2019

Medical Coding Training: CPC®

Answer Key

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HCPCS Level II codes and guidelines discussed in this book are current as of press time. The 2017 code set for HCPCS Level II was unavailable when published.

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AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides, exams, and workbooks are *actual, redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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Section Review—Answers and Rationales

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Section Review 1.1

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

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

2. **Answer:** B. Chronic venous insufficiency

   Rationale: According to the LCD, Chronic venous insufficiency is a systemic condition that may result in the need for routine foot care.

3. **Answer:** D. ABN

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

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

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

5. **Answer:** C. $100 or 25 percent

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

Section Review 1.2

1. **Answer:** D. Patients

   Rationale: Covered entities in relation to HIPAA include healthcare providers, health plans, and healthcare clearing houses. The patient is not considered a covered entity although it is the patient's data that is protected.

2. **Answer:** A. Only individuals whose job requires it may have access to protected health information.

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

3. **Answer:** B. HITECH

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

4. **Answer:** A. OIG Compliance Plan Guidance

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

5. **Answer:** C. OIG Work Plan

   Rationale: On its website, the OIG releases a Work Plan outlining its priorities. Within the Work Plan, potential problem areas with claims submissions are listed and will be targeted with special scrutiny.

Section Review 2.1

1. **Answer:** C. Root

   Rationale: The root is the word part holding the fundamental meaning to the medical term, and each medical term contains at least one root or base word.

2. **Answer:** B. Eyelid

   Rationale: The root Blephar- means eyelid, indicating a blepharoplasty is performed on the eyelid.

3. **Answer:** D. Surgical removal of an ovary and tube.

   Rationale: The root salpingo- means oviduct or tube. The root oophor- means ovary. The suffix -ectomy means excision or surgical removal of. The pairing of salpingo- with oophor- tells you the procedure was performed on the female reproductive organs and not the auditory system.

4. **Answer:** B. Nail

   Rationale: The root onych- means nail. Paronychia is inflammation of the nail fold surrounding the nail plate.

5. **Answer:** B. Beneath the fascia.

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

6. **Answer:** B. Creation of a hole in the trachea.

   Rationale: The root trache- means trachea. The suffix -ostomy means surgical creation of an opening. A tracheostomy is surgical creation of an opening in the trachea and is used to help a patient breath.

7. **Answer:** A. White blood cells.

   Rationale: The root leukocyte- means white blood cell. Leukocytosis is an increase in white blood cells, which can indicate infection in the body.

8. **Answer:** B. Surgical removal of the tongue.

   Rationale: The root gloss- means tongue. The suffix -ectomy means excision or surgical removal of. A glossectomy is partial or total removal of the tongue and can be performed to remove tongue cancer.

9. **Answer:** C. Common bile duct

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

10. **Answer:** A. Bladder and urethra

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

Section Review 2.2

1. **Answer:** D. Epithelial tissue

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

2. **Answer:** C. Thoracic cavity

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

3. **Answer:** A. Mucous membrane

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

4. **Answer:** B. Stratum Lucidum

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

5. **Answer:** C. Hypodermis

   Rationale: The hypodermis (subcutaneous) serves to protect the underlying structures, prevent loss of body heat and anchor skin to the underlying musculature. Fibrous connective tissue referred to as superficial fascia is included in this layer.

Section Review 2.3

1. **Answer:** D. Greenstick fracture

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

2. **Answer:** B. Pelvic Girdle

   Rationale: The axial skeleton includes the skull, hyoid and cervical spine, ribs, vertebrae, and sacrum. The appendicular skeleton includes the shoulder girdle, pelvic girdle, and extremities.

3. **Answer:** A. Metacarpals

   Rationale: Long bones are named for their shape, not their size. Metacarpals are long bones found in the hand that form the skeletal structure of the palm.

4. **Answer:** C. Synovial

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

5. **Answer:** A. Arthr/o

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

Section Review 2.4

1. **Answer:** C. Inferior and Superior Vena Cava

   Rationale: Deoxygenated blood enters the right atrium through the superior vena cava and inferior vena cava.

2. **Answer:** B. Left and right pulmonary veins

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

3. **Answer:** C. Angiocarditis

   Rationale: The root angi/o means vessel, the root cardi/o means heart, and the suffix -itis means inflammation. Angiocarditis is inflammation of the heart and vessels.

4. **Answer:** D. Endocardium

   Rationale: The prefix endo- means inner. The root cardi/o means heart. The endocardium is the inner lining of the heart.

5. **Answer:** B. Oxygen deficiency

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

Section Review 2.5

1. **Answer:** C. With a system of one-way valves

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

2. **Answer:** B. Phagocytes

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

3. **Answer:** D. Splenectomy

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

4. **Answer:** B. Subclavian veins

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

5. **Answer:** B. Lymphangitis

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

Section Review 2.6

1. **Answer:** D. At the bifurcation of the trachea into two bronchi

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

2. **Answer:** B. Nose

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

3. **Answer:** B. Incision into the chest wall

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

4. **Answer:** C. Alveoli and capillaries

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

5. **Answer:** B. -pnea

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

Section Review 2.7

1. **Answer:** A. Duodenum

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

2. **Answer:** C. Liver

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

3. **Answer:** B. Transverse colon

   Rationale: The ascending colon proceeds from the ileocecal valve upward to the hepatic flexure, becomes the transverse colon, and then turns downward to become the descending colon at the splenic flexure.

4. **Answer:** A. Buccal

   Rationale: Bucca means cheek. Buccal is relating to the cheek. Buccal swabs can be used for DNA testing.

5. **Answer:** D. Peristalsis

   Rationale: Wave like contractions called peristalsis move food through the digestive tract.

Section Review 2.8

1. **Answer:** B. Urethra

   Rationale: The male and female urethras are quite different anatomically in position and length; however, they perform the same function with regard to urine, and are treated similarly for many surgical procedures in the coding genre.

2. **Answer:** A. Excretion of metabolic wastes, and fluid and electrolyte balance

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

3. **Answer:** C. Cowper's glands

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

4. **Answer:** B. Epispadias

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

5. **Answer:** D. Either side of the introitus in the female

   Rationale: Bartholin's glands are found on either side of the introitus (external opening to the vagina).

Section Review 2.9

1. **Answer:** C. Central Nervous System

   Rationale: The brain and spinal cord are the components of the central nervous system (CNS). The Somatic Nervous System and the Autonomic Nervous System are the two divisions of the Peripheral Nervous System.

2. **Answer:** B. Choroid

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

3. **Answer:** D. Vitreous humor

   Rationale: A clear gel-like substance filling the posterior segment of the eye is called the vitreous and prevents the eyeball from collapsing.

4. **Answer:** B. Labyrinth

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

5. **Answer:** B. Otopyorrhea

   Rationale: Otopyorrhea is pus draining from the ear.

Section Review 2.10

1. **Answer:** D. Thyroid gland

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

2. **Answer:** B. Carotid body

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

3. **Answer:** C. Thymus gland

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

4. **Answer:** B. Pituitary gland

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

5. **Answer:** A. Adrenal glands

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

Section Review 2.11

1. **Answer:** A. Erythrocytes

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

2. **Answer:** B. Lymphocytes

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

3. **Answer:** C. Monocytes

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

4. **Answer:** D. Eosinophils

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

5. **Answer:** C. Mononucleosis

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

Section Review 3.1

1. **Answer:** C. NEC

   Rationale: NEC - Not elsewhere classifiable. This abbreviation, in the ICD-10-CM Alphabetic Index, represents "other specified." When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List. When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.

2. **Answer:** B. D70.4, R50.81

   Rationale: The instructions under code category D70 state to use additional code for any associated: fever (R50.81); mucositosis (J34.81, K12.3-, K92.81, N76.81). Cyclic neutropenia with an associated fever is reported with D70.4, R50.81. Additional codes are not reported as primary codes.

3. **Answer:** D. They do not affect code assignment.

   Rationale: Parentheses are used in both the ICD-10-CM Alphabetic Index and Tabular List to enclose supplementary words that may be present in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

4. **Answer:** C. The code that represents the condition most commonly associated with the main term.

   Rationale: The default code represents the condition that is most commonly associated with the main term, or is the unspecified code for the condition.

5. **Answer:** B. Category

   Rationale: Categories are three-character codes representing a single condition or disease.

Section Review 3.2

1. **Answer:** D. Always consult the Alphabetic Index first. Refer to the Tabular List to locate the selected code.

   Rationale: Introduction ICD-10-CM—How to Use the ICD-10-CM—Steps to Correct Coding tells us to locate the main term in the Alphabetic Index, then verify the code in the Tabular List.

2. **Answer:** B. S80.02XA

   Rationale: In the ICD-10-CM Alphabetic Index, look for the main term Bruise. You are directed to *see also* Contusion. Look for the main term Contusion, locate the site (subterm) knee and you are referred to S80.0-√. Review in the Tabular List. There is a 5th character symbol in front of subcategory code S80.0 to indicate the laterality of the contusion. The contusion is on the left knee, reporting so far is S80.02. There is a symbol for a 7th character, indicating you need to report two more characters to complete this code. Because you only have five characters, S80.02, you need to report an X as a placeholder for your 6th character and then an A to indicate the initial encounter for your 7th character. There is an instructional note under category code S80 that indicates which letters can be used as the 7th character. Correct code choice is S80.02XA.

3. **Answer:** D. N40.1, R33.8

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hyperplasia, hyperplastic/prostate/with lower urinary tract symptoms, which refers you to N40.1. In the Tabular List, code N40.1 has instructions to use an additional code for associated symptoms. Code R33.8 is listed as one of those additional codes to report the urinary retention. Correct code choice is N40.1 and R33.8. In ICD-10-CM, go to the Tabular List at the beginning of Chapter 14: Diseases of Genitourinary System (N00-N99); there is information on Anatomy of the Male Reproductive System/Common Pathologies/Benign Prostate Hyperplasia (BPH), which gives you a description of this condition.

4. **Answer:** D. I10

   Rationale: In the ICD-10-CM Alphabetic Index, look for Hypertension. You will see next to the main term Hypertension subterms (or nonessential modifiers) listed in parentheses, and the subterm essential is in parenthesis. Subterms that follow the main term, and are enclosed in parentheses, are nonessential modifiers, which clarify the diagnosis but are not required. Verify in the Tabular List that code I10 is for Essential Hypertension.

5. **Answer:** D. M25.551, M25.552

   Rationale: In the ICD-10-CM Alphabetic Index, look for Pain(s)/joint/hip. You are directed to subcategory code M25.55-. In the Tabular List, a 6th character is assigned to indicate laterality. Because there is no code choice for bilateral, M25.551 is reported for the right hip pain and M25.552 is reported for the left hip pain.

Section Review 3.3

1. **Answer:** B. R11.2

   Rationale: The ICD-10-CM Official Guidelines for Coding and Reporting, section I.B.9, give instructions to code both conditions together when a combination code applies. Look in the ICD-10-CM Alphabetic Index for Nausea/with vomiting. R11.2 combines the nausea and vomiting conditions. R11 is an incomplete code and requires additional characters.

2. **Answer:** C. There is no time limit on sequelae

   Rationale: ICD-10-CM Official Guidelines for Coding and Reporting, section I.B.10, state there is no time limit when sequela codes can be used.

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

   Rationale: ICD-10-CM Official Guidelines for Coding and Reporting, section I.B.8, state to code the acute condition first, followed by the chronic condition.

4. **Answer:** A. Check the ICD-10-CM Index to Diseases and Injuries to see if there are listings under threatened or impending; and if not, code the existing underlying condition(s), not the condition described as impending.

   Rationale: ICD-10-CM Official Guidelines for Coding and Reporting, section I.B.11, state to check the Alphabetic Index for listings under threatened or impending; and if not, code the existing underlying condition(s), not the condition described as impending.

5. **Answer:** C. S82.891A, S82.892A

   Rationale: ICD-10-CM Official Guidelines for Coding and Reporting, sections I.B.12 and I.B.13, state to use a diagnosis code only once for an encounter and to identify laterality when possible. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classifies to the same ICD-10-CM diagnosis code. If no bilateral codes are provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

   Look for Fracture, traumatic/ankle and you are referred to S82.899-. In the question, the ankle fracture does not further indicate a specific location or bone in the ankle that has been fractured, so subcategory S82.89- is correct. Verification in the Tabular List shows that there are specific codes for the right and left ankle and the codes require additional characters for laterality and initial encounter. Code S82.891A for the right ankle and S82.892A for the left, since there is not a code choice for bilateral.

Section Review 3.4

1. **Answer:** A. K80.20, G89.18

   Rationale: According to the ICD-10-CM Official Guidelines for Coding and Reporting, section IV.A.2, when a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the primary diagnosis and the complications as secondary diagnosis. Look for the main term Gallstone in the ICD-10-CM Alphabetic Index and you are referred to see also Calculus, gallbladder. Look for Calculus/gallbladder, which refers you to K80.20. For the postoperative pain, look for Pain(s)/postoperative NOS and you are referred to G89.18. Verify codes in the Tabular List.

2. **Answer:** D. N83.201, J06.9, Z53.09

   Rationale: ICD-10-CM coding guidelines, section IV.A.1, state to report the reason for surgery as the first listed diagnosis even if the surgery is cancelled due to a contraindication. Look in the ICD-10-CM Alphabetic Index for Cyst/ovary, ovarian (twisted) and you are referred N83.201. In the Tabular List, 6th character 1 is reported for the right side. For the respiratory infection, look in the Alphabetic Index for Infection/respiratory (tract)/upper (acute) NOS and you are referred to J06.9. Then, look for Canceled procedure/because of/contraindication, which refers you to Z53.09. Verify codes in the Tabular List.

3. **Answer:** C. R07.9, R50.9, R05

   Rationale: ICD-10-CM coding guidelines, section IV.H, instruct you to code signs and symptoms when the diagnosis is uncertain. Diagnosis stated as "rule out," "suspected," or "probably" are not reported. The pneumonia is a rule out diagnosis and is not coded. Instead, code the symptoms. In the ICD-10-CM Alphabetic Index, look for Pain(s)/chest (central) (R07.9), Fever (R50.9), and Cough (R05). Verify code selection in the Tabular List.

4. **Answer:** D. Z00.01, L98.9

   Rationale: ICD-10-CM coding guidelines, section IV.P. requires the coder to report first the general medical exam diagnosis and then the abnormal finding. Look in the ICD-10-CM Alphabetic Index for Examination (for) (following) (general) (of) (routine)/annual (adult) (periodic) (physical)/with abnormal findings Z00.01. In the Tabular List, there is a note to also report the code to identify the abnormal finding. Look in the ICD-10-CM Alphabetic Index for Lesion/Skin L98.9. Verify code selection in the Tabular List.

5. **Answer:** D. Z01.811, D73.1

   Rationale: ICD-10-CM coding guidelines, section IV.M, state to sequence first a code from subcategory Z01.81, *Encounter for preprocedural examinations.* Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Look in the ICD-10-CM Alphabetic Index for Examination/pre-procedural/respiratory (Z01.811) and for Hypersplenia, hypersplenism (D73.1). Verify the codes in the Tabular List.

Section Review 4.1

1. **Answer:** D. S72.052B, B20

   Rationale: ICD-10-CM guideline I.C.1.a.2.b. states, "If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (eg, the nature of the injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions." The open fracture of the head of the femur (S72.052B) is reported first as the reason for the visit because it is unrelated to HIV. To locate the diagnosis, look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/femur, femoral/upper end/head referring you to subcategory code S72.05-. In the Tabular List, 6th character 2 indicates the left femur. 7th character B indicates the initial encounter for a type 1 open fracture. HIV is symptomatic so it is reported secondarily with B20.

2. **Answer:** A. A41.9, R65.20, N17.9

   Rationale: ICD-10-CM guideline I.C.1.d.1.b indicates: The coding of severe sepsis requires a minimum of two codes. First, a code for the underlying systemic infection, followed by a code from subcategory *R65.2, Severe sepsis.* If the causal organism is not documented, assign code *A41.9, Sepsis, unspecified organism*, for the infection. Additional codes(s) for the associated acute organ dysfunction are also required (if present). The first code to report is sepsis; look for the main term Sepsis in the ICD-10-CM Alphabetic Index referring you to code A41.9. Next, look for Sepsis/with organ dysfunction (acute) (multiple) referring you to code R65.20. For the last code, look for Failure/renal/acute referring you to code N17.9. In the Tabular List, you will find an instructional note under subcategory R65.2 indicating what codes should be reported first and what codes should be reported as additional codes.

3. **Answer:** B. J15.212

   Rationale: Look in the ICD-10-CM Alphabetic Index for Pneumonia/in (due to)/staphylococcus/aureus/methicillin resistant (MRSA) J15.212. According to ICD-10-CM guideline 1.C.1.e.1.(a), when a combination code exists for MRSA and the infection, only the combination code should be reported. Pneumonia due to Methicillin-resistant Staphylococcus aureus is reported with J15.212.

