2013 Midterm- CPC

Answers & Rationales

1. Many coding professionals go on to find work as:
   a. Accountant
c. Medical Assistants
   b. Consultant
d. Financial Planning

ANS: B
Rationale: The coding profession has evolved significantly over the past several decades into a career path with unlimited possibilities. Many professionals who have learned coding have also gone on to roles as consultants, educators, or medical auditors. There are endless possibilities in an ever changing field.

2. A medical record contains information on all but what areas?
   a. Observations
c. Treatment outcomes
   b. Medical or surgical interventions
d. Financial records

ANS: D
Rationale: Every time a patient receives health care, a record is maintained of the observations, medical or surgical interventions, and treatment outcomes.

3. Local Coverage Determinations are administered by ____?
   a. Each regional MAC
c. LMRP’s
   b. NCD’s
d. State Law

ANS: A
Rationale: Each Medicare Administrative Contractor (MAC) is then responsible for interpreting national policies into regional policies

4. The minimum necessary rule is based on sound current practice that protected health information should not be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. What does this mean?
   a. Providers should allow all staff members to access any record without restriction
   b. Providers should develop safeguards to prevent unauthorized access
   c. Practices should send records without releases
   d. All of the above

ANS: B
Rationale: The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information.

5. The minimum necessary rule applies to
   a. Disclosures to or requests by a health care provider for treatment purposes.
b. Disclosures to the individual who is the subject of the information.
c. Uses or disclosures that are required by other law.
d. Covered entities taking reasonable steps

ANS: D
Rationale: The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, protected health information to the minimum necessary to accomplish the intended purpose. The minimum necessary standard does not apply to the following:
   Disclosures to or requests by a health care provider for treatment purposes.
   Disclosures to the individual who is the subject of the information.
Uses or disclosures made pursuant to an individual’s authorization.

6. Muscle is attached to bone by what method?
   a. Tendons, ligaments, and directly to bone
   b. Tendons and cartilage
   c. Tendons, aponeurosis and directly to bone
   d. Ligaments, aponeurosis, and directly to bone

   ANS: C

7. What is affected by myasthenia gravis?
   a. Neuromuscular junction
   b. Muscle belly
   c. Muscle/bone connection
   d. Bone

   ANS: A

8. Which bone(s) have trochanters?
   a. Humerus
   b. Tibia
   c. Femur
   d. Both A and C

   ANS: C

9. Which of the following best describes constituent components of the human lymphatic system?
   a. Lymph nodes, lymphatic vessels, spleen, thoracic duct
   b. Lymph nodes, lymphatic vessels, tonsils, liver
   c. Lymph nodes, lymphatic vessels, bone marrow, kidneys
   d. Lymph nodes, lymphatic vessels, thymus gland, pancreas

   ANS: A

10. The term “hemic” specifically refers to what bodily fluid?
    a. Bile interstitial fluid
    b. Lymph
    c. Blood
    d. Interstitial fluid

   ANS: C

11. What distinguishes a “sentinel” node from other lymph nodes?
    a. A sentinel node is swollen or diseased
    b. A sentinel node is the first lymph node in a group of nodes to be reached by metastasizing cancer cells
    c. A sentinel node stores white blood cells
    d. A sentinel node contains both afferent and efferent lymph vessels

   ANS: B

12. The structure of the male anatomy carrying sperm out of the epididymis is called:
    a. Vas deferens
    b. Seminal vesicles
    c. Tunica vaginalis
    d. Testicles

   ANS: A

13. What is the function of the Cowper’s glands?
    a. Produces sperm food
    b. Delivers spermatozoa to the urethra
    c. Promotes maturation of the egg
    d. Helps lubricate the urethra

   ANS: D
14. A deficiency of cells in the blood is defined as:
   a. Erythremia
   b. Phagocytosis
   c. Cytopenia
   d. Bacteremia

   ANS: C

15. Bone marrow harvesting is a procedure to obtain bone marrow from a donor. Bone marrow collected from a close relative is:
   a. Autologous
   b. Allogenic
   c. Autoinfusion
   d. Alloplasty

   ANS: B

16. The root word for mouth is:
   a. Gloss/o
   b. Bucc/o
   c. Stomat/o
   d. Dent/o

   ANS: C

17. A surgical procedure creating an opening into the jejunum is defined as a:
   a. Colostomy
   b. Gastrojejunostomy
   c. Gastroenterostomy
   d. Jejunostomy

