Chapter 1

Section Review 1.1

1. B. Physician work, practice expense, and professional liability

RATIONALE: Resource costs are divided into three components: physician work, practice expense, and professional liability.

2. B. 1.14

RATIONALE: According to the excerpt from the 2010 National Medicare Fee schedule, the fully implemented non-facility physician expense RVU for CPT® code 99214 is 1.14.

3. D. Conversion factor

RATIONALE: The conversion factor is a fixed dollar amount used to translate the calculated RVUs into a fee.

4. C. $98.35

RATIONALE: Use the 2010 Non-Facility Pricing Amount formula [(Work RVU * Work GPCI)+(Transitioned Non-Facility PE RVU * PE GPCI)+(MP RVU * MP GPCI)] * (CF).

\[
\text{Work RVU} \times \text{Work GPCI} = 1.42 \times 1.000 = 1.42000 \\
\text{Transitioned Non-Facility Practice RVUs} \times \text{Practice Expense GPCI} = 1.19 \times 0.979 = 1.16501 \\
\text{MP RVUs} \times \text{MP GPCI} = 0.10 \times 0.822 = 0.08220 \\
\text{Sum of geographic adjustment} = 2.66721
\]

The sum of geographic adjustment x CF $2.66721 \times 36.8729 = $98.35
5. B. $ 86.59

RATIONALE: Use the 2010 Non-Facility Pricing Amount formula [(Work RVU * Work GPCI) + (Transitioned Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * (CF).

\[
\text{Work RVU} \times \text{Work GPCI} = 0.97 \times 1.500 = 1.45500 \\
+ \text{Transitioned Non-Facility Practice RVUs} \times \text{Practice Expense GPCI} = 0.79 \times 1.090 = 0.86110 \\
+ \text{MP RVUs} \times \text{MP GPCI} = 0.05 \times 0.646 = 0.03230 \\
= \text{Sum of geographic adjustment} = 2.34840 \\
\text{The sum of geographic adjustment} \times \text{CF} = 2.34840 \times 36.8729 = $86.59
\]

Section Review 1.2

1. B. Using the least radical service/procedure that allows for effective treatment of the patient’s complaint or condition.

RATIONALE: Medical necessity is using the least radical services/procedure that allows for effective treatment of the patient’s complaint or condition.

2. B. fibromyalgia

RATIONALE: According to the LCD, measurement of vitamin D levels is indicated for patients with fibromyalgia.

3. D. ABN

RATIONALE: An Advanced Beneficiary Notice (ABN) is used when a Medicare beneficiary requests or agrees to receive a procedure or service that Medicare may not cover. This form notifies the patient of potential out of pocket costs for the patient.

4. A. ABNs may not be recognized by non-Medicare payers.

RATIONALE: ABNs may not be recognized by non-Medicare payers. Providers should review their contracts to determine which payers will accept an ABN for services not covered.

5. C. $100 or 25%

RATIONALE: CMS instructions stipulate, “Notifiers must make a good faith effort to insert a reasonable estimate...the estimate should be within $100 or 25 percent of the actual costs, whichever is greater.”
Section Review 1.3

1. **D. Patient**

   RATIONALE: Covered entities in relation to HIPAA include health care providers, health plans, and health care clearinghouses. The patient is not considered a covered entity although it is the patient’s data that is protected.

2. **A. Only individuals whose job requires it may have access to protected health information.**

   RATIONALE: It is the responsibility of a covered entity to develop and implement policies, best suited to its particular circumstances to meet HIPAA requirements. As a policy requirement, only those individuals whose job requires it may have access to protected health information.

3. **B. HITECH**

   RATIONALE: The Health Information Technology for Economic and Clinical Health Act (HITECH) was enacted as a part of the American Recovery and Reinvestment Act of 2009 (ARRA) to promote the adoption and meaningful use of health information technology. Portions of HITECH strengthen HIPAA rules by addressing privacy and security concerns associated with the electronic transmission of health information.

4. **A. OIG Compliance Plan Guidance**

   RATIONALE: The OIG has offered compliance program guidance to form the basis of a voluntary compliance program for physician offices. Although this was released in October 2000, it is still active compliance guidance today.

5. **C. OIG Work Plan**

   RATIONALE: Each October, the OIG releases a Work Plan outlining its priorities for the fiscal year ahead. Within the Work Plan, potential problem areas with claims submissions are listed and will be targeted with special scrutiny.
Chapter 2

Section Review 2.1

1. C. Word root
   RATIONALE: The root word is the word part that holds the fundamental meaning to the medical term and each medical term contains at least one root or base word.

2. B. Eyelid
   RATIONALE: The root word Blephar/o means eyelid indicating a Blepharoplasty would be performed on the eyelid.

   RATIONALE: The root word salpingo- means oviduct or tube. The root word oophor- means ovary. The suffix -ectomy means excision or surgical removal of.

4. B. Nail
   RATIONALE: The root word onych- means nail. Paronychia is inflammation of the nail fold surrounding the nail plate.

5. B. Beneath the fascia.
   RATIONALE: The root word fasci- means facia. Subfascial is beneath the fascia. The fascia is a sheath of fibrous tissue covering individual skeletal muscles or certain organs.

6. B. Creation of a hole in the trachea.
   RATIONALE: The root word trache- means trachea. The suffix -ostomy means surgical creation of an opening. A tracheostomy is the surgical creation of an opening in the trachea and is used to help a patient breathe.

7. A. White blood cells.
   RATIONALE: The root word leukocyte- means white blood cell. Leukocytosis is an increase in white blood cells which can indicate some type of infection in the body.

8. B. Surgical removal of the tongue.
   RATIONALE: The root word gloss- means tongue. The suffix -ectomy means excision or surgical removal of. A glossectomy is partial or total removal of the tongue and can be used to remove tongue cancer.
9. **C. Common bile duct**

**RATIONALE:** The root word choledoc- means common bile duct. A choledochal cyst originates from the common bile duct and usually has symptoms including right upper abdominal pain and jaundice.

10. **A. Bladder and urethra**

**RATIONALE:** The root word cyst- means urinary bladder. The root word urethr- means urethra. A cystourethroscopy is an examination of the urinary bladder and urethra.

### Section Review 2.2

1. **D. Epithelial tissue**

**RATIONALE:** Squamous cell carcinoma and basal cell carcinoma are both cancers of cells in epithelial tissue. Epithelial tissue is found in the skin, lining of the blood vessels, respiratory, intestinal, urinary tracts, and other body systems.

2. **C. Thoracic cavity**

**RATIONALE:** The thoracic, or chest, cavity is the space containing the heart, lungs, esophagus, trachea, bronchi, and thymus.

3. **A. Mucous membrane**

**RATIONALE:** The mucous membrane lines the interior walls of the organs and tubes that open to the outside of the body, such as those of the digestive system, respiratory, urinary, and reproductive systems. Mucous membranes are often adapted for absorption and secretion.

4. **B. Stratum Lucidum**

**RATIONALE:** The stratum lucidum is a clear layer normally found only on the palms of the hands and the soles of the feet.

5. **C. Hypodermis**

**RATIONALE:** The hypodermis (subcutaneous) serves to protect the underlying structures, prevent loss of body heat and anchor the skin to the underlying musculature. The fibrous connective tissues referred to as superficial fascia are included in this layer.
Section Review 2.3

1. **D. Greenstick fracture**

**RATIONALE:** A greenstick fracture is a fracture where only one side of the shaft is broken, and the other is bent. It is common in children due to their soft bones. The greenstick fracture is named due to the analogy of breaking a young tree branch where the outer side breaks and the inner side bends.

2. **B. Pelvic Girdle**

**RATIONALE:** The axial skeleton includes the skull, hyoid and cervical spine, ribs, vertebrae, and sacrum. The appendicular skeleton includes the shoulder girdle, pelvic girdle, and extremities.

3. **A. Metacarpals**

**RATIONALE:** Long bones are named for their shape, not their size. Metacarpals are long bones in your fingers.

4. **C. Synovial**

**RATIONALE:** Most joints in the body are synovial joints. All joints in the extremities are synovial joints. Synovial joints allow for smooth motion within the joint.

5. **A. Arthr/o**

**RATIONALE:** The root word part Arthr/o stands for joint. You will notice in the list of medical terms related to the musculoskeletal system, all of the words beginning with “arthr” are conditions or procedures related to the joint.

Section Review 2.4

1. **C. Vena cava**

**RATIONALE:** Deoxygenated blood enters the right atrium through the superior vena cava and inferior vena cava.

2. **B. Left and right pulmonary veins**

**RATIONALE:** Oxygenated blood enters the left atrium through the left and right pulmonary veins.

3. **C. Angiocarditis**

**RATIONALE:** The root word “angi/o” means vessel, the root word “cardi/o” means heart, and the suffix “-itis” means inflammation. Angiocarditis is inflammation of the heart and vessels.
4.  **D. Endocardium**

   **RATIONALE:** The prefix “endo-” means inner. The root word “cardi/o” means heart. The endocardium is the inner lining of the heart.

5.  **B. Oxygen deficiency**

   **RATIONALE:** Cyanosis is bluing of the skin and mucous membranes caused by oxygen deficiency.

### Section Review 2.5

1.  **C. With a system of one way valves**

   **RATIONALE:** The lymphatic system operates without a pump by using a series of valves to ensure the fluid travels in one direction back to the heart.

2.  **B. Phagocytes**

   **RATIONALE:** The lymphoid organs scattered throughout the body house phagocytic cells and lymphocytes, which are essential to the body’s defense system.

3.  **D. Splenectomy**

   **RATIONALE:** Splen is the root word for spleen. The suffix -ectomy is surgical removal of. A splenectomy is the removal of the spleen, total or partial. If only part of the spleen is removed from a patient under 12 years of age, it can regenerate.

4.  **B. Subclavian veins**

   **RATIONALE:** Both of the lymphatic ducts empty their contents into the subclavian veins. The right lymphatic duct empties into the right subclavian vein and the thoracic duct empties into the left subclavian vein.

5.  **B. Lymphangitis**

   **RATIONALE:** Lymphangitis is the inflammation of lymphatic vessels as a result of bacterial infection. It appears as painful red streaks under the skin.
Section Review 2.6

1. **D. At the bifurcation of the trachea into two bronchi**
   
   RATIONALE: At the last cartilage of the trachea, there is a spar of cartilage projecting posteriorly from its inner face, marking the point where the trachea branches into the two main bronchi. This cartilage projection is the carina.

2. **B. Nose**
   
   RATIONALE: The nose is responsible for providing an airway to breathe, moistening, warming, and filtering inspired air, serving as a resonating chamber for speech, and housing the smell receptors.

3. **B. Incision into the chest**
   
   RATIONALE: The root word “thorac/o” means chest. The suffix “-otomy” means cutting into. Thoracotomy is making an incision into the chest.

4. **C. Alveoli and capillaries**
   
   RATIONALE: Gases are exchanged across the single-cell-layer of tissue comprising the alveolar sac into the pulmonary circulation. Capillaries from the pulmonary circulation are also a single cell layer thick. They form a bed around each alveoli; gas is exchanged between the alveoli and the capillaries via the principles of diffusion.

5. **B. -pnea**
   
   RATIONALE: The suffix “-pnea” means breathing. You can derive this from the list of definitions on page 25. Each definition relating to breathing is for a word ending in –pnea.

Section Review 2.7

1. **A. Duodenum**
   
   RATIONALE: The first one-third of the small intestine is the duodenum, the second one-third is the jejunum, and the distal one-third is the ileum.

2. **C. Liver**
   
   RATIONALE: The gallbladder stores bile that is produced in the liver. Bile secreted into the intestines from the gallbladder helps the body digest fats.
3. B. Transverse
RATIONALE: The ascending colon proceeds from the ileocecal valve upward to the hepatic flexure, becomes the transverse colon, and then turns downward to become the descending colon at the splenic flexure.

4. A. Buccal
RATIONALE: Bucca means cheek. Buccal is relating to the cheek. Buccal swabs can be used for DNA testing.

5. D. Peristalsis
RATIONALE: Wave like contractions called peristalsis move food through the digestive tract.

Section Review 2.8

1. B. Urethra
RATIONALE: The male and female urethras are quite different anatomically in position and length; however, they perform the same function and are treated similarly for many surgical procedures in the coding genre.

2. A. Excretion of metabolic wastes and fluid electrolyte balance
RATIONALE: The production of urine for the excretion of metabolic wastes along with fluid and electrolyte balance is the main function of the urinary system. This system also provides transportation and temporary storage of urine prior to the intermittent process of urination.

3. C. Cowper’s glands
RATIONALE: Internal organs for the male genital system include the prostate gland, seminal vesicles, and Cowper’s glands. Cowper’s gland is also called the bulbourethral gland. It is a small gland that secretes part of the seminal fluid.

4. B. Epispadias
RATIONALE: Epispadias is a congenital defect in which the urethra opens on the dorsum of the penis. Hypo-spadias is a congenital defect in which the urethra opens on the underside of the penis. (epi=on, over, hypo=under, below.)

5. D. Either side of the introitus in the female
RATIONALE: Bartholin’s glands are found on either side of the introitus (external opening to the vagina).
Section Review 2.9

1. C. Central Nervous System

RATIONALE: The brain and spinal cord are the components of the central nervous system (CNS). The Somatic Nervous System and the Autonomic Nervous System are the two divisions of the Peripheral Nervous System.

2. B. Choroid

RATIONALE: The eyeball has three layers: the retina (innermost), choroid (middle), and sclera (outermost).

3. D. Vitreous humor

RATIONALE: A clear gel-like substance filling the posterior segment of the eye is called the vitreous, which is also responsible for intraocular pressure and prevents the eyeball from collapsing.

4. B. Labyrinth

RATIONALE: The ear has three distinct and separate anatomical divisions: The outer ear (external ear), middle ear (tympanic cavity), and inner ear (labyrinth).

5. B. Otopyorrhea

RATIONALE: Otopyorrhea is pus draining from the ear.

Section Review 2.10

1. D. Thyroid gland

RATIONALE: The thyroid gland regulates metabolism and serum calcium levels through the secretion of thyroid hormone and calcitonin.

2. B. Carotid body

RATIONALE: The carotid body is not a true endocrine structure, but is made of both glandular and nonglandular tissue.

3. C. Thymus gland

RATIONALE: The thymus gland does much of its work in early childhood and is at its largest size shortly after birth. By puberty, it is at its smallest size and may be replaced by fat.
4. B. Pituitary gland

RATIONALE: The pituitary gland is also known as the hypophysis cerebri. Pituitary gland is the correct answer.

5. A. Adrenal glands

RATIONALE: The adrenal glands have two separate structural parts; the inner portion is the medulla and the outer portion is the cortex. Each structure performs a separate function.

Section Review 2.11

1. A. Erythrocytes

RATIONALE: Erythrocyte disorders include anemia (a deficiency in the amount of hemoglobin in the blood) and polycythemia (any condition in which there is a relative increase in the percent of red blood cells in whole blood).

2. B. Lymphocytes

RATIONALE: Lymphocytes are involved in protection of the body from viral infections such as measles, rubella, chickenpox, or infectious mononucleosis.

3. C. Monocytes

RATIONALE: Monocytes fight severe infections and are considered the body’s second line of defense against infection.

4. D. Eosinophils

RATIONALE: The body uses eosinophils to protect against allergic reactions and parasites; elevated levels may indicate an allergic response.

5. C. Mononucleosis

RATIONALE: Mononucleosis is a disease of excessive mononuclear leukocytes in the blood due to an infection with the Epstein-Barr virus.
Chapter 3

Section Review 3.1

1. C. NEC
   RATIONALE: NEC “Not elsewhere classifiable” This abbreviation in the index represents “other specified” When a specific code is not available for a condition the index directs the coder to the “other specified” code in the tabular. When a specific code is not available for a condition the tabular includes an NEC entry under a code to identify the code as the “other specified” code. (see “Other” codes)

2. B. 250.41, 583.81
   RATIONALE: The instructions under code 250.41 state “use additional code to identify manifestation, as: diabetic nephropathy, NOS (583.81). “Use additional” indicates the additional code would be reported secondarily. Diabetes Mellitus type I with nephropathy is coded with 250.41, 583.81.

3. D. They do not affect code assignment.
   RATIONALE: Parentheses are used in both the index and tabular to enclose supplementary words which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

4. C. Volumes 1 and 2
   RATIONALE: Volume 1 is the Tabular list of Diseases. Volume 2 is the Index to Diseases. Volume 3 is the Index and Tabular Lists to Procedures. To code for physician services, the diagnosis would first be located in the Index to Diseases (Volume 2) and then verified in the Tabular List of Diseases (Volume 1). Volume 3 is used to code procedures for hospitals.

5. B. Category
   RATIONALE: Categories are three digit codes representing a single condition or disease.

Section Review 3.2

1. D. Always consult Volume 2 first. Refer to Volume 1 to locate the selected code.
2. B. 924.11
RATIONALE: In the alphabetic index, look for bruise. You are directed to see also contusion. Under contusion, you will find the site (knee) and are directed to 924.11. 924.11 is for contusion of the knee.

