Chapter 1

Section Review 1.1

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

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

2. B. fibromyalgia

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

3. D. ABN

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

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

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

5. C. $100 or 25%

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

Section Review 1.2

1. D. Patient

RATIONALE: Covered entities in relation to HIPAA include health care providers, health plans, and health care clearinghouses. The patient is not considered a covered entity although it is the patient’s data that is protected.
2. A. Only individuals whose job requires it may have access to protected health information.

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

3. B. HITECH

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

4. A. OIG Compliance Plan Guidance

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

5. C. OIG Work Plan

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

Section Review 2.1

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

2. B. Eyelid
   RATIONALE: The root word Blepharo means eyelid indicating a Blepharoplasty is performed on the eyelid.

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

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

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

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

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

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

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

10. A. Bladder and urethra

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

Section Review 2.2

1. D. Epithelial tissue

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

2. C. Thoracic cavity

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

3. A. Mucous membrane

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

4. B. Stratum Lucidum

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

5. C. Hypodermis

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

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

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

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

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

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

Section Review 2.4

1. C. Inferior and Superior Vena Cava
RATIONALE: Deoxygenated blood enters the right atrium through the superior vena cava and inferior vena cava.

2. B. Left and right pulmonary veins
RATIONALE: Blood is circulated through the pulmonary vascular tree in the lungs and sent back into the left atrium through the left and right pulmonary veins.

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

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

5. B. Oxygen deficiency

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

Section Review 2.5

1. C. With a system of one way valves

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

2. B. Phagocytes

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

3. D. Splenectomy

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

4. B. Subclavian veins

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

5. B. Lymphangitis

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

1. D. At the bifurcation of the trachea into two bronchi

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

2. B. Nose

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

3. B. Incision into the chest

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

4. C. Alveoli and capillaries

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

5. B. -pnea

RATIONALE: The suffix “-pnea” means breathing. You can derive this from the Medical Terms Related to the Respiratory System section. Each definition relating to breathing is for a word ending in -pnea.

Section Review 2.7

1. A. Duodenum

RATIONALE: The first portion of the small intestine is the duodenum, the second portion is the jejunum, and the distal portion is the ileum.

2. C. Liver

RATIONALE: The gallbladder stores bile produced in the liver. Bile secreted into the intestines from the gallbladder helps the body digest fats.

3. B. Transverse

RATIONALE: The ascending colon proceeds from the ileocecal valve upward to the hepatic flexure, becomes the transverse colon, and then turns downward to become the descending colon at the splenic flexure.
4. A. Buccal
RATIONALE: Bucca means cheek. Buccal is relating to the cheek. Buccal swabs can be used for DNA testing.

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

Section Review 2.8

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

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

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

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

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

Section Review 2.9

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

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

3. D. Vitreous humor

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

4. B. Labyrinth

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

5. B. Otopyorrhea

RATIONALE: Otopyorrhea is pus draining from the ear.

Section Review 2.10

1. D. Thyroid gland

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

2. B. Carotid body

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

3. C. Thymus gland

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

4. B. Pituitary gland

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

5. A. Adrenal glands

RATIONALE: The adrenal glands have two separate structural parts; The inner portion is the medulla and the outer portion is the cortex. Each structure performs a separate function.
Section Review 2.11

1. A. Erythrocytes

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

2. B. Lymphocytes

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

3. C. Monocytes

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

4. D. Eosinophils

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

5. C. Mononucleosis

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

Section Review 3.1

1. C. NEC

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

2. B. 250.41, 583.81

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

3. D. They do not affect code assignment.

RATIONALE: Parentheses are used in both the Index to Diseases and Tabular List to enclose supplementary words which may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

4. C. Volumes 1 and 2

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

5. B. Category

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

Section Review 3.2

1. D. Always consult the Alphabetic Index (Volume 2) first. Refer to the Tabular List (Volume 1) to locate the selected code.

RATIONALE: Introduction ICD-9-CM—How to Use the ICD-9-CM Volumes 1, 2, & 3—Steps to Correct Coding tells us to locate the term in the Alphabetic Index, then verify the code in the Tabular List.

2. B. 924.11

RATIONALE: In the Index to Diseases, look for bruise. You are directed to see also Contusion. Under Contusion, locate the site (knee) and you are referred to 924.11. Code 924.11 is for contusion of the knee.
3. **D. 600.91, 788.20**

**RATIONALE:** Look in the Index to Diseases for hyperplasia, then find prostate/with/urinary retention which refers you to 600.91. In the Tabular List, 600.91 has instructions to use an additional code to identify the symptoms. Code 788.20 is used for the urinary retention.

4. **D. 401.9**

**RATIONALE:** In the Index to Diseases, look for hypertension. When you find the Hypertension Table, you will see essential in parentheses indicating it is a supplementary word that does not affect coding. The documentation does not state if the hypertension is malignant or benign, so unspecified is used. Verify in the Tabular List that code 401.9 is for essential hypertension, unspecified.

5. **D. 719.45**

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

**Section Review 3.3**

1. **B. 787.01**

**RATIONALE:** The ICD-9-CM official guidelines, Section I.A.7 give instructions to code both conditions together when a combination code applies. Look in the Index to Diseases for Nausea/with vomiting. 787.01 combines the nausea and vomiting conditions.

2. **C. There is no time limit on late effects**

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

3. **B. Code the acute condition first, followed by the chronic condition**

**RATIONALE:** ICD-9-CM Official Coding Guidelines, Section I.B.10 state to code the acute condition first, followed by the chronic condition.

4. **A. Check the ICD-9-CM Index to see if there are listings under “threatened” or “impending” and if not, code the existing underlying condition(s) and not the condition described as impending.**

**RATIONALE:** ICD-9-CM Official Coding Guidelines, Section I.B.10 state to check the Index to Diseases for listings under threatened or impending. If not, code the existing underlying condition(s) and not the condition described as impending.
5. C. 824.8

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

Section Review 3.4

1. A. 574.20, 338.18

RATIONALE: According to the ICD-9-CM Guidelines, Section IV.A.2, when a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the primary diagnosis, and the complications as secondary diagnosis. Look for gallstone in the Index to Diseases and you are referred to see also Cholelithiasis, which refers you to 574.2x. Turn to the Tabular List to locate the fifth digit code of 0 for “without mention of obstruction.” For the pain, look for Pain/postoperative and you are referred to 338.18.

2. D. 620.2, 465.9, V64.1

RATIONALE: ICD-9-CM coding guidelines Section IV.A.1 states to report the reason for surgery as the first listed diagnosis even if the surgery is cancelled due to a contraindication. Look in the Index to Disease for Cyst/ovarian. 620.2 gives us the code for Ovarian Cyst. For the respiratory infection, look for Infection/respiratory/upper and you are referred to 465.9. Then, look for Surgery/not done because of/contraindication which refers you to V64.1.

3. C. 786.50, 780.60, 786.2

RATIONALE: ICD-9-CM coding guidelines, Section IV.I, instruct you to code signs and symptoms when the diagnosis is uncertain. Diagnosis stated as “rule out,” “suspected,” or “probably” are not reported. The pneumonia is “rule out” and is not coded. Instead, code the symptoms. In the Index to Diseases, look for Pain/chest (786.50), fever (780.60), and cough (786.2).

4. C. V22.1

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

5. D. V72.82, 289.4

RATIONALE: ICD-9-CM coding guidelines Section IV.N. states to sequence first a code from category V72.8, Other specified examination, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Look in the Index to Diseases for Examination/preoperative/respiratory (V72.82) and for hypersplenism (289.4). Verify the codes in the Tabular List.
Chapter 4

Section Review 4.1

1. D. 820.19, 042

RATIONALE: Section 1.C.1.a.2.b of the ICD-9-CM Coding Guidelines states, “If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (eg, the nature of the injury code) should be the principal diagnosis. Other diagnosis would be 042 followed by additional diagnosis codes for all reported HIV-related conditions.” The open fracture of the head of the femur (820.19) is reported first as the reason for the visit, and is unrelated to HIV. To locate the diagnosis, look in the Alphabetic Index for Fracture/Femur/Head/Open 820.19. The HIV is symptomatic so it is reported secondarily with 042.

2. A. 038.9, 995.92, 584.9

RATIONALE: With severe sepsis, we are instructed to use three codes: First, the underlying infection is reported, followed by severe sepsis, followed by the organ failure. Even though the documentation does not state “severe” sepsis, looking in the ICD-9-CM Index to Diseases under sepsis with acute organ dysfunction, we are directed to 995.92 for severe sepsis. Code 995.92 has instructions to “Code first the underlying infection” and to use an additional code to specify the acute organ dysfunction. Section 1.C.1.b.1.(b),(ii) states to code the systemic infection (038.xx, 112.5, etc.) and either code 995.91 or 995.92. If the causal organism is not documented, assign code 038.9, Unspecified Septecemia.

Section 1.C.1.b.1.(b)(iii) also states severe sepsis requires an additional code for acute organ dysfunction. In this case the organ dysfunction is acute renal failure. Look in the Alphabetic Index for Failure/Renal/Acute 584.9. The correct codes and sequencing are 038.9, 995.92, and 584.9.

3. B. 482.42

RATIONALE: Look in the ICD-9-CM Alphabetic Index for Pneumonia/due to/Staphylococcus/aureus/methicillin/resistant (MRSA) 482.42. According to Section 1.C.1.c.1.(a), when a combination code exists for MRSA and the infection, only the combination code should be reported. Methicillin resistant pneumonia due to Staphylococcus aureus is reported with 482.42.

Section Review 4.2

1. D. 197.0, V10.3

RATIONALE: According to ICD-9-CM Guidelines Section 1.C.2.d., when a primary malignancy has been previously excised and no there is no evidence of any existing primary malignancy, a code from V10, Personal history of malignant neoplasm should be used. Any mention of metastasis to another site is coded as a secondary malignant neoplasm to that site and the secondary site may be the first-listed with the V10 code used as a secondary code. For the lung cancer, look in the Neoplasm Table for lung and use the code from the secondary column (197.0). For the history of breast cancer, look in the Index to Diseases for History of/Malignant Neoplasm/Breast (V10.3). The correct codes and sequencing are 197.0 and V10.3.
2. A. 285.3, 183.0

RATIONALE: According to ICD-9-CM Guidelines Section 1.C.2.c.2., because the treatment is directed at the anemia associated with chemotherapy, and the treatment is only for the anemia, the anemia should be sequenced first, and the neoplasm should be assigned as an additional diagnosis. Look in the Index to Diseases for Anemia/due to/antineoplastic chemotherapy (285.3). To find the code for ovarian cancer, look in the Neoplasm Table for Ovary and use the code from the primary column (183.0). The correct codes and sequencing are 285.3 and 183.0.

