1 C The scenario indicates a previous biopsy came back with “positive margins”, indicating a malignancy. This eliminates multiple choice answers A and D. According to CPT guidelines “Repair of an excision of a malignant lesion requiring intermediate or complex closure should be reported separately”.

2 C Patient is having a debridement performed not an excision of the eschar, eliminating multiple choice answer D. The ulcer was debrided all the way to the bone of the foot, making multiple choice answer C, the correct procedure.

3 D To start narrowing your choices down, the hand and foot were closed with adhesive strips. The Section Guidelines in the CPT manual for Repair (Closure) states “Wound closure utilizing adhesive strips as the sole repair material should be coded using the appropriate E/M code.” Eliminating multiple choice answers A and B. The lacerations on the face are intermediate repairs, since debridement and glass debris was removed. The Section Guidelines in the CPT manual for Repair (Closure) states “Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.” Eliminating multiple choice answer C. The intermediate repair of the lacerations to the face totaled 6 cm (12053). The right arm and left leg had cuts measuring 5 cm each which totaled 10 cm requiring intermediate repair (12034).

4 C The mass growing turned out to be a lipoma found in the subcutaneous tissue of the flank. In the ICD-9-CM alphabetic index, look up Lipoma/subcutaneous tissue. You are referred to code 214.1, eliminating multiple choice answers A and D. Since the 4 cm tumor was found in the subcutaneous tissue code 21931 is the correct code to report.

5 A Patient had an open reduction, meaning an incision was made to get to the fracture, eliminating multiple choice answer B. The fracture site was the scaphoid of the wrist (carpal), eliminating multiple choices C and D.

6 D Your keywords in the scenario to narrow your choices down to code 27485 are: “genu valgum” and “hemiepiphysiodesis”

7 C Patient is having an Infuse-A-Port put in his chest to receive chemotherapy. The subclavian vein (central venous) is being tunneled for the access device, eliminating multiple choices A and D. The patient had a subcutaneous pocket created to insert the power port, eliminating multiple choice answer B. Code 77001 reports fluoroscopic guidance for a central venous access device. Modifier -26 denotes the professional service.

8 A There was removal of fluid from the pleural cavity, eliminating multiple choice answer C. No biopsies were taken, eliminating multiple choice answer D. The procedure was performed under ultrasound guidance, eliminating multiple choice answer B.
9 B The procedure involved removing plaque and the vessel lining from the carotid artery through a neck incision, eliminating multiple choice answers C and D. This was a re-operation (35390), as the original surgery was performed a year ago.

10 B One way to narrow down your choices is by the diagnosis. The patient has chronic cholecystitis. In the ICD-9-CM manual, look under cholecystitis/chronic, referring you to code 575.11. Verify code in the tabular section for accuracy. The patient had a laparoscopic cholecystectomy, eliminating multiple choice answers C and D. An examination of the bile duct was not performed, eliminating multiple choice answer A.

11 B The patient is having a laparoscopic ventral hernia repair, eliminating multiple choice answers A. The hernia is incarcerated as the report states that omentum was adhered to the hernia and was delivered back into the peritoneal cavity, eliminating multiple choice answer C. A parenthetical note in the code descriptive for the laparoscopic hernia repair codes state, that mesh insertion is included when reporting these codes when performed, eliminating multiple choice answer D

12 A Patient is having the surgery performed by a laparoscope, eliminating multiple choice answers B and C. The surgical procedure performed was an appendectomy, eliminating multiple choice D.

13 B This is a surgical laparoscopic procedure for removing the kidney (nephrectomy), eliminating multiple choice answers C and D. The whole kidney was taken out from a donor and put on ice (cold preservation), eliminating multiple choice answer A.

14 A Removal or revision of the sling is not being performed, eliminating multiple choice answer B. The procedure was an open surgery, eliminating multiple choice answer D. Cystoscopy procedure code is a separate procedure. According to CPT Surgery guidelines, “The codes designated as “separated procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.” Meaning that the cystoscopy is included with the sling operation procedure since it was performed at the same time.

15 C The physician is not incising the membrane that attaches the foreskin to the glans and shaft of the penis (frenulum), eliminating multiple choice D. The patient is not having the circumcision for the first time, but needed a repair from a previous circumcision, eliminating multiple choice answers A and B.

16 D The key term to narrow your choices down is the removal of “labial adhesions”. This is found in the code descriptive for multiple choice answer D, 56441.

17 C This was a removal of an intrathecal catheter and pump, eliminating multiple choice answer D. The pump is not being implanted or replaced eliminating multiple choice answer B. Nor is the intrathecal catheter being implanted, revised or repositioned eliminating multiple choice answer A. Diagnosis Rationale: This was a complication; an infection due to a nervous system implant, eliminating multiple choice answers A and D. Seroma is mentioned in the documentation, but there is an “excludes” note for code 998.51, for infection due to an implanted device (996.60-996.69), eliminating multiple choice answer B.
18 B This key word to choose the correct shunt being performed is “ventriculo-peritoneal”, leading you to multiple choice answer B.

19 C The key term to choose the correct answer is “median nerve”, found in code 64721.

20 D There is more than a single chalazion to be removed, eliminating multiple choice answer C. The chalazion was on the upper and lower lid, eliminating multiple choice answer A. The patient was under general anesthesia, eliminating multiple choice answer B.

21 B Scenario documents patient returning to the gynecologist guiding you to the codes for established patient office visit. This eliminates multiple choices A and C. For this scenario, the patient did not have any complaints that required the presence of a physician. There was no examination or medical making decision performed for the patient guiding you to code 99211. There must be an order for the patient to come in for the office visit. For the diagnosis code, the pessary was removed for cleaning with no documentation of a complication of the device nor is this device a contraceptive device; therefore, report V52.8 (Fitting, device, prosthetic, other specified)

22 C According to CPT® guidelines: When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (example, hospital emergency department, observation status in a hospital, physician’s office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date of service. Meaning for this scenario the patient’s physician had come to the ER and also admitted the patient on the same date of service, eliminating multiple choices A and B. The three key components are required for the Initial Hospital Care. Detailed History + Comprehensive Exam + Moderate MDM = 99221.

