

1. This term means the surgical removal of the fallopian tube:

   A. ligation
   B. hysterectomy
   C. salpingostomy
   D. salpingectomy

   POINT VALUE: 1 point

   CORRECT ANSWER:
   D. Salpingectomy is the surgical removal of the fallopian tube.

   RATIONALE:
   A. Ligation is binding or tying off.
   B. Hysterectomy is the surgical removal of the uterus.
   C. Salpingostomy is the creation of a fistula into the fallopian tube.

2. This combining form means “thirst”:

   A. dips/o
   B. acr/o
   C. cortic/o
   D. somat/o

   POINT VALUE: 1 point

   CORRECT ANSWER:
   A. Dips/o means thirst.

   RATIONALE:
   B. Acr/o means height or extremity.
   C. Cortic/o means cortex.
   D. Somat/o means body.

3. This term is also known as a homograft:

A. autograft  
B. allograft  
C. xenograft  
D. xenograft

**POINT VALUE: 1 point**

**CORRECT ANSWER:**  
B. Allograft (between same species) is also known as a homograft.

**RATIONALE:**  
A. Autograft is from the patient’s own body.  
C. Xenograft is a graft from another species.  
D. Zenograft is not a term.

4. Which of the following terms means “taste”?  
A. Meissner  
B. pacinian  
C. gustatory  
D. astrocytes

**POINT VALUE: 1 point**

**CORRECT ANSWER:**  
C. Gustatory means taste.

**RATIONALE:**  
A. Meissner is a corpuscle that senses touch.  
B. Pacinian is a corpuscle that senses pressure.  
D. Astrocytes are part of the glia, which is a cell of the nervous system.

5. This suffix means “removal”:  
A. -penia  
B. -ectomy  
C. -itis  
D. -pexy

**POINT VALUE: 1 point**

**CORRECT ANSWER:**  
B. -ectomy means removal.

**RATIONALE:**  
A. -penia means deficient.  
C. -itis means inflammation.
D. -pexy means fixation.

6. Which of the following terms does NOT describe a receptor of the body?
   A. mechanoreceptor
   B. proprioceptor
   C. thermoreceptor
   D. endoreceptor

POINT VALUE: 1 point

CORRECT ANSWER:
   D. Endoreceptor does NOT describe a receptor of the body.

RATIONALE:
   A. Mechanoreceptor reacts to touch and pressure.
   B. Proprioceptor reacts to position and orientation.
   C. Thermoreceptor senses temperature changes. There is also a nociceptor that senses pain.

7. This term means abnormal thickening of the skin:
   A. ductus
   B. dermatofibroma
   C. dermatitis
   D. pachyderma

POINT VALUE: 1 point

CORRECT ANSWER:
   D. Pachyderma is abnormal thickening of the skin.

RATIONALE:
   A. Ductus is a duct, passage, or channel.
   B. Dermatofibroma is a benign nodular neoplasm of the dermis.
   C. Dermatitis is an inflammation of the skin.

8. The term that defines the relaxation phase of the heartbeat is:
   A. systole
   B. sinoatrial
   C. diastole
   D. septa

POINT VALUE: 1 point
CORRECT ANSWER:
C. Diastole is the relaxation phase of the heartbeat.

RATIONALE:
A. Systole is the contraction phase of the heartbeat.
B. Sinoatrial is a node that functions as nature’s pacemaker and sends impulses to the atrioventricular node.
D. Septa divide the chambers of the heart.

Subject Area: Anatomy

9. This is the first portion of the small intestine:

A. jejunum
B. ileum
C. duodenum
D. cecum

POINT VALUE: 1 point

CORRECT ANSWER:
C. Duodenum is the first portion of the small intestine.

RATIONALE:
A. The jejunum is the second portion of the small intestine.
B. The ileum is the end portion of the small intestine.
D. The cecum is the portion of the large intestine that connects the ileum and colon and from which the appendix extends.

10. This is a part of the inner ear:

A. vestibule
B. malleus
C. incus
D. stapes

POINT VALUE: 1 point

CORRECT ANSWER:
A. Vestibule is part of the inner ear.

RATIONALE:
B. The malleus is part of the middle ear.
C. The incus is part of the middle ear.
D. The stapes is part of the middle ear.
11. This is the area behind the cornea:

   A. anterior chamber  
   B. choroid layer  
   C. ciliary body  
   D. fundus  

**POINT VALUE: 1 point**

**CORRECT ANSWER:**  
A. Anterior chamber is the area behind the cornea.

**RATIONALE:**
B. The choroid layer is the middle layer of the eye.  
C. The ciliary body is located on each side of the lens and connected to the choroid and iris.  
D. The fundus is the posterior portion of the eye.

12. Which of the following is a covering of the chamber walls of the heart?

   A. endocardium  
   B. myocardium  
   C. pericardium  
   D. epicardium  

**POINT VALUE: 1 point**

**CORRECT ANSWER:**  
A. The endocardium is the layer of tissue that covers the chamber wall of the heart.

**RATIONALE:**
B. The myocardium is the middle muscular layer.  
C. The pericardium is the sac that covers the heart, not the chamber wall.  
D. The epicardium is the outer layer of the heart tissue.

13. The shaft of a long bone:

   A. diaphysis  
   B. epiphysis  
   C. metaphysis  
   D. periosteum  

**POINT VALUE: 1 point**

**CORRECT ANSWER:**
A. Diaphysis is the shaft of a long bone.

RATIONALE:
B. The epiphysis is the growth plate of the bone.
C. The metaphysis is the flared portion of the bone near the epiphyseal plate.
D. The periosteum is the surface of the long bone.

14. The act of turning upward, such as the hand turned palm upward:

A. supination
B. adduction
C. pronation
D. circumduction

POINT VALUE: 1 point

CORRECT ANSWER:
A. Supination is turning upward.

RATIONALE:
B. Adduction is turning toward.
C. Pronation is turning downward.
D. Circumduction is circular movement.

15. The middle layer of the skin, also known as the corium or true skin, is the:

A. epidermis.
B. stratum corneum.
C. dermis.
D. subcutaneous.

POINT VALUE: 1 point

CORRECT ANSWER:
C. Dermis is the middle layer of skin.

RATIONALE:
A. The epidermis is the outermost layer.
B. The stratum corneum is another name for the epidermis.
C. The subcutaneous tissue or hypodermis is the innermost layer containing fat tissue.

16. This is the collarbone:
A. patella
B. tibia
C. scapula
D. clavicle
POINT VALUE: 1 point

CORRECT ANSWER:
D. The clavicle is the collarbone.

RATIONALE:
A. The patella is the kneecap.
B. The tibia is the shinbone.
C. The scapula is the shoulder blade.

Subject Area: ICD-9-CM

17. Three-week-old female with obstructive apnea.

A. 770.8
B. 770.82
C. 769
D. 770.83

POINT VALUE: 1 point

CORRECT ANSWER:
B. 770.82 correctly describes obstructive apnea during the perinatal period (the first 28 days after birth).

RATIONALE:
A. 770.8 is the four-digit code for other respiratory problems after birth; however, there is a more specific five-digit code, 770.82.
C. 769 is respiratory distress syndrome, which was not indicated in the question.
D. 770.83 describes a cyanotic attack of a newborn but does not indicate obstructive apnea.

18. Mild intellectual disabilities due to congenital iodine-deficiency hypothyroidism.

A. 243, 317
B. 244.8, 317
C. 243, 318.0
D. 317, 243

POINT VALUE: 1 point

CORRECT ANSWER:
A. 243 correctly describes congenital hypothyroidism and is the first-listed diagnosis. Per the instruction under code 243, an additional code is to be used to identify the associated intellectual disabilities; 317 correctly describes mild intellectual disabilities and is listed second.
RATIONALE:
B. 244.8 is acquired hypothyroidism, not congenital hypothyroidism, and 317 is correct for mild intellectual disabilities.
C. 243 is correct for congenital hypothyroidism, but 318.0 is for moderate intellectual disabilities, not mild intellectual disabilities.
D. The codes are correct, but the order is incorrect because the first-listed code should be that of the primary condition of hypothyroidism.

19. Admission for hemodialysis because of acute renal failure.

A. V56.31, 584.9  
B. V56, 584 
C. V56.0, 584.9  
D. 584.9, V56.0

POINT VALUE: 1 point

CORRECT ANSWER:
C. V56.0 is correct for hemodialysis, and 584.9 is correct for acute renal failure and listed in this order as the reason for the encounter is the hemodialysis. According to Coding Clinic (1993, fourth quarter, p 34), when a patient is admitted for renal dialysis, code V56.0 should be assigned as the principal diagnosis with the reason for the dialysis assigned as an additional code.

RATIONALE:
A. V56.31 is incorrect for an encounter for adequacy testing for hemodialysis and 584.9 is correct for unspecified acute renal failure.
B. There is a four-digit code available for V56, and there is a four-digit code available for 584; and, according to the Official Guidelines for Coding and Reporting, you should always code to the highest specificity.
D. The codes are correct, but the sequence should be as shown in choice C, where the primary reason for the encounter (hemodialysis) is listed first and the underlying etiology (acute renal failure) is listed second.

20. Glomerulonephritis due to viral hepatitis.

A. 580.9, 070 
B. 070, 580.9 
C. 580.81, 070.9 
D. 070.9, 580.81

POINT VALUE: 1 point

CORRECT ANSWER:
D. 070.9 describes unspecified viral hepatitis and without mention of
hepatic coma, and is the first-listed diagnosis; 580.81, the glomerulonephritis, is listed second. This sequencing is correct based on the instructional note under 580.81 to code first the underlying disease.

RATIONALE:
A. 580.9 describes acute glomerulonephritis with an unspecified pathological lesion of the kidney, and 070 is viral hepatitis, but four- and five-digit codes are available, so you must code to the highest specificity possible.
B. 070 is viral hepatitis, but four- and five-digit codes are available, and 580.9 describes acute glomerulonephritis with an unspecified pathological lesion of the kidney.
C. These are the correct codes, but the order is incorrect according to Section I.A.6. of the Official Guidelines for Coding and Reporting, which states that the underlying condition is to be coded first.

21. Initial encounter to repair a laceration of left hand.

A. 882.0  
B. 883.0  
C. 887.2  
D. 882.2

POINT VALUE: 1 point

CORRECT ANSWER:
A. 882.0 reports an open wound of the hand (except the fingers) without mention of complication. When referencing laceration in the Index, the subterms of hand or skin are not listed. The main term and subterm for lacerations of the skin is wound, then open.

RATIONALE:
B. 883.0 is an open wound of finger(s).
C. 887.2 is for traumatic amputation of hand at or above the elbow.
D. 882.2 is for an open wound of hand with tendon involvement, which was not stated in the question.

22. Mr. Hallberger is 62 and has multiple problems. I am examining him in the intensive critical care unit. I understand he has fluid overload with acute renal failure and was started on ultrafiltration by the nephrologist on duty. He has an abnormal chest x-ray. He has preexisting type II diabetes mellitus and sepsis. We are left with a patient now who is still sedated and on a ventilator because of acute respiratory failure. Code the diagnoses only.

A. 782.3, 585.9, 792, 250.40, 039.9, 518.81  
B. 789.59, 584.7, 793.19, 250.4, 039.9, 518.81  
C. 276.50, 587, 793.19, 250.00, 038.9, 518.81, 99223

D. 038.9, 995.92, 584.9, 518.81, 250.00, 793.19

POINT VALUE: 1 point

CORRECT ANSWER:

D. 038.9 is correct for unspecified septicemia (sepsis) (see Coding Clinic, 2005, second quarter, pp. 19-20, and the Official Guidelines for Coding and Reporting, Section I.C.1.b.2. and I.C.1.b.2.c.). 995.92 reports the sepsis with organ failure. 584.9 identifies unspecified acute renal failure, and 518.81 is for the respiratory failure. The sequence of the second through fifth diagnosis codes is correct per the notes in the Tabular under 995.91, which instructs the coder to sequence first the underlying infection (038.9) then use additional code for acute organ dysfunction (584.9 for acute renal failure and 518.81 for acute respiratory failure). 250.00 identifies the diabetes as type II by use of the fifth digit "0" and without mention of complication identified with the fourth digit "0." 793.19 is an abnormal radiological examination of the lung based on the statement "abnormal chest x-ray" (abnormal lung x-ray).

RATIONALE:

A. 782.3 is localized edema, not fluid overload. 585.9 is chronic renal failure, unspecified, when the case indicates acute renal failure. 792 is an abnormal finding in a body substance, not an abnormal chest x-ray. 250.40 identifies diabetes with a renal manifestation, but the renal failure is not indicated to be due to or connected with the diabetes stated in the case. 039.9 is for actinomycotic infection, not sepsis (038.9), and 518.81 is correct for respiratory failure.

B. 789.59 is for ascites, which is accumulation of fluid in the abdominal cavity, also known as peritoneal dropsy. 584.7 is acute renal failure with lesions, 793.19 is correct for abnormal chest x-ray or abnormal lung x-ray, 250.4 is for type II diabetes with renal manifestation which is not indicated in this case. Furthermore, 250.4 is an incomplete code as it is lacking the fifth digit. 039.9 is for actinomycotic infection, not sepsis (038.9), and 518.81 is correct for respiratory failure.

C. 276.50 is for volume depletion, not the fluid overload as indicated in the case; 587 is for renal sclerosis, not acute renal failure; 793.19 is correct for the abnormal chest x-ray or lung x-ray; 250.00 is correct for the type II diabetes without mention of complication; 038.9 is correct for sepsis; 518.81 is correct for respiratory failure. 99233 is an E/M code and the question indicates to report only the diagnoses.

23. Bloody stool.

A. 772.4
B. 792.1
C. 578.1
D. 578.0

POINT VALUE: 1 point

CORRECT ANSWER:
C. 578.1 correctly describes blood in the stool (melena).

RATIONALE:
A. 772.4 is melena or gastrointestinal hemorrhage in a fetus or neonate.
B. 792.1 is incorrect because it describes fecal occult blood which is different than melena. Melena is obvious blood in the stool whereas occult blood is detected via a lab test. This case does not describe fecal occult blood detected via a lab test.
D. 578.0 is hematemesis, or vomiting of blood.

24. A lethargic patient presents with vomiting and severe cramping, and the physician determines during the initial encounter that the condition was caused by the ingestion of five tablets of Tylenol With Codeine and half a bottle of whiskey.

A. 965.01, 965.4, 980.0, 780.79, 787.03, 789.00, E980.0, E980
B. 965.09, 965.61, 980.0, 780.79, 787.03, 789.00, E980.0
C. 966.09, 965.4, 980.0, 780.71, 787.03, 789.00, E980.4, E980.9
D. 965.09, 965.4, 980.0, 780.79, 787.03, 789.00, E980.0, E980.9

POINT VALUE: 1 point

CORRECT ANSWER:
D. 965.09 (codeine), 965.4 (acetaminophen), and 980.0 (alcohol) report poisoning or toxic effects of these substances. 780.79 (lethargy), 787.03 (vomiting), and 789.00 (abdominal pain and cramping) report the symptoms caused by these substances. E980.0 (acetaminophen and codeine, both analgesics) and E980.9 (alcohol, a liquid substance). Unspecified E codes are assigned to this case (E980-E989) because it is not stated if this was an accidental or intentional poisoning.

RATIONALE:
A. There are two incorrect codes in this choice. 965.01 (heroin) is incorrect; E980 to report the alcohol requires a fourth digit of "9"; all other codes are correct.
B. There is one incorrect code in this choice. 965.61 (ibuprofen or other propionic acid derivatives) rather than 965.4 to report the Tylenol (acetaminophen); E980.9 to report the alcohol is missing; all other codes are correct.
C. There are three incorrect codes in this choice. 966.09 is invalid (there is no 966.09); 780.71 is for chronic fatigue syndrome, not lethargy (780.79). E980.4 reports other specified drugs and medicinal substances (codeine), but both the codeine and Tylenol are reported with E980.0, so E980.4 is not necessary. All other codes are correct.
25. Initial encounter to treat a fracture of the right patella with abrasion.

   A. 822.0, 916.0
   B. 822.0
   C. 916.0, 822.1
   D. 823.00

   POINT VALUE: 1 point

   CORRECT ANSWER:
   B. 822.0 is correct. When a fracture is not specified as open or closed, assign a code that indicates a closed fracture. See the 800-829 section note regarding fractures that states to assign a closed fracture code to a fracture not specified as open or closed. The abrasion code is not assigned because the Official Guidelines for Coding and Reporting, Section I.C.17.a.1., indicate that superficial injuries are not coded when associated with more severe injuries of the same site.

   RATIONALE:
   A. 822.0 is correct to report the fracture, but you would not code the abrasion (916.0) because there is a more severe injury of the same site (the fracture). See rationale B.
   C. You would not code the abrasion (916.0) because there is a more severe injury of the same site (the fracture). See Rationale B. 822.1 is for an open fracture; if the fracture is not stated as being open or closed, you are to assign a code to indicate a closed fracture. See the 800-829 section note regarding fractures, which states to assign a closed fracture code to a fracture not specified as open or closed.
   D. 823.00 is for a closed fracture of the tibia, whereas the fracture site in this case is patella.

26. Sarcoidosis with cardiomyopathy.

   A. 135, 517.8
   B. 135, 425.8
   C. 425.8, 135
   D. 135, 425.8, V71.7

   POINT VALUE: 1 point

   CORRECT ANSWER:
   B. 135, sarcoidosis, is the first-listed diagnosis, and 425.8, cardiomyopathy in other diseases, is listed second. You know this because listed in the Index of the ICD-9-CM under "Sarcoidosis" is subterm "cardiac 135 [425.8]." You are to list these codes in the order presented in the Index of the ICD-9-CM. Further, when referencing the Tabular, a directional note
under 425.8, cardiomyopathy, directs the coder to "Code first any underlying disease" and includes "sarcoidosis 135" in the list of other diseases. This also directs the coder to report 135 first followed by 425.8.

RATIONALE:
A. 135 is correct for the underlying disease of sarcoidosis, but 517.8 is for lung involvement, not cardiac involvement.
C. The codes are correct, but the underlying condition (sarcoidosis) is to be listed first and the cardiomyopathy is listed second as indicated in the directional note under code 425.8 in the ICD-9-CM Tabular.
D. The codes are correct and in the correct order, except V71.7 (observation for suspected cardiovascular disease) is incorrect because there was no indication of evaluation for a suspected condition.

Subject Area: HCPCS

27. A patient is issued a 22-inch seat cushion for his wheelchair.
   A. E2601
   B. E0950
   C. E0190
   D. E2602

POINT VALUE: 1 point

CORRECT ANSWER:
D. E2602 is for a seat cushion for a wheelchair 22 inches wide or greater, any depth.

RATIONALE:
A. E2601 is for wheelchair seat cushion, width LESS than 22 inches, any depth.
B. E0950 is for a tray for a wheelchair.
C. E0190 is for positioning cushion/pillow/wedge for decubitus care.

28. A patient with chronic lumbar pain previously purchased a TENS and now needs replacement batteries.
   A. E1592
   B. A5082
   C. A4772
   D. A4630

POINT VALUE: 1 point

CORRECT ANSWER:
D. **A4630 is for replacement batteries for a previously purchased TENS.**

**RATIONALE:**
A. E1592 is for an intermittent peritoneal dialysis system.
B. A5082 is for a catheter for a continent stoma.
C. A4772 is for blood glucose test strips.

29. **A patient presents for trimming of 10 dystrophic toenails.**

A. G0127 × 2, 703.8
B. G0127, G0127 × 9, 703.0
C. G0127, 703.8
D. G0127 × 5, G0127 × 5, 703.9

**POINT VALUE:** 1 point

**CORRECT ANSWER:**
C. G0127. The description of the code indicates for any number of dystrophic nails. 703.8 is the correct diagnosis code for specified diseases of the nail.

**RATIONALE:**
A. Because the description of G0127 indicates that any number of dystrophic nails can be reported using this code, there is no need for the number of units; therefore, choices A, B, and D are not correct because each contains units. 703.8 is the correct diagnosis code for specified diseases of the nail.
B. Because the description of G0127 indicates that any number of dystrophic nails can be reported using this code, there is no need for the number of units; therefore, choices A, B, and D are not correct because each contains units. 703.0 is incorrect because it describes an ingrown nail.
D. Because the description of G0127 indicates that any number of dystrophic nails can be reported using this code, there is no need for the number of units; therefore, choices A, B, and D are not correct because each contains units. 703.9 is incorrect because it describes an unspecified disease of the nail.

30. **A patient with chronic obstructive pulmonary disease is issued a medically necessary nebulizer with a compressor and humidifier for extensive use with oxygen delivery.**

A. E0570, E0550
B. E0555, E0571
C. E0580, E0550
D. E0575, E0550

**POINT VALUE:** 1 point

**CORRECT ANSWER:**

A. E0570 correctly identifies the nebulizer with compressor, and E0550 correctly identifies the humidifier.

RATIONALE:
B. E0555 is for use of a humidifier with a regulator or flowmeter, and E0571 is for an aerosol compressor to be used with a nebulizer.
C. E0580 is for use of a nebulizer with a regulator or flowmeter, and E0550 is correct for a humidifier for use with extensive oxygen delivery.
D. E0575 is for an ultrasonic, large-volume nebulizer, but E0550 is correct for the humidifier.

31. Which HCPCS modifier indicates the great toe of the right foot?

   A. T1
   B. T3
   C. T4
   D. T5

POINT VALUE: 1 point

CORRECT ANSWER:
   D. T5 is the great toe of the right foot.

RATIONALE:
   A. T1 is the second digit of the left foot.
   B. T3 is the fourth digit of the left foot.
   C. T4 is the fifth digit of the left foot.

Subject Area: Practice Management

32. This entity develops and publishes an annual plan that outlines the Medicare monitoring program.

   A. MACs
   B. FIs
   C. OIG
   D. CMS

POINT VALUE: 1 point

CORRECT ANSWER:
   C. OIG is the entity that develops and publishes the annual Work Plan that outlines how the Medicare program will be monitored for the coming year.

RATIONALE:
A. MACs are Medicare Administrative Contractors who handle the paperwork and
pay claims.
B. FIs are Fiscal Intermediaries who historically handled the paperwork and paid the claims for Medicare, but they were replaced by MACs
D. CMS is the Centers for Medicare and Medicaid Services and they do not publish the plan to monitor the program.

33. This program was developed by CMS to promote national correct coding methods and to control inappropriate payment of Part B claims and hospital outpatient claims.

A. NCCI
B. NFS
C. HIPAA
D. MA-PA

POINT VALUE: 1 point

CORRECT ANSWER:
A. NCCI is the program created by CMS to promote national correct coding methods and to control inappropriate payment of Part B claims and hospital outpatient claims.

RATIONALE:
B. NFS replaced the RBRVS and is also known as the Medicare Fee Schedule (MFS). The NFS lists payment amounts.
C. HIPAA is the Health Insurance Portability and Accountability Act of 1996.
D. MA-PA is a Part D plan—Medicare Advantage Plans

34. What is an NPI?

A. National Payer Incentive
B. National Provider Identification
C. National Provider Index
D. National Payer Identification

POINT VALUE: 1 point

CORRECT ANSWER:
B. National Provider Identification is the 10-digit number assigned to all health care providers.

RATIONALE:
A. National Payer Incentive is not the correct answer; rather it is National Provider Identification.
C. National Provider Index is not the correct answer; rather it is National Provider Identification.
D. National Payer Identification is not the correct answer; rather it is National Provider Identification.
35. The RBRVS is a
   A. payment reform implemented in 1992
   B. listing of the customary charge for services
   C. payment list that indicates the prevailing charge in a locality
   D. listing of the physician’s individual charges for a service

   POINT VALUE: 1 point
   CORRECT ANSWER:
   A. RBRVS is a payment reform implemented in 1992.

   RATIONALE
   B. This choice is incorrect because RBRVS is not a listing of the customary charge for services; but rather a payment reform implemented in 1992.
   C. This choice is incorrect because RBRVS is not a payment list that indicates the prevailing charge in a locality; but rather a payment reform implemented in 1992.
   D. This choice is incorrect because RBRVS is not a listing of the physician’s individual charges for a service; but rather a payment reform implemented in 1992.

36. Which of the following is NOT considered fraud or abuse?
   A. Lack of documentation of medical necessity for services reported
   B. Accepting a $20 gift card from a shoe repair representative for each Medicare patient referred to his store
   C. Referring patients to a radiology center in which your physician is a partner
   D. Going to lunch with a pharmaceutical representative

   POINT VALUE: 1 point
   CORRECT ANSWER:
   D. Going to lunch with a pharmaceutical representative is not fraud or abuse as long as there is no financial gain by either party.

   RATIONALE:
   A. Lack of documentation of medical necessity for services reported is fraud.
   B. Accepting a $20 gift card from a shoe repair representative for each Medicare patient referred to his store is fraud.
   C. Referring patients to a radiology center in which your physician is a partner is fraud.

37. This document is a notification in advance of services that Medicare probably will not pay for and the estimated cost to the patient.
A. Wavier of Liability  
B. Coordination of Benefits  
C. Advanced Beneficiary Notice  
D. UPIN  

POINT VALUE: 1 point  

CORRECT ANSWER:  
C. Advanced Beneficiary Notice (ABN) is the document that is a notification in advance of services that Medicare probably will not pay for and the estimated cost to the patient.  

RATIONALE:  
A. Wavier of Liability is not correct because the Advanced Beneficiary Notice (ABN) is the document that is a notification in advance of services that Medicare probably will not pay for and the estimated cost to the patient.  
B. Coordination of Benefits is not correct because the Advanced Beneficiary Notice (ABN) is the document that is a notification in advance of services that Medicare probably will not pay for and the estimated cost to the patient.  
D. UPIN is not correct because the Advanced Beneficiary Notice (ABN) is the document that is a notification in advance of services that Medicare probably will not pay for and the estimated cost to the patient.  

Subject Area: Coding Guidelines  

38. Which punctuation mark between codes in the index of the CPT manual indicates a range of codes is available?  

A. period  
B. comma  
C. semicolon  
D. hyphen  

POINT VALUE: 1 point  

CORRECT ANSWER:  
D. The hyphen is located between two codes in the index of the CPT manual, indicating a range of codes is available.  

RATIONALE:  
A. There is no period between codes.  
B. The comma is located between two codes.  
C. The semicolon is not used in the index of the CPT manual; rather, it is used in the main portion of the manual, and an indented code depends on the words before the semicolon in the stand-alone code.  

39. Which of the following most accurately describes the designation “(Separate
procedure)? The procedure is:

A. incidental to another procedure
B. reported if it is the only procedure performed
C. reported if the procedure is unrelated to a more major procedure performed at the same time on the same site
D. All of the above

POINT VALUE: 1 point

CORRECT ANSWER:
D. “All of the above” is the most accurate description of the designation “(Separate procedure).”

RATIONALE:
A. “Incidental to another procedure” is correct but choice D, “All of the above,” is the most accurate choice.
B. “Reported if it is the only procedure performed” is correct but choice D, “All of the above,” is the most accurate choice.
C. “Reported if the procedure is unrelated to a more major procedure performed at the same time on the same site” is correct but choice D, “All of the above,” is the most accurate choice.

40. Specific coding guidelines in the CPT manual are located in:

A. the index.
B. the introduction.
C. the beginning of each section.
D. Appendix A.

POINT VALUE: 1 point

CORRECT ANSWER:
C. The specific coding guidelines for CPT are located at the beginning of each of the six sections in the manual.

