Coding Edge Tests Your Knowledge

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1. A physician provides an E/M service that determines the need for a procedure the same day. Which of the following best describes the circumstances under which it is appropriate to append modifier 57 to the E/M code?
   a. The procedure is a surgical procedure.
   b. The procedure is a surgical procedure or a "major" non-surgical procedure.
   c. The procedure is any "major" procedure.
   d. The E/M service meets the requirements of a level III service or higher.

2. Which of the following defines a "major" procedure, per CMS guidelines?
   a. A 10-day global period
   b. A 90-day global period
   c. An "xxx" global period
   d. All surgical procedures are major.

3. According to Medicare guidelines, which statement is true regarding signatures?
   a. All provider signatures must include a full name and credentials.
   b. A signature stamp is acceptable as the sole means of identifying the provider.
   c. A signature can be a mark that the provider uses to identify him- or herself.
   d. Dictated or typed names are the same as a signature that has been electronically signed.

4. Which of the following is not a reliable source when auditing the documentation for E/M services?
   a. CPT® codebook
   b. Medicare 1997 Documentation Guidelines for Evaluation & Management Services
   c. OIG compliance guidelines
   d. Your opinion based on years of experience

5. What is acceptable for a nurse or a medical student to document in the medical record?
   a. Any part of the history
   b. Chief complaint
   c. Review of systems (ROS)
   d. History of the present illness (HPI)

6. A physician spends 20 minutes at home reviewing Mrs. Jones' medical record in preparation for her new patient visit the next day, at which he spends 40 minutes with her. What is the best way to account for this time when selecting the code(s) to report?
   a. Report 99205 by adding together the time the physician spent reviewing records at home with the clinic time.
   b. You cannot count this time. It's included in the normal preparation for a visit.
   c. If the physician documented a summary of his findings from the record review, you may use it to increase the data points in MDM and, possibly, the level of service.
   d. Anything less than a 30-minute record review does not count.

7. A physician reviews 10 lab results plus orders two more. How many data points may you award?
   a. 1
   b. 12
   c. 10
   d. 3

8. The physician checks a patient's lab work for signs of toxicity once a year. Could this count as intensive drug monitoring for toxicity?
   a. Yes. "Intensive" is not defined so you may apply it however you wish.
   b. No. You've been on the drug and you know it is not toxic.
   c. Probably not. Although "intensive" is not defined, most people would not consider once-a-year testing to be intensive.
   d. No. You would only count it if the patient is tested every two weeks.

9. Regulating physician financial arrangements to ensure that no referrals are induced or rewarded because of improper arrangements is the basis for the:
   a. Anti-kickback Statute
   b. Stark law
   c. False Claims Act
   d. Both a and b

10. Which code properly describes a separate encounter for simple suture removal for a Medicare patient?
    a. 15850
    b. 15851
    c. S0630
    d. Medicare does not designate a separate code for simple suture removal.

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Page 2

11. **Which is NOT true regarding coding/billing for postoperative care only?**
    a. The surgeon/physician who provided the surgical care had to report his or her services with modifier 54 appended.
    b. Payers will reimburse only once for postoperative care for a given procedure.
    c. Postoperative care only would be reported using a reduced services modifier (52).
    d. Postoperative care only would be reported by appending modifier 55 to the code that described the previously provided service.

12. **EBM:**
    a. Is an outdated concept
    b. Will guarantee improved patient satisfaction
    c. Will reduce malpractice claims
    d. Will help ensure quality and value in medicine

13. **Which is a good process for a billing company to follow when coding changes are necessary to claims sent from a medical practice?**
    a. Make the changes and document them in the patient's billing record with an explanation why the changes were made.
    b. Send a change request email to the practice and wait for their email approval.
    c. Send a secure email to the practice documenting the change.
    d. Fax a request for the change to the practice and wait for their fax approval.

14. **Refunds should be processed:**
    a. According to policies and procedures
    b. As an adjustment
    c. As a negative payment
    d. As either a negative payment or an adjustment

15. **What EHR feature would be worrisome from a coding and compliance standpoint?**
    a. Free text
    b. Timely system updates for CPT® and ICD-9-CM codes
    c. Tracking the authentication of the person entering information for the visit
    d. The inability to make MDM a required element in selecting the E/M visit level

16. **What is the difference between documentation for manual vs. unattended electrical stimulation?**
    a. There are no differences in documentation between the two modalities.
    b. Manual requires patient response to the treatment and unattended does not.
    c. Unattended requires documentation of electrode placement and manual requires the specific area of manual application by the therapist.
    d. Manual requires length of treatment time and unattended does not.

17. **Documentation for ultrasound should include all of the following parameters, except:**
    a. Location and time of treatment
    b. Size of sound head and depth of penetration
    c. Continuous versus pulsed
    d. Temperature of gel used

18. **Minutes for which treatments may all be added together for total treatment time, allowing use of the Medicare "eight-minute rule" for billing purposes when applicable?**
    a. Ultrasound, manual electrical stimulation, and iontophoresis (set-up time)
    b. Unattended electrical stimulation, iontophoresis (set-up time), and ultrasound
    c. Vasopneumatic device, traction, and ultrasound
    d. Whirlpool, ultrasound, and iontophoresis (set-up time)

19. **Clinical documentation is used for:**
    a. Patient care
    b. Protecting the physician, the patient, and the practice in a legal situation
    c. Reporting statistical data to aide in quality reporting
    d. All of the above

20. **To code for diabetes mellitus using ICD-10-CM, which information does not need to be included in the documentation?**
    a. Type of diabetes
    b. Body system affected
    c. Controlled or uncontrolled
    d. Complication or manifestation