

## 2012 Final

### Multiple Choice

Identify the choice that best completes the statement or answers the question.

- \_\_\_\_\_ 1. The Medicare program is made up of several parts. Which part is affected by the Centers for Medicare and Medicaid Services - hierarchical condition categories (CMS-HCC)?
- a. Part A
  - b. Part B
  - c. Part C
  - d. Part D
- \_\_\_\_\_ 2. Healthcare providers are responsible for developing \_\_\_\_\_ and policies and procedures regarding privacy in their practices.
- a. Patient hotlines
  - b. Work around procedures
  - c. Fees
  - d. Notices of Privacy Practices
- \_\_\_\_\_ 3. A covered entity may obtain consent of the individual to use or disclose protected health information to carry out all but what of the following?
- a. for public use
  - b. treatment
  - c. payment
  - d. healthcare operations
- \_\_\_\_\_ 4. How many components should be included in an effective compliance plan?
- a. 3
  - b. 4
  - c. 7
  - d. 9
- \_\_\_\_\_ 5. According to the AAPC Code of Ethics, Member shall use only \_\_\_\_\_ and \_\_\_\_\_ means in all professional dealings.
- a. private and professional
  - b. efficient and inexpensive
  - c. legal and profitable
  - d. legal and ethical
- \_\_\_\_\_ 6. Medicare Part D is what type of insurance?
- a. A Medicare Advantage program managed by private insurers
  - b. Hospital coverage available to all Medicare Beneficiaries
  - c. Prescription drug coverage available to all Medicare Beneficiaries
  - d. Physician coverage requiring monthly premiums
- \_\_\_\_\_ 7. Which option below is NOT a covered entity under HIPAA?
- a. Medicare
  - b. Medicaid
  - c. BCBS
  - d. Worker's' Compensation
- \_\_\_\_\_ 8. The 2012 OIG Work Plan prioritizes which of the following topics for review?
- a. Dystrophic nail care
  - b. Lesion removal
  - c. E/M services during the global surgery periods
  - d. Fracture repair
- \_\_\_\_\_ 9. Muscle is attached to bone by what method?
- a. Tendons, ligaments, and directly to bone
  - b. Tendons and aponeurosis
  - c. Tendons, aponeurosis and directly to bone
  - d. Tendons, ligaments, aponeurosis, and directly to bone
- \_\_\_\_\_ 10. What is affected by myasthenia gravis?
- a. Neuromuscular junction
  - b. Muscle belly
  - c. Muscle/bone connection
  - d. Bone
- \_\_\_\_\_ 11. Which respiratory structure is comprised of cartilage and ligaments?
- a. Alveoli
  - b. Lung
  - c. Bronchiole
  - d. Trachea

- \_\_\_\_\_ 12. Upon leaving the last portion of the small intestine, nutrients move through the large intestine in what order?
- Cecum, transverse colon, ascending colon, descending colon, sigmoid colon, rectum, anus
  - Cecum, ascending colon, transverse colon, descending colon, sigmoid colon, rectum, anus
  - Cecum, ascending colon, transverse colon, sigmoid colon, descending colon, rectum, anus
  - Cecum, descending colon, transverse colon, ascending colon, sigmoid colon, rectum, anus
- \_\_\_\_\_ 13. What are chemicals which relay, amplify and modulate signals between a neuron and another cell?
- Neurotransmitters
  - Hormones
  - Interneurons
  - Myelin
- \_\_\_\_\_ 14. A surgeon performs an “escharotomy.” This procedure is best described as:
- Removal of scar tissue resulting from burns or other injuries
  - Removal of a basal cell carcinoma
  - Debridement of a pressure ulcer
  - Removal of a fingernail
- \_\_\_\_\_ 15. The dome-shaped muscle under the lungs flattening during inspiration is the:
- Bronchus
  - Diaphragm
  - Mediastinum
  - Pleura
- \_\_\_\_\_ 16. A thin membrane lining the chambers of the heart and valves is called the:
- Myocardium
  - Endocardium
  - Pericardium
  - Epicardium
- \_\_\_\_\_ 17. A vesiculotomy is defined as:
- Removal of an obstruction from the vas deferens
  - Surgical cutting into the seminal vesicles
  - Removal of one of the seminal vesicles
  - Incision into the prostate
- \_\_\_\_\_ 18. Destruction of lesions of the vulva can be done with “cryosurgery”. This method uses:
- Chemicals
  - Extreme cold
  - Laser
  - Heat conduction
- \_\_\_\_\_ 19. What term describes a woman in her first pregnancy?
- Primigravida
  - Primipara
  - Nulligravida
  - Parturition
- \_\_\_\_\_ 20. A form of milk produced the first few days after giving birth is:
- Chorion
  - Lactose
  - Colostrum
  - Prolactin
- \_\_\_\_\_ 21. The root for pertaining to pancreatic islet cells is:
- Cyt/o
  - Insul/o
  - Pancreat/o
  - Endocrin/o
- \_\_\_\_\_ 22. Sialography is an x-ray of :
- Sinuses
  - Liver
  - Salivary glands
  - Ventricles of the brain
- \_\_\_\_\_ 23. `What is the meaning of “provider” in the ICD-9-CM guidelines refers to?
- the hospital
  - the physician
  - insurance Company
  - the patient
- \_\_\_\_\_ 24. What is an example of an injury that would be considered a superficial injury?
- blister
  - laceration
  - nerve injury
  - venomous insect bite

- \_\_\_\_\_ 25. When can you use the code for HIV (042)?
- The test result is inconclusive
  - The test result is confirmed by the physician's diagnostic statement
  - Known HIV without symptoms
  - Suspected HIV
- \_\_\_\_\_ 26. What are some examples of fracture aftercare?
- Follow-up for healed fracture, cast change, medication adjustment
  - Follow-up for healed fracture, cast change
  - Follow-up for healed fracture, medication adjustment
  - Cast change, medication adjustment
- \_\_\_\_\_ 27. The instructions and conventions of the classification take precedence over
- Physicians
  - Official Coding Guidelines
  - CPT®
  - Nothing, they are only used in the event of no other instruction.
- \_\_\_\_\_ 28. What diagnosis code(s) should be reported for spastic cerebral palsy due to meningitis?
- 322.9, 344.89
  - 344.89, 326
  - 326, 344.89
  - 344.89, 346, 322.9
- \_\_\_\_\_ 29. What diagnosis code(s) should be reported for a patient with polyneuropathy and sarcoidosis?
- 357.4, 135
  - 356.9, 135
  - 135, 357.4
  - 135, 356.9
- \_\_\_\_\_ 30. 32-year-old sees her obstetrician about a lump in the right breast. Her mother and aunt both have a history of breast cancer. What diagnosis code(s) should be reported?
- 611.72, V10.3
  - 611.72
  - 611.72, V18.9
  - 611.72, V16.3
- \_\_\_\_\_ 31. A 50-year old female visits her physician with symptoms of insomnia and upset stomach. The physician suspects she is pre-menopausal. His diagnosis is impending menopause. What diagnosis code(s) should be reported?
- 780.52, 536.8
  - 626.9
  - 626.9, 780.62, 536.8
  - V25.3
- \_\_\_\_\_ 32. What does MRSA stand for?
- Methicillin resistant staphylococcus aureus
  - Methicillin resistant streptococcus aureus
  - Moderate resistance susceptible aureus
  - Mild resistance streptococcus aureus
- \_\_\_\_\_ 33. When the type of diabetes mellitus is not documented in the medical note, what is used as the default type?
- Type II
  - Type I
  - Can be Type I or II
  - Secondary
- \_\_\_\_\_ 34. A patient with viral Hepatitis A is being treated for glomerulonephritis. What ICD-9-CM code(s) should be reported?
- 070.9, 580.81
  - 070.1, 583.9
  - 580.81, 070.9
  - 070.1, 580.81
- \_\_\_\_\_ 35. A patient is coming in for followup of his essential hypertension and cardiomegaly. Both conditions are stable and he is told to continue with his medications. What ICD-9-CM code(s) should be reported?
- 402.90, 429.3
  - 401.9, 429.3
  - 402.90
  - 401.1, 429.3

- \_\_\_ 36. Patient is seeing the ophthalmologist to examine an old retained metal foreign body in his retina. There is the possibility of infection. What ICD-9-CM code(s) should be reported?
- |                   |                   |
|-------------------|-------------------|
| a. 871.6, V90.10  | c. 360.69, V90.12 |
| b. 360.55, V90.11 | d. 360.65, V90.10 |
- \_\_\_ 37. What type of fracture is considered traumatic?
- |                        |                      |
|------------------------|----------------------|
| a. Pathologic fracture | c. Stress fracture   |
| b. Malunion fracture   | d. Compound fracture |
- \_\_\_ 38. Under what circumstances would an external cause code be reported?
- |  |   |
|--|---|
| a. Illness and injuries                              | b. Causes of injury, poisoning, and other adverse affects |
| c. Causes of neoplasms, hypertension and medications | d. Only for the cause of accidents                        |
- \_\_\_ 39. What chapter contains codes for diseases and disorders of the nails?
- |  |   |
|--|---|
| a. Chapter 13: Diseases of Musculoskeletal and Connective Tissue | c. Chapter 10: Diseases of the Genitourinary system         |
| b. Chapter 14: Congenital Anomalies                              | d. Chapter 12: Diseases of the Skin and Subcutaneous Tissue |
- \_\_\_ 40. The patient has benign prostate hypertrophy with urinary retention. What ICD-9-CM code(s) should be reported?
- |                   |                   |
|-------------------|-------------------|
| a. 600.00         | c. 600.20, 788.20 |
| b. 600.01, 788.20 | d. 600.91         |
- \_\_\_ 41. A 2-month-old is seeing his pediatrician for a routine health check examination. The physician notices a diaper rash and prescribes an ointment to treat it. What ICD-9-CM code(s) should be reported?
- |                 |                 |
|-----------------|-----------------|
| a. 691.0        | c. 691.0, V20.2 |
| b. V20.2, 691.0 | d. V70.0        |
- \_\_\_ 42. A three-year-old is brought to the burn unit after pulling a pot of hot soup off the stove spilling onto to her body. She sustained 18% second degree burns on her legs and 20% third degree burns on her chest and arms. Total body surface area burned is 38%. What ICD-9-CM code(s) should be reported for the burns (do not include E codes for the accident)?
- |                                   |                                   |
|-----------------------------------|-----------------------------------|
| a. 945.20, 943.30, 945.20, 948.33 | c. 942.32, 943.30, 945.20, 948.32 |
| b. 942.32, 943.30, 945.20, 948.33 | d. 945.20, 943.30, 945.20, 948.12 |
- \_\_\_ 43. A patient is coming in for followup of a second-degree burn on the arm. The physician notes the burn is healing well. He is to come back in two weeks for another check-up. What ICD-9-CM code(s) should be reported?
- |                   |                   |
|-------------------|-------------------|
| a. 943.20         | c. V67.59, 943.20 |
| b. V58.89, 943.20 | d. V67.9          |
- \_\_\_ 44. A patient was treated in the emergency department for a nasal fracture. Bleeding was controlled, a splint applied and the patient sent home. He returned to the ED several hours later with new bleeding from both nares. What ICD-9-CM code(s) should be reported for the second ED visit?
- |          |                 |
|----------|-----------------|
| a. 958.2 | c. 802.0, 958.2 |
| b. 802.0 | d. 958.2, 802.0 |
- \_\_\_ 45. 40-year-old woman, 25-weeks-pregnant with her second child, is seeing her obstetrician. She is worried about decreased fetal movement. During the examination the obstetrician detects bradycardia in the fetus. What ICD-9-CM code(s) should be reported?
- |                   |                   |
|-------------------|-------------------|
| a. 659.73, V23.82 | c. 648.63, V23.82 |
| b. 779.81, 656.63 | d. 659.73, 659.63 |

