Coding Edge Tests Your Knowledge

January 2012

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1. Does ICD-10 allow for NOS codes? Why or why not?
   a. Yes: It would be appropriate to use them at any time.
   b. No: ICD-10 does not have NOS codes.
   c. No: The payers won't accept them.
   d. Yes: But you should use NOS codes only if there is no other ICD-10 code that is more specific, based on documentation.
2. Along with your billing system being able to transmit in the 5010 format, what is another requirement that will help ensure your EHR is ICD-10 compliant?
   a. That's the only requirement for ICD-10.
   b. Your EHR doesn't have to integrate with your billing system.
   c. You must determine if your EHR can document the specificity necessary for ICD-10 coding.
   d. If your EHR is CCHIT certified, you will be compliant.
3. Name three things you should identify in your EHR ICD-10 readiness audit.
   a. Laterality, placeholders, documentation specificity
   b. Placeholders, documentation of a complete ROS, laterality
   c. Documentation of family history, secondary codes, preventive codes
   d. Documentation of family history, laterality, secondary codes
4. Which of the following is NOT a stand-alone procedure?
   a. 62160
   b. 62161
   c. 62162
   d. 62165
5. Which of the following codes represents neuroendoscopy with retrieval of foreign body?
   a. 62161
   b. 62162
   c. 62163
   d. 62164
6. Which of the following are bundled to neuroendoscopic procedures 62161–62165, per the NCCI?
   a. Access via twist drill
   b. Access via burr hole(s)
   c. Access via trephine
   d. All of the above
7. A sterilization that causes cannulation of the tubes requires placement of:
   a. Siliastic band
   b. Hulka clip
   c. Essure™ implant
   d. Yoon ring
8. The physician performs sterilization for a patient who is status post-spontaneous vaginal delivery one day before hospital discharge. Which code would be used?
   a. 58605
   b. 58615
   c. 58670
   d. 58600
9. In which locations can tubal sterilizations occur?
   a. Inpatient
   b. Outpatient
   c. Office setting
   d. All of the above
10. Per CPT®, a new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice, within the past ___ years.
    a. two
    b. three
    c. four
    d. five

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11. Which of the following statements describe the significance of a reference time for E/M services codes?
    1. Face-to-face prolonged services may be reported only in addition to E/M services with reference times.
    2. E/M services with reference times may be billed using time as the controlling factor to determine the service level.
    3. E/M services with reference times may be reported for counseling and coordination of care
    a. 1 only
    b. 1 and 2 only
    c. 2 and 3 only
    d. 1, 2, and 3

12. A neonate is transferred to critical care on the same day that initial intensive care services were performed. In this case, the transferring physician reports:
    a. Critical care (99291-99292) and the intensive care (99477)
    b. Either the critical care (99291-99292) or the intensive care (99477), but not both
    c. Inpatient neonatal or pediatric critical care (99469, 99472)
    d. Subsequent hospital care (99231-99233)

13. Which of the following does NOT meet the criteria for a "complicated" wound by ICD-9 standards?
    a. Delayed healing
    b. Delayed treatment
    c. Foreign body
    d. >20 mm

14. Why are modifier FB and FC important to report if a device is procured by a facility at no cost or at a reduced cost?
    a. They trigger an increase in payment for certain APCs.
    b. They trigger a decrease in payment for certain APCs.
    c. They bypass the fixed dollar threshold requirement for an outlier payment.
    d. They are not important, just another step slowing down claims processing.

15. Which statement does NOT describe part of the reconsideration criteria of the physician supervision level for an OP therapeutic procedure?
    a. The acuity of patients receiving the service
    b. The probability of an adverse event occurring
    c. The complexity of the service
    d. The APC status indicator and payment amount

16. To move towards a standard code editing system, HB 10-1332 Colorado Task Force was assigned to identify a base set of rules and edits using existing national industry sources. Which is NOT one of the industry sources?
    a. NCCI edits
    b. CMS directives, manuals, and transmittals
    c. CMS national clinical laboratory fee schedule
    d. Local medical specialty society coding guidelines

17. The HB 10-1332 Colorado Task Force created a NCCI-sub-group team to analyze NCCI concepts and methodologies to understand its application and to make recommendations. The analysis is based on what?
    a. RVUs
    b. CPT®
    c. NCCI
    d. MPFS

18. What item in the 2012 OIG Work Plan has appeared in previous years?
    a. High Cumulative Part B Payments
    b. Physician-Owned Distributors of Spinal Implants
    c. Impact of Opting Out of Medicare
    d. Place of Service (POS) Errors

19. If your practice sees Medicaid patients, what section in the OIG Work Plan may be helpful to you when creating an auditing and monitoring plan specific to your practice?
    a. Part I
    b. Medicare Part A and B
    c. Part III
    d. Part V

20. ICD-10 will be implemented on what day?
    a. June 1, 2013
    b. October 1, 2013
    c. January 1, 20114
    d. It is not going into effect after all.