RATIONALE:
A. The index of the CPT contains terms that indicate the location of codes within the main portion of the manual.
B. The introduction of the CPT contains (1) a list of the categories of CPT codes, the CPT sections, and the code number sequences for each category/section and (2) instructions for use of the CPT code book that are general in nature and are applicable to all sections of the manual.
D. Appendix A of the CPT manual contains a list of modifiers.

41. The symbol that indicates an add-on code in the CPT manual is:
42. When you see the symbol next to a code in the CPT manual, you know that:

A. the code is a new code.
B. the code contains new or revised text
C. the code is a modifier -51 exempt code.
D. FDA approval is pending.

**CORRECT ANSWER:**
C. This is a modifier -51 exempt code.

**RATIONALE:**
A. A new code symbol is a circle.
B. An arrow pointing right and left indicates new or revised text.
D. A lightning bolt indicates that FDA approval is pending.

43. The term that indicates this is the type of code for which the full code description can be known only if the common part of the code (the description preceding the semicolon) of a preceding entry is referenced:

A. stand-alone
B. indented
C. independent
D. add-on

**CORRECT ANSWER:**
B. The indented code indicates this is the type of code for which the full
code description can be known only if the text preceding the semicolon of a preceding entry is referenced. The CPT manual is formatted in this manner in order to save space.

RATIONALE:
A. The stand-alone code has all the words in the description.
C. There is no independent code status in the CPT manual.
D. The add-on codes represent services or procedures that are done in addition to a primary service or procedure. The add-on code cannot stand alone. It must be reported in addition to the primary procedure.

Subject Area: 10000 Integumentary System

44. OPERATIVE REPORT

OPERATIVE PROCEDURE: Excision of back lesion.

INDICATIONS FOR SURGERY: The patient has an enlarging lesion on the upper midback.

FINDINGS AT SURGERY: There was a 5-cm, upper midback lesion.

OPERATIVE PROCEDURE: With the patient prone, the back was prepped and draped in the usual sterile fashion. The skin and underlying tissues were anesthetized with 30 mL of 1% lidocaine with epinephrine.

Through a 5-cm transverse skin incision, the lesion was excised. Hemostasis was ensured. The incision was closed using 3-0 Vicryl for the deep layers and running 3-0 Prolene subcuticular stitch with Steri-Strips for the skin.

The patient was returned to the same-day surgery center in stable postoperative condition. All sponge, needle, and instrument counts were correct. Estimated blood loss is 0 mL.

PATHOLOGY REPORT LATER INDICATED: Dermatofibroma, skin of back.
Assign code(s) for the physician service only.

A. 11406, 12002, 216.5
B. 11424, 215.7
C. 11406, 12032, 216.5
D. 11606, 232.5

POINT VALUE: 1 point

CORRECT ANSWER:
C. 11406 identifies the excision of a benign lesion more than 4 cm; the deep layers were closed, which is a layered or intermediate closure reported in addition to the lesion removal with 12032. Diagnosis code 216.5 is
accurate because it describes a benign lesion of the skin of the back.

**RATIONALE:**
A. 11406 is correct for the lesion excision of a benign lesion larger than 4 cm; 12002 is a simple closure, and a simple closure is included in the excision code, so 11406 and 12002 would not be reported together. Further, the report describes a deep layer closure that is an intermediate closure, which should be reported with 12032. Diagnosis code 216.5 is accurate because it describes a benign lesion of the skin of the back.

B. 11424 is an excision of a benign lesion but of the scalp, neck, hands, feet, or genitalia, not of the back or trunk as indicated in the operative report, and there is no code to report the intermediate closure (12032). Code 215.7 reports a benign neoplasm of the connective and soft tissue of the trunk that is not otherwise specified; however, the documentation indicated a benign lesion of the skin on the back, accurately reported with 216.5.

D. 11606 is excision of the correct size and site of a lesion but for a malignant lesion, not a benign lesion as specified in the report. Also, the code for the intermediate closure is missing in this choice. Diagnosis code 232.5 describes a carcinoma in situ of the skin of the back. Carcinoma in situ is a specific carcinoma localized to one site, noninvasive, this does not describe the diagnostic statement.

45. What CPT and ICD-9-CM codes would be used to code a subsequent encounter in which a split-thickness skin graft, both thighs to the abdomen, measuring 45 × 21 cm, is performed on a patient who has third-degree burns of the abdomen? Documentation stated 20% of the body surface was burned, with 9% third degree. The patient also sustained second-degree burns of the upper back.

A. 15100 × 2, 949.3, 949.2, 948.00
B. 15100, 15101 × 9, 942.33, 942.24, 948.20
C. 15100, 15101-51 × 9, 946.3, 949.2, 948.02
D. 15100, 15101 × 8, 948.01, 942.29

**POINT VALUE:** 1 point

**CORRECT ANSWER:**
B. 15100 is the correct code for the first 100 sq cm and 15101 × 9 to report the additional 845 sq cm. To calculate the square centimeters, take 45 cm and multiply it by 21 cm, which equals 945 sq cm. As indicated above, 15100 reports the first 100 sq cm. There is a remaining 845 sq cm. The code description indicates that 15101 is for reporting each additional 100 sq cm "or part thereof." Therefore the additional 845 sq cm is reported with 9 units of 15101 (8 units accounts for an even 800 sq cm. An additional unit of 1 is added to account for the remaining 45 sq cm). 15101 is an add-on code; therefore, the -51 modifier is not necessary. Diagnosis code 942.33 describes third-degree burns of the abdominal wall. Code 942.24 describes the second-degree burn of the back.
Diagnosis code 948.20 is assigned to explain the percentage of body surface burned and the percentage with third-degree burns, which in this report was 20% and 9% in third-degree burn.

RATIONALE:
A. 15100 is the correct code to report a split graft of the trunk for the first 100 sq cm or less, but the "× 2" is not correct because this would indicate that there were 2 different recipient sites each 100 sq cm or less. There was only one recipient site, therefore 15100 (first 100 sq cm) can be reported only as 1 unit along with the add-on code 15101 × 9 to report the additional 845 sq cm. See rationale B for explanation on determining the correct number of units. Code 949.3 reports a full-thickness (third degree) that is not otherwise specified when there is the more definitive code 942.33 reports third-degree burns of the abdominal wall. Code 949.2 reports a second-degree burn that is unspecified; however, 942.24 more specifically reports a second-degree burn of the back as indicated in the report. Code 948.00 reports less than 10% of the body surface was burned, but there was a 20% body surface burn. Diagnosis code 948.20 more definitively reports the percentage of body surface burned (20% indicated by fourth digit 2) and the percentage with third-degree burns (9% indicated by fifth digit 0).

C. 15100 is correct for the first 100 sq cm, and 15101 × 9 is correct for the additional 845 sq cm; but the add-on code 15101 is exempt from the use of modifier -51, making this choice incorrect. Diagnosis code 946.3 reports a full-thickness (third-degree) burn, 949.2, 948.02.

D. 15100 is correct for the first 100 sq cm. 15101 is correct for reporting the additional sq cm; but the number of units (8) is incorrect. See rationale B for explanation on determining the correct number of units. To calculate the square centimeters, take 45 cm and multiply it by 21 cm, which equals 945 sq cm. As indicated above, 15100 reports the first 100 sq cm. There are 845 sq cm remaining. The code description indicates that 15101 is for reporting each additional 100 sq cm "or part thereof." Therefore, the additional 845 sq cm is reported with 9 units of 15101. (Eight units accounts for an even 800 sq cm. An additional unit of 1 is added to account for the remaining 45 sq cm.) 15101 is an add-on code; therefore, the -51 modifier is not necessary.

46. EMERGENCY DEPARTMENT REPORT CHIEF COMPLAINT: Nasal bridge laceration.

SUBJECTIVE: The patient is a 74-year-old male who presents to the emergency department with a laceration to the bridge of his nose. He fell in the bathroom tonight. He recalls the incident. He just sort of lost his balance. He denies any vertigo. He denies any chest pain or shortness of breath. He denies any head pain or neck pain. There was no loss of consciousness. He slipped on a wet floor in the bathroom and lost his balance; that is how it happened. He has not had any blood from the nose or mouth.

PAST MEDICAL HISTORY:
1. Parkinson's.
2. Back pain.
3. Constipation.

MEDICATIONS: See the patient record for a complete list of medications.

ALLERGIES: NKDA.

REVIEW OF SYSTEMS: Per HPI. Otherwise, negative.

PHYSICAL EXAMINATION: The exam showed a 74-year-old male in no acute distress. Examination of the HEAD showed no obvious trauma other than the bridge of the nose, where there is approximately a 1.5- to 2-cm laceration. He had no bony tenderness under this. Pupils were equal, round, and reactive. EARS and NOSE: OROPHARYNX was unremarkable. NECK was soft and supple. HEART was regular. LUNGS were clear but slightly diminished in the bases.

PROCEDURE: The wound was draped in a sterile fashion and anesthetized with 1% Xylocaine with sodium bicarbonate. It was cleansed with sterile saline and then repaired using interrupted 6-0 Ethilon sutures (Dr. Barney Teller, first-year resident, assisted with the suturing).

ASSESSMENT: Nasal bridge laceration, status post fall.

PLAN: Keep clean. Sutures out in 5 to 7 days. Watch for signs of infection.

A. 12051, 873.20, E885.9
B. 12011, 873.20, E885.9
C. 12011, 873.32, E888.8
D. 12011, 11000, 873.32, E929.9

POINT VALUE: 1 point

CORRECT ANSWER:
B. 12011 identifies the repair, simple 2.5 cm or less. 873.20 is the diagnosis for the open wound of the nose, and E885.9 is the external causes of injury code for slipping on a flat, wet surface.

RATIONALE:
A. 12051 is an intermediate repair, and no indication was given in the report that anything other than a simple repair was conducted. 873.20 is the correct diagnosis code for the open wound of the nose. E885.9 is correct to report a fall from slipping on a flat wet surface.

C. 12011 is the correct repair code for a simple repair; 873.32, however, is not correct because it is a complicated open wound of the nasal cavity, which is not indicated in the report. E888.8 is an "Other fall," which is incorrect because it is known that the fall occurred when the patient slipped on a wet bathroom
D. 12011 is the correct code for the simple repair, but 11000 is a code for a debridement of eczematous or infected skin. Debridement would only be coded separately if the wound were significantly contaminated and required extensive debridement, which was not indicated in the report. 873.32 indicates a complicated open wound of the nasal cavity, which is not stated in the report, and E929.9 indicates a late effect, and this is a new injury, not a late effect.

47. The patient is brought to surgery for repair of an accidentally inflicted open wound of the left thigh, the total extent measuring approximately 40 × 35 cm.

DESCRIPTION OF PROCEDURE: The legs were prepped with Betadine scrub and solution and then draped in a routine sterile fashion. Split-thickness skin grafts measuring about a 10,000th inch thick were taken from both thighs, meshed with a 3:1 ratio mesher, and stapled to the wounds. The donor sites were dressed with scarlet red, and the recipient sites were dressed with Xeroform, Kerlix fluffs, and Kerlix roll, and a few ABD pads were used for absorption. Estimated blood loss was negligible. The patient tolerated the procedure well and left surgery in good condition.

A. 15120, 15121 × 12, 891.0, E929.9
B. 15100, 15101, 11010, 891.0, E928.9
C. 15220, 15221 × 13, 890.0, E928.9
D. 15100, 15101 × 13, 890.0, E928.9

POINT VALUE: 1 point

CORRECT ANSWER:
D. 15100 reports the split graft, trunk, arms, and legs, first 100 cm or less. 15101 reports each additional 100 cm with the "× 13." The recipient site measures 40 × 35, which is 1400 sq cm; the first 100 sq cm is reported with 15100, and the remaining 1300 sq cm (or 13 units of 100 each) is reported with 15101 × 13. Diagnosis code 890.0 reports an open wound of hip or thigh without mention of complication. E928.9 reports a wound from an unspecified cause.

RATIONALE:
A. This choice is incorrect because 15120 is for a split-thickness graft but of the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and fingers; and because the area of defect (the recipient area) is the basis for choosing the code, you would need to choose a code that indicated the leg was the recipient area. 15121 is incorrect because it does not report the recipient area (leg) and is also only for 1200 sq cm. 891.0 reports the wound of the knee and leg except the thigh, which is not the area that was repaired. E929.9 incorrectly reports the late effects of an accidental injury.
B. All the codes in this choice are correct except for the units and for the debridement.
(11010). Because the report does not indicate that debridement was performed. If performed, normal debridement is included in the grafting procedure, and would not be reported separately. If the medical record indicated a more than normal or extensive debridement, the service could be reported separately. Open wound of knee and leg except thigh (891.0) is also incorrect.

C. 15220 and 15221 × 13 report a full-thickness graft, but the report indicated a split graft. 890.0 and E928.9 are correct for reporting the wound.

48. What CPT and ICD-9-CM codes would be used to code the destruction of a malignant lesion on the skin of the female genitalia measuring 1.6 cm using cryosurgery?

A. 17272, 184.4
B. 11602, 199.0
C. 11420, 198.82
D. 11622, 184.4

POINT VALUE: 1 point

CORRECT ANSWER:
A. 17272 identifies the destruction by cryosurgery of a malignant lesion of the genitalia, lesion diameter 1.1 to 2 cm. Code 184.4 reports malignant neoplasm of vulva (genitalia, NOS).

RATIONALE:
B. 11602 is excision of a malignant lesion but not of the genitalia; further, the report indicated that the lesion was removed by means of cryosurgery, not excision as is reported with 11602. Code 199.0 reports a malignant neoplasm that is generalized when the more specific code 184.4 reports a malignant neoplasm of the vulva (genitalia, NOS).
C. 11420 reports excision of a benign lesion of the genitalia, not cryosurgery for a malignant lesion. Code 198.82 reports a secondary malignant neoplasm of the genital organs; but the report did not indicate a secondary malignancy, rather it reported a malignant neoplasm of the genitalia NOS (184.4).
D. 11622 is excision of a malignant lesion from the genitalia, but the report indicated that the lesion was removed by means of cryosurgery, not by excision. Code 184.4 correctly reports a malignant neoplasm of vulva (genitalia, NOS).

49. SAME-DAY SURGERY

DIAGNOSIS: Inverted nipple with mammary duct ectasia, left.

OPERATION: Excision of mass deep to left nipple.

With the patient under general anesthesia, a circumareolar incision was made
with sharp dissection and carried down into the breast tissue. The nipple complex was raised up using a small retractor. We gently dissected underneath to free up the nipple entirely. Once this was done, we had the nipple fully unfolded, and there was some evident mammary duct ectasia. An area 3 × 4 cm was excised using electrocautery. Hemostasis was maintained with electrocautery, and then the breast tissue deep to the nipple was reconstructed using sutures of 3-0 chromic. Subcutaneous tissue was closed using 3-0 chromic, and then the skin was closed using 4-0 Vicryl. Steri-Strips were applied. The patient tolerated the procedure well and was returned to the recovery area in stable condition. At the end of the procedure, all sponges and instruments were accounted for.

A. 19120-RT, 610.4
B. 11404-LT, 611.1
C. 19112, 610.4
D. 19120-LT, 610.4

POINT VALUE: 1 point

CORRECT ANSWER:

D. 19120-LT identifies the excision of a single duct lesion of the left breast. 610.4 is the diagnosis code for a mammary duct ectasia.

RATIONALE:

A. 19120-RT identifies the excision of a single duct lesion of the right breast, but the left breast (LT) was indicated in the report. 610.4 is the correct diagnosis code for a mammary duct ectasia.

B. 11404-LT identifies the removal of a lesion from the trunk of the body but is not used to identify breast procedures, as described in the report. LT is the correct HCPCS modifier to indicate the left breast. 611.1 is hypertrophy of the breast, not ductal ectasia (distention) as indicated in the report.

C. 19112 is the excision of a fistula of the milk duct (lactiferous) and not the procedure specified in the report (excision of a lesion). 610.4 is the correct diagnosis code.

50. This patient returns today for palliative care to her feet. Her toenails have become elongated and thickened, and she is unable to trim them on her own. She states that she has had no problems and no acute signs of any infection or otherwise to her feet. She returns today strictly for trimming of her toenails.

EXAMINATION: Her pedal pulses are palpable bilaterally. The nails are mycotic, 1 through 4 on the left, and 1 through 3 on the right.

ASSESSMENT: Onychomycosis, 1 through 4 on the left and 1 through 3 on the right.

PLAN: Mild debridement of mycotic nails × 7. This patient is to return to the clinic in 3 to 4 months for follow-up palliative care.
A. 11721 \times 7, 117.9
B. 99212, 11721, 110.1
C. 11719, 110.1
D. 11721, 110.1

POINT VALUE: 1 point

CORRECT ANSWER:
D. 11721 identifies the debridement of nails, 6 or more, by any method, and the report indicated that 7 nails were debrided. 110.1 is the diagnosis code for onychomycosis of the nail, which is a fungal infection and is stated in the assessment section of the report.

RATIONALE:
A. The units are specified in code 11721, making it unnecessary to use the "\times 7" with the code to indicate the number of nails trimmed. 117.9 is mycosis of the skin or subcutaneous tissues or organs, not of the nails.
B. 99212 is an office visit for an established patient and because the only service the physician provided was a nail debridement, it is inappropriate to report the procedure as an office visit service. 11721 and 110.1 are correct for the debridement service and the diagnosis of onychomycosis.
C. 11719 is the simple trimming of healthy nails, but the nails in this case were debrided, as stated in the plan section of the report. Simple trimming includes the physician’s trimming of healthy nails, whereas debridement is a cleaning that includes the tops and undersides of the exposed nails with shortening and shaping of the nail. 110.1 is the correct diagnosis code.

51. OPERATIVE REPORT

With the patient having had a wire localization performed by radiology, she was taken to the operating room and, under local anesthesia of the left breast, was prepped and draped in a sterile manner. A breast line incision was made through the entry point of the wire, and a core of tissue surrounding the wire (approximately 1 × 2 cm) was removed using electrocautery for hemostasis. The specimen, including the wire, was then submitted to radiology, and the presence of the lesion within the specimen was confirmed. The wound was checked for hemostasis, and this was maintained with electrocautery. The breast tissue was reapproximated using 2-0 and 3-0 chromic. The skin was closed using 4-0 Vicryl in a subcuticular manner. Steri-Strips were applied. The patient tolerated the procedure well and was discharged from the operating room in stable condition. At the end of the procedure, all sponges and instruments were accounted for.

Pathology report later indicated: Benign tissue, breast.

A. 11602-LT, 238.3
B. 11400-LT, 174.9
C. 19125-LT, 217  
D. 19125-LT, 239.3

POINT VALUE: 1 point

CORRECT ANSWER:
C. 19125-LT identifies the excision of a single breast lesion, on the left breast of which radiology performs placement of the marker, in this case a wire. As with most surgery cases, many different codes should be reviewed before deciding on the correct code assignment. In the process of doing so, the coder would determine that this procedure is not a breast biopsy (19101) because the report does not indicate the tissue is being removed for diagnostic reasons. Nor is it a lumpectomy (19301) because the report does not indicate specific attention to surgical margins. This procedure describes a breast lesion excision without specific attention to surgical margins; therefore 19125 is the correct code. See the guidelines preceding code 19100 for more information in this regard. 217 is the diagnosis code for a benign neoplasm of the breast.

RATIONALE:
A. 11602-LT is excision of a 1.1- to 2-cm malignant lesion of the left breast, but of the trunk, arms, or legs. The procedure report describes removal of breast tissue; therefore the code for skin lesion excision (11602) is not correct. Furthermore, code 11602 is for malignant lesion removal, and there was no indication of a malignancy because the pathologist confirmed that the lesion was benign. 238.3 is a lesion of uncertain behavior, but the pathology report indicated the behavior was known and benign.

B. 11400-LT is a benign skin lesion excision from the left side, but the lesion was of the left breast tissue, and there are specific codes for breast lesion removal. 174.9 is a primary malignancy of the breast, but the pathology report in this case indicated a benign lesion.

D. 19125-LT is the correct code for the lesion removal of the left breast. 239.3 identifies a lesion of unspecified nature, but the nature of this lesion is known to be benign based on the pathology report.

52. What CPT and ICD-9-CM codes would be assigned to report an initial encounter for treatment of a 40 sq cm debridement of an open anterior abdominal laceration, including subcutaneous tissue and muscle, with grit and rubble? The patient fell while speed walking and landed on a sharp rock, injuring the epigastric region of the abdomen.

A. 11000, 879.2, E880.1, E920.8  
B. 11010, 879.6, E880.1  
C. 11042, 11045, 879.2  
D. 11043, 11046, 879.3, E888.0, E920.8, E001.0
Correct Answer:
D. Code 11043 reports the first 20 sq cm of this 40 sq cm debridement and code 11046 reports the remaining 20 sq cm. Diagnosis code 879.3 accurately describes open wound of the abdomen, complicated. Code E888.0 reports a fall and striking an object. Code E920.8 reports the object as a cutting, piercing object. Also report code E001.0 for walking as the activity during which the injury occurred.

Rationale:
A. 11000 reports only debridement of skin, not the subcutaneous tissue or muscle. Furthermore, this code is for extensive eczematous or infected skin which was not stated in this case. Code 879.2 describes an open wound of “other and unspecified sites,” whereas the more specific code 879.3 describes a complicated open wound of the abdomen. E880.1 reports a fall on or from a sidewalk curb but the report indicated a fall that resulted in the striking on an object, which is reported with E888.0. E920.8 correctly reports the object as a cutting, piercing object.
B. 11010 reports debridement of skin and subcutaneous tissue, not of muscle, and is associated with an open fracture or dislocation. Code 879.6 incorrectly reports an open wound of the trunk without a complication and not otherwise specified and the report indicated an abdominal wound (879.2). E880.1 reports a fall on or from a sidewalk curb but the report indicated a fall that resulted in the striking on an object, which is reported with E888.0. Missing is E920.8 to correctly report the object as a cutting, piercing object.
C. 11042 and 11045 report debridement of subcutaneous tissue, but not of muscle. Code 879.2 describes an open wound of and “other and unspecified sites,” whereas the more specific code 879.3 describes a complicated open wound of the abdomen. Missing are E888.0 to report a fall and striking an object and E920.8 to report the object as a cutting, piercing object.

53. What code(s) is used by the radiologist when performing preoperative placement of a needle localization wire of a single lesion of the breast? The patient was diagnosed with adenocarcinoma of the upper outer quadrant of the right breast, primary site.

A. 19290, 19125, 174.5
B. 19125, 174.4
C. 19290, 174.4
D. 19295, 174.5

Correct Answer:
C. 19290 identifies the placement of a wire (marker) preoperatively by a radiologist of a single lesion of the breast. Diagnosis code 174.4
correctly identifies the primary site, breast, upper outer quadrant.

RATIONALE:
A. 19290 correctly reports the placement of the wire. The case did not state to also code the excision of the lesion that was identified with the pre-op marker placement (19125); therefore, this choice is incorrect. Code 174.5 reports a malignant neoplasm of the lower outer quadrant rather than the upper outer quadrant reported with 174.4.
B. 19125 reports removal of a lesion that is identified by a preoperatively placed radiology marker; but the placement of the wire was to be coded. Diagnosis code 174.4 correctly identifies the primary site, breast, upper outer quadrant.
D. 19295 is the image-guided placement during a breast biopsy/aspiration and is an add-on code that cannot be used alone. Code 174.5 reports a malignant neoplasm of the lower-outer quadrant rather than the upper outer quadrant reported with 174.4.

Subject Area: 20000 Musculoskeletal System

54. A small incision was made over the left proximal tibia, and a traction pin was inserted through the bone to the opposite side. Weights were then affixed to the pins to stabilize the closed tibial fracture temporarily until fracture repair could be performed. Assign codes for the physician service.

A. 20650-LT, 823.00
B. 20663-LT, 823.92
C. 20690-LT, 823.40
D. 20692-LT, 823.92

POINT VALUE: 1 point

CORRECT ANSWER:
A. 20650-LT reports the skeletal insertion of pins or wires to affix a traction device to stabilize a fracture temporarily. This code includes the later removal of the device. Diagnosis code 823.00 describes a closed fracture of the tibia, unspecified part.

RATIONALE:
B. 20663-LT is the application of a femoral halo device. Code 823.92 reports a fracture of the tibia and fibula; but the report indicated only the tibia was fractured and should have been reported with 823.80.
C. 20690-LT is the application of a uniplane, external fixation system, but what was described in this case was insertion of pins to stabilize the fracture temporarily. Code 823.40 reports a torus fracture when the report indicated a tibia fracture that should be reported with 823.80
D. 20692-LT is the application of a multiplane, unilateral, external fixation system, but what was described in this case was insertion of pins to stabilize the fracture temporarily. Code 823.92 reports a fracture of the tibia and fibula; but the report indicated only the tibia was fractured and should have been
OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Left thigh abscess.

PROCEDURE PERFORMED: Incision and drainage of left thigh abscess.

OPERATIVE NOTE: With the patient under general anesthesia, he was placed in the lithotomy position. The area around the anus was carefully inspected, and we saw no evidence of communication with the perirectal space. This appears to have risen in the crease at the top of the leg, extending from the posterior buttocks region up toward the side of the base of the penis. In any event, the area was prepped and draped in a sterile manner. Then we incised the area in fluctuation. We obtained a lot of very foul-smelling, almost stool-like material (it was not stool, but it was brown and very foul-smelling material). This was not the typical pus one sees with a \textit{Staphylococcus aureus}–type infection. The incision was widened to allow us to probe the cavity fully. Again, I could see no evidence of communication to the rectum, but there was extension down the thigh and extension up into the groin crease. The fascia was darkened from the purulent material. I opened some of the fascia to make sure the underlying muscle was viable. This appeared viable. No gas was present. There was nothing to suggest a necrotizing fasciitis. The patient did have a very extensive inflammation within this abscess cavity. The abscess cavity was irrigated with peroxide and saline and packed with gauze vaginal packing. The patient tolerated the procedure well and was discharged from the operating room in stable condition.

A. 26990-LT, 682.6
B. 27301-LT, 682.6
C. 27301-LT, 682.60
D. 27025-LT, 682.6

POINT VALUE: 1 point

CORRECT ANSWER:

B. 27301-LT indicates an incision and drainage of a deep abscess of the thigh or knee region. Modifier -LT is correct for the left thigh. 682.6 is an abscess of the leg, except the foot. Notice that the surgeon "opened some of the fascia" in the thigh region. This is considered a fasciectomy. There is a separate code for fasciectomy (27025); but it is not separately reported in this case as the fascia incision is included in the I&D, which is the more comprehensive procedure.

RATIONALE:

A. 26990-LT is the incision and drainage of a deep abscess but of the pelvis or hip joint, not of the upper leg or thigh area as indicated in the case. 682.6 is the correct code to report an abscess of the leg.

C. 27301-LT is correct to report the incision and drainage of a deep abscess of the thigh or knee region, and 682.6 is the correct code to report an abscess of
the leg; however, there is no fifth digit for use with this code (0).
D. 27025-LT is the code for a thigh fasciotomy; but in this case the fascia incision is part of a more comprehensive procedure (the I&D). The correct code would be 27301. 682.6 is the correct code to report an abscess of the leg.

56. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Compound fracture, left humerus, with possible loss of left radial pulse.

PROCEDURE PERFORMED: Open reduction internal fixation, left compound humerus fracture.