   ANS: D

18. Where would a subungual hematoma be located?
   a. Mouth – under the tongue
   b. Under the toenail/fingernail
   c. Scalp
   d. Bottom of the foot

   ANS: B

19. Impetigo is best described as:
   a. A dry, scaly condition of the skin
   b. A bacterial skin infection
   c. Severe itching
   d. Acute eruption of vesicles along the path of a nerve

   ANS: B

20. Arthritis is an inflammation of what?
   a. Muscle
   b. Nerve
   c. Joint
   d. Tendon

   ANS: C

21. The dome-shaped muscle under the lungs flattening during inspiration is the:
   a. Bronchus
   b. Diaphragm
   c. Mediastinum
   d. Pleura

   ANS: B

22. What type of code is assigned when the provider documents a reason for a patient seeking health care that is not an injury or disease?
   a. E code (E000-E999)
   b. Volume 3 code
   c. Nonspecific code
   d. V code (V01.0-V91.99)

   ANS: D
Rationale: The Supplementary Classification of Factor Influencing Health Status and Contact with Health Services (V01.0-V91.99), also known as V codes, are provided to record heath care encounters for circumstances other than a disease or injury. ICD-9-CM coding guidelines, Section I.C.18.a., states V codes provide codes to deal with encounters for circumstances other than a disease or injury (also stated in Chapter 3 of Textbook).

23. A hospital coder will use what volume(s) of the ICD-9-CM book to code an inpatient procedure?
   a. Volumes 2 & 3
   b. Volume 3
   c. Volumes 1 & 2
   d. Appendix and Index only

ANS: B
Rationale: Per ICD-9-CM Official Guidelines for Coding and Reporting, 3rd paragraph, it states the diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals.

24. What does ICD-9-CM stands for?
   a. International Code Diagnosis-9-Coding Medical
   b. International Class Diagnosis -9th book-Clinical Medicine
   c. Infections Classified Diseases-9th revision-Clinical Modification
   d. International Classification of Diseases-9th Revision-Clinical Modification

ANS: D

25. Patient with postoperative anemia due to acute blood loss during the surgery needs a blood transfusion. What ICD-9-CM code is reported?
   a. 280.0
   b. 285.1
   c. 285.8
   d. 281.9

ANS: B
Rationale: In the ICD-9-CM Index to Diseases (Alphabetic Index) look for Anemia/postoperative/due to (acute) blood loss guiding you to code 285.1. Verify in the Tabular List.

PTS: 1

26. What ICD-9-CM code is used for the first episode of an acute myocardial infarction?
   a. 410.1
   b. 410.90
   c. 410.11
   d. 410.91

ANS: D
Rationale: In the Index to Diseases (Alphabetic Index) look for Infarct, infarction/myocardium, myocardial guiding you to subcategory code 410.9. Your fifth digit is 1 for the first (initial) episode. Verify in the Tabular List.

27. What diagnosis code is reported for “secondary neoplasm of the descending colon”?
   a. 153.2
   b. 230.2
   c. 239.0
   d. 197.5

ANS: D
Rationale: ICD-9-CM Index to Diseases (Alphabetic Index), Neoplasm Table, look for Neoplasm/colon. We are directed to – See also Neoplasm, intestine, large. Find Neoplasm/intestine/large/colon/descending/Malignant/Secondary (column) guiding you to code 197.5.

28. Can V codes be listed as a primary code?
   a. No; V codes are never listed as primary codes
   b. No; V codes are always reported as secondary codes
   c. No; V codes are reported for external injuries and where it happened which is always listed as secondary.
   d. Yes; V codes can be sequenced as primary and secondary codes

ANS: D
Rationale: Per ICD-9-CM guidelines, Section I.C.18.b, V codes may be used as either a first listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter.

29. Where can you find the Table of Drugs and Chemicals?
   a. Volume 1 of the ICD-9-CM codebook
   b. Volume 2 of the ICD-9-CM codebook
   c. Volume 3 Index to Procedures of the ICD-9-CM codebook
   d. CPT® codebook

   ANS: B
Rationale: The Table of Drugs and Chemicals is located in Volume 2 of the ICD-9-CM codebook.