3. D. V58.11, 162.3

RATIONALE: The ICD-9-CM Official Coding Guidelines, Section 1.C.2.e.2., state that if the reason for the encounter is solely chemotherapy, a diagnosis for chemotherapy administration should be listed first, and a diagnosis for the malignancy requiring the chemotherapy is reported secondarily. Look in the Index to Diseases for Chemotherapy/encounter for (V58.11). A Pancoast tumor is a rapid growing tumor in the apex of the lung. The apex of the lung is in the upper lobe. Look in the Neoplasm Table for Lung/upper lobe and select the code from the primary column (162.3). The correct codes and sequencing are V58.11 and 162.3.

Section Review 4.3

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

RATIONALE: The ICD-9-CM Official Coding Guidelines, Section 1.C.3.a.6., states to use 996.57 as the primary diagnosis for an underdose of insulin followed by the appropriate diabetes mellitus code based on documentation.

2. A. 250.00

RATIONALE: According to ICD-9-CM Official Coding Guidelines, Section 1.C.3.a.1., the age of the patient is not the determining factor in what type of diabetes is coded. In addition, Section 1.C.3.a.2 says if the type of diabetes mellitus is not documented in the medical record the default type is type II. To find the code, look in the ICD-9-CM Index to Diseases for diabetes. The default code is 250.0x. Turn in the Tabular List to 250.0x. Review the fifth digits. Based on the guidelines stated, a fifth digit of 0 is selected.

3. B. 250.50, 362.01, 362.07

RATIONALE: According to ICD-9-CM Official Coding Guidelines, Section 1.C.3.a.4.a., macular edema is only present with diabetic retinopathy. Code 362.07 should be used in addition to another code from subcategory 362.0. Codes under subcategory 362.0 are diabetes manifestation codes, so they must be used following the appropriate diabetes code. The diabetes category 250 is reported first. To locate the codes in the ICD-9-CM codebook, look in the Index to Diseases for Diabetes, diabetic/retinopathy 250.5x [362.01]. Locate the code for macular edema by looking for Edema/macula/diabetic 250.5x [362.07]. Because 250.5x is already reported for the diabetic retinopathy, it is not reported again. However, 362.07 is reported in addition to 250.50 and 362.01.
Section Review 4.4

1. C. The chronic condition causing the anemia

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

2. A. 185, 285.22

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.C.4.a.2., state to use 285.22 when the anemia is due to cancer, and 285.3 when the anemia is due to chemotherapy. The patient visited the oncologist for the prostate cancer and the lab tests indicate anemia due to cancer. According to the guidelines, the primary diagnosis is the reason for the visit, which is prostate cancer. Look in the Neoplasm Table for prostate (gland) and select the code from the Primary column 185. Then look in the Index to Diseases for Anemia/in (due to) (with)/antineoplastic disease 285.22.

3. B. 285.21, 585.3

RATIONALE: ICD-9-CM Official Coding Guidelines, Section I.C.4.a., address the sequencing of anemia with other chronic conditions. If the anemia is the primary reason for the encounter code 285.21 is listed first followed by the stage of chronic kidney disease. Look in the Index to Diseases for Anemia/in (due to) (with)/chronic kidney disease 285.21. According to ICD-9-CM Guidelines Section I.C.4.a.1, a code indicating the stage of chronic kidney disease should also be reported. Look in the Index to Diseases for Disease/Kidney/chronic/stage/III (moderate) 585.3.

Section Review 4.5

1. D. 331.0, 294.10

RATIONALE: In Volume 2, the Index to Diseases, look at the main term Alzheimer’s/due to or associated with condition(s) classified elsewhere/Alzheimer’s. The patient has dementia with no documented behavioral disturbances. Two codes are required: 331.0 and 294.10. There is a bracket surrounding 294.10; According to ICD-9-CM Conventions and coding guidelines, brackets are used to identify manifestation codes. In the Tabular List, category 331 instructions are to Use additional code, where applicable to identify dementia: with behavioral disturbance (294.11) or without behavioral disturbance (294.10).

2. B. 303.91

RATIONALE: The patient’s diagnosis is alcoholism. From Volume 2, the Index to Diseases, look up “alcoholism.” You are referred to 303.9. Category 303 requires a fifth digit. The patient drinks excessively every day. Fifth digit “1”, “continuous” is the appropriate fifth digit.

3. A. 314.00

RATIONALE: The patient is diagnosed with ADD, Attention Deficit Disorder. From Volume 2, the Index to Diseases find Disorder/attention deficit. You are referred to 314.00. Validate the code in Volume 1, Tabular List.
Section Review 4.6

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

RATIONALE: According to ICD-9-CM Official Coding Guidelines, Section I.C.6.a.1.(a), when pain control or pain management is the reason for the admission/encounter, a diagnosis from 338 can be reported as the primary diagnosis.

2. B. 162.9, 338.3

RATIONALE: According to ICD-9-CM Official Coding Guidelines, 1.C.6.a.5, when the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code 338.3 may be assigned as an additional diagnosis. In Neoplasm Table, look for lung and select the code from the Primary column. To report the pain associated with the neoplasm, look in the Index to Diseases for Pain/due to/malignancy 338.3.

3. C. 338.21, 724.2

RATIONALE: According to ICD-9-CM Official Coding Guidelines, Section I.C.6.a.1.(a), when a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the first listed diagnosis. According to Section 1.C.6.b.ii., a code to report the site of pain may be sequenced as a secondary diagnosis. In the Index to Diseases, look for Pain/Chronic/due to trauma 338.21 (because the pain is due to the falling off a roof). To report the location of the pain, look in the Index to Diseases for Pain/back/lower 724.2.

Section Review 4.7

1. D. First code the retinopathy, then the hypertension.

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

2. C. Code only STEMI

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

3. B. Hypertension and chronic kidney disease

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.7.a.3, state that hypertension has a presumed cause-and-effect relationship with CKD.
Section Review 4.8

1. B. Worsening or decompensation of a the asthma or COPD

RATIONALE: ICD-9-CM Official Coding Guidelines, Section 1.C.8.a.2., states an acute exacerbation is a worsening or decompensation of a chronic condition.

2. B. 493.91

RATIONALE: According to ICD-9-CM Official Coding Guidelines, Section 1.C.8.a.4., it is inappropriate to assign an asthma code with fifth digit 2, with acute exacerbation, together with an asthma code with fifth digit 1, with status asthmatics. Only the fifth digit 1 should be assigned. To locate the code in the Index to Diseases, look for Asthma, asthmatic which refers to 493.9x. Turn to the Tabular List and select the fifth digit “1” to indicate with status asthmaticus.

3. C. 491.22

RATIONALE: According to ICD-9-CM Official Coding Guidelines, Section 1.C.8.b.1., when acute bronchitis is documented with COPD, 491.22 Obstructive chronic bronchitis with acute bronchitis should be assigned. Locate the correct code in the Index to Diseases by looking for Disease/pulmonary/obstructive diffuse (chronic)/with/acute bronchitis. Verify accuracy in the Tabular List.

Section Review 4.9

1. B. 553.01

RATIONALE: From Volume 2, Alphabetic Index to Diseases, look up Hernia/femoral/recurrent (unilateral). You are directed to 553.01. Verify the code in Volume 1, Tabular List.

2. B. 571.2

RATIONALE: From Volume 2, Index to Diseases, look up Cirrhosis/Laennec’s (of liver). There are two options: 571.2 and 571.5. Refer to Volume 1, Tabular List; code 571.2 is defined as Laennec’s cirrhosis (alcoholic); code 571.5 is cirrhosis of the liver without mention of alcohol. In this scenario the patient has a history of alcohol use making 571.2 the correct code.

3. C. 574.10

RATIONALE: The patient is diagnosed with gallstones (cholelithiasis) and gallbladder inflammation (cholecystitis). In Volume 1, Index to Disease, find Stones; you are referred to calculi by site. Calculi of the gallbladder directs you to cholelithiasis. Find Inflammation, gallbladder; you’re referred to cholecystitis. To locate the diagnosis code, find Cholelithiasis, with cholecystitis. You are referred to 574.1. A fifth digit is required. Turn to the Tabular List for fifth digit selection. There is no mention of obstruction making fifth digit ‘0’ the correct choice.
Chapter 5

Section Review 5.1

1. C. 591

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

2. D. 218.9

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

3. C. 600.01, 788.63

RATIONALE: The patient is diagnosed with BPH (Benign Prostatic Hypertrophy) and urgency, which is a symptom of urinary obstruction. Look in the Index to Diseases for Hypertrophy/prostate/benign/with/other lower urinary tract symptoms (LUTS). Turn to the Tabular List to confirm 600.01. The obstruction does not have to be complete to report code 600.01. There is a note under 600.01 to “Use additional note to identify symptoms.” A code for urinary urgency (788.63) also is selected. Urinary urgency may also be found by looking in the Index to Diseases under Urgency/urinary.

Section Review 5.2

1. C. 648.23, 280.9

RATIONALE: Codes 648.23, 280.9 are both assigned. ICD-9-CM Guideline 1.C.11.e. states to assign a code from subcategory 648.x for patients that have current conditions when the conditions affect the management of the pregnancy, childbirth, or puerperium. It also instructs to use secondary codes from other chapters to identify the condition(s). Look in the Index to Diseases for Pregnancy/complicated/anemia. Turn in the Tabular List for fifth digit selection. Code 648.23 is assigned because it is complicating the pregnancy, requiring transfusion, and it is antepartum. To report the specific condition, look in the Index to Diseases for Anemia/iron (Fe) deficiency. Code 280.9 is assigned to provide greater specificity as to the type of anemia.