PROCEDURE: While under a general anesthetic, the patient's left arm was prepped with Betadine and draped in sterile fashion. We then created a longitudinal incision over the anterolateral aspect of his left arm and carried the dissection through the subcutaneous tissue. We attempted to identify the lateral intermuscular septum and progressed to the fracture site, which was actually fairly easy to do because there was some significant tearing and rupturing of the biceps and brachialis muscles. These were partial ruptures, but the bone was relatively easy to expose through this. We then identified the fracture site and thoroughly irrigated it with several liters of saline. We also noted that the radial nerve was easily visible, crossing along the posterolateral aspect of the fracture site. It was intact. We carefully detected it throughout the remainder of the procedure. We then were able to strip the periosteum away from the lateral side of the shaft of the humerus both proximally and distally from the fracture site. We did this just enough to apply a 6-hole plate, which we eventually held in place with six cortical screws. We did attempt to compress the fracture site. Due to some comminution, the fracture was not quite anatomically aligned, but certainly it was felt to be very acceptable.

Once we had applied the plate, we then checked the radial pulse with a Doppler. We found that the radial pulse was present using the Doppler, but not with palpation. We then applied Xeroform dressings to the wounds and the incision. After padding the arm thoroughly, we applied a long-arm splint with the elbow flexed about 75 degrees. He tolerated the procedure well, and the radial pulse was again present on Doppler examination at the end of the procedure.

A. 24515-RT, 812.30, E887
B. 24500-LT, 812.20, E888.9
C. 24515-LT, 812.31, E887
D. 24505-LT, 812.20, E888.9

POINT VALUE: 1 point

CORRECT ANSWER:
C. 24515-LT. Open treatment of humeral shaft fracture with plates/screws
with LT to indicate the left side; 812.31, open fracture of the shaft of the humerus. You know this is an open fracture by the statement "compound," which is identified as an open fracture in the Note box located in the Index of the ICD-9-CM. The following statement from the operative report confirms that the fracture is of the humeral shaft: "We then were able to strip the periosteum away from the lateral side of the shaft of the humerus both proximally and distally from the fracture site." E887 fracture, cause not specified in report.

**RATIONALE:**

A. 24515-RT is the correct code for an open treatment of a humeral shaft fracture with plates/screws but to the right humerus (RT), and the case indicated the left (LT) humerus. 812.30 is incorrect as it reports an open fracture of humerus, site not specified, and in this case, the fracture site is of the shaft. See rationale C for explanation. E887 is correct to report a fracture in which the cause is not specified in the report.

B. 24500-LT is a closed treatment of a humeral shaft fracture, and the procedure was an open procedure as indicated in the Procedure Performed section of the report and in the body of the report, where it is stated "...and carried the dissection through the subcutaneous tissue." The LT correctly indicates the left humerus; 812.20 reports an unspecific site of a humeral fracture that is specified as closed, and this fracture was indicated as being open and of the humeral shaft. E888.9 indicates that the injury was sustained due to a fall and is not correct as there was no indication as to the incident that caused the fracture.

D. 24505-LT reports a closed treatment with manipulation of a humeral shaft fracture and the case indicated that the repair was accomplished by means of an open procedure. Use of the LT is correct because it was the left humerus, and 812.20 reports a closed fracture of an unspecific site of the humerus; but this fracture was indicated as being open ("left open humerus fracture") and in the body of the report the site is specified as being of the humeral shaft. See rationale C. E888.9 indicates that the injury was sustained from a fall and is not correct as there was no indication as to the incident that caused the fracture.

57. John, an 84-year-old male, tripped while on his morning walk. He stated he was thinking about something else when he inadvertently tripped over the sidewalk curb and fell to his knees. X-ray indicated a fracture of his right patella. With the patient under general anesthesia, the area was opened and extensively irrigated. The left aspect of the patella was severely fragmented, and a portion of the patella was subsequently removed. The remaining patella fragments were wired. The surrounding tissue was repaired, thoroughly irrigated, and closed in the usual manner.

A. 27524-RT, 822.0, E880.1
B. 27520-RT, 822.0, E880.1
C. 27524-RT, 822.1, E888.9
D. 27524-RT, 822.0, E888.9

POINT VALUE: 1 point

CORRECT ANSWER:
A. 27524-RT is an open surgical procedure ("...the area was opened...") that includes the placement of internal fixation ("The remaining patella fractures were wired") with modifier -RT to indicate right side. 822.0 is a closed fracture of the patella; no indication was made that the fracture was open (the bones sticking through the skin). If not stated as open or closed, the fracture is reported as closed. E880.1 reports a fall on or from a sidewalk or curb.

RATIONALE:
B. 27520-RT is a closed treatment of a patellar fracture, and the case indicated that the procedure was an open procedure. Both 822.0 and E880.1 are correct to report the closed fracture of the patella and the fall from the curb.
C. 27524-RT is the correct code for the open surgical procedure to repair the patella fracture, but 822.1 is an open patella fracture, and there was no indication of an open fracture in the case. If the fracture is not reported as open or closed, it should be reported as closed. E888.9 is used to report a fall when no other more specific code is available, and because the case indicates how the fall occurred, it is not correct to use a general code when a more specific code is available.
D. 27524-RT and 822.0 are correct, but E888.9 is used to report a fall when no other more specific code is available, and because the case indicates how the fall occurred, it is not correct to use a general code when a more specific code is available.

58. Libby was thrown from a horse while riding along the side of the road; a truck that honked the horn as it passed her startled her horse. The horse reared up, and Libby was thrown to the ground. The condyle of her left tibia was fractured and required insertion of multiple pins to stabilize the defect area. A Monticelli multiplane external fixation system was then attached to the pins. Code the placement of the fixation device and diagnosis(es) only.

A. 20661-LT, 823.82, E828.9
B. 20692-LT, 823.00, E828.2
C. 20692-LT, 823.82, E828.2
D. 20690-LT, 823.00, E828.2

POINT VALUE: 1 point

CORRECT ANSWER:
B. 20692-LT reports the application of a unilateral multiplane external fixation device (Monticelli type), with modifier -LT to indicate the left side. 823.00 is assigned to report a tibial fracture when the medial...
condyle (upper end) is specified. E828.2 is assigned to report a rider thrown from a horse.

RATIONALE:
A. 20661-LT is the application of a halo, not a multiplane external fixation device. 823.82 is assigned to a fracture of the tibia that includes the fibula (the fibula was not mentioned in the case). E828.9 is assigned to report an unspecified person being thrown from a horse, not the rider; in this case it was the rider who was thrown.
B. 20692-LT correctly reports the application of a unilateral multiplane external fixation device with modifier -LT to indicate the left side. 823.82 is not correct because it is assigned to a fracture of the tibia that includes the fibula (the fibula was not mentioned in the case). E828.2 correctly reports a rider being thrown from a horse.
C. 20690-LT reports the application of a unilateral plane external device but not a multiplane device. 823.00 is correctly assigned to report a tibial fracture when condyle is reported as the site of the closed fracture. E828.2 is correctly assigned to report a rider thrown from a horse.

59. Maryann received a blow to her right tibial shaft while moving a large stuffed chair up a flight of stairs when the person in front of the chair slipped and released his hold on the chair. The full weight of the chair was pushed against her; when she was unable to hold the chair in place, both she and the chair fell to the landing a dozen steps below. The chair tipped on its side and landed on her tibia. On x-ray, the right tibia shaft was fractured in three places. Screws and pins were placed through the skin to secure the fracture sites.

A. 27750-RT, 823.80, E917.3
B. 27756-RT, 823.80, E917.3
C. 27756-RT, 823.20, E917.3
D. 27750-RT, 823.20, E917.3

POINT VALUE: 1 point

CORRECT ANSWER:
C. 27756-RT reports the percutaneous skeletal fixation of the shaft of the tibia by means of screws and pins. The modifier -RT indicates the right side. 823.20 indicates a closed tibial shaft fracture, and E917.3 indicates that the patient was struck by furniture.

RATIONALE:
A. 27750-RT is incorrect because it reports a closed treatment of a tibial shaft fracture without placement of screws or pins. 823.80 is incorrect because it reports a tibial fracture, unspecified site, but the shaft was indicated. E917.3 is correct for reporting being struck by furniture.
B. 27756-RT is correct for the percutaneous fracture repair, and 823.80 is incorrect because it is a tibial fracture, unspecified site, but the shaft was
indicated. E917.3 is correct for reporting being struck by furniture.
D. 27750-RT is incorrect because it reports a closed treatment of a tibial shaft fracture without placement of screws or pins. 823.20 and E917.3 are correct diagnosis codes.

60. The physician applies a Minerva-type fiberglass body cast from the hips to the shoulders and to the head. Before application, a stockinette is stretched over the patient’s torso, and further padding of the bony areas with felt padding was done. The patient was diagnosed with Morquio-Brailsford kyphosis. Assign codes for the physician service only.

A. 29040, 277.5, 737.41
B. 29590, 737.41
C. 29025, 737.41, 277.5
D. 29000, 737.10, 277.5

POINT VALUE: 1 point

CORRECT ANSWER:
A. 29040 is assigned to report the application of a fiberglass body cast that goes from the hips to the head. Diagnosis code 277.5 reports the underlying condition, Morquio-Brailsford disease, and the manifestation code 737.41 (must be sequenced as shown) reports the kyphosis.

RATIONALE:
B. 29590 is a splint strapping (Denis-Browne) that is applied to an infant to correct a foot deformity in which the heel is turned inward. Code 737.41 reports the manifestation of kyphosis but does not report the underlying condition of Morquio-Brailsford disease (277.5). The two codes are to be reported as 277.5, 737.41, with the underlying condition listed first followed by the manifestation.
C. 29025 is the application of a turnbuckle jacket that is a rectangular frame with straps that are attached to the patient to correct a curvature of the spine. The diagnosis codes are correct, but incorrectly sequenced. The two codes are to be reported as 277.5, 737.41, with the underlying condition listed first followed by the manifestation.
D. 29000 is the application of a body cast that is used to stabilize a halo on the head. Code 737.10 reports kyphosis when there is no underlying condition, but in this report it is stated there is an underlying condition (Morquio-Brailsford disease). The two codes are to be reported as 277.5, 737.41, with the underlying condition listed first followed by the manifestation.

61. Mary tells her physician that she has been having pain in her left wrist for several weeks. The physician examines the area and palpates a ganglion cyst of the tendon sheath. He marks the injection sites, sterilizes the area, and injects corticosteroid into two areas.
A. 20550-LT × 2, 727.42  
B. 20551-LT, 727.41  
C. 20551-LT × 2, 727.43  
D. 20612-LT, 727.42

POINT VALUE: 1 point

CORRECT ANSWER:  
D. 20612-LT reports the injections to the ganglion cyst. As noted in the CPT instructional notes regarding the use of this code, “To report multiple ganglion cyst injections, report 20612 and append modifier -59.” This rule is not recognized if the injections are performed on the same cyst, therefore it is not reported twice for this case. Modifier -LT is correctly used to indicate the left side. 727.42 is assigned to a ganglion cyst of the tendon sheath.

RATIONALE:  
A. 20550 reports the injection of the tendon sheath, but the scenario indicates that a ganglion cyst was injected, and it is therefore reported with 20612-LT and 20612-59-LT. 727.42 is correctly assigned to a ganglion cyst of the tendon sheath.  
B. 20551 is an injection(s) into the tendon origin or insertion, not a ganglion cyst, which was specified in this case. 727.41 is assigned to indicate a ganglion cyst of the joint, but the case indicated that the cyst was of the tendon sheath, not the joint.  
C. 20551 reports injection(s) into the tendon origin or insertion not of a ganglion cyst as indicated in the case, and this code does not require the use of units (× 2) for multiple injections into the same site because the code description indicates injection or injections. 727.43 is assigned to a ganglion cyst that is unspecified as to location, but in this case, the location is specified as the tendon sheath.

62. Darin was a passenger in an automobile rollover accident and was not wearing a seat belt at the time. He was thrown from the automobile and was pinned under the rear of the overturned vehicle. He sustained craniofacial separation, Le Forte III fracture, that required complicated internal and external fixation using an open approach to repair the extensive damage. A halo device was used to hold the head immobile.

A. 21435, 20661  
B. 21435  
C. 21432  
D. 21436, 20661

POINT VALUE: 1 point

CORRECT ANSWER:
B. 21435 reports an open treatment of a craniofacial separation, referred to as a LeFort III type, that includes wiring and may include internal fixation. The halo device is included in the code (see code description for full text) and is not reported separately.

RATIONALE:
A. 21435 is the correct code to report the open treatment of the craniofacial separation that included wiring and internal fixation; however, 20661 reports the application of a halo device, and the halo was included in 21435 (see code description for full text) and is not reported separately.
C. 21432 reports an open treatment of a craniofacial separation with wiring and internal fixation but does not specify "complicated," and the case specified that the fixation was complicated.
D. 21436 is the code for open treatment of a craniofacial separation with wiring and internal fixation. The fixation is specified as being complicated; however, this code also includes multiple open approaches and bone grafting, which were not specified in the case. 20661 reports the application of a halo device and is not separately coded because it would be included in the code for complicated treatment.

63. Carl Ostrick, a 21-year-old male, slipped on a patch of ice on his sidewalk while shoveling snow. When he fell, his left hand was wedged under his body and his carpometacarpal joint was dislocated. After manipulating the joint back into normal alignment, the surgeon on the following day fixed the dislocation by placing a wire through the skin at the tip of the finger and on through the carpometacarpal joint to maintain alignment. Code the subsequent procedure and diagnoses.

A. 26608-F1, 833.01, E886.0
B. 26650-FA, 833.14, E888.9
C. 26706-LT, 833.00, E885.9
D. 26676-LT, 833.04, E885.9

POINT VALUE: 1 point

CORRECT ANSWER:
D. 26676-LT reports the percutaneous, "through the skin" skeletal fixation of a carpometacarpal dislocation with manipulation. The carpometacarpal joint is located in the wrist area between a bone of the wrist (carpal) and a bone of the hand (metacarpal); Modifier -LT is used to indicate the left wrist/hand. 833.04 is the correct diagnosis code for a closed dislocation of the carpometacarpal joint. If the dislocation is not specified as open or closed, it is coded as a closed dislocation. E885.9 is the correct code as it describes slipping on ice.

RATIONALE:
A. 26608-F1 is percutaneous skeletal fixation of a metacarpal fracture with no
mention of manipulation. This code is not correct because it describes fracture treatment but the injury in this case is a dislocation. Also, the location of injury in this case is carpometacarpal, not metacarpal. The -F1 modifier (left hand index finger) is incorrect because the metacarpal bones are in the hand, not the finger. 833.04 is the correct code as stated in D. E886.0 is incorrect because it describes a fall during sports.

B. 26650-FA is percutaneous skeletal fixation of a thumb, not a carpometacarpal joint. 833.14 is incorrect because it describes an open dislocation and there is no documentation to support this. E888.9 is incorrect because it describes an unspecified fall.

C. 26706-LT is percutaneous skeletal fixation of a metacarpophalangeal dislocation. The metacarpophalangeal is a joint between a bone of the hand (metacarpal) and a bone of the finger (phalanx). The dislocation in this case was the carpometacarpal joint, which is the joint between a bone of the wrist (carpal) and a bone of the hand (metacarpal). Therefore, this selection is incorrect. 833.00 is incorrect because it describes an unspecified dislocation and the dislocation is specified as carpometacarpal. E885.9 is the correct code.

Subject Area: 30000 Respiratory System and Cardiovascular System

64. OPERATIVE PROCEDURE

PREOPERATIVE DIAGNOSIS: 68-year-old male in a coma.

POSTOPERATIVE DIAGNOSIS: 68-year-old male in a coma.

PROCEDURE PERFORMED: Placement of a triple lumen central line in right subclavian vein.

With the usual Betadine scrub to the right subclavian vein area and with a second attempt, the subclavian vein was cannulated and the wire was threaded. The first time the wire did not thread right, and so the attempt was aborted to make sure we had good identification of structures. Once the wire was in place, the needle was removed and a tissue dilator was pushed into position over the wire. Once that was removed, then the central lumen catheter was pushed into position at 17 cm and the wire removed. All three ports were flushed. The catheter was sewn into position, and a dressing applied.

A. 36011, 780.09
B. 36011, 780.01
C. 36556, 780.09
D. 36556, 780.01

POINT VALUE: 1 point
CORRECT ANSWER:
D. 36556 identifies the placement of a nontunneled central venous catheter for a patient older than the age of 5 years. 780.01 is the diagnosis code for a coma.

RATIONALE:
A. 36011 reports selective intravenous catheter placement within the first order of a vein that is inserted and then removed, but this case was a central venous catheter placement, placed for long-term monitoring or treatment. 780.09 is a state of altered consciousness, drowsiness, semicoma, etc., but not a coma.
B. 36011 reports selective intravenous catheter placement within the first order of a vein that is inserted and then removed, but this case was a central venous catheter placement, placed for long-term monitoring or treatment. 780.01 is the correct diagnosis code for a patient in a coma.
C. 36556 correctly identifies central placement of a subclavian venous catheter for a patient older than the age of 5 years. 780.09 is a state of altered consciousness, drowsiness, semicoma, etc., but not a coma.

65. What CPT and ICD-9-CM codes report a percutaneous insertion of a dual-chamber pacemaker by means of the subclavian vein? The diagnosis is sick sinus syndrome, tachy-brady.

A. 33249, 427.0, 427.81
B. 33217, 427.81
C. 33208, 427.81
D. 33240, 426.12, 427.0

POINT VALUE: 1 point

CORRECT ANSWER:
C. 33208 reports insertion of a permanent dual-chamber (atrial and ventricular) pacemaker with transvenous (by means of a vein) electrode placement. Code 427.81 describes sick sinus syndrome.

RATIONALE:
A. 33249 is for insertion of the electrode lead(s) for a single- or dual-chamber pacing cardioverter-defibrillator and the insertion of a pulse generator, not insertion of a pacemaker and electrodes. Code 427.0 reports a cardiac dysrhythmia, specifically a paroxysmal supraventricular tachycardia; however, the report indicated sick sinus syndrome, reported with 427.81. Only 427.81 needs to be reported because the tachy-brady is included in this code.
B. 33217 is for insertion of the electrodes for a dual-chamber pacemaker, not the insertion of the pacemaker and the electrodes. Code 427.81 is correct for the diagnosis of sick sinus syndrome.
D. 33240 is for insertion of dual-chamber pacing cardioverter-defibrillator pulse generator, not the pacemaker generator and the electrodes. Code 426.12 reports an incomplete atrioventricular block not documented in the report.
Code 427.0 reports a cardiac dysrhythmia, specifically a paroxysmal supraventricular tachycardia; however, the report indicated sick sinus syndrome, which is correctly reported with 427.81.

66. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Atelectasis of the left lower lobe.

PROCEDURE PERFORMED: Fiberoptic bronchoscopy with brushings and cell washings.

PROCEDURE: The patient was already sedated, on a ventilator, and intubated; so his bronchoscopy was done through the ET tube. It was passed easily down to the carina. About 2 to 2.5 cm above the carina, we could see the trachea, which appeared good, as was the carina. In the right lung, all segments were patent and entered, and no masses were seen. The left lung, however, had petechial ecchymotic areas scattered throughout the airways. The tissue was friable and swollen, but no mucous plugs were noted, and all the airways were open, just somewhat swollen. No abnormal secretions were noted at all. Brushings were taken as well as washings, including some with Mucomyst to see whether we could get some distal mucous plug, but nothing really significant was returned. The specimens were sent to appropriate cytological and bacteriological studies. The patient tolerated the procedure fairly well.

A. 31622, 31623-51, 518.0
B. 31623, 770.4
C. 31622-RT, 31623-51-LT, 518.0
D. 31624, 770.4

POINT VALUE: 1 point

CORRECT ANSWER:
C. 31622-RT identifies the diagnostic bronchoscopy of the right lung. 31623-51-LT indicates that a left lung bronchoscopy with washings and brushings was also performed. The CPT guidelines under endoscopy subheading indicate that a code is to be assigned for each anatomic site examined. Therefore, since both lungs were scoped, a code for each lung is assigned. Notice that code 31623 for the left lung bronchoscopy and brushings includes the diagnostic bronchoscopy when performed by the same physician; therefore, 31622 is not assigned separately for the left lung procedure. The anatomical modifiers (-RT and -LT) in addition to the -51 modifier are essential because they show that both the right and left lungs were scoped. Without the -RT and -LT modifiers, these codes (31622 and 31623), when reported together, have the appearance of unbundling. Unbundling occurs when the coder assigns a separate code for a procedure (i.e., 31622) that is inherent to a more comprehensive procedure (i.e., 31623). However, the use of the -RT and -LT in addition to the -51
modifier help to show that different anatomical sites were examined and would support reporting these two codes together. If, however, only one lung is scoped and brushings performed, 31622 would not be reported because diagnostic bronchoscopy is included in the surgical bronchoscopy code (31623). Also, 31622 is a separate procedure and therefore only reported if it is not performed as part of another service. 518.0 reports the atelectasis (a condition in which the lung does not completely inflate).

RATIONALE:
A. 31622 correctly identifies the right lung diagnostic bronchoscopy. 31623 correctly reports the left lung bronchoscopy with cell washings and brushings. However, the essential anatomical modifiers (-RT and -LT) are missing to show that both the right and left lungs were scoped. Without the -RT and -LT modifiers, these codes have the appearance of unbundling. Unbundling occurs when the coder assigns a separate code for a procedure (i.e., 31622) that is inherent to a more comprehensive procedure (i.e., 31623). The use of the -RT and -LT in addition to the -51 modifier as in choice C help to show that different anatomical sites were examined. See rationale C for more information. 518.0 correctly indicates the diagnosis of atelectasis.

B. 31623 correctly reports the left lung bronchoscopy with brushings. The code for the right lung bronchoscopy is missing. See rationale C for more information. 770.4 reports primary atelectasis, which is congenital atelectasis, and the condition was not indicated to be a congenital condition.

D. 31624 is a bronchoscopy with bronchial alveolar lavage, which was not indicated in the case. See rationale C for more information. 770.4 reports primary atelectasis, which is congenital atelectasis, and the condition was not indicated to be a congenital condition.

67. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS:
1. Hypoxia.
2. Pneumothorax.

POSTOPERATIVE DIAGNOSIS:
1. Hypoxia.
2. Pneumothorax.

PROCEDURE: Chest tube placement.

DESCRIPTION OF PROCEDURE: The patient was previously sedated with Versed and paralyzed with Nimbex. Lidocaine was used to numb the incision area in the midlateral left chest at about nipple level. After the lidocaine, an incision was made, and we bluntly dissected to the area of the pleural space, making sure we were superior to the rib. On entrance to the pleural space, there was immediate release of air noted. An 18-gauge chest tube was subsequently placed.
and sutured to the skin. There were no complications for the procedure, and blood loss was minimal.

DISPOSITION: Follow-up, single-view, chest x-ray showed significant resolution of the pneumothorax except for a small apical pneumothorax that was noted.

A. 32422, 799.02, 512.89
B. 32551, 71010, 799.00, 512.89
C. 32551, 512.89, 799.02
D. 32422, 799.00, 512.0

POINT VALUE: 1 point

CORRECT ANSWER:
C. 32551 correctly reports the chest tube placement by thoracostomy ("incision was made …"). 512.89 pneumothorax and 799.02 hypoxia correctly report the diagnoses as stated in the operative report in the Postoperative Diagnosis area of the report.

RATIONALE:
A. 32422 reports a thoracentesis (puncture) with the insertion of a trocar (plastic tube) in which once the fluid is withdrawn, the tube is removed, but in the report an incision was made and a tube was inserted and sutured into place. 799.02 is correct to report the hypoxia, and 512.89 is correct to report the pneumothorax. Pneumothorax code should be sequenced first, however, as it is the reason for the procedure.
B. 32551 is correct to report the chest tube placement. As for 799.00, there is no fifth digit (0) for the hypoxia code. The note at the beginning of the report indicated that you were to code only the operative procedure and diagnosis(es), and so you would not code the single-view chest x-ray (71010). 512.89 is correct for the pneumothorax.
D. 32422 reports a thoracentesis (puncture) with insertion of a trocar (plastic tube), and once the fluid is withdrawn, the tube is removed, but in the report an incision was made and a tube was inserted and sutured into place. As for 799.00, there is no fifth digit (0) for the hypoxia code. 512.0 is spontaneous tension pneumothorax, and no indication was made in the report that the pneumothorax was spontaneous tension type.

68. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Atherosclerotic heart disease.

POSTOPERATIVE DIAGNOSIS: Atherosclerotic heart disease.

OPERATIVE PROCEDURE: Coronary bypass grafts × 2 with a single graft from the aorta to the distal left anterior descending and from the aorta to the distal right
coronary artery.

PROCEDURE: The patient was brought to the operating room and placed in a supine position. Under general intubation anesthesia, the anterior chest and legs were prepped and drapped in the usual manner. A segment of greater saphenous vein was harvested from the left thigh, utilizing the endoscopic vein harvesting technique, and prepared for grafting. The sternum was opened in the usual fashion, and the left internal mammary artery was taken down and prepared for grafting. The flow through the internal mammary artery was very poor. The patient did have a 25-mm difference in arterial pressure between the right and left arms, the right arm being higher. The left internal mammary artery was therefore not used. The pericardium was incised sharply and a pericardial well created. The patient was systemically heparinized and placed on bivacal to aortic cardiopulmonary bypass with the stump in the main pulmonary artery for cardiac decompression. The patient was cooled to 26° C, and on fibrillation an aortic cross-clamp was applied and potassium-rich cold crystalline cardioplegic solution was administered through the aortic root with satisfactory cardiac arrest. Subsequent doses were given down the vein grafts as the anastomoses were completed and via the coronary sinus in a retrograde fashion. Attention was directed to the right coronary artery. The end of the greater saphenous vein was then anastomosed thereto with 7-0 continuous Prolene distally. The remaining graft material was then grafted to the left anterior descending at the junction of the middle and distal third. The aortic cross-clamp was removed after 149 minutes with spontaneous cardioversion. The usual maneuvers to remove air from the left heart were then carried out using transesophageal echocardiographic technique. After all the air was removed and the patient had returned to a satisfactory temperature, he was weaned from cardiopulmonary bypass after 213 minutes utilizing 5 g per kilogram per minute of dopamine. The chest was closed in the usual fashion. A sterile compression dressing was applied, and the patient returned to the surgical intensive care unit in satisfactory condition.

A. 33511, 33517, 440.9
B. 33511, 33508, 414.01
C. 33534, 33508, 414.00
D. 33511, 33517, 414.01

POINT VALUE: 1 point

CORRECT ANSWER:

B. 33511 indicates a coronary artery bypass; with two coronary venous grafts. Code 33508 reports the endoscopically harvested saphenous vein. The saphenous vein harvesting is not separately reported because per CPT, this is included in the bypass grafting procedure code (33511). 414.01 is the code for atherosclerotic heart disease affecting a native coronary artery. If it is apparent that there has been no history of previous coronary artery bypass graft (CABG), the code for arteriosclerosis of the native artery should be assigned.
RATIONAL:
A. 33511 correctly reports the coronary artery bypass with two coronary venous grafts. 33517 incorrectly reports a combination vein and artery graft; only two veins were used. 440.9 reports a generalized and unspecified atherosclerosis, whereas the diagnosis in this case is atherosclerotic heart disease which is classified in ICD-9 as coronary arteriosclerosis (414.01).
C. 33534 incorrectly reports coronary artery bypass using arterial graft. 33508 correctly indicates surgical endoscopy for the harvest of the femoral vein. 414.00 reports coronary atherosclerosis of unspecified type of vessel (native or graft); when there is no evidence of a previous bypass graft, the coder is to assign the code for coronary arteriosclerosis of native artery (414.01). See rationale B.
D. 33511 correctly reports the coronary artery bypass with two coronary venous grafts, 33517 incorrectly reports a combination vein and artery graft because only two veins were used, and 414.01 is the correct diagnosis for atherosclerotic heart disease.