30. In which circumstances would an external cause code be reported?
   a. Illness and injuries
   b. Causes of injury, poisoning, and other adverse affects
   c. Causes of neoplasms, hypertension and medications
   d. Only for the cause of accidents

   ANS: B
Rationale: ICD-9-CM guideline I.C.19.a.1 General E Code Coding Guidelines instructions state “An E code from categories E800-E999 may be used with any code in the range of 001-V91, which indicates an injury, poisoning, or adverse effect due to an external cause.”

31. What would be considered an adverse effect?
   a. Wound infection after surgery
   b. Hemorrhaging after a vaginal delivery
   c. Shortness of breath when running
   d. Rash developing when taking penicillin

   ANS: D
Rationale: An adverse effect is a harmful or abnormal result which caused by administration of a medication or by exposure to a chemical. The effect can be illness or death. A surgery is not a medication or inhalant, a wound infection for surgery and hemorrhaging after delivery would be considered a complication.

32. What publications are copyrighted and maintained by AMA?
   a. CPT®, codebook, HCPCS Level II codebook, ICD-9-CM codebook
   b. CPT® codebook
   c. AHA Coding Clinic
   d. CPT® codebook and CPT® Assistant

   ANS: D
Rationale: CPT® (all three categories) and CPT® Assistant is published, copyrighted, and maintained by AMA.

33. How often is HCPCS Level II permanent national codes updated?
   a. annually
   b. quarterly
   c. bi-annually
   d. three times a year

   ANS: A
Rationale: Permanent national codes are updated once a year in January.

34. What does “non-facility” describe when calculating Physician Fee Schedule payments?
   a. hospitals
   b. nursing homes
   c. non-hospital owned physician practices
   d. hospital owned physician practices

   ANS: C
Rationale: “Non-facility” location calculations are for private practices or non-hospital-owned physician practices. Reimbursement is higher for private practices because the practice incurs the full expense of providing the service.
35. What is the correct anesthesia CPT® code for surgery performed on the frontal lobe of the brain?
   a. 00218  
   b. 00216  
   c. 00212  
   d. 00210

   **ANS:** D  
   **Rationale:** In the CPT® Index, look for Anesthesia/Brain. Here you are directed to see codes 00210-00218, 00220-00222. When you turn to these codes in the Anesthesia section and review them, it is code 00210 you would report. This represents Anesthesia for intracranial (brain) procedures, not otherwise specified.

36. A patient is seen in the OR for an arthroscopy of the medial compartment of his left knee. What is the correct coding to report for the anesthesia services?
   a. 01400  
   b. 01402  
   c. 29870-LT  
   d. 29880-LT

   **ANS:** A  
   **Rationale:** In the CPT® Index, look for Anesthesia/Knee. You are given multiple codes to choose from. When you turn to these codes in the Anesthesia section and review them, it is code 01400 you would report. This represents Anesthesia for arthroscopic procedures performed on the knee.

37. What is the correct CPT® code for the wedge excision of a nail fold of an ingrown toenail?
   a. 11720  
   b. 11750  
   c. 11765  
   d. 11760

   **ANS:** C  
   **Rationale:** In the CPT® Index, look for Excision/Nail Fold. The code you are directed to use is 11765.

38. The Table of Drugs in the HCPCS Level II book indicates various medication routes of administration. What abbreviation represents the route where a drug is introduced into the subdural space of the spinal cord?
   a. IM  
   b. SC  
   c. INH  
   d. IT

   **ANS:** D  
   **Rationale:** In the HCPCS Level II codebook, there is an appendix that lists the abbreviations and acronyms and their meanings listed. IT stands for Intrathecal. IT is the route where a drug is introduced into the subdural space of the spinal cord.

39. What is the correct HCPCS Level II code for parenteral nutrition solution amino acid, 3.5%?
   a. B4176  
   b. B4172  
   c. B4168  
   d. B4178

   **ANS:** C  
   **Rationale:** In the HCPCS Level II Index, look up Parenteral nutrition/solution. You are directed to codes B4164-B5200. When you turn to the B codes to review, it is code B4168 you would report.