3. D. 600.91, 788.20
RATIONALE: Look in the alphabetic index for hyperplasia, then find prostate, with urinary retention which directs you to 600.91. In the tabular index, 600.91 has instructions to use an additional code to identify the symptoms. Code 788.20 is used for the urinary retention.

4. D. 401.9
RATIONALE: In the alphabetic index, look for hypertension. When you find the hypertension table, you will see essential in parentheses indicating it is a supplementary word that does not affect coding. The documentation does not state if the hypertension is malignant or benign, so unspecified is used. Verify in the tabular list that code 401.9 is for essential hypertension, unspecified.

5. D. 719.45
RATIONALE: In the alphabetic index, look for pain, then the location (joint, hip). You are directed to code 719.45. 719.4x is for pain in joint (arthralgia). There is also an indication to look for the fifth digit. The fifth digit in the box for category 719 indicates 5 is for the pelvic and thigh region. 719.45 is the correct code for hip pain.

Section Review 3.3

1. B. 787.01
RATIONALE: The ICD-9-CM official guidelines, Section I.A.7 give instructions to code both conditions together when a combination code applies. 787.01 combines the nausea and vomiting conditions.

2. C. There is no time limit on late effects
RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.B.12 states there is no time limit when late affect codes can be used.

3. B. Code the acute condition first, followed by the chronic condition
RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.B.10 state to code the acute condition first, followed by the chronic condition.
4. A. Check the ICD-9-CM index to see if there are listings under “threatened” or “impending” and if not, code the existing underlying condition(s) and not the condition described as impending.

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.B.10 state to check the index for listings under threatened or impending. If not, code the existing underlying condition(s) and not the condition described as impending.

5. C. 824.8

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.B.14 states to use a diagnosis code only once for an encounter. This includes when two diagnosis codes are classified to the same code, or if a condition exists bilaterally. Look for fracture, ankle, and you are directed to 824.8. The ankle fracture is not further specified to a location in the ankle, so 824.8 is correct.

Section Review 3.4

1. A. 574.20, 338.18

RATIONALE: According to the ICD-9-CM Guidelines, Section IV.A.2, when a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the primary diagnosis, and the complications as secondary diagnosis.

2. D. 620.2, 465.9, V64.1

RATIONALE: ICD-9-CM coding guidelines Section IV.A.1 states to report the reason for surgery as the first listed diagnosis even if the surgery is cancelled due to a contraindication. 620.2 gives us the code for Ovarian Cyst, 465.9, respiratory infection, V64.1 Surgery or other procedure not carried out because of contraindication.

3. C. 786.50, 780.60, 786.2

RATIONALE: ICD-9-CM coding guidelines, Section IV.I. instruct you to code signs and symptoms when the diagnosis is uncertain. Diagnosis states as “rule out,” “suspected,” or “probably” are not reported.

4. C. V22.1

RATIONALE: ICD-9-CM coding guidelines, Section IV.P. instruct you to use V22.1 for routine outpatient prenatal care when no complication are pregnant, for other than the first pregnancy.

5. D. V72.82, 289.4

RATIONALE: ICD-9-CM coding guidelines Section IV.N. indicates to sequence first a code from category V72.8, Other specified examination, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. V72.82 for the respiratory pre-op examination and 289.4 for the hypersplenism.
**Chapter 4**

**Section Review 4.1**

1. **D. 820.19, 042**

   RATIONALE: Section I.C.1.a.2.b of the ICD-9-CM Coding Guidelines states, "If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of the injury code) should be the principal diagnosis. Other diagnosis would be 042 followed by additional diagnosis codes for all reported HIV-related conditions." The correct answer is D.

2. **A. 038.9, 995.92, 584.9**

   RATIONALE: With severe sepsis we are instructed to use two codes: First, the underlying infection is reported, followed by sepsis. Even though the documentation does not state "severe" sepsis, looking in the ICD-9-CM alphabetic index under sepsis with acute organ dysfunction, we are directed to 995.92 for severe sepsis. Code 995.92 has instructions to "Code first the underlying infection" and to use an additional code to specify the acute organ dysfunction. Section 1.C.1.b.1.(b)(ii) states to code the infecting organisms. If the infecting organism is unknown (as is in this case), code 038.9 is used. Section I.C.1.b.1.(b)(iii) also tells us severe sepsis requires an additional code for acute organ dysfunction. The correct coding and sequencing is 038.9, 995.92, and 584.9.

3. **B. 482.42**

   RATIONALE: According to Section 1.C.1.c.1(a), when a combination code exists for MRSA and the infection, only the combination code should be reported. Methicillin resistant pneumonia due to Staphylococcus aureus is reported with 482.42.

**Section Review 4.2**

1. **D. 197.0, V10.3**

   RATIONALE: ICD-9-CM Guidelines Section 1.C.2.d directs us to code secondary site (lung cancer) as the primary diagnosis, with a personal history of breast cancer because the breast cancer had been eradicated. The correct codes are 197.0 (secondary lung CA) and V10.3 (personal history of breast cancer).

2. **A. 285.3, 183.0**

   RATIONALE: According to ICD-9-CM Guidelines Section 1.C.2.c.2, because the treatment is directed at the anemia associated with chemotherapy, and the treatment is only for the anemia, the anemia should be coded sequenced first, and the neoplasm should be assigned as an additional diagnosis.
3. D. V58.11, 162.3

RATIONALE: The ICD-9-CM Official Coding Guidelines, Section 1.C.2.e.2., state that if the reason for the encounter is solely chemotherapy, a diagnosis for chemotherapy administration (V58.11) should be listed first, and a diagnosis for the malignancy requiring the chemotherapy is reported secondarily.

Section Review 4.3

1. A. When a patient’s insulin pump malfunctions

RATIONALE: The ICD-9-CM Official Coding Guidelines, Section 1.C.3.a.6., state to use 996.57 for an under dose or overdose of insulin as the primary diagnosis. For the overdose, 996.57 should be followed by 962.3.

2. A. 250.00

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.3.a.1., tell us the age of the patient is not the determining factor in what type of diabetes is coded. Section 1.C.3.a.2 tells us the default type to use for diabetes is type II.

3. B. 250.50, 362.01, 362.07

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.3.a.4.a., tells us that macular edema is only present with diabetic retinopathy. Code 362.07 should be used in addition to another code from subcategory 362.0. The diabetes with ophthalmic manifestations should be the first listed diagnosis.

Section Review 4.4

1. C. the chronic condition causing the anemia

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.4.a., state when using a code from subcategory 285.2, it also is necessary to use a code for the chronic condition causing the anemia.

2. A. 185, 285.22

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.4.a.2., state to use 285.22 when the anemia is due to the cancer, and 285.3 when the anemia is due to the chemotherapy. The patient visited the oncologist for the prostate CA, so prostate CA is the primary diagnosis listed.

3. B. 285.21, 585.3

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.4.a., address the sequencing of anemia with other chronic conditions. If the anemia is the primary reason for the encounter, the anemia is listed first. If anemia is treated, but not the primary reason for the encounter, it would be listed secondarily to the chronic condition.
Section Review 4.5

1.  D. 331.0, 294.10

RATIONALE: In the Index to Diseases, look at the main term Alzheimer’s. The patient has dementia with no documented behavioral disturbances. Two codes are required: 331.0 and 294.10. There is a bracket surrounding 294.10, which indicates it is sequenced secondary to 331.0.

2.  B. 303.91

RATIONALE: The patient is dependent on alcohol and states she drinks excessively every day. From the Index to Diseases, look up “alcoholism.” You are referred to 303.9, the fifth digit is “1” because the patient states she drinks alcohol every day.

3.  A. 314.00

RATIONALE: The patient is diagnosed with ADD. If you are unfamiliar with the abbreviation ADD, look it up in a medical dictionary. ADD is attention deficient disorder. From the Index to Diseases, look up “disorder” and the sub terms attention deficient. You are referred to 314.00. A review of the tabular section indicates the code is accurate.

Section Review 4.6

1.  B. When the pain control or pain management is the purpose of the encounter

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.C.6.a., state when pain control or pain management is the reason for the admission/encounter, a diagnosis from 338 can be reported as the primary diagnosis.

2.  B. 162.9, 338.3

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.C.6.a., state that when an admission or encounter is aimed at treating the underlying disease (Lung CA, in this case), a code for the underlying condition should be assigned as the primary diagnosis. Guideline (1.C.6.a.5) states: Code 338.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic........When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code 338.3 may be assigned as an additional diagnosis.

3.  C. 338.21, 724.2

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.C.6.a., state that when a patient is admitted for the neurostimulator for pain control, the appropriate pain code is listed as the primary diagnosis. According to Section 1.C.6.b.ii., a code can be used secondarily to report the site of pain.
Section Review 4.7

1. D. First code the retinopathy, then the hypertension.
   RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.7.a.6., state first to code the retinopathy, then a code from categories 401-405, to indicate the type of hypertension.

2. C. Code only STEMI
   RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.7.e.3., state that if STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

3. B. Hypertension and chronic kidney disease
   RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.7.a.3, state that hypertension has a presumed cause-and-effect relationship with CKD.

Section Review 4.8

1. B. Worsening or decompensation of a the asthma or COPD
   RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.8.a.2., state that an acute exacerbation is a worsening or decompensation of a chronic condition.

2. B. 493.91
   RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.8.a.4., state that it is inappropriate to assign an asthma code with fifth digit 2, with acute exacerbation, together with an asthma code with fifth digit 1, with status asthmatics. Only the fifth digit 1 should be assigned.

3. C. 491.22
   RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.8.b.1., state that when acute bronchitis is documented with COPD, 491.22 Obstructive chronic bronchitis with acute bronchitis should be assigned.

Section Review 4.9

1. B. 553.01
   RATIONALE: From the Index to Diseases, look up hernia/femoral/recurrent. You are referred to 553.00. The hernia is only on the left side which is unilateral. The correct code is 553.01.
2. **B. 571.2**

RATIONALE: From the Index to Diseases, look up cirrhosis/Laennec. There are two options: one associated with alcohol (571.2) and one without mention of alcohol (571.5). In this scenario, the patient has a history of alcohol use, thereby making 571.2 the correct code.

3. **C. 574.10**

RATIONALE: The patient is diagnosed with gall stones (cholelithiasis) and gallbladder inflammation (cholecystitis). If you did not know the medical term for these conditions, both can be found using the Index to Diseases. Look up stones. You are referred to calculi by site. Calculi of the gallbladder directs you to cholelithiasis. When you look up inflammation/gallbladder, you are referred to cholecystitis. To locate the diagnosis code, refer to cholelithiasis/with cholecystitis. You are referred to 574.1, which requires a fifth digit. There is no mention of obstruction, which makes 574.10 the correct code.
Chapter 5

Section Review 5.1

1. C. 591

RATIONALE: The indication for the surgery is hydronephrosis. In the Index to Diseases, look up “hydronephrosis.” There is no indication of causal organism, or that it is a congenital condition. The default code is 591. A review of this code in the Tabular Index confirms this is the correct diagnosis, and that it is a valid three-digit code.

2. D. 218.9

RATIONALE: The patient is diagnosed with a uterine fibroid. The symptoms that she is experiencing are integral to the definitive diagnosis and should not be coded. In the Index to Diseases, find “fibroid/uterus.” You are referred to 218.9. Review of the definition in the Tabular Index confirms this is the correct code.

3. C. 600.01, 788.63

RATIONALE: The patient is diagnosed with BPH (Benign Prostatic Hypertrophy) and urgency, which is a symptom of urinary obstruction. The obstruction does not have to be complete to report code 600.01. There is a note under 600.01 to “Use additional note to identify symptoms.” A code for urinary urgency also is selected.

Section Review 5.2

1. C. 648.23, 280.9

RATIONALE: Codes 648.23, 280.9 are both assigned. Code 648.23 is assigned because it is complicating the pregnancy, requiring transfusion. Code 280.9 is assigned to provide greater specificity as to the type of anemia.

2. A. 666.24

RATIONALE: Code 666.24 is correct because it indicates delayed postpartum hemorrhage due to retained placenta. Only code 666.24 is required because it completely explains the circumstances.

3. D. 943.21, 948.00, V22.2

RATIONALE: The pregnancy is incidental to the problem for which the patient is treated. The first listed code is for the burns. The patient has a second degree burn to both forearms. In the Index to Diseases, look up “burn/forearm/second degree.” You are referred to 943.21. A code from category 948 is coded to indicate the TBSA that is burned, as well as the percentage of the burn that is third degree. The TBSA is 9 percent and there are no third degree burns. The final correct code is V22.2, indicating “incidental to pregnancy.”
Section Review 5.3

1. **D. 707.07. 707.20**

   **RATIONALE:** Codes for pressure ulcers are determined by site. A pressure ulcer of the heel is reported with 707.07. Although both heels are involved, the code is listed only once. Two codes are required with pressure ulcers, one for the site and one for the stage. The stage is not documented; therefore, it is coded as unspecified (707.20). Unstageable can only be coded based on clinical documentation, which is not documented in this case.

2. **D. 692.0**

   **RATIONALE:** The patient is diagnosed with dermatitis due to detergent. In the Index to Diseases, look up “dermatitis/detergent.” You are referred to 692.0. Verify the code accuracy in the Tabular Index.

3. **A. 682.6**

   **RATIONALE:** From the Index to Diseases, look up “abscess/leg.” The code referenced is 682.6. Abscesses of the skin are reported with cellulitis codes.

Section Review 5.4

1. **A. 722.10**

   **RATIONALE:** L5 and S1 refer to the fifth lumbar disc and the first sacral disc in the vertebra. There is no entry for “Bulging/disc,” and therefore the first task here is to determine a synonym for “bulging.” In the case of intervertebral discs, “hernia” might work. When you look up “Hernia/intervertebral disc” in the index, you are sent to “Displacement, intervertebral disc/ lumbar, lumbosacral.” This leads to code 722.10. The description validates code choice. Because sciatica is a symptom of a displaced disc, the ICD-9-CM coding guidelines tell us it would not be reported separately. Myelopathy indicates the spinal cord is damaged, and there is no documentation of this; therefore, answer “d” would be incorrect.

2. **B. 726.10, 715.91**

   **RATIONALE:** The patient has a degenerative rotator cuff tear and degenerative arthritis. In the Index to Diseases, look up “tear/rotator cuff/degenerative.” You are referred to 726.10. For the second diagnosis, look up “arthritis/degenerative.” You are referred to osteoarthritis. There is no indication that the arthritis is localized or generalized, or primary or secondary. It is reported with 715.91 because it is the patient’s shoulder.

3. **C. 733.14, 733.00**

   **RATIONALE:** The fracture is sequenced first because it is the reason for the encounter. From the Index of Disease, look up “Fracture/pathologic/hip.” You are referred to 733.14. There is no additional information documented for the osteoporosis; therefore, it is coded as unspecified (733.00).
**Section Review 5.5**

1. **A.** They can be used throughout the life of the patient unless it has been corrected

   **RATIONALE:** Section I.C.14.a. of the ICD-9-CM Official Coding Guidelines states that codes 740-759 “may be used throughout the life of the patient. If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the anomaly.”

2. **C.** V30.00, 758.0

   **RATIONALE:** According to the guidelines Section I.C.14.a. for birth admission, the appropriate code from category V30 Liveborn infants, according to the type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes 740-759. mongolism would be reported secondarily and found in the ICD-9-CM Index under mongolism.

3. **C.** 749.20

   **RATIONALE:** In the alphabetic index under “cheiopalatoschisis,” you are directed to “see also Cleft, palate, with cleft lip” (749.20). Cross-reference in the tabular list and assign the correct code.

**Section Review 5.6**

1. **B.** It ends at 28 days

   **RATIONALE:** The perinatal period is 0 to 28 days.

2. **D.** V30.00, 774.6

   **RATIONALE:** According to the Official Coding Guidelines, the first listed diagnosis code is used to report the birth episode, followed by additional codes for perinatal conditions (in this case, V30.00). In the Index to Diseases, look up “jaundice/newborn.” You are referred to 774.6, which is the correct code.

3. **B.** 779.31

   **RATIONALE:** In the Index to Diseases, look up “feeding/problem/newborn.” You are referred to 779.31, which is the correct code.
Section Review 5.7

1. **B. 783.0, 276.51**

RATIONAL: Although “anorexia” often is a short way of describing “anorexia nervosa,” in this case, there is no documentation of an eating disorder as a psychological disorder; therefore, simple anorexia, 783.0, is the correct diagnosis. Dehydration is reported with 276.51. Each of these terms requires a simple look-up in the index and reference to the tabular section to confirm selection. Guidelines tell us not to report an unsubstantiated “probable” or “rule out” diagnosis; therefore, a diagnosis of dementia would not be appropriate at this time.