69. OPERATIVE REPORT: The patient is in for a bone marrow biopsy. The patient was sterilized by standard procedure. Bone marrow core biopsies were obtained from the left posterior iliac crest with minimal discomfort. At the end of the procedure, the patient denied discomfort, without evidence of complications. The patient has diffuse, malignant lymphoma. Assign codes for the physician service only.

A. 20225, 229.0
B. 38221, 202.80
C. 38230, 200.10
D. 38220, 202.80

POINT VALUE: 1 point

CORRECT ANSWER:
B. 38221 correctly reports a bone marrow biopsy by means of a needle or trocar. Diagnosis code 202.80 describes a diffuse malignant lymphoma, unspecified site.

RATIONALE:
A. 20225 is an excisional bone biopsy, not a bone marrow biopsy. Code 229.0 reports a benign neoplasm of the lymph nodes when the report indicated malignant lymphoma reported with 202.80.
C. 38230 is bone marrow harvesting for the purpose of transplantation and not a bone marrow biopsy. Code 200.10 reports lymphosarcoma when the report indicated the diagnosis was malignant lymphoma reported with 202.80.
D. 38220 is a bone marrow aspiration, and the report indicated that a biopsy was performed. Diagnosis code 202.80 correctly describes a diffuse malignant lymphoma, unspecified site.

70. Patient is a 40-year-old male who was involved in a motor vehicle crash. He is having some pulmonary insufficiency.

PROCEDURE: Bronchoscope was inserted through the accessory point on the end of the ET tube and was then advanced through the ET tube. The ET tube came pretty close down to the carina. We selectively intubated the right mainstem bronchus with the bronchoscope. There were some secretions here, and these were aspirated. We then advanced this selectively into first the lower and then the middle and upper lobes. Secretions were present, more so in the middle and lower lobes. No mucous plug was identified. We then went into the left mainstem and looked at the upper and lower lobes. There was really not much in the way of secretions present. We did inject some saline and aspirated this out. We then removed the bronchoscope and put the patient back on the supplemental O₂. We waited a few minutes. The oxygen level actually stayed pretty good during this time. We then reinserted the bronchoscope and went down to the right side again. We aspirated out all secretions and made sure everything was clear. We then removed the bronchoscope and pulled back on the ET tube about 1.5 cm. We then again placed the patient on supplemental oxygenation.

FINDINGS: No mucous plug was identified. Secretions were found mainly in the right lung and were aspirated. The left side looked pretty clear.

A. 31646, 518.52, E819.9
B. 32654, 518.82, E812
C. 31645-50, 518.52, E819.9
D. 31645-RT, 31622-51-LT, 518.52, E988.5

POINT VALUE: 1 point

CORRECT ANSWER:
D. 31645-RT identifies a right lung bronchoscopy with therapeutic aspiration. 31622-51-LT identifies a left lung diagnostic bronchoscopy. The report indicates that the left lung looked pretty clear; saline was injected and aspirated out. This is different than a therapeutic aspiration. 31622 is designated as a "separate procedure," which is normally not assigned when it is a component of a more comprehensive procedure; but it is appropriate to assign it separately in this case based on CPT guidelines under endoscopy subheading. The guidelines indicate that a code is to be assigned for each anatomic site examined. Therefore, since both lungs were scoped, a code for each procedure is reported. 518.52 reports pulmonary insufficiency following a trauma because the report states that the patient was in a motor vehicle crash. E988.5 reports a motor vehicle crash, unspecified means and intent.

RATIONALE:
A. 31646 is a subsequent therapeutic aspiration of the tracheobronchial tree, and
this was an initial aspiration. 518.52 correctly reports the pulmonary insufficiency following a trauma, and E819.9 incorrectly reports a traffic accident of unspecified nature instead of a motor vehicle crash.

B. 32654 is the code for surgical thoracoscopy, not a bronchoscopy, with control of hemorrhage, and there was no indication of hemorrhage in the report. 518.82 is assigned to pulmonary insufficiency that is not otherwise classified and is caused by a disease of the lung; it contains an "Excludes" note that indicates pulmonary insufficiency following a trauma is reported with 518.52. E812 is assigned to indicate a motor vehicle traffic accident that involved a collision with another motor vehicle, but that type of accident was not indicated; the report stated only that it was a motor vehicle crash. Also, there is a fourth digit for E812, and because a fourth digit is available, it is necessary to assign the fourth digit.

C. 31645-50 identifies a bronchoscopy with therapeutic aspiration. This is incorrect because only the right lung was therapeutically aspirated. The code for the left lung diagnostic bronchoscopy is missing. See rationale D. The diagnosis codes are correct. 518.52 reports pulmonary insufficiency following a trauma because the report states that the patient was in a motor vehicle crash. E819.9 reports a traffic accident of unspecified nature, unspecified person, instead of motor vehicle crash.

71. This 52-year-old male has undergone several attempts at extubation, all of which failed. He also has morbid obesity and significant subcutaneous fat in his neck. The patient is now in for a flap tracheostomy and cervical lipectomy. The cervical lipectomy is necessary for adequate exposure and access to the trachea and also to secure tracheotomy tube placement. Assign code(s) for the physician service only.

A. 31610, 15839-51  
B. 31610  
C. 31610, 15838  
D. 31603, 15839-51

POINT VALUE: 1 point

CORRECT ANSWER:  
A. 31610 identifies a tracheostomy with skin flaps. 15839-51 identifies the cervical lipectomy. The -51 modifier indicates that multiple procedures were performed.

RATIONALE:  
B. 31610 correctly identifies a tracheostomy with skin flaps, but it does not report the cervical lipectomy.  
C. 31610 correctly identifies a tracheostomy with skin flaps. 15838 identifies a submental fat pad lipectomy which is situated below the chin but the lipectomy in this case was of the cervical area and the correct code would be 15839. Modifier -51 is missing to indicate that multiple procedures were performed.
during the same operative session and the code is not modifier -51 exempt.

D. 31603 reports an emergency tracheostomy. There was no indication of an emergency situation with this case. 15839-51 correctly identifies the cervical lipectomy with the correct application of modifier -51.

72. Connie was brought to the operating room for repair of an acute, traumatic diaphragmatic hernia.

A. 39540, 862.0
B. 39503, 756.6
C. 39541, 862.0
D. 39540, 756.6

POINT VALUE: 1 point

CORRECT ANSWER:
A. 39540 reports the repair of an acute, traumatic diaphragmatic hernia using any approach. Diagnostic code 862.0 reports a traumatic diaphragmatic hernia.

RATIONALE:
B. 39503 is to repair a neonatal diaphragmatic hernia. Code 756.6 reports an anomaly of the diaphragm; but the report indicated a diaphragmatic hernia correctly reported with 862.0.
C. 39541 reports the repair of a chronic, traumatic diaphragmatic hernia using any approach; however, the case indicated the hernia was acute not chronic. Diagnostic code 862.0 correctly reports a traumatic diaphragmatic hernia.
D. 39540 is to repair a traumatic acute diaphragmatic hernia. Code 756.6 reports an anomaly of the diaphragm; but the report indicated a diaphragmatic hernia correctly reported with 826.0.

73. This patient returns to the operating room for placement of an additional chest tube for an anterior pneumothorax due to a contusion lung injury. The same physician had just placed a chest tube 4 days earlier.

A. 32551, 860.0
B. 32420, 861.21
C. 32551-58, 861.21
D. 32551, 861.3

POINT VALUE: 1 point

CORRECT ANSWER:
A. 32551 indicates the chest tube placement, and 860.0 identifies the diagnosis for a pneumothorax due to trauma without open wound to the lung. The lung contusion is included in 860.0 per the Includes note for subchapter 860-869; therefore, it is not reported separately.
RATIONAL:
B. 32420 is a pneumocentesis, which is a puncture into the lung for purpose of aspiration and not placement of a chest tube. 861.21 identifies a contusion injury of the lung. The diagnosis is a pneumothorax due to a contusion, reported with 860.0.
C. 32551-58 is the correct code for the chest tube, but the -58 modifier identifies the same physician as having had to do a planned or more extensive procedure in the postoperative period. There are no postoperative days for a chest tube, and the report does not state that it is a more extensive procedure in any event. 861.21 is incorrect, as stated in rationale B.
D. 32551 is the correct answer for chest tube, but 861.3 is the diagnosis code for an injury to the lung with open wound. This was a pneumothorax due to a contusion injury without mention of an open chest wound. Also, 861.3 requires a fifth digit.

Subject Area: 40000 Digestive System

74. What CPT code would you use if the physician performs a pyloroplasty and vagotomy in the same surgical session?

A. 43865
B. 50400
C. 43635
D. 43640

POINT VALUE: 1 point

CORRECT ANSWER:
D. 43640 identifies the pyloroplasty and vagotomy (transection of the vagus nerve).

RATIONALE:
A. 43865 reports a revision of a gastrojejunal anastomosis with vagotomy (transection of the vagus nerve).
B. 50400 is a pyeloplasty (repair operation on the renal pelvis) without mention of a vagotomy (transection of the vagus nerve).
C. 43635 is an add-on code used to report a vagotomy when performed with a gastrectomy.

75. This 43-year-old female comes in with a peritonsillar abscess. The patient is brought to same-day surgery and given general anesthetic. On examination of the peritonsillar abscess, an incision was made and fluid was drained. The area was examined again, saline was applied, and then the area was packed with gauze. The patient tolerated the procedure well.

A. 42825, 475
**Correct Answer:**
B. 42700 indicates the incision and drainage of a peritonsillar abscess; no approach is mentioned. 475 is the correct diagnosis code for the peritonsillar abscess.

**Rationale:**
A. 42825 is a tonsillectomy for a patient younger than age 12, not incision and drainage of a peritonsillar abscess, and 475 is the correct code for the peritonsillar abscess.
C. 42825 is a tonsillectomy for a patient younger than age 12, not incision and drainage of a peritonsillar abscess; 463 is assigned to report acute tonsillitis, not peritonsillar abscess.
D. 42700 is correct to indicate the incision and drainage of a peritonsillar abscess. 474.0 is chronic tonsillitis and adenoiditis, which is not the correct diagnosis; also, this code requires a fifth digit.

76. **Operative Report**

**Preoperative Diagnosis:** Abdominal pain.

**Postoperative Diagnosis:** Normal endoscopy.

**Procedure:** The video therapeutic endoscope was passed without difficulty into the oropharynx. The gastroesophageal junction was seen at 40 cm. Inspection of the esophagus revealed no erythema, ulceration, varices, or other mucosal abnormalities. The stomach was entered and the endoscope advanced to the second duodenum. Inspection of the second duodenum, first duodenum, duodenal bulb, and pylorus revealed no abnormalities. Retroflexion revealed no lesions along the curvature. Inspection of the antrum, body, and fundus of the stomach revealed no abnormalities. The patient tolerated the procedure well. The patient complained of abdominal pain and weight loss.

A. 45378, 789.00, 783.21
B. 43235, 789.00, 783.21
C. 49320, 783.0, 789.00
D. 43255, 278.01, 789.01

**Point Value:** 1 point

**Correct Answer:**
B. 43235 identifies a diagnostic upper gastrointestinal endoscopy to the...
farthest extent of the duodenum. Diagnosis code 789.00 describes abdominal pain, site unspecified, and weight loss reported with 783.21.

RATIONALE:
A. 45378 reports a colonoscopy not a gastroscopy. Diagnosis code 789.00 correctly reports abdominal pain, site unspecified, and weight loss reported with 783.21.
C. 49320 identifies a diagnostic laparoscopy (scope inserted through abdomen) of the abdomen, peritoneum, or omentum, but the procedure used in the case was a gastrointestinal endoscopy. Code 783.0 reports anorexia, which was not stated in the report; rather the report indicated weight loss reported with 783.21. Diagnosis code 789.00 correctly reports abdominal pain, site unspecified.
D. 43255 describes a gastroscopy for the purpose of control of bleeding, but the case indicated that no abnormalities, such as a site of bleeding, were noted or repaired. Code 278.01 reports morbid obesity, which was not documented. Code 789.01 reports abdominal pain of the right upper quadrant, but the documentation did not specify the quadrant. Code 789.00 correctly reports abdominal pain, site unspecified.

77. This 70-year-old male is brought to the operating room for a biopsy of the pancreas. A wedge biopsy is taken and sent to pathology. The report comes back immediately indicating that primary malignant cells were present in the specimen. The decision was made to perform a total pancreatectomy. Code the operative procedure(s) and diagnosis only.

A. 48100, 197.8
B. 48155, 157.8
C. 48155, 48100-51, 157.9
D. 48155, 48100-51, 88309, 157.9

POINT VALUE: 1 point
CORRECT ANSWER:
C. 48155 identifies the total pancreatectomy. 48100-51 indicates an open wedge biopsy of the pancreas with the -51 modifier to indicate a multiple procedure. Diagnosis code 157.9 reports the primary malignant cancer of the pancreas.

RATIONALE:
A. 48100 reports only the open wedge biopsy and does not report the pancreatectomy. Code 197.8 reports a secondary malignant neoplasm of the digestive organ or spleen and the report indicated a primary malignancy of the pancreas correctly reported with 157.9.
B. 48155 reports only the pancreatectomy and does not report the biopsy procedure. Remember, on the certification exam third-party payer guidelines are NOT followed, so the biopsy is reported separately. Code 157.8 reports a
malignant neoplasm of “Other specified sites of the pancreas” and the report did not indicate a specific site of the pancreas; therefore, 157.9, Pancreas, parts unspecified, most correctly reports the diagnosis documented in the report.

D. 48155 correctly reports the pancreatectomy. 48100-51 correctly reports the open wedge biopsy, but 88309 reports the pathology service, and the directions stated to code only the operative procedure(s). Diagnosis code 157.9 correctly reports the primary malignant cancer of the pancreas.

78. This patient is taken to the operating room from the intensive care unit (ICU). The area of the stoma appears to be necrotic, and on this basis the surgeon indicates that the patient has been taken back to the operating room. The stoma was originally created 4 months ago by her previous surgeon.

PROCEDURE PERFORMED: Revision ileostomy stoma.

OPERATIVE NOTE: With the patient moved onto the operating table, the abdomen was prepped and draped. The segment of bowel that was serving as the ileostomy was freed up. Going in through this large open wound, we were able to identify which segment of bowel this was. We resected the end of the bowel that was necrotic and freed up enough of the distal small bowel so that we could bring it out through a new stoma that was placed lateral to the original stoma. The stoma was created, the bowel was brought out, and the mucosa was sewn onto the skin. With this accomplished, we appeared to have a viable stoma. The patient tolerated this procedure and was returned to the ICU in stable condition.

A. 44310, 560.1, E878.1
B. 45136, 009.0, E878.0
C. 44312, 569.62, 557.0, E878.3
D. 44314, 557.0

POINT VALUE: 1 point

CORRECT ANSWER: C. 44312 identifies the revision of the ileostomy stoma. 569.62 identifies a mechanical failure of the stoma graft. 557.0 reports the necrosis, and E878.3 is the correct code for an abnormal reaction of a stoma.

RATIONALE:
A. 44310 incorrectly reports the initial placement of an ileostomy, not, as the report indicates, as a revision of a previously placed stoma. 560.1 identifies a paralytic ileus that is not indicated in the report. Missing is 569.62 to identify the mechanical failure of the stoma and 557.0 for necrosis of the intestine. E878.1 is incorrect as it describes an abnormal reaction to an artificial device/implant.
B. 45136 incorrectly reports an excision of an ileoanal reservoir with an
ileostomy. 009.0 indicates infectious colitis, enteritis, and gastroenteritis, none of which was indicated in the diagnostic statements within the report of "bowel that was necrotic." Missing is 569.62 to identify the mechanical failure of the stoma and 557.0 for necrosis of the intestine. E878.0 is incorrect as it describes an abnormal reaction to a transplanted organ.

D. 44314 is a complicated revision of an ileostomy, but the report did not indicate that the procedure was of a higher complexity than usual. 557.0 is the correct diagnosis for the necrosis of the intestine, but doesn't capture the clinical nature of a stoma failure. A better choice is 569.62 to identify the mechanical failure of the stoma and the E code for the abnormal reaction.

79. This patient is brought back to the operating room during the postoperative period by the same physician to repair an esophagogastrostomy leak, transthoracic approach, done 2 days ago. The patient is status post esophagectomy for esophageal cancer, and is still undergoing chemotherapy. Code the procedure and the diagnosis for the complication.

A. 43320-78, 530.10
B. 43340-78, 578.9
C. 43341, 997.49, 239.0
D. 43415-78, 997.49, 150.9

POINT VALUE: 1 point

CORRECT ANSWER:

D. 43415-78 indicates the repair of the esophageal wound with the correct approach (transthoracic). The -78 modifier indicates a related procedure is being performed during the postoperative period by the physician who initially performed the procedure. You know this procedure takes place during the postoperative period by the statement "2 days later." 997.49 identifies the complication of an anastomosis between the esophagus and stomach. 150.9 identifies cancer of the esophagus and the reason for the anastomosis.

RATIONALE:

A. 43320-78 reports an esophagogastrostomy (cardioplasty) using a transthoracic approach, but the patient was being returned to the operating room for repair of the leaking anastomosis from a previous esophagectomy; modifier -78 is, however, correct to indicate a return to the operating room. 530.10 reports esophagitis, not a postoperative complication. Missing is 997.49 to identify the complication of intestinal anastomosis.

B. 43340-78 reports an esophagojejunostomy using an abdominal approach, and the procedure in the report is the repair of a wound of the esophagus using a transthoracic approach. 578.9 reports intestinal hemorrhage, which is not indicated in the report. Missing is 997.49 to identify the complication of intestinal anastomosis.

C. 43341 is an esophagojejunostomy using a thoracic approach; also, the report
indicates that the patient is being returned to the operating room (-78) for a repair of an esophageal wound. 997.49 identifies the complication of intestinal anastomosis. 239.0 reports a neoplasm of unspecified nature yet the documentation identifies the neoplasm as cancer.

80. The patient was taken to the operating room for a repair of a strangulated inguinal hernia. This hernia was previously repaired 4 months ago.

A. 49521, 550.11
B. 49520, 550.10
C. 49492, 550.90
D. 49521-78, 550.93

POINT VALUE: 1 point

CORRECT ANSWER:
A. 49521 identifies a recurrent inguinal hernia that is strangulated. Code 550.11 reports an inguinal hernia, recurrent, strangulated. The statement "This hernia was previously repaired" identifies the hernia as recurrent.

RATIONALE:
B. 49520 is a repair of a recurrent inguinal hernia that was reducible, which is one that the surgeon is able to return to the normal anatomic location. The hernia in the report is strangulated, not reducible or able to be returned to the original location. Remember, the inclusion note under 550.1 for an obstructed hernia includes strangulation, and strangulated hernia in the Index is referred to obstructed hernia. Code 550.10 reports an inguinal hernia not specified as recurrent, but the report noted the recurrence; 550.11 correctly reports a recurrent strangulated inguinal hernia.
C. 49492 reports an initial repair of an inguinal hernia that is strangulated, and the report indicated a recurrent repair. Code 550.90 reports an inguinal hernia with obstruction or gangrene, but the report did not indicate an obstruction; 550.11 reports a recurrent strangulated inguinal hernia.
D. 49521-78. Although the code is correct, the return to the operating room during the postoperative period is not indicated in the report. Code 550.93 reports a recurrent bilateral inguinal hernia, and the report indicated a recurrent, strangulated unilateral inguinal hernia (550.11).

81. The physician is using an abdominal approach to perform a proctopexy combined with a sigmoid resection; the patient was diagnosed with colon cancer, primary site sigmoid flexure of the colon:

A. 45540, 153.3
B. 45541, 153.7
C. 45550, 153.3
D. 45345, 154.0
POINT VALUE: 1 point

CORRECT ANSWER:
C. 45550 identifies the proctopexy combined with a sigmoid resection using an abdominal approach. Diagnosis code 153.3 reports a malignant neoplasm of sigmoid flexure.

RATIONALE:
A. 45540 correctly reports the service of a proctopexy for a prolapse using an abdominal approach but does not report a sigmoid resection (removal). Diagnosis code 153.3 describes a malignant neoplasm of sigmoid flexure.
B. 45541 incorrectly reports a proctopexy for prolapse using a perineal approach, which is an approach by means of an incision between the anus and coccyx. Code 153.8 reports a malignant neoplasm of other specified sites of the small intestine. Diagnosis code 153.3 describes a malignant neoplasm of sigmoid flexure.
D. 45345 reports an endoscopic stent placement in the rectum but does not correctly report a proctopexy with a sigmoid resection. Code 154.0 reports a malignant neoplasm of the rectosigmoid junction when the report indicated a malignant neoplasm of the sigmoid flexure accurately reported with 153.3.

82. What code would you use to report a rigid proctosigmoidoscopy with removal of two nonadenomatous polyps of the rectum by snare technique?

A. 45320, 569.0
B. 45383, 211.3
C. 45309 × 2, M8210/0
D. 45315, 569.0

POINT VALUE: 1 point

CORRECT ANSWER:
D. 45315 identifies the rigid proctosigmoidoscopy with the removal of the polyps using the correct technique (snare). Diagnosis code 569.0 reports nonadenomatous polyp of the rectum.

RATIONALE:
A. 45320 reports the ablation (removal by cutting) of polyps that could not be removed by snare technique, but the technique specified in the case was a snare technique. Diagnosis code 569.0 correctly reports nonadenomatous polyp of the rectum.
B. 45383 is for colonoscopic ablation of tumors (not snare technique) from the colon (not the sigmoid). Code 211.3 reports benign neoplasm of the colon, but the report indicated a polyp of the rectum (569.0).
C. 45309 is the removal of a single polyp, and two polyps were removed; but there is a specific code to report multiple polyp removal. Code M8210/0 reports the histology of the adenomatous polyp NOS; however, M codes are
morphology codes reported by oncology departments as part of global statistical reporting of morphology of tumors. M codes are not reported by outpatient coder and are not required on the CPC examination.

83. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Leaking from intestinal anastomosis.

POSTOPERATIVE DIAGNOSIS: Leaking from intestinal anastomosis.

PROCEDURE PERFORMED: Proximal ileostomy for diversion of colon. Oversew of right colonic fistula.

OPERATIVE NOTE: This patient was taken back to the operating room from the intensive care unit. She was having acute signs of leakage from an anastomosis I performed 3 days previously. We took down some of the sutures holding the wound together. We basically exposed all of this patient's intestine. It was evident that she was leaking from the small bowel as well as from the right colon. I thought the only thing we could do would be to repair the right colon. This was done in two layers, and then we freed up enough bowel to try to make an ileostomy proximal to the area of leakage. We were able to do this with great difficulty, and there was only a small amount of bowel to be brought out. We brought this out as an ileostomy stoma, realizing that it was of questionable viability and that it should be watched closely. With that accomplished, we then packed the wound and returned the patient to the intensive care unit.

A. 44310, 998.31
B. 44310-78, 997.49, E878.2
C. 45136, 996.5, E878.2
D. 45136-78, 998.32, E879.1

POINT VALUE: 1 point

CORRECT ANSWER:

B. 44310-78 indicates that an ileostomy was performed. The -78 modifier indicates that the patient was brought back to the operating room for a related procedure during a postoperative period by the same physician who performed the procedure initially. 997.49 is the diagnosis for complication of intestinal anastomosis, a complication of the previous procedure. E878.2 is the code for a complication due to anastomosis.

RATIONALE:

A. 44310 correctly reports an ileostomy but does not indicate that the patient was brought back to the operating room for a related procedure during a postoperative period by use of modifier -78. 998.31 is the diagnosis code to report the disruption of an internal operative wound, not a digestive system complication of anastomosis, NEC (997.49). Abnormal reaction E code is
missing. 998.3 would also require a fifth digit.

C. 45136 incorrectly reports an excision of an ileoanal reservoir with an ileostomy. 996.5 incorrectly reports a mechanical complication of other specified prosthetic devices, implants, or grafts, and not complication of an anastomosis; also, 996.5 would require a fifth digit. E878.2 is the correct code.

D. 45136-78 incorrectly reports an excision of an ileoanal reservoir with an ileostomy but correctly indicates a patient brought back to the operating room for a related procedure during a postoperative period by use of modifier -78. 998.32 is the diagnosis code to report the disruption of an external operative wound, not a digestive system complication of anastomosis, NEC (997.49). 998.3 would also require a fifth digit. E879.1 is an incorrect code because it describes an abnormal reaction to dialysis.

Subject Area: 50000 Urinary, Male Genital System, Female Genital System, and Maternity Care and Delivery

84. This patient is 35 years old at 36 weeks' gestation. She presented in spontaneous labor. Because of her prior cesarean section, she is taken to the operating room to have a repeat lower-segment transverse cesarean section performed. The patient also desires sterilization, and so a bilateral tubal ligation will also be performed. A single, liveborn infant was the outcome of the delivery.

A. 59510, 58600-51, V25.2
B. 59620, 58615-51, 644.21, V27.0
C. 59514, 58605-51, V27.0, 644.21
D. 59514, 58611, 654.21, 644.21, V27.0, V25.2

POINT VALUE: 1 point

CORRECT ANSWER:

D. 59514 identifies the C-section. 58611 identifies the tubal ligation done at the time of cesarean delivery and is not a separate procedure; rather, it is listed separately in addition to the primary procedure. No -51 modifier is needed because 58611 is an add-on code. 654.21 is the diagnosis code for previous cesarean section, with the fifth digit (1) indicating delivery. 644.21 is the diagnosis code for early onset of delivery before 37 weeks. V27.0 is for single liveborn infant. V25.2 is the diagnosis code for the sterilization (tubal ligation). According to the Official Guidelines for Coding and Reporting, when a C-section is performed, the reason for the C-section is the principal diagnosis.

RATIONALE:

A. 59510 reports routine obstetrical care that includes antepartum care, cesarean delivery, and postpartum care, but this case did not indicate who provided the
antepartum care or postpartum care; rather, only the delivery was stated. 58600-51 reports the tubal transection (cutting of the fallopian tubes) using a vaginal or abdominal approach; however, the case indicated that the transection was done at the time of the cesarean delivery, and as such 58611 (add-on code not requiring modifier -51) is the correct code to report this portion of the procedure. V25.2 is correct to report the sterilization. Missing are 644.21 (early onset of delivery), 654.21 (previous cesarean section), V27.0 (single, liveborn).

B. 59620 incorrectly reports the cesarean delivery as having followed an attempted vaginal delivery when the mother had previously delivered by means of cesarean. Although the record indicated that the mother had delivered by prior cesarean section, there was no indication that a vaginal delivery had been attempted before this cesarean section. 58615-51 is used to report the occlusion (tying off) of the fallopian tubes using a vaginal or suprapubic (above the pubis) approach, but the tubes were transected (cut), not occluded, and the approach was an open abdominal procedure. Because the service was part of an open abdominal procedure, only the add-on code 58611 is correct to report the tubal transection. 644.21 is the correct diagnosis code for early onset of delivery before 37 weeks, and V27.0 is correct to report one liveborn as the outcome. Missing are 654.21 (previous cesarean section) and V25.2 (sterilization).