- \_\_\_\_\_ 46. What three components are considered when Relative Value Units are established?
- Physician work, Practice expense, Malpractice Insurance
  - Geographic region, Practice expense, Malpractice Insurance
  - Geographic region, Conversion factor, Physician fee schedule
  - Physician work, Physician fee schedule, Conversion factor
- \_\_\_\_\_ 47. CPT® Category III codes are reimbursable at what level of reimbursement?
- 10%
  - 100%
  - 85%
  - Reimbursement, if any, is determined by the payer
- \_\_\_\_\_ 48. HCPCS Level II includes code ranges which consist of what type of codes?
- Category II codes, temporary national codes, miscellaneous codes, permanent national codes.
  - Dental codes, morphology codes, miscellaneous codes, temporary national codes, permanent national codes.
  - Permanent national codes, dental codes, category II codes.
  - Permanent national codes, miscellaneous codes, dental codes, and temporary national codes.
- \_\_\_\_\_ 49. A patient is seen in the OR for an arthroscopy of the medial compartment of his left knee. What is the correct coding to report for the Anesthesia services?
- 01400
  - 01402
  - 29870-LT
  - 29880-LT
- \_\_\_\_\_ 50. What is the correct CPT® code for the wedge excision of a nail fold of an ingrown toenail?
- 11720
  - 11750
  - 11765
  - 11760
- \_\_\_\_\_ 51. What is the correct code for the application of a short arm cast?
- 29065
  - 29075
  - 29125
  - 29280
- \_\_\_\_\_ 52. What is the code for partial laparoscopic colectomy with anastomosis and coloproctostomy?
- 44208
  - 44210
  - 44145
  - 44207
- \_\_\_\_\_ 53. What is the correct CPT® code for strabismus reparative surgery performed on 2 horizontal muscles?
- 67311
  - 67312
  - 67314
  - 67316
- \_\_\_\_\_ 54. What is commonly known as a boil of the skin?
- Abscess
  - Furuncle
  - Lesion
  - Impetigo
- \_\_\_\_\_ 55. What is the correct diagnostic code to report an open wound of the right leg related to a non-healing operative wound of squamous cell carcinoma?
- 173.70
  - 998.83
  - 998.59
  - V10.83

- \_\_\_\_\_ 56. The patient is here to follow-up for a keloid excised from his neck in November of last year. He believes it's coming back. He does have a recurrence of the keloid on the superior portion of the scar. Since the keloid is still small, options of an injection or radiation to the area were discussed. It was agreed our next course should be a Kenalog injection. Risks associated with the procedure were discussed with the patient. Informed consent was obtained. The area was infiltrated with 1.5 cc of medication. This was a mixture of 1 cc of 40-mg Kenalog and 0.5 cc of 1% lidocaine with epinephrine. He tolerated the procedure well. What CPT® and ICD-9-CM code(s) are reported?
- a. 11900, 11901 x 7, J3301, 706.1
  - b. 11900, J3301, 701.4
  - c. 11901, J3301, 701.4
  - d. 11901 x 8, J3301, 238.2
- \_\_\_\_\_ 57. A patient presents with a recurrent seborrheic keratosis of the left cheek. The area was marked for a shave removal. The area was infiltrated with local anesthetic, prepped and draped in a sterile fashion. The lesion measuring 1.8 cm was shaved using an 11-blade. Meticulous hemostasis was achieved using light pressure. The specimen was sent for permanent pathology. The patient tolerated the procedure well. What CPT® code(s) is reported?
- a. 11200
  - b. 11312
  - c. 11442
  - d. 11642
- \_\_\_\_\_ 58. A 45-year-old male with a previous biopsy positive for malignant melanoma, presents for definitive excision of the lesion. After induction of general anesthesia the patient is placed supine on the OR table, the left thigh prepped and draped in the usual sterile fashion. IV antibiotics are given, patient had previous MRSA infection. The previous excisional biopsy site on the left knee measured approximately 4 cm and was widely elipsed with a 1.5 cm margin. The excision was taken down to the underlying patellar fascia. Hemostasis was achieved via electrocautery. The resulting defect was 11cm x 5cm. Wide advancement flaps were created inferiorly and superiorly using electrocautery. This allowed skin edges to come together without tension. The wound was closed using interrupted 2-0 monocryl and 2 retention sutures were placed using #1 Prolene. Skin was closed with a stapler. What CPT® code(s) is/are reported?
- a. 27328
  - b. 14301
  - c. 14301, 27328-51
  - d. 15738, 11606-51

59. Operative Report  
PREOPERATIVE DIAGNOSIS: Diabetic foot ulceration.  
POSTOPERATIVE DIAGNOSIS: Diabetic foot ulceration.  
OPERATION PERFORMED: Debridement and split thickness autografting of left foot

ANESTHESIA: General endotracheal.

INDICATIONS FOR PROCEDURE: This patient with multiple complications from Type II diabetes has developed ulcerations which were debrided and homografted last week. The homograft is taking quite nicely, the wounds appear to be fairly clean; he is ready for autografting.

DESCRIPTION OF PROCEDURE: After informed consent the patient is brought to the operating room and placed in the supine position on the operating table. Anesthetic monitoring was instituted, internal anesthesia was induced. The left lower extremity is prepped and draped in a sterile fashion. Staples were removed and the homograft was debrided from the surface of the wounds. One wound appeared to have healed; the remaining two appeared to be relatively clean. We debrided this sharply with good bleeding in all areas. Hemostasis was achieved with pressure, Bovie cautery, and warm saline soaked sponges. With good hemostasis a donor site was then obtained on the left anterior thigh, measuring less than 100 cm<sup>2</sup>. The wounds were then grafted with a split-thickness autograft that was harvested with a patch of Brown dermatome set at 12,000 of an inch thick. This was meshed 1.5:1. The donor site was infiltrated with bupivacaine and dressed. The skin graft was then applied over the wound, measured approximately 60 cm<sup>2</sup> in dimension on the left foot. This was secured into place with skin staples and was then dressed with Acticoat 18's, Kerlix incorporating a catheter, and gel pad. The patient tolerated the procedure well. The right foot was redressed with skin lubricant sterile gauze and Ace wrap. Anesthesia was reversed. The patient was brought back to the ICU in satisfactory condition.

What CPT® and ICD-9-CM codes are reported?

- a. 15220-58, 15004-58, 707.15, 250.80  
b. 15120-58, 15004-58, 250.80, 707.15  
c. 15950-78, 15004-78, 250.00, 707.14  
d. 11044-78, 15120-78, 15004-78, 250.80, 707.15
60. A patient is seen in the same day surgery unit for an arthroscopy to remove some loose bodies in the shoulder area. What CPT® code(s) should be reported?  
a. 29805  
b. 29806  
c. 29807  
d. 29819
61. What is the acromion?  
a. Part of the elbow joint  
b. Ligament near the knee  
c. Tendon in the shoulder  
d. Extension of the scapula
62. In ICD-9-CM, what do you look for in the alphabetic index, to code a tear of the supraspinatus muscle of the shoulder?  
a. Rotator cuff, sprain  
b. Sprain, shoulder  
c. Injury, shoulder  
d. Tear, rotator cuff
63. A patient presented with a closed, displaced supracondylar fracture of the left elbow. After conscious sedation, the left upper extremity was draped and closed reduction was performed, achieving anatomical reduction of the fracture. The elbow was then prepped and with the use of fluoroscopic guidance, two K-wires were directed crossing the fracture site and pierced the medial cortex of the left distal humerus. Stable reduction was obtained, with full flexion and extension. K-wires were bent and cut at a 90 degree angle. Telfa padding and splint were applied. What CPT® code(s) should be reported?  
a. 24535  
b. 24538  
c. 24582  
d. 24566

- \_\_\_\_\_ 64. A 27-year-old triathlete is thrown from his bike on a steep downhill ride. He suffered a severely fractured vertebra at C5. An anterior approach is used to dissect out the bony fragments and strengthen the spine with titanium cages and arthrodesis. The surgeon places the patient supine on the OR table and proceeds with an anterior corpectomy at C5 with discectomy above and below. Titanium cages are placed in the resulting defect and morselized allograft bone is placed in and around the cages. Anterior Synthes plates are placed across C2-C3 and C3-C5, and C5-C6. What CPT® code(s) should be reported?
- a. 22326, 22554-51, 22845, 22851, 20930      c. 63001, 22554-51, 22845, 20931  
b. 63081, 22554-51, 22846, 22851, 20930      d. 22326, 22548-51, 22846, 20931
- \_\_\_\_\_ 65. This 45-year-old male presents to the operating room with a painful mass of the right upper arm. General anesthesia was induced. Soft tissue dissection was carried through the proximal aspect of the teres minor muscle. Upon further dissection a large mass was noted just distal of the IGHL (inferior glenohumeral ligament), which appeared to be benign in nature. With blunt dissection and electrocautery, the 4-cm mass was removed en bloc and sent to pathology. The wound was irrigated, and repair of the teres minor with subcutaneous tissue was closed with triple-0 Vicryl. Skin was closed with double-0 Prolene in a subcuticular fashion. What CPT® code(s) should be reported?
- a. 23076-RT      c. 23075-RT  
b. 23066-RT      d. 11406-RT
- \_\_\_\_\_ 66. A 50-year-old male had surgery on his upper leg one day ago and presents with serous drainage from the wound. He was taken back to the operating room for evaluation of the hematoma. His wound was explored, and there was a hematoma at the base of the wound, which was very carefully evacuated. The wound was irrigated with antibacterial solution. What CPT® and ICD-9-CM codes should be reported?
- a. 10140-79, 998.12      c. 10140-76, 998.9  
b. 27603-78, 998.59      d. 27301-78, 998.12
- \_\_\_\_\_ 67. A patient presents with a healed fracture of the left ankle. The patient was placed on the OR table in the supine position. After satisfactory induction of general anesthesia, the patient's left ankle was prepped and draped. A small incision about 1 cm long was made in the previous incision. The lower screws were removed. Another small incision was made just lateral about 1 cm long. The upper screws were removed from the plate. Both wounds were thoroughly irrigated with copious amounts of antibiotic containing saline. Skin was closed in a layered fashion and sterile dressing applied. What CPT® code(s) should be reported?
- a. 20680      c. 20670  
b. 20680, 20680-59      d. 20680, 20670-59
- \_\_\_\_\_ 68. A 31-year-old secretary returns to the office with continued complaints of numbness involving three radial digits of the upper right extremity. Upon examination, she has a positive Tinel's test of the median nerve in the left wrist. Anti-inflammatory medication has not relieved her pain. Previous electrodiagnostic studies show sensory mononeuropathy. She has clinical findings consistent with carpal tunnel syndrome. She has failed physical therapy and presents for injection of the left carpal canal. The left carpal area is prepped sterilely. A 1.5 inch 25 or 22 gauge needle is inserted radial to the palmaris longus or ulnar to the carpi radialis tendon at an oblique angle of approximately 30 degrees. The needle is advanced a short distance about 1 or 2 cm observing for any complaints of paresthesias or pain in a median nerve distribution. The mixture of 1 cc of 1% lidocaine and 40 mg of Kenalog is injected slowly along the median nerve. The injection area is cleansed and a bandage is applied to the site. What CPT® code(s) should be reported?
- a. 20526, J3301      c. 20526, J3303  
b. 20551, J3302      d. 20550, J3302
- \_\_\_\_\_ 69. What CPT® code should be reported for a frontal sinusotomy, nonobliterative, with osteoplastic flap, brow incision?
- a. 31080      c. 31084  
b. 31087      d. 31086