40. What agency maintains and distributes HCPCS Level II codes?
   a. AMA  
   b. CMS  
   c. HIPAA  
   d. CPT® Assistant

   **ANS:** B  
   **Rationale:** CMS has been delegated to maintain and distribute HCPCS Level II codes.

41. What temporary HCPCS Level II codes are required for use by Outpatient Prospective Payment System (OPPS) Hospitals?
   a. C codes  
   b. G codes  
   c. H codes  
   d. Q codes

   **ANS:** A
Rationale: Outpatient PPS (C1300-C9899) Guideline explains C codes are required for use by Outpatient Prospective Payment System (OPPS) Hospitals to report new technology procedures, medical devices, drugs, biologicals, and radiopharmaceuticals; that do not have other HCPCS codes assigned. Other facilities may report C-codes at their discretion.

42. What codes are reported voluntarily to payers to provide evidence-based performance-measure data?
   a. CPT® Category I codes  
   b. CPT® Category II codes  
   c. CPT® Category III codes  
   d. HCPCS Level II codes

ANS: B
Rationale: Per AMA, CPT® Category II codes are a set of supplemental tracking codes that can be used for performance measurement.

43. What is the correct diagnostic code to report treatment of a melanoma in-situ of the left arm?
   a. 173.60  
   b. 232.6  
   c. 172.6  
   d. 238.2

ANS: C
Rationale: Melanoma in-situ is not found in the Neoplasm Table, it is necessary to look for Melanoma/arm in the ICD-9-CM Index to Diseases.

44. A patient is taken to surgery for removal of a squamous cell carcinoma of the right thigh. What is the correct diagnosis code for today’s procedure?
   a. 173.70  
   b. 198.2  
   c. 198.5  
   d. 173.72

ANS: D
Rationale: Use the Neoplasm Table in the ICD-9-CM Index to Diseases. See skin NOS/limb/lower/squamous cell carcinoma and use the code from the Primary column.

45. What is the correct diagnosis code to report a non-healing open surgical wound of the right leg from a previous excision of a squamous cell carcinoma?
   a. 173.70  
   b. 998.83  
   c. 998.59  
   d. V10.83

ANS: B
Rationale: In the ICD-9-CM Index to Diseases, see Wound,,open/non-healing surgical. There is no mention of an infection, code 998.59 is not appropriate to report. In the Tabular List, there is a note under 998.59 stating to use an additional code to identify the infection. We do not know the what the infection is so it is not coded.

46. A patient presents to the office with a suspicious lesion of the nose. The physician takes a biopsy of the lesion and pathology determines the lesion to be an uncertain dysplastic nevus. What is the correct diagnosis code to report?
   a. 173.30  
   b. 216.3  
   c. 239.2  
   d. 238.2

ANS: D
Rationale: The pathology report indicates the lesion is an uncertain dysplastic nevus, which is classified in the ICD-9-CM Neoplasm Table (in the Index to Diseases) under skin/nose/Uncertain Behavior (column).

47. Joe has a terrible problem with ingrown toenails. He goes to the podiatrist to have a nail removed along with the nail matrix. What CPT® code is reported?
   a. 11730  
   b. 11750  
   c. 11752  
   d. 11720

ANS: B
Rationale: In the CPT® Index, see Removal/Nails and you are directed to two code ranges. Documentation states the entire nail and root (nail matrix) are removed. In the Integumentary Section of the CPT®, removal of the nail and nail matrix, sets code 11750 apart from 11730 where only the nail is removed. There is no mention of excising/amputation of any bone (tuft of distal phalanx), which is included in 11752.

48. What CPT® code(s) would best describe treatment of 9 plantar warts removed and 6 flat warts all destroyed with cryosurgery during the same office visit?

   a. 17110, 17111-52  
   b. 17110  
   c. 17110, 17003  
   d. 17111

ANS: D
Rationale: In the CPT® Index, see Destruction/Warts/Flat and you are directed to CPT® code range 17110-17111. In the Integumentary Section, subsection guidelines under the subheading Destruction state, flat warts and plantar warts are both included in the definition of lesions. Warts are considered benign lesions; they are coded from code range 17110-17111. A total of 15 lesions were destroyed by cryosurgery. Code 17111 represents the destruction of 15 or more lesions.