2. **B. 796.2**

RATIONAL: Elevated BP is a nonspecific finding with no formal diagnosis of hypertension. This is considered an incidental finding. Hypertension should not be coded unless it is documented specifically by the physician.

3. **C. When it is not integral to the definitive diagnosis**

RATIONAL: Signs and symptoms are reported when a definitive diagnosis has not been established. If the sign or symptom is not integral to the definitive diagnosis, the sign(s) and symptom(s) should be reported.

Section Review 5.8

1. **A. 823.82**

RATIONAL: Only one code is needed to report both fractures. Category 823 includes codes when both the tibia and fibula are fractured. According to the Official Coding Guidelines, when a fracture is not specified as open or closed, the default is to code it as closed. Even though an open repair is performed, the diagnosis is not determined by the type of treatment.

2. **C. 344.30, 907.2**

RATIONAL: When coding for late effects, first sequence the code for the current problem, followed by the late effect that identifies the cause. This case is coded correctly using 344.30 Monoplegia of lower limb affecting unspecified side and 907.2 Late effect of spinal cord injury, late effect of injury classifiable to 806, 952. Monoplegia identifies the paralysis in one limb.

3. **D. 969.00, 780.4, 780.8, E854.0**

RATIONAL: The patient took the correct medication but not as prescribed. This is considered a poisoning. The first code is listed to identify the type of medicine (969.00), which is followed by the symptoms (780.4 and 780.8), and finally the E code for accidental poisoning (E854.0).
Section Review 5.9

1. **C. V70.5**

   **RATIONALE:** The patient has no complaints. The diagnosis codes for screening exams are found under “examination” in the Index to Diseases. The sub term is pre-employment. You are referred to V70.5, which is the correct code.

2. **C. V76.19, 793.82, V16.3**

   **RATIONALE:** Code the special screening as a reason for the encounter, along with a code to report the patient’s breast density, which provides medical necessity for a more extensive test. Dense breast tissue occurs in many premenopausal women, and can interfere with reading a mammogram and may mask abnormalities in the image. Code 793.82 was introduced to ICD-9-CM to capture breast density and provide a way to report the medical necessity of an ultrasound. Code V76.19 reports a known alternative method (ultrasound in this case), while V76.10 reports an unspecified method. Code V76.19 is the appropriate choice to report the encounter for the screening exam, along with V16.3 to report the family history of breast cancer, which may provide medical necessity information for the screening exam in a young patient.

3. **B. The V code to identify the screening**

   **RATIONALE:** According to the Official Coding Guidelines, when a screening test is performed and an abnormality is found, sequence the V code for the screening first, followed by an additional code to report the abnormal findings.

Section Review 5.10

1. **D. 813.33, 802.23, E812.1**

   **RATIONALE:** A code is reported for each fracture. The radius and ulna fracture is open, which makes it the most severe injury; therefore, it is reported first (813.33). The next listed code is the coronoid fracture of the jaw (802.23). The patient was a passenger in a car that collided with another car (E812.1).

2. **B. 784.7, E917.0, E007.6**

   **RATIONALE:** The epistaxis is not caused from an injury; it is not hereditary. The correct code is 784.7. Two E codes are required in the case. The first E code indicates how the injury occurred (hit with a ball), which is reported with E917.0. The next code reports the activity he was involved in at the time (basketball), which is reported with E007.6.

3. **A. E codes are never sequenced first**

   **RATIONALE:** E codes are supplemental codes. According to the Official Coding Guidelines, E codes are never sequenced first.
Chapter 6

Section Review 6.1

1. D. Gastrectomy, total; with formation of intestinal pouch, any type.
   Rationale: The full descriptor of 43622 includes the common portion before the semi-colon of code 43620.

2. D. 20982
   Rationale: CPT® code 20982 has the bulls-eye symbol next to it indicating moderate sedation is included in the procedure.

3. C. Codes exempt from modifier 51 are identified with the universal “forbidden” symbol.
   Rationale: Codes exempt from modifier 51 are identified with the universal “forbidden” symbol. Add-on codes are also exempt from modifier 51. A list of modifier 51 exempt codes can be found in Appendix E of the CPT® code book.

4. A. A CCM is not allowed and will not bypass the edits.
   Rationale: A CCM modifier of 0 indicates a CCM is not allowed and will not bypass the edits.

5. B. 33620
   Rationale: The parenthetical instructions under CPT® code 33690 include:
   (For right and left pulmonary artery banding in a single ventricle [eg, hybrid approach stage 1], use 33620) and (Do not report modifier 63 in conjunction with 33690).

Section Review 6.2

1. A. AMA
   Answer: A. AMA—The CPT® code set (HCPCS Level I) is copyrighted and maintained by American Medical Association (AMA)

2. B. Category I, II, and III
   Answer: B. Category I, Category II, Category III—The main body of the CPT® manual is comprised of the Category I CPT® codes (00100–99607), Category II CPT® codes (0001F–7025F), Category III CPT® codes (0019T–0259T).
3. **B. Condition, synonyms, abbreviations**

   Answer: B. The CPT® manual’s index is alphabetized with main terms organized by condition; procedure; anatomic site; synonyms, eponyms and abbreviations.

4. **C. Malpractice insurance costs, physician work, practice expense**

   Answer: C. RVUs are configured utilizing physician work, practice expense and professional liability/malpractice insurance costs.

5. **D. Both B and C**

   Answer: D. Facility practice RVU expenses include services performed in emergency rooms, hospital settings (inpatient and outpatient), skilled nursing facilities, nursing homes, or ambulatory surgical centers (ASCs). The non-facility RVUs include services performed in non-hospital owned physician practices or privately owned practices.

6. **B. CPT® Category II codes**

   Answer: B. CPT® Category II codes are reported voluntarily by eligible physicians.

7. **A. New and emerging**

   Answer: A. Category III codes do not indicate the service or procedure is experimental, only that it new and/or emerging and is being tracked for trending.

8. **B. C**

   Answer: B. Appendix C—Clinical Examples—Limited to E/M services, the AMA has provided clinical examples for different specialties. These clinical examples do not encompass the entire scope of medical practice, and guides professional coders to follow E/M patient encounter rules for level of service.

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**Section Review 6.3**

1. **D. None of the above**

   Answer: D. The Surgical Global Package includes: Preoperative Visits, Intraoperative Services, Complications Following Surgery, Postoperative Visits, Postsurgical Pain Management, Supplies and Miscellaneous Services. The application of a cast is included in the surgical global package; however, in the physician office setting, cast materials are not included.
2.  C.  90 days

Answer: C. Major procedures and 90-days postoperatively are considered a component of global package of the major procedure.

3.  D.  All of the above

Answer: D. Services included in the surgical package include:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluating the patient in the post-anesthesia recovery area
- Typical postoperative follow-up care

4.  C.  24, 25, 57

Answer: C. Modifiers 24, 25, and 57 are used on evaluation and management CPT® codes only.

5.  A.  000

Answer: A. Status Indicator 000—Endoscopies or minor procedures

Section Review 6.4

1.  C.  Miscellaneous Codes, Permanent National Codes, Dental Codes, Temporary National Codes

Answer: C. HCPCS codes consist of: Permanent National Codes, Miscellaneous Codes/not otherwise classified, Dental Codes, Temporary National Codes.

2.  C.  Quarterly

Answer: C. Temporary codes can be added, changed, or deleted on a quarterly basis and once established; temporary codes are usually implemented within 90 days.

3.  B.  C codes

Answer: B. C codes are required for use under the Medicare Outpatient Prospective Payment System (OPPS). Hospitals report new technology procedures, drugs, biologicals, and radiopharmaceuticals that do not have other HCPCS codes assigned with C codes.
4. **G codes**

Rationale: The G codes are temporary HCPCS Level II codes assigned by CMS. The G codes are reviewed by the AMA for possible inclusion in the CPT®. Until these codes are replaced by CPT® codes and appropriate descriptions, CMS uses the G codes to report specific services and procedures that do not otherwise have a Level I or Level II code.

5. **J codes**

Rationale: The J code category contains codes and descriptions specific to drugs and biologicals (J0120–J8999) as well as chemotherapy drugs (J9000–J9999). The list of drugs described in the J category can be injected by one of three means: subcutaneously, intramuscularly, or intravenously.

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**Section Review 6.5**

1. **B. 50**

   Answer: B. 50 Bilateral Procedure

2. **B. CPT®, ASC, HCPCS, Anesthesia Physical Status Modifiers**

   Answer: B. Appendix A lists modifiers for CPT®, Anesthesia Physical Status Modifiers, ASC, and HCPCS Level II.

3. **D. NU**

   Answer: D. NU—New Equipment

4. **C. 32**

   Answer: C. CPT® modifier 32—Mandated Services

5. **B. When specificity is required for eyelids, fingers, toes, and coronary arteries.**

   Answer: B. HCPCS Level II Modifiers are required to add specificity to CPT® procedure codes performed on eyelids, fingers, toes, and coronary arteries.
Chapter 7

Section Review 7.1

1. **A. 704.00**
   
   **RATIONALE:** Alopecia is hair loss. You can find the correct code in the index by looking under Loss, hair, or under Alopecia. Either entry guides you to 704.00. Telogen effluvium is hair loss due to stress, but the provider only suspects it is due to stress so it would not be coded.

2. **D. 702.0**
   
   **RATIONALE:** Look in your ICD-9-CM index under keratosis, actinic and you will be guided to ICD-9-CM 702.0. This is verified by looking in the Tabular List under 702.0.

3. **B. 707.04, 707.20**
   
   **RATIONALE:** A bed sore is a pressure ulcer. Look in your ICD-9-CM index under ulcer, pressure, hip and you will find 707.04. After verifying 707.04 is the correct code in the index, you will find an additional note under the subcategory 707.0 stating to use an additional code to identify the stage of the pressure ulcer. 707.20 is used because there is no mention of the stage of the ulcer.

4. **C. Sequence first the code that reflects the highest degree of burn**
   
   **RATIONALE:** Guideline Reference: ICD-9-CM Official Coding Guidelines Section I.C.17.c.1. Sequencing of burn and related condition codes, “Sequence first the code that reflects the highest degree of burn when more than one burn is present.”

5. **A. 882.0, 910.8**
   
   **RATIONALE:** The more serious injury is the laceration to the right hand. To find laceration in the index, look under wound, open, and then find hand. This is not considered a complicated wound because there is no mention of infection or delayed healing. The injury to the scalp is only stated as superficial. In the index, look under injury, superficial, scalp.

Section Review 7.2

1. **B. 11100, 11101**
   
   **RATIONALE:** Correct codes would be 11100 and 11101. Code 11100 would be for the first lesion of the left arm and then the add-on code of 11101 would be appended for the lesion on the right arm.
2. A. 10060

RATIONALE: Using the index under cyst, you will be directed to Incision and Drainage, code range 10060-10061. CPT® 10060 best describes the procedure as there is no mention of this being a complicated cyst.

3. D. 11200, 11201

RATIONALE: The correct codes to report are 11200 for the first 15 skin tags and then 11201 for the additional 3. Please note there is no modifier used with an add-on code.

4. A. 11921, 11922

RATIONALE: With the total of the tattooing being 22.0 sq cm the proper selection of CPT® codes would be 11921 with 11922. CPT® 11921 indicates the tattooing for up to 20.0 sq cm and the add-on code 11922 indicates each additional 20.0 sq cm.

5. A. 11312

RATIONALE: Using the index under shaving you will be directed to CPT® code range 11300–11313. Noting that the lesion is located on the face and the size of the lesion is 1.4 cm you would report CPT® 11312

Section Review 7.3

1. B. 11300, 11300-51 x 2

RATIONALE: The lesions are removed using a shaving method reported with CPT® code range 11300-11313. A selection is made from range 11300-11303 since the lesions are all on the leg. Since the specific measurements of the lesions are not stated, the smallest diameter is reported, which is 11300. It would be reported once for each lesions removed.

2. D. 13101, 12035-51, 12052-51, 12011-51

RATIONALE: CPT® code 13101 for the abdominal and buttock with total closure of 4.1 cm; CPT® code 12035 for the arm and scalp with total closure of 15.5, CPT® code 12052 for the 3.8 cm closure of the cheek and CPT® 12011 for the 2.3 cm repair of the lip.

3. C. 11400, 12031

RATIONALE: Because the documentation is missing a key component, you are able to code the excision to the smallest diameter, as there is no indication of the size removed. Though the note supports an intermediate closure, you are still left with the smallest closure due to lack of documentation.
4. B. 11403

RATIONALE: The lesion is dysplastic which is considered a benign lesion. With that said, you are directed to the excision of benign lesions based on size (2.2 cm) which would lead you to 11403.

5. C. 14020

RATIONALE: It is necessary to first multiply the total flap size which calculates to 8 cm². From there you are directed to flap reconstruction of the forearm, which will lead you to 14020. The excision of the lesion is included in the flap reconstruction and is not coded separately.

Section Review 7.4

1. B. 17111

RATIONALE: The patient has a total of 19 warts destructed. 17110 describe the destruction of up to 14 lesions whereas 17111 describe the destruction of 15 or more lesions. The correct CPT® code would be 17111 for the destruction of 19 warts.

2. D. 17272, 17281-51

RATIONALE: Basal Cell Carcinoma is a malignant lesion. To code, look in the index under destruction, lesion, Skin, Malignant which takes you to ranges 17260-17286, and 96567. 17260-17286 is separated by locate, then by size. The correct CPT® for the BCC of the face, .7 cm would be 17281, and the hand lesion, 1.2cm would be 17272. 17272 would be listed first since it has a higher RVU. Modifier 51 would be used on the 17281 to indicate multiple procedures performed.

3. A. 17311, 17312, 17312, 17315, 17315

RATIONALE: The procedure performed is Mohs Micrographic Surgery. There were a total of 3 stages done, with the location of the skin cancer on the nose, CPT® 17311 is reported for the first stage and CPT® +17312, +17312 is listed twice for each additional stage. Because the first stage was divided into seven tissue blocks CPT® +17315, +17315 for the sixth and seventh block.

4. B. 19318-LT

RATIONALE: The patient is having a reduction mammoplasty. To find the procedure in the CPT® index, you can look under reduction, mammoplasty; Breast, reduction; or Mammoplasty, which guides you to look under Breast, reconstruction, mammoplasty.

5. A. 19120-LT

RATIONALE: In the CPT® index, look up Breast/Excision/Lesion. You are referred to 19120-19126, 19301. Review the codes to choose appropriate service. 19120 is the correct code.
Chapter 8

Section Review 8.1

1. **B. Wrist**
   
   RATIONALE: A Colles fracture is a fracture of the distal radius and sometimes involves the ulna. These areas of the arm bones are part of the wrist joint.

2. **B. Reduction**
   
   RATIONALE: Reduction of a fracture is the manipulation or surgical correction of a bone to return it to its normal alignment.

3. **C. One includes manipulation and one does not**
   
   RATIONALE: Both codes are used when coding a CLOSED treatment of a fracture, which means that the fracture (skin) is not opened to view; surgery is not applicable for either procedure. The first code states “without manipulation” after the semicolon, and the second code states “with manipulation.” Internal fixation would require surgery, and that is not a closed treatment.

4. **D. Tendon**
   
   RATIONALE: Tendons attach muscles to bone, and ligaments attach bones to other bones.

5. **A. Striated or skeletal**
   
   RATIONALE: Striated or skeletal muscles are often attached to bones, and help move the body. They are considered voluntary muscles—meaning we have control over their movement.

Section Review 8.2

1. **D. Open fracture**
   
   RATIONALE: A comminuted fracture is a fracture in which the bones are splintered into several pieces. If part of the bone has protruded through the skin, this would be considered an open fracture. Surgery may be required to stabilize the bone.

2. **D. Dislocation, elbow**
   
   RATIONALE: Nursemaid’s elbow is a partial dislocation of the proximal radial head, occurring in young children.
3. A. Syndrome, compartment, traumatic, lower extremity

RATIONALE: Compartment syndrome is listed under Syndrome in ICD-9-CM. The three sub-categories are non-traumatic, post-surgical, and traumatic. An auto accident would be considered a traumatic injury.

4. C. 733.14, 733.00

RATIONALE: Code 733.14 describes a pathological fracture of the femoral neck; 733.00 is the code for osteoporosis. The acute condition is coded first (fracture), followed by the chronic condition (osteoporosis).

5. B. The five lumbar vertebral bones

RATIONALE: L1-L5 is the acronym or abbreviation for the lumbar spine. There are five bones that comprise the lumbar region of the spine, and this would refer to the bones and the spaces between the bones, or the lumbar interspaces.

Section Review 8.3

1. A. 29883

RATIONALE: Code 29883 is for an arthroscopy, knee, surgical; with meniscus repair (medial AND lateral). The code can be found in the index under Arthroscopy, knee, which gives a range of codes for procedures on the knee that can be done with an arthroscope.