- \_\_\_\_\_ 70. A patient's nose was hit with a baseball during a high school baseball game. At that time reconstruction was performed, with local grafts. Patient returns now as an adult, discontent with the bony prominence along the bony pyramid and flat look of the tip of the nose. He underwent major repair with osteotomies and nasal tip work. What CPT® code(s) should be reported?
- a. 30410
  - b. 30435
  - c. 30450
  - d. 30462
- \_\_\_\_\_ 71. A 14-year-old boy presents at the Emergency Department experiencing an uncontrolled epistaxis. Through the nares, the ED physician packs his entire nose via anterior approach with medicated gauze. In approximately 15 minutes the nosebleed stops. What CPT® and ICD-9-CM codes should be reported?
- a. 30903-50, 784.7
  - b. 30901-50, 784.7
  - c. 30901, 784.7
  - d. 30905, 784.7
- \_\_\_\_\_ 72. A surgeon performs a high thoracotomy with resection of a single lung segment on a 57-year-old heavy smoker who had presented with a six-month history of right shoulder pain. An apical lung biopsy had confirmed lung cancer. What CPT® and ICD-9-CM code(s) should be reported?
- a. 32100, 729.5
  - b. 32484, 162.8
  - c. 32503, 162.8
  - d. 19271, 32551-51, 786.50
- \_\_\_\_\_ 73. What part of the cardiovascular system is responsible for the one-way flow of blood through the chambers of the heart?
- a. Septum
  - b. Heart valves
  - c. Bundle of His
  - d. Atria
- \_\_\_\_\_ 74. Which main coronary artery bifurcates into two smaller ones?
- a. Right
  - b. Left
  - c. Inverted
  - d. Superficial
- \_\_\_\_\_ 75. A patient suffering from an abdominal aortic aneurysm involving a renal artery undergoes endovascular repair using modular prosthesis with two docking limbs. Select the CPT® code(s) for this procedure.
- a. 34805
  - b. 0078T, 0079T
  - c. 34803
  - d. 34802
- \_\_\_\_\_ 76. Physician changes the old battery to a new battery on a patient's dual chamber permanent pacemaker.
- a. 33212
  - b. 33229
  - c. 33213, 33233-51
  - d. 33228
- \_\_\_\_\_ 77. A 35-year-old patient presented to the ASC for PTA of an obstructed hemodialysis AV graft in the venous anastomosis and the immediate venous outflow. The procedure was performed under moderate sedation administered by the physician performing the PTA. The physician performed all aspects of the procedure, including radiological supervision and interpretation. Code for all services performed.
- a. 35460, 99144, 75978-26
  - b. 35492, 75978-26
  - c. 35476, 75978-26
  - d. 35476, 99144, 75978-26
- \_\_\_\_\_ 78. What is included in all vascular injection procedures?
- a. Catheters, drugs, and contrast material
  - b. Selective catheterization
  - c. Just the procedure itself
  - d. Necessary local anesthesia, introduction of needles or catheters, injection of contrast media with or without automatic power injection, and/or necessary pre-and post injection care specifically related to the injection procedure.

- \_\_\_\_\_ 79. In the cardiac suite, an electrophysiologist performs an EP study. With programmed electrical stimulation, the heart is stimulated to induce arrhythmia. Observed is: right atrial and ventricular pacing, recording of the bundle of His, right atrial and ventricular recording, and left atrial and ventricular pacing and recording from the left atrium.
- a. 93600, 93602, 93603, 93610, 93612, 93618, 93621, 93622
  - b. 93619, 93621
  - c. 93620, 93621, 93622
  - d. 93620, 93618, 93621

- \_\_\_\_\_ 80. Preoperative Diagnosis: Coronary artery disease associated with congestive heart failure; in addition, the patient has diabetes and massive obesity.  
Postoperative Diagnosis: Same  
Anesthesia: General endotracheal  
Incision: Median sternotomy

Indications: The patient had presented with severe congestive heart failure associated with her severe diabetes. She had significant coronary artery disease, consisting of a chronically occluded right coronary artery but a very important large obtuse marginal artery coming off as the main circumflex system.

She also has a left anterior descending artery, which has moderate disease and this supplies quite a bit of collateral to her right system. The decision was therefore made to perform a coronary artery bypass grafting procedure, particularly because she is so symptomatic. The patient was brought to the operating room.

Description of Procedure: The patient was brought to the operating room and placed in supine position. Myself, the operating surgeon was scrubbed throughout the entire operation. After the patient was prepared, median sternotomy incision was carried out and conduits were taken from the left arm as well as the right thigh. The patient weighs almost three hundred pounds and with her obesity there was some concern as to taking down the left internal mammary artery. Because the radial artery appeared to be a good conduit, she should have an arterial graft to the left anterior descending artery territory. She was cannulated after the aorta and atrium were exposed and after full heparinization.

Attention was turned to the coronary arteries. The first obtuse marginal artery was a very large target and the vein graft to this target indeed produced an excellent amount of flow. Proximal anastomosis was then carried out to the foot of the aorta. The left anterior descending artery does not have severe disease but is also a very good target, and the radial artery was anastomosed to this target, and the proximal anastomosis was then carried out to the root of the aorta.

Sternal closure was then done using wires. The subcutaneous layers were closed using Vicryl suture. The skin was approximated using staples.

- a. 33533, 33510
- b. 33511
- c. 33533, 33517
- d. 33533, 33517, 35600

81. **CLINICAL SUMMARY:** The patient is a 55-year-old female with known coronary disease and previous left anterior descending and diagonal artery intervention, with recent recurrent chest pain. Cardiac catheterization demonstrated continued patency of the stented segment, but diffuse borderline changes in the ostial/proximal portion of the right coronary artery.

**PROCEDURE:** With informed consent obtained, the patient was prepped and draped in the usual sterile fashion. With the right groin area infiltrated with 2% Xylocaine and the patient given 2 mg of Versed and 50 mcg of fentanyl intravenously for conscious sedation and pain control, the 6-French catheter sheath from the diagnostic study was exchanged for a 6-French sheath and a 6-French JR4 catheter with side holes utilized. The patient initially received 3000 units of IV heparin, and then IVUS interrogation was carried out using an Atlantis Boston Scientific probe. After it had been determined that there was significant stenosis in the ostial/proximal segment of the right coronary artery, the patient received an additional 3000 units of IV heparin, as well as Integrilin per double-bolus injection. A 3.0, 16-mm-long Taxus stent was then deployed in the ostium and proximal segment of the right coronary artery in a primary stenting procedure with inflation pressure up to 12 atmospheres applied. Final angiographic documentation was carried out, and then the guiding catheter pulled, the sheath upgraded to a 7-French system, because of some diffuse oozing around the 6-French-sized sheath, and the patient is now being transferred to telemetry for post-coronary intervention observation and care.

**RESULTS:** The initial guiding picture of the right coronary artery demonstrates the right coronary artery to be dominant in distribution, with luminal irregularities in its proximal and mid third with up to 50% stenosis in the ostial/proximal segment per angiographic criteria, although some additional increased radiolucency observed in that segment.

IVUS interrogation confirms severe, concentric plaque formation in this ostial/proximal portion of the right coronary artery with over 80% area stenosis demonstrated. The mid, distal lesions are not significant, with less than 40% stenosis per IVUS evaluation.

Following the coronary intervention with stent placement, there is marked increase in the ostial/proximal right coronary artery size, with no evidence for intimal disruption, no intraluminal filling defect, and TIMI III flow preserved.

**CONCLUSION:** Successful coronary intervention with drug-eluting Taxus stent placement to the ostial/proximal right coronary artery.

- |                                 |                                    |
|---------------------------------|------------------------------------|
| a. 92980-RC, 92978-RC           | c. 92980-RC, 92978-51-RC           |
| b. 92980-RC, 92984-RC, 92978-RC | d. 92982-RC, 92981-RC, 92978-51-RC |

82. What is the correct ICD-9-CM coding for a 30-year-old obese patient with a BMI of 32.5?

- |                   |                   |
|-------------------|-------------------|
| a. 278.00, V85.32 | c. 278.00, V85.30 |
| b. 278.01, V85.35 | d. 278.02, V85.4  |

83. What CPT® code(s) is/are reported for a percutaneous endoscopic direct placement of a tube gastrostomy for a patient who previously underwent a partial esophagectomy?

- |                 |          |
|-----------------|----------|
| a. 49440, 43116 | c. 49440 |
| b. 43246, 43116 | d. 43246 |



- a. 56405  
b. 56420
- c. 56440  
d. 56740
- \_\_\_ 94. What CPT® code is used to report a complete unilateral removal of the vulva and deep subcutaneous tissues?  
a. 56630  
b. 56633  
c. 56625  
d. 56620
- \_\_\_ 95. Vulvar cancer in situ can also be documented as:  
a. VIN I  
b. VIN II  
c. Adenocarcinoma of the vulva  
d. VIN III
- \_\_\_ 96. What does the abbreviation IVF mean?  
a. Intravenous fluids  
b. In vitro fertilization  
c. Intravaginal foreign body  
d. Infundibulum via Fallopian tube
- \_\_\_ 97. A pregnant patient presents to the ED with bleeding, cramping, and concerns of loss of tissue and material per vagina. On examination, the physician discovers open cervical os with no products of conception seen. He tells the patient she has had an abortion. What type of abortion has she had?  
a. Missed  
b. Induced  
c. Spontaneous  
d. None of the above
- \_\_\_ 98. Patient wishes permanent sterilization and elects laparoscopic tubal ligation with fallope ring. What is/are the CPT® code(s) reported for this service?  
a. 58671  
b. 58600  
c. 58615  
d. 58670
- \_\_\_ 99. A patient presents with cervical cancer, it has spread and metastasized throughout the pelvic area. She receives a total abdominal hysterectomy with bilateral salpingo-oophorectomy, cystectomy and creation of an ileal conduit and partial colectomy. What is/are the CPT® code(s) reported for this service?  
a. 58150, 51590, 44140  
b. 58152, 44141  
c. 58150, 51590, 44140, 58720  
d. 58240
- \_\_\_ 100. A pregnant patient presents with the baby in a breech presentation. During the delivery the doctor attempts to turn the baby while it is still in the uterus. The baby turns but then immediately resumes his previous position. Can this service be billed? If so, what is the code?  
a. No, since the doctor was unable to successfully turn the baby.  
b. No, this procedure is included in the obstetrical global package  
c. Yes, since the doctor did the work, even though the outcome was unsuccessful. Report this procedure with code 59412  
d. Yes, only billing it with postpartum care 59515
- \_\_\_ 101. What are the four lobes of the brain?  
a. Frontal, Parietal, Temporal, Occipital  
b. Sulci, Cerebellum, Pons, Medulla  
c. Frontal, Cerebral, Cerebellum, Pons  
d. Frontal, Cerebrum, Temporal, Occipital
- \_\_\_ 102. What disease is characterized by enlarged skeletal parts?  
a. Acromegaly  
b. Goiter  
c. Hyperthyroidism  
d. Cushing's Syndrome
- \_\_\_ 103. What is the term for paralysis affecting one side of the body?  
a. Monoplegia  
b. Paraplegia  
c. Quadriplegia  
d. Hemiplegia
- \_\_\_ 104. A patient with chronic lumbago is seen by the physician to have an epidural injection at the sacral level. What CPT® code(s) is reported for this procedure?  
a. 62319  
b. 62360  
c. 62310  
d. 62311
- \_\_\_ 105. The physician removes the thymus gland in a 27-year-old female with myasthenia gravis. Using a transcervical approach, the blood supply to the thymus is divided and the thymus is dissected free from the pericardium and the thymus is removed. What CPT® code(s) is reported for this procedure?