23 A According to CPT® subsection guidelines under Inpatient Neonatal and Pediatric Critical Care: If the same physician provides critical care services for a neonatal or pediatric patient in both the outpatient and inpatient setting on the same day, report only the appropriate Neonatal or Pediatric Critical Care codes 99468-99476 for all critical care services provided on that day. This eliminates multiple choice answers C and D. The baby is 20-days-old and you can not bill intubation (31500) and ventilation management with the neonatal and pediatric critical care codes, eliminating multiple choice B.

24 C The patient receives anesthesia for a laparoscopic radical nephrectomy. From the CPT® index, look up anesthesia/nephrectomy. You are referred to 00862. Review the code description to verify accuracy. The patient has controlled type II diabetes which supports the use of P2. The patient has renal pelvis cancer. The distinction of secondary cancer is not made so the cancer is coded as a primary neoplasm. In the neoplasm table go to the kidney/pelvis row and the primary column. You are referred to 189.1. The patient also has controlled type II diabetes. To locate, look up diabetes which refers you to 250.0x. A fifth digit is required. The scenario stated the patient is controlled with type II which is reported with a fifth digit of “0.”

25 C The patient receives monitored anesthesia care also known as MAC which is reported with HCPCS Level II modifier QS. There is no indication the patient has a history of cardiopulmonary
condition so G9 would not be appropriate. From the CPT® index, look up anesthesia/forearm. You are referred to multiple codes (00400, 01810-01820, 01830-01860). Refer to these codes to determine the correct code using the code descriptions. The procedure was open and performed on the distal radius. The appropriate code is 01830.

26 B The patient receives general anesthesia for the removal of a laryngeal mass. From the CPT® index, look up anesthesia/larynx. You are referred to 00320 and 00326. Review the code descriptions. 00326 is the correct code to indicate the procedure is performed on a patient younger than one year. 99100 is not reported because the patient’s age range is included in the description of the anesthesia code. There is a parenthetical note following 00326 that states the code should not be reported with 99100.

27 D A first order selective catheter placement in the brachiocephalic system was not performed, eliminating multiple choice answer A. Bilateral angiography of the lower extremities was not performed, eliminating multiple choice answer B. A third order selective catheter placement in the brachiocephalic arterial system was not performed, eliminating multiple choice C. Arterial access was the left common femoral artery. The final selective catheter placement on the right was third order 36247 (femoral artery). Angiography for the right extremity is 75710. An additional angiography was performed to complete the extremity angiography; therefore, 75774 is not reported.

28 C The radiological service is a screening mammogram of both breasts, eliminating multiple choices A, B and D. There is a parenthetical note under code 77057 which states “Use 77057 in conjunction with 77052 for computer-aided detection applied to a screening mammogram”.

29 B This procedure was performed bilaterally (stents placed in the right and left ureter), eliminating multiple choice answer A and C. The pyelogram was retrograde, eliminating multiple choice answer D. Retrograde pyelogram is included in cystoscopy, 52005. The stent placement 52332-50 correctly reports the bilateral procedure. Modifier 26 is correctly appended to 74420 since the procedure was performed in an outpatient facility with the physician interpreting the radiological service.

30 B The first specimen is found under code 88304-Artery, atheromatous plaque. The second specimen is found under code 88305-Skin, other than cyst/tag/debridement/plastic repair. Modifier -26 is appended to show the pathologist’s service.

31 B Since the pathology consultation of the tumor is performed during a surgery you are guided to code 88331. Codes 80500 and 80502 are reported according to CPT® guidelines when the pathologist gives a response to a request from an attending physician in relation to a test result(s) requiring additional medical interpretive judgment. The pathologist did not perform the final report of the tumor, eliminating multiple choice answer D. Modifier -26 reports the professional service.

32 D The young child was administered the Poliovirus vaccine by intramuscular route guiding you to code 90713 eliminating multiple choice B. The influenza vaccine was for intranasal route is code 90660 eliminating multiple choices A and D. For the administration codes the vaccines were administered without face-to-face counseling eliminating multiple choice answers A and B. The first vaccination was administered by the intramuscular route guiding you to code 90471.
The second vaccine (additional vaccine) was administered by the intranasal route guiding you to code 90474. The third vaccine (additional vaccine) is given by the subcutaneous route guiding you to code 90472.

33 C The young child was administered the Poliovirus vaccine by intramuscular route guiding you to code 90713 eliminating multiple choice B. The influenza vaccine was for intranasal route is code 90660 eliminating multiple choices A and D. For the administration codes the vaccines were administered without face-to-face counseling eliminating multiple choice answers A and B. The first vaccination was administered by the intramuscular route guiding you to code 90471. The second vaccine (additional vaccine) was administered by the intranasal route guiding you to code 90474. The third vaccine (additional vaccine) is given by the subcutaneous route guiding you to code 90472.

34 D Patient is having an evaluation for peritoneal dialysis eliminating multiple choices A and B. There is no documentation in the scenario where the physician repeated the dialysis evaluation of the patient due to a complication, eliminating multiple choice C.

35 A Patient is having an ophthalmological evaluation service provided, eliminating multiple choice B. The contact lens is being fitted for a therapeutic use, eliminating multiple choice answers C and D. The description of 92070 states “fitting of contact lens”; therefore, modifier -50 is inappropriate.

36 C The evaluation and management service (99211) would not be reported since the patient is being further evaluated and analyzed for a specific problem that relates to a special otorhinolaryngologic service in determining the patient’s therapeutic treatment, eliminating answers A and D. The patient is having a laryngeal function study in which an acoustic test was performed, eliminating multiple choice answer B. The aerodynamic testing was not performed on this visit so modifier 52 is appended since a parenthetical note states “For performance of a single test, use modifier 52“.

37 A The definitions of ectropion and entropion can be found in the ICD-9-CM tabular index. The alphabetic index refers you to code 374.00 for Entropion and 374.10 for Ectropion.

38 A CPT® defines xenograft: Application of non-human skin graft or biologic wound dressing (example, porcine tissue or pigskin) to a part of the recipient’s body following debridement of the burn wound or area of traumatic injury, soft tissue infection and/or tissue necrosis, or surgery. The index of your CPT® manual has Xenograft referring you to codes 15400-15401. That is where you will find the definition of a xenograft.