C. 59514 correctly reports the cesarean delivery portion of the service. 58605-51 reports a tubal transection that is done as a separate procedure, not one that is performed at the time of a more major procedure as this one was. V27.0 is correct to report one liveborn as the outcome, and 644.21 is the correct diagnosis code for early onset of delivery before 37 weeks. Missing are 654.21 (previous cesarean section) and V25.2 (sterilization).

85. The pediatric physician takes this newborn male to the nursery to perform a clamp circumcision.

A. 54160, V50.2  
B. 54150, V50.21  
C. 54160, V50.21  
D. 54150, V50.2

POINT VALUE: 1 point

CORRECT ANSWER:  
D. 54150 identifies the clamp circumcision. V50.2 is the diagnosis code for a routine circumcision of a newborn.

RATIONALE:  
A. 54160 is a surgical excision circumcision other than clamp, and the report indicated a clamp circumcision. V50.2 is the correct diagnosis code for a routine circumcision of a newborn.

B. 54150 correctly identifies the clamp circumcision, but V50.21 incorrectly
C. 54160 is a surgical excision circumcision other than clamp, and the report indicated a clamp circumcision. V50.21 is incorrect because there is no fifth digit "1" for use with this code.

86. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Possible recurrent transitional cell carcinoma of the bladder.

POSTOPERATIVE DIAGNOSIS: No evidence of recurrence.

PROCEDURE PERFORMED: Cystoscopy with multiple bladder biopsies.

PROCEDURE NOTE: The patient was given a general mask anesthetic, prepped, and draped in the lithotomy position. The 21-French cystoscope was passed into the bladder. There was a hyperemic area on the posterior wall of the bladder, and a biopsy was taken. Random biopsies of the bladder were also performed. This area was fulgurated. A total of 7 sq cm of bladder was fulgurated. A catheter was left at the end of the procedure. The patient tolerated the procedure well and was transferred to the recovery room in good condition. The pathology report indicated no evidence of recurrence.

A. 52224, 596.7, V10.51
B. 51020, 52204, V16.52
C. 52234, V10.51
D. 52224 × 4, 236.7

POINT VALUE: 1 point

CORRECT ANSWER:

A. 52224 × 4 identifies the cystoscopy with fulguration of minor lesions (hyperemic area) and multiple biopsies. Hyperemia/bladder is indexed to 596.7. V10.51 is the diagnosis code for personal history of bladder cancer. You would not report the possibility of a recurrent cancer because the pathology findings indicated no evidence of recurrence. Also, you never code "possible, maybe, consistent with or rule out" for a diagnosis in an outpatient setting.

RATIONALE:

B. 51020 is a cystotomy or cystostomy with fulguration, not a biopsy with fulguration. 52204 is a cystourethroscopy with biopsy but without fulguration and would not be reported with a cystotomy or cystostomy code (51020). V16.52 reports a family history of bladder cancer, not a personal history of urinary cancer, and history codes cannot be first listed diagnoses. The correct diagnoses are 596.7 for the hyperemia and V10.51 for the personal history.

C. 52234 is a cystourethroscopy with fulguration and/or excision of a small
bladder tumor(s). This is incorrect because the report indicates that there was no tumor. V10.51 is the diagnosis code for history of bladder cancer and history codes cannot be first listed diagnoses. The correct diagnoses are 596.7 for the hyperemia and V10.51 for the personal history.

D. 52224 is a cystourethroscopy with fulguration that may include excision of a minor lesion or lesions but also may include a biopsy. So it is the correct code to identify the procedure performed, but the "× 4" should not be used to indicate four biopsy areas because the code states lesion or lesions. 236.7 is for a lesion of uncertain behavior, but you do not code this unless the medical documentation supports the diagnosis. The correct diagnoses are 596.7 for the hyperemia and V10.51 for the personal history.

87. This 1-year-old boy has a midshaft hypospadias with a very mild degree of chordee. He also has a persistent right hydrocele. The surgeon brought the boy to surgery to perform a right hydrocele repair and one-stage repair of hypospadias with preputial onlay flap.

A. 54322, 55040, 752.61, 752.63
B. 54322, 55041-51, 752.61, 752.63, 603.9
C. 54324, 55060-51, 752.61, 752.63, 603.9
D. 54324, 55060, 752.63, 603.9

POINT VALUE: 1 point

CORRECT ANSWER:

C. 54324 identifies the one-stage repair of hypospadias with urethroplasty by skin (preputial) flap. This code includes the repair of chordee. 55060-51 identifies the repair of the hydrocele as a multiple procedure (-51). 752.61 is the diagnosis for the hypospadias (anomaly of the penis). 752.63 is the diagnosis for a congenital chordee. 603.9 is the diagnosis for the hydrocele. Since the hydrocele was not specified as being congenital, the code for congenital hydrocele (778.6) may not be used.

RATIONALE:

A. 54322 is a one-stage distal hypospadias repair with a meatal advancement, not a urethroplasty by local skin flap specified in the report. 55040 incorrectly reports the unilateral excision of a hydrocele, not a repair. 752.61 is the correct diagnosis for the hypospadias (anomaly of the penis), and 752.63 is the correct diagnosis for a congenital chordee. Missing is 603.9 for the hydrocele.

B. 54322 is a one-stage distal hypospadias repair with a meatal advancement, not a urethroplasty by local skin flap, which is specified in the report. 55041-51 incorrectly reports the excision of a bilateral hydrocele as one of multiple procedures performed during the same operative session (indicated by modifier -51), not a hydrocele repair. 752.61 is the correct diagnosis for the hypospadias (anomaly of the penis), and 752.63 is the correct diagnosis for a congenital chordee. 603.9 is the correct diagnosis for the hydrocele.

D. 54324 correctly identifies the one-stage repair of hypospadias with urethroplasty
by skin flap. 55060 correctly identifies the repair of the hydrocele, but is missing modifier -51 to indicate multiple procedures were performed. 752.63 correctly identifies the diagnosis for a congenital chordee, and 603.9 correctly indicates the diagnosis for the hydrocele. Missing is 752.61 for the diagnosis for the hypospadias (anomaly of the penis).

88. This gentleman has worsening bilateral hydronephrosis. He did not have much of a post void residual on bladder scan. He is taken to the operating room to have a bilateral cystoscopy and retrograde pyelogram. The results come back as gross prostatic hyperplasia as the cause of the hydronephrosis.

A. 52005, 600.3  
B. 52000, 591, 600.9  
C. 52005-50, 600.91, 591  
D. 52000-50, 591, 600.9

POINT VALUE: 1 point

CORRECT ANSWER:
C. 52005-50 identifies a cystoscopy with bilateral ureteral catheterization and injection of dye for a retrograde pyelogram (x-ray of the kidney and ureter). 600.91 is the correct diagnosis code for hyperplasia of prostate with urinary obstruction. 591 indicates hydronephrosis, which is usually caused by obstruction.

RATIONALE:  
A. 52005 correctly identifies a unilateral cystoscopy and retrograde pyelogram, but a bilateral procedure was performed and requires the use of modifier -50. 600.3 is a cyst of the prostate, not hyperplasia as indicated in the report. The diagnosis code 591, for hydronephrosis, is missing.  
B. 52000 reports a cystourethroscopy and does not report a bilateral procedure nor does it report the retrograde pyelogram. 591 correctly indicates hydronephrosis, and 600.9 correctly indicates hyperplasia of the prostate but requires a fifth digit.  
D. 52000-50 identifies a cystourethroscopy, not a cystoscopy with retrograde pyelogram. Also, the -50 modifier is not indicated on this particular code since it describes an endoscopy of the urethra and bladder alone and does not involve bilateral structures (i.e., ureters). 591 is correctly assigned to report hydronephrosis, and 600.9 is the correct diagnosis for hyperplasia of prostate but requires a fifth digit.

89. This patient is a 42-year-old female who has been having prolonged and heavy bleeding during menstruation.

SURGICAL FINDINGS: On pelvic exam under anesthesia, the uterus was normal size and firm. The examination revealed no masses. She had a few small endometrial polyps in the lower uterine segment.
DESCRIPTION OF PROCEDURE: After induction of general anesthesia, the patient was placed in the dorsolithotomy position, after which the perineum and vagina were prepped, the bladder straight catheterized, and the patient draped. After bimanual exam was performed, a weighted speculum was placed in the vagina and the anterior lip of the cervix was grasped with a single-tooth tenaculum. An endocervical curettage was then done with a Kevorkian curet. The uterus was then sounded to 8.5 cm. The endocervical canal was dilated to 7 mm with Hegar dilators. A 5.5-mm Olympus hysteroscope was introduced using a distention medium. The cavity was systematically inspected, and the preceding findings noted. The hysteroscope was withdrawn and the cervix further dilated to 10 mm. Polyp forceps was introduced, and a few small polyps were removed. These were sent separately. Sharp endometrial curettage was then done. The hysteroscope was then reinserted, and the polyps had essentially been removed. The patient tolerated the procedure well and returned to the recovery room in stable condition. Pathology confirmed benign endometrial polyps.

A. 58558, 57460-51, 626.2, 621.0
B. 58558, 626.2, 621.0
C. 58558, 57558-51, 626.2, 621.0
D. 58558, 626.6, 239.5

POINT VALUE: 1 point

CORRECT ANSWER:

B. 58558 identifies the hysteroscopy with polypectomy and D&C. 626.2 is the diagnosis code for menorrhagia, as indicated in the term "heavy bleeding," and 621.0 is the diagnosis code for the endometrial polyps.

RATIONALE:

A. 58558 is the correct code to report the service of a surgical hysteroscopy with biopsy of the endometrium and a polypectomy. 57460-51 reports a loop electrode biopsy of the cervix, which was not indicated in the report as having been performed. 626.2 and 621.0 are the correct diagnosis codes.

C. 58558 is the correct code to report the service of a surgical hysteroscopy with biopsy of the endometrium and a polypectomy. 57558-51 is a dilation and curettage of a cervical stump, and that procedure was not indicated in the report as the patient had a uterus. 626.2 and 621.0 are the correct diagnosis codes.

D. 58558 correctly identifies the hysteroscopy with polypectomy and D&C, but 626.6 is the code to report the diagnosis of metrorrhagia, which is bleeding not related to menstruation and is not indicated here. 239.5 reports a neoplasm of the uterus of unspecified behavior, and because there is no indication of this in the pathology of the polyp, it would be incorrect to report the behavior as unspecified.
PREOPERATIVE DIAGNOSIS: Missed abortion with fetal demise, 11 weeks.

POSTOPERATIVE DIAGNOSIS: Missed abortion with fetal demise, 11 weeks.

PROCEDURE: Suction D&C.

The patient was prepped and draped in a lithotomy position under general mask anesthesia, and the bladder was straight catheterized; a weighted speculum was placed in the vagina. The anterior lip of the cervix was grasped with a single-tooth tenaculum. The uterus was then sounded to a depth of 8 cm. The cervical os was then serially dilated to allow passage of a size 10 curved suction curette. A size 10 curved suction curette was then used to evacuate the intrauterine contents. Sharp curette was used to gently palpate the uterine wall with negative return of tissue, and the suction curette was again used with negative return of tissue. The tenaculum was removed from the cervix. The speculum was removed from the vagina. All sponges and needles were accounted for at completion of the procedure. The patient left the operating room in apparent good condition having tolerated the procedure well.

A. 59812, 634.92
B. 59812, 638.90
C. 59820, 632
D. 59856, 632

POINT VALUE: 1 point

CORRECT ANSWER:

C. 59820 identifies the suction dilation and curettage (surgical completion) for the treatment of a fetal death (missed abortion) by means of an abortion that was conducted in the first trimester (LPM [last menstrual period] to 12 weeks) of a pregnancy. 632 is the diagnosis for the missed abortion for a fetus of less than 22 weeks' gestation and in which the products of conception (POC) were retained.

RATIONALE:

A. 59812 incorrectly reports the service as a treatment for an incomplete abortion that was surgically completed, which means the abortion began naturally (spontaneously) and was completed surgically; but the case indicated fetal death (missed abortion) that was surgically remedied. 634.92 is assigned to report a complete spontaneous abortion (that occurs naturally) without mention of complications, but the case indicated fetal death and required surgical removal of the products of conception (POC).

B. 59812 incorrectly reports the service as a treatment for an incomplete abortion that was surgically completed, which means the abortion began naturally (spontaneously) and was completed surgically; but the case indicated fetal death (missed abortion) that was surgically remedied. 638.90 is assigned to report an incomplete abortion that was surgically completed, which means the abortion began naturally (spontaneously) and was completed surgically; but the case indicated fetal death (missed abortion) that was surgically remedied.
death (missed abortion) that was surgically remedied. 638.90 reports a failed attempt at an abortion, not a surgical remedy to a missed abortion (fetal death). There is no fifth digit "0" to go with the failed attempted abortion code 638.

D. 59856 incorrectly reports this service as an induced abortion by vaginal suppositories rather than the surgical remedy to a fetal death (missed abortion). 632 correctly reports the diagnosis for the missed abortion for a fetus of less than 22 weeks' gestation and in which the products of conception (POC) were retained.

91. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Right ureteral stricture.

POSTOPERATIVE DIAGNOSIS: Right ureteral stricture.

PROCEDURE PERFORMED: Cystoscopy, right ureteral stent change.

PROCEDURE NOTE: The patient was placed in the lithotomy position after receiving IV sedation. He was prepped and draped in the lithotomy position. The 21-French cystoscope was passed into the bladder, and urine was collected for culture. Inspection of the bladder demonstrated findings consistent with radiation cystitis, which has been previously diagnosed. There is no frank neoplasia. The right ureteral stent was grasped and removed through the urethral meatus; under fluoroscopic control, a guidewire was advanced up the stent, and the stent was exchanged for a 7-French 26-cm stent under fluoroscopic control in the usual fashion. The patient tolerated the procedure well.

A. 51702-LT, 593.3
B. 52005-RT, 595.9
C. 52332-RT, 595.9
D. 52332-RT, 593.3

POINT VALUE: 1 point

CORRECT ANSWER:
D. 52332-RT identifies the ureteral stent change (insertion of stent) on the right side (RT) by cystoscopy. Note that the stent removal is not additionally reported as it is included in the stent placement procedure code. 593.3 is the diagnosis for the ureteral stricture.

RATIONALE:
A. 51702-LT is insertion of a temporary indwelling bladder catheter, but the report indicated that the procedure was a replacement for a previously placed ureteral stent and there was no indication that this stent was temporary. 593.3 is the correct diagnosis for the ureteral stricture.
B. 52005-RT is a cystourethroscopy with insertion of a temporary ureteral catheter, but the report indicated that the procedure was a replacement for a
previously placed ureteral stent and there was no indication that this stent was
temporary. 595.9 reports cystitis that is unspecified, but in this case the
diagnosis is a right ureteral stricture of the bladder.

C. 52332-RT correctly identifies the ureteral stent change (insertion of stent) on
the right side (RT) by cystoscopy. 595.9 reports cystitis that is unspecified, but
in this case the diagnosis is right ureteral stricture.

92. This 41-year-old female presented with a right labial lesion. A biopsy was taken,
and the results were reported as VIN III, cannot rule out invasion. The decision
was therefore made to proceed with wide local excision of the right vulva.

PROCEDURE: The patient was taken to the operating room, and general
anesthesia was administered. The patient was then prepped and draped in the
usual manner in lithotomy position, and the bladder was emptied with a straight
catheter. The vulva was then inspected. On the right labium minora at
approximately the 11 o’clock position, there was a multifocal lesion. A marking
pen was then used to mark out an elliptical incision, leaving a 1-cm border on all
sides. The skin ellipse was then excised using a knife. Bleeders were cauterized
with electrocautery. A running locked suture of 2-0 Vicryl was then placed in the
deeper tissue. The skin was finally reapproximated with 4-0 Vicryl in an
interrupted fashion. Good hemostasis was thereby achieved. The patient
tolerated this procedure well. There were no complications.

A. 56605, 184.4
B. 56625, 233.32
C. 56620, 233.32
D. 11620, 184.4

POINT VALUE: 1 point

CORRECT ANSWER:
C. 56620 identifies the partial excision of the right labium (vulvectomy); as
stated in this case, "a wide local excision of the vulva" was performed.
The diagnosis is VIN III (vulvar intraepithelial neoplasia). Intraepithelial
indicates that the neoplasm is confined to the epithelium and has not
invaded the basement membrane. This is also known as in situ and is
reported with a code from category 233.3. 233.32 is the diagnosis code for
an intraepithelial neoplasia III of the vulva.

RATIONALE:
A. 56605 is a biopsy of the vulva, not an excision of lesions, and 184.4 is a
primary site neoplasm code. No indication was made as to whether this was a
primary or secondary site; rather, it was cancer that was located in situ, or in
the original place, without spreading to neighboring areas.
B. 56625 is a complete vulvectomy, which according to the subsection notes
located before 56405 indicates that for assignment of a complete vulvectomy
code, the area removed would have to have been greater than 80%, and
because there was no indication in the case of that extent, it would be inappropriate to assign this major removal code. 233.32 is the correct diagnosis code for an intraepithelial neoplasia III of the vulva.

D. 11620 is an excision of a malignant lesion from the skin, and the code description includes genitalia; but the report indicated a "wide local excision of the right vulva," and that is not a simple excision of a lesion of the genitalia but rather a vulvectomy. 184.4 is a malignant neoplasm code, and no indication was made as to whether this was a primary or secondary site; rather, it was cancer that was located in situ, or in the original place.

93. This 32-year-old female presents with an ectopic pregnancy. The physician elects to remove the entire fallopian tube with the products of conception laparoscopically.

A. 59120, 633.90
B. 59151, 633.90
C. 58943, 633.10
D. 59120, 633.80

POINT VALUE: 1 point

CORRECT ANSWER:

B. 59151 identifies laparoscopic treatment of an ectopic pregnancy with salpingectomy. 633.90 is the diagnosis code for an unspecified ectopic pregnancy, without intrauterine pregnancy. Note that the physician treated the ectopic pregnancy by removing the fallopian tube. It would seem reasonable to think that this was a tubal pregnancy; but since the location was not specified, the coder must assign the unspecified location code 633.90.

RATIONALE:

A. 59120 incorrectly reports a salpingectomy and an oophorectomy using an abdominal or vaginal approach, and the approach specified in the report was laparoscopic. 633.90 is the correct diagnosis code for an ectopic pregnancy.

C. 58943 incorrectly reports an oophorectomy with a salpingectomy for a malignancy with pelvic lymph node biopsies, washings, and assessment. 633.10 indicates a tubal pregnancy, and the location of the ectopic pregnancy was not specified.

D. 59120 incorrectly identifies the surgical treatment of an ectopic pregnancy with salpingectomy by abdominal or vaginal approach. 633.80 reports "other ectopic pregnancy," such as cervical, mesometric, combined, cornual, or intraligamentous; but the report did not indicate any location other than "ectopic," so the site of the ectopic pregnancy is "unspecified" as reported with 633.90.

Subject Area: 60000 Endocrine System, Hemic and Lymphatic System, Nervous System, Eye and Ocular Adnexa

94. OPERATIVE REPORT
PREOPERATIVE DIAGNOSIS: FUO.

PROCEDURE PERFORMED: Lumbar puncture.

DESCRIPTION OF PROCEDURE: The patient was placed in the lateral decubitus position with the left side up. The legs and hips were flexed into the fetal position. The lumbosacral area was steriley prepped. It was then numbed with 1% Xylocaine. I then placed a 22-gauge spinal needle on the first pass into the intrathecal space between the L4 and L5 spinous processes. The fluid was minimally xanthochromic. I sent the fluid for cell count for differential, protein, glucose, Gram stain, and culture. The patient tolerated the procedure well without apparent complication. The needle was removed at the end of the procedure. The area was cleansed, and a Band-Aid was placed.

A. 62272, 780.91
B. 62268, 780.60
C. 62272, 782.3, 780.60
D. 62270, 780.60

POINT VALUE: 1 point

CORRECT ANSWER:
D. 62270 indicates aspiration of fluid from the spine (lumbar puncture) for diagnostic purposes. 780.60 correctly reports the only diagnosis listed, that of fever of unknown origin.

RATIONALE:
A. 62272 is a therapeutic spinal puncture for drainage of cerebrospinal fluid, but the reason for the puncture was aspiration of fluid to be used in the diagnosis of the condition. 780.91 is a diagnosis of fussy baby, and there is no indication of this in the diagnosis statement in the report.
B. 62268 is a percutaneous aspiration of a spinal cord cyst rather than the lumbar puncture indicated in the report. 780.60 correctly reports the only diagnosis listed, the fever of unknown origin.
C. 62272 indicates aspiration of fluid from the spine (lumbar puncture) but for therapeutic reason rather than for diagnostic purposes. 782.3 reports edema, which is not mentioned in the report; rather, 780.60 correctly reports the only diagnosis listed, the fever of unknown origin.

95. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Mechanical ectropion, left lower eye.

PROCEDURE PERFORMED: Medial tarsorrhaphy, left lower eye.

In the operating room, after intravenous sedation, the patient was given a total of
about 0.5 mL of local infiltrative anesthetic. The skin surfaces on the medial area of the lid, medial to the punctum, were denuded. A bolster had been prepared and double 5-0 silk suture was passed through the bolster, which was passed through the inferior skin and raw lid margin, then through the superior margin, and out through the skin. A superior bolster was then applied. The puncta were probed with wire instrument and found not to be obstructed. The suture was then fully tied and trimmed. Bacitracin ointment was placed on the surface of the skin. The patient left the operating room in stable condition, without complications, having tolerated the procedure well.

A. 67875-LT, 374.12  
B. 67710-LT, 374.11  
C. 67882-LT, 374.10  
D. 67880-LT, 374.12

POINT VALUE: 1 point

CORRECT ANSWER:

D. 67880-LT is an operative procedure in which the surgeon temporarily sutures the eyelid closed; this is used with some conditions of the eyelid in which the margins of the eyelid are rough and irritate the cornea. Before the closure, the surgeon repairs the eyelid, and so when the sutures are removed, the margin irregularity will have been repaired and no longer cause irritation. Modifier -LT indicates that the procedure was performed on the left eye, and 374.12 correctly describes the condition stated in the report of paralytic (mechanical) ectropion.

RATIONALE:

A. 67875-LT is the temporary closing of the eyelid but with no repair of the margins of the eyelid. 374.12 correctly describes the condition stated in the report of paralytic ectropion.

B. 67710-LT is the removal of the sutures that were previously placed to hold the eyelid shut. 374.11 describes senile ectropion, which is not stated in the report.

C. 67882-LT is the construction of the intermarginal lid as in 67880; however, in a 67882 procedure, there is also a transposition of the tarsal plate, which was not mentioned in the report. 374.10 is ectropion that is unspecified, but the ectropion in the report was stated to be paralytic ectropion.

96. Marginal laceration involving the left lower eyelid and laceration of the left upper eyelid involving the tarsus. Both required full-thickness repair. Also, there were multiple stellate lacerations above the left eye, totaling 24.2 cm and requiring full-thickness layered repair. Assign code(s) for the physician service only.

A. 67935-E2, 12017  
B. 67930-E2, 13152-51, 13153  
C. 67935-E2, 67935-E1-51, 12056-51  
D. 67935-E2, 12017-51
POINT VALUE: 1 point

CORRECT ANSWER:
C. 67935 indicates a full-thickness repair of the eyelid margin and tarsus. The code represents repair of a single eyelid. Since 2 lids were lacerated (left lower eyelid margin and left upper eyelid tarsus) and each required full-thickness repair, 67935 is reported twice: once with modifier -E2 to indicate the lower, left eyelid margin repair and once with the modifiers -E1 and -51 modifiers to show left upper eyelid tarsus repair. The -51 modifier indicates that there were multiple procedures. The full-thickness layered repair of the lacerations above the eye measuring 24.2 cm is reported with 12056-51. The -51 modifier is attached to indicate multiple procedures.

RATIONALE:
A. 67935-E2 correctly indicates a full-thickness repair of the left lower eyelid. The code for the left upper eyelid tarsus repair (67935-E1-51) is missing. 12017 is used to report a simple repair, but the case indicated the repair was a layered repair, which would be an intermediate repair (12056-51). Modifier -51 is also missing from 12017.
B. 67930-E2 is a reconstruction of a partial-thickness wound, and the case indicated a full-thickness wound 13152-51 is complex closure of a wound up to 7.5 cm, and no indication was made in the case for a complex repair. 13153 is complex closure of a wound for the additional centimeters greater than 7.5 cm that were reported with 13152; however, there was no complex closure in the case, only a full-thickness layered repair.
D. 67935-E2 correctly indicates a full-thickness repair of the left lower eyelid. The code for the left upper eyelid tarsus repair (67935-E1-51) is missing. 12017-51 reports a simple repair, but the case indicated the repair was a layered full-thickness (intermediate) repair (12056-51).

97. This 66-year-old male has been diagnosed with a senile cataract of the posterior subcapsular and is scheduled for a cataract extraction by phacoemulsification of the right eye. The physician has taken the patient to the operating room to perform a posterior subcapsular cataract extraction with IOL placement, diffuse of the right eye.

A. 66982-RT, 366.09
B. 66984-RT, 366.14
C. 66983-RT, 366.12
D. 66830-RT, 366.14

POINT VALUE: 1 point

CORRECT ANSWER:
B. 66984-RT is the extracapsular cataract extraction (ECCE), in which the
nucleus of the lens capsule and the front (anterior) shell are removed. An intracapsular cataract extraction (ICCE) is when both the lens and the capsule are totally removed intact. Phacoemulsification is a process in which the lens is softened with ultrasound and the fragments are aspirated out of the area and an IOL (intraocular lens) prosthesis is inserted. 366.14 is a posterior subcapsular senile cataract as indicated in the report.

RATIONALE:
A. 66982-RT is an extracapsular cataract removal but one that is more complex than normal, requiring the use of retractors to manually hold the pupil open, which is not stated in the report. 366.09 is a presenile cataract but this patient has a senile cataract.
C. 66983-RT reports an intracapsular cataract extraction, not an extracapsular cataract extraction. 366.12 is an incipient (one that is just beginning to form) cataract.
D. 66830-RT describes an extracapsular cataract procedure in which only the anterior portion of the lens capsule was removed. 366.14 is correct to report a posterior subcapsular senile cataract removal as indicated in the report.

98. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Brain tumor versus abscess.

PROCEDURE: Craniotomy.

DESCRIPTION OF PROCEDURE: Under general anesthesia, the patient's head was prepped and draped in the usual manner. It was placed in Mayfield pins. We then proceeded with a craniotomy. An inverted U-shaped incision was made over the posterior right occipital area. The flap was turned down. Three burr holes were made. Having done this, I then localized the tumor through the burr holes and dura. We then made an incision in the dura in an inverted U-shaped fashion. The cortex looked a little swollen but normal. We then used the localizer to locate the cavity. I separated the gyrus and got right into the cavity and saw pus, which was removed. Cultures were taken and sent for pathology report, which came back later describing the presence of clusters of gram-positive cocci, confirming that this was an abscess. We cleaned out the abscessed cavity using irrigation and suction. The bed of the abscessed cavity was cauterized. Then a small piece of Gelfoam was used for hemostasis. Satisfied that it was dry, I closed the dura. I approximated the scalp. A dressing was applied. The patient was discharged to the recovery room.