- a. 00300, P2  
b. 00300, P3
- c. 00322, P3  
d. 00350, P3
- \_\_\_ 126. A 59-year-old patient is having surgery on the pericardial sac, without use of a pump oxygenator. The perfusionist placed an arterial line. What CPT® code(s) is reported for anesthesia?  
a. 00560  
b. 00560, 36620
- c. 00561  
d. 00562
- \_\_\_ 127. A CRNA is personally performing a case, with medical direction from an anesthesiologist. What modifier is appropriately reported for the CRNA services?  
a. QX  
b. QZ
- c. QK  
d. QS
- \_\_\_ 128. A 40-year-old female in good physical health is having a laparoscopic tubal ligation. The anesthesiologist begins to prepare the patient for surgery at 0830. Surgery begins at 0900 and ends at 1000. The anesthesiologist releases the patient to recovery nurse at 1015. What is the total anesthesia time and anesthesia code?  
a. 1hr 30 minutes, 00840  
b. 1hr 45 minutes, 00851
- c. 1 hr, 00840  
d. 1 hr 15 minutes, 00851
- \_\_\_ 129. Procedure: Body PET-CT Skull Base to Mid Thigh  
History: A 65-year-old male Medicare patient with a history of rectal carcinoma presenting for restaging examination. Description: Following the IV administration of 15.51 mCi of F-18 deoxyglucose (FDG), multiplanar image acquisitions of the neck, chest, abdomen and pelvis to the level of mid thigh were obtained at one-hour post-radiopharmaceutical administration. (Nuclear Medicine Tumor imaging). What CPT® code(s) is/are reported?  
a. 78815  
b. 78815, 96365  
c. 78816, 96365
- \_\_\_ 130. 25 year old female in her last trimester of her pregnancy comes into her obstetrician's office for a fetal biophysical profile (BPP). An ultrasound is used to first monitor the fetus' movements showing three movements of the legs and arms (normal). There are two breathing movements lasting 30 seconds (normal). Non-stress test (NST) of 30 minutes showed the heartbeat at 120 beats per minute and increased with movement (normal or reactive). Arms and legs were flexed with fetus' head on it chest, opening and closing of a hand. Two pockets of amniotic fluid at 3cm were seen in the uterine cavity (normal). Biophysical profile scored 9 out of 10 points (normal or reassuring). What CPT® code(s) is/are reported reported by the obstetrician?  
a. 76818  
b. 76819
- c. 76815  
d. 59025, 76818
- \_\_\_ 131. 65-year-old female has a 2.5 cm by 2.0 cm non small cell lung cancer in her right upper lobe of her lung. The tumor is inoperable due to severe respiratory conditions. She will be receiving stereotactic body radiation therapy under image guidance. Beams arranged in 8 fields will deliver 25 Gy per fraction for 4 fractions. What CPT® and ICD-9-CM codes are reported?  
a. 77435-26, 162.3, V58.0  
b. 77371-26, 162.9
- c. 77373-26, V58.0, 162.3  
d. 77431-26, V58.0, 162.9
- \_\_\_ 132. A patient with thickening of the synovial membrane undergoes a fluoroscopic guided radiopharmaceutical therapy joint injection on his right knee. What CPT® code(s) is/are reported by the physician if performed in an ASC setting?  
a. 79440  
b. 79440, 20610
- c. 79999, 77002  
d. 79440-26, 77002-26, 20610



- \_\_\_ 133. A patient with bilateral lower extremity deep venous thromboses has a history of a recent pulmonary embolus. Under ultrasound guidance an inferior vena cavagram was performed demonstrating the right and left renal arteries at the level of L1. A tulip filter device was passed down the sheath, positioned, and deployed with excellent symmetry. It showed the filter between the renal veins and the confluence of the iliac veins but well above the bifurcation of the inferior vena cava. What CPT® code(s) is reported?
- a. 75825
  - b. 75827
  - c. 75820
  - d. 75860
- \_\_\_ 134. An oncology patient is having weekly radiation treatments with a total of seven conventional fractionated treatments broken up five on one day and two on the next. What radiology code is appropriate for this series of clinical management fractions?
- a. 77427
  - b. 77427x7
  - c. 77427x2
  - d. 77427-22
- \_\_\_ 135. A patient in her 2<sup>nd</sup> trimester with a triplet pregnancy is seen for an obstetrical ultrasound only including fetal heartbeats and position of the fetuses. What CPT® code(s) is/are reported for the ultrasound?
- a. 76805, 76810, 76810
  - b. 76811, 76812, 76812
  - c. 76815 x 3
  - d. 76815
- \_\_\_ 136. In what section of the Pathology chapter of CPT® would a coder find codes for a FISH test?
- a. Cytopathology
  - b. Immunology
  - c. Chemistry
  - d. Other Procedures
- \_\_\_ 137. A patient has a severe traumatic fracture of the humerus. During the open reduction procedure, the surgeon removes several small pieces of bone embedded in the nearby tissue. They are sent to Pathology for examination without microscopic sections. The pathologist finds no evidence of disease. How should the pathologist code for his services?
- a. This service cannot be billed
  - b. 88304
  - c. 88300
  - d. 88309, 88311
- \_\_\_ 138. A patient presents with right upper quadrant pain, nausea, and other symptoms of liver disease as well as complaints of decreased urination. Her physician orders an albumin; bilirubin, both total and direct; alkaline phosphatase; total protein; alanine amino transferase; aspartate amino transferase, and creatinine. What CPT® code(s) is/are reported?
- a. 82040, 82247, 82248, 84075, 84155, 84460, 84450, 82565
  - b. 80076, 82565
  - c. 80076
  - d. 80076-22
- \_\_\_ 139. 17-year-old girl has a bone marrow biopsy for examination as a potential stem cell donor for her mother who has acute monocytic leukemia (AML). What diagnosis code is used with the typing of the stem cell specimens?
- a. 206.00
  - b. V59.02
  - c. V59.02, 206.00
  - d. 206.00, V59.02
- \_\_\_ 140. A urine pregnancy test is performed by the office staff using the Hybritech ICON (qualitative visual color comparison test). What CPT® code(s) is reported?
- a. 84703
  - b. 84702
  - c. 81025
  - d. 81025, 36415
- \_\_\_ 141. What category of codes should be used to report an evaluation and management service provided to a patient in a psychiatric residential treatment center?
- a. Hospital inpatient services
  - b. Observation services
  - c. Nursing facility services
  - d. Domiciliary, rest home or custodial care



- a. 401.0, 429.2
- b. 402.00, 429.2
- c. 402.90
- d. 402.00

\_\_\_\_ 148. A baby was born with a ventricular septal defect (VSD). The physician performed a right heart catheterization and transcatheter closure with implant by percutaneous approach. What codes are reported?

- a. 93530, 93581-59, 745.9
- b. 93581, 745.4
- c. 93530, 745.3
- d. 93530, 93591-59, 745.4

\_\_\_\_ 149. 30-year-old male cut his hand on a piece of aluminum repairing the gutter on his house. 6 days later, it became infected. He went to the intermediate care center in his neighborhood, his first visit there. The wound was very red and warm with purulent material present. The wound was irrigated extensively with sterile water and covered with a clean sterile dressing. An injection of Bicillin CR, 1,200,000 units was given. The patient was instructed to return in 3-4 days. The physician diagnosed open wound of the hand with cellulitis. A problem focused history and examination with a low MDM were performed. What are the CPT and ICD-9-CM codes?

- a. 96372, 882.1, 682.4, E920.8, E016.9
- b. 99201, J0558 x 4, 881.11, E919.8
- c. 99201, 96372, J0558 x 12, 882.1, 682.4, E920.8, E016.9
- d. 99284, 884.0, 682.4

\_\_\_\_ 150. Mrs. Salas had 30 minutes of angina decubitus and was admitted to the Coronary Care Unit with a diagnosis of R/O MI. The cardiologist (private practice based) takes her to the cardiac catheterization suite at the local hospital for a left heart catheterization. Injection procedures for selective coronary angiography and left ventriculography were performed and imaging supervision and interpretation for the selective coronary angiography and left ventriculography was provided. What CPT® code(s) are reported for the services?

- a. 93452-26
- b. 93458-26
- c. 93453-26
- d. 93453-26, 93462

**2012 Final and answers**  
**Answer Section**

**MULTIPLE CHOICE**

1. ANS: C

Rationale: Accurate and thorough diagnosis coding is important for Medicare Advantage (Part C) claims because reimbursement is impacted by the patient's health status. The Centers for Medicare and Medicaid Services-hierarchical condition category (CMS-HCC) risk adjustment model provides adjusted payments based on a patient's diseases and demographic factors. If a coder does not include all pertinent diagnoses and co-morbidities, the provider may lose out on additional reimbursement for which he is entitled.

PTS: 1                      DIF: Moderate

2. ANS: D

Rationale: Healthcare providers are responsible for developing Notices of Privacy Practices and policies and procedures regarding privacy in their practices.

PTS: 1                      DIF: Moderate

3. ANS: A

Rationale: A covered entity may obtain consent of the individual to use or disclose protected health information to carry out treatment, payment, or health care operations.

PTS: 1                      DIF: Moderate

4. ANS: C

Rationale: The following list of components, as set forth in previous OIG Compliance Program Guidance for Individual and Small Group Physician Practices, can form the basis of a voluntary compliance program for a physician practice:

- Conducting internal monitoring and auditing through the performance of periodic audits;
- Implementing compliance and practice standards through the development of written standards and procedures;
- Designating a compliance officer or contact(s) to monitor compliance efforts and enforce practice standards;
- Conducting appropriate training and education on practice standards and procedures;
- Responding appropriately to detected violations through the investigation of allegations and the disclosure of incidents to appropriate Government entities;
- Developing open lines of communication, such as (1) discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct and (2) community bulletin boards, to keep practice employees updated regarding compliance activities; and
- Enforcing disciplinary standards through well-publicized guidelines.

These seven components provide a solid basis upon which a physician practice can create a compliance program.

PTS: 1                      DIF: Moderate

5. ANS: D

Rationale: Members shall use only legal and ethical means in all professional dealings and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive or illegal acts.

PTS: 1                      DIF: Moderate

6. ANS: C

Rationale: Medicare Part D is a prescription drug coverage program available to all Medicare beneficiaries. Private companies approved by Medicare provide the coverage.

