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1. A patient presents to the OR on July 1 for right shoulder arthroplasty. The patient develops a severe infection and, on July 3, the same operating surgeon performs a shoulder arthrotomy in the OR to incise the affected area and drain the infection. Code the procedure(s) and applicable modifiers for July 3 encounter.
   a. 23472, 23040-79, RT
   b. 23040-78, RT
   c. 23472-58, RT
   d 23040-58, RT

2. On Feb. 1, a patient presents to the OR for surgical treatment of carpal tunnel syndrome in her left hand. The surgeon repairs the median nerve at the carpal tunnel. On March 1, the patient returns to the OR for repair of de Quervain's tendonitis in her right hand. The same operating surgeon performs both surgeries. Code the procedure and applicable modifiers for the March 1 encounter.
   a. 25000-79, RT
   b. 64721-79, RT
   c. 64721-78, RT
   d. 25000-78, RT

3. On July 1, a patient presents to the ED with an acute fracture of the left humerus. The orthopedic surgeon is called in to treat the fracture of the humerus shaft with manipulation. On July 13, the surgeon examines the patient and determines that more extensive treatment is required. On July 14, the patient returns to the OR and the same operating surgeon inserts an intramedullary implant and locking screws. Code the procedure and applicable modifiers for the July 14 encounter.
   a. 24516-78, LT
   b. 24516-79, LT
   c. 24516-58, LT
   d. 24505-58, LT

4. The surgeon performs female breast reconstruction with tissue expander and biologic implant for tissue reinforcement on the left and right sides. Per CPT® guidelines, how would you report this?
   a. 19357, 15777
   b. 19357 x 2, 15777 x 2
   c. 19357-RT, 19357-LT, 15777-RT, 15777-LT
   d. 19357-50, 15777-50

5. Blood must be drawn from a 5-year-old patient. A nurse is unavailable to perform the venipuncture; therefore, the physician performs the procedure. Which is the correct code to report this service?
   a. 36400
   b. 36410
   c. 36415
   d. 36425

6. Chromatographic drug testing for multiple drug classes involves one stationary phase and two mobile phases. Which is the appropriate coding?
   a. 80100
   b. 80100 x 2
   c. 80100 x 3
   d. 80104

Fill In the Blank

7. Following positive identification of opiates by qualitative testing, a single quantitative test is performed to determine the level of drugs present. Code for the quantitative testing.
   a. 80102
   b. 80104
   c. 83925
   d. 83992

8. A 28-year-old slips in the bathtub, striking his right side on the edge of the tub. An X-ray is performed and shows non-displaced fracture of ribs 7 and 8. The ED physician treats the patient's pain, provides patient education, orders an incentive spirometer, and provides the patient with a prescription for Percocet. Which CPT® coding is appropriate?
   a. 21800-54
   b. 21800-54, 21800-54
   c. 21800
   d. 21810-54, 21810-54

9. A 21-year-old female tripped and hit her small toe on the table in her dorm room. An X-ray is performed and shows a fracture of the toe. The ED physician tapes the toe to the other toes and asks that she follow up with an orthopedic physician or her family physician in seven to 10 days. Which CPT® coding would be appropriate?
   a. 28490-54
   b. 28495-54
   c. 28510-54
   d. 28470-54

10. In ICD-10-CM, major depressive disorders include the types mentioned below, except:
    a. Agitated
    b. Major
    c. Vital
    d. Bipolar

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11. Contained in the MDM section of an encounter, which of the following components is worth 2 points toward the four points necessary to attain a level 5 E/M service?
    a. Ordering X-rays/radiology
    b. Discussing results with the performing or consulting physician
    c. Reviewing and summarizing data from old records or history from someone other than the patient
    d. Ordering lab tests

12. True or False: Organ systems and body areas can be used interchangeably to document the exam portion of an encounter and code to a level 5 E/M service.
    a. True
    b. False

13. Which of the following exam components is a body area rather than an organ system?
    a. Abdomen
    b. Hematologic/lymph
    c. Integumentary
    d. Gastrointestinal

14. In which circumstance could a coder or compliance director be liable for a Reverse False Claims provision of the False Claims Act violation?
    a. If the coder or compliance director knew of the overpayment, but failed to report it to the physician or practice executive board
    b. If the coder or compliance director was responsible for causing the overpayment to occur
    c. If the coder or compliance director, in collusion with the physician or practice executive board, aided in the concealment of the overpayment
    d. All of the above

15. How long does a practice have to return an overpayment to the government, and when does the timeframe begin?
    a. 30 days from the time the overpayment is received
    b. 30 days from the time the overpayment is identified or should have been identified
    c. 60 days from the time the overpayment is received
    d. 60 days from the time the overpayment is identified or should have been identified

16. What are the QRURs designed to do?
    a. Put forth the idea of being paid for the quantity of care provided
    b. Reduce physician payment
    c. Discourage care coordination across various specialties
    d. Make physicians aware of their resource use and total cost per beneficiary

17. In 2015, if a practice does not participate in the PQRS or does not meet PQRS reporting criteria, the addition of the value-based modifier would provide a total adjustment of how much?
    a. -1.0 percent
    b. -1.5 percent
    c. -2.5 percent
    d. 1.0 percent

18. All of the following are part of the CPT® global surgical package, except:
    a. Care of the underlying disease process when this is not cured by the surgical procedure
    b. Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical)
    c. Evaluating the patient in the post-anesthesia recovery area
    d. Immediate postoperative care, including dictating operative notes, and talking with the family and other physicians

19. A patient presents at his primary care physician's (PCP's) office for pre-surgical clearance, without any specific signs or symptoms to support medical necessity for the service. Which of the following options is NOT appropriate/NOT complaint for the PCP to be reimbursed for his or her services?
    a. The surgeon and PCP can coordinate their billing, such that the surgeon reports the appropriate CPT® code for the surgery with modifier 54 appended. The PCP reports the same surgical code with modifier 56 appended.
    b. The PCP could provide the preoperative services under contract with the surgeon. The surgeon bills the full surgery fee and pays the PCP separately for his or her services. Documentation must prove that the full surgical package was performed for the patient.
    c. The PCP bills an E/M service at the level supported by documentation, with no modifiers appended.
    d. The PCP may be hired into the surgeon's practice, specifically for the purpose of providing preoperative (and/or post operative) care.

20. Which CPT® code is NOT a new test approved by the FDA as a waived test under CLIA, effective Oct. 1?
    a. G0434-QW
    b. 86318-QW
    c. 87804-QW
    d. 83988-QW