39 B These are types of hernias. CPT® codes 49491-49659 are categorized by the type of hernias to be repaired.

40 C The acetabulum is the cup-shaped socket of the hip joint which is part of the pelvis. You can locate this answer in the ICD-9-CM manual. In the alphabetic index look up Fracture/acetabulum and you are referred to code 808.0. In the tabular index this code falls under the category code 808, Fracture of pelvis.
41 A The abductor hallucis is a muscle of the foot that abducts the big toe. In the CPT® index under Tenotomy there are many anatomical areas to choose from, but you will find this muscle located in the description of code 28240. All the codes in that section deal with the foot.

42 C According to ICD-9-CM guidelines: When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from V10, Personal history of malignant neoplasms, should be used to indicate the former site of the malignancy. The scenario indicates the patient had a history of cervical cancer, and for two years had Pap smears performed to check for the cancer not returning meaning the patient does not have current adenocarcinoma of the cervix. This eliminates multiple choice answers A and B. The reason she is going into surgery is due to a last cervix Pap smear coming back with abnormal results, eliminating multiple choice answer D.

43 C According to ICD-9-CM guidelines: Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. For this scenario a definitive diagnosis was confirmed by the physician with the patient having pneumonia, eliminating multiple choice answers A and B. The diagnosis is congested pneumonia. This is indexed in the ICD-9-CM manual under Pneumonia. The term “congested” is found in parenthesis under the term Pneumonia. According to ICD-9-CM guidelines: () Parentheses are used in both the index and tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. That means since the word congested is in parentheses under Pneumonia it is a supplementary word used for diagnosing the disease and if it is documented with pneumonia you report code 486 for that diagnosis, eliminating multiple choice D.

44 C The Demerol was not taken as an accidental overdose, wrong substance given or taken, or drug taken inadvertently eliminating multiple choice D. The codes under subcategory 995.2 are only used when there is no documentation of specific symptoms associated with the adverse effect. This eliminates multiple choice B, since we know the adverse effect which is bradycardia. According to ICD-9-CM guidelines: When the drug was correctly prescribed and properly administered, code the reaction plus the appropriate code from the E930-E949 series. Codes from the E930-E949 series must be used to identify the causative substance for an adverse effect of drug, medicinal and biological substances, correctly prescribed and properly administered. The effect, such as tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure, is coded and followed by the appropriate code from the E930-E949 series. This would eliminate multiple choice A.

45 B According to ICD-9-CM guidelines: Chapter 11 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 11 codes to further specify conditions.

46 C This patient is qualified by Medicare to be a high risk by having a history of ulcerative colitis. A note is found under code G0105 that states: An individual with ulcerative enteritis or a history of a malignant neoplasm of the lower gastrointestinal tract is considered at high-risk for
colorectal cancer, as defined by CMS. This eliminates multiple choices A and D. The screening was performed via barium enema eliminating multiple choice B.

47 C Protected health information under the Health Information Portability and Accountability Act (HIPAA) is any information, whether oral or recorded, in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse relating to the past, present, or future physical or mental health or condition of an individual, the provision of health services to that individual, or payment around those services. Only health information at the individual level is covered; health information of groups is not.

48 C HIPAA’s provisions protect the privacy and security of electronic claims submission, so these two are not benefits. Timely submission of claims - as well as lower cost - are both benefits of electronic claims submission. Further, data analytics are greatly enabled by electronic transmission and storage of data.

49 A The ICD-9-CM coding guidelines tell us: In most cases the manifestation codes will have in the code title, “in diseases classified elsewhere.” Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. “In diseases classified elsewhere” codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition.

50 D The guidelines say, If two or more events cause separate injuries, an E code should be assigned for each cause. The first listed E code will be selected in the following order: 1. E codes for child and adult abuse take priority over all other E codes. 2. See Section I.C.19.e., Child and Adult abuse guidelines. 3. E codes for terrorism events take priority over all other E codes except child and adult abuse 4. E codes for cataclysmic events take priority over all other E codes except child and adult abuse and terrorism. 5. E codes for transport accidents take priority over all other E codes except cataclysmic events and child and adult abuse and terrorism. The first-listed E code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

51 A To start narrowing your choices was the biopsy performed percutaneously or by an open incision? The op note documents that a “SenoRx needle” was used to obtain the biopsy, eliminating multiple choice answer B. There is a parenthetical note under code 19103 that states “For imaging guidance performed in conjunction with 19102, 19103 see 76942, 77012, 77021, 77031, 77032”. The op note documents “stereotactic used to target coordinates for the biopsy”, leading you to radiology code 77031. Code 19295 is correctly coded since a “tissue marking clip (metallic localization clip) was deployed into the biopsy cavity”.

52 B The first procedure performed was a punch biopsy, eliminating multiple choice C and D. The second lesion on the lip was removed by the shaving technique. Modifier -59 indicates that the biopsy was totally separate (from another site), otherwise it is bundled with 11310. Modifier -51 indicates multiple procedures performed during the same session.

53 C Patient is having blepharoplasty done on the upper eyelids, eliminating multiple choice answer D. There is no indication in the scenario that excessive skin weighing down the lid had to
be excised, eliminating multiple choice answers A and B. Modifier 50 is appended to indicate the procedure was performed on both eyelids.

54 D To start narrowing down your choices was the procedure an open procedure or performed with an arthroscope? It was performed with an arthroscope, eliminating multiple choice answers A and B. The diagnostic arthroscopy (29805) is a separate procedure, and according to CPT Surgery guidelines “The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component”. Meaning code 29806 already includes the diagnostic arthroscopy code, so you would only report code 29806. Code 29806 represents suturing of the capsule (capsulorrhaphy); however, this was not the procedure performed. The procedure performed was a lysis of adhesions for a frozen shoulder (29825) noted in multiple choice answer D.

55 C To start narrowing the correct arthrodesis code to report, you first need to determine the approach. The scenario tells us that the patient was placed in prone position (lying face down) and a lumbar incision was made indicating a posterior approach, eliminating multiple choices B and D. The next bit of information to look for is the technique that was used for the arthrodesis, which was the interbody fusion technique guiding you to code 22630.

