1. Which of the following is not reported using ICD-9-CM 625.4?
   a. PMS
   b. PMDD
   c. Menstrual migraine
   d. Menstrual molimen

2. The physician makes two separate injections of a corticosteroid to the plantar nerve, between the third and fourth toes of the left foot. Which is/are the appropriate code(s) to describe the injection portion of the service?
   a. 64455
   b. 64455 x 2
   c. 64455, 64455-59
   d. 64632 x 2

3. A limited bedside abdominal ultrasound (US) is performed to rule out cholelithiasis for a patient with abdominal pain. An interpretation and report with the US findings are recorded in the patient’s record. A stored image is in a retrievable location. Which is the correct code?
   a. 76817-52
   b. 76700
   c. 76705
   d. 76830-52

4. FAST studies (93308, 76705) can be reported when:
   a. A patient with chest pain and dyspnea requires a cardiac US to rule out pericardial disease.
   b. A patient fell striking his/her abdomen and a limited abdominal US is performed.
   c. A patient has major trauma from an MVA, and a limited transthoracic echocardiogram and a limited abdominal US is performed to rule out internal injuries. The interpretation and report include the findings of both ultrasounds.
   d. The interpretation and report only include the limited abdominal study and the findings for the abdominal US.

5. A 55-year-old patient requires a US-guided central line placed in the left femoral vein. What is the correct code selection?
   a. 36556, +76937
   b. 76937
   c. 76882
   d. 76942

6. Which of the following typically drives the most revenue for medical practices?
   a. Self-pay patients
   b. New patients
   c. Adding new physicians to a practice
   d. Health plan contracts

7. A health plan proposal letter helps you define: (choose the best answer)
   a. What you want for your practice from the payer
   b. Who to talk to at the payer
   c. What the going rates are so you can barter effectively
   d. What other practices received in reimbursement rates

8. The payer contract negotiations are over when: (choose the best answer)
   a. The credentials are approved by the credentialing committee
   b. The physician signs the agreement
   c. A counter-executed copy of the agreement is returned to the practice
   d. The front desk and billing office is given a cheat sheet of key terms

9. The doctor’s office progress note states: “The patient comes in today with shortness of breath. Differential diagnoses include: COPD, CHF, pulmonary embolism, pneumonia. The patient was sent to the hospital for a chest X-ray, CHEM-7, BNP and pulmonary function tests. Results are not yet in. Patient will be called immediately with any abnormal results and is instructed to return to the emergency room for any worsening shortness of breath.”
   What diagnosis code(s) should be reported for this encounter?
   a. 496, 428.0, 415.19, 486
   b. 786.9, 496, 428.0, 415.19, 486
   c. 786.05
   d. 786.05, 428.0, 496, 415.19, 486

10. The patient comes in today for a recheck of his end-stage renal disease. He has been feeling well and has been attending hemodialysis sessions four days per week. The patient’s lab results came back with a GFR of 14. Exam is normal. The assessment and plan reads: “ESRD.” Patient continues attending dialysis at the dialysis center four days per week. Continue same treatment plan with a recheck in one month.
    Diagnosis codes to report are:
    a. 585.5, V56.0
    b. 585.5, V45.11
    c. 585.6, V56.0
    d. 585.6, V45.11
11. On Aug. 1, a 12-year-old female patient presents to the hospital for strabismus surgery on her left eye. On Sept. 5, the patient presents to the same physician’s office complaining of an irritation in her right eye. The physician performs a problem-focused history and examination, at which time he discovers an ingrown eyelash on her right, lower eyelid. The MDM is straightforward. At this visit, the physician decides to remove the irritating eyelash with forceps.

How would you code the visit on Sept. 5?

a. 67820-E4, 374.05
b. 99212-24-E4, 67820-E4, 374.05
c. 99212-24-25, 67820-79-E4, 374.05
d. 99212-24, 67820-E4, 374.05

12. On March 25, a 25-year-old new patient presents to the surgeon’s office complaining of abdominal pain. The physician performs an expanded problem focused history and exam, and his MDM is of low complexity. The physician orders a CT scan and complete blood count (CBC) and sends the patient to the outpatient department of the hospital to have the tests performed. On March 26, the physician receives the CT scan results, and he discovers a stone in the gallbladder. The physician schedules surgery for the next available date, which is March 29. At this visit, the physician examines the patient and reviews his vital signs to ensure that he is physically able to undergo the surgery. He documents a problem focused history and examination, and straightforward MDM. He performs a cholecystectomy.

Code the visit on March 29.

a. 99212-57, 47600, 574.10
b. 99212-25, 47600, 574.10
c. 47600, 574.10
d. 99202-24, 47600, 574.10

13. Which are typical signs of a compliance risk with EHR documentation?

a. “31-year-old female here for…” in a note for a 64-year-old male patient
b. “Yesterday the patient fell in the hall!” This sentence appears in every note during patient’s stay.
c. “Patient’s history was reviewed and there are no changes” in most notes for a given patient
d. A and B

14. Which is/are acceptable documentation practices for a provider?

a. Copying and pasting his or her previous note to use as a base for the current visit
b. Copying and pasting another physician’s note to use as a base for the current visit
c. Using the same template for every patient, every day
d. All of these could be acceptable documentation practices

15. When is the patient eligible for the “welcome to Medicare preventive visit” (G0402)?

a. At any time after becoming eligible and enrolled in Part B Medicare
b. Only during the first 12 months of being eligible and enrolled in Part B Medicare
c. At the age of 65, regardless of Medicare eligibility
d. During the first 48 months of being eligible and enrolled in Part A Medicare

16. Can a Medicare patient receive the AAU screening at any point after becoming eligible for Medicare Part B?

a. Yes, this is part of the “subsequent initial wellness visit” (G0439).
b. No, only during the first 12 months the patient is eligible and enrolled in Medicare Part B and a referral has resulted from the “welcome to Medicare preventive visit” (G0402).
c. No, only during the “initial wellness visit” (G0438).
d. Yes, this is part of the Medicare wellness screening program.

17. As a result of its “Coding Trends of Medicare Evaluation and Management Services,” the OIG recommended that CMS provide:

a. Rebates to physicians who document appropriately
b. Further physician incentives to adopt EHRs
c. Education to the physician community about appropriate documentation guidelines
d. A list of physicians who bill only high-level E/M services to patients who inquire

18. What are the areas with the highest concentration of high-level E/M services according to the OIG’s “Coding Trends of Medicare Evaluation and Management Services?”

a. New York, New Jersey, and Florida
b. Montana, Nebraska, and Wyoming
c. The states with high concentrations of people on Medicare
d. Geographic location did not factor into the results.

19. Which of the following statement is true in a retrospective review? (Choose all that apply.)

a. HCC data is captured via chart extractions.
b. Documentation in the medical record must support captured HCCs.
c. Payment is based on the current year from CMS.
d. A and C

20. What is a benefit of having a retrospective and prospective approach to risk adjustment and HCC capture?

a. Improved cost containment through better disease management
b. Lowered premiums per member, per month
c. Lowered RAF scores
d. None of the above