2. A. 666.24

RATIONALE: Look in the Index to Diseases for Retention, retained/placenta/portions or fragments. Turn in the Tabular List for fifth digit selection. Fifth digit is “4” because this is a postpartum condition. Code 666.24 is correct because it indicates delayed postpartum hemorrhage due to retained placenta. Only code 666.24 is required because it completely explains the circumstances.
3. D. 943.21, 948.00, V22.2

RATIONALE: The pregnancy is incidental to the problem for which the patient is treated. ICD-9-CM Guideline 1.C.18.d.3. indicates V22.2 is a secondary code only for use when the pregnancy is in no way complicating the reason for the visit. The first listed code is for the burns. The patient has a second degree burn to both forearms. In the Index to Diseases, look up Burn/forearm/second degree. You are referred to 943.21. A code from category 948 is coded to indicate the TBSA burned, as well as the percentage of the burn that is third degree. The TBSA is 9 percent and there are no third degree burns.

Section Review 5.3

1. D. 707.07, 707.20

RATIONALE: Codes for pressure ulcers are determined by site. In this case, the patient has pressure ulcers on each heel. Look in the Index to Diseases for Ulcer/pressure/heel. A pressure ulcer of the heel is reported with 707.07. Although both heels are involved, the code is listed only once. Turn to the Tabular List to verify the code. Code 707.0 has a note under it stating to report an additional code to identify the stage. The guidelines state two codes are required with pressure ulcers, one for the site and one for the stage. Look in the Index to Diseases for Ulcer/pressure/stage. The stage is not documented; it is coded as unspecified (707.20). Unstageable can only be coded based on clinical documentation, which is not documented in this case.

2. D. 692.0

RATIONALE: The patient is diagnosed with dermatitis due to detergent. In the Index to Diseases, look for Dermatitis/due to/detergents. You are referred to 692.0. Verify the code accuracy in the Tabular List.

3. A. 682.6

RATIONALE: From the Index to Diseases, look for Abscess/leg. The code referenced is 682.6. Abscesses of the skin are reported with cellulitis codes. Verify the code in the Tabular List. Category 682 has a note to report an additional code for the causal organism. This is unknown, so it is not coded.

Section Review 5.4

1. A. 722.10

RATIONALE: L5 and S1 refer to the fifth lumbar disc and the first sacral disc in the vertebra. Look in the Index to Diseases for Hernia/intervertebral disc, you are referred to Displacement/intervertebral disc/lumbar, lumbosacral. This entry refers you to code 722.10. The description validates code choice. Because sciatica is a symptom of a displaced disc, the ICD-9-CM coding guidelines tell us it would not be reported separately. Myelopathy indicates the spinal cord is damaged, and there is no documentation of this.

2. B. 726.10, 715.91

RATIONALE: The patient has a degenerative rotator cuff tear and degenerative arthritis. The primary reason for the procedure is the tear, so it is reported first. In the Index to Diseases, look for Tear/rotator cuff/degenerative. You are referred to 726.10. For the second diagnosis, look for Arthritis/rotator cuff. You are referred to osteoarthritis. There is no indication that the arthritis is localized or generalized, or primary or secondary. It is reported with 715.91 because it is the patient’s shoulder.
3. C. 733.14, 733.00

RATIONALE: The fracture is sequenced first because it is the reason for the encounter. From the Index to Disease, look for Fracture/due to/osteoporosis and you are directed to see Fracture, pathologic. Fracture/pathologic/hip refers you to 733.14. There is no additional information documented for the osteoporosis; therefore, it is coded as unspecified (733.00).

Section Review 5.5

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

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

2. C. V30.00, 758.0

RATIONALE: According to the guidelines Section I.C.14.a. for birth admission, the appropriate code from category V30 Liveborn infants, according to the type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes 740–759. To find the type of birth, look in the Index to Diseases for Newborn/single/born in hospital V30.00. Mongolism would be reported secondarily and found in the ICD-9-CM Index to Diseases under mongolism.

3. C. 749.20

RATIONALE: Look in the Index to Diseases for Cheilopalatoschisis. You are directed to “see also Cleft, palate, with cleft lip” (749.20). Cross-reference in the Tabular List and assign the correct code.

Section Review 5.6

1. B. It ends at 28 days

RATIONALE: According to the ICD-9-CM Guidelines for Coding and Reporting, Section I.C.15, “For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth.”

2. D. V30.00, 774.6

RATIONALE: According to the Official Coding Guidelines, the first listed diagnosis code is used to report the birth episode, followed by additional codes for perinatal conditions. Look in the Index to Diseases for Newborn/single/born in hospital. You are referred to V30.00. In the Index to Diseases, look for Jaundice/newborn. You are referred to 774.6. Verify all codes in the Tabular List.

3. B. 779.31

RATIONALE: In the Index to Diseases, look for Feeding/problem/newborn. You are referred to 779.31. Verify the code in the Tabular List.
Section Review 5.7

1. B. 783.0, 276.51

RATIONALE: Guidelines tell us not to report an unsubstantiated “probable” or “rule out” diagnosis; therefore, a diagnosis of dementia would not be appropriate at this time. The symptoms are dehydration and anorexia. Each of these terms requires a simple look-up in the Index to Diseases. Although “anorexia” often is a short way of describing “anorexia nervosa,” in this case, there is no documentation of an eating disorder as a psychological disorder; simple anorexia, 783.0, is the correct diagnosis. Dehydration is reported with 276.51. Verify all codes in the Tabular List.

2. B. 796.2

RATIONALE: Elevated BP is a nonspecific finding with no formal diagnosis of hypertension. This is considered an incidental finding. Hypertension should not be coded unless it is documented specifically by the physician. Look in the Index to Diseases for Elevation/blood pressure/reading.

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

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

Section Review 5.8

1. A. 823.82

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

2. C. 999.31, 041.12

RATIONALE: When complications are reported, a code for the complication is reported first. If the cause of the complication is known, it is reported secondarily. Look in the Index to Diseases for Complication/infection and inflammation/due to/catheter/peripherally inserted central (PICC) 999.31. For MRSA, look for Methicillin/resistant staphylococcus aureas (MRSA) 041.12. Verify both codes in the Tabular List.

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

RATIONALE: The patient took the correct medication but not as prescribed accidentally. This is considered a poisoning. The first code is listed to identify the poisoning code for type of medicine, followed by the symptoms, and finally the E code for accidental poisoning. Look in the Drug Table for antidepressants. The first code reported is the code from the poisoning column (969.00). The last code reported is the E code from the Accident column (E854.0). The manifestation or condition codes are reported in between. Look in the Index to Diseases for dizziness (780.4) and Sweat(s), sweating/excessive 780.8.
Section Review 5.9

1. C. V70.5

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

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

RATIONALE: Code the special screening as a reason for the encounter, along with a code to report the patient’s breast density, which provides medical necessity for a more extensive test. Dense breast tissue occurs in many premenopausal women, and can interfere with reading a mammogram and may mask abnormalities in the image. Look in the Index to Diseases for Screening/malignant neoplasm/breast/specified type NEC (V76.19). For the breast density, look in the Index to Diseases for Dense/breast (793.82). This code provides medical necessity of an ultrasound. To report the family history of breast cancer, look in the Index to Diseases for History/family/malignant neoplasm/breast (V16.3), which may provide medical necessity information for the screening exam in a young patient. Verify all codes in the Tabular List.

3. B. The V code to identify the screening

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

Section Review 5.10

1. D. 813.33, 802.23, E812.1

RATIONALE: A code is reported for each fracture. The radius and ulna fracture is open, which makes it the most severe injury; therefore, it is reported first. Look in the Index to Diseases for Fracture/radius/shaft/with ulna/open (813.33). The next listed code is the coronoid fracture of the jaw. Look in the Index to Diseases for Fracture/coronoid process/mandible (closed) (802.23). The patient was a passenger in a car that collided with another car. Look in the Index to External Causes for Collision/motor vehicle/and/another motor vehicle (E812). This code indicates to check for a fourth digit. Look in the Tabular List for E812. The patient was a passenger making “1” the correct fourth digit (E812.1). There are no other circumstances known about the collision, so no other E codes are reported.

2. B. 784.7, E917.0, E007.6, E849.4

RATIONALE: The epistaxis is caused from an injury; it is not hereditary. This is found by looking in the Index to Diseases for Epistaxis and using the default code (784.7). Three E codes are required in this case. The first E code indicates how the injury occurred (hit with a ball). Look in the Index to External Causes for Striking against/object/in/sports (E917.0). The next code reports the activity he was involved in at the time (basketball). Look in the Index to External Causes for Activity/basketball, which is reported with E007.6. The last E code to report is the place of occurrence. Look in the Index to External Causes for Accident/occurring/gymnasium (E849.4).

3. A. E codes are never sequenced first

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

Section Review 6.1

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

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

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

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

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

Section Review 6.2

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

2. B. Category I, II, and III
Answer: B. Category I, Category II, Category III—The main body of the CPT® codebook is comprised of the Category I CPT® codes (00100–99607), Category II CPT® codes (0001F–7025F), Category III CPT® codes (0019T–0318T).

3. B. Condition, synonyms, abbreviations
Answer: B. The CPT® codebook’s index is alphabetized with main terms organized by condition; procedure; anatomic site; synonyms, eponyms and abbreviations.
4. C. Malpractice insurance costs, physician work, practice expense

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

5. D. Both B and C

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

6. B. CPT® Category II codes

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

7. A. New and emerging

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

8. B. C

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

Section Review 6.3

1. D. None of the above

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

2. C. 90 days

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

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

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

4. C. 24, 25, 57

Answer: C. Modifiers 24 Unrelated evaluation and management service by the same physician during a postoperative period, 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, and 57 Decision for surgery are used on evaluation and management CPT® codes only.

5. A. 000

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

Section Review 6.4

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

Answer: C. Three types of HCPCS codes printed in the HCPCS Level II codebook consist of: Permanent National Codes, Miscellaneous Codes/not otherwise classified, Temporary National Codes.