2. C. 29877

RATIONALE: Code 29877 is used for Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty). Note that the code is in the arthroscopy section, not an open procedure.

3. B. 20610

RATIONALE: Code 20610 describes an arthrocentesis, aspiration and/or injection; major joint or bursa (eg; shoulder, hip, knee joint, subacromial bursa). The code indicates that the arthrocentesis is for aspiration and/or injection, so this can be used for an injection alone. The drug used in the injection (usually a steroid) is coded separately. Any E/M service, if significant and separately identifiable, also may be reported (append modifier 25 to the appropriate E/M service code).

4. D. 27506-RT

RATIONALE: The surgery is an open treatment of a closed femoral shaft fracture with internal fixation (intramedullary implant), and is reported 27506-RT.
5.  C. 29075-58

RATIONALE: The first cast or splint is included as part of the initial fracture treatment; because this was a replacement cast, it can be coded.

6.  A. 21073

RATIONALE: Manipulation of a TMJ requiring anesthesia would be reported with 21073. If the TMJ was dislocated, a different code would be used.

7.  B. 20550

RATIONALE: An injection of a single tendon sheath, or ligament, aponeurosis (eg: plantar fascia) is coded with a 20550.

8.  C. 28470-TA

RATIONALE: This would be considered a closed treatment because no surgery was performed. The orthotic boot could be coded separately, by whomever supplied it.

9.  B. 28299-RT

RATIONALE: A double osteotomy can be performed on the phalanx and the metatarsal, or by making two incisions on the metatarsal bone.

10. D. 22800

RATIONALE: Spinal arthrodesis is coded based on the approach; L3-L5 is considered to be three segments. Instrumentation also would be coded for this procedure, if it were used.
Chapter 9

Section Review 9.1

1. **C. Alveoli**

   **RATIONALE:** The alveoli or air sacs are where the exchange of oxygen from the lungs and carbon dioxide from the capillaries of the circulatory system take place. High partial pressure of oxygen in the alveoli diffuses into the low partial pressure of oxygen in the capillaries and high partial pressure of carbon dioxide in the capillaries diffuses to the low partial pressure of carbon dioxide in the alveoli.

2. **D. Epiglottis**

   **RATIONALE:** The epiglottis is the lid that covers the larynx during swallowing to prevent food or liquid from entering the trachea, which can lead to choking.

3. **D. 5**

   **RATIONALE:** There are five lobes total, three in the right and two in the left.

4. **B. Diaphragm**

   **RATIONALE:** The diaphragm separates the thoracic cavity from the abdominal cavity and is the primary muscle used during respiration. The diaphragm contracts during inspiration and relaxes during exhalation.

5. **C. Trachea**

   **RATIONALE:** The trachea carries air from the mouth and throat down to the lungs and is often referred to as the windpipe.

6. **D. Bone Marrow**

   **RATIONALE:** Bone marrow is not an organ of the lymphatic system; rather, it is included in the hemic system.

7. **B. Lymphadenectomy**

   **RATIONALE:** The suffix “ectomy” means removal, so lymphadenectomy is the correct answer.

8. **C. Directly under the sternum**

   **RATIONALE:** The mediastinum is the part of the thoracic cavity between the lungs that contains the heart, aorta, esophagus, trachea, and thymus gland, as well as blood vessels and nerves. The Diaphragm is the muscle separating the thoracic and abdominal cavities and plays a significant role in respiration.
9. B. Diaphragm

RATIONALE: The diaphragm is the muscle separating the thoracic and abdominal cavities and plays a significant role in respiration.

10. C. voice box

RATIONALE: The larynx is responsible for speech and therefore is known as the voice box.

Section Review 9.2

1. D. 491.22

RATIONALE: Acute bronchitis with COPD always should be coded in the COPD section of codes, not as an acute disease. Notes under 491.22 in the Tabular index state, "When acute bronchitis, 466.0 is documented with COPD, code 491.22 should be assigned." Look in the ICD-9-CM Index for Disease, pulmonary, diffuse obstructive, with acute bronchitis.

2. C. 474.10

RATIONALE: Enlargement of the tonsils and adenoids over a period of a year is a chronic condition. Therefore, coding from the acute section of codes would not be correct. Hypertrophy is a synonym for enlargement. Look in the ICD-9-CM Index for Enlarged, tonsils, with adenoids.

3. C. 033.9, 484.3

RATIONALE: Code underlying disease first (whooping cough), then the pneumonia. The ICD-9-CM Index shows "033.9 [484.3]," which indicates 484.3 is the second-listed code. The Tabular 033 indicates "Use additional code to identify any associated pneumonia (484.3)." Look in the ICD-9-CM Index for Pneumonia in, whooping cough.

4. B. 493.02

RATIONALE: Hay fever is an extrinsic asthma. The fifth digit 2 is appropriate for the acute exacerbation of the extrinsic asthma. Look in the ICD-9-CM Index for Asthma, with, Hay Fever.

5. D. 512.0, 305.1

RATIONALE: Spontaneous tension pneumothorax is reported with 512.0. Look in the ICD-9-CM for Pneumothorax, tension. Pneumothorax due to trauma would be coded from the Injury section of ICD-9-CM. Cigarette smoking is reported with 305.1 as it relates to the pneumothorax. Look in the ICD-9-CM Index for Abuse, tobacco.
6. **A. 164.0**

RATIONALE: Primary malignancy of the thymus is coded with 164.0. Look in the ICD-9-CM Index for Thymoma, malignant.

7. **B. 457.1**

RATIONALE: Lymphedema can be congenital, 757.0, or it can be acquired later in life, which would be coded 457.1. Look in the ICD-9-CM Index for lymphedema, acquired.

8. **A. 466.11**

RATIONALE: RSV is a common cause for bronchiolitis. Look in the ICD-9-CM Index for bronchiolitis, respiratory syncytial virus. Code 466.11 is Acute bronchiolitis due to respiratory syncytial virus (RSV) so two codes are not required to report this diagnosis accurately.

9. **D. 471.9**

RATIONALE: Look in the ICD-9-CM Index for Polyp, nasal. Nasal polyps are diagnosed in the range 471.0–471.9. Since this is an unspecified nasal polyp, 471.9 would be correct.

10. **C. 162.3**

RATIONALE: A Pancoast tumor is typically a fast growing, non-small cell tumor in the upper part of the right or left lung. To find the diagnosis, look in the ICD-9-CM Index under Pancoast syndrome or tumor.

**Section Review 9.3**

1. **C. 30801**

RATIONALE: Code 30801 is superficial ablation of the turbinates, as compared to 30802, which is intramural ablation of the turbinates. Code 30140 is a submucous resection of the inferior turbinate, not an ablation.

2. **D. 31231**

RATIONALE: Code 31231 is a diagnostic nasal endoscopy, unilateral and bilateral; therefore, no modifier is necessary

3. **B. With mirrors**

RATIONALE: Indirect endoscope of the larynx is performed by viewing the larynx with the use of mirrors. In contrast, a direct scope would view the larynx directly through the scope.
4. B. Yes: Report multiple procedures with a modifier -51 (if required by the payer)
   
   RATIONALE: Yes, bronchoscopy codes are billed as multiple procedures with a modifier -51. List the highest
   RVU valued code first and then all other codes with a modifier -51.

5. B. 32110
   
   RATIONALE: Thoracotomy main code is 32100, but control of the hemorrhage and lung tear would be
   code, 32110.

6. B. 32422
   
   RATIONALE: Thoracentesis can be the insertion of a tube to remove air from the pleural space in order to
   re-inflate the lungs following a pneumothorax. There are two types of thoracentesis, puncture and insertion
   of a tube.

7. A. No: A diagnostic VATS is always included in the surgical VATS.
   
   RATIONALE: Diagnostic VATS are bundled into surgical VATS and cannot be billed separately during the same
   surgical session, per CPT® instruction. In contrast, if the results of a diagnostic VATS prompts an open proce-
   dure to excise tissue, the diagnostic VATS may be billed, and the appropriate open surgical code may be
   reported with modifier 58 Staged procedure; some payers may require a modifier 59 in this situation; check
   with your payers for appropriate modifier usage.

8. D. 32663
   
   RATIONALE: Wedge resection is bundled into the lobectomy when it is the same lobe; can only code sepa-
   rately if procedures performed on different lobes.

9. D. 38525
   
   RATIONALE: The CPT® Index for Excision, Lymph Nodes indicates 38500, 38510-38530. Reference the CPT®
   Tabular and review the codes. The correct code is 38525 (Biopsy or excision of lymph nodes; open, deep axil-
   lary node[s]).

10. C. 43336
    
    RATIONALE: Code 43336 is the correct code as it is without mention of mesh implanted and is also via a thora-
    coabdominal incision. Code 43337 includes mesh insertion and codes 43334 and 43335 are performed via
    thoracotomy.
Chapter 10

Section Review 10.1

1. B. Heart
RATIONAL: The heart is a fist-sized, cone-shaped muscle that sits between the lungs and behind the sternum.

2. D. Coronary
RATIONAL: Coronary circulation refers to the movement of blood through the tissues of the heart.

3. A. Tachycardia
RATIONAL: Tachy = fast and cardia = heart

4. D. Pulmonary and Aortic
RATIONAL: The tricuspid and mitral valves are the atrioventricular valves. The pulmonary and aortic valves are called the semilunar valves because of their shape.

5. D. all of the above
RATIONAL: CPT® codes for the Cardiovascular system are found in multiple sections of CPT® (30000, 70000, and 90000).

Section Review 10.2

1. C. 424.1
RATIONAL: No mention was made of a congenital condition, or rheumatic condition. In the alphabetic index you would look under stenosis then aortic and go to 424.1.

2. B. 410.11
RATIONAL: Anteroapical wall falls under “other anterior wall” infarction 410.1x. Since the patient was admitted through the ED, the fifth digit for the initial episode of care would be appropriate.

3. C. 403.9, 585.6
RATIONAL: According to the ICD-9 Official Guidelines a relationship is assumed between hypertension and chronic kidney disease.

4. A. 428.33
RATIONAL: There is a combined code for acute on chronic diastolic heart failure.

5. C. 426.13
RATIONAL: The syncope is a sign/symptom of the AV block. A Mobitz I is a second degree block.
Section Review 10.3

1. B. 33534, 33519, 35572, 35600, 33508

RATIONALE: 33534 is for the 2 arterial grafts. Because a combination AV graft was performed, instead of using a code from 33510-33516 for the venous grafts, we have to use 33517-33523. 35572 is for procurement of the fem-pop vein, 35600 is for harvesting the radial artery, and 33508 is the add-on code for endoscopic harvesting of the saphenous vein.

2. C. 33235, 33208-51, 33233-51

RATIONALE: Multiple codes are needed to show the entire procedure. 33235 is for removing the electrodes, 33208 is for putting in the new system, and 33233 is for removing the pacemaker pulse generator.

3. A. 33426

RATIONALE: The mitral valve was repaired, not replaced. The fact that the patient was on cardiopulmonary bypass did not affect code choice.

Section Review 10.4

1. B. 36245-RT, 36245-59-LT, 75724-26

RATIONALE: Using Appendix L the renals are first order vessels. As the right and left were catheterized, it is 2 separate vascular families, so 36245 is reported twice with modifiers RT and LT to indicate the sides. A modifier 59 is used to indicate it is a separate location. Since the catheter was manipulated into the renals, the selective bilateral RS&I code 75724 reported. Modifier 26 reports the professional service.

2. C. 36217, 36216-59, 36215-59, 36218, 75650-26, 75680-26, 75685-26, 75685-26-59

RATIONALE: Three separate vascular families are catheterized. The right vertebral and the right common carotid are in the same family, so the highest order (right vertebral) is coded using 36217 and the right common carotid is coded using the add-on code 36218. The left vertebral is a second order vessel off the aorta; therefore, reported with 36216 with modifier 59 to report a separate vascular family. The left common carotid is a first order vessel off the aorta, reported with 36215-59. There is only one code for vertebral angiography; therefore, 75685 is reported twice; once with modifier 59 to indicate separate vessels. The radiological S&I for bilateral common carotids (85680) and the aortic arch (75650) are reported. All radiology codes are reported with modifier 26 to indicate the professional service.

3. A. 36200, 75630-26

RATIONALE: 75630 had to be used because only one complete study was performed that included the abdominal aorta and both (bilateral) extremities from two catheter placement sites in the abdominal aorta. A modifier 26 is appended to indicate the professional component of the radiology code.

4. C. 36245-RT, 36245-59-LT, 36245-59, 75724-26, 75726-26

RATIONALE: The renals and the SMA are all first order vessels from the aorta, so each family is coded separately.
5. **D. 36200, 75710-26, 75625-26**  
**RATIONALE:** The catheter was placed at the level of the renals, not in the renals, so this is a non-selective catheterization.

**Section Review 10.5**

1. **C. 93460-26, 93567**  
**RATIONALE:** The cardiac catheterization code 93460 reports right and left heart catheterization, selective coronary angiography with imaging interpretation and reporting as well as left ventriculography. The cardiac catheterization code includes injection procedures and radiologic S & I. The ascending aortography to review the aortic root is reported with add-on code 93567. Aortography is always included in a cardiac catheterizations unless it is performed for a specific purpose such as to study an aortic aneurysm or occlusive disease. The right iliac angiogram is not reported as it was performed to assess the femoral artery for the Perclose device. The Perclose closure is not reported as it is bundled with a cardiac the catheterization procedure. Modifier 26 is required to indicate the professional services only.

2. **A. 92982-LD, 92978-26**  
**RATIONALE:** IVUS separately reportable.

3. **D. 93016, 93018**  
**RATIONALE:** Since the study was performed in the hospital, the physician bills for the professional services.

4. **C. 93610, 93618, 93600**  
**RATIONALE:** Although the surgeon documented a “comprehensive” study, it does not include all components listed in the CPT code 93619, so the individual codes are billed.

5. **B. 93306**  
**RATIONALE:** A combination code exists to bundles in the Doppler and color flow.
Appendix A Answers and Rationales

Chapter 11

Section Review 11.1

1. **B. -stomy**
   
   **RATIONALE:** -ectasis means dilation, -cele means hernia, -lysis means release.

2. **C. cheil/o**
   
   **RATIONALE:** An/o means anus, cec/o means cecum, col/o means colon.

3. **B. It conveys and stores bile.**
   
   **RATIONALE:** The gall bladder is a sac-shaped organ located under the liver. It stores bile that is produced by the liver.

4. **D. Duodenum, jejunum, ileum**
   
   **RATIONALE:** The three sections of the small intestine are the duodenum, jejunum, and the ileum. The ilium (note spelling) is one of the bones located in the pelvis. The sigmoid, rectum, and cecum are parts of the large intestine.

5. **B. The transverse colon**
   
   **RATIONALE:** The name of the large intestine that runs horizontally across the abdomen is the transverse colon.

6. **C. Liver**
   
   **RATIONALE:** The liver is the only organ in the human body that can self-regenerate, which is why an adult can donate a portion of a liver to a child and that transplanted portion will reregenerate, usually within six weeks of the procedure.

7. **A. Mechanical and chemical**
   
   **RATIONALE:** Digestion consists of two processes, mechanical and chemical. Mechanical digestion is chewing the food and your stomach and smooth intestine churning the food, but chemical digestion is the work the enzymes do when breaking large carbohydrate, lipid, protein and nucleic acid molecules down into their subcomponents -these and others are the nutrients.
8. B. Incisors, Cuspids, Molars

RATIONALE: There are three categories of teeth:

- The Incisors—These are the teeth in the front of the mouth. They are shaped like chisels and are useful in biting off large pieces of food. Each person has eight of these (four on the top, four on the bottom).

- The Cuspids—These are the pointy teeth immediately behind the incisors. Also called the canines, these teeth are used for grasping or tearing food. Each person has four of these (two on the top and two on the bottom).

- The Molars—These are flattened teeth used for grinding food. They are the furthest back in the mouth, and their number can vary among people.

9. D. 5 ft. long

RATIONALE: The large intestine is about five feet long.

10. A. 4 lobes

RATIONALE: The human liver has four lobes: the right lobe and left lobe, which may be seen in an anterior view, plus the quadrate lobe and caudate lobe.

Section Review 11.2

1. B. 530.81

RATIONALE: GERD is the definitive diagnosis. Chest pain and a dry cough are both symptoms of GERD and would not be reported separately. GERD is an acronym for gastroesophageal reflux disease. In the ICD-9-CM Index, look under disease, then gastroesophageal reflux (GERD), and you are guided to 530.81.

2. D. 564.1

RATIONALE: IBS is an acronym for irritable bowel syndrome, and can cause the intestinal tract to contract stronger and longer than normal. This may cause symptoms such as abdominal pain, constipation or diarrhea, and/or flatulence. To find IBS in the ICD-9-CM, look in the Index under Syndrome, then find irritable, then bowel, leading you to code 564.1. Because abdominal pain and diarrhea are symptoms of IBS, they would not be coded separately. Ulcerative colitis is a rule-out diagnosis, and therefore, should not be coded.

