT® code for gastric lavage performed for the treatment of ingested poison and is found in the CPT® Index under Gastric Lavage, Therapeutic.
    The ICD-9-CM code for the poisoning is in the Table of Drugs under Valium, referring you to code 969.4. The next code is the manifestation of ingesting the Valium – unconsciousness 780.09, this is found in the Index to Diseases under Unconsciousness. Using the Table of Drugs, find valium, and then find the E code for accidental ingestion, 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

    ANS: B
    Rationale: Code 43753 is the correct CPT® code for gastric lavage performed for the treatment of ingested poison and is found in the CPT® Index under Gastric Lavage, Therapeutic.
    The ICD-9-CM code for the poisoning is in the Table of Drugs under Valium, referring you to code 969.4. The next code is the manifestation of ingesting the Valium – unconsciousness 780.09, this is found in the Index to Diseases under Unconsciousness. Using the Table of Drugs, find valium, and then find the E code for accidental ingestion, E853.2.

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

    ANS: D
    Rationale: CPT® code 45315 is the correct code for the removal of more than one polyp by snare technique. In the index, look up Proctosigmoidoscopy/Removal/Polyp directing you to 45308-45315. During the proctosigmoidoscopy polyps were removed by snare technique.

The correct ICD-9-CM code is 569.0 because the polyps are located in the rectum. In the Index to Diseases, look up Polyp, polypus/rectum directing you to 569.0. 211.3 is for polyps that are located in the large intestine.

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

    ANS: C
    Rationale: An incisional hernia is when the scarred muscle tissue of a previous abdominal surgical incision bulges through a weak area in the lower abdominal muscles. The physician did not document that the patient's hernia was bilateral, obstructed or had gangrene. This repair was performed by an open approach, because it is not documented that the procedure was done laparoscopically. The code is indexed under Hernia Repair/Incisional/Recurrent/Incarcerated referring you to code 49566. When a recurrent incisional hernia is repaired, the age of the patient is not a factor in choosing the correct CPT® code for the repair. Mesh was used in the repair. Coding Tip note under code 49566 in the CPT® codebook states the use of mesh (49568) can be reported with incisional hernia repair codes.
    The ICD-9-CM diagnosis code is indexed under Hernia/incisional/recurrent, coding is 553.21.

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

    ANS: B
    Rationale: In the CPT® Index, look for Palatoplasty.Code 42220 represents a secondary repair to a cleft palate. Modifier 53 is appended because the procedure was terminated after anesthesia due to extenuating circumstances.

    The diagnosis of a complete cleft palate is indexed under Cleft/palate/unilateral/complete referring you to code 749.01 (unilateral as we have no documentation this is a bilateral cleft palate). Code 780.39 is reported because the patient began to seize after administering the general anesthesia. This is indexed in the ICD-9-CM under Seizure(s).

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

    ANS: C
    Rationale: An upper GI diagnostic endoscopy up through to a portion of the small intestine is represented by code 43235. Combined with balloon dilation (surgical endoscopy) for an esophageal stricture the correct code for this scenario is 43249. Surgical endoscopy always includes diagnostic endoscopy. In the CPT® Index, look for Endoscopy/Gastrointestinal/Upper/Dilation directing you to 43235, 43248-43249.

    The ICD-9-CM code is indexed under Stricture/esophagus giving us code 530.3. We do not code for GI cancer, as "rule out" diagnoses are not reported in outpatient coding.

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

ANS: A
Rationale: In the CPT® Index, look for Appendectomy/Appendix Excision directing you to 44950, 44965, 44960. Code 44950 is correct.The appendectomy was performed via open incision not by using a laparoscope.

According to the ICD-9-CM Official Coding Guidelines Section I.B.6-8, if a definitive diagnosis is established, that is reported. Any signs or symptoms that would be an integral part of that definitive diagnosis/disease process would not be separately reported. RLQ abdominal pain, fever and vomiting are signs and symptoms of acute appendicitis, only diagnosis code 540.9 is reported. In the Index to Diseases, look up Appendicitis/acute.

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

ANS: B
Rationale: In the CPT® Index, look for Polyp/Colon/Removal to locate code 45384 and 45385. We can code both procedure codes 45384 and 45385 as two different removal techniques (hot forceps and snare) were used to remove the polyps. Modifier 59 is used to indicate this.

ICD-9-CM code 211.3 represents polyps of the large intestine, indexed under Polyp/colon and V16.0 the family history of colon cancer, indexed under History/family/malignant neoplasm/colon. The pathology code cannot be reported as we are only planning to send the tissue for examination and we do not have a definitive outcome indicating the patient has a malignancy therefore no cancer codes can be reported.

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

ANS: B
Rationale: CPT® code 43622 represents the complete gastrectomy with intestinal pouch formation. In the index, look for Gastrectomy/Total directing you to 43620-43622. Code 38102 represents the en bloc total splenectomy and is an add-on code so it is modifier 51 exempt. In the index, look for Splenectomy/Total/En bloc directing you to 38102.

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

    ANS: B
    Rationale: Ligation of esophageal varices endoscopically is coded with CPT® code 43244.This is indexed in CPT® under Ligation/Esophageal Varices.

    The patient has cirrhosis reported with code 571.5, in the ICD-9-CM Index to Diseases, look up Cirrhosis/liver directing you to 571.5 as well and is coded along with 456.21 for the esophageal varices.

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

    ANS: A
    Rationale: Repair for penile injury is reported using CPT® 54440. Do not report CPT® codes used for treatment of priapism when there is injury to the penis. In the index locate Repair/Penis/Injury.

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

    ANS: A
    Rationale: When a stent is removed and replaced, the removal of the initial stent is included in the stent replacement and is not reported. Usually the basketing of the stones is included with the laser lithotripsy; however, because ureteroscopy is performed on a separate part of the ureter than the laser lithotripsy, it is appropriate to add modifier 59 to CPT® 52352. In the Index, look up Cystourethroscopy/Lithotripsy directing you to 52353. In the Index, look up Cystourethroscopy/Insertion/Indwelling Ureteral Stent directing you to 52332.