Section Review 4.2

1. **Answer:** D. C78.01, Z85.3

   Rationale: According to ICD-10-CM guidelines 1.C.2.d., when a primary malignancy has been previously excised and there is no evidence of any existing primary malignancy, a code from category *Z85.-, Personal history of malignant neoplasm* should be used. Any mention of metastasis to another site is coded as a secondary malignant neoplasm to that site and the secondary site may be the first-listed with the Z85- code used as a secondary code. For the metastasized lung cancer, look in the Table of Neoplasms for lung and use the code from the Malignant Secondary column (C78.0-). In the Tabular List, C78.01 is selected for the right lung. For the history of breast cancer, look in the ICD-10-CM Alphabetic Index for History/personal (of)/malignant neoplasm (of)/breast Z85.3. The correct codes and sequencing are C78.01 and Z85.3.

2. **Answer:** A. D64.81, C56.9, T45.1X5A

   Rationale: According to ICD-10-CM guidelines 1.C.2.c.2., because the treatment is directed at the anemia associated with chemotherapy, and the treatment is only for the anemia, the anemia should be sequenced first, followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5). Look in the ICD-10-CM Alphabetic Index for Anemia/due to (in) (with)/antineoplastic chemotherapy (D64.81). According to guideline 1.C.2.c.2. the malignancy is reported secondarily followed by code T45.1X5. Look in the ICD-10-CM Table of Neoplasms for ovary and report the code from the Malignant Primary column (C56.-). In the Tabular List, C56.9 is reported because the laterality is not stated. Next, to locate T45.1X5, look in the Table of Drugs and Chemicals for Antineoplastic NEC and selecting the code from the Adverse effect column (T45.1X5). In the Tabular List, T45.1X5 requires a 7th character extender. A is selected because this is considered active treatment.

3. **Answer:** D. Z51.11, C34.12

   Rationale: The ICD-10-CM Official Coding Guidelines, Section 1.C.2.e.2., states that if the reason for the encounter is solely chemotherapy, a diagnosis for chemotherapy administration should be listed first, and a diagnosis for the malignancy requiring the chemotherapy is reported secondarily. Look in the ICD-10-CM Alphabetic for Chemotherapy (session) (for)/neoplasm or Encounter (with health service) (for)/chemotherapy for neoplasm (Z51.11). A Pancoast's tumor is a rapid growing tumor in the apex of the lung. The apex of the lung is in the upper lobe for Pancoast's Tumor. Look for Tumor/Pancoast's - see Pancoast's syndrome. Look for Pancoast's syndrome or tumor C34.1-. Add 2 as the 5th character for left lung. The correct codes and sequencing are Z51.11 and C34.12.

Section Review 4.3

1. **Answer:** C. The chronic condition causing the anemia

   Rationale: ICD-10-CM Official Coding Guidelines, Section I.A.13., state when using a code from a category that indicates "in diseases classified elsewhere," such as in category D63, it is necessary to code first the chronic condition (underlying condition) causing the anemia. The codes from category D63 are manifestation codes that must be reported as the additional code following the underlying condition.

2. **Answer:** A. C61, D63.0

   Rationale: ICD-10-CM Official Coding Guidelines, Section I.C.2.c.1, states when the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for the anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia. The patient visited the oncologist for the prostate cancer and the lab tests indicate anemia due to cancer. According to the guidelines, the primary diagnosis reported for the visit, is prostate cancer. Look in the Table of Neoplasms for prostate (gland) and select the code from the Malignant Primary column C61. Then look in the Alphabetic Index for Anemia/in (due to) (with)/neoplastic disease D63.0. Verify codes in the Tabular List.

3. **Answer:** B. N18.3, D63.1

   Rationale: ICD-10-CM Official Coding Guidelines, Section I.A.13., states codes that fall under the category "in diseases classified elsewhere," are manifestation codes. There will be an instructional note (such as a code first note) with these manifestation codes that will indicate the proper sequencing order of the codes. Look in the ICD-10-CM Alphabetic Index for Anemia/in (due to) (with)/chronic kidney disease D63.1. See the Code first note instructing to report the CKD (N18-) code first. Look in the ICD-10-CM Alphabetic Index for Disease/kidney/chronic/stage 3 (moderate) N18.3. Verification in the Tabular List verifies correct sequencing as N18.3, D63.1

Section Review 4.4

1. **Answer:** A. When a patient's insulin pump malfunctions

   Rationale: The ICD-10-CM Official Coding Guidelines, Section I.C.4.a.5.a states to use a code from category T85.6 as the primary diagnosis for an underdose of insulin, due to insulin pump malfunction. The second code would be T38.3x6-, for the underdosing of insulin, followed by the appropriate diabetes mellitus code based on documentation.

2. **Answer:** A. E11.9, Z79.84

   Rationale: According to ICD-10-CM Official Coding Guidelines, Section I.C.4.a.1, the age of the patient is not the determining factor in what type of diabetes is coded. In addition, Section I.C.4.a.2 says if the type of diabetes mellitus is not documented in the medical record the default type is type 2. To find the code, look in the ICD-10-CM Alphabetic Index for Diabetes, diabetic (mellitus) (sugar). The default code is E11.9. Verification in the Tabular List verifies code selection. ICD-10-CM guideline I.C.4.a.3 directs the coder to report Z79.84 to indicate the patient uses oral hypoglycemic or antidiabetic drugs. Look in the Alphabetic Index for Long-term (current) (prophylactic) drug therapy (use of)/oral/ antidiabetic Z79.84.

3. **Answer:** A. E11.311

   Rationale: According to ICD-10-CM Official Coding Guidelines, Section I.C.4.a the diabetes codes are combination codes that include the type of diabetes, the body system affected, and the complications affecting that body system. To locate the codes in the ICD-10-CM code book, look in the ICD-10-CM Alphabetic Index for Diabetes, diabetic/with/retinopathy/ with macular edema E11.311. Verify code choice in the Tabular List.

Section Review 4.5

1. **Answer:** D. F50.01

   Rationale: In the ICD-10-CM Alphabetic Index, look for Anorexia/nervosa/restricting type which directs you to code F50.01. The patient is losing weight due to restricting her intake of food; this is considered restricting type. Weight loss is integral to the diagnosis of anorexia nervosa; therefore, no additional codes are assigned. Verify code selection in the Tabular List.

2. **Answer:** B. F10.20

   Rationale: The patient's diagnosis is uncomplicated alcohol dependence. In the ICD-10-CM Alphabetic Index, look for dependence/alcohol F10.20. Verify code selection in the Tabular List.

3. **Answer:** A. F90.0

   Rationale: The patient is diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), predominately inattentive type. In the ICD-10-CM Alphabetic Index, look for Disorder (of)/attention deficit hyperactivity (adolescent) (adult) (child)/ inattentive/ type F90.0. Verify code selection in the Tabular List.

Section Review 4.6

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

   Rationale: According to ICD-10-CM Official Coding Guidelines, Section I.C.6.b.1(a), when pain control or pain management is the reason for the admission/encounter, a diagnosis from G89 can be reported as the primary diagnosis.

2. **Answer:** B. C34.92, G89.3

   Rationale: According to ICD-10-CM Official Coding Guidelines, 1.C.6.b.5, when the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional diagnosis. In the Table of Neoplasms, look for lung and select the code from the Malignant Primary column. The Tabular List indicates a 5th character 2 for the left lung. To report the pain associated with the neoplasm, look in the ICD-10-CM Alphabetic Index for Pain/due to cancer G89.3.

3. **Answer:** C. G89.21, M54.5

   Rationale: According to ICD-10-CM Official Coding Guidelines, Section I.C.6.b.1(a), when a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the first listed diagnosis. According to ICD-10-CM guideline 1.C.6.b.1.b.ii, a code to report the site of pain may be sequenced as a secondary diagnosis. In the ICD-10-CM Alphabetic Index, look for Pain/Chronic/due to trauma G89.21 (because the pain is due to the falling off a roof). To report the location of the pain, look in the ICD-10-CM Alphabetic Index for Pain/low back M54.5.

Section Review 4.7

1. **Answer:** D. H40.1312, H40.1321

   Rationale: ICD-10-CM Official Coding Guidelines, Section 1.C.7.a.3, state when the glaucoma codes report laterality, and each eye is in a different stage, a code is reported for each eye. Look in the ICD-10-CM Alphabetic Index for Glaucoma/pigmentary and you are directed to *see* Glaucoma, open angle, primary, pigmentary. This path directs you to code H40.13-. In the Tabular List, 6th character 1 indicates the right eye, 7th character 2 indicates moderate stage. For the left eye, 6th character 2 indicates the left eye and 7th character 1 indicates mild stage. The moderate stage is reported first because it is more severe.

2. **Answer:** B. H10.021

   Rationale: Look in the ICD-10-CM Alphabetic Index for Pink/eye and you are directed to see conjunctivitis, acute, mucopurulent. Mucopurulent is a secretion of mucus or pus from the eye. This path directs you to H10.02-. In the Tabular List, 6th character 1 indicates the right eye.

3. **Answer:** A. H25.12

   Rationale: Look in the ICD-10-CM Alphabetic Index for Cataract/age-related and you are directed to see Cataract, senile. Cataract/senile/nuclear (sclerosis) directs you to H25.1-. A 5th character 2 is selected for the left eye.

Section Review 4.8

1. **Answer:** D. H66.91

   Rationale: Look in the ICD-10-CM Alphabetic Index for Otitis (acute)/media/acute, subacute H66.90. In reviewing the Tabular List, H66.90 is unspecified and there are more specific codes that indicate laterality. The 5th character 1 indicates the right ear. Right ear pain (H92.01) and fever (R50.9) are signs/symptoms for the acute otitis media and not separately reported (refer to ICD-10-CM guideline I.B.5).

2. **Answer:** B. H81.01

   Rationale: Look in the ICD-10-CM Alphabetic Index for Meniere's disease, syndrome or vertigo H81.0-. The 5th character 1 indicates the right ear. The vertigo (R42), loss of hearing (H91.91) and the tinnitus (H93.11) are signs/symptoms for the Meniere's disease and not separately reported (refer to ICD-10-CM Guideline Section I.B.5.).

3. **Answer:** A. H61.23

   Rationale: Look in the ICD-10-CM Alphabetic Index for Impaction, impacted/cerumen (ear) (external) H61.2-. In the Tabular List, a 5th character 3 indicates bilateral. Because there is a bilateral code for this condition only one code is reported for both ears (refer to ICD-10-CM guideline I.B.13).

Section Review 4.9

1. **Answer:** D. Sequencing is based on the reason for the encounter.

   Rationale: ICD-10-CM Official Coding Guidelines, Section I.C.9.a.5, state Background retinopathy and retinal vascular changes, should be used with a code from category I10-I15 to identify the hypertension. Sequencing is based on the reason for the encounter.

2. **Answer:** C. Code only STEMI

   Rationale: ICD-10-CM Official Coding Guidelines, Section 1.C.9.e.1, state that if STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

3. **Answer:** B. Hypertension and chronic kidney disease

   Rationale: ICD-10-CM Official Coding Guidelines, Section 1.C.9.a.2 - Section I.C.9.a.3, state that hypertension has a presumed cause-and-effect relationship with CKD.

Section Review 4.10

1. **Answer:** B. Worsening or decompensation of asthma or COPD

   Rationale: ICD-10-CM Official Coding Guidelines, Section 1.C.10.a.1, states an acute exacerbation is a worsening or decompensation of a chronic condition.

2. **Answer:** C. J45.902

   Rationale: The final diagnosis is asthma with status asthmaticus. To locate the code in the ICD-10-CM Alphabetic Index, look for Asthma/with/status asthmaticus, J45.902. Verify code selection in the Tabular List.

3. **Answer:** C. J44.0, J20.9

   Rationale: Locate the correct code in the ICD-10-CM Alphabetic Index by looking for Disease/pulmonary/chronic obstructive/with/acute bronchitis, J44.0. In the Tabular List, there is a note under J44.0 to use an additional code to identify the infection. Look in the Alphabetic Index for Bronchitis/acute or subacute (with bronchospasm or obstruction) J20.9. Verify code selection in the Tabular List.

Section Review 4.11

1. **Answer:** B. K41.91

   Rationale: In the ICD-10-CM Alphabetic Index, look for Hernia/femoral/recurrent. You are directed to K41.91. Verify the code selection in Tabular List.

2. **Answer:** B. K70.30, F10.20

   Rationale: In the ICD-10-CM Alphabetic Index, look for Cirrhosis, cirrhotic (hepatic) (liver)/Laennec's/alcoholic K70.30. In this scenario the patient has a history of alcohol use making K70.30 the correct code. There is an instructional note under category code K70 to use additional code to identify alcohol abuse and dependence. The patient is alcohol dependent. In the Alphabetic Index, look for Dependence/alcohol referring you to code F10.20. Verify code selection in the Tabular List.

3. **Answer:** C. K80.10

   Rationale: The patient is diagnosed with gallstones (cholelithiasis) and gallbladder inflammation (cholecystitis). In the ICD-10-CM Alphabetic Index, look for Cholecystitis/with calculus, stones in/gallbladder; you are referred to – *see* Calculus gallbladder, with cholecystitis. Look for Calculus/gallbladder/with cholecystitis which directs you to K80.10. Because code K80.10 is a combination code for both cholelithiasis and cholecystitis only one code is reported, not each separately (Refer to ICD-10-CM guideline I.B.9). Verify code selection in Tabular List.

Section Review 5.1

1. **Answer:** D. L89.619, L89.629

   Rationale: Codes for pressure ulcers are determined by site, stage, and laterality. In this case, the patient has pressure ulcers on each heel. Look in the ICD-10-CM Alphabetic Index for Ulcer/pressure/heel L89.6-. In the Tabular List, a 5th character is required for laterality and 6th character is required for the stage. Report L89.619 for the right and L89.629 for the left. The stage is not documented; it is coded as unspecified stage. Unstageable can only be coded based on clinical documentation, which is not documented in this case.

2. **Answer:** D. L24.0

   Rationale: The patient is diagnosed with dermatitis due to detergent. In the ICD-10-CM Alphabetic Index, look for Dermatitis/due to/detergents (contact) (irritant). You are referred to L24.0. Verify the code selection in the Tabular List.

3. **Answer:** A. L02.416

   Rationale: In the ICD-10-CM Alphabetic Index, look for Abscess/leg. This refers you to see Abscess, lower limb L02.41-. In the Tabular List, a 6th character is required for laterality and location. 6th character 6 is reported for the left lower limb.

Section Review 5.2

1. **Answer:** A. M51.17

   Rationale: L5 and S1 refer to the 5th lumbar disc and the 1st sacral disc in the vertebra. Look in the ICD-10-CM Alphabetic Index for Hernia, hernial/intervertebral cartilage or disc, you are referred to see Displacement, intervertebral disc. Look for Displacement, displaced/intervertebral disc NEC/lumbosacral region/with neuritis, radiculitis, radiculopathy or sciatica M51.17. Verify code selection in the Tabular List.

2. **Answer:** B. M75.111, M19.011

   Rationale: The patient has a degenerative incomplete rotator cuff tear on the right shoulder and primary degenerative arthritis. The primary reason for the procedure is the tear, so it is reported first. In the ICD-10-CM Alphabetic Index, look for Tear, torn/rotator cuff (nontraumatic)/incomplete M75.11-. A trauma or injury needs to be indicated to report a traumatic rotator cuff tear code. In the Tabular List, complete the code for right shoulder. 6th character 1 is reported for the right shoulder. The complete code is M75.111. For the second diagnosis, look for Arthritis, arthritic/degenerative. You are referred to see Osteoarthritis. Look for Osteoarthritis/primary/shoulder M19.01-. In the Tabular List, a 6th character is required to report laterality. 6th character 1 reports the right shoulder. The complete code is M19.011.

3. **Answer:** C. M80.051A

   Rationale: A combination code is reported for the pathological fracture and osteoporosis. In the ICD-10-CM Alphabetic Index, look for Osteoporosis/age related/with current pathological fracture/ilium M80.05-. In the Tabular List, this section includes osteoporosis with current pathological fracture and the subcategory code is reported for age-related osteoporosis with current pathological fracture of hip. A 6th character is required. Complete the code with 6th character 1 for right femur and 7th character A for initial encounter.

Section Review 5.3

1. **Answer:** C. N13.30

   Rationale: The indication for the surgery is hydronephrosis. In the ICD-10-CM Alphabetic Index, look for the main term Hydronephrosis. There is no indication of causal organism, or that it is a congenital condition. The default code is N13.30. A review of this code in the Tabular List confirms this is the correct diagnosis.