56 B In the beginning of the procedure note it documents, “the fracture was manipulated”, eliminating multiple choice answer A. Was the fracture treatment opened or closed? There is no indication in the op note that an incision was made for internal fixation, eliminating multiple choice answer D. The key words to choose the correct code between B and C is “external fixator” where pins are connected to bone and to an external fixator to help the fracture heal. The fixator was a uniplane system as only one external fixator was applied in one plane (20690).

57 A The patient is having an insertion of a pace maker, eliminating multiple choice answers C and D. A subcutaneous pocket was created for the pacemaker generator and the leads connected to the generator were placed in the atrium and ventricle leading you to multiple choice answer A.

58 B Patient was having a lumpectomy, eliminating multiple choice answers A and D. An injection of blue dye was performed in the periareola area and two lymph nodes were removed along with an axillary “hot node”, eliminating multiple choice C. Only one incision was made to accommodate the removal of the breast lesion and the axillary lymph nodes. Modifier -52 is appended to 38525 because a separate incision was not performed for the axillary lymph nodes. Note that 19302 which describes a lumpectomy includes axillary lymphadenectomy. In this procedure lymph nodes between the pectoralis major and the pectoralis minor and nodes in the axilla are removed which was not the case.

59 D You can start narrowing your choices by the modifiers. Appendix A in the CPT manual lists the numeric modifiers. The key phrase to choose the correct modifier is “planned return”, which is found in the descriptive for modifier 58.

60 D The patient had a secundum atrial septal (atrioseptal) defect, eliminating multiple choice answers A and C. The surgery was only performed on the atrial septum, eliminating multiple choice answer B. According to ICD-9 guidelines: “Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis
has not been established (confirmed) by the provider. Signs and symptoms that are associated routinely with a disease process should not be coded assigned as additional codes, unless otherwise instructed by the classification.” Shortness of breath (786.05) is a symptom of an atrium secundum defect and would not be coded.

61 C This surgical procedure was not performed by a laparoscope: it was an open surgery, eliminating multiple choice answers B and D. It is documented the adhesions were “extensive” and the procedure was “time consuming” to free up the attachments to the gastrointestinal tract. These are key words in indicating modifier 22 should be appended to the procedure code. Appendix A lists the modifiers.

62 B The endoscopy was performed along with a placement of a catheter, eliminating multiple choice answers C and D. Since the placement was a catheter, multiple choice answer A is eliminated. The correct answer is 43241 with modifier -52 appended to indicate that the endoscope did not pass into the duodenum and/or jejunum.

63 A The surgery was not performed with a laparoscope, eliminating multiple choice answer D. The patient did not have a diagnosis of congenital atresia, eliminating multiple choice answer B. This was an unplanned return to the operating room due to the patient having a complication from the original surgery that was performed a week ago, eliminating multiple choice answer C.

64 B The surgery was not performed by a laparoscope, eliminating multiple choice answer D. The patient had a colostomy (Artificial surgical opening anywhere along the length of the colon to the skin surface for the diversion of feces) done, not an anastomosis (surgically creating a connection between bowel segments to allow flow from one to the other), eliminating multiple choice answer A. The op note documents that the distal left colon was divided and the sigmoid colon excised, eliminating multiple choice answer C.

65 A Patient does not have a penile injury, eliminating multiple choice D. Code 54360, Plastic operation on penis to correct angulation is not correct because this patient has hypospadias and 54304 is the correct answer, thus eliminating multiple choice C. The surgery is not correcting a hypospadias complication, but straightening the curvature (chordee), eliminating multiple choice answer B. The correct answer is A, 54304. The penis was degloved and the foreskin divided into flaps to accommodate a plastic repair of the chordee. The hypospadias was not repaired at this time; however, the repair of the angulation is the first step before the hypospadias can be repaired.

66 B Patient is terminating her pregnancy by dilation and evacuation (D&E), eliminating multiple choice answer A. There is no documentation of this being an incomplete abortion, eliminating multiple choice answer C. The abortion was not induced by intra-amniotic injection(s), eliminating multiple choice answer D.

67 B One way to narrow down the choices is to code for the endometrial ablation using the hysteroscope. Since the endometrial ablation was done with hysteroscopic guidance, multiple choice answer A is eliminated. No biopsies were taken or polyps removed eliminating multiple choice answer C. The removal of her ovaries and fallopian tubes (oophorectomy and salpingectomy) were performed by a laparoscope, eliminating multiple choice answer D.
68 D Laminectomy was performed, eliminating multiple choice answer B. Facetectomy and foraminotomy were performed, eliminating multiple choice answer C. The laminectomy is performed bilaterally on three segments of the cervical. Modifier 50 is not appended to code 63045-63048, since the code descriptive has a parenthetical note indicting that these codes include unilateral or bilateral, eliminating multiple answer A.

69 C The surgery is an extracapsular cataract removal, eliminating multiple choice D. The removal of the cataract and the insertion of the lens were performed at the same time, eliminating multiple choice A. The keyword to choose between codes 66982 and 66984 is “iris expansion device” which was used to remove the cataract, eliminating multiple choice answer B.

70 A The patient is under general anesthesia eliminating multiple choice answer C. A ventilating tube was placed in the ears eliminating multiple choice answer D. The diagnosis is indexed in the ICD-9-CM manual under Otitis/media/chronic/mucoid, mucous guiding you to code 381.20, eliminating multiple choice answer B.

71 A According to E/M Guidelines “When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M services.” The extent of the counseling/coordination of care must be documented. In this case, the office level visit was 99213 (Expanded problem focused exam and low medical decision making). The average time listed in the description of 99213 is 15 minutes. The report states that an additional 45 minutes was spent in counseling for a total time of 60 minutes of which, more than 50% was spent in counseling. The E/M visit is taken up to 99215 which has a time description of 40 minutes. Prolonged services can only be reported after 30 additional minutes. In this case 10 minutes remain; therefore, only report 99215.

72 C Patient was not initially admitted to the hospital. The scenario indicates the physician evaluating the patient on the following day of admission, eliminating multiple choice B. The patient is not in observation status in which she was admitted and discharged on the same date of service, eliminating multiple choice answer D. There is no request documented in the scenario for another physician to recommend care for the condition, eliminating multiple choice A. Subsequent hospital care codes require two of the three key components be met. In this case, we have detailed history and exam and low MDM which qualify for 99233.

