1. Using the PFS Relative Value File, what is the Medicare payment status for CPT® code 23100?
   a. Active code
   b. Bundled code
   c. Carrier-priced code
   d. Not valid for Medicare purposes

2. What is the endoscopic base code for CPT® 31640?
   a. 31620
   b. 31622
   c. 31630
   d. 31640 does not have an endoscopic base code.

3. Using the PFS Relative Value File as a guide, which of the following is NOT true of CPT® 51550?
   a. It is valued at 17.23 work RVUs.
   b. It has a 90-day global period.
   c. It is subject to the standard multiple-procedure reduction.
   d. When reported as a bilateral procedure, 51550 will be paid at 150 percent of its RVU total.

4. A chest X-ray will be covered by Medicare when it’s a?
   a. routine pre-operative chest X-ray
   b. yearly chest X-ray for someone with a Dx of COPD that is stable and no other chest X-ray has been done in the last 12 months.
   c. screening chest X-ray for TB with no signs or symptoms
   d. routine chest X-ray required for employment

5. A patient in an outpatient services department is receiving a blood transfusion. He will receive 5 units of blood and the physician ordered an H&H after each infusion. No other documentation is in the medical record. How many H&H’s can the patient receive before he exceeds the limit in testing for the visit?
   a. 2
   b. 3
   c. 4
   d. 5

6. Physician orders a hemoglobin A1C test for the patient. Which of the following examples provide medical necessity for this patient’s test?
   a. diabetes stable, no changes in treatment, last A1C two months ago within normal limits
   b. diabetes stable, added Actos one month ago, last A1C two weeks ago within normal limits
   c. patient is three months pregnant, no history of diabetes, A1C done two weeks ago within normal limits
   d. diabetes stable, recent glucocorticoid therapy, last A1C one month ago within normal limits

7. Which of the following is the overarching criterion for payment of E/M services?
   a. medical necessity
   b. medical decision making
   c. time
   d. nature of the presenting problem

8. Using the NCCI “Column 1/Column 2” edits as a reference, which of the following codes may NEVER be unbundled from 10040?
   a. 36410
   b. 43752
   c. 51703
   d. 62310

9. Which of the following is true of a CPT® designated “separate procedure?”
   a. A CPT® designated separate procedure may be reported separately in every case.
   b. A CPT® designated separate procedure may be reported only when provided at the same time as another, related procedure at the same anatomic location.
   c. A CPT® designated separate procedure may reported separately only if it’s not provided at the same time as another, related procedure at the same anatomic location.
   d. You should always append modifier 59 when reporting a CPT® designated separate procedure.

10. Per NCCI, which of the following is NOT a Column 2 (bundled) code with Column 1 code 80053?
    a. 80076
    b. 82128
    c. 82310
    d. 84075
11. On April 5, 2011, a physician percutaneously implants one trial spinal cord neurostimulator lead with eight electrodes in his office procedure room. The physician reports 63650 x 1 unit of service for the surgical procedure code. What code and units of service, if any, should the physician report for the neurostimulator lead?
   a. L8680 x 1 unit of service
   b. The implant is not separately billable by the physician.
   c. C1778 x 8 units of service
   d. L8680 x 8 units of service

12. A physician implants two trial percutaneous peripheral nerve neurostimulator leads in a Medicare beneficiary. Each lead had four contact points. The procedure was performed in the outpatient department of the local hospital. What code and units of service, if any, should the hospital bill to Medicare?
   a. L8680 x 1 unit of service
   b. The implants are not separately billable by the hospital.
   c. C1778 x 2 units of service
   d. L8680 x 8 units of service

13. A payer processes a physician’s claim for a single neurostimulator array with eight contact points with payment for L8680 x 1 unit of service. The trial implantation was performed in the physician’s office. Following the review of the explanation of benefits, what should be the next step for the physician’s billing staff?
   a. accept payment because it was billed and processed correctly
   b. appeal the incorrect processing because it was billed correctly as L8680 x 2 units of service
   c. appeal the incorrect processing because it was billed correctly as L8680 x 8 units of service
   d. refund the payment for L8680 x 1 unit of service because the physician should not have billed for the implant

14. A physician performs chemodenervation on the left and right upper extremities for a Medicare patient, date of service May 1, 2011. Which is the correct coding?
   a. 64614
   b. 64614-50
   c. 64614-LT, 64614-RT
   d. 64614, 64614-59

15. Per the April 1 update to the 2011 Medicare Physician Fee Schedule Database, which is the correct global period for 92511 (nasopharyngoscopy)?
   a. 0 day
   b. 10 day
   c. 90 day
   d. xxx (concept does not apply)

16. A 70-year-old patient with type II diabetes presents with a 5 cm x 3.5 cm left heel ulceration involving the skin and subcutaneous tissues, extending to the tendon and bone. Debridement is performed using a scalpel, through the skin, subcutaneous tissue, the tendon, and part of the exposed bone to bleeding bone. What is the correct CPT® code assignment?
   a. 11042
   b. 11043
   c. 11044
   d. 11045

17. Non-excisional debridement is defined as nonsurgical because it does not involve cutting away or excising devitalized tissue. Which answer contains examples that are considered non-excisional debridement?
   a. Arobella Qoustic Wound Therapy™, mechanical debridement
   b. Versajet™, pulsed lavage, hydrotherapy
   c. mechanical irrigation, brushing, scrubbing
   d. All of the above

18. A 75-year-old diabetic patient presents with a 3 cm x 4 cm ulceration on their right heel. Which answer contains the proper elements for excisional debridement?
   a. I debrided the nonviable, necrotic tissue through the subcutaneous tissue to pink, bleeding tissue.
   b. Using forceps, I debrided the necrotic tissue to pink, bleeding tissue.
   c. I excisionally debrided the tissue through the subcutaneous tissue to pink, bleeding tissue. Wound measured 3 cm by 4 cm.
   d. Using a #5 scalpel, I excisionally debrided the nonviable, necrotic tissue though the subcutaneous tissue to pink, bleeding tissue. The wound measured 3 cm by 4 cm and was covered with a dressing.

19. Under S. 454’s enhancements to Medicare & Medicaid program integrity provision what is the time frame that the HHS secretary can extend Medicare payment in cases where there is merely a likelihood of fraud, waste, or abuse?
   a. 60 days
   b. 90 global days
   c. six months
   d. 365 days

20. Which is not one of the nine S.454 sections, which give the secretary of HHS substantial additional authority in the detection and prevention of fraud, waste, and abuse?
   a. restrictions on payment for legal and approved drugs
   b. provisions to make Medicare claims data relative to providers public
   c. medical identification theft information sharing; expanded permissive exclusion
   d. restrictions on Medicaid participation for entities with certain ownership