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

    ANS: D
    Rationale: When a circumcision is performed requiring tissue transfer or reconstruction, you report the circumcision and the tissue transfer codes. You do not append modifier 22 to the circumcision code, and reporting only the tissure transfer is incorrect. Reporting repair of an incomplete circumcision is also incorrect, as we have no documentation to support a previous circumcision. In the Index, look up Circumcision/Surgical Excision directing you to 54161. In the Index, look up Tissue/Transfer/Adjacent/Skin directing you to 14000-14350.

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

ANS: C
Rationale: Ureteroscopic procedures have no global period and the use of modifier 58 or 76 would not be appropriate. Though a stent exchange was performed, you do not report removal of the previous stent (52310). You would report the laser lithotripsy (52353) and stent insertion (52332) with no modifier(s) appended. In the Index, look up Lithotripsy/Ureter directing you to 52353. In the Index, look up Cystourethroscopy/Insertion/Indwelling Ureteral Stent directing you to 52332.

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

ANS: C
Rationale: Brachytherapy is a form of radiation in which radioactive seeds or pellets are implanted directly into the tissue being treated to deliver their dose of radiation in a direct fashion and longer period of time. The placement of the seeds is performed percutaneously (going through the skin by needle). The code is indexed under Prostate/Insertion/Needle guiding you to code 55875.

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

ANS: B
Rationale: Surgical laparoscopy is performed to remove the five fibroid tumors weighing over 250 grams. This procedure is indexed under Laparoscopy/Removal/Leiomyomata referring you to codes 58545-58546. The diagnosis is indexed in the ICD-9-CM Index to Diseases, under Leiomyoma/uterus/intramural guiding you to code 218.1

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

ANS: D

Rationale: Due to the patient having cervical cancer metastasized to the pelvic area (gynecological malignancy) the procedure performed is a pelvic exenteration. This is a total hysterectomy with removal of ovaries and fallopian tubes (salpingo-oophorectomy). This includes the removal of her bladder (cystectomy) with creation of a passageway to drain the kidneys through an opening on the abdomen (ileal conduit) and partial removal of the large bowel or colon (resection of the rectum and colon). This procedure is located in the CPT® Index under, Exenteration/Pelvis guiding you to codes 45126 and 58240. Code 58420 is the only code needed to report this surgical procedure. Reporting the other codes is considered unbundling.

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

ANS: C
Rationale: In the CPT® Index, look for Vertebra/Arthrodesis/Posterior and you are directed to code range 22590-22802. The procedure is performed on the lumbar spine, making 22612 the correct code. Posterior, non segmental spinal instrumentation was used. In the CPT® Index, look for Spinal Instrumentation/Posterior Nonsegmental directs you to 22840. A laminotomy is performed (hemilaminectomy) which is reported with 63030. In thei Index, look for Hemilaminectomy to locate code 63030. Intraoperative fluoroscopy (76000) during an open spine procedures, such as a laminotomy, is considered an integral part of the procedure and is not separately reportable.

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

    ANS: C
    Rationale: After general anesthesia was given and the surgery for the laparoscopic hysterectomy had started, the patient's blood pressure dropped and could not be stabilized. Using the CPT® Index, there are two ways to find the code for a laparoscopic hysterectomy. Start with Hysterectomy/Laparoscopic/Total or see Laparoscopy/Hysterectomy/Total. Both indicate code range 58570-58573. Modifier 53 is the correct modifier to append because there was a threat to the well being of the patient during the surgery. You do not code for the colpopexy (57425) because the colpopexy surgery had not begun.

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

    ANS: B
    Rationale: This procedure was performed on a pregnant patient (obstetrical) with an incomplete spontaneous abortion. The first procedure to report is the dilation and curettage (D & C) is located in the CPT® Index under Abortion/Incomplete guiding you to code 59812. You report the antenatal care service, because the patient had four antepartum visits before the abortion happened. This is indexed under Obstetrical Care/Antepartum Care referring you to code 59425-59426.

    The diagnosis is located in the ICD-9-CM Index to Diseases under Abortion/spontaneous guiding you to code 634.9x and the fifth digit being "1". See the Guideline 11. Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium, k. Abortions, 1) "Fifth digit assignment is based on the status of the patient at the beginning (or start) of the encounter."

    PTS: 1 DIF: Difficult

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

ANS: D

Rationale: Look in the CPT® Index for Suture/Nerve or Repair/Nerve/Suture. 64831 is the correct code to report the digital nerve was repaired. 64832 is the correct secondary code since there was an additional digital nerve that needed repair. 51 is not appended to the secondary code since this code is an add-on code and add-on codes are modifier 51 exempt.

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

ANS: B

Rationale: Two co-surgeons performed distinct parts of the same surgery. The surgery performed is a vertebral corpectomy, thoracic. Look in the CPT® Index for Vertebral/Corpectomy and you are directed to code range 63081-63103, 63300-63308. 63300-633008 are for excision of intraspinal lesions. The code selection for 63081-63103 is based on location, approach and number of vertebral segments. 63085 is for a transthoracic approach, thoracic, single segment. The additional two segments are reported with 63086. As indicated by the guidelines (top of page 336336 in CPT®) for this section, each provider will report the same CPT® code and append a modifier 62.

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

ANS: B

Rationale: In the CPT® Index, look for Tympanoplasty/without Mastoidectomy. You are referred to 69631. Review the code to verify accuracy. This is the correct code with LT modifier because the repair of the left ear is performed (tympanoplasty) with a canaloplasty, without an ossicular chain replacement or mastoidectomy (removal of a portion of the mastoid of the posterior temporal bone).

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

ANS: A

Rationale: In the CPT® Index, look for Blepharoptosis/Repair/Tarso Levator Resection/ Advancement/External Approach. You are referred to 67904. Review the code Eye and Ocular Adnexa Section to verify accuracy. This is the correct code because the external approach of cutting the skin of the eyelid was performed and dissection is carried to the levator tendon. The physician uses sutures to advance the levator tendon to create a new eyelid crease. Append modifier E1for Upper left, eyelid.

