

# Coding Edge Tests Your Knowledge



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- Revise ABN Form CMS-R-131 is required for dates on or after:
  - March 2011
  - Sept. 1, 2011
  - Jan. 1, 2012
  - July 1, 2012
- Which of the following modifiers indicates the provider believes the service is not covered and the office has a signed ABN on file?
  - GA
  - GY
  - GZ
  - ABN
- A 76-year-old man is brought to the OR with a biopsy-proven 0.8 cm malignant melanoma on his left cheek. Following excision of the lesion at 1.5 sq cm with the margins, at the same operative session a 3.4 sq cm rhomboid flap design is created and stretched to cover the defect. Proper CPT® coding would be:
  - 13132
  - 14040
  - 11642, 14040-58
  - 14040, 11642-51
- A 42-year-old woman is brought to the OR for excision of a 2.7 cm benign growth on her abdomen (excised area 9 sq cm). A 4.8 cm-diameter disc of skin is taken in a Burow's graft of 18.09 sq cm from her left thigh and transplanted adjacent to the abdominal incision. One-layer closure of 5.6 cm is done to seal the thigh incision. At the same time, a 1.2 cm nevus is noted on the right shoulder, excised, biopsied, and proven benign. Proper CPT® coding would be:
  - 13101, 11404-51, 11402-59
  - 14001, 12002-51, 11404-51
  - 14001, 11402-59
  - 14001, 13101, 11402-59
- A 57-year-old man is involved in an industrial accident and presents for removal of a spiral-shaped shard of steel shrapnel that flew from his lathe and got embedded deep in his right upper arm. Extensive undermining and debridement of 9 cm is done to remove the metal and disinfect the wounded area. The undermined flaps, totaling 27.86 sq cm, are bound together to achieve closure. In the heading of the op report, the dermatologist documents this as an "adjacent tissue rearrangement." Proper CPT® coding for this scenario would be:
  - 12031
  - 13101
  - 13101, 13102
  - 14021, 13101, 13102
- If you find that your practice billing curve does not look like the national average for your specialty, what steps should you take?
  - Immediately change your billing to more closely match the national averages.
  - Ignore it. If you're confident you're a good coder this information is unimportant.
  - Review documentation and medical necessity to verify that your billing is correct, then prepare to defend your charges.
  - All of the above.
- For convenience, your physician sees a patient at the hospital right after his daily inpatient rounds. Although the patient indicated an urgent need to see the doctor, this was not an emergency and a standard established patient E/M code will be billed. Your billing system is set up to include your office address on all claims. What should you do?
  - Find a work-around to correct the place of service to 22 (outpatient hospital) including that service address, even if this means you must prepare a paper claim.
  - Bill it with your office address and place of service 11 (doctor's office) because you're billing an established clinic visit.
  - Bill it with your office address and place of service 22 (outpatient hospital) because it was performed at the hospital, but they are supposed to pay you.
  - It doesn't matter which of these options you choose. Place of service is not a big deal unless the patient is admitted.
- If a Medicare patient who has an ongoing need for CPAP and sees you annually for follow up, needs a replacement machine and contacts your office nine months after her last appointment. What step(s) do you need to take?
  - Make an appoint to re-evaluate the patient's ongoing need for CPAP.
  - Write the order for the replacement.
  - Keep a copy of the order in the patient's medical record, along with the record of your visit.
  - All of the above
- What is the correct code(s) to describe abdominal aortography followed by first order selection of the right, main renal artery and two accessory right renal arteries (arising off the aorta), with injection and imaging of these three vessels?
  - 36251
  - 36251, 36245-59 x 2, 75774 x 2
  - 36251, 75625
  - 36253

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10. What code(s) describe removal of an IVC filter from the jugular approach, with imaging of the IVC prior to removal?
  - a. 37192
  - b. 37193
  - c. 36010, 37193, 75825-59
  - d. 36010, 75825-59, 37203, 75961
11. What code describes ultrasound-guided placement of an 8FR non-tunneled catheter into the abdomen for removal ascites (paracentesis), with removal of the catheter at the end of the procedure?
  - a. 49082
  - b. 49083
  - c. 49018
  - d. 49422
12. A patient with right ventricular and right atrial leads already in place and buried under the skin presents for placement of a generator. The existing incision is opened and the existing leads dissected out, tested, and attached to a new dual lead pacemaker generator. Correct coding is:
  - a. 33213, 33217
  - b. 33213
  - c. 33213, 33233
  - d. 33230
13. End of life parameters are detected on an existing single lead defibrillator. The existing incision is opened and the generator exposed. The lead is found to be satisfactory, so the old generator is removed and the existing lead is attached to the new defibrillator generator. Correct coding is:
  - a. 33262, 33241
  - b. 33249
  - c. 33262
  - d. 33263
14. A patient has a pocket created for a pacemaker, and a right ventricular lead is placed. This is followed by placement of a left ventricular lead into the coronary sinus for bi-ventricular pacing. Fluoroscopy is used during placement of the leads. Correct coding is:
  - a. 33207, 76000, 33225
  - b. 33207, 33225
  - c. 33249, 33225
  - d. 33207, 33225
15. How does Medicare define "direct physician supervision" with regard to outpatient services?
  - a. A physician must personally provide the entire service.
  - b. A physician must be in attendance in the room during the performance of the procedure.
  - c. The supervising physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.
  - d. The procedure is furnished under the physician's overall direction and control.
16. Which is the appropriate code to report physician services for placement of an On-Q pain pump?
  - a. Proper coding/billing is payer dependent
  - b. 11981
  - c. A4306
  - d. 64416
17. What is the claims starting date that OIG will review for accuracy of present-on-admission indicators?
  - a. January 2008
  - b. October 2008
  - c. January 2012
  - d. October 2012
18. Fill in the blank: In 2012, the OIG will compare \_\_\_\_\_ to other hospitals, specifically by size, services, and distance from the hospitals.
  - a. CAHs
  - b. SNFs
  - c. ASCs
  - d. Hospice
19. The timeframe for coding an acute MI in ICD-10 is:
  - a. 8 weeks
  - b. 4 weeks
  - c. 4 weeks from discharge date
  - d. 8 weeks for STEMI and 4 weeks for NSTEMI
20. To correctly code an MI in ICD-10, you need to know:
  - a. Location—chronic or acute
  - b. Initial/subsequent episode—native or coronary vessel
  - c. Location—initial or subsequent episode, STEMI or NSTEMI
  - d. Transmural or subendocardial—STEMI or NSTEMI