49. What CPT® codes are reported for the destruction of 16 premalignant lesions and 10 benign lesions using cryosurgery?

   a. 17000, 17003 x 14, 17110  
   b. 17000, 17003, 17004  
   c. 17004, 17110 x 10  
   d. 17004, 17110

ANS: D
Rationale: Cryosurgery is a method of destruction using extreme cold to destroy the lesion. Method selected for destroying benign or premalignant lesions is based on the type of lesion and number of lesions. There were 16 premalignant destroyed. Look in the CPT® Index for Destruction/Skin/Premalignant and you are directed to codes 17000-17004, 96567. In the Integumentary Section, code 17004 is the only code reported for this procedure. There is a parenthetical note under code 17004 that states “Do not report 17004 in conjunction with 17000-17003.” 10 benign lesions were destroyed. Code 17110 is reported for this procedure. Code 17110 is only reported once for when there are up to 14 lesions removed, not reported in units.

50. While whittling a piece of wood, the patient sustained an avulsion injury to a portion of his left index finger and underwent formation of a direct pedicle graft with transfer from his left middle finger. Immobilization was accomplished with a plaster splint. What CPT® codes is reported?

   a. 15574  
   b. 15740  
   c. 15750  
   d. 15758

ANS: A
Rationale: In the CPT® Index see Pedicle Flap/Formation, you are directed to 15570-15576. Code selection is based on location. Subsection guidelines for Flaps state the codes refer to the recipient site not the donor site. The term “pedicle” indicates this is a flap not a direct graft, where skin is removed from one site and transferred to another. Instead, a “flap” of skin is raised, leaving it attached to its source location to maintain blood supply until it is established sufficiently in the new site. Code 15574 describes a direct pedicle graft of the hands with or without transfer.

51. A patient presents to the physician with multiple burns. After examination the physician determines the patient has 3rd degree burns of the anterior portion of his left leg, below the knee extending to the foot (4.5%). He also has 3rd degree burns of the anterior portion of the left side of his chest (4.5%). The patient also has 2nd degree burns of the posterior portion of his back and left arm (13.5%). What ICD-9-CM codes are reported?

   a. 945.29, 945.19, 948.31  
   b. 942.34, 945.31, 948.31  
   c. 945.10, 945.13, 942.12, 943.30, 942.24, 948.31  
   d. 945.39, 942.32, 942.24, 943.20, 948.20

ANS: D
Rationale: ICD-9-CM Guidelines 1.C.17.c.1 state, when more than one burn is present to sequence first the code reflecting the highest degree of burn. In the Index to Diseases, see Burn/leg/lower/with other part(s) of lower limb(s)-see Burn, leg, multiple sites. Third degree burns to the left leg below the knee extending to the foot (multiple sites) are coded as 945.39; third degree burns to the left side of the chest is indexed Burn/chest wall (anterior)/third degree referring you to code 942.32; second degree burns to the posterior back is indexed Burn/back/second degree referring you to code 942.24; and second degree burns to the left arm is indexed Burn/arm/second degree referring you to code 943.20. Category 948 is used to identify the extent of the body surface involved. The fourth digit identifies the total body surface area (TBSA) involved (all degrees); the fifth digit identifies the percentage of body surface involved in third-degree burns. The TBSA is 22.5% (948.2x) and third degree is 9% reporting the fifth digit “0”. This is coded with 948.20.

52. A patient presents to the physician to discuss her acne and ask the physician about a suspicious lesion of the left ear. The patient and physician discuss further treatment of the acne and agree to take a biopsy of the lesion of the ear. Billing was sent prior to receiving the pathology report. What ICD-9-CM code(s) is/are reported?

a. 706.1, 238.2  
b. 706.1  
c. 706.1, 239.2  
d. 706.1, 173.20

ANS: C

Rationale: The patient is presenting with acne, additionally the patient has a suspicious lesion the physician has taken a biopsy of. In the Index to Diseases, see Acne for the first code. For the ear lesion, because it is “suspicious” see the Neoplasm Table (in the Index to Diseases) look for Neoplasm, neoplastic/skin/ear/Unspecified (column). Because this is being submitted to the carrier prior to the pathology report it is necessary to report unspecified for the lesion.

53. A patient has a greenstick fracture of the radial shaft. It is treated by surgically placing a bone plate on the distal radial shaft. What ICD-9-CM code is reported?

a. 813.81  
b. 813.31  
c. 813.21  
d. 733.12

ANS: C

Rationale: A greenstick fracture occurs when the bone does not break completely through, and the bone does not protrude through the skin. This is a closed fracture. The treatment to fix the fracture is open; however, the fracture care treatment is not considered when coding for the diagnosis. In the Index to Diseases look under Fracture/radius (alone) (closed)/shaft (closed).