2. **Answer:** D. D25.9

   Rationale: The patient is diagnosed with a uterine fibroid. The symptoms, heavy bleeding and painful menstruation, she is experiencing are integral to the definitive diagnosis and should not be coded. In the ICD-10-CM Alphabetic Index, look for main term Fibroid and then uterus. You are referred to D25.9. There is no location given of where the fibroid (leiomyoma) is located. Review of the code in the Tabular List confirms this is the correct code.

3. **Answer:** C. N40.1, R39.15

   Rationale: The patient is diagnosed with BPH (Benign Prostatic Hypertrophy) and urgency, which is a symptom of this condition. Look in the ICD-10-CM Alphabetic Index for the main term Hypertrophy then prostate, which directs you to see Enlargement, enlarged, prostate. Look for Enlargement, enlarged/prostate/with lower urinary tract symptoms (LUTS) N40.1. In the Tabular List, N40.1 has a note to "Use additional code for associated symptoms, when specified." Use R39.15 to report the urinary urgency. Because code R39.15 is listed as an additional code, it is not reported as primary code.

Section Review 5.4

1. **Answer:** C. O99.012, D50.9, Z3A.21

   Rationale: Codes O99.012, Z3A.21 are both assigned. ICD-10-CM guideline 1.C.15.b.3 indicates, "in episodes where no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter". Look in the Alphabetic Index for Pregnancy/complicated by/anemia O99.01-. Verification in the Tabular List indicates the code is completed with a 6th character based on trimester. Choose O99.012 for second trimester. There is an instructional note under category code 099 that indicates to use an additional code to identify the specific condition. Code D50.9 is reported for iron deficiency anemia. Use additional code for number of weeks. Look for Pregnancy/weeks of gestation/21 weeks Z3A.21.

2. **Answer:** A. O72.2

   Rationale: Look in the ICD-10-CM Alphabetic Index for Retention/placenta/portions or fragments (with hemorrhage) O72.2. Verification in Tabular List confirms correct code choice.

3. **Answer:** D. T22.212A, T22.211A, T31.0, Z33.1.

   Rationale: The pregnancy is incidental to the problem for which the patient is treated, so complication pregnancy code O09.90 is not reported. The first listed code is for the burns. The patient has a second degree burn to both forearms. In the ICD-10-CM Alphabetic Index, look for Burn/forearm/right/second degree T22.211 and Burn/forearm/left/second degree T22.212. The 7th character, A, completes the code to indicate initial encounter. A code from category T31 is coded to indicate the TBSA burned, as well as the percentage of the burn that is third-degree. The TBSA is 9 percent and there are no third-degree burns. Look for Burn/extent (percentage of body surface)/less than 10 percent T31.0. The last code is for the pregnancy. Look for State (of)/pregnant, incidental or status (post)/pregnancy, incidental referring you to Z33.1. A code from category Z34 is not reported because that is if the patient was being seen for routine care or check-up of the pregnancy.

Section Review 5.5

1. **Answer:** B. It ends at 28 days

   Rationale: According to the ICD-10-CM Guidelines for Coding and Reporting, Section I.C.16, "For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth."

2. **Answer:** D. Z38.00, P59.9

   Rationale: The question is asking for the codes for the newborn's record. According to the ICD-10-CM guidelines I.C.16.a.1 codes from the obstetric chapter (Chapter 15) are never permitted on the newborn record, do not report codes O80 and Z37.0. ICD-10-CM guideline I.C.16.a.2 indicates, the first listed diagnosis code, Z38.00, is used to report the birth episode, followed by additional codes for perinatal conditions. Look in the ICD-10-CM Alphabetic Index for Newborn/born in hospital. You are referred to Z38.00. In the Alphabetic Index, look for Newborn/jaundice and you are referred to P59.8. Look in the Alphabetic Index for Jaundice/newborn and you are referred to P59.9. In the Tabular List, P59.9 is unspecified which is correct for this case. Verify all codes in the Tabular List.

3. **Answer:** B. P92.9

   Rationale: In the ICD-10-CM Alphabetic Index, look for Feeding/problem/newborn. You are referred to P92.9. Verify the code in the Tabular List.

Section Review 5.6

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

   Rationale: ICD-10-CM guideline I.C.17 states that codes Q00-Q99 "may be used throughout the life of the patient. If a congenital anomaly has been corrected, a personal history code should be used to identify the history of the malformation/deformation or deformity."

2. **Answer:** C. Z38.00, Q90.9

   Rationale: According to ICD-10-CM guideline I.C.17 for birth admission, the appropriate code from category Z38-Liveborn infants, according to the type of birth should be sequenced as the principal diagnosis, followed by any congenital anomaly codes Q00-Q99. To find the type of birth, look in the ICD-10-CM Alphabetic Index for Newborn/born in hospital Z38.00. Down Syndrome is reported secondarily and is found in the ICD-10-CM Alphabetic Index by looking for the main term Down Syndrome, Q90.9. Although category Q90 has a use additional note to also report associated physician condition and degree of intellectual disabilities, this is a newborn and this information is not known so it is not reported.

3. **Answer:** C. Q36.9

   Rationale: Look in the ICD-10-CM Alphabetic Index for Cheiloschisis referring you to *see* Cleft, lip. Look for Cleft/lip, you are directed to Q36.9. Verification in the Tabular List reports Cleft lip NOS under code Q36.9.

Section Review 5.7

1. **Answer:** B. R63.0, E86.0

   Rationale: ICD-10-CM guidelines tell us not to report an unsubstantiated, probable, or rule out diagnosis; therefore, a diagnosis of dementia is not appropriate at this time. The symptoms are dehydration and anorexia. Each of these terms requires a simple look-up in the ICD-10-CM Alphabetic Index. Although anorexia often is a short way of describing anorexia nervosa, in this case, there is no documentation of an eating disorder as a psychological disorder; look for the main term anorexia, R63.0, which is the correct diagnosis. Look for the main term Dehydration, E86.0. Verify all codes in the Tabular List.

2. **Answer:** B. R03.0

   Rationale: Elevated blood pressure is a nonspecific finding with no formal diagnosis of hypertension. This is considered an incidental finding. Hypertension should not be coded unless it is documented specifically by the physician. Look in the ICD-10-CM Alphabetic Index for Elevated, elevation/blood pressure/reading (incidental) (isolated) (nonspecific), no diagnosis of hypertension.

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

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

Section Review 5.8

1. **Answer:** A. S82.402A, S82.202A

   Rationale: Look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/fibula (shaft) (styloid) S82.40-. Next look for Fracture, traumatic/tibia (shaft) S82.20-. Verification in the Tabular List indicates the 6th character 2 for left side. 7th character A for initial encounter is also reported. S82.402A, S82.202A. According to the ICD-10-CM guidelines, when a fracture is not specified as open or closed, the default is to code it as closed. Even though an open repair is performed, the diagnosis is not determined by the type of treatment.

2. **Answer:** C. T80.218A, A49.02

   Rationale: When complications are reported, a code for the complication is reported first. If the cause of the complication is known, it is reported as the additional code(s). Look in the ICD-10-CM Alphabetic Index for Infection/due to or resulting from/central venous catheter/specified NEC T80.218-. Verification in the Tabular List indicates this code needs a 7th character. 7th character extension A is reported for the initial encounter. T80.218A is correct because we do know that this is an MRSA infection, however, we do not know whether it is a local infection or bloodstream infection. Next look for MRSA (Methicillin resistant Staphylococcus aureus)/infection A49.02. Verify code in the Tabular List.

3. **Answer:** D. T43.201A, R42, R61

   Rationale: The patient took the correct medication but accidently did not take it as prescribed. This is considered poisoning. The first code to report is the poisoning code for type of medicine, followed by the symptoms. Look in the Table of Drugs and Chemicals for antidepressant. The first code reported is the code from the Poisoning, Accidental (unintentional) column T43.201. Verification in the Tabular List indicates the need for a 7th character choosing A for initial encounter, T43.201A. The manifestation or condition codes are reported next. Look in the Alphabetic Index for Dizziness R42 and Sweating, excessive R61. Verify codes in the Tabular List.

Section Review 5.9

1. **Answer:** D. S52.302B, S52.202B, S02.630A, V43.62XA

   Rationale: A code is reported for each fracture. The radius and ulna fracture is open, which makes it the most severe injury; therefore, it is reported first. Look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/radius/shaft S52.30-. Verification in Tabular List indicates for the 6th character 2 for left radius and B for the 7th character for initial encounter for open Type 1 fracture, S52.302B. Next look for Fracture, traumatic/ulna (shaft) S52.20-. 6th character 2 is for the left radius and B for the 7th character for initial encounter for open Type I fracture, S52.202B. Look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/jaw (bone) (lower) - *see* Fracture, mandible. Look for Fracture, traumatic/mandible (lower jaw (bone))/coronoid process S02.63. In the Tabular List, 6th character 0 is reported for unspecified side and an A for the 7th character for initial encounter for a closed fracture, S02.630A. The patient was a passenger in a car that collided with another car. Look in the External Cause of Injuries Index for Accident/car - *see* Accident/transport, car occupant. Look for Accident/transport (involving injury to)/car occupant/passenger/collision (with)/car(traffic) V43.62-. Add placeholder X for the 6th character and A for the 7th character for initial encounter. There are no other circumstances known about the collision, so no other external cause codes are reported.

2. **Answer:** B. R04.0, W21.05XA, Y92.39, Y93.67, Y99.8

   Rationale: The epistaxis is caused from an injury; it is not hereditary. This is found by looking in the ICD-10-CM Alphabetic Index for Epistaxis (multiple) and using the default code R04.0. Four external cause codes are required in this case. The first code indicates how the injury occurred (hit with a ball). Look in the External Cause of Injuries Index for Struck (accidentally) by/ball (hit) (thrown)/basketball W21.05-. Add a placeholder X for the 6th character and an A for the 7th character to indicate initial encounter, W21.05XA. The next code reports where the accident occurred. Look for Place of occurrence/Gymnasium, Y92.39. Next, code the activity he was involved in at the time. Look for Activity/basketball Y93.67. The last external cause code is a status code. Look for Status of external cause/student activity, Y99.8.

3. **Answer:** A. External cause codes are never sequenced first.

   Rationale: According to the ICD-10-CM guideline I.C.20.a.6, an external cause code can never be a principal/first-listed diagnosis.

Section Review 5.10

1. **Answer:** C. Z02.1

   Rationale: The patient has no complaints. The diagnosis codes for employment exams are found under the main term Examination in the ICD-10-CM Alphabetic Index. Look for Examination/medical (adult) (for) (of)/pre-employment you are referred to Z02.1. Verification in the Tabular List confirms this is the correct code.

2. **Answer:** D. Z12.39, R92.2, Z80.3

   Rationale: Code the special screening as a reason for the encounter, along with a code to report the patient's breast density, which provides medical necessity for a more extensive test. Dense breast tissue occurs in many premenopausal women, and can interfere with reading a mammogram and may mask abnormalities in the image. Look in the ICD-10-CM Alphabetic Index for Screening/neoplasm (malignant) (of)/breast Z12.39. For the breast density, look in the Alphabetic Index for Dense/breasts R92.2. This code provides medical necessity of an ultrasound. To report the family history of breast cancer, look in the Alphabetic Index for History/family (of)/malignant neoplasm (of)/breast Z80.3, which may provide medical necessity information for the screening exam in a young patient. Verify all codes in the Tabular List.

3. **Answer:** B. The Z code to identify the screening

   Rationale: According to the ICD-10-CM guidelines I.C.21,c.5, when a screening test is performed and an abnormality is found, sequence the Z code for the screening first, followed by an additional code to report the abnormal findings.

Section Review 6.1

1. **Answer:** D. Gastrectomy, total; with formation of intestinal pouch, any type

   Rationale: The full descriptor of 43622 includes the common portion before the semi-colon of code 43620, followed by the description next to 43620 (with formation of intestinal pouch, any type).

2. **Answer:** D. 37650

   Rationale: CPT® code 37650 has a parenthetic instruction below it stating to report 37650 with modifier 50 when performed bilaterally. CPT®code 22510 states it is for a unilateral or bilateral procedure so modifier 50 is not appropriate. CPT®code 36251 is for a unilateral procedure and CPT®code 36252 is for the same procedure performed bilaterally. Because there is a code option for unilateral and another code option for bilateral, modifier 50 is not appropriate for either code.

3. **Answer:** C. Codes exempt from modifier 51 are identified with the universal forbidden symbol.

   Rationale: Codes exempt from modifier 51 are identified with the universal forbidden symbol. Add-on codes are also exempt from modifier 51. A list of modifier 51-exempt codes can be found in Appendix E of the CPT® code book.

4. **Answer:** A. A CCM is not allowed and will not bypass the edits.

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

5. **Answer:** B. 33620

   Rationale: The parenthetical instructions under CPT® code 33690 include:

   (For right and left pulmonary artery banding in a single ventricle [eg, hybrid approach stage 1], use 33620) and (Do not report modifier 63 in conjunction with 33690).

Section Review 6.2

1. **Answer:** A. AMA

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

2. **Answer:** B. Category I, II, and III

   Rationale: The main body of the CPT® code book is comprised of the Category I CPT® codes (00100–99607), Category II CPT® codes (0001F–9007F), Category III CPT® codes (0042T–0339T).

3. **Answer:** B. Condition, synonyms, abbreviations

   Rationale: The CPT® code book's index is alphabetized with main terms organized by condition; procedure; anatomic site; synonyms, eponyms, and abbreviations. This is listed in the first page of the CPT®Index, under the heading for Main Terms.

4. **Answer:** C. Malpractice insurance costs, physician work, practice expense

   Rationale: RVUs are configured utilizing physician work, practice expense and malpractice insurance costs

5. **Answer:** D. Both B and C

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

6. **Answer:** B. Category II codes

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

7. **Answer:** A. New and emerging

   Rationale: Category III codes do not indicate the service or procedure is experimental, only that they are new and emerging and are being tracked for trending purposes. This information is found in the guidelines for the Category II Codes section.

8. **Answer:** B. Appendix C

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

Section Review 6.3

1. **Answer:** D. Preoperative visits, Intraoperative services, Postsurgical pain management

   Rationale: The Surgical Global Package includes: Preoperative Visits, Intraoperative Services, Complications Following Surgery, Postoperative Visits, Postsurgical Pain Management, and Miscellaneous Services.

2. **Answer:** C. 90 days

   Rationale: The global period of major procedures is 90 days.

3. **Answer:** D. All of the above

   Rationale: Services included in the surgical package include:

   - Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical).
   - Local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia
   - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified healthcare professionals
   - Writing orders
   - Evaluating the patient in the post-anesthesia recovery area
   - Typical postoperative follow-up care

4. **Answer:** C. 24, 25, 57

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

5. **Answer:** A. 000

   Rationale: Status Indicator 000—Endoscopies or minor procedures

Section Review 6.4

1. **Answer:** C. Miscellaneous Codes, Permanent National Codes, Temporary National Codes

   Rationale: Three types of HCPCS codes printed in the HCPCS Level II code book consist of: Permanent National Codes, Miscellaneous Codes/not otherwise classified, Temporary National Codes. This can be verified by reviewing the HCPCS Coding Procedures in the front of the HCPCS Level II code book.

2. **Answer:** C. Quarterly

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

3. **Answer:** B. C codes

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

4. **Answer:** C. G codes

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

5. **Answer:** D. J codes

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

Section Review 6.5

1. **Answer:** B. 50

   Rationale: 50 Bilateral Procedure

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

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

3. **Answer:** D. NU

   Rationale: New Equipment. For example, append NU when a new walker, folding, wheeled, adjustable or fixed height is sold to a patient.

4. **Answer:** C. 32

   Rationale: CPT® modifier 32—Mandated Services

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

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

Section Review 7.1

1. **Answer:** A. L64.8
   Rationale: Alopecia is hair loss. You can find the correct code by looking for Loss (of)/hair, which directs you to *see* Alopecia. Look for Alopecia in the ICD-10-CM Alphabetic Index. Alopecia/premature L64.8. Verify in the Tabular List. L65.0 *Telogen effluvium* is hair loss due to stress, but the provider only suspects it is due to stress so it is not coded.

2. **Answer:** D. L57.0
   Rationale: Look in the ICD-10-CM Alphabetic Index for Keratosis/actinic and you are referred to L57.0. This is verified by looking in the Tabular List under L57.0.

3. **Answer:** B. L89.223
   Rationale: A bed sore is a pressure ulcer. If you look in the ICD-10-CM Alphabetic Index for Sore/bed, you are directed to *see* Ulcer, pressure, by site. Look in the ICD-10-CM Alphabetic Index for Ulcer/pressure/stage 3/hip and you find L89.2-. Subcategory L89.2 requires a 5th character for laterality and a 6th character for the stage. The complete code is L89.223.

4. **Answer:** C. Sequence first the code reflecting the highest degree of burn
   Rationale: ICD-10-CM Official Coding Guidelines Section I.C.19.d.1. Sequencing of burn and related condition codes, "Sequence first the code that reflects the highest degree of burn when more than one burn is present."