3. C. 455.6

RATIONALE: Hemorrhoids are dilated or enlarged varicose veins, which occur in and around the anus and rectum. The condition can be complicated by thrombosis, strangulation, prolapse, and ulceration. To find hemorrhoids in the ICD-9-CM, locate Hemorrhoids in the Index, which will guide you to 455.6. If there is a complication to the hemorrhoids, you will look further in the Index to locate the complication. For this record, there is no mention of complication, so the correct code would be 455.6.
4.  **B. 211.3**

RATIONALE: The definitive diagnosis is polyps. Rectal bleeding is a sign of polyps in the colon, and therefore, not coded separately. In the ICD-9-CM Index, look under Polyps. Polyps can occur in a variety of locations, follow the Index to the site of the polyps, colon. You are directed to 211.3.

5.  **C. 250.60, 536.3**

RATIONALE: Gastroparesis is also named delayed gastric emptying. Gastroparesis may occur when the vagus nerve is damaged and the muscles of the stomach and intestines do not work normally. Food then moves slowly or stops moving through the digestive tract. The most common cause of gastroparesis is diabetes. In this case, the physician did link the gastroparesis to the patient’s diabetes; therefore, we can use the appropriate diabetic complication code, 250.6x. The correct fifth digit would be 0, because the physician did not document that the patient’s diabetes was uncontrolled. To find this in the Index, look under Diabetes, gastroparesis, which leads to 250.6x [536.3]. The code in the slanted brackets always is a secondary code.

**Section Review 11.3**

1.  **B. 44204**

RATIONALE: Even though a peritoneoscopy was performed, it is not separately reportable because it is incidental to the more extensive procedure of the laparoscopic colectomy and the anastomosis.

2.  **A. 41008**

RATIONALE: The CPT® code 41008 is specifically for Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space.

3.  **A. 48150**

RATIONALE: The CPT® code 48150 is specifically for pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy, and gastrojejunostomy (Whipple-type procedure); with pancreateojejunostomy

4.  **A. 46200**

RATIONALE: In the CPT® index, look up Anus/Fissure/Excision. You are referred to 46200. This is the correct code. There was a removal (excision) of a fissure, not fistula, without a sphincterotomy or hemorrhoidectomy.
5. **B. 49505-LT**

RATIONALE: In the CPT® index, look up Hernia Repair/Inguinal. You are referred to 49491, 49495–49500, and 49505. Review the codes to choose the appropriate service. 49505 is the correct code. The repair was through an incision (not by laparoscopy) on an initial inguinal hernia on a patient over five years of age. According to CPT® guidelines, “With the exception of the incisional hernia repairs (49560–49566), the use of mesh or other prosthesis is not separately reported.” It would be inappropriate to code the mesh in this scenario.
Chapter 12

Section Review 12.1

1. A. Kidneys
   RATIONALE: The renal pelvis receives urine from the kidney, travels through the ureters on the way to the bladder, but urine is formed in the kidney.

2. C. Urethra
   RATIONALE: The urine travels from the kidneys to the ureters, to the bladder, where it is stored and expelled through the urethra.

3. D. Testes
   RATIONALE: The testes are the reproductive glands, the seminal vesicles contribute fluid to the ejaculate, and the vas deferens transports the sperm, where it exits through the urethra.

4. C. Spleen
   RATIONALE: The organs making up the urinary system consist of the kidneys, bladder, urethra, and ureters.

5. A. Prostate
   RATIONALE: The prostate gland is the gland that is partly muscular and glandular.

Section Review 12.2

1. C. 592.0
   RATIONALE: Documentation of calculus of the kidney and ureter are very specific to the organ site involved. Though most stones are calcium based, coding a disorder of calcium metabolism would be incorrect. Calculus of the urethra and ureter are not correct because the documentation states “nephrolithiasis (kidney). Kidney stones, or nephrolithiasis, is coded 592.0

2. C. 599.71
   RATIONALE: Although there is documentation that the patient previously had a TURP, there is no documentation of continuing BPH (a condition for which a TURP routinely is performed). Because documentation states “gross” hematuria, microscopic or unspecified hematuria would be inappropriate codes. Gross hematuria 599.71 is the correct answer.
3. D. 866.00

RATIONALE: There is no specific information available regarding an “open” wound into the cavity; therefore, diagnosis 866.11 is not applicable. 866.0 is an incomplete code because a fifth digit is required for the codes within the 866 series. Because there is no documentation regarding a laceration of the kidney, the only other applicable code is 866.00. A diagnosis code within the “E” series also should be added.

4. A. 600.01, 788.20

RATIONALE: In the ICD-9-CM Index, look for enlarged, prostate with urinary retention and you are directed to 600.01. There is a note under 600.01 to use an additional code to identify the urinary retention. Urinary retention is coded with 788.20.

5. D. 594.0

RATIONALE: A prime example of (incorrectly) choosing a code from the index without accessing the tabular list, would be if you chose 562.10 diverticulosis. Bladder diverticulum 596.3 would be the correct code for bladder diverticulum, alone, and 594.1 describes a bladder stone within the bladder, but not within the bladder diverticulum. Calculi in diverticulae of the bladder is coded 594.0.

6. D. 590.10

RATIONALE: Acute pyelonephritis is coded 590.10, unless mention of a lesion of renal medullary necrosis is documented. You would not use chronic pyelonephritis because the documentation clearly states “acute;” nor would you use 590.0 because this is an incomplete code and must be coded to the fifth digit. Remember that all ICD-9-CM codes must be coded to the highest specificity.

7. D. 788.32

RATIONALE: Female stress incontinence is documented using ICD-9-CM 625.6 and is specific to the female gender. Incontinence unspecified is coded as 788.30; because documentation clearly states stress incontinence, this code would be inappropriate. Mixed urinary incontinence is a combination of urge and stress incontinence; because there is no mention of urge incontinence, this code would be incorrect. Male stress incontinence is coded using 788.32.

8. B. 185

RATIONALE: Because this patient still has documented disease, V10.46 personal history of prostate cancer would not be correct. Unspecified neoplasm of the prostate, 239.5, would not be coded because there is a specific diagnosis of prostate cancer; therefore, 185 would be the correct code. Uncertain behavior of prostate neoplasm, as well as uncertain behavior of other neoplasms, should be coded only when the pathological report states “uncertain.”
9. **A. 223.0**

**RATIONALE:** When assigning this code, you would look up oncocytoma in the index of ICD-9-CM, which tells you to “see Neoplasm, by site, benign.” Neoplasm, kidney, benign is 223.0, which is the correct code to assign. Renal cancer, 189.0 and 189.1, would be incorrect because there is no documentation of malignancy and 223.1 is specific to the calyx, hilus and pelvis of the kidney.

10. **D. 599.0**

**RATIONALE:** Urinary hesitancy (788.41), urinary frequency (788.63) and dysuria (788.1) are all symptoms of a urinary tract infection. Because the diagnosis of UTI was confirmed by microscopic analysis, 599.0 urinary tract infection would be correct. If there was no confirmed diagnosis of UTI, the appropriate codes to note would be the presenting symptoms.

Section Review 12.3

1. **D. 52224**

**RATIONALE:** CPT® 52234 and 52235 describe a cystourethroscopy with fulguration or treatment of small (0.5 up to 2.0cm) and medium bladder tumors (2.0-up to 5.0cm), respectively. Because there is no mention of the size of the tumors treated, these codes would not be appropriate. CPT® 52204 describes a cystoscopy with biopsy and normally would be appropriate when “cold cup biopsy” is performed. But, the note states that all tumor sites are “cauterized” or fulgurated. Therefore, the correct code would be 52224, which describes cystourethroscopy with fulguration or treatment of MINOR (less than 0.5cm) lesion(s) with or without biopsy. Because of the description of CPT® 52224, the number of lesion(s) treated does not factor into the code selection.

2. **B. 52630**

**RATIONALE:** As a previous TURP was performed, CPT® 52601 would not be the appropriate because this code is used for the initial TURP. CPT® 52648 is described as laser vaporization of the prostate, and would not be coded. CPT® 52500 is described as “transurethral resection of bladder neck;” because the prostate was resected, not the bladder neck, this would not be appropriate. CPT® 52630 describes TURP of residual or regrowth of obstructive prostate tissue, which is the appropriate code. Had the patient needed a “repeat” TURP within the global period of his initial TURP, CPT® 52630 would be reported with modifier 78 appended.

3. **B. 51040**

**RATIONALE:** Aspiration of bladder with insertion of suprapubic catheter (51102) does not describe an “open” suprapubic tube insertion. Suprapubic catheter change is reported using CPT® 51705; therefore, this code would not be reported for an insertion procedure. Because 51045 describes a ureteral catheter or stent, this code would not be appropriate for a suprapubic catheter change. CPT® 51040 “Cystostomy, cystotomy with drainage” describes the suprapubic tube placement.
Answers and Rationales

4. D. 51500

RATIONALE: Umbilical hernia repair codes are reported 49580-49587 and are differentiated by the age of the patient and whether the hernia is reducible, or incarcerated/strangulated. A reducible hernia is one that can be replaced to a normal position. An incarcerated or strangulated hernia is one that cannot be replaced to a normal position without surgical intervention. The description of CPT® 51500 “Excision of urachal cyst or sinus, with or without umbilical hernia repair” includes the umbilical hernia repair. Hernia repair would not be reported separately; therefore, CPT® 51500 is the correct answer.

5. B. 52005

RATIONALE: Placement of the ureteral catheters was performed via cystoscopy; therefore, CPT® 50605 would not be appropriate because this code is for an open insertion of indwelling stent into the ureter. CPT® 52332 describes the insertion of indwelling ureteral stents and would not be reported for temporary catheter insertion. CPT® 52310 describes the removal of ureteral stents, but does not cover the insertion of the catheters. CPT® 52005 “Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic services” would be the correct. There would be no additional code reported for removal of these catheters.

Section Review 12.4

1. D. 54060

RATIONALE: Surgical excision of condyloma(s) of the penis are reported using CPT® 54060. You would report this procedure only once because the description includes multiple condyloma excision during a single surgical setting. CPT® 11420 describes excision of a benign lesion of the genitalia, but the diameter of the lesion excision is stated as 0.5cm or less. CPT® 11421 describes a benign lesion excised from the genitalia 0.6cm to 1.0cm, and would be appropriate had there not been a clear and concise code for condyloma excision. CPT® 11621 describes a malignant lesion excision and would not be reported because there is no documentation of a malignant lesion excision. Tip: When ascertaining the specific code to report, the body system or organ should be accessed first, before using the integumentary codes.

2. C. 55250

RATIONALE: Although CPT® 55250 is the correct code to report, no modifiers would be reported with the vasectomy code because the descriptor clearly states “unilateral or bilateral;” therefore, modifier 53 and 52 are inappropriate. The procedure was not terminated due to the well-being of the patient (modifier 53), nor would you report a decreased service (modifier 52).

3. A. 55250-58

RATIONALE: Using modifier 76 on the left vasectomy would not be appropriate because modifier 76 denotes a return to the operating room on the same day as the initial procedure. Modifier 58 would be appropriate because the vasectomy is a follow-up to the initial vasectomy (staged or related procedure).
4. C. 54840

RATIONALE: The spermatocele excision (spermatocelectomy) states, with or without epididymectomy; therefore, the epididymectomy codes would not be reported. Epididymectomy codes are described as unilateral (54860) or bilateral (54861). Because a lesion was not removed from the epididymis, CPT® 54830 would be incorrect.

5. A. 54150

RATIONALE: In the CPT® index, look for Circumcision, surgical excision, newborn. You are directed to 54150, 54160. A Plastibell is a type of clamp used in circumcision. Code 54150 is correct.

Section Review 12.5

1. B. 52

RATIONALE: Modifiers 52 is used to report reduced services. This would be used when a bilateral procedure is performed unilaterally.

2. A. 76

RATIONALE: Sometimes it is necessary for a physician to repeat a procedure. When this occurs, modifier 76 should be appended.

3. A. TC

RATIONALE: Some CPT® codes have a technical component and a professional component. Modifier 26 is appended when the professional component is provided and modifier TC is appended when the technical component is provided. Professional services are those in which the physician performs an interpretation and report. Technical services includes ownership of the equipment, space, and employment of the technicians or nurses who performed the study.

4. D. B or C

RATIONALE: Depending upon the insurer, either modifier 50 or RT and LT would be appended to the surgical procedure.

5. B. 53

RATIONALE: When a procedure is terminated to preserve the well-being of the patient, modifier 53 is appended to the procedure code.
Chapter 13

Section Review 13.1

1.  D. Fallopian tubes and ovaries

   RATIONALE: The word adnexa means “appendages.” The uterine appendages are the tubes and ovaries.

2.  A. Bartholin’s glands

   RATIONALE: The Bartholin’s glands are the large glands located on either side of the vaginal introitus.

3.  B. The cervix and uterine fundus

   RATIONALE: The uterine tubes, vulva and vagina are not part of the uterus. The uterus is made up of the cervix (cervix uteri) and the fundus (corpus uteri).

4.  C. Colposcopy

   RATIONALE: The root word colp/o means vagina; colposcopy is examination of the vagina using a scope.

5.  C. Cervix

   RATIONALE: The ovaries and salpinx (fallopian tubes) are found on both sides of the uterus. The Bartholin’s glands are found on both sides of the vaginal introitus. The cervix is singular, connecting the uterus to the vagina.

Section Review 13.2

1.  C. 233.32

   RATIONALE: VIN III is coded as cancer in situ and VIN indicates a vulvar lesion.

2.  C. With forceps

   RATIONALE: Code 650 is for a normal delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [rotation] or instrumentation [forceps] of spontaneous, cephalic, vaginal, full-term, single, live-born infant.
3. **B. Spontaneous abortion**

**RATIONALE:** ICD-9-CM and CPT® recognize three types of abortions, spontaneous (also called a miscarriage), induced (caused by a deliberate procedure), or missed. A missed abortion is when the fetus dies but the products of conception are retained.

4. **C. 642.02**

**RATIONALE:** Although the hypertension is pre-existing, it should be recoded in chapter 11 during the pregnancy and post-partum period. It is not necessary to add code 401.1 because the condition is already specified as benign. The fifth digit “2” is appropriate because the woman delivered during this episode of care but still has a condition that will carry over into the post-partum period.

5. **D. 627.1**

**RATIONALE:** This bleeding is after the end of the woman's menses and should be described as postmenopausal.
Chapter 14

Section Review 14.1

1. **B. Glands**

   RATIONALE: The endocrine system is comprised of glands, located throughout the body, that produce various hormones.

2. **D. Produces insulin and glucagon to regulate blood glucose levels and secretes digestive enzymes**

   RATIONALE: The pancreas gland performs both endocrine and exocrine (digestive) functions. It produces several hormones (including insulin and glucagon) that regulate blood glucose levels. It also secretes digestive enzymes that flow via the pancreatic duct to the small intestine.

3. **A. Near the kidneys**

   RATIONALE: Adrenal means near the kidneys since the adrenal glands sit directly atop of the kidneys, one per side.

4. **C. Excision of the thymus by cutting into the chest**

   RATIONALE: Thymectomy (partial or total) describes excision of the thymus. This may be achieved by a number of surgical approaches, including transcervical (via the neck), transthoracic or sternal split (via chest).

5. **B. Pineal**

   RATIONALE: The pineal gland, found deep within the brain, looks like a pine cone and is the size of a grain of rice. The thyroid, pituitary and thymus have two lobes.

6. **A. Central and Peripheral nervous system**

   RATIONALE: The nervous system is comprised of two parts: (1) Central Nervous System (CNS) which is the brain and spinal cord in command of the entire body movement and function. (2) Peripheral Nervous System (PNS) which incorporates all the nerves running throughout the body that sends information to, and receives instruction from the CNS.

7. **D. Sciatic**

   RATIONALE: The largest nerve of the body is the sciatic nerve which divides into the tibial and common fibular (common peroneal) nerves.
8. **C. Vertebra**

RATIONALE: Vertebra is not a region of the spinal nerve segments since that is the cartilaginous segment that makes up the spinal cord. The lumbar region has five segments that form five pairs of lumbar nerves. The cervical region has seven segments that form eight pairs of cervical nerves. The coccygeal region has three segments forming one pair of coccygeal nerves.

9. **A. A single complete vertebral bone**

RATIONALE: A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular process and laminae.

10. **D. Parietal lobe**

RATIONALE: The parietal lobes are at the top of the brain. The right lobe processes visuo-spatial information, while the left lobe processes spoken and/or written information.

**Section Review 14.2**

1. **C. 242.31**

RATIONALE: The diagnosis is indexed in the Alphabetical Index under Thyrotoxicosis, with goiter, nodular guiding you to code 242.3. Your fifth digit is a one to indicate the crisis. There is no documentation of the nodule being uninodular or multinodular.