54. The acronym BKA means:

a. bilateral-knee arthritis  
b. bursitis knee & arthritis  
c. bilateral-knee amputation  
d. below-knee amputation

ANS: D

Rationale: BKA stands for below-knee amputation.

55. A patient presents to the ED with back pain and is diagnosed with a lumbar sprain. What ICD-9-CM code is reported?

a. 847.2  
b. 846.0  
c. 724.6  
d. 724.2

ANS: A

Rationale: In the ICD-9-CM Index to Diseases (Alphabetic Index), look for Sprain/lumbar (spine) and you are directed to 847.2. Verification of the code in the Tabular List confirms the code selection. Back pain is not reported since a definitive diagnosis was documented. (See ICD-9-CM guideline: I.B.6).

56. A(n) ________ fixation with pins, screws, plates, or wires (is) are placed directly on the bone to immobilize a fractured bone and to maintain alignment while it heals.

a. reduction  
b. internal  
c. manipulation  
d. casting

ANS: B
Rationale: Some fractures are treated with either internal or external fixation to maintain the alignment of the bone and immobilize it while it heals, or to reinforce the bone permanently. Internal fixation can be done with pins, screws, plates or wires placed directly on the bone to immobilize it.

57. The patient fell and fractured his femoral shaft in three places. He has to have an ORIF of the left femur with an intramedullary nail and interlocking screws (peritrochanterically). The orthopedist also places the leg in a plaster splint prior to leaving the OR. What CPT® code(s) is reported?
   a. 27245       c. 27513
   b. 27507       d. 27506

ANS: D
Rationale: Documentation shows the patient had a fracture of his femoral shaft. The fracture was repaired with open reduction and internal fixation (ORIF) using an intramedullary nail and interlocking screws. Selection of codes depends on the fracture site and the method of treatment (closed, open, or percutaneous) used. The range of codes can be found in the CPT® Index under Fracture/Femur/Peritrochanteric/Intramedullary Implant Shaft. Go to the code descriptions to select the correct code.

58. 44-year-old male with bplanar deformity, acquired limb length discrepancies and tibial nonunion has undergone deformity correction. He now requires exchange of an external fixation strut 45 days postoperatively. The intraoperative mounting parameters, deformity parameters, and initial strut settings are inserted into the computer prior to Jim’s discharge and a daily schedule is generated for him to perform the gradual deformity correction necessary. What CPT® code(s) should be reported?
   a. 20696       c. 20694
   b. 20697       d. 20692, 20697

ANS: B
Rationale: The exchange of a computer assisted external strut is coded with 20697. There is a parenthetical note under code 20697 that it is not to be used in combination with 20672 or 20696. 20697 can be found in the index under External Fixation/Application/Stereotactic Computer Assisted directing you to 20696-20697.

59. A patient is given Xylocaine, a local anesthetic, by injection in the thigh above the site to be biopsied. A small bore needle is then introduced into the muscle, about 3 inches deep, and a muscle biopsy is taken. What CPT® code is reported for this service?
   a. 20205       c. 20225
   b. 20206       d. 27324

ANS: B
Rationale: In the CPT® Index, look for Biopsy/Muscle. You are referred to 20200-20206. The biopsy is taken through the skin, or percutaneously with a needle. Although the biopsy is deep, it is performed percutaneously, which is reported with 20206.

60. The patient presents today for closed reduction of the nasal fracture. The depressed right nasal bone was elevated using heavy reduction forces while the left nasal bone was pushed to the midline. This resulted in good alignment of the external nasal dorsum. What CPT® code is reported for this procedure?
   a. 21325       c. 21315
   b. 21310       d. 21337

ANS: C
Rationale: In the CPT® Index, look for Fracture/Nasal Bone/Closed Treatment. You are referred to 21310-21320. Review codes to choose the appropriate service. 21315 is the correct code to report a displaced nasal fracture that is manipulated with the forceps to realign the nasal bones. Code 21310 is reported when a non-displaced fracture of the nose requires no manipulation just treatment by prescribing medication and application of ice.
61. A 22-year-old female has a retained Kirschner wire in the left little finger. Using local anesthesia, the left upper extremity was thoroughly cleansed with Betadine. The end portion of the little finger was opened by a transverse incision through the subcutaneous tissue to the bone. The retained Kirschner wire was located within the distal phalanx. It was removed and closed with sutures. What CPT® code is reported?

a. 10120-F4  
  b. 20680-F4  
  c. 20670-F4  
  d. 10121-F4

ANS: B
Rationale: In the CPT® Index, look for Removal/Fixation Device. You are referred to 20670-20680. Review the codes to choose the appropriate service. 20680 is the correct code because a deep incision was made all the way to the bone to locate the wire for removal. Modifier F4 is reported to indicate the finger the procedure is performed on.