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

ANS: A

Rationale: In the CPT® Index, look up Transplantation/Eye/Amniotic Membrane. You are referred to 65778-65780. Verify in the Eye and Ocular Adnexa Section. Code 65780 is the correct code because the amniotic membrane transplantation is for an ocular surface reconstruction for corneal defects of scarring and perforation.

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

ANS: B

Rationale: In the CPT® Index, look for Trabeculoplasty/by Laser Surgery 65855. Verify this in the Eye and Ocular Adnexa Section. Code 65855 is the correct code since trabeculoplasty by laser surgery was performed on the patient. You would not code 65855 three times since the code includes multiple sessions to accomplish the trabeculoplasty.

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

ANS: C

Rationale: In the CPT® Index, look for Tympanostomy/General Anesthesia 69436, then verify the code in the numerical Index. Code 69436 is the correct code to report because a small incision is made in the tympanum, the fluid in the middle ear is suctioned, and an insertion of a small ventilating tube is placed into the opening of the tympanum under general anesthesia. Modifier RT is appended to indicate the side of the body the procedure was performed. In the ICD-9-CM Index to Diseases, look up, Otitis/chronic/serous. You are referred to 381.10. Review the code in the Tabular List to verify accuracy.

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

ANS: B

Rationale: In the CPT® Index, look for Trichiasis/Repair/Epilation, by Other than Forceps. Verify this code in the numerical Index. Code 67825 describes the correction of trichiasis by other than forceps, eg cryotherapy. In the ICD-9-CM Index to Diseases, look for Trichiasis/eyelid that directs to code 374.05 and is verified in the Tabular List as Trichiasis without entropian.

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

ANS: C

Rationale: In the CPT® Index, look for Chemodenervation/Facial Muscle 64612, 64615. Code 64612 is used for chemodenervation of muscles that are innervated by the facial nerve for conditions such as blepharospasm. Botulinum toxin is the substance most commonly used for chemodenervation of muscle tissue innervated by the facial nerve. Blepharospasm in the ICD-9-CM Index to Diseases directs you to 333.81 and is verified from the Tabular List.

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

ANS: A

Rationale: TThe CPT® Index lists Insertion/Intraocular Lens/Manual or Mechanical Technique/Not Associated with Concurrent Cataract Removal and directs you to code 66985. The procedure was planned, as it was decided upon with the patient before the cataract removal was performed six weeks earlier. This “planned” procedure indicates the need for modifier 58 Staged or related procedure or service by the same physician during the postoperative period.

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

    ANS: A
    Rationale: This is a follow up visit indicating an established patient seen in the clinic. In the CPT® Index, see Established Patient/Office Visit. The code range to select from is 99211-99215. For this code range, two of three key components must be met. History – PF (HPI-Brief, ROS-None, PFSH-Pert), Exam – Problem Focused, MDM – Moderate (Mgmt options - 1 stable problem, one new problem with workup; Data reviewed – lab and EKG; Level of Risk Moderate with unknown cause of pulmonary HTN). 99212 is the level of visit supported.

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

    ANS: C
    Rationale: The patient is being discharged from the hospital. Hospital discharge codes are determined based on the time documented the physician spent providing services to discharge the patient. The provider documented 20 minutes, which is reported with 99238.

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

    ANS: B

Rationale: Patient is coming to the doctor's office for help to to quit smoking. The patient is new. The physician documents 20 minutes of the 30 minute visit was spent counseling the patient. E/M Guidelines identify when time is considered the key or controlling factor to qualify for a E/M service. When counseling and/or coordination of care is more than 50% face to face time in the office or other outpatient setting, time may be used to determine the level of E/M. The correct code is 99203 based on the total time of the visit which is 30 minutes.

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

ANS: D
Rationale: Physician is providing subsequent hospital care to an inpatient. The physician performed an expanded problem focused interval history (brief HPI, pertinent ROS since last assessment) + problem focused exam (1 system) + low MDM (prescription drug management, two data points and established diagnosis is improving. Subsequent hospital codes require two out of three key components. The code documented is a 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

ANS: D
Rationale: For this encounter, no additional work in evaluating the patient has been performed to support an E/M service that is significant and separately identifiable from the procedure. Only the procedure should be billed. To perform an arthrocentesis, the physician inserts a needle through the skin and into a joint or bursa. A fluid sample may be removed from the joint or fluid may be injected for lavage or drug therapy. In the CPT® Index, look for Shoulder/Arthrocentesis. You are referred to code 20610. Review the code description to verify accuracy. Modifier 50 Bilateral Procedure is attached since both shoulders are injected.

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

ANS: B

Rationale. The patient is an established patient. In the CPT® Index, find Evaluation and Management/Office and Other Outpatient. You are referred to 99201-99215. An established patient visit requires 2 of 3 key components. The physician documents an Expanded Problem Focused History (brief HPI, pertinent ROS, and no PFSH), a Problem Focused Exam (1 affected body area) and Straightforward MDM (New Problem to examiner, 0 data points, and one self limited/minor problem). Review codes to choose the appropriate level of service. Code 99212 is the correct code. Back strain was the doctor's diagnosis. In the ICD-9-CM Index to Diseases, look for Sprain, strain/back. You are referred to 847.9. Review the code in the tabular section to verify accuracy. In the ICD-9-CM Index to Diseases, go to Section 3, Alphabetic Index to External Causes of Injury and Poisoning (E code). Look for Slipping/surface/wet. You are referred to E885.X. A fifth digit is needed to complete code. Review the code in the tabular section to verify accuracy. E885.9 is the most accurate code. In the ICD-9-CM Index to Diseases, go to Section 3, Alphabetic Index to External Causes of Injury and Poisoning (E code). Look for Accident/occurring/home. You are referred to E849.0. Review the code in tabular section to verify accuracy.