PTS: 1 DIF: Moderate

7. ANS: D

Rationale: The definition of “health plan” in the HIPAA regulations exclude any policy, plan, or program that provides or pays for the cost of excepted benefits. Excepted benefits include:

Coverage only for accident, or disability income insurance, or any combination thereof;

Coverage issued as a supplement to liability insurance;

Liability insurance, including general liability insurance and automobile liability insurance;

Workers’ compensation or similar insurance;

Automobile medical payment insurance;

Credit-only insurance;

Coverage for on-site medical clinics;

Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

PTS: 1 DIF: Moderate

8. ANS: C

Rationale: The OIG outlines a review of industry practices related to the number of evaluation and management services provided by physicians and reimbursed as part of the global surgery fee.

PTS: 1 DIF: Moderate

- |            |        |               |
|------------|--------|---------------|
| 9. ANS: C  | PTS: 1 | DIF: Moderate |
| 10. ANS: A | PTS: 1 | DIF: Moderate |
| 11. ANS: D | PTS: 1 | DIF: Moderate |
| 12. ANS: B | PTS: 1 | DIF: Moderate |
| 13. ANS: A | PTS: 1 | DIF: Moderate |
| 14. ANS: A | PTS: 1 | DIF: Moderate |
| 15. ANS: B | PTS: 1 | DIF: Moderate |
| 16. ANS: B | PTS: 1 | DIF: Moderate |
| 17. ANS: B | PTS: 1 | DIF: Moderate |
| 18. ANS: B | PTS: 1 | DIF: Moderate |
| 19. ANS: A | PTS: 1 | DIF: Moderate |
| 20. ANS: C | PTS: 1 | DIF: Moderate |
| 21. ANS: B | PTS: 1 | DIF: Moderate |
| 22. ANS: C | PTS: 1 | DIF: Moderate |
| 23. ANS: B |        |               |

Rationale: Per ICD-9-CM Official Guidelines for Coding and Reporting: In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.

PTS: 1 DIF: Easy

24. ANS: A

Rationale: In the Volume II index look up Injury. There is a Note that lists examples of a superficial injury: Abrasion, insect bite (nonvenomous), blister, or scratch.

PTS: 1 DIF: Moderate

25. ANS: B

Rationale: Per the coding guideline Section I.C.1.a.1., “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

PTS: 1                   DIF: Moderate

26. ANS: D

Rationale: Per the guidelines Section I.C.18.d.7, use aftercare codes after the patient has received active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase.

PTS: 1                   DIF: Moderate

27. ANS: B

Rationale: Per ICD-9-CM Official Guidelines for Coding and Reporting, the instructions and conventions of the classification take precedence over guidelines.

PTS: 1                   DIF: Moderate

28. ANS: B

Rationale: ICD-9-CM, Section.I.B.12 coding guidelines indicate the coding of late effects generally requires two codes sequenced in the following order: “The condition or nature of the late effect is sequenced first (344.89 Spastic cerebral palsy). The late effect code is sequenced second (326 Meningitis). The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect.” In Volume II look up Palsy/cerebral/spastic guiding you to code 344.89; Late/effect/meningitis/unspecified cause-see Category 326.

PTS: 1                   DIF: Difficult

29. ANS: C

Rationale: In Volume II index look up Polyneuropathy/in/sarcoidosis guiding you to codes 135 [357.4]. Code 357.4 is a manifestation code. In the Tabular List the description is *Polyneuropathy in other diseases classified elsewhere*. There’s an instructional note to “Code first underlying disease as:” Sarcoidosis (135) is one of the diseases listed

PTS: 1                   DIF: Difficult

30. ANS: D

Rationale: In Volume II index look up Lump/breast guiding you to code 611.72, Next, look up, History/family/malignant neoplasm/breast guiding you to code V16.3. According to Section IV.K, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

PTS: 1                   DIF: Difficult

31. ANS: A

Rationale: ICD-9-CM coding guideline I.B.13 tells us to reference the Alphabetic Index to determine if the condition has a subentry for “impending” or “threatened” and also reference main term entries for “Impending” and “Threatened.” If the subterms are listed, assign the given code. If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

PTS: 1                   DIF: Difficult

32. ANS: A

Rationale: Methicillin-resistant Staphylococcus aureus (MRSA) infection is caused by a strain of staph bacteria that's become resistant to the antibiotics commonly used to treat ordinary staph infections. In the alphabetic index look up Infection/ staphylococcal/ aureus/ methicillin / resistant (MRSA).

- PTS: 1                    DIF: Easy
33. ANS: A  
Rationale: Per the ICD-9-CM guidelines, Section I.C.3.a.2, when the type is not documented the default type is Type II.
- PTS: 1                    DIF: Easy
34. ANS: D  
Rationale: In the alphabetic index look up Glomerulonephritis/due to or associated with infectious hepatitis guiding you to codes 070.9 [580.81]. Category 070 is further divided into types of hepatitis (A, B,C). 070.9 is coded first if we do not have a classification of the type of hepatitis. In the tabular index, code 580.81 has a “code first” instructional note to first code infectious hepatitis (070.0-070.9). Your primary coded will be 070.1, for Viral Hepatitis A without mention of hepatic coma followed by 580.81 for the manifestation.
- PTS: 1                    DIF: Difficult
35. ANS: B  
Rationale: Per ICD-9-CM guidelines, I.C.7.a.2, If the documentation does not have a casual relationship between the hypertension and heart disease (eg. Cardiomegaly due to the hypertension) then the conditions are coded separately.
- PTS: 1                    DIF: Difficult
36. ANS: D  
Rationale: In the alphabetic index look up foreign body/retained/retina guiding you to code 360.65. Subcategory code 360.6 has instructions to use an additional code to identify the foreign body (V90.01-V90.10, V90.12, V90.2-V90.9). V90.10 identifies a retained metal fragment, unspecified.
- PTS: 1                    DIF: Difficult
37. ANS: D  
Rationale: Traumatic fractures will always be coded from categories 800-829. A compound fracture is a type of open traumatic fracture found listed under the main term Fracture in the Index to Diseases. Pathologic fracture is another term for stress fracture. Malunion fracture is indexed to 733.82. Stress Fracture is indexed to 733.95.
- PTS: 1                    DIF: Easy
38. ANS: B  
Rationale: ICD-9-CM guideline I.C.19.a.1 General E Code Coding Guidelines instructions state “An E code from categories E800-E999 may be used with any code in the range of 001-V91, which indicates an injury, poisoning, or adverse effect due to an external cause.
- PTS: 1                    DIF: Easy
39. ANS: D  
Rationale: In the alphabetic index look up Disease, diseased/nail referring you to code 703.9. In the Tabular List code 703.9 is in Chapter 12, Diseases of the Skin and Subcutaneous Tissue.
- PTS: 1                    DIF: Easy
40. ANS: B  
Rationale: In the alphabetic index look up Hypertrophy/prostate/benign/with/urinary/retention guiding you to code 600.01. There are instructions below code 600.01 to “Use additional code to identify symptoms.” Code 788.20 is listed as the second code to identify urinary retention.
- PTS: 1                    DIF: Moderate

41. ANS: B

Rationale: In the Index to Diseases look up Examination/health (of) child, routine which refers you to code V20.2. Per ICD-9-CM guidelines, Section I.C.18.d.13, The infant is coming in for a general check-up. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. The second code is found in the Index to Diseases by looking for Rash/diaper. All codes should be verified in the Tabular List.

PTS: 1 DIF: Moderate

42. ANS: C

Rationale: ICD-9-CM Coding guidelines I.C.17.c.1.a state sequence first the code that reflects the highest degree of burn when more than one burn is present. In this case, the burns on her chest and arms are third degree and should be reported first. In the Index to Diseases, look for Burn/chest/third degree referring you to code 942.32; Burn/arm(s)/ third degree guiding you to code 943.30; Burn/legs/second degree guiding you to code 945.20. Refer to ICD-9-CM guidelines Section I.C.17.c.6 for instructions on assigning a code from category 948. The fourth digit represents the total body surface area (all degrees) that was burned. The fifth digit represents the percentage of third degree burns to the body . In the scenario 38% is documented as the TBSA, making 3 as the fourth digit; 20% is third degree burns making 2 as the fifth digit. E codes would also be reported for the accident.

PTS: 1 DIF: Difficult

43. ANS: B

Rationale: Per ICD-9-CM guidelines, Section I.C.18.d.7, Aftercare visit codes cover situations when the initial treatment of a disease or injury has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare codes are generally first listed to explain the specific reason for the encounter. Aftercare codes should be used in conjunction with any other after care codes or other diagnosis codes to provide better detail on the specifics of the aftercare. Look in the Index to Diseases for Aftercare/specified type NEC. To detail the burn, look for Burn/arm/second degree. Verify all codes in the Tabular List.

PTS: 1 DIF: Difficult

44. ANS: A

Rationale: In the Index to Diseases, look for Hemorrhage/traumatic/recurring or secondary guiding you to code 958.2. You will not code 802.0 since that will be reported for the first visit indicating that is when the acute injury was diagnosed.

PTS: 1 DIF: Difficult

45. ANS: D

Rationale: In the Index to Diseases look for Pregnancy/management affected by fetal/bradycardia guiding you to code 659.7x. Turn to the Tabular List. Fifth digit 3 is reported to indicate an antepartum condition or complication. Pregnancy after age 35 is considered an elderly pregnancy. Pregnancy/management affected by abnormal/advanced maternal age/multigravida (because this is her second child) guiding you to code 659.6x. Turn to the Tabular List. Fifth digit 3 is reported to indicate an antepartum condition or complication, Code V23.82 is only reported when there are no complications reported.

PTS: 1 DIF: Difficult

46. ANS: A

Rationale: Per CMS - Relative value units (RVUs) – RVUs capture the three following components of patient care: Physician work RVU, Practice Expense RVU, and Malpractice RVUs.

PTS: 1 DIF: Moderate



47. ANS: D  
Rationale: Per AMA, no relative value units (RVUs) are assigned to these codes. Payment for these services or procedures is based on the policies of payers.
- PTS: 1                    DIF: Moderate
48. ANS: D  
Rationale: HCPCS Level II codes consist of permanent national codes, miscellaneous codes, dental codes, and temporary national codes.
- PTS: 1                    DIF: Moderate
49. ANS: A  
Rationale: In the CPT® Index, first look up Anesthesia then knee. You are given multiple codes to choose from. When you turn to these codes in the Anesthesia section and review them, it is code 01400 you would report. This represents Anesthesia for arthroscopic procedures performed on the knee.
- PTS: 1                    DIF: Moderate
50. ANS: C  
Rationale: In the CPT® Index, first look up Excision then nail fold. The code you are directed to use is 11765.
- PTS: 1                    DIF: Moderate
51. ANS: B  
Rationale: In the CPT® Index, first look up Cast then short arm. The code you are directed to use is 29075.
- PTS: 1                    DIF: Moderate
52. ANS: D  
Rationale: In the CPT® Index, first look up Laparoscopy, colectomy and partial. Here you are directed to see codes 44204-44208 and 44213. When you turn to these codes in the Digestive code section and review them, it is code 44207 which represents a partial colectomy with anastomosis and coloproctostomy performed laparoscopic ally.
- PTS: 1                    DIF: Moderate
53. ANS: B  
Rationale: In the CPT® Index, first look up Strabismus, repair and two horizontal muscles. The code you are directed to use is 67312.
- PTS: 1                    DIF: Moderate
54. ANS: B  
Rationale: Carbuncles and furuncles (boils) typically are caused by a staphylococcal infection. Several furuncles together make up a carbuncle and often involve a group of hair follicles.
- PTS: 1                    DIF: Easy
55. ANS: B  
Rationale: In the ICD-9-CM Index to Diseases, see Wound/open/non-healing surgical. There is no mention of an infection, code 998.59 is not appropriate to report.
- PTS: 1                    DIF: Easy
56. ANS: B

Rationale: Using the index in CPT® under injection/lesion you are directed to CPT 11900-11901. Code selection is based on the number of lesions treated, not the number of injections. In this case one lesion is treated, making 11900 the correct code. Using the HCPCS Index or the Table of Drugs find code J3301 for Kenalog 40-mg. Verify the code in the J code section. Using the ICD-9-CM Index to Diseases, Keloid directs you to 701.4, Keloid scar. Verify the code in the Tabular List.