73 B According to CPT® subsection guidelines under Initial Observation Care: When “observation status” is initiated in the course of an encounter in another site of service (example, hospital emergency department, physician’s office, nursing facility) all evaluation and management services provided by the supervising physician in conjunction with initiating “observation status” are considered part of the initial observation care when performed on the same date. Meaning you will not report an emergency service code since the patient was placed in observation care from the ER on the same date of service, eliminating multiple choice C. CPT® subsection guidelines add: Evaluation and management services on the same date provided in sites that are related to initiating “observation status” should not be reported separately. This eliminates multiple choice A. Patient was not admitted and discharged in observation status on the same date of service, eliminating multiple choice D.
74 C The patient receives general anesthesia for the repair of a cleft palate. From the CPT®
index, look up anesthesia/cleft palate repair. You are referred to 00172. Verify the code
description for accuracy. The patient is 6 months old, 99100 is appropriate for this scenario.

75 B The patient had a previous mastectomy. For this encounter the mastopexy and
reconstruction is performed. From the CPT® index, look up anesthesia/breast. You are referred
to 00402-00406. Refer to the code description for the correct code. 00402 is the correct code
for anesthesia administered for breast reconstruction.

76 C A code is selected for the general anesthesia performed for the total knee replacement.
From the CPT® index, look up anesthesia/replacement/knee. You are referred to 01402 which is
the correct code. The lumbar epidural is also reported because the purpose is for postoperative
pain. The procedure is reported with 62319. There is a parenthetical note following 62319 that
indicates to use 01996 in conjunction with 62318-62319. 01996 is a per day code. In this
scenario, the physician performs two days of daily management. Modifier AA indicates the
anesthesia was performed by an anesthesiologist.

77 C Angiography was of the common carotids, eliminating multiple choice answers A and B and
C. The angiogram was performed bilaterally in the right and left cervical carotid. Access to the
right common carotid is second order 36216 while the access on the left is first order
brachiocephalic 36215. Modifier -59 is required to show two separate brachiocephalic families
coming off the aorta.

78 D Radioactive seeds were inserted directly into the prostate transperineally using needles
(percutaneous), eliminating multiple choice answers A and C. There is a parenthetical note
under code 55875 that states “For interstitial radioelement application, see 77776-77787“. A
urologist may insert the hollow needles into the prostate (55875) and the physicist may insert
the seeds into the needles. Some insurance companies permit one physician to report both the
insertion of the needles and the seeds.

79 A The x-ray was taken in two views (oblique and lateral) without arthrography, eliminating
multiple choice answers B and C. The fracture is an open fracture which is indexed in the ICD-9-
CM manual under Fracture/radius/lower end or extremity/open referring you to code 813.52.

80 A To report codes for drug testing depends on the method and how many drug classes are to
be tested. The scenario documents the method of the drug screening being performed by using
an immunoassay method on each single drug class, guiding you to code 80101. Each drug class is
reported separately for this code meaning since there are three drug classes being tested you
will report 80101 three times. A drug confirmation was performed for one drug, reporting code
80102 only once.

81 C The lab test being performed in this scenario is for therapeutic drug monitoring to assist
the physician in drug regimen adjustment to reach an optimal drug concentration ensuring an
adequate therapeutic response without drug-induced adverse effects, guiding you to codes
80150-80299. The patient is not having a drug screening test in which the physician is
determining a specific drug present or not present in the patient (qualitative) eliminating
multiple choice answer A. Drug confirmation code, 80102, is only used with the drug testing
codes not therapeutic drug assay codes according to CPT ® guidelines.
The test being performed is a glucose tolerance test (GTT) guiding you to code 82951. Five blood specimens were taken in which the first three blood specimens are reported with code 82951. The last two blood specimens will be reported with code 82952 twice.

The physician requests a blood gas for oxygen saturation ($O_2$) only, guiding you to code 82810. Modifier 51 is appended to surgical procedure codes meaning since this code is a lab code modifier 51 is inappropriate, eliminating multiple choice answers A and C. There is no mention of an outside lab, eliminating multiple choice D. The physician would report 36600 for the arterial puncture.

All three components are documented to report code 93015, in which the cardiologist is supervising, he owns the equipment (tracing), since the test is being performed in the office, and the physician interpreted the test. Modifier 26 would be inappropriate to append to code 93015 since it denotes the global service.

Patient is having a hydration infusion eliminating multiple choices C and D. The add-on-code is incorrect to report for this scenario. A parenthetical statement states: (Report 96361 for hydration infusion intervals of greater than 30 beyond 1 hour increments) meaning if the hydration infusion is 30 minutes or less you would not report 96361.

This patient is coming in for occupational therapy which helps a patient to improve basic motor functions and reasoning abilities for independent daily living. This eliminates multiple choice B. This is a re-evaluation visit eliminating multiple choice C. The diagnosis code V57.21 is correct to report since the patient is receiving occupational therapy, eliminating multiple choice D.

Osteomyelitis is an inflammation of bone and bone marrow caused by a bacterial infection which can lead to a reduction of blood supply to the bone. In the ICD-9-CM alphabetical index, osteomyelitis guides you to code 730.2. In the tabular index, category code 730 is Osteomyelitis, periostitis, and other infections involving bone.

Trich/o means hair. In the ICD-9-CM alphabetical index look for a diagnosis that starts with Trich. The first diagnosis that starts with that root word is, Trichiasis referring you to code 704.2. In the tabular section for category 704 is Diseases of hair and hair follicles.

The series of terms are lobes found in the brain. You can find an illustration of the brain showing the different lobes in your CPT® manual in the beginning of the Nervous System section.

Pyeloplasty is the surgical reconstruction or revision of the pelvis of the kidney (renal) to correct an obstruction. The CPT® manual index refers you to codes 50400-40504, and 50544 for Pyeloplasty. The code is found under the Repair heading in the Tabular and the code description states “plastic operation on renal pelvis” to help you know what is being performed.