2. C. Quarterly

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

3. B. C codes

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

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

5. D. J codes

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

Section Review 6.5

1. B. 50

Answer: B. 50 Bilateral Procedure

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

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

3. D. NU

Answer: D. NU—New Equipment

4. C. 32

Answer: C. CPT® modifier 32—Mandated Services

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

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

Section Review 7.1

1. A. 704.00

RATIONALE: Alopecia is hair loss. You can find the correct code in the index by looking for Loss/hair, or for Alopecia in the Index to Diseases. Either entry refers you to 704.00. Telogen effluvium is hair loss due to stress, but the provider only suspects it is due to stress so it is not coded.

2. D. 702.0

RATIONALE: Look in the ICD-9-CM Index to Diseases under Keratosis/actinic and you are referred to ICD-9-CM 702.0. This is verified by looking in the Tabular List under 702.0.

3. B. 707.04, 707.20

RATIONALE: A bed sore is a pressure ulcer. Look in the ICD-9-CM Index to Diseases for Ulcer/pressure/hip and you find 707.04. After verifying 707.04 is the correct code in the Tabular List, you will find a note under subcategory 707.0 stating to use an additional code to identify the stage of the pressure ulcer. 707.20 is used because there is no mention of the stage of the ulcer.

4. C. Sequence first the code reflecting the highest degree of burn

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

5. A. 882.0, 910.8

RATIONALE: The more serious injury is the laceration to the right hand. To find laceration in the Index to Diseases, look for Wound/open/hand. This is not considered a complicated wound because there is no mention of infection or delayed healing. The injury to the scalp is only stated as superficial. In the Index to Diseases, look for Injury/superficial/scalp.

Section Review 7.2

1. B. 11100, 11101

RATIONALE: Correct codes are 11100 and 11101. Code 11100 is for the first lesion of the left arm and the add-on code of 11101 is appended for the lesion on the right arm. The codes are found in the CPT® Index by looking for Skin/biopsy which refers you to codes 11100–11101.
2. A. 10060

RATIONALE: Codes 10060–10061 describe the incision and drainage of abscess of a cyst; simple or complicated/multiple. There is no indication the cyst is complicated resulting in 10060.

3. D. 11200, 11201

RATIONALE: Codes 11200–11201 describe removal of skin tags. 11200 is used for up to and including 15 tags; 12001 is used for each additional 10 or part thereof. The removal of 18 skin tags is reported with 11200 and 11201. There is no modifier used with an add-on code.

4. A. 11921, 11922

RATIONALE: Code selection is based on square centimeters. The total square centimeters is 1.5 cm² plus 10.5 cm² equaling 22.0 cm². Code 11921 is used to report 6.1 cm² to 20 cm²; 11922 is used to report each additional 20 cm², or part thereof. The codes are located by looking in the CPT® Index for Tattoo/skin which refers you to 11920–11922. 11922 is an add-on code making it exempt from modifier 51.

5. A. 11312

RATIONALE: Look in the CPT® Index for Shaving/Skin Lesion and you are referred to 11300–11313. Shaving of lesions is based on anatomical location and lesion size in centimeters. The shaving of a 1.4 cm cheek lesion is reported with 11312.

Section Review 7.3

1. B. 11300, 11300-51 x 2

RATIONALE: The lesions are removed using a shaving method reported with CPT® code range 11300–11313. Shaving of lesions is based on anatomical location and lesion size in centimeters. Each lesion is coded separately. All lesions are on the leg and the code selection is made from range 11300–11303. Since the specific measurements of the lesions are not stated, the smallest diameter is reported. Code 11300 is reported three times and may be reported as 11300, 11300-51x2 or 11300, 11300-51, 11300-51.

2. D. 13101, 12035-59, 12052-59, 12011-59

RATIONALE: Repair (Closure) codes are classified as Simple, Intermediate, and Complex. Code selection is based on the type of repair and the anatomical location. Repairs within the same anatomical location are added together. The abdomen and buttock are both part of the trunk, so these repairs are added together. The most complex repair is coded first; CPT® code 13101 is reported for the complex repair of abdominal and buttock with total closure of 4.1 cm. The arms and scalp are in the same anatomical category for these codes, so the repair length for the arm and scalp are added together. CPT® code 12035-59 is reported for the intermediate repair of the arm and scalp with total closure of 15.5, CPT® code 12052-59 is reported for the 3.8 cm intermediate repair of the cheek and CPT® 12011-59 is reported for the 2.3 cm simple repair of the lip. The CPT® guidelines state to use modifier 59 when more than one classification of wounds is repaired.
3. C. 12032, 11403-51

RATIONALE: The lesion is suspicious and not classified as malignant. A code from Excision—Benign lesion is reported. Code selection is based on anatomic location and size in centimeters. The size is noted as 1.5 cm with margins of 3 mm on each side. 3 mm = 0.3 cm. 1.5 cm + 0.3 cm + 0.3 cm = 2.1 cm. Code range 11400–11406 is used for excision of benign lesions on the trunk, arms, or legs. A size of 2.1 cm is reported with 11403. The note supports an intermediate closure was performed. The repair measured 5.0 cm and is documented to be in layers, indicating an intermediate closure. Code range 12031–12037 is used to report intermediate repairs on the scalp, axillae, trunk and/or extremities. The repair measures 5 cm, making 12032 the correct code.

4. B. 11403

RATIONALE: A dysplastic nevus is considered a benign lesion. Excision of benign lesions is reported by anatomical location and size in centimeters. Code range 11400–11406 is used to report excision of benign lesions on the trunk. The excision of benign lesions are based on size (2.2 cm), which leads you to 11403.

5. C. 14020

A rhomboid flap is an adjacent tissue transfer. Adjacent tissue transfer or rearrangement codes are selected based on anatomical location and defect size in square centimeters. Look in the CPT® Index for Skin/Adjacent Tissue Transfer and you are referred to code range 14000–14350. Code range 14020–14021 is used to report rhomboid flaps on the scalp/arms/and/or legs. The total defect size is 5.44 sq cm (1.2 cm x 1.2 cm = 1.44 sq cm; 2 cm x 2 cm = 4 sq cm; 1.44 sq cm + 4 sq cm = 5.44 sq cm). Refer to measurements of rotation flaps in CPT® Professional Edition, page 70. Code 14020 is reported for an adjacent tissue transfer or rearrangement of arm with a defect of 10 sq cm or less. According to CPT® guidelines, excision of the lesion is included in the flap reconstruction and is not coded separately.

Section Review 7.4

1. B. 17111

RATIONALE: The code range for destruction of warts is reported with 17110 or 17111. Code selection is based on the number of warts destroyed. The patient has a total of 19 warts destroyed. 17110 describes destruction up to 14 lesions; 17111 describes the destruction of 15 or more lesions. The correct CPT® code is 17111 for destruction of 19 warts.

2. D. 17272, 17281-51

RATIONALE: Basal Cell Carcinoma (BCC) is a malignant lesion. Destruction of malignant lesions are reported with code range 17260–17286. Code selection is based on anatomical location and lesion size in centimeters. A 0.7 cm lesion of the face is reported with 17281; a 1.2 cm lesion of the hand is reported with 17272. 17272 has a higher RVU and is listed first. 17281 is listed second with modifier 51 indicating multiple procedures performed at the same operative session by the same provider.
3. A. 17311, 17312, 17312, 17315, 17315

Codes are reported by the number of stages and tissue blocks. There were a total of 3 stages performed. CPT®
17311 is reported for the first stage and add-on code 17312, +17312 is listed twice for each additional stage. The
first stage was divided into seven tissue blocks. Code 17315 is reported for each piece of tissue beyond five for any
one stage. It isn't appropriate to add and average all blocks from all layers. CPT® +17315, +17315 for the sixth and
seventh block.

4. B. 19318-LT

Code 19318 is found in Repair and or Reconstruction and is used to report a reduction mammoplasty. In the CPT®
Index, see Breast/reconstruction/mammoplasty.

5. A. 19120-LT

The excision of a breast cyst is reported with 19120 and is found in the CPT® Index by finding Breast/Excision/
Lesion. Review the codes to choose appropriate service.
Chapter 8

Section Review 8.1

1. B. Wrist

RATIONALE: A Colles' fracture is a fracture of the distal radius and sometimes involves the ulna. These areas of the forearm bones are part of the wrist joint.

2. B. Reduction

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

3. C. One includes manipulation and one does not

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

4. D. Tendon

RATIONALE: Tendons attach muscles to bone, and ligaments attach bones to other bones.

5. A. Striated or skeletal

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

Section Review 8.2

1. D. Open fracture

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

2. D. Dislocation

RATIONALE: Nursemaid's elbow is a partial dislocation of the proximal radial head, occurring in young children.

3. A. Syndrome, compartment, traumatic, lower extremity

RATIONALE: Compartment syndrome is listed under Syndrome in ICD-9-CM. The three sub-categories are non-traumatic, post-surgical, and traumatic. An auto accident would be considered a traumatic injury.
4. C. 733.14, 733.00

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

5. B. The five lumbar vertebral bones

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

Section Review 8.3

1. A. 29883

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

2. C. 29879

RATIONALE: Code 29879 is used for Arthroscopy, knee, surgical; abrasion arthroplasty (Includes chondroplasty where necessary) or multiple drilling or microfracture. Note that the code is in the arthroscopy section, not an open procedure.

3. B. 20610

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

4. D. 27506-RT

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

5. C. 29075-58

RATIONALE: The first cast or splint is included as part of the initial fracture treatment; because this was a replacement cast, it can be coded.
6. A. 21073
RATIONALE: Manipulation of a TMJ requiring anesthesia would be reported with 21073. If the TMJ was dislocated, a different code would be used.

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

8. C. 28470-TA
RATIONALE: This would be considered a closed treatment because no surgery was performed. The orthotic boot could be coded separately, by whomever supplied it.

9. B. 28299-RT
RATIONALE: A double osteotomy can be performed on the phalanx and the metatarsal, or by making two incisions on the metatarsal bone.

10. D. 22800
RATIONALE: Spinal arthrodesis is coded based on the approach; L3-L5 is considered to be three segments. Instrumentation also would be coded for this procedure, if it were used.
Chapter 9
Section Review 9.1

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

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

3. D. 5
   RATIONALE: There are five lobes total, three in the right and two in the left.

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

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

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

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

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

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

10. C. voice box

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

Section Review 9.2

1. D. 491.22

RATIONALE: Acute bronchitis with COPD always should be coded in the COPD section of codes, not as an acute disease. Excludes notes under 466.0 in the Tabular List state, “acute bronchitis with chronic obstructive pulmonary disease (491.22).” Look in the ICD-9-CM Index to Diseases for Disease/pulmonary/diffuse obstructive with acute bronchitis.