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

ANS: C

Rationale: ED Physician documents an amount of time spent with this critical patient. According to CPT® guidelines: "The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient. Time spent with individual patient should be recorded in the patient's record." According to CPT® guidelines: "Services such as endotracheal intubation (31500) and cardiopulmonary resuscitation (92950) are not included in the critical care codes. Therefore, they can be coded separately in addition to critical care services if the critical care is a significant, separately identifiable service, and is reported with modifier -25. The time spent performing these other services, eg, endotracheal intubation, is excluded from the determination of the time spent providing critical care." In the CPT® Index, look for Cardiopulmonary Resuscitation (CPR). You are referred to 92950. Review code to verify accuracy. In the CPT® Index, look for Catheterization/Central. You are referred to 36555-36566. 36556 is the correct code since patient is 5 years of age and there is no indication the CVP was tunneled. In the CPT® Index, look for Intubation/Endotracheal Tube. You are referred to 31500. Review code to verify accuracy.

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

ANS: D

Rationale: Dr. X asks Dr. Y to perform a consultation on a patient residing in a nursing facility. According to CPT® guidelines: "The initial inpatient consultation codes (99251-99255), are to be used only once by the reporting physician for an individual hospital or nursing facility patient for a particular admission. These codes are to be reported for consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting." A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and /or management of a specific problem is requested by another physician. The consulting physician performs the consultation, documents his or her opinion in the patient's medical record, and communicates findings/recommendations by written report to the requesting physician or other appropriate source. Consultations require the documentation of three of three key components. The provider performed a detailed history, detailed exam and moderate MDM. The correct code is 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

ANS: D

Rationale: The patient was seen in the clinic, which is an outpatient service. The physician performed a problem focused history (brief HPI, no ROS, and pertinent PFSH) + expanded problem focused exam + moderate MDM (new problem to examiner, three data points, and acute illness with systemic symptoms and prescription drug management). Established patient office visits require two of three components be met. Code 99213 is the appropriate code for this visit.

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

ANS: A

Rationale: This patient was admitted and discharged on the same date of service. According to CPT® guidelines for Observation or Inpatient Care Services (Including Admission and Discharge Services), services for a patient admitted and discharged on the same date of service should be reported by one code. For a patient admitted and discharged from observation or inpatient status on the same date, codes 99234-99236 should be reported as appropriate." The provider performed a comprehensive history, comprehensive exam and moderate MDM (New problem to the examiner, 0 data points and moderate risk). The correct code is 99235.

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

    ANS: C
    Rationale: An anesthesia service was NOT performed; therefore, 00400 is not reported. Look in the Alphabetical Index under Catheterization/Central Venous and reference is made to *see* Central Venous Catheter Placement. Many codes are listed. The catheter is non-tunneled; therefore, there are two codes from which to choose; 36555 and 36556, based on patient age. This patient is 5-years-old; therefore, 36556 is correct.

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

    ANS: B
    Rationale: Look in the CPT® Index for Anesthesia/Neck, which lists a range of codes or Anesthesia/Integumentary System/Neck which lists one code, 00300. A P3 modifier may be reported for a patient with severe systemic disease.

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

    ANS: D
    Rationale: Each of the qualifying circumstances codes identifies a different circumstance, and more than one may be appended when applicable, unless the reported anesthesia code already contains the risk factor. In this case, 99100 is assigned for extreme age of one year or younger and 99140 is assigned for emergency conditions.

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

    ANS: A
    Rationale: Look for Anesthesia/Heart in the CPT® Index or Anesthesia/Intrathoracic System. Check this listing with the Anesthesia Subsection, Intrathoracic to determine 00560 is the correct code reported for patient's age and without use of a pump oxygenator. The arterial line placement is NOT reported as the perfusionist, not the anesthesia provider, performed it.

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

ANS: B
Rationale: A patient who is undergoing monitored anesthesia care (MAC) for a deep complex, complicated, or markedly invasive surgical procedure may be reported with modifier G8. The additional modifier -QS is not necessary, because the description for G8 includes monitored anesthesia care.

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

ANS: C
Rationale: An anesthesiologist who is personally performing services reports the service with a modifier AA. The service performed was MAC (Monitored Anesthesia coverage); therefore, modifier QS is also reported. Modifier QS always follows the anesthesia provider modifier.

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

ANS: A
Rationale: A CRNA with medical direction is appropriately reported with a modifier -QX.

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

ANS: B
Rationale: An anesthesiologist who is medically supervising reports anesthesia service separately from the CRNA. The anesthesia modifier for the anesthesiologist depends on the number of concurrent cases. There are six concurrent cases; therefore, the appropriate modifier to report is "AD" for the physician (anesthesiologist).

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

ANS: D

Rationale: The first radiological code is 70450, because a CT scan without contrast of the brain was performed. Code 71250 is correct, because thorax is a synonym for chest and the CT was performed without contrast. Code 71275 is a CTA (computed tomographic angiography) which is used for imaging vessels to find a blood clot, aneurysm, and other vascular irregularities in the chest making it an inappropriate code to report for this scenario. Code 71110 is correct to report the X-ray of the ribs taken bilaterally (left and right side). These codes are found in the CPT Index under CT Scan/without contrast/Brain 70450, and Thorax 71250. Radiology for the ribs is found in the Index under X-ray/Ribs 71100-71111. Modifier 26 denotes the professional service.
The first diagnosis is found in the Index to Diseases under Fracture/skull/base, guiding you to code 801.0. The fifth digit is six, because the patient did have a loss consciousness but there is no documentation of how long the patient was unconscious. Two ribs were fractured, this is indexed under Fracture/rib(s) (closed) guiding you to subcategory code 807.0. The fifth digit is 2 to indicate two ribs were fractured. For the first E code is found in the Index to External Causes under Collision/motor vehicle/and guard post or guard rail guiding you to category code E815. Your fourth digit is 2 for motorcyclist. The last E code is indexed under Accident/occurring (at) (in)/highway guiding you to code 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

ANS: D
Rationale: The chest X-ray was taken in the doctor's office and interpreted. This means the doctor's office can bill for the code without appending a modifier. Modifier 26 is appended to the CT scan code, because, it was performed at another site and the physician only interpreted the image. Look in the CPT® Index for X-ray/chest 71010-71035, and CT Scan/without Contrast/Abdomen 74150, 74176, 74178.