PTS: 1 DIF: Moderate

57. ANS: B

Rationale: In the CPT® Index, see Shaving/Skin Lesion, you are directed to range 11300-11313. Code selection is based on location and size. This lesion is on the left cheek narrowing the range to 11310-11313. The size is 1.8 cm making 11312 the correct code choice.

PTS: 1 DIF: Moderate

58. ANS: B

Rationale: In the CPT® Index, Advancement Flap directs you to Skin, Adjacent Tissue Transfer, directing you to code range 14000-14350. Adjacent tissue transfer or rearrangement includes lesion excision and is selected based on size and location. The defect is 11 cm x 5 cm (55 cm<sup>2</sup>) and located on the knee. Due to the size being 55 sq cm, the correct code is 14301.

PTS: 1 DIF: Moderate

59. ANS: B

Rationale: The wound was prepped with sharp debridement. Look in the CPT® Index for Creation/recipient site (range 15002-15005). Code selection is based on location and size. Then a split thickness graft was performed. Look in the CPT® Index for Skin Graft and Flap/Split Graft referring you to range 15100-15101-15120-15121. The measurement applies to the recipient area, which is stated as 60 cm<sup>2</sup>. A split thickness autograft to the foot for the first 100 sq cm is coded with 15120. The operative note states, "The homograft is taking quite nicely, the wounds appear to be fairly clean; he is ready for autografting," indicating this is a staged procedure and modifier 58 is appended. In the ICD-9-CM Index, see Diabetic/ulcer/foot, directing you to 250.8X [707.15]. The 5<sup>th</sup> digit 0 indicates it is Type II diabetes. Although there are complications, it does not indicate it is uncontrolled. 707.15 is used for ulcer of the foot.

PTS: 1 DIF: Difficult

60. ANS: D

Rationale: In the CPT® Index, first look up Arthroscopy/Surgical/Shoulder. Here you are directed to see codes 29606-29828. When you turn to these codes in the Surgery section to review them, it is code 29819 you would report. This represents an arthroscopy on the shoulder to remove loose bodies.

PTS: 1 DIF: Easy

61. ANS: D

Rationale: The acromion is an extension of the scapula that meets the clavicle at the shoulder to form the acromioclavicular joint.

PTS: 1 DIF: Easy

62. ANS: D

Rationale: The supraspinatus muscle is part of the rotator cuff, and the injury is listed under tear. Although it is a shoulder injury, this definition is not specific enough, and neither is the sprain code.

PTS: 1 DIF: Easy

63. ANS: B

Rationale: This is a supracondylar fracture of the elbow repaired by percutaneous fixation. In the CPT® index, look up Fracture/Humerus/Supracondylar/Percutaneous Fixation, 24538.

PTS: 1                   DIF: Moderate

64. ANS: B

Rationale: Anterior approach is used to perform several procedures on the cervical spine. The corpectomy has the highest RVUs and is listed first. Code 63081 is the removal of one single cervical segment. Arthrodesis, anterior interbody technique is coded with 22554. Plates are used for anterior instrumentation and placed over a total of five segments (C2, C3, C4, C5, and C6), 22846. Modifier 51 is appended to 22554 to indicate multiple procedures. The application of the titanium cages is described by add-on code 22851; and the morselized allograft is described by 20930—both of which are modifier 51 exempt.

PTS: 1                   DIF: Difficult

65. ANS: A

Rationale: The 4-cm mass was removed from the soft tissue of the shoulder. To access the mass, the provider had to go through the proximal aspect of the teres minor (muscle). The mass was located distal to the inferior glenohumeral ligament (IGHL). Masses that are removed from joint areas as opposed to masses removed close to the skin require special knowledge and become more of an orthopedic concern due to joint involvement. Therefore, it is coded from codes within the orthopedic section. 23076 is used because dissection was carried through the proximal aspect of the teres minor.

PTS: 1                   DIF: Difficult

66. ANS: D

Rationale: In the CPT® index, look up Hematoma/Leg, Upper. You are referred to 27301. Verify the code for accuracy. Modifier 78 is appended to 27301 to indicate that an unplanned procedure related to the initial procedure was performed during the postoperative period. In the ICD-9-CM index, look up Complications/surgical procedures/hematoma. You are referred to 998.12. Review the code in the tabular section for accuracy.

PTS: 1                   DIF: Difficult

67. ANS: A

Rationale: When reporting the removal of hardware (pins, screws, nails, rods), the code is selected by fracture site, not the number of items removed or the number of incisions that are made. To report 20670 or 20680 more than once, there would need to be more than one fracture site involved. In this case, there is only one fracture site even though two incisions are made. We know the removal is deep because the screws were in the bone. From the CPT® index, look up Removal/Implantation. The correct code is 20680.

PTS: 1                   DIF: Difficult

68. ANS: A

Rationale: Look in your HCPCS book for Kenolog-40 in the Table of Drugs, J3301 and then check the tabular listing to verify. This eliminates choices B, C, and D. For the CPT® code, look in the CPT® index under Injection/Carpal Tunnel/Therapeutic, 20526.

PTS: 1                   DIF: Difficult

69. ANS: D

Rationale: In the CPT® Index, look up Sinusotomy/Frontal Sinus/Nonobliterative and you are directed to code range 31086-31087. Code selection is based on whether it is a brow or coronal incision. 31086 is the correct code.

PTS: 1                   DIF: Easy

70. ANS: C  
Rationale: The procedure performed now is a secondary rhinoplasty. In the CPT® Index, look up Rhinoplasty/ Secondary, which directs you to code range 30430-30450. Code selection is based on the reason for the repair and the extensiveness of the repair. 30450 reports a secondary revision including osteotomies and nasal tip work.
- PTS: 1                    DIF: Moderate
71. ANS: A  
Rationale: Epistaxis is the term for nasal hemorrhage. In the CPT® Index look up Packing/Nasal Hemorrhage which directs you to code range 30901-30906. 30903 represents anterior packing for an uncontrolled or extensive nasal hemorrhage. Modifier 50 indicates this was done in both nares (bilaterally). ICD-9-CM indexing is Epistaxis which leads us to code 784.7.
- PTS: 1                    DIF: Difficult
72. ANS: B  
Rationale: We are removing a segment of the lung. In the CPT® Index, look up removal/lung and then single segment. This directs us to use code 32484. We have a confirmed diagnosis of apical lung cancer which is code 162.8. We find this by looking in the neoplasm table under lung/apical. In the primary malignant column we are directed to code 162.8.
- PTS: 1                    DIF: Difficult
73. ANS: B  
Rationale: Heart valves are made of flaps (cusps/leaflets) opening and closing like one way swinging doors, preventing blood from flowing back.
- PTS: 1                    DIF: Easy
74. ANS: B  
Rationale: The left main coronary artery branches into two slightly smaller arteries: the left anterior descending coronary artery and the left circumflex coronary artery.
- PTS: 1                    DIF: Easy
75. ANS: B  
Rationale: The Category III code states “involving a visceral vessel”, such as the renal artery. The directions under 0079T state “Use 0079T in conjunction with 0078T”. Code 0078T reports the endovascular repair of the abdominal aortic aneurysm, and 0079T reports the visceral extension prosthesis. This can be found in the CPT® index under Aneurysm Repair/Abdominal Aorta.
- PTS: 1                    DIF: Easy
76. ANS: D  
Rationale: CPT® guidelines state, “when the battery of a pacemaker ... is changed, it is actually the pulse generator that is changed.” It is reported with one code. Look in the CPT® index for Pacemaker, Heart/Replacement/Pulse Generator. Code 33228 is reported for dual chamber (dual lead system).
- PTS: 1                    DIF: Moderate
77. ANS: C

Rationale: Moderate sedation is bundled, so it is not reported. Code 35460 is for an open procedure. Venoplasty includes three zones for AV fistulas: the A/V graft and peripheral veins, the central veins, and the vena cava. Only one venoplasty is reported for the A/V graft and peripheral veins. Read the guidelines above 36147, Interventions for Arteriovenous (AV) Shunts Created for Dialysis (AV Grafts and AV Fistulae) for guidance. Code 35476 is found in the CPT® index under Percutaneous Transluminal Angioplasty/Venous. Modifier 26 reports the professional services.

PTS: 1                   DIF: Difficult

78. ANS: D

Rationale: CPT® guidelines under Vascular Injection Procedures indicate the above-listed in d as being included.

PTS: 1                   DIF: Difficult

79. ANS: C

Rationale: The studies performed make up a comprehensive study (93620) which includes: evaluation with right atrial pacing and recording, right ventricular pacing and recording, and His bundle recording with induction of or attempted induction of arrhythmia. Left atrial pacing and recording (93621) and left ventricular pacing and recording (93622) are add-on codes. This is found in the CPT® index under Heart/Electrical Recording/Comprehensive.

PTS: 1                   DIF: Difficult

80. ANS: D

Rationale: One arterial graft and one vein graft was performed. Look in the CPT® index for Coronary Artery Bypass Graft (CABG),/Arterial-Venous for range 33517-33523. Then look under Arterial 33533-33536. This was a combination arterial-venous graft with one vein graft (33517) and one an arterial graft (33533). The upper extremity radial artery graft procurement (35600) is separately reportable. Codes 33517 and 35600 are add-on codes and are modifier 51 exempt.

PTS: 1                   DIF: Difficult

81. ANS: A

Rationale: Stent placement (92980) and IVUS (92978) are reportable. No 51 modifier on IVUS as it is an add-on code. IVUS is reported for each vessel when performed in multiple vessels; therefore, RC is appended to 92978 to indicate the right coronary artery. The stent procedure is found in the CPT® index under Coronary Artery/Insertion/Stent 92980-92981. IVUS is found in the CPT® index under Vascular Procedures/Intravascular Ultrasound/Coronary Vessels 92978-92979.

PTS: 1                   DIF: Difficult

82. ANS: A

Rationale: Code 278.00 represents obesity, unspecified. At code category 278.0, we have an instructional note, which tells us to “Use additional code to identify Body Mass Index (BMI) if known. Code V85.32 represents an adult BMI of 32.0-32.9

PTS: 1                   DIF: Moderate

83. ANS: D

Rationale: Code 43246 represents the direct percutaneous placement of a gastrostomy tube. We would not code for the partial esophagectomy (43116) as it was not performed at this time but was done prior to the tube placement.

PTS: 1                   DIF: Moderate

84. ANS: B

Rationale: Ligation of esophageal varices laparoscopically is coded with CPT® code 43244. The patient has cirrhosis (571.5) as well and is coded along with 456.21 for the esophageal varices.

PTS: 1                   DIF: Difficult

85. ANS: A

Rationale: Code 47140 represents the portion of the liver taken from the donor to be allotransplanted. Codes 47146 and 4147 represent the backbench work. We have a vein and a artery anastomosed so we only report each of these codes one time. The final code of 47135 represents the orthotopic allotransplantation into the patient.