2. C. 474.10

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

3. C. 033.9, 484.3

RATIONALE: Code underlying disease first (whooping cough), then the pneumonia. The ICD-9-CM Index shows Whooping cough/with pneumonia “033.9 [484.3],” which indicates 484.3 is the second-listed code. The Tabular List for category code 033 indicates “Use additional code to identify any associated pneumonia (484.3).” This code can also be indexed under Pneumonia/in/whooping cough.

4. B. 493.02

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

5. D. 512.0, 305.1

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

6. A. 164.0

RATIONALE: Primary malignancy of the thymus is coded with 164.0. Look in the ICD-9-CM Index to Diseases for Thymoma/malignant.
7. B. 457.1

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

8. A. 466.11

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

9. D. 471.9

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

10. C. 162.3

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

Section Review 9.3

1. C. 30801

RATIONALE: Code 30801 is superficial ablation of the turbinates, as compared to 30802, which is intramural ablation of the turbinates. Code 30140 is a submucous resection of the inferior turbinate, not an ablation. In the index, look for Ablation/Turbinate Mucosa which directs you to 30801-30802.

2. D. 31231

RATIONALE: Code 31231 is a diagnostic nasal endoscopy, unilateral and bilateral as stated in the code; no modifier is necessary. In the index, look for Endoscopy/Nose/Diagnostic which directs you to 31231–31235.

3. B. With mirrors

RATIONALE: Indirect endoscopy of the larynx is performed by viewing the larynx with the use of mirrors. In contrast, a direct scope views the larynx directly through the scope.

4. B. Yes: Report multiple procedures with a modifier 51 (if required by the payer)

RATIONALE: Yes, bronchoscopy codes are billed as multiple procedures with a modifier 51. List the highest RVU valued code first and then all other codes with a modifier 51.
5. B. 32110

RATIONALE: Thoracotomy main code is 32100, but control of the hemorrhage and lung tear would be code, 32110. In the index, look for Thoracotomy/Hemorrhage.

6. B. 32440

RATIONALE: A pneumonectomy is removal of a lung. We are not told both lungs are removed, only “a pneumonectomy.” In the index, look for Pneumonectomy 32440–32445. Read the code descriptors to select the correct code.

7. A. No: A diagnostic VATS is always included in the surgical VATS.

RATIONALE: Diagnostic VATS are bundled into surgical VATS and cannot be billed separately during the same surgical session, per CPT® instruction. In contrast, if the results of a diagnostic VATS prompts an open procedure to excise tissue, the diagnostic VATS may be billed, and the appropriate open surgical code may be reported with modifier 58 Staged procedure; some payers may require a modifier 59 in this situation; check with your payers for appropriate modifier usage.

8. D. 32663

RATIONALE: Wedge resection is bundled into the lobectomy when it is the same lobe; can only code separately if procedures performed on different lobes.

9. D. 38525

RATIONALE: The CPT® Index for Excision/Lymph Nodes indicates 38500, 38510–38530. Reference the CPT® Tabular and review the codes. The correct code is 38525 Biopsy or excision of lymph nodes; open, deep axillary node[s].

10. C. 43336

RATIONALE: Code 43336 is the correct code as it is without mention of mesh implanted and is also via a thoracoabdominal incision. Code 43337 includes mesh insertion and codes 43334 and 43335 are performed via thoracotomy. In the index, look for Repair/Hernia/Paraesophageal Hiatal/Thoracoabdominal Incisional which directs you to 43336–43337.
Chapter 10

Section Review 10.1

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

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

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

4. D. Pulmonary and Aortic
   RATIONALE: The tricuspid and mitral valves are the atrioventricular valves. The pulmonary and aortic valves are the semilunar valves because of their shape, a half moon or crescent shaped.

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

Section Review 10.2

1. C. 424.1
   RATIONALE: No mention was made of a congenital condition, or rheumatic condition. In the Index to Diseases look under Stenosis/aortic, and you are referred to 424.1. Verify the code in the Tabular List.

2. B. 410.11
   RATIONALE: Look in the Index to Diseases for Infarct/myocardium/anteroapical, you are referred to 410.1x. Verify in the Tabular List, you will see 410.1 Of other anterior wall with anteroapical listed below the code. Because the patient was admitted through the ED, the fifth digit for the initial episode of care is 1, initial episode of care.

3. C. 403.91, 585.6, V45.11
   RATIONALE: According to the ICD-9 Official Guidelines, a relationship is assumed between hypertension and chronic kidney disease. Go to the Hypertension Table in the Index to Diseases, and look under Hypertension/ with/chronic kidney disease/Stage V or end stage renal disease/Unspecified, and you see 403.91. Now verify in the Tabular List. The fifth digit is 1 with chronic kidney disease stage V or end stage renal disease. Below this, you see “Use additional code to identify the stage of chronic kidney disease (585.5-585.6). Next, report the dialysis status, which is found in the Index to Diseases under Dialysis/hemodialysis/status only V45.11. Verify these codes in the Tabular List.
4. **A. 428.33, 428.0**

RATIONALE: There is a combined code for acute on chronic diastolic heart failure. Look in the Index to Diseases for Failure/heart/diastolic/acute on chronic 428.33. Always verify your codes in the Tabular List. According to AHA Coding Clinic Fourth Quarter 2002 and 2004, congestive heart failure is not an inherent component of systolic or diastolic heart failure. When the diagnostic statement lists congestive heart failure along with either systolic or diastolic heart failure, two codes are required. For example, a diagnosis of “acute combined systolic and diastolic congestive heart failure,” is assigned two codes 428.41 Combined systolic and diastolic heart failure, acute, and 428.0 Congestive heart failure, unspecified. Both codes are needed to report the specific type of heart failure, congestive. This applies to subcategories 428.2, 428.3, and 428.4. Note this in your ICD-9-CM codebook.

5. **C. 426.13**

RATIONALE: The syncope is a sign/symptom of the AV block. A Mobitz I is a second degree block. Find this in your Index to Diseases under Block/atrioventricular/with/second degree (Mobitz type I) 426.13. Verify your code.

**Section Review 10.3**

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

RATIONALE: 33534 is for the two arterial grafts. Because a combination of AV grafts were used, instead of using a code from 33510–33516 for the venous grafts, we use add-on codes 33517–33523. There are three venous grafts (33519). Code 35572 is for procurement of the femoropopliteal vein, 35600 is for harvesting the radial artery, and 33508 is the add-on code for endoscopic harvesting of the saphenous vein. Look in the CPT® Index for Coronary Artery Bypass Graft (CABG)/Arterial 33533–33536, and /Arterial-Venous 33517–33523. See the notes above these sections for coding 35572 and 35600. Highlight these codes for easy reference in your codebook. All the codes except 33534 are add-on codes; therefore, modifier 51 exempt.

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

RATIONALE: Multiple codes are needed to show the entire procedure. 33235 is for removing the electrodes, 33208 is for putting in the new system, and 33233 is for removing the pacemaker pulse generator. These codes are all found under Pacemaker, Heart/Insertion 33206–33208, Pacemaker, Heart/Removal/Pulse Generator Only, and Pacemaker, Heart /Removal/Transvenous Electrodes 33234–33235. Modifier 51 reports multiple procedures performed during the same session.

3. **A. 33426**

RATIONALE: The mitral valve was repaired, not replaced. Look in the CPT® Index for Repair/Heart/Mitral Valve 33420–33427. Code 33426 Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring, is correct. The fact the patient was on cardiopulmonary bypass did not affect code choice.
Section Review 10.4

1. **B. 36252**

   **RATIONALE:** Look in the CPT® Index for Angiography/Renal Artery, and you are directed to 36251–36254. Code 36252 includes selective catheter placement (first-order) of the main renal artery and any accessory arteries, including arterial puncture, catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed, bilaterally.

2. **C. 36222-50, 36226-50**

   **RATIONALE:** Three separate vascular families are catheterized; however, the codes for angiography of the common carotids and the vertebrals include selective catheterization. Report 36222 for the selective catheter placement and angiography of the right and left common carotid. This code includes arch aortography. For the selective bilateral vertebral angiography report 36226. Both procedures are performed bilaterally, report modifier 50. Some payers may require RT and LT modifiers. Always check with your carriers.

3. **A. 36200, 75630-26**

   **RATIONALE:** Nonselective catheter placement in the aorta is reported with 36200, which is found in the CPT® Index under Aorta/Catheterization/Catheter. Contrast was injected from one catheter placement site, and there is a report for the aorta and the extremities, making this an abdominal aortogram with bilateral iliofemoral lower extremity angiography, 75630. This is found in the CPT® Index under Aortography/with Iliofemoral Artery 75630. Modifier 26 is required for the professional service.

4. **C. 36252, 36245-59, 75726-26**

   **RATIONALE:** Look in the CPT® Index for Angiography/Renal Artery, you are directed to 36251–36254. Code 36252 includes selective catheter placement (first-order) of the main renal artery and any accessory arteries, including arterial puncture, catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed, bilaterally. The selective catheterization code for the SMA is found in the CPT® Index under Artery/Abdomen/Catheterization 36245–36248. The SMA is considered a visceral artery. Look in Appendix L and you will see the SMA is a first order vessel. The radiology code is found in the CPT® Index under Angiography/Abdomen. You are referred to 74174, 74175, 74185, 75635, and 75726. The correct code is 75726. Modifier 26 denotes the professional service.