A. 61154, 324.0
B. 61154, 239.6
C. 61320, 324.0, 041.89
D. 61150, 239.6
Final Examination With Answers

POINT VALUE: 1 point

CORRECT ANSWER:
C. 61320 identifies a craniotomy with removal of abscess. The report states that the scalp was incised in a U shape. Three burr holes were made. Then the dura was incised in a U-shaped fashion. The creation of the burr holes was followed by a craniotomy; therefore the burr hole procedure is not separately reported. 324.0 is the diagnosis for the intracranial abscess as stated in the report. Gram-positive cocci was confirmed and reported with 041.89.

RATIONALE:
A. 61154 reports burr holes made for the purpose of evacuation of an extradural or subdural hematoma, but the report does not indicate that a hematoma was removed, but rather a craniotomy with the removal of an abscess. 324.0 is the correct diagnosis for the intracranial abscess as stated in the report and 041.89.
B. 61154 reports burr holes made for the purpose of evacuation of an extradural or subdural hematoma, but the report does not indicate that a hematoma was removed, but rather a craniotomy with the removal of an abscess. 239.6 is a neoplasm of the brain, which is not stated in the report.
D. 61150 identifies burr holes with drainage of brain abscess; but in this case, the abscess is removed via a craniotomy. 239.6 is a neoplasm of the brain, which is not stated in the report.

99. This patient is in for a recurrent herniated disc at L5-S1 on the left. The procedure performed is a repeat laminotomy and foraminotomy at the L5-S1 interspace.

A. 63030-LT, 722.10
B. 63030-LT, 722.11
C. 63042-LT, 722.11
D. 63042-LT, 722.10

POINT VALUE: 1 point

CORRECT ANSWER:
D. 63042-LT identifies the reexploration of a lumbar interspace with excision of a herniated disc. Modifier -LT indicates the left side was done. 722.10 is the diagnosis of a herniated lumbar disc.

RATIONALE:
A. 63030-LT is the original procedure, not the repeat procedure described in 63042 and specified in the report. 722.10 is the correct diagnosis of a herniated lumbar disc.
B. 63030-LT is the original procedure, not the repeat procedure described in 63042 and specified in the report. 722.11 is a thoracic disc, not a lumbar disc.
C. 63042-LT correctly identifies the reexploration of a lumbar interspace with excision of a herniated disc. Modifier -LT indicates that the left side was done. 722.11 is a thoracic disc, not a lumbar disc.

100. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Herniated disc L4-5 on the left.

PROCEDURE PERFORMED: Laminotomy, foraminotomy, removal of herniated disc L4-5 on the left.

PROCEDURE: Under general anesthesia, the patient was placed in the prone position and the back was prepped and draped in the usual manner. An incision was made in the skin extending through subcutaneous tissue. Lumbodorsal fascia was divided. The erector spinae muscles were bluntly dissected from the lamina of L4-5 on the left. The interspace was localized. I then performed a generous laminotomy and foraminotomy here, and retracted on the nerve root. It was obvious there was a herniated disc. I removed it, entered the space, and removed degenerating material, satisfied that I had decompressed the root well. There were free fragments lying around beneath the nerve root. We removed all of these. I was able to pass a hockey stick down the foramen across the midline, satisfied I had taken out the large fragments from the interspace at L4-5, and decompressed it well. I irrigated the wound well, put a Hemovac drain in the wound, and then closed the wound in layers using double-knotted 0 chromic on the lumbodorsal fascia with Vicryl 2-0 plain in the subcutaneous tissue, and surgical staples on the skin. A dressing was applied. The patient was discharged to the recovery room.

A. 63030-LT, 722.10  
B. 63012-LT, 722.32  
C. 63047-LT, 722.92  
D. 63047-LT, 63048-LT, 722.10

POINT VALUE: 1 point

CORRECT ANSWER:
A. 63030-LT identifies the posterior approach hemilaminectomy (laminotomy) and foraminotomy with excision of herniated disc from one interspace, lumbar region (L4-5). Modifier -LT indicates the left side. 722.10 is the diagnosis for the herniated disc, lumbar region (L4-5).

RATIONALE:
B. 63012-LT reports a laminectomy with removal of facets, but no mention was made of a facet being removed in the report. Modifier -LT indicates the left, and that is correct. 722.32 incorrectly reports a Schmorl's node of the lumbar region, which is a node type named after a German pathologist, Christian Schmorl.
C. 63047-LT reports a laminectomy, facetectomy, and foraminotomy of a single vertebral segment of the lumbar area, but there was no mention of a laminectomy (excision of posterior arch of a vertebra). 722.92 is an unspecified type of disc disorder of the thoracic region, but the report indicates the condition is of the lumbar region.

D. 63047-LT reports a laminectomy, facetectomy, and foraminotomy of a single vertebral segment of the lumbar area, but there was no mention of a laminectomy (excision of posterior arch of a vertebra). 63048-LT is an add-on code for each segment removed in the laminectomy, facetectomy, and foraminotomy, but only one segment was done, L4-5. 722.10 is the correct diagnosis for a herniated disc of the lumbar region.

101. This patient came in with an obstructed ventriculoperitoneal shunt. The procedure performed was to be a revision of shunt. After inspecting the shunt system, the entire cerebrospinal fluid shunt system was removed and a similar replacement shunt system was placed. Patient has normal pressure hydrocephalus (NPH).

A. 62180, 996.1, 331.3
B. 62258, 996.2, 331.5
C. 62256, 996.2, 331.4
D. 62190, 996.2, 331.5

POINT VALUE: 1 point

CORRECT ANSWER:

B. 62258 identifies the complete removal and replacement of the cerebrospinal shunt system. 996.2 is the diagnosis for a mechanical complication of a nervous system device, ventricular shunt. 331.5 is the correct diagnosis code for normal pressure hydrocephalus.

RATIONALE:

A. 62180 is a ventriculocisternostomy that forms a channel between the ventricles and the cisterna magna to drain cerebral fluid, and was not the procedure performed in this report, which was the removal and replacement of cerebrospinal shunt system. 996.1 incorrectly reports the diagnosis for a mechanical complication of a vascular system device. 331.3 is incorrect because it describes communicating hydrocephalus.

C. 62256 is the removal of a cerebrospinal fluid shunt system without replacement; however, the report indicates a similar replacement shunt system was placed; 996.2 is the diagnosis for a mechanical complication of a nervous system device. 331.4 is incorrect because it describes obstructive hydrocephalus.

D. 62190 reports incorrectly the creation of a cerebrospinal fluid shunt. 996.2 correctly identifies diagnosis of a mechanical complication of a nervous system device. 331.5 is the correct diagnosis code.

102. Burr hole for a left frontal ventricular puncture for implanting catheter, layered repair of 8-cm scalp laceration, and repair of multiple facial and eyelid lacerations
with an approximate total length of 12 cm. Assign code(s) for the physician service only.

A. 61020, 12015-51
B. 61107, 12034-51, 12015-51
C. 61215, 12015-51
D. 61107, 12034-51

POINT VALUE: 1 point

CORRECT ANSWER:
B. 61107 identifies the ventriculostomy for implanting a ventricular catheter. 12034-51 identifies the layered closure 7.6 to 12.5 cm of the scalp. 12015-51 identifies the repair code for the face and eyelid, 7.6 to 12.5 cm. The -51 modifier is added to the 12015 and 12034 to indicate multiple procedures.

RATIONALE:
A. 61020 describes a ventricular catheter placement through a burr hole that was previously established. The report did not indicate that a previous burr hole was used. 12015-51 correctly identifies the repair code for the face and eyelid, 7.6 to 12.5 cm. 12034-51 for the scalp closure was not coded in this report, and it should have been.
C. 61215 incorrectly reports the insertion of a reservoir, pump, or other continuous infusion system that is then connected to a ventricular catheter. 12015-51 correctly identifies the repair code for the face and eyelid, 7.6 to 12.5 cm, with modifier -51 to indicate a multiple procedure. 12034-51 was not coded and should have been to indicate the scalp closure.
D. 61107 correctly reports a twist drill hole that was placed to implant a ventricular catheter. 12034-51 correctly identifies the layered closure 7.6 to 12.5 cm of the scalp and the code for the repair of the face and eyelid. 12015-51 was not coded to report the facial and eyelid repair and should have been.

103. What CPT and ICD-9-CM codes would you assign to report the removal of 30% of the left thyroid lobe, with isthmusectomy? The diagnosis was benign growth of the thyroid.

A. 60210, 226
B. 60220, 237.4
C. 60212, 239.7
D. 60225, 226, 239.7

POINT VALUE: 1 point

CORRECT ANSWER:
A. 60210 identifies a partial unilateral thyroid lobectomy with
Isthmusectomy. You know this is a partial unilateral removal by the statement "30% of the left." Diagnosis code 226 describes a benign growth of the thyroid gland.

**RATIONALE:**

B. 60220 is a total lobectomy with isthmusectomy, not a partial as indicated in the report. Code 237.4 reports a neoplasm of uncertain behavior and the report indicated a benign growth (226).

C. 60212 is a partial lobectomy on one side and subtotal lobectomy on the opposite side with isthmusectomy. Code 239.7 to report a neoplasm of an unspecified nature does not need to be reported. Diagnosis code 226 describes a benign growth of the thyroid gland and is the only code necessary to report.

D. 60225 is a total lobectomy on one side and a subtotal lobectomy on the other side. Diagnosis code 226 describes a benign growth of the thyroid gland and is the only code necessary to report. Code 239.7 to report a neoplasm of an unspecified nature does not need to be reported.

**Subject Area: Evaluation and Management (E/M)**

104. Dr. Black admits a patient with an 8-day history of a low-grade fever, tachycardia, tachypnea, and possible radiologic evidence of basal consolidation of the lung and limited pleural effusion on the left side, per patient as seen at outside clinic several days prior. The patient has also been experiencing swelling of the extremities. The pulse is rapid and thready, as checked by patient on her own during the past couple days. A complete ROS of constitutional factors, ophthalmologic, otolaryngologic, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic was performed and negative except for the symptoms described above. Past history includes tachycardia and pneumonia. Family history includes heart disease, hypertension, and high cholesterol in both parents. The patient drinks only occasionally and quit smoking 4 years ago. The comprehensive examination was performed and diminished bowel sounds were noted. The physician orders laboratory tests and radiographic studies, including a follow-up chest x-ray, as he considers the extensive diagnostic options; the medical decision making complexity is high for this patient.

A. 99233, 780.60, 785.0, 786.06, 511.9, 787.5, V15.82
B. 99233, 780.60, 427.0, 786.06, 486, 511.9
C. 99223, 780.60, 785.0, 786.06
D. 99223, 780.60, 785.0, 786.06, 511.9, 787.5, V15.85, V17.49

**POINT VALUE: 1 point**
CORRECT ANSWER:

D. 99223 reports a hospital admission. The HPI is comprehensive and contains 4 elements of location (lung), duration (8 days), severity (rapid and thready pulse), and associated signs and symptoms (swelling). A complete ROS was performed and found negative. The PFSH included all three elements of past (tachycardia and pneumonia), family (heart disease, hypertension and high cholesterol in both parents), and social (drinks only occasionally and quit smoking 4 years ago). This is a comprehensive history. The description of the service states that this was a hospital admission involving a comprehensive exam and high complexity medical decision making. 780.60 reports a fever not otherwise specified or of unknown origin, 785.0 indicates tachycardia that is unspecified, and 786.06 reports tachypnea. 511.9 is a pleural effusion that is not further specified. 787.5 is abnormal bowel sounds, used to report "feeble bowel sounds." V15.82 reports the patient's history of tobacco use and V17.49 reports the patient's pertinent family history of cardiovascular disease.

RATIONALE:

A. 99233 is incorrect because it reports a subsequent hospital service, when the service was a hospital admission. All other codes are correct. Missing from the diagnostic codes is the patient's family history of cardiovascular disease, V17.49.

B. 99233 is incorrect because it reports a subsequent hospital service, when the service was a hospital admission. 780.60 is correct for the fever. 427.0 reports paroxysmal tachycardia and 486 reports pneumonia but neither of these were specified in the report; rather, tachycardia (785.0), tachypnea (786.06), and pleural effusion (511.9) were indicated in the report. Missing from the list of diagnoses is 787.5 to report the "feeble" bowel sounds. Also missing is V15.82 to report the patient's history of tobacco use and V17.49 to report the patient's pertinent family history of cardiovascular disease.

C. 99223 is the correct code for the admission. The diagnoses codes are correct; but missing from this answer are codes to report pleural effusion (511.9) and abnormal bowel sounds (787.5). Also missing is V15.82 to report the patient's history of tobacco use and V17.49 to report the patient's pertinent family history of cardiovascular disease.

105. Bill, a retired U.S. Air Force pilot, was on observation status 12 hours to assess the outcome of a fall from the back of a parked pickup truck into a gravel pit.

History of Present Illness: The patient is a 42-year-old gentleman who works at the local garden shop. He explained that yesterday he fell from his pickup truck as he was loading gravel for a landscaping project. He lost his footing when attempting to climb from the pickup bed and fell approximately 4 feet and landed on a rock that was protruding from the ground 4 inches, striking his head on the
rock. He did not lose consciousness, but was dizzy. He subsequently developed a throbbing headache (8/10) and swelling at the point of impact. The duration of the dizziness was approximately 10 minutes. The headache persisted for 26 hours after the fall. He did take ibuprofen without significant improvement in the pain level.

Review of Systems: Constitutional, eyes, ears, nose, throat, lungs, cardiovascular, gastrointestinal, skin, neurologic, lymphatic, and immunologic negative except for HPI statements. PFSH: He is married and has 2 children. He has been working at the garden shop for 4 years. He currently smokes one pack of cigarettes a day and has smoked for 10 years. His father died of heart disease when he was 52. He has one brother with ankylosing spondylitis and one sister who is healthy as far as he knows. His mother died when he was 14 years old. He is currently on no prescribed medications. A comprehensive exam is documented and rendered. The medical decision making is of low complexity.

The physician discharged Bill from observation that same day after 10 hours, after determining that no further monitoring of his condition was necessary. The physician provided a detailed examination and indicated that the medical decision making was of a low complexity.

A. 99218, 784.0, E888.8
B. 99234, V71.4, E884.9
C. 99217, V71.4, E888.8
D. 99234, 99217, 784.0, E884.9

POINT VALUE: 1 point

CORRECT ANSWER:

B. 99234 correctly reports an observation service, when the patient was admitted and discharged on the same day. The HPI contains 7 elements of location (head), quality (throbbing), severity (8/10), duration (yesterday), timing (on impact), context (fell from pickup bed), modifying factors (ibuprofen), associated signs and symptoms (swelling). This HPI was comprehensive. The ROS was comprehensive and included 10 elements—constitutional, eyes, ears/nose/throat, lungs, cardiovascular, gastrointestinal, skin, neurologic, lymphatic, and immunologic were noted as being negative. All 3 elements of the PFSH were reviewed for a comprehensive PFSH. The history was comprehensive. The examination was detailed. The medical decision making was low complexity.

V71.4 reports observation of a patient for an accident that is not otherwise specified because no diagnosis or symptom was stated in the report and the condition requiring observation was ruled out, and E884.9 is a fall from one level to another level from a stationary vehicle.

RATIONALE:
A. 99218 is an initial observation care service and at the correct level; however, the CPT indicates within the notes preceding 99218 that "For a patient admitted and discharged from observation or inpatient status on the same date, the service should be reported with codes 99234-99236." Bill was admitted and discharged from observation status on the same day, so 99218 would not be correct to report the observation service; rather the service would be reported with 99234. 784.0 is the correct ICD-9-CM code to indicate a headache; however, the patient was admitted for observation of a closed head injury later determined not to exist. The correct ICD-9-CM code to indicate observation of a patient after an accident is V71.4. E888.8 is an accidental fall that is not otherwise specified, but this case indicated that the fall was from a pickup truck.

C. 99217 is a discharge from observation care; however, the code description indicates that "For a patient admitted and discharged from observation or inpatient status on the same date, the service should be reported with codes 99234-99236." Bill was admitted and discharged from observation status on the same day and the service should have been reported with 99234. V71.4 is correct for the observation of a patient for an accident. E888.8 is an accidental fall that is not otherwise specified, but this case indicated that the fall was from a pickup truck (stationary vehicle).

D. 99234 is the correct code to report the admission and discharge from observation on the same day; however, 99217, discharge service, is not necessary because 99234 already reported the discharge service along with the admission service. 784.0 is the correct ICD-9-CM code to indicate a headache; however, the patient was admitted for observation of a closed head injury later determined not to exist. The correct ICD-9-CM code to indicate observation of a patient after an accident is V71.4. E884.9 is correct for a fall from one level to another level from a stationary vehicle.

106. A gynecologist admits an established patient, a 35-year-old female with dysfunctional uterine bleeding, after seeing her in the clinic that day. During the course of the history, the physician notes that the patient has a history of infrequent periods of heavy flow. She has had irregular heavy periods and intermittent spotting for 4 years. The patient has been on a 3-month course of oral contraceptives for symptoms with no relief. The patient states that she has occasional headaches. A complete ROS was performed, consisting of constitutional factors, ophthalmologic, otolaryngologic, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic which were all negative, except for the symptoms described above. The family history is positive for endometrial cancer, with mother, two aunts, and two sisters who had endometrial cancer. The patient has a personal history of cervical and endometrial polyp removal 3 years prior to admission. The patient states that she does not smoke and only drinks socially. As a part of the comprehensive examination, the physician notes the patient has a large amount of blood in the vault and an enlarged uterus. The prolonged
hemorrhaging has resulted in a very thin and friable endometrial lining. The physician orders the patient to be started on intravenous Premarin and orders a full laboratory workup. The medical decision making is of moderate complexity.

A. 99215, 99222, V13.29, V16.49
B. 99222, 626.8, V13.29, V16.49
C. 99215, 99222, 623.8, V13.29, V16.4
D. 99222, 626.1, V16.49

POINT VALUE: 1 point

CORRECT ANSWER:

B. 99222 reports a hospital admission. The HPI is comprehensive and contains 5 elements: Location (uterus), timing (infrequent, irregular, and intermittent), duration (4 years), modifying factors (oral contraceptives), and associated signs and symptoms (headaches). A complete or comprehensive ROS was performed and was negative. The PFSH included all 3 elements of past (cervical and endometrial polyp removal), family (mother, two aunts, and two sisters who had endometrial cancer), and social (does not smoke and drinks socially). The physical exam was comprehensive, with a moderate level of complexity of medical decision making. The patient had “irregular heavy periods and intermittent spotting,” infrequent menses, which are symptoms of the stated diagnosis of dysfunctional uterine bleeding; therefore, 626.8 is the only code necessary to report the diagnosis. V13.29 reports a personal history of disorders of the genital system (endometrial and cervical polyps) that might contribute to this current problem, and V16.49 reports a family history of malignant neoplasms of the uterus.

RATIONALE:

A. The patient is seen in the clinic and then the same day admitted to the hospital. The office visit (99215) is bundled into the initial hospital admission service of 99222 and not reported separately. The V codes are correct; however, diagnosis code 626.8 to report DUB is missing.
C. 99215 reports an office visit. Because the patient was seen in the clinic and then on the same day was admitted to the hospital, the office visit is bundled into the initial hospital admission service (99222) and not reported separately. 623.8 is incorrect as this diagnosis reports hemorrhage and other noninflammatory disorders of the vagina. V13.29 is correct because it reports the personal history of disorders of the genital system. V16.4 reports a family history of malignant neoplasm of the genital organs, but the fourth digit of "9" is necessary to indicate "Other." You must always code to the highest level of specificity.
D. 99222 is correct for the hospital admission; 626.1 is incorrect because it reports scanty or infrequent menstruation, and the primary reason the patient...
is being admitted is excessive irregular bleeding with intermittent spotting, which are symptoms of DUB (626.8). V16.49 correctly reports a family history of malignant neoplasm of the uterus. Omitted from this choice is personal history of disorders of the genital system (endometrial and cervical polyps), reported with V13.29.

107. Karra Hendricks, a 37-year-old female, is an established patient who presents to the office with right lower quadrant abdominal pain with fever. The patient states she has had the pain for 3 days. She has taken Tylenol for her fever with some relief. The patient does have occasional diarrhea and headaches. She smokes approximately 5-10 cigarettes a day and drinks socially. The physician performs a detailed examination. The medical decision making is noted to be of a moderate complexity.

A. 99203, 789.03  
B. 99213, 789.04, 780.60  
C. 99214, 789.03, 780.60  
D. 99221, 789.05, 780.60

POINT VALUE: 1 point

CORRECT ANSWER:

C. 99214 reports an office visit. This is an established patient as stated in the first sentence of the report. The HPI included the location (right lower abdominal quadrant), duration (3 days), modifying factors (Tylenol), and associated signs and symptoms (fever) for a detailed HPI. The ROS included two elements of gastrointestinal (diarrhea) and neurologic (headaches) for a detailed ROS. Only one of the elements of the PFSH was performed (social history) for a detailed PFSH. Even though the HPI is comprehensive, the other two items of this component are detailed. This is a detailed history. The note also included a detailed physical examination with medical decision making of moderate complexity. 789.03 is the correct diagnosis code for right lower quadrant pain and 780.60 is the correct code to report the fever.

RATIONALE:

A. 99203 reports a service to a new patient and the patient in this case was established. 789.03 is correct to report the right lower quadrant pain, but the code to report the fever is missing (780.60).

B. 99213 reports an established patient office visit but at too low a level. The history in this case was detailed, the examination was detailed, and the medical decision making was of moderate complexity. This level of service should have been reported with
99214. 789.04 is incorrect because it describes left lower quadrant pain and the case indicated right lower quadrant pain. 780.60 is correct to report the fever.

D. 99221 is incorrect as it reports an initial hospital care service and the patient in this case was seen in the office. 789.05 is incorrect as it describes periumbilical pain and the pain in this case was in the right lower quadrant (789.03). 780.60 is correct to report the fever.

108. A neurological consultation in the emergency department of the local hospital is requested by the ED physician for a 25-year-old male with suspected closed head trauma. The neurologist saw the patient in the ED. The patient had a loss of consciousness this morning after receiving a blow to the head in a basketball game. He presents to the emergency department with a headache, dizziness, and confusion. During the course of the history, the patient relates that he has been very irritable, confused, and has had a bit of nausea since the incident. All other systems reviewed and are negative: Constitutional, ophthalmologic, otolaryngologic, cardiovascular, respiratory, genitourinary, musculoskeletal, integumentary, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic. The patient states that he does have a history of headaches and that both parents have hypertension, also a grandfather with heart disease. He also states that he does drink beer on the weekends and does not smoke. Physical examination reveals the patient to be unsteady and exhibiting difficulty in concentration when stating months in reverse. The pupils dilate unequally (anisocoria). The physician continues with a complete comprehensive examination involving an extensive review of neurological function. The neurologist orders a stat CT and MRI. The physician suspects a subdural hematoma or an epidural hematoma and the medical decision making complexity is high. The neurologist admits the patient to the hospital. Assign codes for the neurologist's services only.

A. 99285, 780.09, 780.4, 784.0
B. 99253, 784.0, 780.09, 780.4
C. 99255, 379.41, 784.0, 298.9, 780.4, E917.0, E007.6
D. 99245, 784.0, 780.09, 780.4, E917.0, E007.6

POINT VALUE: 1 point

CORRECT ANSWER:

C. 99255 reports a consultation that takes place in an outpatient department (emergency department) but is followed by an admission to the hospital. Code the inpatient consultation code. The HPI included 4 elements of location (head), timing (this morning), context (basketball game), associated signs and symptoms (loss of consciousness) for an extended HPI. The ROS
is complete stating 2 elements of gastrointestinal (nausea) and neurologic (confusion) and all other systems negative for a complete ROS. All 3 of the PFSH elements were included for a complete PFSH. This is a comprehensive history. The service also includes a comprehensive physical exam with high level medical decision making. Code 379.41 reports anisocoria, or uneven pupils. 784.0 describes headache symptom, code 298.9 describes confusion state, and code 780.4 describes dizziness. The E codes report that the accident occurred when the patient was struck while playing basketball.

RATIONALYSIS:
A. 99285 is an emergency department service; the patient was admitted and all outpatient services are rolled into inpatient code. E codes describing the cause of the injury are missing here.
B. 99253 is an inpatient consultation, but documentation supported a higher level of service. E codes describing the cause of the injury are missing here.
D. 99245 is an outpatient consultation, and the service was provided in an outpatient setting but progressed to an inpatient admission. Diagnosis code 780.09 is inaccurate because it describes an alteration in consciousness.

109. Dr. Stephanopolis makes subsequent hospital visits to Salanda Ortez, who has been in the hospital for primary viral pneumonia. She was experiencing severe dyspnea, rales, fever, and chest pain for over a week. The patient states that this morning she had nausea and her heart was racing while she was experiencing some dyspnea and SOB. The chest radiography showed patchy bilateral infiltrates and basilar streaking. Sputum microbiology was positive for a secondary bacterial pneumonia. An expanded problem-focused physical examination was performed. The medical decision making was moderate. The patient was given intravenous antibiotic as treatment for the bacterial pneumonia.

A. 99233, 786.09, 786.7, 780.60, 729.1, 786.50, 793.19, 795.39
B. 99232, 482.9, 480.9
C. 99221, 786.09, 786.7, 780.60, 729.1, 786.50, 793.19, 795.39
D. 99234, 482.89

POINT VALUE: 1 point

CORRECT ANSWER:
B. 99232 reports a subsequent hospital care service. The interval history for this subsequent visit includes the HPI which is comprehensive and
contains 4 elements of location (heart), quality (racing), timing (this morning), and associated signs and symptoms (nausea). The ROS included 3 systems of cardiovascular (tachycardia), respiratory (dyspnea, SOB), and gastrointestinal (nausea). None of the PFSH elements were reviewed. This is an expanded problem-focused history. The physical examination was expanded problem-focused with moderate complexity of medical decision making. The diagnoses are correctly reported with 482.9 for unspecified bacterial pneumonia and 480.9 for viral pneumonia.

RATIONALE:

A. 99233 incorrectly reports the subsequent hospital care service, the MDM was of moderate complexity and code 99233 requires a detailed H&P and high-complexity MDM. The diagnosis codes are the symptoms stated in the report which is incorrect because more definitive diagnoses are stated (bacterial and viral pneumonia, 482.9, 480.9). Signs and symptoms of the condition are not reported when they are related to more specific diagnoses.

C. 99221 is incorrect as it reports an initial hospital care service, not a subsequent care service. The diagnosis codes are the symptoms stated in the report, when there are more specific diagnoses stated (bacterial and viral pneumonia, 482.9 and 480.9). Signs and symptoms of the condition are not reported when they are related to more specific diagnoses.

D. 99234 is incorrect as it reports an observation admission and discharge service, not a subsequent hospital visit. The diagnosis code for bacterial pneumonia (482.89) is incorrect because it represents pneumonia due to a specified type of bacteria. The bacteria in this case is not specified; therefore the correct code is 482.9 (unspecified bacterial pneumonia). The code for viral pneumonia (480.9) is missing in this choice.

110. An obstetrician is requested to provide an office consultation to a 23-year-old female with first-trimester bleeding from Dr A. The patient presents with a history of brownish discharge and occasional pinkish discharge. During the history, the patient relates that she has had suprapubic pain in the past week and cramping. She states her pain is 8/10. She has felt nausea and has vomited on three occasions. On one occasion, the nausea was accompanied by dizziness and vertigo. All other systems are negative at this time and included: Constitutional factors, ophthalmologic, otolaryngologic, cardiovascular, respiratory, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic. The PFSH included patient history of tonsillectomy with family history of breast cancer on her mother’s side. The patient does not smoke or drink. The physician conducts a comprehensive examination focused on the chief complaint and related systems. The uterus is found to be soft and involuted. There is cervical motion tenderness and
significant abdominal tenderness on palpation. A left pelvic mass is palpated in
the left quadrant. The physician orders a pelvic ultrasound, a complete CBC,
and differential. Considering the range of possible diagnoses, the medical
decision making complexity is high.