5. **Answer:** A. S61.411A, S00.00XA
   Rationale: The more serious injury is the laceration to the right hand; this injury is sequenced first. To find laceration in the ICD-10-CM Alphabetic Index, look for Laceration/hand/right S61.411-. Add 7th character A for the initial encounter. S61.411A is the correct code. The injury to the scalp is stated as superficial. In the ICD-10-CM Alphabetic Index, look for Injury/superficial/scalp S00.00-. A 6th character of X is needed and add 7th character A for the initial encounter. Verify in the Tabular List that S00.00XA is the correct code.

Section Review 7.2

1. **Answer:** B. 11104, 11105

   Rationale: Look in the CPT® Index for Biopsy/Skin Lesion/Punch and you are directed to 11104, 11105. Code 11104 is reported for biopsy of the first lesion of the left arm and add-on code 11105 is reported for the biopsy of the lesion on the right arm. The simple one-layered closure (simple repair) is included in the codes and is not reported separately.

2. **Answer:** A. 10060

   Rationale: Codes 10060–10061 describe the incision and drainage of a cyst; simple or complicated/multiple. There is no indication the cyst is complicated resulting in 10060. Look in the CPT® Index for Incision and Drainage/Cyst/Skin.

3. **Answer:** D. 11200, 11201

   Rationale: Codes 11200–11201 describe removal of skin tags. 11200 is used for up to and including 15 tags; 12001 is an add-on code used for each additional 10 or part thereof. The removal of 18 skin tags is reported with 11200 and 11201. Modifier 51 is not appropriate for 12001 as add-on codes are exempt from the multiple procedure concept. Look in the CPT® Index for Skin/Tags/Removal.

4. **Answer:** A. 11921, 11922

   Rationale: Code selection is based on square centimeters. The total square centimeters is 11.5 cm^2 plus 10.5 cm^2 equaling 22.0 cm^2. Code11921 is used to report 6.1 cm^2 to 20 cm^2; 11922 is used to report each additional 20 cm^2, or part thereof. The codes are located by looking in the CPT® Index for Tattoo/Skin which refers you to 11920–11922. 11922 is an add-on code making it exempt from modifier 51.

5. **Answer:** A. 11312

   Rationale: The lesion is removed by the shave technique. Look in the CPT® Index for Shaving/Skin Lesion and you are referred to 11300–11313. Shaving of lesions is based on anatomical location and lesion size in centimeters. The shaving of a 1.4 cm cheek lesion is reported with 11312. Code 11102 is reported for a skin biopsy.

Section Review 7.3

1. **Answer:** B. 11300, 11300-51 x 2
   Rationale: The lesions are removed using a shaving method reported with CPT® code range 11300–11313. Shaving of lesions is based on anatomical location and lesion size in centimeters. Each lesion is coded separately. All lesions are on the leg and the code selection is made from range 11300–11303. Because the specific measurements of the lesions are not stated, the smallest diameter is reported. Code 11300 is reported three times and may be reported as 11300, 11300-51x2 or 11300, 11300-51, 11300-51. Look in the CPT® Index for Shaving/Skin Lesion. Codes 11106 and 11107 are reported for an incisional biopsy.

2. **Answer:** D. 13101, 12035-59, 12052-59, 12011-59
   Rationale: Repair (Closure) codes are classified as Simple, Intermediate, and Complex. Locate the code ranges by looking in the CPT® Index for Repair/Skin/Wound, then selecting Complex, Intermediate, or Simple. Code selection is based on the type of repair and the anatomical location. Repairs within the same anatomical location are added together. The abdomen and buttock are both part of the trunk, so these repairs are added together. The most complex repair is coded first; CPT® code 13101 is reported for the complex repair of abdominal and buttock with total closure of 4.1 cm. The arms and scalp are in the same anatomical category, so the repair length for the arm and scalp are added together. CPT® code 12035-59 is reported for the intermediate repair of for the arm and scalp with total closure of 15.5, CPT® code 12052-59 is reported for the 3.8 cm intermediate repair of the cheek and CPT® 12011-59 is reported for the 2.3 cm simple repair of the lip. The CPT® guidelines state to use modifier 59 when more than one classification of wounds is repaired. Look in the CPT® Index for Repair/Wound and you will see the code ranges for Complex, Intermediate, and Simple.

3. **Answer:** C. 12032, 11403-51
   Rationale: The lesion is suspicious and not classified as malignant. A code from Excision-Benign Lesions is reported. Locate the code ranges by looking in the CPT® Index for Excision/Skin/Lesion, Benign. Code selection is based on anatomic location and size in centimeters. The size is noted as 1.5 cm with margins of 3 mm on each side. 3 mm = 0.3 cm. 1.5 cm + 0.3 cm + 0.3 cm = 2.1 cm. Code range 11400–11406 is used for excision of benign lesions on the trunk, arms, or legs. A size of 2.1 cm is reported with 11403. The note supports that an intermediate closure was performed. The repair measured 5.0 cm and is documented to be in layers, indicating an intermediate closure. Code range 12031–12037 is used to report intermediate repairs on the scalp, axillae, trunk and/or extremities. The repair measures 5 cm, making 12032 the correct code.

4. **Answer:** B. 11403

   Rationale: A dysplastic nevus is considered a benign lesion. Excision of benign lesions is reported by anatomical location and size in centimeters. Look in the CPT® Index for Excision/Skin/Lesion, Benign. Code range 11400–11406 is used to report excision of benign lesions on the trunk. The excision of benign lesions are based on size. A 2.2 cm lesion is coded with 11403.

5. **Answer:** C. 14020

   Rationale: A rhomboid flap is an adjacent tissue transfer. Adjacent tissue transfer or rearrangement codes are selected based on anatomical location and defect size in square centimeters. Look in the CPT® Index for Skin/Adjacent Tissue Transfer and you are referred to code range 14000–14350. Code range 14020–14021 is used to report rhomboid flaps on the scalp/arms/and/or legs. The total defect size is 5.44 sq cm (1.2 cm x 1.2 cm = 1.44 sq cm; 2 cm x 2 cm = 4 sq cm; 1.44 sq cm + 4 sq cm = 5.44 sq cm). Refer to the illustrations on adjacent tissue repairs in the *CPT® Professional Edition* found in code range 14000-14061. Code 14020 is reported for an adjacent tissue transfer or rearrangement of arm with a defect of 10 sq cm or less. According to CPT® guidelines, excision of the lesion is included in the flap reconstruction and is not coded separately.

Section Review 7.4

1. **Answer:** B. 17111

   Rationale: The destruction of warts is reported with 17110 or 17111. Code selection is based on the number of warts destroyed. The patient had a total of 19 warts destroyed. 17110 describes destruction up to 14 lesions; 17111 describes the destruction of 15 or more lesions. The correct CPT® code is 17111 for destruction of 19 warts. Look in the CPT® Index for Destruction/Warts/Flat.

2. **Answer:** D. 17272, 17281-51

   Rationale: Basal Cell Carcinoma (BCC) is a malignant lesion. Destruction of malignant lesions is reported with code range 17260–17286. Code selection is based on anatomical location and lesion size in centimeters. A 0.7 cm lesion of the face is reported with 17281; Look in the CPT® Index for Destruction/Lesion/Facial. A 1.2 cm lesion of the hand is reported with 17272, which has a higher RVU and is listed first. CPT® 17281 is listed second with modifier 51 indicating multiple procedures performed at the same operative session by the same provider. Look in the CPT® Index for Destruction/Lesion/Skin/Malignant.

3. **Answer:** A. 17311, 17312, 17312, 17315, 17315

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

4. **Answer:** B. 19318-LT

   Rationale: CPT® 19318 is found in Repair and/or Reconstruction and is used to report a reduction mammoplasty. Look in the CPT® Index for Breast/Reduction.

5. **Answer:** A. 19120-LT

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

Section Review 8.1

1. **Answer:** B. Wrist

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

2. **Answer:** B. Extension causes straightening of the wrist; flexion causes bending of the wrist.

   Rationale: When muscles are named for their action, words like flexor and extensor are often included in the name. Flexion is bending of a limb or body part and extension is straightening of a limb or body part.

3. **Answer:** C. One includes manipulation and one does not.

   Rationale: Both codes are used when coding a closed treatment of a calcaneal fracture. "Closed" treatment means there is not an incision made over the fracture site. Code 28400 is "without manipulation" and code 28405 is "with manipulation." Internal fixation is not a closed treatment procedure.

4. **Answer:** D. Tendon

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

5. **Answer:** A. Striated or skeletal

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

Section Review 8.2

1. **Answer:** D. E

   Rationale: Look up Fracture/fibula/comminuted S82.45-. Verification in the Tabular List indicates the correct 6th character is 1 for the right side. The correct 7th character is E, for subsequent encounter, open fracture Type 1. See the list of 7th digits under category S82. Per chapter 19 guidelines, "A fracture not indicated whether displaced or not displaced should be coded as displaced."

2. **Answer:** D. S53.032A

   Rationale: Look up nursemaid's elbow, S53.03-. Verification in Tabular List verifies code choice S53.032A, for left elbow, initial encounter.

3. **Answer:** A. Syndrome/compartment /lower extremity

   Rationale: Compartment syndrome is listed under Syndrome in ICD-10-CM. Traumatic is considered the default unless specifically stated as nontraumatic. An auto accident is considered a traumatic injury.

4. **Answer:** C. M80.051A

   Rationale: Code M80.051A describes a pathological fracture of the right femur. In the ICD-10-CM Alphabetic Index look up Fracture/pathological/due to/osteoporosis/postmenopausal — see Osteoporosis/postmenopausal/with pathologic

fracture. You're directed to M80.00. In the Alphabetic Index, there is no listing for femur. Review the subcategories for M80.0 in the Tabular List. Subcategory M80.05 is used to identify current pathological fracture of femur. 6th character 1 is used for the right femur and 7th character A is used for the initial encounter.

5. **Answer:** B. S62.326G

Rationale: In the ICD-10-CM Alphabetic Index, look for Fracture/traumatic/metacarpal/fifth/shaft (displaced), which directs you to S62.32-. In the Tabular List, subcategory S62.32 requires a 6th character for laterality and a 7th character for type of encounter. S62.326G is the correct code. ICD-10-CM guidelines I.19.c states, "A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced."

Section Review 8.3

1. **Answer:** A. 29883

Rationale: Code 29883 is for an arthroscopy, knee, surgical; with meniscus repair (medial AND lateral). Look in the CPT® Index for Arthroscopy/Surgical/Knee, which gives a range of codes for procedures on the knee that can be done with an arthroscope.

2. **Answer:** C. 29879

Rationale: The medial femoral condyle is part of the knee. Look in the CPT® Index for Arthroscopy/Surgical/Knee 29871–29889. In the code section, review the indentations until you arrive at 29879 *Abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.* Note that the code is in the arthroscopy section so it's not an open procedure.

3. **Answer:** B. 20610

Rationale: Code 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee, subacromial bursa), without ultrasound guidance indicates that the arthrocentesis is for aspiration and/or injection. The drug used in the injection (usually a steroid) is coded separately. Look in the CPT® Index for Arthrocentesis/Large Joint.

4. **Answer:** D. 27506-RT

Rationale: The surgery is an open treatment of a closed femoral shaft fracture with internal fixation (intramedullary implant) and is reported 27506-RT. Look in the CPT® Index for Fracture/Femur/Peritrochanteric/Intramedullary Implant Shaft. Report modifier RT to indicate right femur.

5. **Answer:** C. 29075-58

Rationale: The first cast or splint is included as part of the initial fracture treatment; because this was a replacement cast, it can be coded. Look in the CPT® Index for Cast/Elbow to Finger. Append modifier 58 to indicate this was a related procedure by the same physician during the postoperative period.

6. **Answer:** A. 21073

Rationale: Manipulation of a TMJ requiring anesthesia would be reported with 21073. If the TMJ was dislocated, a different code would be used. Look in the CPT® Index for Temporomandibular Joint (TMJ)/Manipulation.

7. **Answer:** B. 20550

   Rationale: An injection of a single tendon sheath, or ligament, aponeurosis (for example, plantar fascia) is coded with a 20550. Look in the CPT® Index for Tendon Sheath/Injection.

8. **Answer:** C. 28470-TA

   Rationale: This is a closed treatment because no surgery was performed. The orthotic boot would be coded separately by the DME supplier. Look in the CPT® Index for Fracture/Metatarsal/Closed Treatment. Modifier TA is appended to indicate the left foot, great toe.

9. **Answer:** B. 28299-RT

   Rationale: A double osteotomy can be performed on the phalanx and the metatarsal, or by making two incisions on the metatarsal bone. Look in the CPT® Index for Osteotomy/Phalanges/Toe.

10. **Answer:** D. 22800

    Rationale: Spinal arthrodesis is coded based on the approach; L3-L5 is considered three segments. Instrumentation is also coded, if performed. Look in the CPT® Index for Arthrodesis/Vertebra/Spinal Deformity/Posterior Approach.

Section Review 9.1

1. **Answer:** C. Alveoli

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

2. **Answer:** D. Epiglottis

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

3. **Answer:** D. 5

   Rationale: There are five lobes total, three in the right and two in the left.

4. **Answer:** B. Diaphragm

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

5. **Answer:** C. Trachea

   Rationale: The trachea carries air from the mouth and throat down to the lungs and is often referred to as the windpipe.

6. **Answer:** D. Bone Marrow

   Rationale: Bone marrow is not an organ of the lymphatic system; rather, it is included in the hemic system.

7. **Answer:** B. Lymphadenectomy

   Rationale: The suffix "ectomy" means removal, so lymphadenectomy is the correct answer.

8. **Answer:** C. In between the two lungs

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

9. **Answer:** A. Mediastinum

   Rationale: The mediastinum contains the heart and great vessels and lies between the lungs in the thoracic cavity.

10. **Answer:** C. Voice box

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

Section Review 9.2

1. **Answer:** D. J44.0, J20.9

   Rationale: Acute bronchitis with COPD should be coded as COPD with a lower respiratory tract infection. An instructional note states to code also for the infection. In this case - we know bronchitis is the infection, but the infectious agent is not specified. Look in the ICD-10-CM Alphabetic Index for Disease/pulmonary/chronic obstructive with lower respiratory infection referring you to J44.0. Look for Bronchitis/acute or subacute referring you to J20.9.

2. **Answer:** C. J35.3

   Rationale: Repetitive enlargement of the tonsils and adenoids in a year is a chronic condition. Look in the ICD-10-CM Alphabetic Index for Enlargement, enlarged (see also Hypertrophy)/adenoids/with tonsils.

3. **Answer:** C. A37.91

   Rationale: This condition is coded with a combination code. A combination code is a single code used to describe a diagnosis with an associated secondary process (manifestation) or a diagnosis with an associated complication. A secondary code is not required. In the ICD-10-CM Alphabetic Index locate Pneumonia/In (due to)/whooping cough.

4. **Answer:** B. J45.901

   Rationale: Look in the ICD-10-CM Alphabetic Index for Asthma/with/Hay Fever which points to see Asthma, allergic extrinsic. Locate Asthma/allergic extrinsic/with/exacerbation (acute) referring you to J45.901. In ICD-10-CM asthma codes are specific to severity - mild, moderate, severe as well as intermittent or persistent. In this case the indexing leads to an unspecified code.

5. **Answer:** D. J93.0, F17.210

   Rationale: Spontaneous tension pneumothorax is reported with J93.0. Look in the ICD-10-CM Alphabetic Index for Pneumothorax NOS/tension (spontaneous). Nicotine dependence is reported as it could be significant to the patient's condition. Look in the ICD-10-CM Alphabetic Index for Dependence/drug/nicotine/cigarettes.

6. **Answer:** A. C37

   Rationale: Primary malignancy of the thymus is coded with C37. Look in the ICD-10-CM Alphabetic Index for Thymoma/malignant.

7. **Answer:** B. I89.0

   Rationale: Acquired lymphedema typically occurs after major surgery or cancer treatment such as radiation therapy. It is more common than congenital lymphedema. Look in the ICD-10-CM Alphabetic Index for Lymphedema (acquired) (see also Elephantiasis). Locate Elephantiasis (nonfilarial) referring you to I89.0.

8. **Answer:** A. J21.0

   Rationale: RSV is a common cause for bronchiolitis. Look in the ICD-10-CM Alphabetic Index for Bronchiolitis/due to/respiratory syncytial virus. Code J21.0 is a combination code used to describe a diagnosis with an associated secondary process (manifestation) or a diagnosis with an associated complication. A secondary code is not required.

9. **Answer:** D. J33.9

   Rationale: Look in the ICD-10-CM Alphabetic Index for Polyp, polypus/nasal, J33.9. This is the correct code for an unspecified nasal polyp.