5. **D. 36200, 75716-26, 75625-26**

   **RATIONALE:** The catheter was placed at the level of the renals, not in the renals, so this is a non-selective catheterization. Nonselective catheter placement in the aorta is reported with 36200, which is found in the CPT® Index under Aorta/Catheterization/Catheter. Because the catheter was repositioned and separate studies were performed, both the aortography and the extremity angiography are reported. Look in the CPT® Index for Catheterization/Aorta for the range 36160–36215. In the index, see Aorta/Aortography; you are referred to 75600–75630. Angiography of the lower extremities is found under Angiography/Leg Artery; you are referred to 73706, 75635, 75710–75716. Modifier 26 reports the professional service.
Section Review 10.5

1. C. 93460-26, 93567

RATIONALE: Cardiac catheterization code 93460 reports right and left heart catheterization, selective coronary angiography with imaging interpretation and reporting, as well as left ventriculography. The cardiac catheterization code includes injection procedures and radiologic S&I (Supervision & Interpretation). The ascending aortography to review the aortic root is reported with add-on code 93567. Aortography is always included in cardiac catheterizations unless it is performed for a specific purpose, such as to study an aortic aneurysm or occlusive disease.

The right iliac angiogram is not reported, it was performed to assess the femoral artery for the Perclose device. The Perclose closure is not reported; it is bundled with the cardiac catheterization procedure. Modifier 26 is required to indicate the professional services only for 93460. The add-on code for the injection service is a professional service; a modifier is not required. In the index, look up Catheterization/Cardiac/Combined Left and Right Heart and with Left Ventriculography directing you to the correct codes.

2. A. 92920-LD, 92978-26

RATIONALE: IVUS is separately reportable. The angioplasty code is found in the CPT® Index under Percutaneous Transluminal Angioplasty/Artery/Coronary, 92920–92921. The diagonal branch is a branch of the left anterior descending; therefore, modifier LD is appended. IVUS is found in the CPT® Index under Vascular Procedures/Intravascular Ultrasound/Coronary Vessels 92978–92979. Modifier 26 denotes the professional service.

3. D. 93016, 93018

RATIONALE: Because the study was performed in the hospital, the physician bills for the professional services. Look in the CPT® Index for Stress Tests/Cardiovascular, and you are referred to 93015–93024. Modifier 26 is not required, because these services are professional services.

4. C. 93618-26, 93610-26, 93600-26

RATIONALE: Although the surgeon documented a “comprehensive” study, it does not include all components listed in CPT® code 93619; the individual codes are billed. Look in the CPT® Index for Electrophysiology Procedure 93600–93660. The procedure was performed in the hospital; modifier 26 is appended to all the codes to report the professional service.

5. B. 93306

RATIONALE: A combination code exists to bundle the Doppler and color flow. Look in the CPT® Index for Echocardiography/Cardiac/Transthoracic 93303–93317. Code 93306 is correct.
Chapter 11

Section Review 11.1

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

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

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

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

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

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

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

RATIONALE: There are three categories of teeth:

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

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

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

9. D. 5 ft. long

RATIONALE: The large intestine is about five feet long.

10. A. 4 lobes

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

**Section Review 11.2**

1. B. 530.81

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

2. D. 564.1

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

3. C. 455.6

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

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

5. C. 250.60, 536.3

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

Section Review 11.3

1. B. 44204

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

2. A. 41008

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

3. A. 48150

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

4. A. 46200

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

5. B. 49505-LT

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

Section Review 12.1

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

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

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

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

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

Section Review 12.2

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

2. C. 599.71
   RATIONALE: Although there is documentation that the patient previously had a TURP, there is no documentation of continuing BPH (a condition for which a TURP routinely is performed). Because documentation states “gross” hematuria, microscopic or unspecified hematuria would be inappropriate codes. Gross hematuria 599.71 is the correct answer.
3. C. 866.02

RATIONALE: There is no specific information available regarding an “open” wound into the cavity; diagnosis 866.11 is not applicable. 866.0 is an incomplete code because a fifth digit is required for the codes within the 866 series. A fractured kidney is a laceration connecting to two cortical surfaces. Look in the Index to Diseases for Laceration/kidney. A diagnosis code within the “E” series also should be added.

4. A. 600.01, 788.20

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

5. D. 594.0

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

6. D. 590.10

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

7. D. 788.32

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

8. B. 185

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

9. A. 223.0

RATIONALE: When assigning this code, you would look up oncocytoma in the index of ICD-9-CM, which tells you to “see Neoplasm, by site, benign.” *Neoplasm, kidney, benign* is 223.0, which is the correct code to assign. Renal cancer, 189.0 and 189.1, would be incorrect because there is no documentation of malignancy and 223.1 is specific to the calcyx, hilus, and pelvis of the kidney.
10.  D.  599.0

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

Section Review 12.3

1.  D.  52235

RATIONALE: Look in the CPT® Index for Fulguration/Cystourethroscopy with/Tumor. You are referred to 52234–52240. When different size bladder tumors are removed in one surgical session, the code selection is based on the largest tumor size. In this example, the largest tumor removed is 3.0 cm. Only one code is reported regardless of the number of tumors removed.

2.  B.  52630

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

3.  B.  51040

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

4.  D.  51500

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

5. B. 52005

RATIONALE: Placement of the ureteral catheters was performed via cystoscopy; therefore, CPT® 50605 would not be appropriate because this code is for an open insertion of indwelling stent into the ureter. CPT® 52332 describes the insertion of indwelling ureteral stents and would not be reported for temporary catheter insertion. CPT® 52330 describes the removal of ureteral stents, but does not cover the insertion of the catheters. CPT® 52005 "Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic services” would be the correct. There would be no additional code reported for removal of these catheters.

Section Review 12.4

1. D. 54060

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

2. C. 55250

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

3. A. 55250-58

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

4. C. 54840

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

5. A. 54150

RATIONALE: In the CPT® Index, look for Circumcision, surgical excision, newborn. You are directed to 54150, 54160. A Plastibell is a type of clamp used in circumcision. Code 54150 is correct.
Section Review 12.5

1. B. 52

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

2. A. 76

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

3. A. TC

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

4. D. B or C

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

5. B. 53

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

Section Review 13.1

1. D. Fallopian tubes and ovaries

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

2. A. Bartholin's glands

RATIONALE: Bartholin's glands are the large glands located on either side of the vaginal introitus or opening. Another name for these glands is greater vestibular glands.

3. B. The cervix and uterine fundus

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

4. C. Colposcopy

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

5. C. Cervix

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

Section Review 13.2

1. C. 233.32

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

2. C. With forceps

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

3. B. Spontaneous abortion

RATIONALE: ICD-9-CM and CPT® recognize three types of abortions, spontaneous (also called a miscarriage), induced or therapeutic (TAB) caused by a deliberate procedure, or missed. A missed abortion is when the fetus dies but the products of conception are retained.
4. C. 642.02

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

5. D. 627.1

RATIONALE: This bleeding is after the end of the woman’s menses and is described as postmenopausal.
Chapter 14

Section Review 14.1

1. B. Glands

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

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

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

3. A. Near the kidneys

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

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

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

5. B. Pineal

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

6. A. Central and Peripheral nervous system

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

7. D. Sciatic

RATIONALE: The largest nerve of the body is the sciatic nerve which divides into the tibial and common fibular (common peroneal) nerves.
8. C. Vertebra  
RATIONALE: Vertebra is not a region of the spinal nerve segments since it is the bony segment surrounding the spinal cord. The lumbar region has five segments forming five pairs of lumbar nerves. The cervical region has seven segments forming eight pairs of cervical nerves. The coccygeal region has three segments forming one pair of coccygeal nerves.

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

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

Section Review 14.2

1. C. 242.31  
RATIONALE: The diagnosis is indexed under Thyrotoxicosis/with/goiter/nodular guiding you to code 242.3. Your fifth digit is a one to indicate the crisis. There is no documentation of the nodule being uninodular or multinodular.

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

3. A. 250.71, 785.4  
RATIONALE: Diabetes with gangrene is found in the Index to Diseases under Diabetes/gangrene, guiding you to code 250.7. Your fifth digit is one since the patient is a type I diabetic and there is no documentation of the diabetes being uncontrolled. In the Tabular section under subcategory code, 250.7, there is a note that states: Use additional code to identify manifestation as: diabetic: gangrene (785.4) which means gangrene will be coded as a secondary code. There is no documentation that the patient has secondary diabetes so it would be inappropriate to code that type of diabetes for this scenario.
4. C. 987.8, 323.72, E869.8

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

5. B. 338.11, 723.1

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

Section Review 14.3

1. D. 62362, 62350-51

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

2. C. 62270

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

3. B. 61154

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

4. A. 63005

RATIONALE: Only a laminectomy and decompression is being performed in the scenario. There is no documentation of a facetectomy, foraminotomy, or discectomy being performed. This is indexed in the CPT® codebook under Laminectomy or Decompression/Spinal Cord.
5. C. 95955-26

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

Section Review 14.4

1. B. S2348

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

2. B. 64721-53

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

3. C. 57

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

4. C. 62258-78

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

5. A. 99212-24

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

Section Review 15.1

1. B. Balancing the strength of extraocular muscles

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

2. D. Iris

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

3. B. Air conduction

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

4. B. The middle ear

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

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

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

6. C. Surgical repair of the eyelid.

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

7. A. Cornea

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

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

9. A. The inner ear

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

10. D. All of the above.

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

Section Review 15.2

1. B. 250.51, 362.04

RATIONALE: In the ICD-9-CM Index, see Retinopathy/diabetic. The note under 362.0 reads, “Code first diabetes (249.5, 250.5).” Code 250.5 is not a valid code and requires a fifth-digit to indicate Type 1 or Type II Diabetes and if the diabetes is controlled or uncontrolled. Under 250.5 are the fifth-digit subclassifications for type of diabetes and whether it is controlled or uncontrolled. The patient has Type 1 DM in good control. The correct diabetes code is 250.51. Code 362.04 exactly matches the documentation: mild nonproliferative diabetic retinopathy. ICD-9-CM Guideline 1.C.3.a.4 says codes from category 250 must be sequenced before the codes for associated conditions.

2. D. 780.91

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

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

4. D. 872.01, V03.7

RATIONALE: This is an open wound of the earlobe, reported with 872.01. In the index, see Wound/ear. The earlobe is part of the auricle; therefore, nonspecific code 872.8 would be inappropriate. The patient received a vaccination for tetanus, which is reported with V03.7. Look in the Index to Diseases for Vaccination/prophylactic (against)/tetanus toxoid (alone). There was no reported “exposure,” as is needed to report V01.89 V06.5 reports tetanus in combination with another drug, which was not administered.