62. A 63-year-old man presents with a neck mass to be excised. The neck mass was palpated and an incision was then made and carried down through the dermis with electrocautery. The subcutaneous tissue of the skin was opened encountering an organized mass with a benign appearance of a lipoma. Using careful blunt and sharp dissection, the mass measuring 5 cm was completely excised around its entire circumference leaving the capsule intact. The mass was removed from its posterior attachments using electrocautery. What CPT® code is reported for this procedure?

a. 11426  
  b. 21552  
  c. 11626  
  d. 21555

ANS: B
Rationale: In the CPT® Index, look for Neck/Tumor/Excision. You are referred to 21552-21558. Review the codes to choose the appropriate service. 21552 is the correct code to report the excision of a 5-cm mass where the surgeon incised all the way through the subcutaneous tissue to remove the mass. Codes 11426 and 11626 are coded for removal of a benign or malignant lesion, not an internal mass.

63. What CPT® code is reported for a major thoracotomy for post-op hemorrhage following an endoscopic upper lobectomy?

a. 32110  
  b. 32100  
  c. 32310  
  d. 32120

ANS: D
Rationale: In the CPT® Index, look for Thoracotomy/for Post-op Complications. This directs you to code 32120. Since post-op hemorrhage is considered a complication, code 32120 is the correct code to report.

64. Johnny has a penny removed from his left nostril in the doctor’s office. What CPT® code is reported?

a. 30320  
  b. 30300  
  c. 30100  
  d. 30160

ANS: B
Rationale: A penny in the nostril is considered a foreign object. In the CPT® Index, look up Nose/Removal/Foreign Body, directing you to code 30300. The description of the code confirms this is a removal that would be performed in a doctor’s office.

65. What ICD-9-CM code is reported for a patient that has RSV, respiratory syncytial virus?

a. 480.1  
  b. V04.82  
  c. 466.11  
  d. 079.6

ANS: D
Rationale: RSV stands for respiratory syncytial virus. In the ICD-9-CMAlphabetic Index (volume 2), look up Respiratory syncytial virus (RSV). This directs you to code 079.6. When we check this in the tabular listing (volume 1), we see that code 079.6 is correct for reporting RSV. The question is only asking for RSV not a respiratory condition that is due to RSV, nor is an inoculation given.
66. What ICD-9-CM code is reported for pyopneumothorax with fistula?
   a. 510.0  
   b. 510.9  
   c. 512.89  
   d. 512.1  

   ANS: A  
   Rationale: In the ICD-9-CM Index (volume 2), look up Pyopneumothorax/with fistula. You are referred to code 510.0. You are able to confirm that 510.0 is for empyema (pus in the pleural space) with fistula in the tabular section. “Pyo” is the prefix for pus; pneumothorax is air in the pleural cavity. Not all words listed in the index are carried over into the code description in the tabular section. 510.9 would be used if there were no mention of the fistula. The 512 category is for pneumothorax with no pus in the pleural space.

67. A patient presents with wheezing and shortness of breath. After evaluating the patient, the physician determines the patient is suffering from an exacerbation of his asthma. The physician orders nebulizer treatments to be administered in his office. According to the ICD-9-CM guidelines for coding signs and symptoms, what is/are the correct ICD-9-CM code(s)?
   a. 493.92  
   b. 493.91, 786.07, 786.05  
   c. 786.07, 786.05  
   d. 493.91  

   ANS: A  
   Rationale: Since the type of asthma is not indicated, the correct subcategory code is 493.9. In the Index to Diseases, look up Asthma, asthmatic directing you to 493.9. When you go to the Tabular List, you see a fifth digit is required. The fifth digit, 2, is appropriate as the documentation states it is with exacerbation. This makes the correct code 493.92. Wheezing and shortness of breath are signs and symptoms of an exacerbation of asthma and not reported separately. According to the Official ICD-9-CM Guidelines (Sect I. B.6), do not report signs and symptoms when a definitive diagnosis has been established.