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

ANS: A
Rationale: A radiographic study of the superior vena cava is performed to visualize and evaluate any abnormalities. For the insertion of the catheter look in the CPT® Index under Catheterization/Vena Cava referring you to code 36010. For the radiology code look in the CPT® index under Venography/Vena Cava guiding you to code range 75825-75827. Radiology code 75827 is correct for the superior vena cava. Modifier 26 is appended to the radiology code, because the physician is performing the procedure in an outpatient facility setting.

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

ANS: C

Rationale: Look in the CPT Index for X-ray/Knee 73560-73564, 73580. Code 73562 reports three views of one knee. The scenario is reported with one ICD-9-CM code. In the ICD-9-CM Index to Diseases (Alphabetical Index) under Arthritis/degenerative, there is a *see also* note to go to Osteoarthrosis. Under Osteoarthrosis /localized, guides you to code 715.3 with the fifth digit being six, 715.36. If you look at chapter 13 in your ICD-9-CM codebook, you will see that the fifth digit 6, lower leg, includes the knee joint. Localized osteoarthrosis is appropriate to report, because it is stated as localized.. You do not report the ICD-9-CM code for knee pain as this is a symptom of the degenerative arthritis and included in the code.

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

ANS: B

Rationale: Tomographic myocardial perfusion imaging was performed. In this procedure the patient receives an intravenous injection of a radionuclide, which localizes in nonischemic tissue. SPECT (single photon emission computed tomographic) images of the heart are taken immediately to identify areas of perfusion vs. infarction. In the CPT® Index, see Heart/Myocardium/Perfusion Study 78451-78454. A single study SPECT was performed, 78451. This was performed in the office; therefore, report the Cardiolite. Using your HCPCS codebook go to the Table of Drugs and Biologicals and look for Cardiolite A9500. The code A9500 reports the dose per study

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

ANS: B
Rationale: The nuclear imaging test follows the blood as it flows to the kidneys identifying any obstruction and to determine the rate at which the kidneys are filtering. The scenario does not document the function of the tubes and ducts . In the CPT® Index, see Nuclear Medicine/Diagnostic/Kidney/Vascular Flow 78701-78709.

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

ANS: A
Rationale: There are seven fractions given in this patient's weekly treatment. According to CPT® guidelines,*radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time-period in which the services are furnished. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment, one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately." This instruction is found in CPT® under the heading "Radiation Treatment Management" in the Radiology/Radiation Oncology Section of the Radiology Chapter.*

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

ANS: B
Rationale: The patient is having magnetic resonance imaging in which the images were performed first without contrast and again following the injection of contrast. In the CPT® Index, see Magnetic Resonance Imaging (MRI)/Chest 71550-71552.

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

ANS: C
Rationale: The CT scan with contrast is performed on the maxillofacial area. The maxilla is the upper part of the jawbone. In the CPT® Index, see CT Scan/with Contrast/Maxilla 70487. Modifier 26 is denotes the professional service.

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

ANS: D

Rationale: In the CPT® Index, see Magnetic Resonance Imaging (MRI)/Diagnostic/Spine/Thoracic for the code range. Code 72147 describes and MRI of the thoracic spine with contrast.
This is a secondary (metastasized) cancer to the thoracic spinal cord. It is indexed in the ICD-9-CM Index to Diseases (Alphabetical Index) under Leiomyosarcoma *see* Neoplasm, connective tissue, malignant. In the Neoplasm Table look for Neoplasm/connective tissue/cord (true) (vocal)/spinal (thoracic). Under Malignant, secondary (column) you are guided to code 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

    ANS: B
    Rationale: Separately code for each, the lung examination (all lung specimens are 88309), the lymph node biopsy (88305), the frozen section (first specimen 88331), and for the special trichrome stain (88313). In the CPT® Index, see Pathology/Surgical/Level IV and Level VI. Also, see Surgical Pathology//Consultation/Intraoperative directing you to code range 88329-88334.

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

    ANS: C
    Rationale: Choose the CPT® code completely identifying the service. Only use multiple codes if there is no code describing everything performed. Only use V codes when there is no final diagnosis. In this case, a very specific diagnosis is known and the code is used. In the CPT® Index, see Semen Analysis directing you to code range 89300-89322. Code 89320 reports all of the tests performed.
    For the ICD-9-CM diagnosis, code, in the Index to Diseases, see Infertility/male/oligospermia leading you to 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

    ANS: B
    Rationale: Always choose codes identifying the service and reason for the service as specifically as possible. Parenthetic comments in CPT® can sometimes assist in finding a challenging code. Modifier 32 is appropriate when services are mandated by courts or insurers. In the CPT® Index, see Paternity testing. For the ICD-9-CM code, look in the Index to Diseases for Paternity testing also.

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

ANS: D
Rationale: Presumptive identification identifies microorganisms like viruses by observing growth patterns and other characteristics.

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

ANS: B
Rationale: Code 88305 is for examination of biopsy specimen without margins. Also code the decalcification procedure, and frozen section. Use the final diagnosis for all services. In the CPT® Index, see Pathology and Laboratory/Surgical Pathology/Gross and Micro Exam/Level IV; also see Pathology and Laboratory/Surgical Pathology/Consultation/Intraoperative; also see Pathology and laboratory/Surgical Patholoogy/Decalcification Procedure directing you to 88311.
For the ICD-9-CM, look in the Index to Diseases for Fibrosclerosis/breast 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

ANS: A
Rationale: Code the urinalysis with microscopy (81000) and with the code for presumptive identification through inoculation with observation and dissection, code 87003. In the CPT® Index, see Urinalysis/Screen; also see Animal inoculation.

The diagnosis code for Schistosomiasis is 120.0. In the Index to Diseases, see Schistosomiasis/bladder.