5. A. 360.44

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

6. B. 372.03

RATIONALE: Pink eye, a highly infectious form of mucopurulent conjunctivitis, is indexed to 372.03. In the index, see Pink/eye or Conjunctivitis/purulent. This infection typically is accompanied by very bloodshot eyes and a heavy discharge.

7. D. 389.9

RATIONALE: Without more specific information for the type of hearing loss, we will report a nonspecific diagnosis. In the index, see Loss/hearing which directs you to category 389.x Hearing loss. Code 389.9 Unspecified hearing loss is the appropriate code. No scientific study of the hearing loss was made, making 794.15 incorrect.

8. A. 996.69, 376.01, V43.0, V10.84

RATIONALE: In the index, see Complication/infection and inflammation/due to (presence of) any device, implant or graft/orbital (implant). Code 996.69 describes an infection due to an orbital implant. We will also code for the organ (eye globe) transplant using V43.0. Orbital cellulitis is indexed under Cellulitis/orbit, orbital 376.01. Cellulitis code 682.0 is incorrect as it excludes orbit (367.01). The implant is the result of the patient’s previous cancer and indicated with V10.84. A note under 996.6 states, “Use additional code to identify specified infections.” We don’t have documentation of the infective agent.
9. C. 872.61

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

10. A. 365.9

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

Section Review 15.3

1. B. 65275

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

2. B. 69105

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

3. A. 65420-50

RATIONALE: In the index, see Pterygium/Excision. A pterygium is an overgrowth of conjunctiva forming in the nasal aspect of the eye and grows outward toward the cornea. Pterygiums are reported in ICD-9-CM with codes from 372.4; 372.44 reports recurrent pterygium and is the correct choice. Excision of a pterygium is reported separately from other conjunctival disorders, with codes 65420 and 65426. Because this was a simple repair, 65420 is the correct code. Modifier 50 indicates a bilateral procedure was performed.
4. C. 69310

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

5. C. 67318, 67331, 67335

RATIONALE: In the index, see Strabismus/Repair/Superior Oblique Muscle. Code 67318 is the only code listed describing a procedure on the superior oblique muscle. In addition to 67318, we report add on codes for adjustable suture (in the index, see Strabismus/Repair/Adjustable Sutures) and also for a patient with a history of ophthalmic surgery (67331). The medical history of ocular surgery makes the procedure more risky and difficult, and use of this code helps the physician report this complexity. Modifier 51 never is applied to add-on codes.

6. A. 69799

RATIONALE: In the index, see Ear/Unlisted Services and Procedures. The correct answer is A, for an unlisted procedure. Round window implants are a new technology not yet assigned CPT® a code. The word “transducer” should alert you to the hearing aid component of this procedure. There isn’t a new technology code for this type of procedure and an unlisted code is your best option. The round window is the barrier between the middle and inner ear, but is still considered middle ear.

7. C. 68520

RATIONALE: In the index, see Dacryocystoectomy. The stone was embedded in the sac, which was removed. We cannot code for both removal of the stone and removal of the sac. Only 68520 is reported. The lacrimal gland is located near the eyebrow; the lacrimal sac is the upper dilated end of the lacrimal duct, aligned with the nostril. Don’t confuse the two sites.

8. D. 69637

RATIONALE: In the index, see Mastoidotomy directing you to code range 69635–69637. Code 69637 represents a mastoidotomy (including atticotomy and tympanic membrane repair) with ossicular chain reconstruction and partial ossicular replacement prosthesis.

9. C. 67120

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

10. C. 92012

RATIONALE: In the index, see Ophthalmology, Diagnostic/Eye Exam/Established Patient. Intermediate ophthalmological services are described in CPT® as the evaluation of a new or existing condition of the eye not requiring comprehensive services. This is reported with 92002 for a new patient, or 92012 for an existing patient. This service is for an existing patient, making 92012 is the correct code. Documentation does not support any level of E/M.
Chapter 16

Section Review 16.1

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

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

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

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

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

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

Section Review 16.2

1. A. 577.9

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

2. D. 218.9

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

3. C. 374.84, V15.80

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

4. C. 715.96

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

5. C. 823.00

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

1. C. Arterial line placement

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

2. B. When the anesthesiologist begins to prepare the patient

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

3. A. The anesthesia code representing the most complex procedure is reported

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

4. D. P1

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

5. D. None of the above

RATIONALE: Qualifying circumstances may not be separately reported if the anesthesia code already takes difficulty into consideration.

6. B. 93503

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

7. D. 31500

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

8. C. 74

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

1. C. 00142-AA-QS

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

2. B. 01961-QK and 01961-QX

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

3. D. AD and QX

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

4. B. QZ

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

5. C. G9

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

Section Review 17.1

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

2. C. At an angle, neither frontal or lateral
   RATIONALE: An oblique position is a slanted position where the patient is lying at an angle which is neither prone nor supine.

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

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

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

Section Review 17.2

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

2. D. 823.82
   RATIONALE: The final diagnosis is available at the time of reporting so the final diagnosis should be used instead of the sign or symptom. The final diagnosis of a fracture of the tibia and fibula is reported as the diagnosis.
3. **B. 793.0, 473.9, 478.30**

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

4. **C. V72.5**

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

5. **D. V72.83**

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

**Section Review 17.3**

1. **D. 70390, 527.4**

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

2. **C. 74176**

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

3. **B. 76010**

**RATIONALE:** In the CPT® Index, look up “X-ray.” Then, find Nose to Rectum/Foreign Body.” The index guides you to 76010. Turning to 76010, you will find this code is applicable to a child only as it is a single view.

4. **C. 70150**

**RATIONALE:** Three views of the facial bones (Waters' view, Caldwell view, and lateral view) were ordered. Looking in the CPT® Index, “X-ray/Facial Bones” guides you to codes 70140–70150. Code 70150 is for a complete, minimum of three views X-ray of the facial bones.

5. **D. 72156**

**RATIONALE:** In the CPT® Index, “Magnetic Resonance Imaging (MRI)/Spine/Cervical” guides you to codes 72141–72142, 72156–72158. Because both without contrast and with contrast were used for this cervical MRI, CPT® code 72156 is selected.
**Section Review 17.4**

1. **B. 76705**  
   **RATIONALE:** Ultrasound of the abdomen includes the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava. Because the ultrasound was of only the liver, it is considered a limited abdominal ultrasound.

2. **D. 76815**  
   **RATIONALE:** The position of the fetus is the reason for the test; therefore, the ultrasound is limited. The description of 76815 includes one or more fetuses and the code is reported once only.

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

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

5. **A. 76506**  
   **RATIONALE:** In the CPT® Index, Echoencephalography guides you directly to 76506.

**Section Review 17.5**

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

2. **D. 76499**  
   **RATIONALE:** Dual energy X-ray absorptiometry (DEXA) studies are found in the code range 77080–77082. Under this range of codes is a parenthetical instruction stating to use 76499 for a DEXA body composition study.
3. A. 77777

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

4. D. 19102-RT, 77031-26

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

5. A. 77080

RATIONALE: DEXA is dual-energy X-ray absorption. The site is of the spine, which is part of the axial skeleton. From the CPT® Index, look up “Bone Density/Axial Skeleton 77078, 77080.” In this case one site (spine) is involved in the study. The correct code is 77080.
Chapter 18

Section Review 18.1

1. C. Disease
   RATIONALE: The word root path means "disease." The suffix \textasciitilde{}logy is "study of."

2. D. Microbiology
   RATIONALE: The root words micro (small) and bio (life) combined with \textasciitilde{}logy describe the study of small life forms.

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

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

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

Section Review 18.2

1. C. V01.5
   RATIONALE: The codes in category V01 are for exposure to a disease without signs or symptoms of infection. In the index look up Exposure/to/rabies.

2. C. 174.9
   RATIONALE: Always code the most specific diagnosis known. When a diagnosis of carcinoma of the breast has been confirmed, it is inappropriate to code a less specific diagnosis, no matter what the reason was for the original test. In the index, look up Exposure/to/rabies. In the Neoplasm Table in the index, look up Neoplasms/breast/malignant/primary.
3. B. 714.0, V58.64

RATIONALE: Code both the arthritis and the long-term use of NSAIDs. Although the use of the NSAID is the reason for the test, the codes in category V58.6 cannot be used alone or as the first diagnosis code listed. Note: Code 714.0 indicates an additional code is to be used to identify the manifestation. In the index, look up Arthritis/rheumatoid, directing you to 714.0. For the V-code, in the index, look up Long-term drug use/pain killers/anti-inflammatories, non-steroidal (NSAID) directing you to V58.64. Verify these codes in the Tabular List and read any instructions there.

4. B. V10.46

RATIONALE: Once cancer has been excised and there is no further treatment directed toward the cancer site without recurrence, code a personal history of malignancy code. In this case, use V10.46. In the index, look up History of/malignant neoplasm/prostate directing you to V10.46. Confirm this code in the Tabular List.

5. D. 795.09

RATIONALE: Choose a code that identifies unspecified previous abnormal findings on cervical Pap smear. Although the second test results came back normal, the previous abnormal finding supports the need for a repeat test. In the index, look up Abnormal/Papanicolaou (smear)/cervix/with/nonspecific finding NEC directing you to 795.09. Verify this code in the Tabular List.

Section Review 18.3

1. A. 85730

RATIONALE: PTT stands for partial thromboplastin time. In the index look for PTT, you are directed to see Thromboplastin/Partial Time/85730–85732. Checking the listing, 85730 Thromboplastin time, partial (PTT); plasma or whole blood is the correct code for this test.

2. C. 81002-QW

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

3. B. 80076, 82565

RATIONALE: Code the panel anytime all of the tests listed in the panel are completed. If additional tests are also performed, they are coded separately. The first 7 tests are all listed in code 80076. This leaves creatinine, which is reported with code 82565. In the index, look up Panel, this directs you to See Blood Tests; Organ or Disease-Oriented Panel. If you look at Blood Tests/panels/Hepatic Function you are directed to 80076. Next, look up Creatinine/Blood directing you to 82565. Verify these codes.