A. 99255, 634.91, 719.65
B. 99242, 634.90, 719.65
C. 99245, 640.93, 789.34
D. 99245, 649.53, 789.34

POINT VALUE: 1 point

CORRECT ANSWER:

C. 99245 reports an outpatient consultation. The HPI included 4 elements of
location (suprapubic), severity (8/10), duration (week), associated signs and
symptoms (nausea/vomiting, dizziness) for a comprehensive HPI. A
complete ROS was performed for a comprehensive ROS. All 3 PFSH
elements were included for a comprehensive PFSH. This is a
comprehensive history. The note included a comprehensive physical
examination with a high level of medical decision-making complexity.
The diagnosis is bleeding (hemorrhage) during first-trimester
pregnancy, reported with 640.93 for hemorrhage in early (before 22
completed weeks of gestation) pregnancy. Code 789.34 describes the
left pelvic mass.

RATIONALE:

A. 99255 is a consultation at the correct levels for each of the key components
but is provided in an inpatient setting rather than an outpatient setting. 634.91
is incorrect because the code reports an incomplete abortion without
complication. Code 719.65 is inaccurate because it describes pelvic joint
mass.
B. 99242 is an outpatient consultation, but at an incorrect level. 634.90 is
incorrect because it reports an unspecified abortion without complication.

D. 99245 is the correct code for the consultation. 649.53 is incorrect
because the patient’s condition is specific to hemorrhage in early
pregnancy. The correct code is 640.93 to report bleeding (hemorrhage)
during first-trimester pregnancy.

111. Dr. Martin admits a 65-year-old female patient to the hospital to rule out acute
pericarditis following a severe viral infection. The patient has complained of
retrosternal, sharp, intermittent pain of 2 days' duration that is reduced by sitting
up and leaning forward, accompanied by tachypnea. ROS: She does not currently
have chest pain but is complaining of shortness of breath. She states that her legs
and feet have been swollen of late. She reports no change in her vision or her
hearing, and she has not had a rash. No dyspnea stated. PFSH: She states that she has had an echocardiogram in the past when she complained of chest tightness and her family physician gave her some medication, but she is not certain what it was. She has three adult children, all healthy. Her husband is deceased. She does not smoke or consume alcohol. Her father died at age 69 from congestive heart failure and her mother died of influenza at 70. Refer to the admission form for a list of current medications. The examination was detailed. The medical decision making was of high complexity.

A. 99236, 786.51, 786.06, 786.05
B. 99223, 420.91, 411.1, 442.9, 415.19, 530.9
C. 99245, 420.91, 411.1, 442.9, 415.19, 530.9
D. 99221, 786.51, 786.06, 786.05

POINT VALUE: 1 point

CORRECT ANSWER:

D. 99221 reports a hospital admission. The HPI is comprehensive and contains 6 elements of location (retrosternal), quality (sharp), timing (intermittent), duration (2 days), modifying factors (sitting up, leaning forward) and associated signs and symptoms (viral infection, tachypnea). The ROS was detailed, which included 5 systems: Cardiovascular (chest pain, swollen legs and feet), respiratory (shortness of breath), ophthalmologic (no change in vision), otolaryngologic (hearing), and integumentary (no rash). The PFSH included all three elements. While the HPI and PFSH were documented at the comprehensive level, the ROS was not complete; therefore the history level is detailed. The examination was detailed and the medical decision making is of a high level of complexity. Code 99221 meets these key components (3 of 3 met or exceeded).

786.51 reports the retrosternal pain, 786.06 reports the tachypnea, and 786.05 reports the shortness of breath. The physician’s professional evaluation and management service is reported with the codes for definitive diagnoses, signs, or symptoms. Possible, probable, and rule-out diagnosis codes are not assigned for physician reporting.

RATIONALE:

A. 99236 is incorrect because it is an observation code used when the patient is placed on observation and discharged on the same day. Because the patient in this case was admitted to the hospital, not on observation status, 99236 is not correct to report the service. The diagnoses codes are correct because 786.51 reports the retrosternal pain, 786.06 reports the tachypnea, and 786.05 reports the shortness of breath. The physician’s professional...
evaluation and management service is reported with the codes for definitive diagnoses, signs, or symptoms. Possible, probable, and rule-out diagnosis codes are not assigned for physician reporting.

B. 99223 is in the correct category of E/M code but is the incorrect level for the initial inpatient service. The diagnosis codes are the possible conditions rather than the more specific reasons for the service (i.e., retrosternal pain and tachypnea). Correct diagnoses codes would be 786.51 to report the retrosternal pain, and 786.06 to report the tachypnea. The physician’s professional evaluation and management service is reported with the codes for definitive diagnoses, signs, or symptoms. Possible, probable, and rule-out diagnosis codes are not assigned for physician reporting.

C. 99245 is incorrect because it is an office consultation and not a hospital admission. The diagnosis codes are incorrect because they are the possible conditions rather than the more specific reasons for the service (i.e., retrosternal pain and tachypnea). Correct diagnoses codes would be 786.51 to report the retrosternal pain, and 786.06 to report the tachypnea. The physician’s professional evaluation and management service is reported with the codes for definitive diagnoses, signs, or symptoms. Possible, probable, and rule-out diagnosis codes are not assigned for physician reporting.

112. A 57-year-old male was sent by his family physician to a urologist for an office consultation due to hematuria. The patient has had bright red blood in his urine sporadically for the past 3 weeks. His family physician gave him a dose of antibiotic therapy for urinary tract infection; however, the symptom still persists. The patient states that he does experience some lower back discomfort when urinating, with no fever, chills, or nausea. The patient is currently taking Lotrel 10/20 for his hypertension, which is stable at this time, and has allergies to Sulfa. The urologist performs a detailed history and physical examination. The urologist recommends a cystoscopy to be scheduled for the following day and discusses the procedure and risks with the patient. The urologist also contacted the family physician with the recommendations and is requested to proceed with the cystoscopy and any further follow-up required. The medical decision making is of moderate complexity. A report was sent to attending physician. Report only the office service.

A. 99243, 599.70, 724.2
B. 99244-57, 52000, 599.0, 724.2
C. 99253, 599.9, 724.2
D. 99221, 599.70, 724.2

POINT VALUE: 1 point

CORRECT ANSWER:

A. 99243 is a consultation provided in an outpatient setting. The HPI
included the 4 elements of duration (3 weeks), timing (sporadically), modifying factors (antibiotics), and associated signs and symptoms (lower back discomfort) for a comprehensive HPI. There were 2 elements in the ROS of constitutional (fever, chills) and gastrointestinal (nausea) for a detailed ROS. The PFSH included past history (current medications and allergies) for a detailed PFSH. This represents a detailed history. The note indicates a detailed examination was performed with moderate medical decision making complexity. 599.70 is the correct diagnosis code for hematuria (blood in urine). Code 724.2 describes the low back pain.

RATIONALE:

B. 99244 is a comprehensive history and examination and a moderate complexity of medical decision making. While the decision making supports a 99244 level, the history and examination do not. Since all three key components must be present to assign a code in this category of E/M codes, 99243 is the correct code to report this service. Modifier -57 is incorrectly assigned to indicate that a decision for surgery was made during the visit, the cystoscopy procedure has no global period. 52000 reports a cystoscopy and the procedure was ordered but not indicated to have been performed, only to have been scheduled. 599.0 is incorrect because it reports a urinary tract infection.

C. 99253 is an inpatient hospital consultation, not an office consultation as indicated in the case. 599.9 is incorrect because it describes unspecified urinary tract disorder.

D. 99221 is an initial hospital care service reported by an attending. The purpose of this service was for a consultant to assist the family physician in diagnosing the condition responsible for the bright red blood in the urine. 599.70 is the correct diagnosis code.

113. A 56-year-old established male patient presents to his family physician for a preventive checkup at the local outpatient clinic. The physician conducts a multisystem history and physical examination, and the checkup takes 45 minutes.

A. 99214, V70.4
B. 99403, V70.7
C. 99386, V70.0
D. 99396, V70.0

POINT VALUE: 1 point

CORRECT ANSWER:
D. 99396 correctly reports a periodic comprehensive preventive medicine examination of an established patient. You know this patient is established by the statement "his family physician." The term comprehensive, when used with a preventive medicine examination, indicates an examination that is appropriate to the age and gender of the patient and is not related to the term comprehensive as used in other codes in the E/M section. So the statements about the level of history and physical examination are not necessary to assign a preventive medicine code. This patient is 56 years old, which is the age range for this code, 40 to 64 years old. V70.0 is the correct code to assign for a routine health examination.

RATIONALE:

A. 99214 is an office visit that includes a detailed history and physical; however, the service in this case was a preventive medicine service and as such an office visit code is incorrect to report the service described in the case. V70.4 is incorrect because it describes an examination for medicolegal purposes.

B. 99403 is individual preventive medicine counseling, not an examination of the patient. V70.7 is incorrect because it describes an examination of a participant in a research or clinical trial.

C. 99386 is a periodic comprehensive preventive medicine examination but for a new patient, and the case indicated an established patient. V70.0 is the correct diagnosis code.

Subject Area: Anesthesia

114. Which HCPCS modifier indicates an anesthesia service in which the anesthesiologist medically directs one CRNA?

A. -QX  
B. -QY  
C. -QZ  
D. -QK

POINT VALUE: 1 point

CORRECT ANSWER:  
B. -QY is for an anesthesia service in which the anesthesiologist medically directs one CRNA.

RATIONALE:

A. -QX is the service of a CRNA (certified registered nurse anesthetist) with medical direction by a physician, not specifically by an anesthesiologist.  
C. -QZ is for a CRNA service without medical direction by a physician.  
D. -QK is appended to the anesthesia CPT code to report the anesthesiologist's
medical direction of two to four concurrent anesthesia cases involving qualified individuals (CRNA or AA).

115. This is the anesthesia formula:

A. B + M + P
B. B + M + P
C. B + T + M
D. B + T + N

POINT VALUE: 1 point

CORRECT ANSWER:  
C. B + T + M is the anesthesia formula meaning base unit, time, and modifying unit.

RATIONALE:
A. B + M + P is incorrect; the formula is B + T + M as stated in choice C
B. B + P + M is incorrect; the formula is B + T + M as stated in choice C
D. B + T + N is incorrect; the formula is B + T + M as stated in choice C

116. Anesthesia service for a pneumocentesis for lung aspiration, 32420.

A. 00522
B. 00500
C. 00520
D. 00524

POINT VALUE: 1 point

CORRECT ANSWER:  
D. 00524 is for anesthesia for a pneumocentesis for lung aspiration, 32420.

RATIONALE:
A. 00522 is anesthesia for a needle biopsy of the pleura.
B. 00500 is anesthesia for a procedure on the esophagus.
C. 00520 is for anesthesia for a closed chest procedure that has not been specified.

117. If the anesthesia service were provided to a patient who had severe systemic disease, what would the physical status modifier be?

A. P1
B. P2
C. P3
D. P4
POINT VALUE: 1 point

CORRECT ANSWER:
C. P3. The physical status modifiers are found in the Anesthesia section guidelines of the CPT manual. The modifiers are assigned based on the patient’s condition at the time of surgery. P3 represents a patient with a severe systemic disease.

RATIONALE:
A. P1 indicates a normal healthy patient.
B. P2 indicates a patient with a mild systemic disease.
D. P4 indicates a patient with severe systemic disease in constant threat of life.

118. This type of anesthesia is also known as a nerve block.

A. Local
B. Epidural
C. Regional
D. MAC

POINT VALUE: 1 point

CORRECT ANSWER:
C. Regional is also known as a nerve block.

RATIONALE:
A. Local is incorrect as it is the application to an area.
B. Epidural is incorrect as it is between vertebral spaces.
D. MAC is incorrect as it is monitored anesthesia care.

119. The following is the anesthesia formula:

A. BTC
B. TBC
C. BTQ
D. BTM

POINT VALUE: 1 point

CORRECT ANSWER:
D. BTM. The anesthesia formula is B for base units, T for time, and M for modifying units, which are added together and multiplied by the conversion factor to determine change.

RATIONALE:
A. not the anesthesia formula
B. not the anesthesia formula
C. not the anesthesia formula

120. Anesthesia service includes the following care:

A. Preoperative, intraoperative
B. Preoperative, intraoperative, postoperative
C. Intraoperative, postoperative
D. Preoperative, postoperative

POINT VALUE: 1 point

CORRECT ANSWER:
B. The anesthesia service includes the preparation of the patient to receive anesthesia (preoperative), during the procedure (intraoperative), and the time after the procedure until the patient is awake (postoperative).

RATIONALE:
A. The selection does not include all the postoperative care.
C. The selection does not include all the preoperative care.
D. The selection does not include all the intraoperative care.

121. What qualifying circumstances code would be used to identify the administration of anesthesia that is complicated by an emergency condition?

A. 99100
B. 99116
C. 99135
D. 99140

POINT VALUE: 1 point

CORRECT ANSWER:
D. The guideline for qualifying circumstances codes are found in the Anesthesia section guidelines of the CPT manual. The codes, however, are located in the Medicine section of the CPT manual. These codes identify those situations that make the administration of the anesthesia more difficult. Emergency conditions are identified by the use of 99140.

RATIONALE:
A. 99100 indicates extreme age.
B. 99116 indicates total body hypothermia.
C. 99135 indicates controlled hypotension.

Subject Area: 70000 Radiology

122. EXAMINATION OF: Right hip.

DIAGNOSIS: Primary unilateral osteoarthritis right hip.
ONE-VIEW RIGHT HIP: A single frontal view is obtained of the right hip. No previous studies are available for comparison. Right hip arthroplasty is seen. Alignment appears grossly unremarkable on this single view. There are skin staples present. Air is seen in the soft tissues, likely due to recent surgery. There appear to be two drains present. The tip of one overlies the soft tissues superolateral to the greater trochanter. The second one is more inferior. The tip overlies the right proximal femoral prosthesis.

IMPRESSION: Single view of the right hip with findings consistent with recent right total hip arthroplasty.

A. 72100, 719
B. 73500-RT, 715.95
C. 72100-26, 715.9
D. 73500-26-RT, 715.95, V43.64

POINT VALUE: 1 point

CORRECT ANSWER:

D. 73500-26-RT identifies the physician component (-26 modifier) of the unilateral or one-view radiological exam of the right hip, with modifier -RT{ED: need to re-set break so hyphen is on the same line as RT?} indicating the right side. 715.95 is the diagnosis for osteoarthritis of the pelvic region or thigh. V43.64 is the diagnosis for status post hip arthroplasty.

RATIONALE:

A. 72100 is an x-ray of the lumbar spinal area, not the hip. 719 is a derangement of an unspecified joint, not the osteoarthritis indicated in the report, and 719 requires a fourth and fifth digit. The code for status post hip arthroplasty (V43.64) is missing.

B. 73500-RT correctly identifies the unilateral or one-view radiological exam but does not have the professional component modifier -26 added. 715.95 correctly reports osteoarthritis of the pelvic region or thigh. The code for status post hip arthroplasty (V43.64) is missing.

C. 72100-26 is an x-ray of the lumbar spinal area, not the hip, but with the correct use of modifier -26. Missing is modifier -RT to indicate right. 715.9 reports osteoarthritis, which is the correct code; however, this code needs the fifth digit "5" to specify the area, which is the hip (pelvic region or thigh). The code for status post hip arthroplasty (V43.64) is missing.

123. EXAMINATION OF: Cervical spine.

CLINICAL SYMPTOMS: Herniated disc.
FINDINGS: A single spot fluoroscopic film from the operating room is submitted for interpretation. The cervical spine is not well demonstrated above the level of the inferior aspect of C6. There is a metallic surgical plate seen anterior to the cervical spine. The cephalic portion of the plate is at the level of C6 at its superior endplate. That extends in an inferior direction, presumably anterior to C7; however, there is not adequate visualization of C7 to confirm location. Density overlies the C6-7 intervertebral disc space, suggesting the presence of a bone plug in this area; however, again visualization is not adequate in this area. Further evaluation with plain radiographs is recommended.

A. 72100-26, 722.10
B. 722020-26, 722.0
C. 72100-52-26, 722.0
D. 72020-52-26, 722.11

POINT VALUE: 1 point

CORRECT ANSWER:

B. 72020-26 identifies the physician component (-26 modifier) of a radiological examination of the spine at a specified level with a single view. 722.0 is the diagnosis code for a herniated disc of the cervical spine.

RATIONALE:

A. 72100-26 reports a lumbosacral spine radiological examination, not of the cervical area as indicated in the report; modifier -26 has been correctly used to indicate the professional component of the service, and 722.10 reports an intervertebral disc disorder of the lumbar spine rather than the cervical spine. (Myelopathy, referred to in 722, is a dysfunction due to compression of the spinal cord.)

C. 72100-52-26 reports a lumbosacral spine radiological examination, not of the cervical area as indicated in the report; modifier -26 has been correctly used to indicate the professional component of the service, but modifier -52 (reduced service) is incorrectly used because there was no indication of a reduction in service. 722.0 is the correct diagnosis code for a herniated disc of the cervical spine.

D. 72020-52-26 correctly identifies the physician component (-26 modifier) of a radiological examination of the spine at specified level with a single view; however, modifier -52 (reduced service) is incorrectly used because there was no indication in the report of a reduction of service. 722.11 reports an intervertebral disc disorder of the thoracic spine rather than of the cervical spine. (Myelopathy referred to in 722 is a dysfunction due to compression of the spinal cord.)

124. This patient undergoes a gallbladder sonogram due to epigastric pain. The report indicates that the visualized portions of the liver are normal. No free fluid noted within Morison's pouch. The gallbladder is identified and is empty. No evidence of
wall thickening or surrounding fluid is seen. There is no ductal dilatation. The common hepatic duct and common bile duct measure 0.4 and 0.8 cm, respectively. The common bile duct measurement is at the upper limits of normal.

A. 76700-26, 789.07
B. 76705-26, 789.06
C. 76775-26, 789.05
D. 76705, 789.07

POINT VALUE: 1 point

CORRECT ANSWER:
B. 76705-26 identifies the sonogram of the gallbladder as a limited abdominal ultrasound. This case describes a limited study because some of the organs required for a complete study were not visualized. See the guidelines for a complete abdominal US in the CPT manual preceding code 76700. The -26 modifier indicates the physician component only. 789.06 is the diagnosis for epigastric pain, with the fifth digit "6" identifying the epigastric area.

RATIONALE:
A. 76700-26 is incorrect as it identifies a complete abdominal sonogram. A complete abdominal ultrasound is defined in the CPT manual preceding code 76700. This report indicates that only the gallbladder, liver, common bile duct, and hepatic duct were imaged; therefore this was a limited study and should be reported with 76705. 789.07 is assigned to report a generalized abdominal pain, but the report indicated the epigastric area.
C. 76775-26 is incorrect as it reports a limited retroperitoneal ultrasound, which is an ultrasound to image the posterior (retro-) structures. This would be noted in the report and was not. 789.05 is assigned to report a pain in the periumbilical area, but the report indicated an epigastric pain.
D. 76705 correctly identifies the sonogram of the gallbladder, but no -26 modifier is added to report only the professional portion. 789.07 is incorrectly assigned to report generalized abdominal symptoms, but the report indicated the epigastric area.

125. EXAMINATION OF: Chest.

CLINICAL SYMPTOMS: Pneumonia.

PA AND LATERAL CHEST X-RAY WITH FLUOROSCOPY.

CONCLUSION: Ventilation within the lung fields has improved compared with previous study.

A. 71020-26, 482.89
B. 71034, 482.83
C. 71023-26, 486
D. 71023, 486

POINT AREA: 1 point

CORRECT ANSWER:
C. 71023-26 identifies the two views of the chest with fluoroscopy, with modifier -26 to identify only the professional component of the service. 486 is the diagnosis code for pneumonia.

RATIONALE:
A. 71020-26 is a two-view chest x-ray (front and side) but without the use of fluoroscopy, which was indicated in the report. 482.89 indicates pneumonia due to other specified bacteria, which was not indicated in the report.
B. 71034 is a complete fluoroscopic chest x-ray with a minimum of four views; only two views were indicated in the report. The code also does not have the professional component modifier -26 added. 482.83 is pneumonia due to a bacterium, which was not indicated in the report.
D. 71023 identifies the two views of the chest with fluoroscopy but is incorrect because there should be a modifier -26 added to indicate only the professional component of the service. 486 correctly reports the diagnosis code for pneumonia.

126. EXAMINATION OF: Abdomen and pelvis.

CLINICAL SYMPTOMS: Ascites.

CT OF ABDOMEN AND PELVIS: Technique: CT of the abdomen and pelvis was performed without oral or IV contrast material per physician request. No previous CT scans for comparison.

FINDINGS: No ascites. Moderate-sized pleural effusion on the right.

A. 74160-26, 789.59
B. 74176-26, 511.9
C. 74150, 511.9
D. 74160, 789.59

POINT VALUE: 1 point

CORRECT ANSWER:
B. 74176-26 identifies the CT scan of the abdomen and pelvis without contrast material. 511.9 is the diagnosis code for the pleural effusion. You would not code the clinical symptoms of ascites when the more definitive diagnosis of pleural effusion is documented within the report.
RATIONALE:
A. 74160-26 identifies a CT scan of only the abdomen with contrast; the report specifically indicated that the physician ordered no contrast. Modifier -26 is correctly used to report the professional component. 789.59 reports abdominal ascites as indicated in the Clinical Symptoms section of the report, but a more definitive diagnosis is indicated in the Findings section of the report as pleural effusion. You would not code the clinical symptoms of ascites when the more definitive diagnosis of pleural effusion is documented within the report.
C. 74150 identifies a CT scan of the abdomen without contrast material but this CT was of the abdomen and pelvis (74176). Modifier -26 is also missing. 511.9 correctly reports the pleural effusion.
D. 74160 identifies a CT scan of the abdomen with contrast; the report specifically indicated that the physician ordered no contrast. 789.59 reports abdominal ascites as indicated in the Clinical Symptoms section of the report, but a more definitive diagnosis is indicated in the Findings section of the report as pleural effusion.

127. Report the professional component of the following service: This 68-year-old male is seen in Radiation Oncology Department for prostate cancer. The oncologist performs a complex clinical treatment planning, approves a dosimetry calculation, manages a complex isodose plan and orders treatment devices which include blocks, special shields, and wedges. He also performs treatment management. The patient had 5 days of radiation treatments for 2 weeks, a total of 10 days of treatment.

A. 77263, 77300-26, 77315-26, 77334, 185
B. 77300, 77315, 77334, 77427 × 2, 185
C. 77263, 77300-26, 77315-26, 77334-26, 77427 × 2, 185
D. 77263, 77427 × 2, 185

POINT VALUE: 1 point

CORRECT ANSWER:
C. 77263 reports the professional component of the complex clinical treatment planning (the prescription for radiation). 77300-26 reports the dosimetry calculation, which is the calculation of the radiation surface and depth dose. 77315-26 reports the isodose plan (teletherapy). 77334-26 reports the design and construction of complex treatment devices used for the radiation. 77427 × 2 reports the radiation treatment management, reported in increments of 5 days for a total of 10 treatments. 185 correctly reports the diagnosis statement of prostate cancer.

RATIONALE:
A. 77263 correctly reports the complex clinical treatment planning (the prescription for radiation). 77300-26 correctly reports the dosimetry calculation, which is the calculation of the radiation surface and depth dose.
77315-26 correctly reports the isodose plan (teletherapy). 77334 correctly reports the design and construction of complex treatment devices used for the radiation; however, modifier -26 is missing. 185 correctly identifies the diagnosis statement of prostate cancer. The actual radiation treatment management is missing from this answer and should have been reported with 77427 × 2 to identify the actual radiation treatment management, reported in increments of 5 days for a total of 10 days.

B. 77300 correctly reports the dosimetry calculation, which is the calculation of the radiation surface and depth dose. 77315 correctly reports the isodose plan (teletherapy). 77334 correctly reports the design and construction of complex treatment devices used for the radiation, all three codes are missing -26. 77427 × 2 correctly identifies the actual radiation treatment management, reported in increments of 5 days for a total of 10 days. 185 correctly identifies the diagnosis statement of cancer. Missing is 77263 to report the clinical treatment planning.

D. 77263 correctly reports the complex clinical treatment planning (the prescription for radiation). 77427 × 2 identifies the actual radiation treatment management, reported in increments of 5 days for a total of 10 days. 185 correctly identifies the diagnosis statement of prostate cancer. This answer does not report 77300 to report the dosimetry calculation, which is the calculation of the radiation surface and depth dose, 77315 to report the isodose plan (teletherapy), and 77334 to report the design and construction of complex treatment devices used for the radiation.

128. This 69-year-old female is in for a magnetic resonance examination of the brain because of new seizure activity. After imaging without contrast, contrast was administered and further sequences were performed. Examination results indicated no apparent neoplasm or vascular malformation.

A. 70543-26, 780.31
B. 70543-26, 780.39
C. 70553-26, 780.39
D. 70553, 345.90

POINT VALUE: 1 point

CORRECT ANSWER:
C. 70553-26 identifies the MRI of the brain without contrast and then with contrast, with the -26 modifier used to indicate the physician component only. 780.39 is the diagnosis for seizure activity and is correct because no more definitive diagnostic statement was made within the report.

RATIONALE:
A. 70543-26 reports an MRI of the orbit, face, or neck, not of the brain, as indicated in the report, with modifier -26 correctly added to indicate the physician component only. 780.31 represents seizures due to a fever (febrile), but the report did not indicate a reason for the seizures.
B. 70543-26 reports an MRI of the face, not of the brain, as indicated in the report, with modifier -26 correctly added to indicate the physician component only. 780.39 is the correct diagnosis for seizure activity.

D. 70553 correctly identifies the MRI of the brain but does not have the -26 modifier to indicate the physician component only. 345.90 is an epileptic seizure without mention of intractable epilepsy, but the reason for the seizures was not indicated in the report.

129. EXAMINATION OF: Brain.

CLINICAL FINDING: Acute onset, severe headache.

COMPUTED TOMOGRAPHY OF THE BRAIN was performed without contrast material.

FINDINGS: There is blood within the third ventricle. The lateral ventricles show mild dilatation with small amounts of blood.

IMPRESSION: Acute subarachnoid hemorrhage.

A. 70460-26, 784.0
B. 70250, 784.0
C. 70450-26, 430
D. 70450-26, 784.0

POINT VALUE: 1 point

CORRECT ANSWER:

C. 70450-26 correctly reports a CT of the brain without contrast material with modifier -26 to indicate that the professional component is being reported. 430 reports the subarachnoid hemorrhage as indicated in the Impression section of the report.

RATIONALE:

A. 70460-26 is a CT with contrast, but the report indicated that no contrast was used; modifier -26 is correctly used to indicate that only the professional component is being reported. 784.0 incorrectly reports the Clinical Finding of headache rather than the more definitive diagnosis of a subarachnoid hemorrhage from the Impression section of the report.

B. 70250 is an x-ray of the skull, not a CT of the brain as indicated in the report, and there is no modifier -26 to indicate that only the professional component is being reported. 784.0 incorrectly reports the Clinical Finding of headache rather than the more definitive diagnosis of a subarachnoid hemorrhage from the Impression section of the report.