According to ICD-9-CM guidelines: Sequence first the code that reflects the highest degree of burn when more than one burn is present. This eliminates multiple choice A. When reporting
the percentage of body burns (948.XX) you first need to know the total percentage of the body burned to report the fourth digit. For our scenario the total percentage of the body burned is 10 percent which guides you to code 948.1X. Your fifth digit indicates the total body percentage of a third degree burn. For our scenario the hands had a 4 percent third degree burn guiding you to zero for your fifth digit eliminating multiple choices B and D. The second degree lower arm burn is indexed under Burn/arm/lower-see Burn, forearm(s). Burn/forearm(s)/with/second degree burn guiding you to code 943.21.

92 C The diagnosis esophageal varices in indexed in the ICD-9-CM manual under Varix/esophagus/bleeding/in/cirrhosis of liver guiding you to codes 571.5 [456.20]. This eliminates multiple choices B and D. According to ICD-9-CM guidelines: Brackets are used in the index to identify manifestation codes. In most cases the manifestation codes will have in the code title, “in diseases classified elsewhere.” “In diseases classified elsewhere” codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. In the tabular section under subcategory code 456.2 there is a color prompt statement: Code first underlying cause, as: cirrhosis of liver (571.0-571.9); portal hypertension (572.3). Meaning for the scenario cirrhosis of liver is coded first then the esophageal varices with bleeding are coded as a secondary code.

93 D According to ICD-9-CM Guidelines: A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The code for the acute phase of an illness or injury that led to the late effect is never used with a code for the late effect. This eliminates multiple choice answers A and B. The guidelines further state: Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second. This eliminates multiple choice C.

94 C According to ICD-9-CM guidelines: V codes are for use in any healthcare setting. V codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain V codes may only be used as first-listed, others only as secondary codes.

95 B The key word to guide you to HCPCS code V2785 is cornea. The scenario addresses the code description. The donor cornea preparation indicates the processing, then the donor cornea being stored indicates the preserving and it being rinsed and transferred indicates the transporting.

96 A The injection given is Kenalog eliminating multiple choices C and D. Kenalog-40 provides 40 mg of triamcinolone acetonide. Code J3301 is reported for 10 mg so it will have to be reported four times to cover 40 mg. If 1cc Kenalog-10 was given, J3301 is only reported once since that provides 10 mg of triamcinolone acetonide.

97 A While B, C, or D might be done electronically, by definition they aren’t required to be done electronically. A digital X-ray is an X-ray with an image that is stored electronically rather than on film, and so A is the correct answer.
C Workers’ compensation is excluded from the definition of a health plan under the Health Insurance Portability and Accountability Act (HIPAA). Therefore, Workers Comp plans are not required to meet HIPAA standards for privacy, security or code sets.

ICD-9-CM guidelines are the only guidelines specifically mentioned in HIPAA. While HIPAA requires the use of the other code sets listed, there is no specific mention of the other guidelines in the law. This information is found in the guidelines at the front of your ICD-9-CM code book. These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. These guidelines are based on the coding and sequencing instructions in Volumes I, II and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

The guidelines read: An underdose of insulin due to an insulin pump failure should be assigned 996.57, Mechanical complication due to insulin pump, as the principal or first listed code, followed by the appropriate diabetes mellitus code based on documentation.

(D) patient is having Mohs Micrographic Surgery being performed only, eliminating multiple choice answer C. The first stage had three tissue blocks removed to report code 17313. The second stage had six blocks removed requiring two codes to be reported. Code 17314 covers the first five tissue blocks and code 17315 covers the remaining tissue block (or the sixth tissue block) removed in the second stage.

An adjacent tissue transfer (advancement flap) was used to repair a defect on the nose due to an excision of a malignant lesion, eliminating multiple choice answers C and D. The Section Guidelines in the CPT manual for Adjacent Tissue or Rearrangement state “Codes 14000-14032 are used for excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement”. “The excision of a benign lesion (11400-11446) or a malignant lesion (11600-11646) is not separately reportable with codes 14000-14302” thus eliminating multiple choice answer B.

C The abscess had already burst, with no need to perform an incision to open it, eliminating multiple choice answers A and B. The difference between multiple choice answers C and D, is that the patient is having the debridement performed due to a soft tissue infection in the perineum area.

You can narrow your choices down by the diagnosis. The beginning of the op note documents that core biopsies showed “papilloma”. In the alphabetic index, look up Papilloma, which refers you to see also Neoplasm, by site, benign. Neoplasm Table /breast/ benign (column) refers you to code 217. Procedure code 19125 is correct since preoperative placement of radiologic marker (preoperative needle localization with hookwire needle injection with methylene blue) was used to excise the lesion.

A The patient is having a fasciectomy, eliminating multiple choice answers C and D. The fasciectomy was performed on the hand as noted in “the fascial attachments to the flexor tendon sheath were released” and “subtotal palmar fasciectomy” The op note also mentions the middle finger where diseased fascia was also excised.
106 C The injection of is being performed in a joint, eliminating multiple choice answers B and D. The injection was performed on the sacroiliac joint with imaging confirmation eliminating multiple choice answer A. Arthrography was not performed; therefore, fluoroscopic guidance is reported with 77003-26 as noted in the notes below 27096.

107 C For this op note scenario only the meniscus was performed on, eliminating multiple choice answers A and D. There are two ways to choose the correct codes for this op note. One way, is procedure code 29875 is a separate procedure, according to CPT Surgery Guidelines: “The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.” A limited synovectomy (29875) was performed; however, it was performed in the medial compartment of the knee along with the medial meniscectomy; therefore, is not reported. Debridement was performed in the lateral and patellofemoral compartments; therefore, it is reported with 29822. Modifier -59 is appended to show a different compartment from the compartment for the meniscectomy. The diagnosis of chondromalacia (733.92) for the fibrillated articular cartilage of the tibial plateau and patella (717.7) are report with the debridement. The other way to choose the correct code for this procedure is by the diagnoses. The patient had a meniscus tear, but the op note indicates a more specific area of the tear. It documents that, “An upbiting basket was introduced to transect the base of the posterior horn flap tear”, indexed in the ICD-9-CM as Tear/ meniscus/ medial/ posterior horn/ old.

108 D The procedure performed is the reduction of an odontoid fracture, by incising (open treatment) the anterior neck (anterior approach) to reduce the fracture and placement of internal fixation (Kirschner wire and lag screw). Gardner-Wells tongs (20660) were applied originally to try to reduce the fracture with axial traction; however, this procedure is listed as a separate procedure and it should not be reported during the same session for reduction of the fracture.