10. **Answer:** C. C34.11

    Rationale: A Pancoast tumor is typically a fast growing, non-small cell tumor in the upper part of the lung. Look in the ICD-10-CM Alphabetic Index for Pancoast's syndrome or tumor, C34.1-. A 5th character is needed to identify laterality. C34.11 identifies a malignant neoplasm of the upper lobe of the right lung.

Section Review 9.3

1. **Answer:** C. 30801

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

2. **Answer:** D. 31231

   Rationale: Code 31231 is a diagnostic nasal endoscopy, unilateral or bilateral. No modifier is necessary. In the CPT® Index, look for Endoscopy/Nose/Diagnostic which directs you to 31231–31235.

3. **Answer:** B. With mirrors

   Rationale: Indirect endoscope of the larynx is performed by viewing the larynx with the use of mirrors. A direct laryngoscopy is the use of an endoscope to look directly at the larynx.

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

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

5. **Answer:** B. 32110

   Rationale: Thoracotomy main code is 32100; control of the hemorrhage and lung tear would be code 32110. In the CPT® Index, look for Thoracotomy/Hemorrhage.

6. **Answer:** B. 32440

   Rationale: A pneumonectomy is removal of a lung. In the CPT® Index, look for Pneumonectomy 32440–32445. Read the code descriptors to select the correct code.

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

   Rationale: Diagnostic thoracoscopy is bundled into surgical VATS and cannot be billed separately during the same surgical session, per CPT® instruction.

8. **Answer:** D. 32663

   Rationale: CPT® subsection guidelines for Lungs and Pleura indicate therapeutic wedge resection is bundled into the lobectomy when it is the same lobe. The wedge resection can only be coded separately if it was performed on a different lobe or contralateral lung.

9. **Answer:** D. 38525

   Rationale: The patient has an excisional biopsy of the left axillary node. Because the lymph node biopsied is under the pectoralis minor muscle, it is considered a deep lymph node. Look in the CPT® Index for Biopsy/Lymph Nodes/Open and you are directed to 38500, 38510–38530. 38525 is for biopsy of the deep axillary nodes.

10. **Answer:** B. 38510

    Rationale: The patient had a deep cervical node excisional biopsy. It is considered deep because the node was below the muscle. Look in the CPT® Index for Biopsy/Lymph Nodes/Open and you are directed to 38500, 38510-38530. There is no mention of excision of the scalene fat pad. 38510 is for a biopsy of the deep cervical node(s).

Section Review 10.1

1. **Answer:** B. Heart

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

2. **Answer:** D. Coronary

   Rationale: Coronary circulation refers to the movement of blood through the tissues of the heart.

3. **Answer:** A. Tachycardia

   Rationale: Tachy = fast and cardia = heart.

4. **Answer:** D. Pulmonary and Aortic

   Rationale: The tricuspid and mitral valves are the atrioventricular valves. The pulmonary and aortic valves are the semi-lunar valves because of their shape, a half moon or crescent shaped.

5. **Answer:** D. All of the above

   Rationale: CPT® codes for the Cardiovascular System are found in multiple sections of CPT® (30000, 70000, and 90000).

Section Review 10.2

1. **Answer:** C. I35.0

   Rationale: No mention was made of a congenital condition or rheumatic condition. In the ICD-10-CM Alphabetic Index look for Stenosis, stenotic/aortic (valve), referring you to I35.0. Verify the code in the Tabular List.

2. **Answer:** B. I21.09

   Rationale: Look in the ICD-10-CM Alphabetic Index for Infarct, infarction/myocardium, myocardial (acute) (with stated duration of 4 weeks or less)/ST elevation (STEMI)/anterior (anteroapical). You are referred to I21.09. The Tabular List verifies code choice.

3. **Answer:** C. I12.0, N18.6, Z99.2

   Rationale: According to the ICD-10-CM guideline I.C.9.a.2., a relationship is assumed between hypertension and chronic kidney disease. Look in the ICD-10-CM Alphabetic Index for Hypertension, hypertensive/kidney/with/stage 5 chronic kidney disease (CKD) or end stage renal disease (ESRD) referring you to I12.0. Verify in the Tabular List. An instructional note indicates to use additional code to identify the stage of chronic kidney disease (N18.5, N18.6). Code N18.6 is reported for the end stage renal failure. There is an instructional note to use additional code to identify dialysis status (Z99.2).

4. **Answer:** A. I50.33

   Rationale: There is a combination code for acute on chronic diastolic congestive heart failure. Look in the ICD-10-CM Alphabetic Index for Failure, failed/heart/diastolic (congestive)/acute/and (on) chronic (congestive) referring you to I50.33. Always verify your codes in the Tabular List.

5. **Answer:** C. I44.1

   Rationale: The syncope is a sign/symptom of the AV block and is not reported. Mobitz I is a second-degree block. Look in the ICD-10-CM Alphabetic Index for Mobitz heart block (atrioventricular) or Block, blocked/atrioventricular/types I and II referring you to I44.1. Verification in the Tabular List confirms the correct code choice.

Section Review 10.3

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

   Rationale: 33534 is used for the two arterial grafts. Because a combination of AV grafts is used, instead of using a code from 33510–33516 for the venous grafts, we use add-on codes 33517–33523. There are three venous grafts (33519). Code 35572 is for procurement of the femoropopliteal vein, 35600 is for harvesting the radial artery, and 33508 is the add-on code for endoscopic harvesting of the saphenous vein. Look in the CPT® Index for Coronary Artery Bypass Graft (CABG)/Arterial Bypass 33533–33536, and Arterial-Venous Bypass 33517–33519, 33521-33523. See the notes above these sections for coding 35572 and 35600. Highlight these codes for easy reference in your code book. All the codes except 33534 are add-on codes and are modifier 51 exempt.

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

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

3. **Answer:** A. 33426

   Rationale: The mitral valve was repaired, not replaced. Look in the CPT® Index for Repair/Heart/Mitral Valve 0345T, 33418-33420, 33422, 33425-33427 Code 33426 *Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring*, is correct. Cardiopulmonary bypass is included in the code description and not coded separately.

Section Review 10.4

1. **Answer:** B. 36252

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

2. **Answer:** C. 36226-50, 36222-50-51

   Rationale: Three separate vascular families are catheterized; however, the codes for angiography of the common carotids and the vertebrals include selective catheterization. Report 36222 for the selective catheter placement and angiography of the right and left common carotid arteries. This code includes arch aortography. For the selective bilateral vertebral angiography report 36226. Both procedures are performed bilaterally with modifier 50. Some payers may require RT and LT modifiers or modifier 59 appended to the second code. Always check with your carriers. In the CPT® Index, look for Angiography/Carotid Artery; also look for Angiography/Vertebral Artery. Code 36226 is listed first, followed by 36222, which is less work-intensive. Modifier 51 is appended to the second procedure.

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

   Rationale: Nonselective catheter placement in the aorta is reported with 36200. Look in the CPT® Index for Aorta/Catheterization/Catheter. Contrast was injected from one catheter placement site, and there is a report for the aorta and the lower extremities, making this an abdominal aortogram with bilateral iliofemoral lower extremity angiography, 75630. Look in the CPT® Index for Aortography/with Iliofemoral Artery referring you to 75630, 75635. Modifier 26 is required for the professional service.

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

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

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

   Rationale: The catheter was placed at the level of the renals or renal arteries, not in the renal arteries, so this is a nonselective catheterization. Nonselective catheter placement in the aorta is reported with 36200. Look in the CPT® Index for Aorta/Catheterization/Catheter or Catheterization/Aorta. Because the catheter was repositioned and separate studies were performed, both the aortography and the extremity angiography are reported. In the CPT® Index, look for Aorta/Aortography referring you to 75600, 75605, 75625, 75630. For angiography of the lower extremities look in the CPT® Index for Angiography/Leg Artery referring you to 73706, 75635, 75710–75716. Modifier 26 reports the professional service.

Section Review 10.5

1. **Answer:** C. 93460-26, 93567

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

   The right iliac angiogram is not reported. It was performed to assess the femoral artery for the Perclose device. The Perclose closure is not reported; it is bundled with the cardiac catheterization procedure. Modifier 26 is required to indicate the professional services only for 93460. The add-on code for the injection service is a professional service; a modifier is not required. In the CPT® Index, look for Cardiac Catheterization/Combined Left and Right Heart/with Left Ventriculography directing you to 93453, 93460, 93461. Check the numeric listing and 93460 is correct. Look In the CPT® Index for Cardiac Catheterization/Injection for the list of injection codes.

2. **Answer:** A. 92920-LD, 92978-26

   Rationale: IVUS is separately reportable. For the angioplasty code look in the CPT® Index for Percutaneous Transluminal Angioplasty/Artery/Coronary referring you to 92920-92921. The diagonal branch is a branch of the left anterior descending and modifier LD is appended. For IVUS look in the CPT® Index for Vascular Procedures/Intravascular Ultrasound/Coronary Vessels referring you to 92978–92979. Modifier 26 denotes the professional service.

3. **Answer:** D. 93016, 93018

   Rationale: Because the study was performed in the hospital, the physician bills for the professional services. Look in the CPT® Index for Stress Tests/Cardiovascular referring you to 93015–93024. Modifier 26 is not required, because these services are professional services. These codes do not have a professional and technical component.

4. **Answer:** C. 93618-26, 93610-26, 93600-26

   Rationale: Although the surgeon documented a "comprehensive" study, it does not include all components listed in CPT® for 93619 or 93620; therefore, the individual procedures are reported. The only procedures performed were 93618 (induction of arrhythmia), 93610 (intra-atrial pacing), and 93600 (bundle of His recording). Look in the CPT® Index for Electrophysiology Procedure referring you to 93600–93660. The procedure was performed in the hospital; the physician must report only the professional service with modifier 26 appended to all the codes.

5. **Answer:** B. 93306

   Rationale: A combination code exists to bundle the Doppler and color flow. Look in the CPT® Index for Echocardiography/Transthoracic referring you to 93306–93308, 93350–93352. Code 93306 is correct.

Section Review 11.1

1. **Answer:** B. -stomy

   Rationale: -ectasis means dilation, -cele means hernia, -lysis means release.

2. **Answer:** C. cheil/o

   Rationale: An/o means anus, cec/o means cecum, col/o means colon.

3. **Answer:** B. It conveys and stores bile.

   Rationale: The gallbladder is a sac-shaped organ located under the liver. It stores bile that is produced by the liver.

4. **Answer:** D. Duodenum, jejunum, ileum

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

5. **Answer:** B. The transverse colon

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

6. **Answer:** C. Liver

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

7. **Answer:** A. Mechanical and chemical

   Rationale: Digestion consists of two processes, mechanical and chemical. Mechanical digestion is chewing the food and your stomach and smooth intestine churning the food, and chemical digestion is the work the enzymes do by breaking large carbohydrate, lipid, protein, and nucleic acid molecules into their subcomponents of nutrients.

8. **Answer:** B. Incisors, Cuspids, Molars

   Rationale: There are three categories of teeth:

   - The Incisors—The teeth in the front of the mouth. They are shaped like chisels and are useful in biting off large pieces of food. Each person has eight of these (four on the top, four on the bottom).
   - The Cuspids—The pointy teeth immediately behind the incisors. Also called the canines, these teeth are used for grasping or tearing food. Each person has four of these (two on the top and two on the bottom).
   - The Molars—The flattened teeth used for grinding food. They are the furthest back in the mouth, and their number can vary among people.

9. **Answer:** D. 5 ft. long

   Rationale: The large intestine is about 5 ft. long.

10. **Answer:** A. 4 lobes

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

Section Review 11.2

1. **Answer:** B. K21.9

Rationale: GERD is the definitive diagnosis. Chest pain and a dry cough are both symptoms of GERD and are not reported separately. GERD is an acronym for Gastroesophageal Reflux Disease. In the ICD-10-CM Alphabetic Index, look for Disease, diseased/gastroesophageal reflux (GERD) or look for GERD, and you are guided to K21.9. There is no indication the patient has esophagitis.

2. **Answer:** D. K58.0

Rationale: IBS is an acronym for Irritable Bowel Syndrome and can cause the intestinal tract to contract stronger and longer than normal. This may cause symptoms such as abdominal pain, constipation or diarrhea, and/or flatulence. To find IBS in the ICD-10-CM, look in the ICD-10-CM Alphabetic Index for Syndrome/irritable/bowel/with/diarrhea leading you to code K58.0. Abdominal pain and diarrhea are symptoms of IBS, and not coded separately. Ulcerative colitis is a rule-out diagnosis and is not coded.

3. **Answer:** C. K64.8

Rationale: Hemorrhoids are dilated or enlarged varicose veins which occur in and around the anus and rectum. The condition can be complicated by thrombosis, strangulation, prolapse, and ulceration. To find hemorrhoids in the ICD-10-CM Alphabetic Index, locate Hemorrhoids/prolapsed directing you to K64.8. Verify code selection in the Tabular List.

4. **Answer:** B. D12.3

Rationale: The definitive diagnosis is polyps and identified as benign. Rectal bleeding is a sign of polyps in the colon and not coded. In the ICD-10-CM Alphabetic Index, look for Polyp, polypus/colon/transverse directing you to D12.3. You can also use the Table of Neoplasms and look for Neoplasm, neoplastic/Intestine, intestinal/large/transverse; the Benign column indicates D12.3.

5. **Answer:** D. E11.43, K31.84

Rationale: Gastroparesis is also called delayed gastric emptying. Gastroparesis may occur when the vagus nerve is damaged and the muscles of the stomach and intestines do not work normally. Food then moves slowly or stops moving through the digestive tract. The most common cause of gastroparesis is diabetes. In this case, the physician did link the gastroparesis to the patient's diabetes, so we will use a diabetic complication code. In ICD-10-CM Alphabetic Index look for Diabetes, diabetic/type 2/with/gastroparesis which directs you to E11.43. Even if the provider had not linked the gastroparesis with diabetes, because it is listed under 'with' in the Alphabetic Index, there is a presumed causal relationship. In the Tabular List, there is an instructional note for code K31.84 that indicates to Code first underlying disease, if known and code E11.43 is listed. There is also an Excludes2 note under category code K31 which indicates that code E11.43 can be reported with codes in category K31.

Section Review 11.3

1. **Answer:** B. 44204

   Rationale: A peritoneoscopy is a separate procedure and is not separately reportable when it is performed with a more extensive procedure. It is incidental to the laparoscopic partial colectomy and anastomosis. Look in the CPT® Index for Colectomy/Partial/with Anastomosis/Laparoscopic. The code is selected based on whether additional procedures, such as a coloproctostomy, are performed. There are no additional procedures in this case making 44204 the correct code choice.

2. **Answer:** A. 41008

   Rationale: CPT® code 41008 is specifically for Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space. Look in the CPT® Index for Drainage/Hematoma/Mouth/Submandibular Space. The code selection is made because it is intraoral, not extraoral.

3. **Answer:** A. 48150

   Rationale: The CPT® code 48150 is specifically for pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy, and gastrojejunostomy (Whipple-type procedure); with pancreatojejunostomy. Look in the CPT® Index for Pancreas/Excision/Partial.

4. **Answer:** A. 46200

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

5. **Answer:** B. 49505-LT

   Rationale: In the CPT® Index, look for Hernia Repair/Inguinal/Initial, Child 5 years or older. You are referred to 49505 and 49507. Review the codes to choose the appropriate service. 49505 is the correct code. The repair was through an incision (not by laparoscopy) on an initial inguinal hernia on a patient over five years of age and the hernia was not incarcerated or strangulated. According to CPT® guidelines, "With the exception of the incisional hernia repairs (49560–49566), the use of mesh or other prosthesis is not separately reported." It is inappropriate to code the mesh in this scenario. Modifier LT is appended to indicate the hernia is on the left side.

Section Review 12.1

1. **Answer:** A. Kidneys

   Rationale: Urine is formed in the renal tubules and empties into the calyces, then into the renal pelvis of the kidney. It then travels through the ureters to the bladder.

2. **Answer:** C. Urethra.

   Rationale: The urine travels from the kidneys to the ureters, to the bladder, where it is stored until it is expelled through the urethra.

3. **Answer:** D. Testes

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

4. **Answer:** C. Spleen

   Rationale: The organs making up the urinary system consist of the kidneys, ureters, bladder, and urethra.

5. **Answer:** A. Prostate

   Rationale: The prostate gland is the gland that is partly muscular and glandular.

Section Review 12.2

1. **Answer:** C. N20.0

   Rationale: Documentation of calculus of the kidney and ureter are very specific to the organ site involved. Though most stones are calcium based, coding a disorder of calcium metabolism would be incorrect. Calculus of the urethra and ureter are not correct because the documentation indicates nephrolithiasis (kidney stone). Kidney stone, or nephrolithiasis, is coded N20.0. In the ICD-10-CM Alphabetic Index, look for Calculus, calculi, calculous/kidney directing you to N20.0. Verify code selection in the Tabular List.