2. **B. 193. 246.0**

RATIONALE: When a patient has functional activity associated with any neoplasm such as thyrotoxicosis or disorders of thyrocalcitonin secretion, the neoplasm should be reported first and the functional activity caused by the neoplasm should be reported as a secondary code. There is no documentation of the patient having a history of cancer so it would be inappropriate to code the V code for this scenario. Thyroid cancer is indexed in the Neoplasm Table under thyroid (gland), Malignant, Primary (column) guiding you to code 193. The Tabular for 193 states “Use additional code to identify any functional activity.” The second diagnosis is indexed under Hypersecretion, calcitonin guiding you to code 246.0.

3. **A. 250.71, 785.4**

RATIONALE: Diabetes with gangrene is found in the Alphabetical Index under Diabetes, gangrene, guiding you to code 250.7. Your fifth digit is one since the patient is a type I diabetic and there is no documentation of the diabetes being uncontrolled. In the Tabular section under subcategory code, 250.7, there is a note that states: *Use additional code to identify manifestation as: diabetic: gangrene (785.4)* which means gangrene will be coded as a secondary code. There is no documentation that the patient has secondary diabetes so it would be inappropriate to code that type of diabetes for this scenario.
4. C. 987.8, 323.72, E869.8

RATIONALE: Toxic myelitis is indexed under Myelitis, due to, toxic, guiding you to code 989.9 [323.72]. Note: Brackets are used in the Alphabetic Index to identify manifestation codes. In the Tabular Listing code 989.9 is an unspecified substance, chiefly nonmedicinal as to source. In this scenario we do know the substance that poisoned the patient. In the Table of Drugs and Chemicals look for carbon, tetrachloride (vapor) guiding you to code 987.8. For the E code, we know that is an accidental poisoning since the substance was inhaled by putting out a fire guiding us to code E869.8. Code 323.72 will be reported as a secondary code. There is a Code first note under the subcategory code 323.7 that states: Code first underlying cause, as: carbon tetrachloride (982.1); however, this code represents poisoning by liquid carbon tetrachloride. The correct code is 987.8 for poisoning by carbon tetrachloride vapor. According to the Official Guidelines for Coding and Reporting I.C.17.e.3.b. the toxic effect should be sequenced first, followed by the result of the toxic effect.

5. B. 338.11, 723.1

RATIONALE: The scenario documents the patient of having acute pain due to being in a MVA accident (trauma). In the Alphabetical Index look under Pain, acute, due to trauma guiding you to code 338.11. The keywords to direct you to the codes in the 338 category are “acute pain” and there is no documentation on a definitive diagnosis on what is causing the pain. The Guidelines state that codes from 338 may be used in conjunction with codes that identify the site of pain; therefore, 723.1 Cervalgia, is reported.

Section Review 14.3

1. D. 62362, 62350-51

RATIONALE: Patient is having an insertion of a programmable pump and an intrathecal catheter performed to infuse pain meds for pain management. Patient is not having an infusion of pain meds performed in this scenario. This is indexed in the CPT® manual under Infusion Pump, Spinal Cord guiding you to codes 62361–62362. The second code is indexed under Catheterization, Spinal Cord guiding you to codes 62350–62351.

2. C. 62270

RATIONALE: Patient is not having an injection or an aspiration of contents found in the nucleus pulposus, intervertebral disc, or paravertebral tissue. The procedure is a spinal puncture in the lumbar area for a diagnostic purpose of finding out if the patient has meningitis. This is indexed in the CPT® manual under Spinal Tap, Lumbar guiding you to code 62270.

3. B. 61154

RATIONALE: The keywords in the scenario to guide you to the correct code is burr hole, evacuation, hematoma and subdural. All those words are found in the code description of procedure code 61154. This is indexed in the CPT® manual under Burr Hole, Skull, Drainage, Hematoma guiding you to codes 61154–61156.
4. A. 63005

RATIONALE: Only a laminectomy and decompression is being performed in the scenario. There is no documentation of a facetectomy, foraminotomy, or discectomy being performed. This is indexed in the CPT® manual under Laminectomy or Decompression, Spinal Cord.

5. C. 95955-26

RATIONALE: The physician is using an EEG to record and measure the patient’s brain electrical activity while performing thromboendarterectomy (not intracranial surgery). This is indexed in the CPT® manual under Electroencephalography, Intraoperative guiding you to code 95955.

Section Review 14.4

1. B. S2348

RATIONALE: This HCPCS code is indexed under Decompression, disc guiding you to code S2348.

2. B. 64721-53

RATIONALE: Modifier 53 is the appropriate modifier to append since the surgeon elects to terminate the surgical procedure due to the patient’s blood pressure dropping which is threatening the well being of the patient.

3. C. 57

RATIONALE: Modifier 57 is the appropriate modifier to append to the Evaluation and Management Service since the evaluation or examination of the child’s condition lead the surgeon to make a decision to perform surgery. The surgical procedure of draining the hematoma is a major procedure that has a 90 day global period. Modifier 25 is only appended to minor procedures which have a 0-10 day global period. Modifiers 22 and 54 are only appended to procedure codes not Evaluation and Management services,

4. C. 62258-78

RATIONALE: The baby is having a complete removal of the cerebrospinal fluid shunt system with a replacement. This is indexed in the CPT® Index under Shunt, Brain, Removal guiding you to codes 62256–62258. Modifier 78 is the appropriate modifier to append for two reasons: (1) The CSF shunt had a complication and the baby had to return to the operating room following the initial procedure during the post-operative period; (2) The same surgeon that performed the initial procedure is also performing the removal and replacement of the shunt.
5. **A. 99212-24**

RATIONALE: Even though the patient is in a post-operative period from a surgery, the physician can bill this E/M visit and append modifier 24. The reason is that the physician had to perform an examination that was unrelated to her surgery (repair of the nerve to her finger). Modifiers 55 and 54 are only appended to surgical procedure codes not Evaluation and Management services.
Chapter 15

Section Review 15.1

1. **B. Balancing the strength of extraocular muscles**

   RATIONALE: Strabismus in the CPT® index takes you to codes 67311-67399, a subsection entitled Extraocular Muscles. All of these codes involve the muscles that move the eyeball, and most address adjusting one or more ocular muscles to correct an imbalance in the muscles that causes the eye to be pulled too much in one direction, causing disorders like crossed or wandering eyes.

2. **D. Iris**

   RATIONALE: The iris is the colorful muscle that contracts and expands in a measured fashion, controlling the amount of light that is permitted into the posterior segment of the eye. While the iris is involved in rationing light, it does not have any effect on the bending of light. As an opaque body, the iris has no refractive qualities.

3. **B. Air conduction**

   RATIONALE: The hearing of a patient would be interrupted by impacted ear wax, called cerumen. The wax would interrupt the air conduction of sound as it traveled through the ear canal across the tympanic membrane to the middle and inner ear. Bone conduction would not be affected by ear wax buildup.

4. **B. The middle ear**

   RATIONALE: The three ossicles (malleus, incus and stapes) are found in the middle ear. When sound travels by air into the external auditory canal, it causes the tympanic membrane to vibrate. The sound is then transferred from the membrane to the tiny ossicles. From the stapes, the vibration is transferred to the oval window, and into the fluid of the inner ear. From there, the signal is transmitted through the cochlear nerve.

5. **D. It holds the retina firmly against the blood-rich choroid**

   RATIONALE: Vitreous humor is a gel like substance in the posterior segment. In addition to its refractive qualities, the vitreous is responsible for holding the shape of the eyeball and keeping the retina pressed against the blood rich choroid in the posterior segment.

6. **C. Surgical repair of the eyelid.**

   RATIONALE: Blephar/o is a root word identifying the eyelid, and plasty indicates a surgical repair; therefore, the correct answer is C.

7. **A. Cornea**

   RATIONALE: Kerato/ is a root word identifying the cornea. In keratoconus, the cornea protrudes, causing a refraction error. Its cause is unknown, but it is thought to be hereditary.
8. D. The tympanic membrane is incised.

RATIONALE: Myring/a is a root word identifying the tympanic membrane and -otomy is a suffix indicating an incision, so D is the correct answer.

9. A. The inner ear

RATIONALE: The inner ear is responsible for balance in addition to conduction of sound, and therefore A is the correct answer. Vertigo, or extreme dizziness, is often a symptom of inner ear disorders including Meniere’s disease and vestibular neuronitis.

10. D. All of the above.

RATIONALE: All of the above are correct. The eye and ear both occur bilaterally, and their individual components occur bilaterally as well. Even within ophthalmology, you will find specialists in one area, for example, retinal specialists or ophthalmologists specializing in cataract surgery. The same is true for otorhinolaryngology: within that specialty, you will find subspecialists for hearing and vestibular disturbances. Because they are organs of communication, the eye and the ear are considered to be the most important sense organs in the body, and physicians work very hard to safeguard and optimize their patients’ sight and hearing.

Section Review 15.2

1. B. 250.51, 362.04

RATIONALE: The note under 362.0 reads, “Code first diabetes (249.5, 250.5).” However, 250.5 is not a valid code. It requires a fifth digit. You should not code from the instructions or notes, but use these notes to guide you to the right codes. Under 250.5, you are instructed in ICD-9-CM to select a fifth digit based on the patient’s status as Type I or Type II and whether the patient is stated as uncontrolled. Reading the notes, we can see the correct diabetes code is 250.51, and that it should be sequenced first. Code 362.04 exactly matches the documentation: mild nonproliferative diabetic retinopathy. B is the correct answer.

2. D. 780.91

RATIONALE: Look at the chief complaint—the reason for the visit—when considering the primary diagnosis. In this case, the mother thought the son has a recurring ear infection because of the child’s excessive crying. D is the correct answer because it is the chief complaint and no other diagnosis was found. The V70 and V72 codes are inappropriate because these codes describe routine exams in asymptomatic populations. Code 380.22 would be wrong because as a rule-out diagnosis it was not validated in the exam.
3. C. 192.0

RATIONALE: Although an acoustic neuroma is indexed to 225.1 Benign neoplasm of cranial nerve, the descriptor, “malignant” changes the way we would report this disorder. A note at the beginning of the Table of Neoplasms discusses the classifications in the columns of the table, and advises, “the guidance in the index can be overridden if one of the descriptors … is present.” Therefore, because the pathologist has said that this particular “acoustic neuroma” is malignant, the word “malignant” would override the index entry. Therefore, the correct code is 192.0 Malignant neoplasm of cranial nerves. It’s very important that we study and understand the information provided in the guidelines and notes within our code books. We don’t have to memorize the information, but we must be willing to look beyond the codes for the answers. Sometimes, the answers are in the instructional notes and guidelines.

4. D. 872.01, V03.7

RATIONALE: This is a simple open wound of the earlobe, reported with 872.01. Although you might consider an earring a “foreign body,” the earring was not part of the presenting problem; the wound was the presenting problem. The earlobe is clearly part of the auricle; therefore, nonspecific code 872.8 would be inappropriate. The patient needed tetanus prophylaxis, and this is reported with V03.7. There was no reported “exposure,” as is needed to report V01.89, but only a need for the vaccination. V06.5 reports tetanus in combination with another drug, which is not what was administered here. D is the correct answer.

5. A. 360.44

RATIONALE: Leucocoria is indexed to 360.44 and reports a symptom rather than an actual diagnosis. In leucocoria, a white mass behind the lens is visible to the physician upon examination of the eye. It can be indicative of retinoblastoma, a congenital retinal cancer, but until this diagnosis is confirmed, the symptom of leucocoria is the appropriate diagnosis to report.

6. B. 372.03

RATIONALE: Pink eye, a highly infectious form of mucopurulent conjunctivitis, is indexed to 372.03. Other mucopurulent conjunctivitis. This infection typically is accompanied by very bloodshot eyes and a heavy discharge.

7. D. 389.9

RATIONALE: Sometimes, the best we can do until we have more information is to report a nonspecific diagnosis. In this case, the patient has an unspecified hearing loss. No scientific study of the hearing loss was made, so 794.15 would not be appropriate. Instead, report the nonspecific loss with 389.9.
8. A. 996.69, 376.01, V43.0, V10.84

RATIONALE: A is the correct answer. It captures the entire story: The patient has an infection due to an implant (996.69) in her orbit (V43.0) causing cellulitis (376.01). The implant is the result of the patient’s previous cancer (V10.84). A note under 996.6 states, “Use additional code to identify specified infections.” Although we don’t have documentation of the infective agent, we do know the patient has orbital cellulitis and we code that secondarily. The V codes are informational. We wouldn’t report a foreign body because this is an implant, covered with 996.69. If you selected 996.63, infection due to nervous system implant, you probably didn’t use your index to determine the code, or you didn’t read the entire code set—“prosthetic orbital implant” is listed as an inclusion term under 996.69. If you selected cellulitis code 682.0, you neglected to review the “excludes” notes, which state orbital cellulitis is reported instead with 376.01.

9. C. 872.61

RATIONALE: The correct answer is C. Foremost, this is an acute injury. The codes in the 384.2 subcategory are for perforations that persist after an illness or injury is resolved. Excluded is “traumatic perforation (current injury)” Code 910.8 is for a superficial injury, but this isn’t superficial because it is in the middle ear. Do not confuse “simple” with “superficial.” Code 872.71 is “complicated,” and this wound is simple, without a foreign body or sign of infection. You also could report E codes to describe the circumstance of the injury: E920.8 Cutting and piercing as cause of accident. Plant thorn is an inclusion term in this category. Also consider reporting E016.1 Accident occurring while gardening or landscaping and E849.0 Place of occurrence, home. These E codes help establish the proper insurer for the services provided.

10. A. 365.9

RATIONALE: We don’t have a lot of information to work with here, so 365.9 Unspecified glaucoma is our best choice. In a medical office, you would have access to the entire patient record and to the physician to find out more about what type of glaucoma the patient has. The important thing to remember here is that the patient still has glaucoma, despite the normal (WNL is “within normal limits”) IOP (intraocular pressure). Without medication, the patient has glaucoma. Therefore, V12.49 would be inappropriate because it reports a history of a resolved condition.

Section Review 15.3

1. B. 65275

RATIONALE: The presence of the foreign body has no bearing on code selection. Note that the code reads “with or without removal of foreign body.” Key to code choice is the site of the injury (the cornea) and that it was a nonperforating injury. The topical anesthetic is bundled into the procedure, although the physician could bill separately for any IV sedation that was used or if a therapeutic contact lens was applied (92070).
2. B. 69105

RATIONALE: Although the area biopsied is skin, a code from the Auditory System chapter of CPT® is appropriate for this biopsy. CPT® tells us to report code 69100 for a biopsy of the external ear, and 69105 for a biopsy of the external auditory canal. The tragus is the protective cartilage knob anterior to the ear canal. Code 69105 is the correct code for a biopsy, by any method of the external auditory canal.

3. A. 65420-50

RATIONALE: A pterygium is an overgrowth of conjunctiva that forms in the nasal aspect of the eye and grows outward toward the cornea. Pterygium are reported in ICD-9-CM with codes from 372.4; 372.44 reports recurrent pterygium and would be the correct choice here. Excision of pterygium is reported separately from other conjunctival disorders, with codes 65420 and 65426. Because this was repaired simply, 65420 is the correct code. Modifier 50 indicates a bilateral procedure was performed.

4. C. 69310

RATIONALE: Consider the goal of this procedure: to reduce the stenosis in the external auditory canal. This is called a “meatoplasty” and is reported with 69310 for an acquired condition, regardless of how simple or complex the reconstruction is.

5. C. 67318, 67331, 67335

RATIONALE: Code 67318 is the only code listed that describes a procedure on the superior oblique muscle. In addition to 67318, we would report add on codes for adjustable suture and also for a patient with a history of ophthalmic surgery (67331). The medical history of ocular surgery makes the procedure more risky and difficult, and use of this code helps the physician report this complexity. Modifier 51 never is applied to add-on codes.

6. A. 69799

RATIONALE: The correct answer is A, an unlisted procedure. Round window implants are a new technology not yet assigned CPT® a code. The word “transducer” should have alerted you to the hearing aid component of this procedure. There is no new technology code for this type of procedure, so an unlisted code is your best option. The round window is the barrier between the middle and inner ear, but is still considered middle ear.

7. C. 68520

RATIONALE: The stone was embedded in the sac, which was removed. Therefore, you cannot bill for both removal of the stone and removal of the sac. Only 68520 would be reported. This is an unbundle that typically will be documented with payers, but logic should let coders know these two codes wouldn’t be reported together. The lacrimal gland is located near the eyebrow; the lacrimal sac is the upper dilated end of the lacrimal duct, aligned with the nostril. Don’t confuse the two sites.
8. D. 69637

RATIONALE: When you are looking at operative notes, use a highlighter to note the key words on the note. Here, we note the approach, mastoidotomy. Most important to code selection, though is the use of a prosthetic implant, reported with 69637.