PTS: 1                   DIF: Difficult

86. ANS: A

Rationale: Bladder repair (51860) does not describe closure of exstrophy, nor was there closure of a cystostomy (51880). When reporting the closure of the exstrophy of bladder, you are instructed to also see CPT® 54390, which describes a closure of bladder exstrophy with plastic operation on penis for epispadias. As epispadias repair was performed, code 54390 would be the correct code to report.

PTS: 1                   DIF: Moderate

87. ANS: D

Rationale: When a circumcision is performed requiring tissue transfer or reconstruction, you report the circumcision and the tissue transfer codes. You do not append modifier 22 to the circumcision code, nor do you report the tissue transfer, alone. Reporting repair of an incomplete circumcision is also incorrect, as there was no previous circumcision performed.

PTS: 1                   DIF: Difficult

88. ANS: C

Rationale: Reporting 51726 would be incorrect as the description is for “simple cystometrogram”. Also, CPT® 51797 is an “add-on” code and per description can only be added when CPT® 51728 or 51729 are reported. As the procedures were performed in the office setting, under the direct supervision of the physician, you would not append a modifier to the procedures.

PTS: 1                   DIF: Difficult

89. ANS: D

Rationale: Laser vaporization is coded using CPT® 52648, 52647 describes laser coagulation of the prostate and 52649 laser enucleation of the prostate. As the biopsy would usually not be reported at the same time of the laser procedure, the operative report clearly states that this is a separate procedure from the GreenLight and should be reported separately. Because the site of biopsies were “fulgurated”, CPT® 52224 would be the correct code, with modifier 59 appended.

PTS: 1                   DIF: Difficult

90. ANS: D

Rationale: In the Index see Cyst/Kidney/Excision. CPT® description of 50280 states cyst(s) and therefore, CPT® 50280 would not be reported 3 times, nor would any modifier be appended. CPT® 50290 describes the excision of perinephric cyst and 50060 describes open removal of a kidney stone.

PTS: 1                   DIF: Difficult

91. ANS: B

Rationale: Colp/o refers to the vagina.

PTS: 1                   DIF: Easy

92. ANS: D  
Rationale: The Bartholin's gland glands (also called the greater vestibular glands) are located slightly below and to either side of the vaginal introitus. The Fallopian tubes are two tubes, one on either side of the uterus, leading from the bilateral ovaries into the uterus.
- PTS: 1                   DIF: Easy
93. ANS: C  
Rationale: Marsupialization is a procedure where a scalpel is used to cut an opening in the top of the abscess pocket. The leaflets created by this procedure are pulled away from the pocket and attached to the surrounding skin with stitches or glue. This creates an open pouch to help prevent recurrence of the abscess. Marsupialization of the Bartholin's gland is coded with CPT® code 56440.
- PTS: 1                   DIF: Easy
94. ANS: A  
Rationale: The vulva is not a bilateral structure, so removal of 50% of the tissue is a partial vulvectomy. Read the definitions in CPT® at the beginning of the section: Vulva, Perineum, and Introitus.
- PTS: 1                   DIF: Moderate
95. ANS: D  
Rationale: VIN III is coded as cancer in situ. The other VINs listed are coded as hyperplasia and adenocarcinoma is a primary malignancy.
- PTS: 1                   DIF: Moderate
96. ANS: B  
Rationale: In the CPT® index, look under IVF and you are directed to See Artificial Insemination; In Vitro Fertilization. IVF stands for In Vitro Fertilization.
- PTS: 1                   DIF: Moderate
97. ANS: C  
Rationale: There is no indication this was an induced abortion. A missed abortion does not usually occur with passage of material and tissue, it is silent. This is considered a spontaneous abortion or miscarriage.
- PTS: 1                   DIF: Moderate
98. ANS: A  
Rationale: Patient is having a laparoscopic tubal ligation, her fallopian tubes (oviduct) are surgically blocked off (occlusion) with a falope ring to prevent pregnancy (permanent sterilization). To find the CPT® code, look in the index under Laparoscopy/Oviduct Surgery will guide you to codes 58670-58671, 58679. Reviewing the codes, 58671 is the correct code for the procedure being performed.
- PTS: 1                   DIF: Moderate
99. ANS: D  
Rationale: Due to the patient having cervical cancer metastasized to the pelvic area (gynecological malignancy) the procedure performed is a pelvic exenteration. This is a total hysterectomy with removal of ovaries and fallopian tubes (salpingo-oophorectomy). This includes the removal of her bladder (cystectomy) with creation of a passageway to drain the kidneys through an opening on the abdomen (ileal conduit) and partial removal of the large bowel or colon (resection of the rectum and colon). This procedure is indexed under, Exenteration/Pelvis guiding you to codes 45126 and 58240. Code 58420 is the only code needed to report this surgical procedure. Reporting the other codes would be considered unbundling.
- PTS: 1                   DIF: Difficult

100. ANS: C  
Rationale: The physician can bill for this service separately.
- PTS: 1 DIF: Difficult
101. ANS: A  
Rationale: The four lobes of the brain are the Frontal lobe, Parietal Lobe, Temporal Lobe, and Occipital Lobe.
- PTS: 1 DIF: Easy
102. ANS: A  
Rationale: Acromegaly is characterized by enlarged skeletal parts, especially the nose, ears, jaws, fingers, and toes; caused by hypersecretion of growth hormone (GH) from the pituitary gland.
- PTS: 1 DIF: Easy
103. ANS: D  
Rationale: Hemi is half. Hemiplegia is paralysis affecting one side of the body.
- PTS: 1 DIF: Easy
104. ANS: D  
Rationale: Documentation shows a single injection was given at the sacral level. Neither a catheter nor a device is documented as being used. In the CPT® Index, look for Epidural, Injection. Single injection codes are selected based on the level of the spine injected. The lumbar sacral area is 62311.
- PTS: 1 DIF: Moderate
105. ANS: A  
Rationale: Excision of the thymus gland is a thymectomy and is coded based on the approach. Code 60520 is for a transcervical approach, as documented. In the index, Thymectomy/Transcervical Approach.
- PTS: 1 DIF: Moderate
106. ANS: B  
Rationale: In the CPT® Index, look for Decompression/Nerve Root, and you are directed to a series of codes. The transpedicular approach is defined by codes 63055-63057. 63056 specifies the lumbar spine. 63057 is used for the second segment.
- PTS: 1 DIF: Moderate
107. ANS: B  
Rationale: A laminotomy is also known as a hemilaminectomy. In the CPT® Index, look under Hemilaminectomy and you are directed to code range 63020 – 63044. In the ICD-9-CM Index, look under Hernia/Intervertebral Disc and you are directed to see Displacement/Intervertebral Disc. For the cervical spine, the code is 722.0.
- PTS: 1 DIF: Moderate
108. ANS: B  
Rationale: Codes for the injection of an anesthetic and/or steroid are selected based on the location and number of levels. Code 64493 is for injection of the lumbar, single level L3-L4; and 64494 is the add-on code for the additional level L-4-L-5. Modifier 50 Bilateral procedure is appended to both codes as the injection was on both sides.
- PTS: 1 DIF: Difficult
109. ANS: D



Rationale: In the CPT® index, look up Nerves/Injection/Anesthetic. You are referred to 01991-01992 or 64400-64530. Review the codes to choose appropriate service. 64483 is the correct code since the anesthetic was injected into the epidural space in one single level (L5-S1) in the transforaminal approach.

PTS: 1                   DIF: Difficult

110. ANS: B

Rationale: In the CPT® Index, look for Injection/Paravertebral Facet Joint/Nerve with Image Guidance and you are directed to 64490-64495. Code selection is based on the section of the spine (lumbar) and the levels injected (3). Modifier 50 is appended since it is bilateral. In the ICD-9-CM Index, look for pain, lumbar and you are directed to 724.2.

PTS: 1                   DIF: Difficult

111. ANS: B

Rationale: Two co-surgeons performed distinct parts of the same surgery. The surgery performed is a vertebral corpectomy, thoracic. Look in the CPT® Index for Vertebral/Corpectomy and you are directed to code range 63081-63103, 63300-63308. 63300-63308 are for excision of intraspinal lesions. The code selection for 63081-63103 is based on location, approach and number of vertebral segments. 63085 is for a transthoracic approach, thoracic, single segment. The additional two segments are reported with 63086. As indicated by the guidelines for this section, each provider will report the same CPT® code and append a modifier 62.

PTS: 1                   DIF: Difficult

112. ANS: D

Rationale: 64831 is the correct code to report the digital nerve was repaired. 64832 is the correct secondary code since there was an additional digital nerve that needed repair. 51 is not appended to the secondary code since this code is an add-on code and add-on codes are modifier 51 exempt. (Index: Suture/Nerve.)

PTS: 1                   DIF: Difficult

113. ANS: D

Rationale: In the CPT® Index, look for Biopsy/Spinal Cord/Percutaneous and you are directed to code 62269. In the ICD-9-CM, Syringomyelia indexes to 336.0. Verification in the Tabular List confirms code selection.

PTS: 1                   DIF: Difficult

114. ANS: A

Rationale: 62270 is the correct code since a spinal puncture was performed in the lumbar region(L4 and L5). It was done to withdraw cerebral spinal fluid for testing to determine if the patient had meningitis (diagnostic).

PTS: 1                   DIF: Difficult

115. ANS: B

Rationale: IOL stands for intraocular lens.

PTS: 1                   DIF: Easy

116. ANS: C

Rationale: Code 69020 is the appropriate code for drainage of an abscess of the external auditory canal of the ear. The physician makes an incision in the skin and drains an abscess in the external auditory canal.

PTS: 1                   DIF: Moderate

117. ANS: C

Rationale: Code 69200 is the appropriate code for the removal of a foreign body from the external auditory canal without general anesthesia. Under direct visualization, the foreign body is removed from the external auditory canal using delicate forceps, a cerumen spoon, or suction. No anesthetic or local anesthetic is used.

PTS: 1 DIF: Moderate

118. ANS: A

Rationale: In the ICD-9-CM Index, look for Ptosis, eyelid, and you are directed to 374.30. Verification in the Tabular List confirms code selection.

PTS: 1 DIF: Moderate

119. ANS: B

Rationale: 69105 is the correct code since the biopsy was taken from the left ear in the auditory canal.

PTS: 1 DIF: Moderate

120. ANS: B

Rationale: Appendix or Appendectomy is not listed separately under the Anesthesia Section. The anesthesia code selections are under “Abdomen” in the CPT® Index, Anesthesia/Abdomen. Coder will need to know the appendix is an intraperitoneal organ located in the lower abdomen to assign the correct anesthesia code, 00840.

PTS: 1 DIF: Moderate

121. ANS: A

Rationale: Cholecystectomy is not listed separately in the Anesthesia Section. The anesthesia code selections are listed under Anesthesia/Abdomen in the Index. Coder will need to know “cholecystectomy” refers to the gallbladder, which is an Intraperitoneal organ located in the upper abdomen to assign the correct anesthesia code, 00790. The same code is reported whether the cholecystectomy is an open procedure, or performed laparoscopically. Hint – If your anatomy is not up to par, try looking up the surgical code for a cholecystectomy. The Tabular Listing 47562 offers an anatomical illustration of the gallbladder removal.