109 C Modifiers need to be appended to all the procedures since the patient had to return to surgery within the postoperative period, eliminating multiple choice answer B. Appendix A lists the modifiers needed to append to the procedure codes. The patient did not have a planned return to surgery, eliminating multiple choice answer D. Nor did the patient have a repeat procedure on the same day of service, eliminating multiple choice answer A. The patient had to return to the operating room to have a thrombectomy and balloon angioplasty of the venous anastomosis due to the AV graft failing which is a complication that followed the initial procedure

110 A The key term for this scenario is “temporal artery biopsy”, which is found in the code descriptive for multiple choice answer A.

111 C A needle was used to obtain the biopsies, eliminating multiple choice answers B and D. An aspiration (drawing fluid out) was not performed, eliminating multiple choice answer A. Imaging guidance (ultrasound) was performed, correctly reporting 76942 from the parenthetical note.

112 B Patient had an open surgery appendectomy, eliminating multiple choice answer D. The scenario documents that there was also an abscess, eliminating A and C. The diagnosis is
indexed under Appendicitis/with peritoneal abscess, referring you to code 540.1. Verify code in the tabular section for accuracy.

113 C The age of this patient is 15, eliminating multiple choice answer B. The patient only had tonsils removed eliminating multiple choice A. Part of the uvula was removed, eliminating multiple choice answer D.

114 D The surgery was not performed by a laparoscope, eliminating multiple choice answer C. There is no mention of the hernia being incarcerated or strangulated, eliminating multiple choice answer B. According to CPT guidelines in the hernia repair section, codes 49560-49566 can be reported with mesh add-on code, 49568.

115 D Patient had started with a laparoscopic treatment for a tubal ectopic pregnancy. Due to the patient’s body size the laparoscopic approach was terminated, eliminating multiple choice answers A and B. The patient had the left fallopian tube removed (salpingectomy) removed, eliminating multiple choice answer C. When an laparoscopic surgical procedure fails, only the successful open procedure is reported (NCC Manual, version 6.1, April-June, 2000). Modifier -22 for unusual procedure would only be appended if the situation was truly unusual; therefore, it is not appropriate for this case.

116 C There is no documentation that supports the patient had a previous cesarean, eliminating multiple choice answer A. There is no documentation that supports patient having antepartum care or will be having postpartum care with the obstetrician delivering the baby, eliminating multiple choice answers B and D.

117 C Patient is having a repair for a rectocele, not a cystocele, eliminating multiple choice answers B and D. The repair of rectocele was performed by a “posterior” colporrhaphy approach, eliminating multiple choice answer A.

118 C The keywords in this craniectomy procedure to guide you to the correct code are cervical (C-1 and C-2) laminectomy, medulla, and Chiari malformation found in the code description of code 61343.

119 D The patient is having the injection in the paravertebral facet joints, eliminating multiple choice answers A and C. The code description for code 64490 has the fluoroscopic guidance included in the code, meaning that it should not be coded separately. Also there is a parenthetical note under code 64492 that states not to report 64492 more than once per day, eliminating multiple choice answer B.

120 B The procedure being performed is an entropian repair on the left lower eyelid, eliminating multiple choice answers A and D. Since there was a tarsal strip performed the procedure is an extensive repair, eliminating multiple choice C.

121 C According to CPT® guidelines: An established patient is one who has received professional face-to-face services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. This eliminates multiple choices A and B. The documentation in the scenario provides a problem focused history (Brief HPI, No ROS, No Past, Family or Social History). The physical exam is an Expanded problem focused (Limited exam
of three organ systems—Constitutional [vitals], Respiratory, and Cardiovascular). An established office visit requires at least 2 of 3 key components: Problem Focused History + Expanded Problem Focused Exam + Straightforward MDM = 99212

122 C All three key components (history, exam, and medical decision making) need to be met to qualify for a particular level of E/M service for an office visit of a new patient. According to the subsection guidelines in the CPT® manual under the heading: Instructions for Selecting a Level of E/M Service: Determine the Extent of History Obtained: (Scenario) -Extended HPI + Extended ROS + Complete PFPSH = Detailed History; Determine the Extent of Examination Performed: - Extended Examination = Detailed Exam; [Detailed history + Detailed exam + Medical Decision Making of high complexity = 99203] Detailed history and exam brought the level down to code 99203.

123 A According to the CPT® subsection guidelines for Inpatient Neonatal and Pediatric Critical Care: To report critical care services provided in the outpatient setting (example, emergency department or office) for neonates and pediatric patients of any age, see the Critical Care codes 99291, 99292. This would eliminate multiple choice D. There is documentation in which the ER physician spent a total of 30 minutes on a critical patient, eliminating multiple choice C. Blood gas (82803) is a lab procedure that is not separately reported by the physician when billing for critical care. A list of services included in reporting critical care is found in the subsection guidelines under Critical Care Services. Modifier 25 needs to be appended to 99291 since it is an evaluation and management service in which billable procedures were performed on the same date of service.

124 D An established patient office visit requires 2 of the 3 key components (history, exam and medical decision making) to qualify for a particular level of E/M service. The documentation in the scenario provides: Expanded Problem Focused History = Brief history (HPI) + Problem Pertinent review of systems (ROS) + No documentation of a Past, Family, and Social history (PFPSH); Expanded Problem Focused Exam =Limited two organ systems (Ears, nose, mouth and throat and Respiratory); Medical Decision Making = Moderate complexity [Expanded Problem Focused History + Expanded Problem Focused Exam + MDM Moderate = 99213] The strep culture came back positive for strep. This is indexed in the ICD-9-CM under Infection/streptococcal/sore throat guiding you to code 034.0. The second diagnosis is indexed under Otitis/media/acute/with effusion guiding you to code 381.00.

125 A MAC is performed for a procedure performed on the anterior trunk of the integumentary system. From the CPT® index, look up anesthesia/integumentary system/anterior trunk. You are referred to 00400 which is the correct code. The QS modifier is appended to identify that the type of anesthesia is MAC. The QX modifier is appended to report the service was provided by a medically directed CRNA.