9. C. 67120

RATIONALE: If you didn’t know that an aqueous shunt is implanted material in the extraocular posterior segment, you could come to that understanding by reviewing all the aqueous shunt codes in the Eye and Adnexa section of CPT®. Within the aqueous shunt subsection is the parenthetical note, “For removal of implanted shunt, use 67120.”

10. C. 92012

RATIONALE: Intermediate ophthalmological services are described in CPT® as the evaluation of a new or existing condition of the eye not requiring comprehensive services. This would be reported with 92002 for a new patient, or 92012 for an existing patient. This service is for an existing patient, so 92012 is the correct code. Documentation does not support any level of E/M.
Chapter 16

Section Review 16.1

1. **A. 00528**
   
   RATIONALE: Thoracoscopy in the Index provides the above four choices. All of these codes are related to thoracoscopy. The coder must review the codes in the anesthesia section to determine that 00528 describes a diagnostic procedure, without an indication of one-lung ventilation utilization.

2. **D. 00406**
   
   RATIONALE: Mastectomy is not listed in the Index. The coder must look under “Breast,” which provides a range of three choices. The coder must review the codes in the anesthesia section to determine that 00406 is the appropriate code selection.

3. **B. 00790**
   
   RATIONALE: A cholecystectomy is the surgical removal of the gallbladder. If a coder is not familiar with this surgery or terminology, look under “Cholecystectomy” in the Index and review the surgical section under 47562. The surgery is described as removal of the gallbladder—identifying the anatomical area as upper abdomen. Reference the Index for Anesthesia, Abdomen, Intraperitoneal, and you are directed to 00790, which describes this procedure including laparoscopy.

4. **A. 01622**
   
   RATIONALE: Diagnostic arthroscopy is not listed in the Index. The coder must either look under “Arthroscopic Procedures, Shoulder” or “Shoulder.” Both provide a range of code choices. The coder must review the codes in the anesthesia section to determine that 01622 is the appropriate code selection.

5. **D. 01638, 64416-59**
   
   RATIONALE: In this example, it is quickest to look at the two anesthesia code selections first. 01630 is not a total shoulder replacement. Since the brachial plexus was requested for postoperative pain management, it is appropriate to report separately. However, 64415 describes a single injection and 01996 is reported with epidurals—not brachial plexus blocks, as noted below the description of 64415. Therefore, the correct answer is 01638, 64416-59. Modifier 59 is appended because nerve blocks are bundled with anesthesia codes. In this case, the block is for postoperative pain and is reported separately.
6. B. 01967

RATIONALE: The continuous epidural catheter from the surgical section (62319) is a flat-fee code and does not accurately describe the anesthesia service. 01961 describes a cesarean delivery. Reference the Index for “Anesthesia, Childbirth, Vaginal Delivery.” The description of 01967 includes replacement of the catheter during labor. Because the code includes any repeat needle placement or replacement of the epidural during labor, it is not reported twice.

Section Review 16.2

1. A. 577.9

RATIONALE: Pancreas is not listed in the Index under “Mass;” however, “Mass, specified organ NEC” indicates the coder must look under Disease of specified organ or site. “Disease, pancreas” is coded correctly as 577.9. The coder should not default to the Neoplasm Table because the term “mass,” unless otherwise stated, should not be coded as a neoplasm.

2. D. 218.9

RATIONALE: The preoperative diagnosis is disregarded in this case because a more definitive diagnosis was determined following surgery. Although “Fibroid” under the Alphabetic Index indicates see also “Neoplasm, connective tissue, benign—uterus” is listed under Fibroid as 218.9, which takes precedence over the Neoplasm Table.

3. C. 374.84, V15.80

RATIONALE: The reason for the anesthesiologist’s involvement for the MAC in the surgery is the patient’s history of failed sedation. The eye cyst is first-listed as it is the medical necessity for the anesthesia care and V15.80 is an additional diagnosis to explain the need for anesthesia care. Also, as noted in the Tabular, V15.80 cannot be listed as a primary diagnosis.

4. C. 715.96

RATIONALE: The patient’s previous surgery has no relevance to the anesthesia for the knee surgery. DJD, using either Degeneration or Disease of joint leads the coder to Osteoarthrosis. The coder should not assign 715.96 without checking the numeric Index. As indicated in the Tabular at the beginning of Chapter 13, the fifth digit “6” includes the knee joint.

5. C. 823.00

RATIONALE: A linear fracture identifies this as a closed fracture (See Notes above Fracture). Using the Alphabetic Index under “Fracture, tibia, proximal end” sends the coder to upper end. The fifth digit “0” identifies the tibia alone.
Section Review 16.3

1. C. Arterial line placement
RATIONALE: The placement of an arterial line for intraoperative monitoring is not included in the base value services listed in the Anesthesia Guidelines.

2. B. When the anesthesiologist begins to prepare the patient
RATIONALE: Anesthesia time begins when the anesthesia provider begins to prepare the patient for the induction of anesthesia, as listed in the Anesthesia Guidelines.

3. A. The anesthesia code representing the most complex procedure is reported
RATIONALE: Only the anesthesia code representing the most complex procedure is reported. The most complex procedures are usually the highest base unit value service.

4. D. P1
RATIONALE: A normal healthy patient is reported as P1 as listed in the Anesthesia Guidelines. No additional value is recognized.

5. D. None of the above
RATIONALE: Qualifying circumstances may not be separately reported if the anesthesia code already takes difficulty into consideration.

6. B. 93503
RATIONALE: Coder may look under either “Insertion” or “Catheterization” to find the Flow Directed (93503) catheter code listed under Cardiac. This service may not be reported as a right heart catheterization (93451) because it is a diagnostic procedure performed to assess right heart function. Catheterization of the pulmonary artery (93503) is a right heart catheterization which is performed for monitoring purposes.

7. D. 31500
RATIONALE: The anesthesiologist is not providing an intubation for a patient undergoing anesthesia. An emergency intubation is correctly reported as 31500.

8. C. -74
RATIONALE: Although not typically reported by physicians, insurance companies may require specific modifiers. The 74 modifiers best describes an anesthesia service that was discontinued after administration of anesthesia (complications were during surgery) in an ASC.
Section Review 16.4

1. C. 00142-AA-QS

RATIONALE: An anesthesiologist who is performing personally reports her service to Medicare with an “AA” modifier. Because the service was performed under MAC, a “QS” modifier is also reported.

2. B. 01961-QK and 01961-QX

RATIONALE: An anesthesiologist who is medically directing reports her service separately from the CRNA, depending on the number of concurrent cases. Because there was more than one concurrent (QY) case and fewer than five concurrent (AD) cases, the appropriate modifiers to report are “QK” for the physician claim and “QX” for the CRNA claim. A QZ modifier indicates a case performed by a CRNA without medical direction by a physician.

3. D. AD and QX

RATIONALE: An anesthesiologist who is medically supervising reports his/her service separately from the CRNA, depending on the number of concurrent cases. Because there are five concurrent cases, the appropriate modifiers to report are AD for the physician claims and QX for the CRNA claims. Reporting a QZ modifier indicates a case performed by a CRNA without medical direction by a physician. Only one claim is filed for the case (the CRNA claim).

4. B. QZ

RATIONALE: A CRNA without medical direction is reported appropriately with a “QZ” modifier.

5. C. G9

RATIONALE: Anesthesia care for a patient who is undergoing MAC and has a history of severe cardiopulmonary disease is reported appropriately with a G9 modifier. The additional modifier QS is not necessary because the description for G9 includes monitored anesthesia care.
Chapter 17

Section Review 17.1

1. **D. Superior and inferior**

   RATIONALE: The axial plane, also known as the transverse plane, slices the body horizontally and cuts the body into inferior and superior sections.

2. **C. At an angle, neither frontal or lateral**

   RATIONALE: An oblique position is a slanted position where the patient is lying at an angle which is neither prone nor supine.

3. **A. AP**

   RATIONALE: AP is the abbreviation for anteroposterior where the projection enters the front of the body and exits through the back of the body. Because the patient is lying on their back, it can not be oblique.

4. **D. Coronal**

   RATIONALE: The coronal plane is also known as the frontal plane and divides the body into front (anterior) and back (posterior) sections.

5. **B. Projection**

   RATIONALE: The projection is the path the X-ray beam takes through the body.

Section Review 17.2

1. **B. 611.72**

   RATIONALE: When a test is ordered for a sign or symptom, and the outcome of the test is a normal result with no confirmed diagnosis, the coder will report the sign or symptom that prompted the physician to order the test. Because the test was ordered for a lump in the breast, but the outcome is normal, the lump in the breast (611.72) is reported as the diagnosis.

2. **D. 823.82**

   RATIONALE: The final diagnosis is available at the time of reporting so the final diagnosis should be used instead of the sign or symptom. The final diagnosis of a fracture of the tibia and fibula should be reported as the diagnosis.
3. **B. 793.0, 473.9, 478.30**

RATIONALE: The findings of the CT were nonspecific and would not be considered a final diagnosis. The first diagnosis reports the nonspecific findings. Because the findings were inconclusive, you also would report the signs and symptoms for which the CT was ordered.

4. **C. V72.5**

RATIONALE: For encounters for routine radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign V72.5. Because there were no signs or symptoms for the chest X-ray, and it was routinely performed as part of a preventive medicine exam, ICD-9-CM V72.5 is reported.

5. **D. V72.83**

RATIONALE: The pre-operative exam is a general preoperative exam. When an X-ray is performed as part of a general preoperative exam, ICD-9-CM code V72.83 should be used.

Section Review 17.3

1. **D. 70390, 527.4**

RATIONALE: A contrast radiography of the salivary gland and ducts is considered sialography. Code 70390 describes Sialography supervision and interpretation. The patient is diagnosed with salivary fistula indexed under Fistula/salivary duct or gland referring you to code 527.4.

2. **C. 74176**

RATIONALE: Both a CT of the abdomen and of the pelvis was obtained. There is one code to report for both anatomical areas taken at the same time. “Without contrast” codes would be used.

3. **B. 76010**

RATIONALE: In the index, look up “X-ray.” Then, find “nose to rectum, Foreign body.” The index guides you to 76010. Turning to 76010, you will find this code is applicable to a child only. This is due to the length of the nose to rectum in a child, versus the length in an adult.

4. **C. 70150**

RATIONALE: Three views of the facial bones (Waters view, Caldwell view, and lateral view) were ordered. Looking in the index, “X-ray, facial bones” guides you to 70140–70150. Code 70150 is for a complete, minimum three view X-ray of the facial bones.
5. D. 72156

RATIONALE: In the CPT® Index, “magnetic resonance imaging, spine, cervical” guides you to codes 72141–72142, 72156–72158. Because both without contrast and with contrast were used for this cervical MRI, CPT® code 72156 would be selected.

Section Review 17.4

1. B. 76705

RATIONALE: Ultrasound of the abdomen includes the liver, gall bladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava. Because the ultrasound was of only the liver, it would be considered a limited abdominal ultrasound.

2. D. 76815

RATIONALE: The position of the fetus is the reason for the test; therefore, the ultrasound is limited. The description of 76815 includes 1 or more fetuses and thus the code would be reported once only.

3. B. 76775

RATIONALE: In the CPT® index, “Ultrasound, Kidney” guides you to range 76700-76776. CPT® code 76776 is an ultrasound for a transplanted kidney, including real-time and duplex Doppler with image documentation. In our scenario, duplex Doppler of the kidney is not performed. The parenthetical instruction under CPT® 76776 indicates to report 76775 for an ultrasound of transplanted kidney without duplex Doppler. Therefore, the correct code is 76775.

4. C. 77055, 77051

RATIONALE: The physician has ordered a unilateral diagnostic mammogram. CPT® 77055 is the code for a unilateral diagnostic mammography. The use of computer aided detection software is reported by the add-on code 77051 for a diagnostic mammogram.

5. A. 76506

RATIONALE: In the CPT® index, echoencephalography guides you directly to 76506.
Section Review 17.5

1.  B. 77427

RATIONAL: Radiation therapy management is based on the number of fractions. Each time the patient receives the radiation is considered a fraction. If the patient receives radiation two times in one day, it is considered two fractions. This patient had a total of 6 fractions of radiation. Code 77427 indicates five fractions. According to the radiation treatment management guidelines, when a patient has one or two fractions left at the end of a course of treatment, it is not separately billable. 77431 is used when the entire course of treatment consist of only 1 or 2 fractions. The correct code to report for the management would be 77427.

2.  D. 76499

RATIONAL: Dual energy X-ray absorptiometry (DEXA) studies are found in the code range 77080-77082. Under this range of codes is a parenthetical instruction stating to use 76499 for a DEXA body composition study.

3.  A. 77777

RATIONAL: In this case, brachytherapy is performed using interstitial radiation seeds. The code is determined based on the number of radioactive sources. In this case there are nine, which is reported as intermediate with code 77777. Review the CPT® coding guidelines for the definition of simple, intermediate, and complex for clinical brachytherapy.

4.  D. 19102-RT, 77031-26

RATIONAL: In this case a needle biopsy is performed on the right breast using stereotactic imaging guidance. You need to select the code for the biopsy. In this case, it is a needle biopsy. 19102 is the correct code to report a biopsy obtained using imaging guidance. There is a parenthetical note following 19102 that states to report the imaging guidance. In this case, it is stereotactic which is reported with 77031. Modifier RT is used to indicate the right breast. Modifier 26 is appended to report the professional component.

5.  A. 77080

RATIONAL: DEXA is dual-energy X-ray absorption. The site is of the spine, which is part of the axial skeleton. From the CPT® index, look up “bone density/axial skeleton.” In this case one site (spine) is involved in the study. The correct code is 77080.
Chapter 18

Section Review 18.1

1. C. Disease

RATIONALE: The word root path means “disease”. The suffix -logy is “study of”.

2. D. Microbiology

RATIONALE: The root words micro (small) and bio (life) combined with -logy describe the study of small life forms.

3. B. Forensic

RATIONALE: The word forensic refers to information related to an investigation of legal matters. A forensic pathologist examines specimens for causes of disease or death related to legal matters.

4. A. Qualitative

RATIONALE: A qualitative test determines the presence or absence of the substance.

5. C. Quantitative

RATIONALE: A quantitative test determines the amount of a substance found in the specimen. A qualitative test determines the presence or absence of the substance.

Section Review 18.2

1. C. V01.5

RATIONALE: The codes in category V01 are for exposure to a disease without signs or symptoms of infection.

2. C. 174.9

RATIONALE: Always code the most specific diagnosis that is known. When a diagnosis of carcinoma of the breast has been confirmed, it is inappropriate to code a less specific diagnosis, no matter what reason was for the original test.
3. B. 714.0, V58.64

RATIONALE: Code both the arthritis and the long-term use of NSAIDs. Although the use of the NSAID is the reason for the test, the codes in category V58.6 cannot be used alone or as the first diagnosis code. Note: Code 714.0 indicates that an additional code is to be used to identify manifestation.

Myopathy (359.6)
Polyneuropathy (357.1)

These codes would be used only if the manifestation was indicated in the report.

4. B. V10.46

RATIONALE: Once cancer has been excised and there is no further treatment directed toward the cancer site without recurrence, code a personal history of malignancy code. In this case, use V10.46.

5. D. 795.09

RATIONALE: Choose a code that identifies unspecified previous abnormal findings on cervical Pap smear. Although the second test results came back normal, the previous abnormal finding supports the need for a repeat test.

Section Review 18.3

1. A. 85530

RATIONALE: PTT stands for protamine tolerance test. This can be found in the Index, under Heparin, Protamine Tolerance Test.

2. C. 81002-QW

RATIONALE: 81002 is for dipstick urinalysis. Modifier 26 is not needed in the physician office but QW is required as this is a CLIA waived test.

3. B. 80076, 82565

RATIONALE: Code the panel anytime all of the tests listed in the panel are completed. If additional tests are also performed, they are coded separately.

4. C. 88040

RATIONALE: Services related to legal investigations and trials are forensic examinations.
5. D. 86359

RATIONALE: Code 86359 is for total T-cell count. If other studies were performed, they were not ordered and may not be billed, not matter how seemingly appropriate.
Chapter 19

Section Review 19.1

1. C. Outpatient consultation

RATIONALE: Dr. Smith has sent the patient for a consultation to Dr. Parker. Dr. Parker evaluates the patient and provides a written report back to the requesting physician. An evaluation and management code from outpatient consultation should be selected.

2. B. Preventive medicine, established patient

RATIONALE: The mother "brings her 2-year-old back to Dr. Denton" indicates this is an established patient. This is a well child exam with no complaints so a code from preventive medicine, established patient, would be selected. The preventive medicine, individual counseling codes are used for risk reduction such as diet and exercise, substance abuse, family problems, etc.

3. D. Initial observation care

RATIONALE: The patient came through the Emergency Department. However, the patient was admitted to observation. The guidelines for Initial Observation Care tell us that all services provided by the admitting physician for the same date of service are included in the initial hospital care, such as emergency department services. If the patient was discharged on the same date of service, a code from Observation or Inpatient Care Services (Including Admission and Discharge Services) would be selected.