2. **Answer:** C. R31.0

   Rationale: Although there is documentation that the patient previously had a TURP, there is no documentation of continuing BPH (a condition for which a TURP routinely is performed). Because documentation states gross hematuria, microscopic or unspecified hematuria would be inappropriate codes. Gross hematuria R31.0 is the correct answer. In the ICD-10-CM Alphabetic Index, look for Hematuria/gross directing you to R31.0. Verify code selection in the Tabular List.

3. **Answer:** C. S37.041A

   Rationale: A fractured kidney is a laceration connecting to two cortical surfaces. Look in the ICD-10-CM Alphabetic Index for Laceration/kidney/minor directing you to S37.04-. In the Tabular List, seven characters are required to complete the code. The 6th character 1 is for right kidney and the 7th character of A is for initial encounter. Complete code is S37.041A. Verify code selection in the Tabular List. A diagnosis code for the external cause also would be added for the MVA.

4. **Answer:** A. N40.1, R33.8

   Rationale: In the ICD-10-CM Alphabetic Index look for Enlargement, enlarged/prostate/with lower urinary symptoms (LUTS) and you are directed to N40.1. In the Tabular List there is an instructional note to Use additional code for associated symptoms, when specified. Urinary retention is coded with R33.8.

5. **Answer:** D. N21.0

   Rationale: Looking in the ICD-10-CM Alphabetic Index in this example is critical in selecting the correct code. If you look for the main term Bladder in the Alphabetic Index it indicates to see condition. If you look for the main term Diverticulum, diverticula/bladder it directs you to code N32.3 which is diverticulum of bladder. There is a stone in the diverticulum of bladder. If you look for Calculus, calculi, calculous/bladder (diverticulum) it directs you to the code N21.0 which is the correct code. Verify code selection in the Tabular List.

6. **Answer:** D. N10

   Rationale: Acute pyelonephritis is coded N10, unless mention of a lesion of renal medullary necrosis is documented. Do not use chronic pyelonephritis because the documentation clearly states "acute." Look in the ICD-10-CM Alphabetic Index for Pylonephritis/acute N10. Verify code selection in the Tabular List.

7. **Answer:** D. N39.3

   Rationale: Unspecified urinary incontinence is coded as R32; because documentation clearly states stress incontinence, this code would be inappropriate. Mixed urinary incontinence is a combination of urge and stress incontinence; because there is no mention of urge incontinence, codes N39.41 and N39.46 would be incorrect. Look in the ICD-10-CM Alphabetic Index for Incontinence/urine/stress (female) (male) directing you to N39.3. Verify code selection in the Tabular List.

8. **Answer:** B. C61

   Rationale: Because this patient still has documented disease, Z85.46 *Personal history of malignant neoplasm of prostate* is incorrect. Neoplasm of unspecified behavior of other genitourinary organs, D49.59 not coded because prostate cancer is documented. Uncertain behavior of prostate neoplasm, as well as uncertain behavior of other neoplasms, should be coded only when the pathological report states uncertain. Look in the ICD-10-CM Alphabetic Index for Cancer and you are directed to *see also* Neoplasm, by site, malignant. In the Table of Neoplasms look for Neoplasm, neoplastic/prostate/Primary column C61. Verify code selection in the Tabular List.

9. **Answer:** A. D30.01

   Rationale: Look in the ICD-10-CM Alphabetic Index for Oncocytoma, which directs you to *see* Neoplasm, by site, benign. Look in the Table of Neoplasms for Neoplasm, neoplastic/renal/Benign column D30.0-. In the Tabular List report 5th character 1 for right kidney. Correct code choice is D30.01.

10. **Answer:** D. N39.0

    Rationale: Urinary hesitancy (R39.11), urinary frequency (R35.0) and dysuria (R30.0) are all symptoms of a urinary tract infection. Because a diagnosis of UTI was confirmed by microscopic analysis, the symptoms would not be coded. Look in the ICD-10-CM Alphabetic Index for Infection, infected, infective/urinary (tract) N39.0. Verify code selection in the Tabular List.

Section Review 12.3

1. **Answer:** D. 52235

   Rationale: Look in the CPT® Index for Fulguration/Cystourethroscopy with/Tumor. You are referred to 52234, 52235, 52240, and 52250. When different size bladder tumors are removed in one surgical session, the code selection is based on the largest tumor size. In this example, the largest tumor removed is 3.0 cm. Only one code is reported regardless of the number of tumors removed.

2. **Answer:** B. 52630

   Rationale: As a previous TURP was performed, CPT® 52601 is not appropriate because this code is used for the initial TURP. CPT® 52648 describes laser vaporization of the prostate, which is not the case. CPT® 52500 is described as transurethral resection of bladder neck. Because the prostate was resected, not the bladder neck, this is inappropriate. CPT® 52630 describes TURP of residual or regrowth of obstructive prostate tissue, which is the appropriate code. Look in the CPT® Index for TURP—*See* Prostatectomy, Transuretheral 52601, 52630. Verify in the numeric section.

3. **Answer:** B. 51040

   Rationale: Aspiration of bladder with insertion of suprapubic catheter (51102) does not describe an open suprapubic tube insertion. Suprapubic catheter change is reported using CPT® 51705; therefore, this code is not reported for an insertion procedure. Because 51045 describes a ureteral catheter or stent, this code is not appropriate. CPT® 51040 *Cystostomy, cystotomy with drainage* describes the open suprapubic tube placement. Look in the CPT® Index for Cystostomy/with Drainage 51040. Verify in the numeric section.

4. **Answer:** D. 51500

   Rationale: Umbilical hernia repair codes are reported 49580–49587 and are differentiated by the age of the patient and whether the hernia is reducible, or incarcerated/strangulated. A reducible hernia is one that can be reduced to a normal position. An incarcerated or strangulated hernia is one that cannot be reduced to a normal position without surgical intervention. The description of CPT® 51500 *Excision of urachal cyst or sinus, with or without umbilical hernia repair* includes the umbilical hernia repair. Hernia repair is not reported separately; therefore, CPT® 51500 is the correct answer. Look in the CPT® Index for Cyst/Urachal/Bladder/Excision 51500.

5. **Answer:** B. 52005

   Rationale: Placement of the ureteral catheters was performed via cystoscopy; CPT® 50605 would not be appropriate because this code is for an open insertion of indwelling stent into the ureter. CPT® 52332 describes the insertion of an indwelling ureteral stent and is not reported for temporary catheter insertion. CPT® 52310 describes the removal of a ureteral stent but does not cover the insertion of the catheters. CPT® 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic services* is correct. There would be no additional code reported for removal of these catheters. Look in the CPT® Index for Catheterization/Cystourethroscopy/Ureteral. No modifier is used because this code includes both ureters.

Section Review 12.4

1. **Answer:** D. 54060

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

2. **Answer:** C. 55250

   Rationale: CPT® 55250 is the correct code to report. No modifiers are reported with the vasectomy code because the descriptor states unilateral or bilateral. The procedure was not terminated due to the well-being of the patient (modifier 53), nor would you report a decreased service (modifier 52). Because of the code description, modifier RT is not necessary. Look in the CPT® Index for Vasectomy 55250.

3. **Answer:** A. 55250-58

   Rationale: Using modifier 76 on the left vasectomy is not appropriate because modifier 76 denotes a return to the operating room for a repeat procedure by the same physician during the global period. This is not a repeat procedure on the right side. Modifier 58 is appropriate because the vasectomy is a follow up to the initial vasectomy (staged or related procedure). Look in the CPT® Index for Vasectomy and refer to Appendix A for modifier 58.

4. **Answer:** C. 54840

   Rationale: Code 54840 describes the excision of spermatocele, with or without epididymectomy and is the correct code. The epididymectomy codes (58460-58461) are not reported as the procedure is included in 54840. A lesion was not removed from the epididymis, making 54830 incorrect. Look in the CPT® Index for Spermatocele/Excision 54840.

5. **Answer:** A. 54150

   Rationale: In the CPT® Index, look for Circumcision/Surgical Excision/Neonate 54150, 54160. A Plastibell is a type of device used in a circumcision. Code 54150 is correct. Modifier 52 is not required; because a dorsal penile nerve block was used.

Section Review 12.5

1. **Answer:** B. 52

   Rationale: Modifier 52 is used to report reduced services. This is used when a bilateral procedure is performed unilaterally.

2. **Answer:** A. 76

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

3. **Answer:** A. TC

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

4. **Answer:** D. B or C

   Rationale: Depending upon the insurer, either modifier 50 or RT and LT is appended to the surgical procedure.

5. **Answer:** B. 53

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

Section Review 13.1

1. **Answer:** D. Fallopian tubes and ovaries

   Rationale: The word adnexa means appendages. Uterine appendages are the tubes and ovaries.

2. **Answer:** A. Bartholin's glands

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

3. **Answer:** B. The cervix and uterine fundus

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

4. **Answer:** C. Colposcopy

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

5. **Answer:** C. Cervix

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

Section Review 13.2

1. **Answer:** C. D07.1

   Rationale: VIN III is coded as cancer in situ and VIN indicates a vulvar lesion. Look in the ICD-10-CM Alphabetic Index for VIN and you are directed to *see* Neoplasia, intraepithelial, vulva. Look in the Alphabetic Index for Neoplasia/intraepithelial/vulva/grade III referring you to D07.1. Verify in the Tabular List.

2. **Answer:** C. With forceps

   Rationale: Code O80 is for a normal delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [eg, rotation version] or instrumentation [forceps] of a spontaneous, cephalic, vaginal, full-term, single, live-born infant. Forceps delivery is found in the ICD-10-CM Alphabetic Index under Delivery/failed/forceps directing you to O66.5.

3. **Answer:** B. Spontaneous abortion

   Rationale: ICD-10-CM and CPT® recognize three types of abortions, spontaneous (also called a miscarriage), induced or therapeutic (TAB) caused by a deliberate procedure, or missed. A missed abortion occurs when the fetus dies but the products of conception are retained.

4. **Answer:** C. O10.03

   Rationale: It is important to assess if a condition existed prior to pregnancy, developed during, or due to the pregnancy in order to assign the correct code. In this case, the hypertension is pre-existing. Look in the ICD-10-CM Alphabetic Index for Hypertension/complicating/puerperium, pre-existing/pre-existing/essential O10.03. Puerperium is the time period immediately after the birth of the baby and up to six weeks following childbirth.

5. **Answer:** D. N95.0

   Rationale: This bleeding is after the end of the woman's menses and is described as postmenopausal. Look in the ICD-10-CM Alphabetic Index for Bleeding/postmenopausal N95.0. Verify in the Tabular List.

Section Review 13.3

1. **Answer:** B. 56405

   Rationale: The vulva consists of the external female genitalia, which includes the labia minora and majora, clitoris, and vestibule. Code 56405 reports the I&D of the abscess of the vulva or perineal abscess. Because there is a specific code for an ID of an abscess of the vulva, do not code 10060. Look in the CPT® Index for Incision and Drainage/Abscess/Vulva 56405 Verify in the numeric section.

2. **Answer:** D. 58120

   Rationale: The D&C is performed in the uterus. Look in the CPT® Index for Dilation and Curettage/Corpus Uteri 58120. There is no mention that the patient is postpartum, so you do not report 59160. Verify in the numeric section.

3. **Answer:** C. 59510, 59409-51

   Rationale: Only one baby is delivered vaginally making 59400, 59409-51 incorrect. Only one baby was delivered by cesarean section making 59510 incorrect. Because this is the patient's first pregnancy, do not report codes 59618, 59612. Look in the CPT® Index for Cesarean Delivery/Routine Care 59510 and Vaginal Delivery/Delivery Only 59409. Modifier 51 is appended to indicate additional procedures during the same session. The code with the highest value is sequenced first. Verify codes in the numeric section.

4. **Answer:** A. 58940

   Rationale: The right ovary was removed which is an oophorectomy. Code 58925 reports removal of an ovarian cyst. Code 58920 reports removal of a wedge (triangular piece) of an ovary or of both ovaries. Code 58720 reports the removal of tube and ovary, unilateral or bilateral. Look in the CPT® Index for Ovary/Excision/Total 58940-58943. Code 58940 is reported for the removal of an ovary. Verify in the numeric section.

5. **Answer:** B. 58150

   Rationale: This is an open total abdominal hysterectomy, not a vaginal hysterectomy 58262. The procedure was not performed laparoscopically 58548. It does not mention that a partial vaginectomy with para-aortic and pelvic lymph node sampling was performed 58200. Look in the CPT® Index for Hysterectomy/Abdominal/Total 58150, 58200, 58956. The correct code is 58150. Verify in the numeric section.

Section Review 14.1

1. **Answer:** B. Glands

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

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

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

3. **Answer:** A. Near the kidneys

   Rationale: Adrenal means near the kidneys. The adrenal glands are above each kidney.

4. **Answer:** C. Excision of the thymus by cutting into the chest

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

5. **Answer:** B. Pineal

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

6. **Answer:** A. Central and Peripheral Nervous Systems

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

7. **Answer:** D. Sciatic

   Rationale: The largest nerve of the body is the sciatic nerve which divides into the tibial and common fibular (common peroneal) nerves.

8. **Answer:** C. Vertebra

   Rationale: Vertebra is not a region of the spinal nerve segments because it is the bony segment surrounding the spinal cord. The lumbar region has five segments forming five pairs of lumbar nerves. The cervical region has seven segments forming eight pairs of cervical nerves. The coccygeal region has three segments forming one pair of coccygeal nerves.

9. **Answer:** A. A single complete vertebral bone with its associated articular process and laminae

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

10. **Answer:** D. Parietal lobe

    Rationale: The parietal lobes are at the top of the brain. The right lobe processes visuo-spatial information, while the left lobe processes spoken and written information.

Section Review 14.2

1. **Answer:** C. E05.21

   Rationale: The diagnosis is indexed under Thyrotoxicosis/with/goiter/nodular/with thyroid storm directing you to code E05.21. Verify code selection in the Tabular List.

2. **Answer:** B. C73, E07.0

   Rationale: When a patient has functional activity (thyrotoxicosis or disorders of thyrocalcitonin secretion) associated with a neoplasm, the neoplasm should be reported first, and the functional activity caused by the neoplasm is reported as a secondary code. There is no documentation of the patient having a history of other cancers, so a Z code is not appropriate. In the ICD-10-CM Alphabetic Index look for Carcinoma/thyroid; there is no listing in the Alphabetic Index. Use the instruction - *see also* Neoplasm, by site, malignant which is next to Carcinoma. In the Table of Neoplasms, look for Neoplasm, neoplastic/thyroid (gland)/Malignant Primary (column) directing you to code C73. In the Tabular List, C73 states to "Use additional code to identify any functional activity." The second diagnosis code is in the Alphabetic Index under Hypersecretion/calcitonin directing you to code E07.0. Verify code selection in the Tabular List.

3. **Answer:** A. E10.52

   Rationale: Type 1 diabetes with diabetic gangrene is found in the ICD-10-CM Alphabetic Index under Diabetes, diabetic/type 1/with/gangrene, directing you to E10.52. Code E10.52 is a combination code so a separate code for the gangrene is not reported. Verify code selection in the Tabular List.

4. **Answer:** C. T53.0X1A, G92

   Rationale: Toxic myelitis is in the ICD-10-CM Alphabetic Index under Myelitis/toxic, directing you to code G92. Under G92 in the Tabular List, there is an instructional note to code first, if applicable, (T51-T65) to identify toxic agent. In the Table of Drugs and Chemicals, look for Carbon/tetrachloride (vapor) NEC/Poisoning Accidental (unintentional) column guiding you to code T53.0X1-. Verification in the Tabular List indicates to add a 7th character; A is reported for the initial encounter. Code G92 is reported as a secondary code. Verify code selection in the Tabular List.

5. **Answer:** B. G89.11, M54.2

   Rationale: The scenario documents the patient has acute neck pain due to an MVA accident (trauma). In the ICD-10-CM Alphabetic Index look for Pain(s)/acute/due to trauma directing you to code G89.11. ICD-10-CM coding guideline I.C.6.b.1.(b).(ii) indicates that codes from G89 are reported as the primary code if the encounter is for pain control or pain management and may be used with codes identifying the site of pain. In the Alphabetic Index locate Pain/neck NEC and you're directed to M54.2. In the Tabular List, code M54.2 is Cervicalgia which is the medical term for neck pain.

Section Review 14.3

1. **Answer:** D. 62362, 62350-51

   Rationale: The patient is having an insertion of a programmable pump and an intrathecal catheter implanted to infuse pain meds for pain management. An infusion of pain medications is not performed. Look in the CPT® Index for Infusion Pump/Spinal Cord directing you to codes 62361–62362. Look in the CPT® Index for Catheterization/Spinal Cord, directing you to codes 62350–62351 for the second code. Look in the Nervous System section to select the correct code.