126 A The procedure performed is a coronary artery bypass. From the CPT® index, look up anesthesia/heart/coronary artery bypass grafting. You are referred to 00566 and 00567. The note indicates that the heart and lung bypass was used. Select 00567 because the code description includes “with pump oxygenator.” The anesthesia start time is 6:00 PM and the anesthesia ends at 12:00 AM which is six hours.
127 C This radiological service is a bone density study using computed tomography (CT) to assess bone mass or density of the spine.

128 B This is a follow-up ultrasound since the previous ultrasound showed abnormalities of the fetuses. The note under 76816 states to report 76816 with modifier -59 for each additional fetus.

129 B Patient is having a broken tip of a catheter removed from the right ventricle, eliminating multiple choices A and D. There is a parenthetical note under code 37203 that states “For radiological supervision and interpretation use 75961”, eliminating multiple choice C. The fracture of the port-a-cath is a mechanical complication of a vascular device.

130 A Patient is having a peritoneocentesis performed, eliminating multiple choice answers B and D. The needle placement to withdraw the fluid was done under ultrasonic (imaging) guidance, eliminating multiple choice answer C. There is a parenthetical note under procedure code 49080 that states “If imaging guidance is performed, see 76942, 77012”.

131 B The chromosome analysis was taken from amniotic fluid eliminating multiple choices A, C and D. There were two karyotypes performed. Code 88267 only has one karyotype in its code description so code 88280 is reported for the additional karyotype. 30 cells were analyzed in which code 88285 is reported for the additional cells over the initial 15 cell count.

132 B Sperm isolation is performed. Sperm washing refers to separating the sperm from semen and getting rid of dead or slow-moving sperm as well as additional chemicals that may impair fertilization (89260). After this is done each egg is injected with sperm for fertilization. A needle is inserted through the egg’s outer shell into the cytoplasm of the egg for 10 oocytes or less (89280).

133 A In the CPT® index, look up Pathology/Surgical/Consultation. You are referred to 88321-88325. 88325 is the correct code. According to CPT® guidelines, “Code 88325 is used for a more comprehensive consultation on referred material that involves review of records and specimens.”

134 D The therapist is at the patient’s home site to teach home management for self care, guiding you to code 97535. The patient has a residual effect of hemiparesis from having a CVA. According to ICD-9-CM guidelines Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. The late effect codes for CVA’s are combination codes which means code 438.21 reports both the residual and cause in one code.

135 B The patient is 10-years-old with a cochlear implant. The CPT index for Cochlear Device, Programming guides you to code 92603.

136 C Infant is having the echocardiogram performed through the chest (transthoracic) not through the a device in the esophagus (transesophageal), eliminating multiple choices B and D. Modifier 26 needs to be appended since only the interpretation of the echocardiogram was performed by the pediatrician.
137 C Glomerulonephritis is a form of nephritis marked by inflammation of the glomeruli of the kidney. The ICD-9-CM alphabetical index refers you to code 583.9 for Glomerulonephritis. In the tabular index this code is found in the chapter for DISEASES OF THE GENITOURINARY SYSTEM.

138 A The humerus is the bone extending from the shoulder to the elbow. The humerus is a relatively thick bone with a large, round, smooth head that is joined at its upper end (proximally) with the shoulder blade (scapula) to form the shoulder joint and is joined at its lower end (distally) with the elbow. In the ICD-9-CM index Fracture, humerus, proximal end refers you to see Fracture/humerus/ upper end.

139 B The subsection guidelines in the CPT® manual in the Musculoskeletal System section defines Manipulation: is used throughout the musculoskeletal fracture and dislocation subsections to specifically mean the attempted reduction or restoration of a fracture or joint dislocation to its normal anatomic alignment by the application of manually applied force.

140 B This is when a man produces very little sperm count. The ICD-9-CM alphabetical index refers you to code 606.1 for Oligiospermia. In the tabular section oligiospermia is a type male infertility and most ICD-9-CM manuals have a definition under this diagnosis that states: Insufficient number of sperm in semen. Oligio means few and spermia (sperma) means sperm.

141 B Thoracentesis is indexed in the CPT® manual guiding you to codes 32421-32422. The code description has pleural cavity. Pleura is a thin serous membrane that envelops each lung and folds back to make a lining for the chest cavity. Thorac/o means chest or chest wall.

142 C An angiogram is an X-ray photograph or an imaging technique that uses contrast/dye to look inside blood vessels. The CPT® index under Angiography refers to codes in the Radiology section in which many arteries are listed in alphabetical order.

143 A Labyrinthitis is an inflammation of the inner ear which can cause vertigo and vomiting. In the alphabetical index, look for Labyrinthitis and you will see next to the term inner ear in parenthesis.

144 B According to ICD-9-CM guidelines: Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients. This eliminates multiple choice answers A and D. The patient is in a post-operative period since she is going back to the OR when just having a laminectomy performed and that is when the seroma was found. This eliminates multiple choice C because there is no mention of an infected seroma. The seroma is found in the index under Complications/surgical procedures/seroma, 998.13. A seroma is a pocket of clear serous fluid. After an operation, small blood vessels are ruptured and blood plasma can seep out and create seroma.

145 A This diagnosis is indexed under Hypertension/with/cardiovascular disease/with/heart failure/ Benign (column) guiding you to code 402.11. This eliminates multiple choice answers B and C. In the tabular index under category code 402 there is a color prompt note that states: Use additional code to specify type of heart failure (428.0-428.43), if known. Meaning code 428.0 (Congestive heart failure) is reported as a secondary code.
146 A The patient being 10 years-old that is getting a short arm fiberglass cast guides you to code Q4012.

147 B HCPCS code J7302 is reported specifically for the Mirena intrauterine contraceptive device.

148 D Local Coverage Decisions are Medicare Administrative Contractor rules that link procedure codes to diagnoses that are not considered medically necessary for a specific procedure. Most LCDs also provide a list of diagnosis codes for which a procedure may be covered; however, because other issues factor into payment, coverage is not guaranteed. Modifier guidelines and fee schedule information is included in the annual Medicare Physician Fee Schedule.

149 C Place of service codes are reported on the CMS-1500 to identify the location where a service was provided. In the front of the CPT® is a list of all place of service codes. A service provided in an ASC is reported with POS code 24.

150 B The guidelines say, If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.