4. C. 88040

RATIONALE: Services related to legal investigations and trials are forensic examinations. In the index look up Autopsy/Forensic Exam/88040. Read the code to verify this as the correct listing.

5. D. 86359

RATIONALE: Code 86359 is for total T-cell count. If other studies were performed, they were not ordered and may not be billed, no matter how seemingly appropriate. In the index look up T-Cells/Count/86359. Read code 86359 to verify.
Chapter 19

Section Review 19.1

1. C. Outpatient consultation

RATIONALE: Dr. Smith requests Dr. Parker to see Mr. Andrews for a neurologic consultation. Dr. Parker evaluates the patient and provides a written report to Dr. Smith with a recommendation. The requirements for a consultation have been met and an evaluation and management code from outpatient consultation would be selected.

2. B. Preventive medicine, established patient

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

3. D. Initial observation care

RATIONALE: The patient presented to the Emergency Department and was admitted to observation by the ED physician. The guidelines for Initial Observation Care tell us that all services provided by the admitting physician for the same date of service are included in the initial hospital care, and in this instance the emergency department services would not be coded if the patient was discharged on the same date of service, a code from Observation or Inpatient Care Services (Including Admission and Discharge Services) would be selected.

4. C. Nonbillable

RATIONALE: The follow up visit from the neurosurgeon the day following surgery bundled in the surgical procedure and not billable. The visit is within the global period of the procedure.

5. A. Office visit, new patient

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

1. A. Problem Focused

**RATIONALE:**

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<th>Brief (1–3)</th>
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<tr>
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<td></td>
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<tr>
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<td>Extended (2–9 systems)</td>
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<tr>
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<td>None</td>
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<td>Complete (2 (est) or 3 (new) history areas)</td>
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<td>Family history (a review of medical events in the patient’s family)</td>
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<tr>
<td><strong>CC:</strong></td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

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

**HPI:** Modifying Factor: He was placed back on Singulair® and has been improving with his breathing since then.

**ROS:** None

**PFSH:** None
2. C. Detailed

**RATIONALE:**

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<tr>
<td>Problem Focused Expanded Problem Focused Detailed Comprehensive</td>
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</tbody>
</table>

**CC:** Asthma exacerbation

**HPI:** Duration—2–3 days
Assoc S & S: cough
Quality—"productive" cough
Severity—getting worse

**ROS:** Constitutional—denies fever or chills
Respiratory—difficulty breathing

**PFSH:** Past History—Currently uses inhalers (current medication)
3. **B. Expanded problem focused**

**RATIONALE:**

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<td></td>
</tr>
<tr>
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<td>None</td>
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<tr>
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<td>Expanded Problem Focused</td>
<td>Detailed Comprehensive</td>
</tr>
</tbody>
</table>

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

Duration—about a year

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

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

**PFSH:** Past, Family, and Social all reviewed as it relates to skin.
4. D. Comprehensive

**RATIONALE:**

### History

<table>
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<tr>
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<tr>
<td><strong>HPI</strong> Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs &amp; Symptoms</td>
<td>None</td>
<td>Pertinent to problem (1 system)</td>
<td>Complete (2–9 systems)</td>
</tr>
<tr>
<td>ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo</td>
<td>None</td>
<td>None</td>
<td>Complete (2–9 systems)</td>
</tr>
<tr>
<td><strong>PFSH</strong> Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient’s family) Social history (an age appropriate review of past and current activities)</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
</tr>
</tbody>
</table>

**CC:** Fever

**HPI:** Duration—less than one day
Severities—high fever
Associated S & S—decreased appetite
Modifying Factor—Tylenol has been given which reduced the fever

**ROS:** GI—no vomiting or diarrhea
Resp—parents unaware of any cough
Rest of review of systems reviewed and negative: Complete ROS

**PFSH:** Personal history—current meds
Social history—not exposed to second hand smoke
5. B. Expanded problem focused

RATIONALE:

<table>
<thead>
<tr>
<th>History</th>
<th>Brief (1–3)</th>
<th>Brief (1–3)</th>
<th>Extended (4 or more)</th>
<th>Extended (4 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HPI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location Severity Timing Modifying Factors</td>
<td></td>
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</tr>
<tr>
<td>Quality Duration Context Assoc Signs &amp; Symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ROS</td>
<td>None</td>
<td>Pertinent to problem (1 system)</td>
<td>Extended (2–9 systems)</td>
<td>Complete</td>
</tr>
<tr>
<td>Const GI Integ Hem/lymph</td>
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<tr>
<td>Eyes GU Neuro All/Immuno</td>
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<td></td>
</tr>
<tr>
<td>Card/Vasc Musculo Psych All other negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resp ENT, mouth Endo</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFSH</td>
<td>None</td>
<td>None</td>
<td>Pertinent (1 history area)</td>
<td>Complete (2 est) or 3 (new) history areas</td>
</tr>
<tr>
<td>Past history (current meds, past illnesses, operations, injuries, treatments)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Family history (a review of medical events in the patient’s family)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social history (an age appropriate review of past and current activities)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CC: ATV accident</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>HPI:</td>
<td>Context—ATV Accident</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Location—Lip and chin lacerations</td>
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<td></td>
</tr>
<tr>
<td>ROS:</td>
<td>GI—negative for nausea &amp; vomiting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes—negative for blurred vision</td>
<td></td>
<td></td>
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<tr>
<td>Neuro—negative for headache</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>PFSH:</td>
<td>Past history—surgeries and illnesses reviewed, current meds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social history—nonsmoker, moderate alcohol</td>
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</tr>
</tbody>
</table>

Note: only 2 of 3 PFSH are needed for complete for Emergency Department, but all three are needed for a complete PFSH for a hospital admit.
Section Review 19.3

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

2. D. Comprehensive
   RATIONALE: Organ Systems: The documentation supports a comprehensive/complete single system (Female Genitourinary) exam. The level of exam is Comprehensive.

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

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

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

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

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

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

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

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

Section review 19.5

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

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

RATIONAL: For a new patient visit, all three key components must be met:
History—HPI (Extended), ROS (Extended), PFSH (none) = EPF
Exam—Expanded problem focused (limited exam of ears, nose, throat, and neck)
MDM—Moderate for the prescription drug management
The documentation supports 99202.

4. C. 99309

RATIONAL: For subsequent nursing facility care codes, two of three key components must be met.
History—(Extended), ROS (Extended), PFSH (1-Pertinent) = Detailed
Exam—Detailed exam of Eyes, ENT, Neuro
MDM—New problem with additional workup, lab ordered, moderate risk (undiagnosed new problem with uncertain prognosis) = moderate medical decision making
The documentation supports 99309.

5. B. 99243

RATIONAL: A consultation requires all three key components be met to support the level of visit.
History—HPI (extended), ROS (Extended), PFSH (complete) = Detailed
Exam—Detailed
MDM—New problems, no credit given in the EM for the EMG or Nerve conduction study because they will be billed with a separate CPT® code. The level of risk is moderate (elective major surgery).
This supports a 99243.
Chapter 20

Section Review 20.1

1. B. 90375, 96372

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

2. A. 90658, 90732, 90471, 90472

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

3. A. 90717, 90471

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

Section Review 20.2

1. C. 90847

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

2. B. 90882

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

3. D. 90834

RATIONALE: Code 90834 describes a 45 minute outpatient/office encounter for psychotherapy.
Section Review 20.3

1. A. 90911

RATIONALE: Code 90911 describes biofeedback training for the urethral sphincter.

Section Review 20.4

1. A. 90937

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

2. C. 90969 x 25

RATIONALE: Code 90969 describes ESRD related services for dialysis less than a full month of service per day, for patients 12–19 years of age. In this case, the patient is 18-years-old. This was not a full month of ESRD related services; therefore, 90969 is reported per day with 25 units, 1 unit for each day. See the example in CPT® under End Stage Renal Disease Services.

3. C. 90989

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

Section Review 20.5

1. D. 93926

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

2. D. 93990

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

3. B. 93975

RATIONALE: Code 93975 describes a complete scan of arterial inflow and venous outflow of the abdominal, pelvic, scrotal contents, and/or retroperitoneal organs.
Section Review 20.6

1. A. 95004 x 12
RATIONALE: Code 95004 describes scratch tests with allergenic extracts, immediate type of reaction. Code includes interpretation and report. Report the code with the correct number of units for the number of tests.

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

3. B. 95144 x 4
RATIONALE: Code 95144 describes preparation and provision of antigen for immunotherapy in single dose vials. Show number of vials in unit field.

Section Review 20.7

1. D. 96040 x 3
RATIONALE: Code 96040 describes genetic counseling by a qualified counselor for each 30 minutes of face-to-face time. Report three units for the session lasting 1.5 hours. Report E/M codes if counseling is provided by a physician.

Section Review 20.8

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

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

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

1. A. 96360, 96361

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

2. B. 96522

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

3. D. 96450

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

Section Review 20.10

1. A. 97001-GP, 97110-GP x 4

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

2. C. 97001-GP, 97110-GP x 3, 97116-GP

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

3. A. 97760

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

1. C. 97802 x 2

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

Section Review 20.12

1. C. 97813

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

Section Review 20.13

1. B. 98925

RATIONALE: Code 98925 describes manipulation of one to two body regions. Both feet were manipulated during the session.

Section Review 20.14

1. A. 98943

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

2. C. 98940

RATIONALE: Code 98940 describes manipulation of one to two spinal regions.

3. A. 98941

RATIONALE: Three regions of the spine were manipulated. Code 98941 describes manipulation of three to four regions.

Section Review 20.15

1. D. 98962 x 3

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

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

Section Review 20.16

1. D. 98967

RATIONALE: Code 98967 describes a telephone discussion with a qualified health care professional lasting 11–20 minutes not leading to an appointment within the next 24 hours or the soonest available appointment not relating to an E/M service within the previous seven days.

2. D. 98969

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

Section Review 20.17

1. D. 99075

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

2. B. 99027 x 13

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

3. A. 99000

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

4. D. 99050

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

1. D. 99175

RATIONALE: Code 99175 describes administration of ipecac to induce emesis for emptying the stomach.

2. B. 99170

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

Section Review 20.19

1. D. 99507

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

2. A. 99505

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

3. D. 99601

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

Section Review 20.20

1. D. 99606, 99607

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