2. **Answer:** C. 62270

   Rationale: The patient is not having an injection or an aspiration of contents found in the nucleus pulposus, intervertebral disc, or paravertebral tissue. The procedure is a spinal puncture in the lumbar area to determine if the patient has meningitis. Look in the CPT® Index for Spinal Tap/Lumbar guiding you to code 62270. Verify the code in the Nervous System section.

3. **Answer:** B. 61154

   Rationale: The keywords in this scenario are burr hole, evacuation, hematoma, and subdural. All of those words are found in the code description of procedure code 61154. Look in the CPT® Index for Burr Hole/for Drainage/Hematoma, guiding you to codes 61154–61156. Look in the Nervous System section to select the correct code.

4. **Answer:** A. 63005

   Rationale: Only a laminectomy with decompression is performed. There is no documentation to indicate a facetectomy, foraminotomy, or discectomy was performed. Look in the CPT® Index for Laminectomy/for Decompression/Lumbar or Decompression/Spinal Cord. Verify code selection in the Nervous System section.

5. **Answer:** C. 95955-26

   Rationale: The physician is using an EEG to record and measure the patient's brain electrical activity while performing the thromboendarterectomy (not intracranial surgery). Look in the CPT® Index for Electroencephalography/Intraoperative, guiding you to code 95955. Verify code selection in the Medicine section. Modifier 26 is added to report the physician's professional component of the procedure.

Section Review 14.4

1. **Answer:** B. S2348

   Rationale: Look in the HCPCS Level II Index for Decompression procedure, intervertebral disc, directing you to code S2348.

2. **Answer:** B. 64721-53

   Rationale: Modifier 53 is the appropriate modifier to append when the surgeon elects to terminate a surgical procedure due to the patient's blood pressure dropping, which threatens the well-being of the patient.

3. **Answer:** C. 57

   Rationale: Modifier 57 is the appropriate modifier to append to the Evaluation and Management Service because the evaluation and examination of the child's condition led the surgeon to make a decision for surgery. This surgical procedure is a major procedure with a 90-day global period. Modifier 25 is only appended to minor procedures which have a 0–10-day global period. Modifiers 22 and 54 are only appended to procedure codes, not Evaluation and Management services.

4. **Answer:** C. 62258-78

   Rationale: A complete removal of the cerebrospinal fluid shunt system with a replacement is performed. Look in the CPT® Index for Shunt/Brain/Removal, directing you to codes 62256–62258. Modifier 78 is the appropriate modifier to append for two reasons: (1) the patient returned to the operating room following the initial procedure during the postoperative period; (2) the same surgeon performed the initial procedure and the removal and replacement of the shunt.

5. **Answer:** A. 99212-24

   Rationale: Even though the patient is in a postoperative period from surgery, the physician can bill this E/M visit and append modifier 24. The examination is unrelated to the nerve repair surgery. Modifiers 55 and 54 are only appended to surgical procedure codes not Evaluation and Management services.

Section Review 15.1

1. **Answer:** B. Balancing the strength of extraocular muscles

   Rationale: Strabismus in the CPT® Index takes you to code range 67311–67345. In the text, find the subheading entitled Extraocular Muscles. All of these codes involve the muscles moving the eyeball, and most of these codes address adjusting one or more ocular muscles to correct an imbalance in the muscles causing the eye to be pulled too much in one direction, causing disorders like crossed or wandering eyes.

2. **Answer:** D. Iris

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

3. **Answer:** B. Air conduction

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

4. **Answer:** B. The middle ear

   Rationale: The three ossicles (malleus, incus, and stapes) are found in the middle ear. When sound travels by air into the external auditory canal, it causes the tympanic membrane to vibrate. The sound is then transferred from the membrane to the tiny ossicles. From the stapes, the vibration is transferred to the oval window, which causes the round window to move and vibrate the endolymph of the cochlear duct. This causes the fine hairs in the organ of Corti to transmit impulses through the cochlear nerve to the brain.

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

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

6. **Answer:** C. Surgical repair of the eyelid.

   Rationale: Blephar/o is a root word identifying the eyelid, and plasty indicates a surgical repair.

7. **Answer:** A. Cornea

   Rationale: Kerat/o is a root word identifying the cornea. In keratoconus, the cornea protrudes, causing a refraction error. Its cause is unknown, but it is thought to be hereditary.

8. **Answer:** D. The tympanic membrane is incised.

   Rationale: Myring/a is a root word identifying the tympanic membrane and -otomy is a suffix indicating an incision.

9. **Answer:** A. The inner ear

   Rationale: The inner ear is responsible for balance in addition to conduction of sound. Vertigo, or extreme dizziness, is often a symptom of inner ear disorders including Mèniére's disease and vestibular neuronitis.

10. **Answer:** D. All of the above.

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

Section Review 15.2

1. **Answer:** B. E10.3292

   Rationale: In the ICD-10-CM Alphabetic Index look for Diabetes, diabetic/type 1/with/retinopathy/non-proliferative/mild and directs you to E10.329-. In the Tabular List, 7th character 2 is reported to indicate the left eye. This is a combination code that includes the diabetes and the complication of retinopathy. A separate code for retinopathy is not reported. Because macular edema is not indicated in the scenario, the default is without macular edema.

2. **Answer:** D. R68.12

   Rationale: Look at the chief complaint—the reason for the visit—when considering the primary diagnosis. In the ICD-10-CM Alphabetic Index, look for Fussy baby directing you to code R68.12. In this case, the mother thought her son had a recurring ear infection because of the child's excessive crying. D is the correct answer because it is the chief complaint and no other diagnosis was found. Codes Z00.129 and Z01.10 are inappropriate because these codes describe routine exams in asymptomatic populations. Code H66.90 is incorrect, as no definitive diagnosis is made.

3. **Answer:** C. C72.40

   Rationale: In the ICD-10-CM Alphabetic Index look for Neuroma/acoustic (nerve) D33.3. Although an acoustic neuroma is indexed to D33.3, the question indicates malignant which changes the way the diagnosis is reported. A note at the beginning of the Table of Neoplasms discusses classifications in the columns of the table, and advises, "the guidance in the index can be overridden if one of the descriptors … is present." Because the pathologist stated this particular acoustic neuroma is malignant, the word malignant overrides the index entry. Look in the Table of Neoplasms for Neoplasm, neoplastic/acoustic nerve/Malignant Primary which directs you to C72.4-. Verify in the Tabular List and code C72.40 is reported because the laterality is not addressed. It's very important to study and understand the information provided in the guidelines and notes within the code book. Be willing to look beyond the codes for the answers because the answers may be in the instructional notes and guidelines.

4. **Answer:** D. S01.312A, Z23

   Rationale: This is an open wound of the earlobe. In the ICD-10-CM Alphabetic Index look for Laceration/ear (canal) (external), which directs you to S01.31-. In the Tabular List, the code selection indicates a 6th character for laterality and 7th character to indicate the episode of care is required. Complete code S01.312A is for laceration of the left ear, initial encounter. The patient received a vaccination for tetanus, which is reported with Z23. Look in the Alphabetic Index for Vaccination/encounter for directs you to Z23.

5. **Answer:** A. H44.532

Rationale: Look in the ICD-10-CM Alphabetic Index for Leukocoria and you are directed to see Disorder, globe, degenerated condition, leukocoria. Disorder/globe/degenerated condition/leukocoria directs you to H44.53-. In the Tabular List, 6th character 2 is reported to indicate the left eye. Leukocoria reports a symptom rather than an actual diagnosis. In leukocoria, an abnormal white reflection from the retina is visible through the pupil upon examination of the eye. It can be indicative of retinoblastoma, a congenital retinal cancer, but until this diagnosis is confirmed, the symptom of leukocoria is the appropriate diagnosis to report.

6. **Answer:** B. H10.023

Rationale: Pink eye is a highly infectious form of mucopurulent conjunctivitis. This infection typically is accompanied by very bloodshot eyes and a heavy discharge. In the ICD-10-CM Alphabetic Index, look for Pink/eye - *see* Conjunctivitis, acute, mucopurulent. Look for Conjunctivitis/acute/mucopurulent H10.02-. In the Tabular List, the codes contain laterality and documentation indicates both eyes (bilateral) are affected.

7. **Answer:** D. H91.90

Rationale: Without more specific information for the type of hearing loss, a nonspecific diagnosis is reported. In the ICD-10-CM Alphabetic Index, look for Loss/hearing (*see also* Deafness). Look for Deafness directing you to H91.9-. In the Tabular List, select code H91.90 *Unspecified hearing loss, unspecified ear.* No scientific study of the hearing loss was made, making R94.120 incorrect.

8. **Answer:** A. T85.79XA, H05.011, Z85.840

Rationale: In the ICD-10-CM Alphabetic Index, look for Complication/eye/implant (prosthetic)/infection and inflammation directing you to T85.79-. In the Tabular List, code T85.79- requires a 7th character. Based on active treatment for the condition this would support A, initial encounter. Because T85.79 is a five-character code the placeholder X is needed to maintain the 7th character position. Subcategory code T85.7 states to "Use additional code to identify specified infections". There is no documentation of the infective agent. Orbital cellulitis is indexed under Cellulitis/orbit, orbital H05.01-. In the Tabular List, the 6th character 1 is for the right side. The implant is the result of the patient's previous cancer indicated with Z85.840. This is found under History/personal (of)/malignant neoplasm (of)/eye Z85.840. This is not a family history of cancer of the eye, Z80.8.

9. **Answer:** C. S09.21XA, W60.XXXA, Y92.017, Y93.H2

Rationale: This is an acute injury and in ICD-10-CM injuries have different categories for open wounds, lacerations, bites, and are specific to with or without a foreign body. In the ICD-10-CM Alphabetic Index, look for Wound/puncture wound - *see* Puncture. Look for Puncture/ear/drum directing you to S09.2-. In the Tabular List subcategory S09.2- requires a 5th digit for laterality and a 7th character for the type of encounter. Because S90.21 is a five-character code, the place holder X is needed to maintain the 7th character position. The complete code is S09.21XA. Codes in the H72.0- subcategory are for perforations persisting after an illness or injury is resolved. Code S00.401- is for a superficial injury, but this isn't superficial because it is in the middle ear. Do not confuse simple with superficial. External cause codes describe the circumstance of the injury. These codes are found in External Cause of Injuries Index. Look for Contact/with/plant thorns, spines, sharp leaves or other mechanisms W60. Category W60 requires a 7th character for type of encounter. Because this is a three-character code, the placeholder X is needed to maintain the 7th character position. The complete code is W60.XXXA. Next, in the External Cause of Injuries Index for look for Place of occurrence/yard, private/single family house Y92.017. In the same index look for Activity/gardening Y93.H2. Verify these codes in the Tabular List. These External cause codes help establish the cause of the injury for the payer.

10. **Answer:** A. H40.9

Rationale: There is not a lot of information to work with and H40.9 *Unspecified glaucoma* is the appropriate choice. In the ICD-10-CM Alphabetic Index, look for Glaucoma and the default code is H40.9. In a medical office, you would have access to the entire patient record and to the physician to find out more about the type of glaucoma. The important thing to remember is the patient still has glaucoma, despite the normal (WNL is within normal limits) IOP (intraocular pressure). Code Z86.69 is inappropriate because it reports a history of a resolved condition.

Section Review 15.3

1. **Answer:** B. 65275

Rationale: The presence of the foreign body has no bearing on code selection. In the CPT® Index, see Cornea/Repair/Wound/Nonperforating 65275. Note the code reads with or without removal of foreign body. The key to code choice is the site of the injury, which is the cornea and it was a nonperforating injury (lamellar means partial thickness of the cornea). The topical anesthetic is bundled into the procedure, although the physician could bill separately for any IV sedation used or if a therapeutic contact lens was applied.

2. **Answer:** B. 69105

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

3. **Answer:** A. 65420-50

Rationale: In the CPT® Index, see Pterygium/Excision 65420. A pterygium is an overgrowth of conjunctiva forming in the nasal aspect of the eye and growing outward towards the cornea. Excision of a pterygium is reported separately from other conjunctival disorders, with codes 65420 and 65426. Because this was a simple repair without a graft, 65420 is the correct code. Modifier 50 indicates a bilateral procedure was performed.

4. **Answer:** C. 69310

Rationale: In the CPT® Index, see Meatoplasty/External Auditory Canal 69310. The external opening of the ear is referred to as the meatus. A meatoplasty enlarges the opening. Another index option is to look for Auditory Canal/External/Reconstruction/for Stenosis 69310.

5. **Answer:** C. 67318, 67331, 67335

Rationale: In the CPT® Index, look for Strabismus/Repair/Superior Oblique Muscle 67318. Code 67318 is the only code listed describing a procedure on the superior oblique muscle. In addition to 67318, report add-on codes for adjustable sutures. In the index, see Strabismus/Repair/Adjustable Sutures 67335. This patient has a history of ophthalmic surgery. The medical history of ocular surgery makes the procedure riskier and more difficult. Look in the index for Strabismus/Repair/Previous Surgery, Not Involving Extraocular Muscles 67331. Modifier 51 is never applied to add-on codes.

6. **Answer:** A. 69799

   Rationale: In the CPT® Index, look for Ear/Unlisted Services and Procedures. The correct answer is A, for an unlisted procedure. Round window implants are a new technology not yet assigned CPT® a code. The word transducer should alert you to the hearing aid component of this procedure. There isn't a new technology Category III code for this type of procedure, so an unlisted code is the best choice. The round window is the barrier between the middle and inner ear, but it is still considered middle ear.

7. **Answer:** C. 68520

   Rationale: In the CPT® Index, look for Dacryocystectomy referring you to 68520. The stone was embedded in the sac, which was removed. Only one code is used for removal of the stone and removal of the sac. The lacrimal gland is located near the eyebrow; the lacrimal sac is the upper dilated end of the lacrimal duct, aligned with the nostril.

8. **Answer:** D. 69637

   Rationale: In the CPT® Index, look for Mastoidotomy. Code 69637 represents a mastoidotomy (including atticotomy and tympanic membrane repair) with ossicular chain reconstruction and partial ossicular replacement prosthesis.

9. **Answer:** C. 67120

   Rationale: An aqueous shunt is implanted material in the extraocular posterior segment of the eye. In the CPT® Index, look for Eye/Removal/Implant/Posterior Segment referring you to 67120-67121. It can also be found by looking for Removal/Implant/Eye.

10. **Answer:** C. 92012

    Rationale: In the CPT® Index, look for Ophthalmology, Diagnostic/Eye Exam/Established Patient referring you to 92012-92014. A comprehensive exam includes a biomicroscopy and tonometery. Code 92002 is reported for a new patient and 92012 for an existing patient. This service is for an existing patient, making 92012 the correct code.

Section Review 16.1

1. **Answer:** A. 00528

   Rationale: Look in the CPT® Index for Anesthesia/Thoracoscopy. All of these codes are related to thoracoscopy. Code 00528 describes a diagnostic procedure not using 1 lung ventilation utilization.

2. **Answer:** D. 00406

   Rationale: Anesthesia/Mastectomy is not listed in the CPT® Index. Look for Anesthesia/Breast to see the code range. Code 00406 is the appropriate anesthesia code for a radical mastectomy with internal mammary node dissection.

3. **Answer:** B. 00790

   Rationale: A cholecystectomy is the surgical removal of the gallbladder. The gallbladder is an intraperitoneal organ located in the upper abdomen. Look in the CPT® Index for Anesthesia/Abdomen/Intraperitoneal and you are directed to code range 00790-00797, 00840-00851. A review of the codes verifies 00790 as the correct code. Another index option is to look for Anesthesia/Laparoscopy.

4. **Answer:** A. 01622

   Rationale: There is no listing for Anesthesia/Diagnostic Arthroscopy in CPT® Index. Look for Anesthesia/Arthroscopic Procedures/Shoulder or Anesthesia/Shoulder. Both provide a range of code choices. Code 01622 identifies anesthesia for a diagnostic arthroscopic procedure of the shoulder joint.

5. **Answer:** D. 01638, 64416-59

   Rationale: In the CPT® Index locate Anesthesia/Replacement/Shoulder directing you to 01638. The brachial plexus block was requested for postoperative pain management and is appropriate to report separately. To find this code in the index look for Brachial Plexus/Anesthetic Injection 64415-64416. Code 64415 describes a single injection. Code 01996 is reported with epidurals—not brachial plexus blocks. The correct answer is 01638, 64416-59. Modifier 59 is appended because nerve blocks are bundled with anesthesia codes. In this case, the block is for postoperative pain and is reported separately.

6. **Answer:** B. 01967

   Rationale: Look in the CPT® Index for Anesthesia/Childbirth/Vaginal Delivery and you're directed to 01960, 01967. Code 01960 is used for a vaginal delivery only while 01967 describes neuraxial labor anesthesia with replacement of the catheter if necessary. Code 01961 is used for a cesarean delivery. Code 62320 is not used by the anesthesiologist for an epidural for an obstetric patient.