D. 70450-26 correctly reports a CT of the brain without contrast material, with modifier -26 to indicate the professional component is being reported. 784.0
incorrectly reports the Clinical Finding of headache rather than the more definitive diagnosis of a subarachnoid hemorrhage from the Impression section of the report.

130. This patient is suffering from primary lung cancer and is in for a follow-up CT scan of the thorax with contrast material. Code the physician component only.

A. 71250-26, 197.0
B. 71260, 162.9
C. 71260-26, 162.9
D. 71270-26, 239.1

POINT VALUE: 1 point

CORRECT ANSWER:
C. 71260-26 identifies the physician component (-26 modifier) for the CT of the thorax with contrast material. 162.9 is the diagnosis code for unspecified primary cancer of the lung.

RATIONALE:
A. 71250-26 reports the CT without contrast material; the report specified with contrast. Modifier -26 indicates that the professional component was provided and is correctly used. 197.0 reports a secondary site of cancer, and the lung cancer was specified as primary; so only the primary cancer (162.9) is appropriate to report.
B. 71260 correctly reports a CT of the thorax with contrast; however, modifier -26 needs to be added to indicate that the professional component was provided. 162.9 correctly reports a primary lung cancer.
D. 71270-26 incorrectly reports a CT without contrast material followed by CT with contrast material; the report specified that this was a CT with contrast above. Modifier -26 is used correctly to indicate that the professional component was provided. 239.1 is incorrectly used to report a neoplasm of unspecified nature (unknown if benign or malignant) of the lung when the report states a primary lung cancer.

Direction: Report only the professional component unless specifically directed to do otherwise within the question. {ED: ok to have directions here? Should go before 139?}

Subject Area: 80000 Pathology and Laboratory

131. This 69-year-old female presents to the laboratory after her physician ordered quantitative and qualitative assays for troponin to assist in the diagnosis of her chief complaint of acute onset of chest pain.

A. 84484, 80299, 786.51
B. 84512, 84484, 80299, 786.59
C. 84484, 84512, 786.50
D. 84484, 84512, 786.59

POINT VALUE: 1 point

CORRECT ANSWER:
C. 84484 identifies the quantitative, and 84512 identifies the qualitative assay for troponin. 786.50 is the diagnosis code for the chest pain.

RATIONALE:
A. 84484 identifies the quantitative assay, but 80299 incorrectly reports a therapeutic drug assay that is performed to identify the amount of a therapeutic drug in a sample; also, this choice does not identify the qualitative assay for troponin with 84512. 786.51 is an incorrect diagnosis of precordial pain, which is not specified in the record.
B. 84512 correctly identifies the qualitative assay for troponin. 84484 correctly identifies the quantitative portion of the service, but 80299 incorrectly reports a therapeutic drug assay that is performed to identify the amount of a stated therapeutic drug in a sample. 786.59 is the diagnosis for "other chest pain," such as discomfort, pressure, or tightness as listed in the code description; this chart specified "chest pain."
D. 84484 correctly identifies the quantitative assay, and 84512 correctly identifies the qualitative assay for troponin; but 786.59 is the diagnosis for other chest pain, such as discomfort, pressure, or tightness as listed in the code description; this chart specified "chest pain."

132. Report the global service.

CLINICAL HISTORY: Mass, left atrium.

SPECIMEN RECEIVED: Left atrium.

GROSS DESCRIPTION: The specimen is labeled with patient's name and "left atrial myxoma" and consists of a 4 × 4 × 2-cm ovoid mass with a partially calcified hemorrhagic white-tan tissue.

INTRAOPERATIVE FROZEN SECTION DIAGNOSIS: Myxoma.

MICROSCOPIC DESCRIPTION: Sections show a well-circumscribed mass consisting of fibromyxoid tissue showing numerous vascular channels. Areas of superficial ulceration and chronic inflammatory infiltrate are noted. Areas of calcification are also present.

DIAGNOSIS: Myxoma, benign, left atrium.

A. 88305, 239.89
B. 88307-26, 88331-26, 212.7  
C. 88307, 88331-26, 212.7  
D. 88305, 212.7

**POINT VALUE: 1 point**

**CORRECT ANSWER:**
B. 88307-26 identifies the pathologic gross and microscopic exam and interpretation of the specimen. 88331-26 identifies the intraoperative consultation with frozen section of the atrium mass. Modifier -26 is appended to indicate the professional component. 212.7 is the diagnosis code for the benign neoplasm of the atrium.

**RATIONALE:**
A. 88305 is not the correct code for the pathologic examination of the specimen, and the frozen section of the atrium was not reported with 88331. 239.89 is the diagnosis code for a neoplasm of the atrium for which the behavior has not been specified; in this case, the behavior was specified as benign.
C. 88307 is correct to report the pathology service; however, modifier -26 is missing. 88331-26 is the correct code to report the frozen section. 212.7 is the correct diagnosis code for the benign neoplasm of the atrium.
D. 88305 is the incorrect code for the pathologic examination of the specimen, but the frozen section of the atrium was not reported with 88331. 212.7 is the correct diagnosis code for the benign neoplasm of the atrium.

133. **CLINICAL HISTORY:** Boil, left groin.

**SPECIMEN RECEIVED:** Necrotic fascia left groin and leg (anterior and posterior).

**GROSS DESCRIPTION:** The specimen is labeled with the patient's name and "fascia left groin and leg" and consists of multiple segments of skin and soft tissue measuring up to 30 cm in greatest dimension. The skin is unremarkable, with the soft tissue being hemorrhagic and friable and foul smelling.

**MICROSCOPIC DESCRIPTION:** Sections of skin and soft tissue show coagulative necrosis with neutrophilic exudates.

**DIAGNOSIS:** Skin and soft tissue, left groin and leg, anterior and posterior showing coagulative necrosis and acute inflammation.

A. 88304, 680.9  
B. 88305-26, 709.8  
C. 88304-26, 709.8, 680.2  
D. 88305, 682.2

**POINT VALUE: 1 point**
CORRECT ANSWER:
C. 88304-26 identifies the pathology of the skin and soft tissue debrided from the groin and leg. 709.8 is the diagnosis code for necrosis of the skin and 680.2 reports the boil. Note that the final diagnosis includes “acute inflammation.” This is captured as a common symptom seen in a boil.

RATIONALE:
A. 88304 is the correct pathology code but does not have modifier -26 to indicate that only the professional component was provided. 680.9 reports a boil of an unspecified site and the site in this report was indicated as the groin and leg. The correct site (680.2) should be reported in addition to the necrosis (709.8).
B. 88305-26 is a level higher than the specimen examined in this report. To qualify at the 88305 level, the specimen would have to have been a polyp or mass or other tissue with a higher probability of being cancerous. 709.8 is the correct diagnosis for necrosis of the skin; however, the boil also needs to be reported (680.2).
D. 88305 is a level higher than the specimen examined in this report. To qualify at the 88305 level, the specimen would have to have been a polyp or mass or other tissue with a higher probability of being cancerous. Also, the -26 modifier needs to be included to show professional component. 682.2 reports cellulitis of the groin, which is not documented.

134. This 34-year-old established female patient is in for her yearly physical and lab. The physician orders a comprehensive metabolic panel, automated hemogram and manual differential WBC count (CBC), and a thyroid-stimulating hormone. Code the lab only.

A. 99395, 80050
B. 80050-52
C. 80069, 80050
D. 80050

POINT VALUE: 1 point

CORRECT ANSWER:
D. 80050 identifies a general health panel that includes all of the lab tests indicated in the report. If you were to code individually for each test, you would report codes 80053 for the metabolic panel, 85009 for the hemogram, and 84443 for the thyroid test; however, because this is a panel for general health and there is a code for all these tests, you would report 80050.

RATIONALE:
A. 99395 reports the preventive medicine service; but the directions indicated
that only the laboratory services were to be reported. 80050 correctly reports a general health panel.
B. 80050-52 correctly reports a general health panel but with a reduced service modifier, which is never correct to use with laboratory services.
C. 80059 reports a renal function panel that was not indicated in the case. 80050 correctly reports a general health panel.

135. CLINICAL HISTORY: Necrotic soleus muscle, right leg.

SPECIMEN RECEIVED: Soleus muscle, right leg.

GROSS DESCRIPTION: Submitted in formalin, labeled with the patient's name and "soleus muscle right leg," are multiple irregular fragments of tan, gray, and brown soft tissue measuring 8 × 8 × 2.5 cm in aggregate. Multiple representative fragments are submitted in four cassettes.

MICROSCOPIC DESCRIPTION: The slides show multiple sections of skeletal muscle showing severe coagulative and liquefactive necrosis. Patchy neutrophilic infiltrates are present within the necrotic tissue.

DIAGNOSIS: Soft tissue, soleus muscle, right leg debridement; necrosis and patchy acute inflammation, skeletal muscle—infective myositis.

A. 88305-26, 728.2
B. 88304-26, 728.0
C. 88307-26, 785.4
D. 88304-26, 728.2

POINT VALUE: 1 point

CORRECT ANSWER:
B. 88304-26 correctly reports the pathology examination of a soft tissue specimen from a debridement and is not suspected of neoplastic behavior, and 728.0 correctly reports the infectious myositis (infected and inflamed muscle).

RATIONALE:
A. 88305-26 is too high a level to report the examination of a muscle debridement because a muscle tissue submitted for pathological examination at the 88305 level would be from a biopsy and suspected of having neoplastic behavior, and 728.2 is a diagnosis for muscle wasting or withering, not infectious myositis.
C. 88307-26 is too high a level to report the examination of a muscle debridement because muscle tissue submitted for pathological examination at the 88307 level would be of a soft tissue mass from a biopsy or excision and is suspected of having neoplastic behavior. 785.4 is the code to report gangrene, which is not indicated in the report.
D. 88304-26 correctly reports the pathology examination of a specimen that is not suspected of neoplastic behavior, but 728.2 is a diagnosis for muscle wasting or withering, not infectious myositis.

136. This patient is in for a kidney biopsy (50200) because a mass was identified by ultrasound. The specimen is sent to pathology for gross and microscopic examination. Report the technical and professional components for this service. The results are pending.

A. 88305-26, 593.9
B. 88307-26, 593.89
C. 88307, 593.9
D. 88305, 593.9

POINT VALUE: 1 point

CORRECT ANSWER:
D. 88305 identifies the gross and microscopic exam of the kidney specimen and reports both the technical and professional portions of the service as directed in this case. 593.9 is the diagnosis code for diseases of the kidney that include a mass not otherwise specified.

RATIONALE:
A. 88305-26 identifies the gross and microscopic exam of the kidney specimen, but with modifier -26 to indicate that only the professional component was provided, whereas the report indicated that both the technical and professional components were to be reported, which is accomplished by the use of the code without modifier -26. 593.9 is the diagnosis code for diseases of the kidney, which includes a mass.

B. 88307-26 is too high a level to report this specimen because "Kidney Biopsy" is listed under code 88305; to qualify for the higher level code, the service would have to have been a partial or total removal of the kidney. Further, modifier -26 is used only to report the professional component of the service, but the directions in this case indicated that the entire service was to be reported. 593.89 is incorrect because it reports an "Other" disorder, such as adhesions, periureteritis, polyps, pyelectasia, or ureterocele as listed in the code description, not the mass as indicated in the report.

C. 88307 is too high a level to report this specimen because "Kidney Biopsy" is listed under code 88305; to qualify for the higher level code, the service would have to have been a partial or total removal of the kidney. 593.9 is the correct diagnosis code for diseases of the kidney, which includes a mass.

137. This patient presented to the laboratory yesterday to have blood drawn for a creatine measurement. The results came back at higher than normal levels; therefore, the patient was asked to return to the laboratory today for a repeat creatine blood test before the nephrologist is consulted. Report the second day of test only.
A. 82540 × 2, 790.6
B. 82550, 790.6
C. 82550, 790.91
D. 82540, 790.6

POINT VALUE: 1 point

CORRECT ANSWER:
D. 82540 identifies the correct chemistry code for the second creatine level. 790.6 is the correct diagnosis code for abnormal blood chemistry findings.

RATIONALE:
A. 82540 × 2 incorrectly codes both creatine levels, when the directions indicated that only the second day was to be reported. 790.6 is the correct diagnosis code for abnormal blood chemistry findings.
B. 82550 incorrectly reports a creatine kinase, which is a more extensive assessment than indicated in the report that stated a "creatine" with no further indications that would direct this more complex analysis code; 790.6 is the correct diagnosis code for abnormal blood chemistry findings.
C. 82550 incorrectly reports a creatine kinase, which is a more extensive assessment than indicated in the report that stated a "creatine" with no further indications that would direct this more complex analysis code; 790.91 incorrectly reports a diagnosis of abnormal findings of arterial blood gas rather than an abnormal blood chemistry test.


A. 84702
B. 84703
C. 81025
D. 84702 × 2

POINT VALUE: 1 point

CORRECT ANSWER:
C. 81025 identifies the urine pregnancy test. Be certain always to know if the specimen for a pregnancy test is performed on urine or blood.

RATIONALE:
A. 84702 incorrectly reports a quantitative pregnancy test (gonadotropin, chorionic [hCG]) that is performed on a blood specimen; the report indicated a urine sample.
B. 84703 incorrectly reports a qualitative pregnancy test (gonadotropin, chorionic [hCG]) that is performed on a blood specimen; the report indicated a urine sample.
D. 84702 × 2 incorrectly reports two pregnancy tests (gonadotropin, chorionic [hCG]) performed on a blood specimen; the report indicated a urine sample.

139. This is a patient with atrial fibrillation who comes to the clinic laboratory routinely for a quantitative digoxin level. This test was performed today.

A. 80101, 80102, 428.0
B. 81001, V58.83, V58.69, 427.41
C. 80162, V58.83, V58.69, 427.31
D. 80162, 785.0

POINT VALUE: 1 point

CORRECT ANSWER: C. 80162 identifies the quantitative testing for digoxin levels in the body. V58.83 is the correct code for therapeutic drug monitoring. V58.69 is the correct code for long-term use of a medication, and 427.31 is the diagnosis code for atrial fibrillation, which is a form of tachycardia. See Coding Clinic 2002:3Q, pp 15–16, also 2004:2Q pp 10, for information on the V codes.

RATIONALE:
A. 80101 incorrectly reports a drug screening service and the confirmation of a positive result with 80102. 428.0 reports congestive heart failure, not atrial fibrillation stated in the report. The codes for therapeutic drug monitoring and long-term use of a medication are missing.
B. 81001 is a urinalysis, not a therapeutic drug assay. 427.41 is ventricular fibrillation, not the atrial fibrillation stated in the case. The codes V58.83 and V58.69 are correct.
D. 80162 correctly reports the quantitative testing for digoxin, but 785.0 is the diagnosis code for tachycardia, unspecified, which is not stated in the report. The codes for therapeutic drug monitoring and long-term use of a medication are missing.

140. What CPT code would you use to report a bilirubin, total (transcutaneous)?

A. 82252
B. 82247
C. 82248
D. 88720

POINT VALUE: 1 point

CORRECT ANSWER: D. 88720 correctly reports a transcutaneous total bilirubin that uses a subcutaneous tissue sample to measure the bilirubin.
RATIONAL:

A. 82252 reports a bilirubin measurement performed on fecal material, not a transcutaneous assessment as indicated in the report.

B. 82247 reports a bilirubin, total measurement by means of a blood sample, not a transcutaneous assessment as indicated in the report.

C. 82248 reports a bilirubin, direct measurement by means of a blood sample, not a transcutaneous assessment as indicated in the report.

Subject Area: 90000 Medicine

141. What CPT code would be used to code the technical aspect of an evaluation of swallowing by video recording using a flexible fiberoptic endoscope?

A. 92611
B. 92612
C. 92610
D. 92613

POINT VALUE: 1 point

CORRECT ANSWER:

B. 92612 correctly identifies the evaluation by video recording of the patient swallowing by means of a flexible fiberoptic endoscope.

RATIONAL:

A. 92611 reports a motion fluoroscopic evaluation of swallowing function by video recording but without a flexible fiberoptic endoscope.

C. 92610 incorrectly reports evaluation of oral and pharyngeal swallowing functions, not as described in the report as a video swallow with a flexible fiberoptic endoscope.

D. 92613 reports both the technical component and the professional (physician interpretation and report) component of a fiberoptic endoscopic evaluation of swallowing recording. This choice is incorrect because the instruction was to code only the technical aspect of the study.

142. The patient presented for a spontaneous nystagmus test that included gaze, fixation, and recording and used vertical electrodes. Assign code(s) for the physician service only.

A. 92541
B. 92547
C. 92541, 92544, 92547
D. 92541, 92547

POINT VALUE: 1 point
CORRECT ANSWER:
D. 92541 identifies the nystagmus test, and 92547 reports the use of the vertical electrodes.

RATIONALE:
A. 92541 identifies the test but does not report the use of the vertical electrodes, which is reported with 92547.
B. 92547 correctly reports the use of vertical electrodes; however, the nystagmus test must also be reported with 92541.
C. 92541 correctly reports the nystagmus test. 92544 incorrectly reports an additional nystagmus evaluation, which was included in 92541. 92547 correctly reports the use of the vertical electrodes.

143. How would you report a screening hearing test in which no abnormalities are reported?

A. 92551, V72.19
B. 92555, V72.19
C. 92553, V72.19
D. 92620, V80.3

POINT VALUE: 1 point

CORRECT ANSWER:
A. 92551 is a screening hearing test. V72.19 is the correct code for an examination for ears and hearing.

RATIONALE:
B. 92555 is a speech audiometry threshold assessment, not a screening hearing test. V72.19 is correct because it is a screening examination for hearing.
C. 92553 is a pure tone audiometry with air and bone, not a screening hearing test. V72.19 is correct.
D. 92620 is a central auditory function test, not a screening hearing test. V80.3 is incorrect because it is not a screening for ear diseases.

144. This 40-year-old patient who is a type II diabetic is seen in an inpatient setting for psychotherapy. The doctor spends 50 minutes face to face with the patient. The patient is seen for depression.

A. 90818, 311, 250.90
B. 90817, 311, 250.90
C. 90818, 311
D. 90817, 311

POINT VALUE: 1 point

CORRECT ANSWER:
C. 90818 identifies individual psychotherapy with a patient who is an inpatient with 45 to 50 minutes of face-to-face therapy time. 311 is the diagnosis code for depression.

RATIONALE:

A. 90818 correctly identifies individual psychotherapy with a patient who is an inpatient with 45 to 50 minutes of face-to-face therapy time. 311 is the correct diagnosis code for depression. It is incorrect to report the diabetes (250.90) because there is no correlation in the record between the diabetes and the reason the patient is receiving psychotherapy, and physician coders report only those conditions that affect the care of the patient for the service that is being reported.

B. 90817 incorrectly reports individual psychotherapy with a patient who is an inpatient with 20 to 30 minutes of face-to-face therapy time, and the medical evaluation and management services indicated in the code description are not supported in the record. 311 is the correct diagnosis code for depression. It is incorrect to report the diabetes (250.90) because there is no correlation in the record between the diabetes and the reason the patient is receiving psychotherapy. Physician coders report only those conditions that affect the care of the patient for the service that is being reported.

D. 90817 incorrectly reports individual psychotherapy with a patient who is an inpatient with 20 to 30 minutes of face-to-face therapy time, and the medical evaluation and management services indicated in the code description are not supported in the record. 311 is the correct diagnosis code for depression.

145. A patient presents for a pleural cavity chemotherapy session with 10 mg doxorubicin HCl that requires a thoracentesis to be performed.

A. 96446, J9000
B. 96440, 32421, J9000
C. 96440, J9000
D. 96446, 32421, J9000

POINT VALUE: 1 point

CORRECT ANSWER:

C. 96440 identifies the chemotherapy administration into the pleural cavity, which requires and includes the thoracentesis; therefore, you would not report the thoracentesis separately. J9000 reports the provision of the chemotherapy agent that was inserted into the pleural cavity.

RATIONALE:

A. 96446 incorrectly reports a peritoneal cavity chemotherapy session via an indwelling port, not a pleural cavity chemotherapy session. J9000 correctly reports the provision of the chemotherapy agent that was inserted into the pleural cavity.
B. 96440 correctly identifies the chemotherapy administration into the pleural cavity, which requires and includes the thoracentesis; therefore, the thoracentesis (32421) is not reported separately. J9000 correctly reports the provision of the chemotherapy agent that was inserted into the pleural cavity.

D. 96446 incorrectly reports a peritoneal cavity chemotherapy session via an indwelling port, not a pleural cavity chemotherapy session. 32421 incorrectly reports a thoracentesis; that is included in the correct code 96440. J9000 correctly reports the provision of the chemotherapy agent that was inserted into the pleural cavity.

146. What CPT code would be used to report a home visit for a respiratory patient to care for the mechanical ventilation?

A. 99503
B. 99504
C. 99505
D. 99509

POINT VALUE: 1 point

CORRECT ANSWER:
B. 99504 identifies the care of mechanical ventilation performed in the patient’s home.

RATIONALE:
A. 99503 incorrectly reports home visit for respiratory therapy, not mechanical ventilation care.
C. 99505 incorrectly reports home visit for stoma care, not mechanical ventilation care.
D. 99509 incorrectly reports home visit for assistance with daily living tasks, not mechanical ventilation care.

147. Which code would be used to report an EEG (electroencephalogram) provided during carotid surgery?

A. 95816
B. 95819
C. 95822
D. 95955

POINT VALUE: 1 point

CORRECT ANSWER:
D. 95955 is the code for an EEG during a nonintracranial surgery such as carotid surgery.

RATIONALE:
A. 95816 incorrectly reports an awake and drowsy EEG.
B. 95819 incorrectly reports a standard EEG.
C. 95822 incorrectly reports a sleep EEG.

148. INDICATION: Pulmonary hypertension secondary to newly diagnosed acute myocardial infarction.

PROCEDURE PERFORMED: Insertion of Swan-Ganz catheter.

DESCRIPTION OF PROCEDURE: The right internal jugular and subclavian area was prepped with antiseptic solution. Sterile drapes were applied. Under usual sterile precautions, the right internal jugular vein was cannulated. A 9-French introducer was inserted, and a 7-French Swan-Ganz catheter was inserted without difficulty. Right atrial pressures were 2 to 3, right ventricular pressures 24/0, and pulmonary artery 26/9 with a wedge pressure of 5. This is a Trendelenburg position. The patient tolerated the procedure well.

A. 93451, 93503-51, 410.91
B. 93454, 416.8
C. 93503, 93452, 410.91
D. 93503, 410.91, 416.8

POINT VALUE: 1 point

CORRECT ANSWER:

D. 93503 identifies the insertion of the Swan-Ganz catheter, which was placed for monitoring of the patient. 410.91 is the diagnosis code for the myocardial infarction, unspecified site. 416.8 is the code for pulmonary hypertension, identified here as “secondary to,” which means as a complication of the myocardial infarction.

RATIONALE:

A. 93451 incorrectly reports a right heart catheterization, which was not performed according to the report; 93503 correctly reports the insertion of the Swan-Ganz catheter, but -51 was not required. 410.91 is the correct diagnosis code for the myocardial infarction, but the 416.8 code for the pulmonary hypertension is missing.

B. 93454 incorrectly reports the catheter placement in the coronary artery; this is not stated in the report. 416.8 is the correct diagnosis code for the pulmonary hypertension, but the MI (410.91) should have been reported.

C. 93503 correctly identifies the insertion of the catheter, Swan-Ganz, but 93452 is for a cardiac catheterization, which was not done. 410.91 is the correct diagnosis code for the myocardial infarction. Missing is 416.8 to report pulmonary hypertension.

149. DIALYSIS INPATIENT NOTE: This 24-year-old male patient is on continuous
ambulatory peritoneal dialysis (CAPD) using 1.5%. He drains more than 600 mL. He is tolerating dialysis well. He continues to have some abdominal pain, but his abdomen is not distended. He has some diarrhea. His abdomen does not look like acute abdomen. His vitals, other than blood pressure in the 190s over 100s, are fine. He is afebrile.

At this time, I will continue with 1.5% dialysate. Because of diarrhea, I am going to check stool for white cells, culture. Next we will see what the primary physician says today. His HIDA scan was normal. The patient suffers from ESRD and has had 6 encounters this month. Code this service.

A. 90947, 90960, 585.6, 787.91, V45.11
B. 90945, 585.6, 787.91, V45.11
C. 90960, 585.6, V45.11
D. 90945, 585.6

POINT VALUE: 1 point

CORRECT ANSWER:
B. 90945 identifies peritoneal dialysis with the physician performing a single evaluation. CAPD is continuous ambulatory peritoneal dialysis. 585.6 is the diagnosis code for end stage renal disease (ESRD). 787.91 is the diagnosis code for the diarrhea; because the physician is addressing the diarrhea, this condition would be reported. V45.11 is the correct code to show that a patient is being maintained on dialysis. See Coding Clinic 2004:1Q, p 23.

RATIONALE:
A. 90947 incorrectly reports dialysis requiring repeated evaluation, which was not stated in the report. 90960 reports 1 month of ESRD-related services with four or more encounters that were not indicated in the report. 585.6 is the correct diagnosis code for end stage renal disease (ESRD), and 787.91 is the correct diagnosis code for the diarrhea. Because the physician is treating the diarrhea, this condition would be reported. V45.11 is the correct code for dialysis status.
C. 90960 is 1 month of ESRD-related services that were not indicated in the report. 585.6 is the correct diagnosis code for end stage renal disease (ESRD), and 787.91 should have been reported for the diarrhea. V45.11 is the correct code for dialysis status.
D. 90945 correctly identifies peritoneal dialysis with the physician performing a single evaluation. 585.6 is the correct diagnosis code for end stage renal disease (ESRD). Diarrhea (787.91) should also be coded because the physician is addressing this condition. V45.11 dialysis status should also be coded.

150. DIAGNOSIS: Atrial flutter.
PROCEDURE PERFORMED: Electrical cardioversion.

DESCRIPTION OF PROCEDURE: The patient was sedated with Versed and morphine. She was given a total of 5 mg of Versed. She was cardioverted with 50 joules into sinus tachycardia.

The patient was given a 20-mg Cardizem IV push. Her heart rate went down to the 110s, and she was definitely in sinus tachycardia.

CONCLUSION: Successful electrical cardioversion of atrial flutter into sinus tachycardia.

A. 92961, 427.61
B. 92960, 427.32
C. 92960, 92973, 427.32
D. 92960, 427.89

POINT VALUE: 1 point

CORRECT ANSWER:
B. 92960 identifies the external cardioversion, which is used to improve hemodynamics and control heart rate. 427.32 is the diagnosis code for the atrial flutter, which is a form of supraventricular tachycardia.

RATIONALE:
A. 92961 incorrectly reports elective, internal cardioversion. The chest of the patient was not opened and paddles were not placed directly on the heart; this is not the correct code for the service described in the report (external cardioversion). 427.61 incorrectly reports premature supraventricular beats as the diagnosis, which is not supported in the record.
C. 92960 correctly identifies the elective, external cardioversion. 92973 reports a percutaneous transluminal coronary thrombectomy which was not performed. 427.32 correctly reports the diagnosis code for the atrial flutter, which is a form of supraventricular tachycardia.
D. 92960 correctly identifies the elective, external cardioversion, and 427.89 incorrectly identifies sinus tachycardia, which was the outcome of the cardioversion, not the atrial flutter that was the diagnosis.