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

ANS: A
Rationale: Flow cytometry is a cytopathologic study. Code 88182 specifies flow cytometry for DNA analysis. Look in the CPT® Index for Flow Cytometry.

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

ANS: C
Rationale: Code 81025 is specific for a urine test, (84703 and 84702 are typically performed on blood). Code 36415 is for obtaining a blood specimen and is inappropriate with a urine test. In the CPT® Index, see Pregnancy Test/Urinalysis.

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

ANS: A
Rationale: Guidelines preceding the panel section state, "The tests listed with each panel identify the defined components of that panel." In addition to the tests listed under the Comprehensive metabolic panel, a CBC and TSH are part of 80050 General health panel and are not coded separately. The urine drug screen is not part of the panel and, therefore, coded in addition to the lab panel. Code 80100 Drug screen, qualitative; multiple drug classes chromatographic method, each procedure is described as a drug screen for multiple drug classes. In the CPT® Index, look for Organ or Disease-Oriented Panel/General Health Panel directing you to 80050. In the CPT® Index, look for Drug Screen.

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

ANS: C
Rationale: The post coital test is described by code 89300 Semen analysis; presence and/or motility of sperm including Huhner test (post coital), and is listed in the index under Huhner Test/Semen Analysis. It is not specified as a complete. The second test ordered and performed on the sperm sample is a hamster penetration test, specified by code 89329 Sperm evaluation; hamster penetration test. This can be found in the index under Hamster Penetration Test/Sperm Evaluation.

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

ANS: A
Rationale: In the CPT® Index, look for Hydration, you are directed to codes 96360-96361. The hydration will run 5 hours at 100 cc per hour. Code the hydration therapy as 96360 for the first hour, then 96361 x 4 to get a total infusion time of 5 hours. Code for the normal saline with J7050 x 2 units for 500 cc (HCPCS Level II).

The type of Sickle Cell anemia is not identified, but the patient has painful sickle crisis. In the ICD-9-CM Index to Diseases, look for Crisis/sickle cell. Apply code 282.62.

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

ANS: B

Rationale: The hearing aid is reported with V5261, digital binaural behind the ear appliance. The purpose of the visit is the fitting of the hearing aid. Diagnosis code should be V53.2. The condition necessitating the hearing aid is bilateral sensory hearing loss. In the Index, see Loss/Hearing/sensory/bilateral. Thi s is reported with 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

ANS: C

Rationale: The pacemaker is a single chamber pacemaker. The documentation states a pacing wire (lead) is placed into the right atrium using fluoroscopic guidance. Code 33206 reports insertion of new or replacement of permanent pacemaker with transvenous electrode (s); atrium. Read the Pacemaker guidelines, radiological supervision and interpretation related to the pacemaker or pacing procedure is included in 33206. In the CPT® Index, look for Pacemaker, Heart/Replacement/Insertion. Before threading the lead into the heart, a venogram is taken through the IV placed in the antecubital vein, which is the area of the arm in front of the elbow. In the CPT® Index, go to Venography/Arm, 75820-75822. Documentation does not specify a bilateral venogram so the correct code selection is 75820. Insertion of pacemakers is not a procedure performed in an office and the report indicates she was taken to a procedure room. Modifier 26 is appended to the radiology procedure as the physician was providing only the professional component.

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

ANS: A

Rationale: The patient is an established patient to an urgent care clinic. A code from 99211-99215 is reported. Level three is reported with 99213. Because an EKG was also performed, a modifier 25 is appended to the office visit. The X-ray & EKG equipment are owned by the clinic. The chest X-ray, 2 views, is reported with 71020. In the CPT® Index, look up X-ray/chest. The EKG and rhythm strip are read, interpreted and a report is written by the physician. Modifiers 26 and TC are not appended to the radiology codes because the urgent care center owns the equipment and the radiologist is an employee of the urgent care center. In the CPT® Index, see Electrocardiography/Rhythm/Tracing and Evaluation, you are referred to CPT® code 93040.

The diagnosis is dizziness (780.4). In the ICD-9-CM Index to Diseases, look for Dizziness.

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

ANS: A
Rationale: PTCA is a percutaneous transluminal coronary angioplasty. In the CPT® Index, look for Transcatheter/Placement/Intravascular Stents directing you to 92928-92929. In this case, the angioplasty was followed by stent placement in the LD. Only one procedure can be performed in each of the coronary vessels (LC, LD, and RC). The hierarchy beginning with the lowest is angioplasty, stent, atherectomy, atherectomy & stent placement. Only the stent placement (92928) is reported. Modifier LD indicates the left anterior descending coronary artery.
In ICD-9-CM Index to Diseases, look for atherosclerosis and you are directed to see arteriosclerosis. Under Arteriosclerosis/coronary/native artery, you are directed to 414.01. Verification in the Tabular List confirms code selection.

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

ANS: A
Rationale: When a mother is Rh negative and the father is Rh positive, fetal hemolytic anemia may develop in the fetus. In the CPT® Index, look for Immune Globulins/Rho (D), you are directed to code range 90384-90386. A full dose is 300 mcg. Code 90384 is reported. According to the guidelines for Immune Globulins, an administration code is also reported. In the CPT® Index, look up Immune Globulin Administration/Injection directing you to 96372. The administration code for intramuscular injection is 96372.
In the ICD-9-CM Index to Diseases, look for Rh antigen/incompatibility/affecting management of pregnancy, you are directed to 656.1x. A 5th digit of 3 is used to indicate this is an antepartum condition.

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

ANS: C

Rationale: In the CPT® Index, look for Dialysis/Peritoneal, you are directed to codes 90945,90947 & 4055F(an outcomes measurement code). The peritoneal dialysis with one physician evaluation is reported with 90945.

A combination code is reported for a patient with hypertension and renal failure. The two conditions are not reported separately. In the Hypertension Table, Hypertension with chronic kidney disease, stage V or end stage renal disease, unspecified column directs you to 403.91. The instructions for category 403 state to use an additional code to identify the stage of CKD. In the ICD-9-CM Index to Diseases, look for Disease/renal/end-stage, directing you to 585.6 for end stage renal disease. The patient also has secondary hyperparathyroidism reported with 588.81, found in the index under Hyperparathyroidism.