PTS: 1 DIF: Moderate

122. ANS: C

Rationale: 646.9 indicates the coder went to the Index and referenced Complications/pregnancy 646.9 and stopped looking. This is not the correct code and it requires a fifth digit. 761.9 indicates complications affecting fetus or newborn. Coding notes in the Tabular listing for acute renal failure (586) state “Excludes following labor and delivery (669.3)”. When referencing the Tabular listing for 669.3, the coder sees it requires a 5th digit “2” to indicate delivered, with mention of postpartum complication.

PTS: 1 DIF: Moderate

123. ANS: C

Rationale: Although not typically reported by physicians, insurance companies may require specific modifiers. The modifier 73 best describes an anesthesia service discontinued prior to administration of anesthesia in an ASC.

PTS: 1 DIF: Moderate

124. ANS: D

Rationale: Determining the base value is the first step in calculating anesthesia charges and payment expected. Time reporting is the second step. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia in either the operating room or an equivalent area. Anesthesia time ends when the anesthesiologist is no longer in personal attendance. Ending time is generally reported when the patient is safely placed under postoperative supervision, usually in the Post Anesthesia Care Unit (PACU) or equivalent area. Physical status modifiers and/or qualifying circumstances may also be added to the charge. In the scenario above, Base units equal ten (10) plus one (1) physical status modifier unit (Base 10 + PS 1 = 11 units). Seven (7) time units, in fifteen minute increments, is calculated by taking the anesthesia start time (11:02) and the anesthesia end time (12:47) and determining one hour 45 minutes ( $105/15 = 7$ ) of total anesthesia time. Eighteen units ( $11 + 7 = 18$ ) are then multiplied by the \$100 conversion factor ( $18 \times \$100 = \$1,800.00$ ).

PTS: 1                    DIF: Difficult

125. ANS: B

Rationale: Coder may look in the Index under Anesthesia/Neck or Integumentary/Neck to determine the range of codes related to the neck. A P3 modifier may be reported for a patient with severe systemic disease.

PTS: 1                    DIF: Difficult

126. ANS: A

Rationale: Coder must look under Anesthesia/Heart in the Index or Anesthesia/Intrathoracic System. Check this listing with the Anesthesia Subsection, Intrathoracic to determine 00560 is the correct code reported for patient's age and without use of a pump oxygenator. The arterial line placement is NOT reported as the perfusionist, not the anesthesia provider, performed it.

PTS: 1                    DIF: Difficult

127. ANS: A

Rationale: A CRNA with medical direction is appropriately reported with a modifier -QX.

PTS: 1                    DIF: Difficult

128. ANS: B

Rationale: According to Anesthesia guidelines, "time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia" (08:30) and ends when the patient is transferred to recovery (10:15). In this case, it is a total of 1 hour and 45 minutes. Anesthesia for a tubal ligation is reported with 00851.

PTS: 1                    DIF: Difficult

129. ANS: A

Rationale: The procedure performed is a PET-CT scan. The appropriate code is selected based on the anatomical location of the study. In this scenario, we know the test was performed on the skull base to the mid thigh. In the Index, see Nuclear Medicine/Tumor Imaging/Positron Emission/with Computed Tomography. According to CPT® coding guidelines, the IV administration of FDG is not reported separately. It is bundled in the service for the radiology procedure.

PTS: 1                    DIF: Moderate

130. ANS: A

Rationale: A biophysical test (BPP) measures the health of the fetus during pregnancy. Points are given (0, 1 or 2) in five areas (fetal movement, tone, breathing, amniotic fluid volume). A non-stress [test](#) (NST) monitors the baby's heart rate over a period of 20 minutes or more looking for accelerations with baby's movement. Since fetal non-stress test is included in code 76818, code 59025, Fetal non-stress test, should not be reported separately.

- PTS: 1                    DIF: Moderate  
131. ANS: C  
Rationale: Patient is having stereotactic radiation therapy technique delivered, not managed, in a large radiation dose to tumor sites in the upper right lobe of the lung. In the CPT® index see Radiation Therapy/Stereotactic/Body. According to ICD-9-CM guidelines: *Codes V58.0, Radiotherapy, and codes from subcategory V58.1, Encounter for chemotherapy and immunotherapy for neoplastic conditions. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy or chemotherapy for the treatment of a neoplasm. In the Index, see Encounter for/radiotherapy to find the V-code. In the Neoplasm table, see lung/upper lobe/Malignant/Primary.*
- PTS: 1                    DIF: Moderate  
132. ANS: D  
Rationale: Arthrocentesis is aspiration or injection with a needle involving a joint. According to CPT® coding guidelines, when radiopharmaceutical therapy is performed, you should select a code for the injection as well as the radiological guidance. Because the injection is intra-articular, the radiopharmaceutical therapy is reported with 79440. The fluoroscopic image guidance for a joint injection is reported with 77002. Modifier 26 is appended to both radiology codes to report the professional services performed by the physician in the ASC setting. The joint injection was performed on the knee, which is considered a large joint reported with 20610. When multiple procedures are performed, they are listed in RVU order.
- PTS: 1                    DIF: Difficult  
133. ANS: A  
Rationale: A radiographic study of the veins was performed in the inferior vena cava to visualize and evaluate any abnormalities. In the Index, see Venography/Vena Cava.
- PTS: 1                    DIF: Difficult  
134. ANS: A  
Rationale: There are seven fractions given in this patient's weekly treatment. According to CPT® guidelines: *Radiation treatment management is reported in units of five fractions or treatment sessions, regardless of the actual time-period in which the services are furnished. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment, one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. This instruction is found in CPT® under the heading "Radiation Treatment Management" in the Radiology/Radiation Oncology Section of the Radiology Chapter.*
- PTS: 1                    DIF: Difficult  
135. ANS: D  
Rationale: This is a limited ultrasound performed on three fetuses. CPT® code 76815 has in its code description the ultrasound is for *1 or more fetuses*. There is also a parenthetical note stating: *(Use 76815 only once per exam and not per element)*
- PTS: 1                    DIF: Difficult  
136. ANS: A  
Rationale: The fluorescent in situ hybridization or FISH test is a cytopathology test. You are directed to this by looking at FISH in the CPT® Index.
- PTS: 1                    DIF: Easy  
137. ANS: C  
Rationale: Examination without microscopic sections is coded 88300 for all types of specimens. Code 88304 includes both gross and microscopic exam.

- PTS: 1                    DIF: Moderate  
138. ANS: B  
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. In the Index, see Blood Tests/Panels/Hepatic Function. Also, see Creatinine/Blood
- PTS: 1                    DIF: Moderate  
139. ANS: B  
Rationale: Only the donor code is used. The specimen is being examined to identify a potential donor. The diagnosis of the potential recipient should not be coded. In the Index, see Donor/stem cells.
- PTS: 1                    DIF: Moderate  
140. ANS: C  
Rationale: Code 81025 is specific for a urine test, (84703 and 84702 are typically performed on blood). Code 36415 is for obtaining a blood specimen and is inappropriate with a urine test. In the Index, see Pregnancy/Urinalysis.
- PTS: 1                    DIF: Difficult  
141. ANS: C  
Rationale: The guidelines for Nursing Facility Services state, “These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center.”
- PTS: 1                    DIF: Easy  
142. ANS: C  
Rationale: The physician performed standby services. In the CPT® Index, Look for Standby Services/Physician Services and you are directed to 99360. 99360 is reported based on time. Each 30 minutes is reported if only the entire 30 minutes is met. 99360 with 1 unit is the correct code choice.
- PTS: 1                    DIF: Moderate  
143. ANS: C  
Rationale: When neonatal services are provided in the outpatient setting, Inpatient Neonatal Critical Care guidelines direct the coder to use critical care codes 99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes and 99292 ... each additional 30 minutes (List separately in addition to code for primary service). Care is documented as lasting 45 minutes with the physician in constant attendance. The physician also administered intrapulmonary surfactant (94610), placed an umbilical vein line (36510) and intubated the patient (31500). These services can be separately billed as they are not included in 99291.
- PTS: 1                    DIF: Difficult  
144. ANS: B  
Rationale: Documentation states the encounter is for a “checkup,” which is a Preventive Medicine Service. In the Index, see Preventive Medicine/Established Patient. Preventive Medicine Service codes are age specific. Although the child has a cold and thrush, additional history and exam elements beyond what is performed in the preventative exam are not documented. It would be inappropriate to bill for an additional E/M service with the modifier 25. See Appendix A description of modifier 25.
- PTS: 1                    DIF: Difficult  
145. ANS: B

Rationale: Patient is coming to the doctor's office, wants to quit smoking. The patient is new. The physician documents 20 minutes of the 30 minute visit was spent counseling the patient. E/M Guidelines identify when time is considered the key or controlling factor to qualify for a E/M service. When counseling and/or coordination of care is more than 50% face to face time in the office or other outpatient setting, time may be used to determine the level of E/M. The correct code is 99203 based on the total time of the visit which is 30 minutes.

PTS: 1 DIF: Difficult

146. ANS: B

Rationale: PTCA stands for percutaneous transluminal coronary angioplasty. In the Index, look for PTCA; you are directed to see Percutaneous Transluminal Angioplasty. Under Percutaneous Transluminal Angioplasty, Artery, Coronary, you are directed to code range 92982-92984. Code 92982 is used for one vessel. Code 92984 is used to report the second vessel.

PTS: 1 DIF: Easy

147. ANS: D

Rationale: The Hypertension table indexes "cardiovascular disease" to 402.00 in the malignant column. Guidelines Sec. I. C7 a.2 states code 402 is used when a causal relationship is stated or implied. Vol. 1 confirms code 402.00 is correct, as heart failure is not specified.

PTS: 1 DIF: Moderate

148. ANS: B

Rationale: In the CPT® Index, see Septal Defect/Ventricular/Percutaneous you are directed to code 93581. Code 93581 includes right heart catheterization. It is not separately reported. VSD is a congenital condition (present at birth). In the ICD-9-CM Index see Defect/Ventricular septal, you are directed to 745.4. Verification in the Tabular List confirms code selection.

PTS: 1 DIF: Moderate

149. ANS: C

Rationale: The patient is a new patient to the clinic. Code selection is made from 99201-99205 for the office visit. For a new patient, all three key components must be met. The clinic visit is reported as 99201. ICD-9-CM: The administration of the antibiotic is reported with 96372. In the Index, see Antibiotic Administration/Injection. The Bicillin CR is reported with J0558. The code descriptor for J0558 is 100,000 units. Report 12 units to correctly charge for the 1,200,000 units delivered to the patient, J0558 x 12. In the Index, see Wound, open/hand/complicated. The hand wound is coded as complicated due to the cellulitis (882.1). Cellulitis is in the Index under Cellulitis/hand (682.4). Report both 882.1 and 682.4. The "Index to External Causes" is a separate index, it is found right before the Tabular List of codes in ICD-9-CM. In the Index to External Causes see Cut, cutting/object, edged, pointed, sharp. The external cause of the injury is reported with E920.8. E016.9 is used to identify the activity. In the Index to External Causes, see Activity/maintenance/property.

PTS: 1 DIF: Moderate

150. ANS: B

Rationale: Left heart catheterization in the Index refers you to Cardiac Catheterization, Left Heart. Cardiac Catheterization, Left Heart, with Ventriculography leads to 93452, 93458-93459, 93565. 93452 is for the left heart catheterization for left ventriculography alone. 93458 includes coronary artery angiography, left heart catheterization and injection procedures for coronary angiography and left ventriculography with imaging supervision and interpretation. Modifier 26 is reported for the professional radiologic services.

PTS: 1 DIF: Difficult