68. What is the term for the divider between the heart chamber walls?
   a. SA node  
   b. Bundle branch  
   c. Septum  
   d. Mitral  

   ANS: C  
   Rationale: The heart is divided into right and left sides by a septum, which is a muscular wall.

69. A patient suffering from an abdominal aortic aneurysm involving a renal artery undergoes endovascular repair using modular prosthesis with two docking limbs. Select the CPT® code(s) for this procedure.
   a. 34805  
   b. 0078T, 0079T  
   c. 34803  
   d. 34802  

   ANS: B  
   Rationale: The Category III code states “involving a visceral vessel”, such as the renal artery. The directions under 0079T state “Use 0079T in conjunction with 0078T”. Code 0078T reports the endovascular repair of the abdominal aortic aneurysm, and 0079T reports the visceral extension prosthesis. This can be found in the CPT® index under Repair/Aneurysm/Aorta/Abdominal.

70. A physician places a centrally inserted, tunneled central venous access device with a subcutaneous pump in a 7-year-old patient.
   a. 36561  
   b. 36563  
   c. 36560  
   d. 36558  

   ANS: B  
   Rationale: The code for insertion of a tunneled central venous access device with a subcutaneous pump is 36563. This can be found in the CPT® index under Venous Access Device/Insertion/ Central.
71. Patient presents to her physician 10 weeks following a true posterior wall myocardial infarction. The patient is still symptomatic. What is the correct ICD-9-CM code for this condition?
   a. 414.8  
   b. 410.62  
   c. 410.60  
   d. 412  

   ANS: A  
   Rationale: Because it is past eight weeks and the patient is still symptomatic, according to ICD-9-CM, the patient has chronic coronary insufficiency or ischemia. Notes in the Tabular List for 414.8 indicate “Any condition classifiable to 410 specified as chronic, or presenting with symptoms after 8 weeks from date of infarction.”

72. ____ is a term standing for enlargement of the heart.
   a. Cardiorenal  
   b. Angiomegaly  
   c. Cardiomegaly  
   d. Valvuloplasty  

   ANS: C  
   Rationale: Cardio = heart, megaly = enlargement

73. Repair of coronary vessel is called:
   a. Endarterectomy  
   b. Angioplasty  
   c. Aortic  
   d. Endovascular  

   ANS: B  
   Rationale: Angio = vessel, plasty = repair

74. A physician performs a four-vessel autogenous (one venous, three arterial) coronary bypass on a patient who had a previous CABG two years ago, utilizing the saphenous vein, radial artery and the left and right internal mammary arteries. Select the CPT® codes for this procedure.
   a. 33535, 33510-51, 33530, 35600  
   b. 33534, 33518, 33530  
   c. 33533, 33519, 33530, 35600  
   d. 33535, 33517, 33530, 35600  

   ANS: D  
   Rationale: Because this is a combo graft, codes 33517-33523 must be coded for the venous portion of the graft. Also, this is a redo more than one month after the original surgery, so the add-on code 33530 is appropriate. This is found in the CPT® index under Coronary Artery Bypass Graft (CABG)/Arterial-Venous Bypass 33517-33523, and Arterial Bypass 33533-33536. Also listed under this section in the Index is Reoperation 33530. In this same section under CABG is Harvest/Upper Extremity Artery 35600. Look up the codes in the procedure listing, and you see all additional codes are add-on codes; therefore, no modifiers are required.

75. A patient presented to the ED and was found to have a ruptured abdominal aortic aneurysm. He was taken to emergency surgery; a physician performed a direct repair. The physician documented that the aneurysm involved the common iliac. Select the proper CPT® code for this procedure.
   a. 34800  
   b. 35092  
   c. 35103  
   d. 35102  

   ANS: C  
   Rationale: You must read the question carefully, because this is a ruptured aortic aneurysm involving the common iliac, not a ruptured aneurysm of the common iliac. The CPT® index shows 35103 under Aneurysm Repair/Abdominal Aorta. Check the code range, and code 35103 is correct. Code 35102 is a repair of an aneurysm not ruptured.