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

ANS: A
Rationale: In the CPT® Index, look for Home Services/Respiratory Management, you are directed to code 99503.
In the ICD-9-CM Index to Diseases, look for Failure/heart/congestive and you are directed to 428.0. Then look for Failure/respiration/chronic, you are directed to 518.83. Confirmation in the Tabular List confirms code selection.

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

ANS: A
Rationale: Art therapy is frequently used when working with children who are unable to verbalize well or not at all. It may give insight to thought processes through the expressions captured in the artwork. Art therapy is considered individual psychotherapy. In the CPT® Index, look up Psychotherapy/Interactive Complexity you are directed to code range 90875. Code selection is based on time and whether a medical evaluation and management was performed. Code 90875 is reported with 90832 per instructions at the beginning of this section

The child is currently autistic and does not communicate verbally. In the ICD-9-CM Index to Diseases, Autism directs you to 299.0x. Since an autism spectrum is not defined, the correct diagnosis code is 299.00.

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

ANS: A

Rationale: The psychiatrist has prepared a report about her status, history and current progress. In the CPT® Index, look for Psychiatric Treatment/Report Preparation and you are directed to code 90889.

Panic attacks not defined are reported as 300.01 and is indexed in the ICD-9-CM Index to Diseases, look for Attack/panic.

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

ANS: A

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

ANS: C

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

ANS: C

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

ANS: B

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

ANS: C

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

ANS: D

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

ANS: B

116.The process of preserving cells or whole tissues at extremely low temperatures is known as:

a. Cryotherapy
b. Cryopexy
c. Cryalgesia
d. Cryopreservation

ANS: D

Anatomy

117. Which part of the brain controls blood pressure, heart rate and respiration?

a. Cortex
b. Cerebrum
c. Cerebellum
d. Medulla

ANS: D

118. What are chemicals which relay, amplify and modulate signals between a neuron and another cell?

a. Neurotransmitters
b. Hormones
c. Interneurons
d. Myelin

ANS: A

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

ANS: C

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

ANS: A

121. Which of the following does NOT contribute to refraction in the eye?

a. Aqueous
b. Macula
c. Cornea
d. Lens

ANS: B

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

ANS: C

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

ANS: B

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

ANS: C

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

ANS: A
Rationale: to in Chapter 3, Encounters for circumstances other than disease or injury. ICD-9-CM coding guidelines Section I.C.2.e.2 states, "if a patient admission/encounter is solely for administration of chemotherapy, immunotherapy or radiation therapy assign codes V58.0, V58.11-V58.12 as the first-listed or principal diagnosis. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis" In the Index to Diseases (Alphabetic Index), locate Chemotherapy/encounter (for)(oral)(intravenous) guiding you to V58.11; look up Neoplasm/Mullerian duct/female/Malignant/Primary guiding you to code 184.8.

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

ANS: C
Rationale: In the the Index to Diseases (Alphabetic Index), index look up Pyoderma guiding you to code 686.00. In the Tabular List under category code 686 has a note: Use additional code to identify any infectious organism (041.0-041.8). Turn to that section of codes. Code 041.11 is the code for MSSA. Guideline Section I.B.9 tells us "A "use additional code" note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

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

ANS: B
Rationale: Look in the Index to Diseases (Alphabetic Index) for Nursemaid's/elbow 832.2. Look at 832.2 in the Tabular List. The nursemaid's elbow ICD-9-CM codes does not need a fifth digit. The instruction box under subcategory code 832 has an instructional note that states: The following fifth-digit subclassification is for use with subcategories 832.0 and 832.1.

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

ANS: A

Rationale: Per ICD-9-CM guideline I.C.7.e.1, The ICD-9-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories 410.0-410.6 and 410.8 are used for ST elevation myocardial infarction (STEMI). Per ICD-9-CM guideline I.C.7.e.3, if STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI. In the Index to Diseases (Alphabetic Index) locate Infarct, infarction/ myocardium, myocardial/anterolateral (wall) guiding you to 410.0. Because the episode is not stated, the fifth digit 0 is selected for unspecified.

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

ANS: A

Rationale: Per ICD-9-CM guideline I.C.1.a.2.a, If a patient is admitted for an HIV-related condition, the principal diagnosis should be 042, followed by additional diagnosis codes for all reported HIV-related conditions. In the Index to Diseases (Alphabetic Index) look for Human Immunodeficiency Virus 042. Then, look for Kaposi's/sarcoma/skin directing you to 176.0; for leukoplakia look for Leukoplakia/lip directing you to 528.6; for splenomegaly look for Splenomegaly directing you to 789.2. Verify code selection in the Tabular List.

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

ANS: B

Rationale: Per ICD-9-CM guideline Section IV.I Uncertain Diagnosis, we would not code diagnoses documented as "probable", "suspected", "questionable", "rule out" or "working diagnosis" or other similar terms indicating uncertainty. During the course of the patient's stay septicemia was ruled out and would not be coded. The reason for the visit was to treat the urinary tract infection, making that code primary. Look in the Index to Diseases (Alphabetic Index) for Infection/urinary (tract) NEC 599.0. Look in the Tabular List List for code 599.0. There is an instructional note stating, "Use additional code to identify organism." This note must always be followed when the organism is known. The note states "Pseudomonas showed in the urine culture." Look in the Index to Diseases (Alphabetic Index) for Infection/Pseudomonas NEC 041.7. Hematuria is not an integral to a urinary tract infection and is coded. Look in the Index to Diseases for Hematuria 599.70. Hypertension is coded since it is a co-existing condition that was being affected by having the UTI. Look in the Index to Diseases for Hypertension and select the code from the benign column, 401.1. Verify code Selection in the Tabular List.