4. C. Nonbillable

RATIONALE: The follow up visit from the neurosurgeon is to follow up with care given during the surgery; therefore, it would not be considered a consultation. Postoperative care after the removal of cancer from the spinal cord is bundled in the surgical procedure. Because it would be within the global period, it would not be separately reported.

5. A. Office visit, new patient

RATIONALE: Consultations performed at the request of a patient are coded using office visit codes. Because she had not seen Dr. Howard before, this would be considered a new patient visit.
### Section Review 19.2

1. **B. Expanded problem focused**

**RATIONALE:**

<table>
<thead>
<tr>
<th>History</th>
<th>Brief (–3)</th>
<th>Brief (1–3)</th>
<th>Extended (4 or more)</th>
<th>Extended (4 or more)</th>
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<tr>
<td><strong>HPI</strong></td>
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<td>Location</td>
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<td>Severity</td>
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<td>Assoc Signs</td>
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<td>&amp; Symptoms</td>
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<td>Extended (2-9 systems)</td>
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<td>Card/Vasc Musculo Psych</td>
<td>All other negative</td>
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<td>Resp ENT, mouth</td>
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<td>Endo</td>
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<tr>
<td><strong>PFSH</strong></td>
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<td>None</td>
<td>Pertinent (1 history area)</td>
<td>Complete (2 (est) or 3 (new) history areas)</td>
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<tr>
<td>Past history</td>
<td>None</td>
<td>None</td>
<td>Pertinent (1 history area)</td>
<td>Complete (2 (est) or 3 (new) history areas)</td>
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<td>(current meds, past illnesses, operations, injuries, treatments)</td>
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<tr>
<td>Family history</td>
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<td>None</td>
<td>Pertinent (1 history area)</td>
<td>Complete (2 (est) or 3 (new) history areas)</td>
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<td>(a review of medical events in the patient’s family)</td>
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<td>Social history</td>
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<td>Complete (2 (est) or 3 (new) history areas)</td>
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<td>(an age appropriate review of past and current activities)</td>
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</table>

**CC:** Follow-up of hospitalization for pneumonia.

**HPI:** Quality—doing well

**ROS:** Respiratory—hosp for six days, IV antibiotics, Singulair®, doing well with breathing since.

**PFSH:** None
2. **B. Expanded problem focused**

**RATIONALE:**

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<thead>
<tr>
<th>History</th>
<th>Brief (1–3)</th>
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<td>Location Severity Timing Modifying Factors</td>
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<tr>
<td>Quality Duration Context Assoc Signs &amp; Symptoms</td>
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</table>

**CC:** Asthma exacerbation

**HPI:** Duration—2–3 days

Severity—difficulty breathing

Assoc $ & $: cough

Quality—maybe has slight productive cough

**ROS:** Constitutional—denies fever or chills

Respiratory—has not been able to locate inhalers for a week

**PFSH:** None
3. **B. Expanded problem focused**

**RATIONALE:**

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<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
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**CC:** skin lesions

**HPI:** Location—forehead & lateral to right eye

Duration—about a year

**ROS:** Integumentary—history of squamous cell carcinoma

Stated “Otherwise well,” but this is not an indication that all other systems were reviewed.

**PFSH:** Past, Family, and Social all reviewed as it relates to skin.
### 4. B. Expanded problem focused

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**CC:** Fever

**HPI:** Duration—less than one day

Severity—high fever

Associated S & S—decreased appetite

**ROS:** GI—no vomiting or diarrhea

Resp—parents unaware of any cough

Rest of review of systems reviewed and negative: Complete ROS

**PFSH:** Personal history—current meds

Social history—not exposed to second hand smoke
5. B. Expanded problem focused

**RATIONALE:**

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<td>GI—unremarkable for nausea &amp; vomiting</td>
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<tr>
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<tr>
<td>Note: only 2 of 3 PFSH are needed for complete for Emergency Department, but all three are needed for a complete PFSH for a hospital admit.</td>
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</table>
Section Review 19.3

1. C. Detailed

RATIONALE:
Organ Systems: Constitutional, Skin, Respiratory, Cardiovascular. There are four organ systems examined with detailed documentation. The level of exam is Detailed.

2. C. Detailed

RATIONALE:
Organ Systems: Constitutional, Genitourinary, Gastrointestinal. There are three organ systems examined with detailed documentation. The level of exam is Detailed.

3. D. Comprehensive

RATIONALE:
Organ Systems: Constitutional, ENMT, Lymphatic, Respiratory, Cardiovascular, Gastrointestinal, Skin, Musculoskeletal. There are eight organ systems examined. The level of exam is Comprehensive.

4. B. Expanded problem focused

RATIONALE:
Body Areas: Neck, Abdomen
Organ Systems: Constitutional, ENMT, Respiratory
There three organ systems examined and two Body Areas. This is a limited exam of the affected body areas. The level of exam is Expanded Problem Focused.

5. D. Comprehensive

RATIONALE: Organ Systems: Constitutional, Eyes, ENMT, Respiratory, Cardiovascular, Gastrointestinal, Integumentary, Neurologic, Lymphatic, Musculoskeletal. Ten organ systems were examined. The level of exam is Comprehensive.
Section Review 19.4

1. B. Low

RATIONALE: The patient is in for follow up of chronic conditions. The conditions are both established and stable (two points). There is no data reviews and moderate risk (two stable chronic conditions). Medical Decision Making is Low.

2. D. High

RATIONALE: New problem to examiner, additional workup—dialysis (four points); Labs, EKG, and X-Ray Reviewed (three points); Risk is High (chronic illness posing a threat to life). The medical decision making is high.

3. B. Low

RATIONALE: Established problem worsening (two points); Ultrasound reviewed (one point), Risk is moderate (simple mastectomy). The medical decision making is Low.

4. D. High

RATIONALE: Three problems worsening (six points); Labs reviewed (one point); Chronic illness posing a threat to life (Exacerbation of Chronic Heart Failure, Poorly Controlled Hypertension, Worsening Acute Renal Failure due to cardio-renal syndrome). The medical decision making is high.

5. C. Moderate

RATIONALE: Two problems worsening (4 points). No data reviewed with moderate risk (elective major surgery). The medical decision making is Moderate.

Section review 19.5

1. B. 99213

RATIONALE: Established patient codes require two of three key components be met to determine a level of visit. In this case, the expanded problem focused exam and low level of medical decision making support a level III established patient office visit (99213).

2. C. 99223

RATIONALE: Initial hospital care codes require all three key components be met to determine a level of visit. In this case, the comprehensive history and exam, and the high level of medical decision making support a 99223.
3. **B. 99202**

RATIONALE: For a new patient visit, all three key components must be met:

History—HPI (Extended), ROS (Extended), PFSH (none) = EPF

Exam—Expanded problem focused (limited exam of ears, nose, throat, and neck)

MDM—Moderate for the prescription drug management.

The documentation supports 99202.

4. **C. 99309**

RATIONALE: For subsequent nursing facility care codes, two of three key components must be met.

History—(Extended), ROS (Extended), PFSH (1-Pertinent) = Detailed

Exam—Detailed exam of Eyes, ENT, Neuro.

MDM—New problem with additional workup, lab ordered, moderate risk (undiagnosed new problem with uncertain prognosis) = moderate medical decision making.

The documentation supports 99309.

5. **B. 99243**

RATIONALE: A consultation requires all three key components be met to support the level of visit.

History—HPI (extended), ROS (Extended), PFSH (complete) = Detailed

Exam—Detailed

MDM—New problems, no credit given in the EM for the EMG or Nerve conduction study because they will be billed with a separate CPT® code. The level of risk is moderate (elective major surgery).

This supports a 99243.
Chapter 20

Section Review 20.1

1. B. 90375, 96372

RATIONALE: Code for the product and the administration for rabies immune globulin. In the CPT® Index, look for Immune Globulin, rabies and you are directed to 90375–90376. Since there is not mention of heat-treated, 90375 would be the appropriate code. Reading the guidelines for immune globulins, codes 96365-96368, 96372, 96374, or 96375 should be reported as appropriate for the administration. This is an injection so 96372 would be the appropriate code.

2. A. 90658, 90732, 90471, 90472

RATIONALE: The patient received two vaccines: influenza and pneumonia. Each is charged separately (90658, 90732), depending upon the age category. Code 90471 describes injection of one vaccine. The add-on code 90472 describes each additional vaccine. Add-on codes (+) may not be reported independently, but are a composite of the basic code.

3. A. 90717, 90471

RATIONALE: Code for both the vaccine and the administration. Codes 90717 and 90471 describe the yellow fever vaccine and the immunization administration for 1 vaccine.

Section Review 20.2

1. C. 90847

RATIONALE: A family therapy session with patient present is reported with 90847. The payer may request documentation of those present and areas of discussion.

2. B. 90882

RATIONALE: The services performed by the psychotherapist include environmental interventions by communicating with the social agency. To locate the correct code, look for “Psychiatric Treatment” in the index, and find environmental intervention. Code 90882 describes intervention on a psychiatric patient’s behalf with agencies, employers of institutions.

3. D. 90806

RATIONALE: Code 90806 describes a 45-50 minute outpatient/office encounter for behavior modification and support, insight directed.
Section Review 20.3

1. A. 90911

RATIONALE: Code 90911 describes biofeedback training for urethral sphincter.

Section Review 20.4

1. A. 90937

RATIONALE: Code 90937 describes the hemodialysis procedure requiring physician re-evaluation with or without substantial revision of dialysis.

2. C. 90969 x 25

RATIONALE: Code 90969 describes ESRD related services for dialysis less than a full month of service per day, for patients 12–19 years of age. In this case, the patient is 18 years old and she was hospitalized on the 26th day of the month. This was not a full month of ESRD related services; therefore, 90969 is reported with 25 units for each day. See the example in CPT® under End-Stage Renal Disease Services.

3. C. 90989

RATIONALE: Code 90989 describes a completed course of dialysis training for the patient and a helper.

Section Review 20.5

1. D. 93926

RATIONALE: Code 93926 describes duplex scan, limited or unilateral study, of the lower extremity arteries, including digits. Swelling was only present in the left foot, which was the only extremity that was scanned.

2. D. 93990

RATIONALE: Code 93990 describes a scan of hemodialysis access and includes arterial inflow, body of access and venous outflow.

3. B. 93975

RATIONALE: Code 93975 describes a complete scan of arterial inflow and venous outflow of the abdominal, pelvic, scrotal contents, and/or retroperitoneal organs.
Appendix A Answers and Rationales

**Section Review 20.6**

1. **A. 95004 x 12**

   **RATIONALE:** Code 95004 describes scratch tests with allergenic extracts, immediate type of reaction. Code includes interpretation and report. Report the code with the correct number of units for the number of tests.

2. **C. 95130**

   **RATIONALE:** Code 95130 describes provision of allergenic extract and injection of a single stinging insect venom.

3. **B. 95144 x 4**

   **RATIONALE:** Code 95144 describes preparation and provision of antigen for immunotherapy in single dose vials. Show number of vials in unit field.

**Section Review 20.7**

1. **D. 96040 x 3**

   **RATIONALE:** Code 96040 describes genetic counseling by a qualified counselor for each 30 minutes of face-to-face time. Report three units for the session lasting 1.5 hours. Report E/M codes if the counseling is provided by a physician.

**Section Review 20.8**

1. **B. 96150 x 8**

   **RATIONALE:** Code 96150 describes the clinical interview and behavior observation and assessment, face-to-face per 15 minutes. The encounter lasted 2 hours. The code is reported with 8 units. Time should be documented in the psychologist’s report.

2. **C. 96111**

   **RATIONALE:** Code 96111 describes extensive testing for developmental assessment, including interpretation and report.

3. **D. 96101 x 13**

   **RATIONALE:** Code 96101 describes multiple testing, face-to-face time with the patient and time interpreting and preparing the report, per one hour of time. Number of units reported is 13, and the time must be documented in the psychologist’s record.
Section Review 20.9

1. A. 96360, 96361
   RATIONALE: Codes 96360 and 96361 describe hydration infusion for two hours. Code 96360 covers the first hour and 96361 covers the second hour. The add-on code 96361 cannot be reported independently, but only in addition to 96360. The fluids that are infused are separately reported, using the appropriate code from HCPCS II. Dehydration is the diagnosis code to support the medical necessity of the infusion.

2. B. 96522
   RATIONALE: Code 96522 describes refill and maintenance of an intra-arterial or intravenous implanted pump for drug delivery. The drug is separately reported with HCPCS II codes.

3. D. 96450
   RATIONALE: Code 96450 describes intrathecal delivery of chemotherapy agents. The code includes the spinal puncture. The drugs are separately coded using HCPCS II codes. Spinal catheter placement is included in the technique.

Section Review 20.10

1. A. 97001-GP, 97110-GP x 4
   RATIONALE: At the first visit, the therapist typically evaluates the patient and problem and determines a suitable series of exercises to achieve the goal. Code 97001 is reported for the physical therapy evaluation and 97110 describes exercises performed to develop strength and range of motion, per 15 minutes of time. For one hour, report four units.

2. C. 97001-GP, 97110-GP x 3, 97116-GP
   RATIONALE: The therapist evaluates the patient and problem at the first visit and determines the best exercises to use. Gait training will be necessary and will likely increase in time at subsequent therapy sessions. Code 97001 is reported for the evaluation, 97110 for the exercises and 97116 for the gait training. Report three units for the exercises to cover 45 minutes.

3. A. 97760
   RATIONALE: Code 97760 describes orthotic management and fitting for the lower extremity per 15 minutes of time. Report the orthotic device separately using HCPCS II codes.
Section Review 20.11

1. C. 97802 x 2

RATIONALE: Code 97802 describes the initial medical nutrition assessment interview per 15 minutes of face-to-face time. Report two units for the 30-minute session.

Section Review 20.12

1. C. 97813

RATIONALE: Code 97813 describes a 15-minute face-to-face encounter using acupuncture with electrical stimulation.

Section Review 20.13

1. B. 98925

RATIONALE: Code 98925 describes manipulation of 1–2 body regions. Both feet were manipulated during the session.

Section Review 20.14

1. A. 98943

RATIONALE: Code 98943 describes extraspinal manipulation, one or more regions.

2. C. 98940

RATIONALE: Code 98940 describes manipulation of 1-2 spinal regions.

3. A. 98941

RATIONALE: Three regions of the spine were manipulated. Code 98941 describes manipulation of 3–4 regions.

Section Review 20.15

1. D. 98962 x 3

RATIONALE: A Registered Dietitian is a nonphysician practitioner that is qualified to educate at risk patients in diet management. Code 98962 describes 5–8 patients. Report 3 units for 90 minutes.
2.  B.  98960 x 2

RATIONALE: Code 98960 describes face-to-face education and training with one patient for each 30 minutes. Report two units for one hour.

Section Review 20.16

1.  D.  98967

RATIONALE: Code 98967 describes a telephone discussion with a qualified health care professional lasting 11–20 minutes not leading to an appointment within the next 24 hours or the soonest available appointment nor relating to an E/M service within the previous seven days.

2.  D.  98969

RATIONALE: Code 98969 describes an on-line medical evaluation with a qualified health care professional not relating to a management and assessment service within the previous seven days and not leading to the next urgent care appointment: 21–30 minutes.

Section Review 20.17

1.  D.  99075

RATIONALE: Physicians may be called upon to give a medical opinion about cause of death in a court proceeding. Code 99075 is designated for medical testimony.

2.  B.  99027 x 13

RATIONALE: Code 99027 describes mandated on call personnel that are out of the hospital, but must return upon notification.

3.  A.  99000

RATIONALE: Physicians often contract with an outside laboratory to handle specimens and provide reports. The laboratory will arrange for courier pick up and charge the physician a handling fee.

4.  D.  99050

RATIONALE: Code 99050 describes services provided on holidays & weekends that are outside of normal business hours.
Section Review 20.18

1. D. 99175
   RATIONALE: Code 99175 describes administration of Ipecac to induce emesis for emptying the stomach.

2. B. 99170
   RATIONALE: Code 99170 describes an anogenital examination with colposcopic magnification on a child for suspected trauma.

Section Review 20.19

1. D. 99507
   RATIONALE: Patients often discharge to home when they no longer need the hospital level of care, but still need some assistance. The physician typically arranges the care with a home care agency that sends a qualified person to the patient’s home. Code 99507 describes home care for maintenance of catheters.

2. A. 99505
   RATIONALE: Code 99505 describes a home care visit from a nonphysician practitioner to manage stomas and ostomies.

3. D. 99601
   RATIONALE: Code 99601 describes home infusion of a specialty drug per visit, up to two hours.

Section Review 20.20

1. D. 99606, 99607
   RATIONALE: Code 99606 describes the initial 15-minute consultation with a pharmacist for an established patient. Code 99607 describes an additional 15 minutes. Both are reported for the 23-minute encounter.