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

ANS: D

Rationale: In the Index to Diseases (Alphabetic Index) look for Diabetes/with/coma (with ketoacidosis) guiding you to subcategory code 250.3. In the Tabular List, a fifth digit of 1 is selected indicating type I diabetes with no documentation of it being uncontrolled. Code V58.67 (Long term use of insulin) is not required for a type 1 diabetic because these patients require insulin (Section I.C.3.a.3.). However, this code may be assigned, if desired to provide additional information.

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

ANS: D

Rationale: In the Index to Diseases (Alphabetic Index) look for Depression/manic (see also Psychosis, affective). Psychosis/affective/manic depressive/depressed type guiding you to subcategory code 296.4. Or you can index Manic-depressive insanity/circular/currently/manic guiding you to subcategory code 296.4. In the Tabular List, the fifth digit 0 is assigned to subcategory 296.4 because the status of the manic bipolar disorder is not specified. No code assignment is necessary for depression because depression is a component of bipolar disorder. Although not psychiatric conditions, both hypothyroidism and migraine headaches are coexisting conditions under treatment and should be coded. Look in the Index to Diseases for Hypothyroidism 244.9 and for Migraine 346.9x. In the Tabular List, a fifth digit of zero is selected because there is no mention of an intractable migraine or status migrainosus.

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

ANS: A

Rationale: Look in the ICD-9-CM Index to Diseases for Fracture/femur/shaft. The appropriate diagnosis code is 821.01 because the fracture of the femur is specified as involving the shaft and was closed. Fracture coding guideline (1.c.17.a.1) states separate codes for more superficial injuries of the same site (such as abrasions) should not be assigned. To find the E code, look in the Index to External Causes for Accident/skateboard. An E code for the Activity is also reported and found by looking for Activity/skateboard. There is no mention of the place of occurrence, so it is not coded.

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

ANS: D
Rationale: In the ICD-9-CM Index to Diseases, look for Pregnancy/management affected by fetal/bradycardia guiding you to subcategory code 659.7x. Turn to the Tabular List. Fifth digit 3 is reported to indicate an antepartum condition or complication. Pregnancy after age 35 is considered an elderly pregnancy. Pregnancy/management affected by abnormal/advanced maternal age NEC/multigravida (because this is her second pregnancy) guiding you to subcategory code 659.6x. Turn to the Tabular List. Fifth digit 3 is reported to indicate an antepartum condition or complication. Code V23.82 is only reported when there are no complications reported.

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

ANS: B
Rationale: : In the ICD-9-CM Index to Diseases, locate Infection/stump(amputation) (posttraumatic) (surgical) guiding you to code 997.62.

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

ANS: B
Rationale: Per CMS Temporary codes can be added, changed, or deleted on a quarterly basis. Once established, temporary codes are usually implemented within 90 days, the time needed to prepare and issue implementation instructions and to enter the new code into CMS's and the contractors' computer systems and initiate user education. This time is needed to allow for instructions such as bulletins and newsletters to be sent out to suppliers to provide them with information and assistance regarding the implementation of temporary CMS codes.
http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/LevelIICodingProcedures.pdf

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

ANS: A
Rationale: Outpatient PPS (C1300-C9899) Guideline explains C codes are required for use by Outpatient Prospective Payment System (OPPS) Hospitals to report new technology procedures, medical devices, drugs, biologicals, and radiopharmaceuticals; that do not have other HCPCS codes assigned. Other facilities may report C-codes at their discretion.

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.

ANS: D
Rationale: The payer determines whether a CPT® or HCPCS Level II code is reported.

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

ANS: B
Rationale: In the HCPCS Level II Table of Drugs, look up Bicillin LA. Here you are directed to see Penicillin G benzathine, referring you to code J0561. J0561 is for 100,000 U so 24 units of J0561 are reported for 2,400,000 are reported.

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

ANS: A
Rationale: In the HCPCS Level II Index, look for Support/arch. You are directed to see codes L3040-L3090. When you turn to the L codes to review, it is code L3050 which represents a removable metatarsal foot arch support.

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

ANS: C
Rationale: Modifier 62 is used when two surgeons work together as primary surgeons performing distinct part(s) of a procedure. Modifiers and their descriptions can be found on the inside front cover and Appendix A of your CPT® codebook.

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

ANS: C
Rationale: Look in your CPT® codebook for 49568. The parenthetical instruction under code 49568 states, "Use 49568 in conjunction with 11004-11006, 49560-49566."

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

ANS: C
Rationale: New additions and revisions are indicated in your CPT® codebook each year by green 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

ANS: C
Rationale: Modifier 53 is used to indicate the physician has elected to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threaten the well being of the patient. CPT® modifiers are found on the inside front cover and in Appendix A of your CPT® codebook.

145. What is the correct CPT® code for the extensive excision of nasal polyps?

a. 30020
b. 30100
c. 30110
d. 30115

ANS: D
Rationale: In the CPT® Index, look for Excision/Polyp/Nose. You are directed to 30110, 30115. Looking at the description for each code in the Respiratory Section, 30115 is for extensive.

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

ANS: C
Rationale: The OIG outlines a review of industry practices related to the number of evaluation and management services provided by physicians and reimbursed as part of the global surgery fee.

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

ANS: B
Rationale: Medicare Part B helps to cover medically-necessary doctors' services, outpatient care, and other medical services (including some preventive services) not covered under Medicare Part A. Medicare Part B is an optional benefit for which the patient must pay a premium, and which requires a yearly co-pay. Medicare Part B is the most significant portion of the Medicare program for coders working in physician offices.

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

ANS: B
Rationale: Providers are responsible for obtaining an ABN prior to providing the service or item to a beneficiary.

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

ANS: B

Rationale: Once documentation is translated into codes, it is then sent on a CMS-1500 form to the insurance carrier for reimbursement.

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

ANS: C

Rationale: If an NCD doesn't exist for a particular item, it's up to the MAC to determine coverage. According to CMS guidelines (www.cms.gov/transmittals/downloads/R2NCD1.pdf), "Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in the CMS Manual System, the Medicare contractor is to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings and general program instructions."