Section Review 16.2

1. **Answer:** A. K86.89

   Rationale: Look in the ICD-10-CM Alphabetic Index for Mass/pancreas; there is no listing for Mass/pancreas. Refer to Mass/specified organ NEC - *see* Disease, by site. Look for Disease/pancreas/specified NEC K86.89. The coder should not default to the Table of Neoplasms because the term is Mass, unless otherwise stated. Verify code selection in the Tabular List.

2. **Answer:** D. D25.9

   Rationale: The preoperative diagnosis is disregarded because a more definitive diagnosis is determined following surgery. Look in the ICD-10-CM Alphabetic Index for Fibroid/uterus D25.9. Verify code selection in the Tabular List.

3. **Answer:** C. H02.829, Z92.83

   Rationale: The reason for the anesthesiologist's involvement for the monitored anesthesia care (MAC) in the surgery is the patient's history of failed moderate sedation. The eye cyst is first-listed as it is the medical necessity for the surgery and Z92.83 is an additional diagnosis to explain the need for anesthesia care. In the ICD-10-CM Alphabetic Index, look for Cyst/eyelid (sebaceous) directing you to H02.829. Next, look in the Alphabetic Index for History/personal (of)/failed conscious sedation directing you to Z92.83. Verify code selection in the Tabular List.

4. **Answer:** C. M17.12

   Rationale: The patient's previous surgery has no relevance to the anesthesia for the knee surgery. DJD is an abbreviation for degenerative joint disease. Look in the ICD-10-CM Alphabetic Index for Degeneration, degenerative/joint disease which directs you to see Osteoarthritis. Look in the Alphabetic Index for Osteoarthritis/knee M17.1. According to Coding Clinic, Volume 3, Number 4, Fourth Quarter 2016, "When the type of osteoarthritis is not specified, 'primary' is the default." In the Tabular List, a 5th character is needed to report the laterality. Complete code is M17.12 for the left knee.

5. **Answer:** C. S82.102A

   Rationale: A linear fracture identifies this as a closed fracture. Look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/tibia/proximal end and you are directed to see Fracture, tibia, upper end. Fracture, traumatic/tibia/upper end directs you to code S82.10-. In the Tabular List, 6th character 2 is reported for the left leg and 7th character A is selected for a closed fracture, initial encounter.

Section Review 16.3

1. **Answer:** C. Arterial line placement

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

2. **Answer:** B. When the anesthesiologist begins to prepare the patient

   Rationale: Anesthesia time begins when the anesthesia provider begins to prepare the patient for the induction of anesthesia.

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

   Rationale: Only the anesthesia code representing the most complex procedure is reported. The most complex procedures usually have the highest base unit value.

4. **Answer:** D. P1

   Rationale: A normal healthy patient is reported with physical status modifier P1. No additional value is recognized.

5. **Answer:** D. None of the above

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

6. **Answer:** B. 93503

   Rationale: Look in the CPT® Index for Swan-Ganz Catheter/Insertion. You're directed to 93503 which is the *Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes.*

7. **Answer:** D. 31500

   Rationale: The anesthesiologist is not providing an intubation for a patient undergoing anesthesia. An emergency intubation is correctly reported as 31500. Look in the CPT® Index for Intubation/Endotracheal Tube.

8. **Answer:** C. 47

   Rationale: Modifier 47 is reported by the surgeon when he also provides regional or general anesthesia for the surgical service, and does not apply local anesthesia. Modifier 47 is added to the appendectomy code. This modifier is not to be reported with anesthesia CPT® procedure codes. Anesthesia providers do not report this modifier.

Section Review 16.4

1. **Answer:** C. 00142-AA-QS

   Rationale: An anesthesiologist who is personally performing administration of anesthesia reports the service with an AA modifier. Because the service was performed using MAC, a QS modifier is also reported.

2. **Answer:** B. 01961-QK and 01961-QX

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

3. **Answer:** D. AD and QX

   Rationale: An anesthesiologist who is medically supervising reports the service separately from the CRNA. Supervision of more than four concurrent anesthesia procedures is reported with modifier AD. The CRNA reports with modifier QX.

4. **Answer:** B. QZ

   Rationale: A CRNA without medical direction is reported with QZ modifier.

5. **Answer:** C. G9

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

Section Review 17.1

1. **Answer:** D. Superior and inferior

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

2. **Answer:** C. At an angle, neither frontal nor lateral

   Rationale: An oblique position is a slanted position where the patient is lying at an angle which is neither prone nor supine.

3. **Answer:** A. AP

   Rationale: AP is the abbreviation for anteroposterior where the projection enters the front of the body and exits through the back of the body. Because the patient is lying on their back, it cannot be oblique.

4. **Answer:** D. Coronal

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

5. **Answer:** B. Projection

   Rationale: The projection is the path the X-ray beam takes through the body.

Section Review 17.2

1. **Answer:** B. N63.21

   Rationale: When a test is ordered for a sign or symptom, and the outcome of the test is a normal result with no confirmed diagnosis, the coder reports the sign or symptom that prompted the physician to order the test. Because the test was ordered for a lump in the breast, but the outcome is normal, the lump in the breast, N63 is reported as the diagnosis. In the ICD-10-CM Alphabetic Index, look for Lump/breast/left/upper outer quadrant which directs you to N63.21. Verify code selection in the Tabular List.

2. **Answer:** D. S82.202A, S82.402A

   Rationale: The final diagnosis is available at the time of reporting and is used instead of the sign or symptom. The final diagnosis of a fracture of the tibia and fibula is reported as the diagnosis. In the ICD-10-CM Alphabetic Index, look for Fracture, traumatic/tibia (shaft) S82.20-. In the Tabular List, a 6th character 2, is reported for the left side and the 7th character A, is reported for the initial encounter. Final code choice: S82.202A. Verify code selection in the Tabular List.

   Next, look in the ICD-10-CM Alphabetic Index for Fracture, traumatic/fibula (shaft) (styloid) S82.40-. In the Tabular List, 6th character 2, is reported for the left side and the 7th character A is reported for the initial encounter. Final code choice is S82.402A. Verify code selection in the Tabular List.

3. **Answer:** B. R93.0, J32.9, J38.01

   Rationale: The findings of the CT were nonspecific and are not considered a final diagnosis. The first diagnosis reports the nonspecific findings. Because the findings were inconclusive, you also report the signs and symptoms for which the CT was ordered. In the ICD-10-CM Alphabetic Index, look for Findings, abnormal, inconclusive, without diagnosis/radiologic (X-ray)/head R93.0. Next, look in the Alphabetic Index for Sinusitis J32.9. The last code is found in the Alphabetic Index under Paralysis/vocal cords/unilateral J38.01. Verify code selection in the Tabular List.

4. **Answer:** C. Z00.00

   Rationale: For encounters for routine radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z00.00. Because there were no signs or symptoms for the chest X-ray, and it was routinely performed as part of a preventive medicine exam, ICD-10-CM Z00.00 is reported. In the ICD-10-CM Alphabetic Index, look for Examination/annual (adult) or Examination/radiological (as part of a general medical examination) Z00.00. In the Tabular List, the note under subcategory code Z00.0 indicates the code is for an, "Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations."

5. **Answer:** D. Z01.818

   Rationale: The pre-operative exam is a general preoperative exam. When an X-ray is performed as part of a general preoperative exam, ICD-10-CM code Z01.818 is reported. In the ICD-10-CM Alphabetic Index, look for Examination/pre-operative - *see* Examination, pre-procedural. Examination/pre-procedural/specified NEC Z01.818. Verify code selection in the Tabular List.

Section Review 17.3

1. **Answer:** D. 70390-26, K11.4

   Rationale: Contrast radiography of the salivary gland and ducts is considered sialography. Code 70390 describes sialography supervision and interpretation. Look in the CPT® Index for Salivary Glands/X-ray/with contrast. The patient is diagnosed with a salivary fistula, which is found in the ICD-10-CM Alphabetic Index under Fistula/salivary duct or gland K11.4. Verify code selection in the Tabular List.

2. **Answer:** C. 74176

   Rationale: Both CT of the abdomen and of the pelvis were obtained. There is one code to report for both anatomical areas taken at the same time. The "without contrast" codes are used. Look in the CPT® Index for CT Scan/without Contrast/Abdomen or Pelvis.

3. **Answer:** B. 76010-26

   Rationale: Look in the CPT® Index for X-ray/Nose to Rectum/Foreign Body 76010. Turning to 76010 in the numeric section, this code is applicable to a child for a single view.

4. **Answer:** C. 70150

   Rationale: Three views of the facial bones (Waters' view, Caldwell view, and lateral view) were ordered. Look in the CPT® Index for X-ray/Facial Bones, 70140–70150. Code 70150 is for a complete, minimum of three views X-ray of the facial bones.

5. **Answer:** D. 72156

   Rationale: Look in the CPT® Index for Magnetic Resonance Imaging (MRI)/Diagnostic/Spine/Cervical, 72141–72142, and 72156. Because both without contrast and with contrast were used for this cervical MRI, CPT® code 72156 is selected.

Section Review 17.4

1. **Answer:** B. 76705

   Rationale: Ultrasound of the abdomen includes the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava. Because the ultrasound was of only the liver, it is considered a limited abdominal ultrasound. Look in the CPT® Index for Ultrasound/Abdomen.

2. **Answer:** D. 76815

   Rationale: The ultrasound is limited because the position of the fetuses is all that the ultrasound is verifying. Look in the CPT® Index for Ultrasound/Obstetrical/Pregnant Uterus. The description of 76815 includes one or more fetuses and the code is reported once only.

3. **Answer:** B. 76775

   Rationale: Look in the CPT® Index for Ultrasound/Kidney, 76770–76776. CPT® code 76776 is an ultrasound for a transplanted kidney, including real-time and duplex Doppler with image documentation. A duplex Doppler of the kidney is not performed. The parenthetical instruction under CPT® 76776 indicates to report 76775 for an ultrasound of transplanted kidney without duplex Doppler. The correct code is 76775.

4. **Answer:** C. 77065

   Rationale: The physician ordered a unilateral diagnostic mammogram with computer-aided detection (CAD). Code 77065 describes a diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral.

5. **Answer:** A. 76506

   Rationale: An echoencephalography is performed to identify any abnormalities or disease(s). Look in the CPT®Index for Echoencephalography/Intracranial, code 76506.

Section Review 17.5

1. **Answer:** B. 77427

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

2. **Answer:** D. 76499

   Rationale: Dual energy X-ray absorptiometry (DXA) studies are indexed under Dual X-ray Absorptiometry (DXA) in the code range 77080–77086. Under 77081 is a parenthetical instruction stating to use 76499 for a DXA body composition study.

3. **Answer:** B. 77778

   Rationale: In this case, brachytherapy is performed using interstitial application of radiation seeds. According to the Radiology Guidelines, a complex application has greater than 10 sources, which is reported with code 77778. Review the CPT® coding guidelines for the definition of simple, intermediate, and complex for clinical brachytherapy. Look in the CPT® Index for Brachytherapy/Interstitial Application 0395T, 77778.

4. **Answer:** D. 73600

   Rationale: In this case, no modifiers are reported with the CPT® code; you report the global procedure. Because the ankle X-ray was taken in the physician's office (meaning the office owns the equipment) and the physician reads the X-ray and provides a report, the CPT® code is reported without a modifier. The global service 73600 includes both the professional and technical components.

5. **Answer:** A. 77080

   Rationale: DXA is dual-energy X-ray absorption. The site is of the spine, which is part of the axial skeleton. In the CPT® Index, look for DXA and you are directed to *see* Dual X-ray Absorptiometry (DXA); Dual X-ray Absorptiometry (DXA)/Axial Skeleton. In this case, one site (spine) is involved in the study. The correct code is 77080.

Section Review 18.1

1. **Answer:** C. Disease

   Rationale: The root word path means "disease." The suffix ~logy is "study of."

2. **Answer:** D. Microbiology

   Rationale: The root words micro (small) and bio (life) combined with ~logy describe the study of small life forms.

3. **Answer:** B. Forensic

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

4. **Answer:** A. Qualitative

   Rationale: A qualitative test determines the presence or absence of the substance.

5. **Answer:** C. Quantitative

   Rationale: A quantitative test determines the amount of a substance found in the specimen. A qualitative test determines the presence or absence of the substance.

Section Review 18.2

1. **Answer:** C. Z20.3

   Rationale: The codes in category Z20 are for exposure/contact to a disease without signs or symptoms of infection. Look in the ICD-10-CM Alphabetic Index for Exposure (to)/rabies Z20.3.

2. **Answer:** C. C50.211

   Rationale: Always code the most specific diagnosis known. When a diagnosis of carcinoma of the breast has been confirmed, it is inappropriate to code a less specific diagnosis, no matter the reason for the original test. In the ICD-10-CM Alphabetic Index, look for Carcinoma (malignant) (*see also* Neoplasm, by site, malignant). Go to the Table of Neoplasms, and look for Neoplasm, neoplastic/breast/upper inner quadrant/Malignant Primary (column) C50.2-. Verification in the Tabular List indicates six characters are needed to complete the code. Report C50.211 for the upper inner quadrant of the right breast.

3. **Answer:** B. M06.9, Z79.1, Z51.81

   Rationale: Code both the arthritis and the long-term use of NSAIDs. Look in the ICD-10-CM Alphabetic Index for Arthritis/rheumatoid, directing you to M06.9. For the next code, look for Therapy/drug, long term (current) (prophylactic)/anti-inflammatory directing you to Z79.1. There is an instructional note under category code Z79 to report also any therapeutic drug level monitoring with code Z51.81. This is found in the Alphabetic Index by looking for Monitoring (encounter for)/therapeutic drug level Z51.81. Verify these codes in the Tabular List and read any instructions provided.

4. **Answer:** B. Z08, Z85.46, Z90.79

   Rationale: Per ICD-10-CM coding guideline I.C.21.c.8 follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. The follow-up code is sequenced first followed by the history code. Look in the ICD-10-CM Alphabetic Index for Examination/follow-up (routine) (following)/radiotherapy NEC/malignant neoplasm directing you to Z08. Once cancer has been excised and there is no further treatment directed toward the cancer site without recurrence, choose a personal history of malignancy code. Look for History/personal (of)/malignant neoplasm (of)/prostate directing you to Z85.46. Confirm codes in the Tabular List. According to *AHA Coding Clinic* (2000 Vol. 17 No.4) screening codes are not used for patients who have any sign or symptom of a suspected condition or history of a condition. The instructional note in the Tabular List for Z08 indicates to use additional code to identify any acquired absence of organs (Z90.-). Look in the Alphabetic Index for Absence/prostate (acquired) referring you to Z90.79.

5. **Answer:** D. R87.619

   Rationale: Choose a code that identifies unspecified previous abnormal findings on cervical Pap smear. Although the second test results came back normal, the previous abnormal finding supports the need for a repeat test. Look in the ICD-10-CM Alphabetic Index for Findings, abnormal, inconclusive, without diagnosis/Papanicolaou cervix, directing you to R87.619. Verify this code in the Tabular List.

Section Review 18.3

1. **Answer:** A. 85730

   Rationale: PTT stands for partial thromboplastin time. Look in the CPT® Index for PTT, you are directed to—*See* Thromboplastin, Partial Time, which directs you to 85730–85732. Checking the listing, 85730 *Thromboplastin time, partial (PTT); plasma or whole blood* is the correct code for this test.

2. **Answer:** D. 81002

   Rationale: 81002 is for dipstick urinalysis. Modifier 26 is not needed in the physician office and QW is not required. Look in the CPT® Index for Urinalysis/Routine.

3. **Answer:** B. 80076, 82565

   Rationale: Code the panel when all of the tests listed in the panel are completed. If additional tests are also performed, they are coded separately. The first 7 tests are all listed in code 80076. This leaves creatinine, which is reported with code 82565. Look in the CPT® Index for Panel, this directs you to *See* Blood Tests; Organ or Disease-Oriented Panel. Look for Blood Tests/Panels/Hepatic Function, and you are directed to 80076. Next, look for Creatinine/Blood directing you to 82565. Verify these codes.

4. **Answer:** C. 88040

   Rationale: Services related to legal investigations and trials are forensic examinations. Look in the CPT® Index for Autopsy/Forensic Exam, and you are directed to 88040. Read the code to verify this as the correct listing.

5. **Answer:** D. 86359

   Rationale: Code 86359 is for total T-cell count. If other studies were performed, they were not ordered and may not be billed, no matter how seemingly appropriate. Look in the CPT® Index for TCells/Count, which directs you to 86359.

Section Review 19.1

1. **Answer:** C. Outpatient consultation

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

2. **Answer:** B. Preventive medicine, established patient

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

3. **Answer:** D. Initial observation care

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

4. **Answer:** C. Non-billable

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

5. **Answer:** A. Office visit, new patient

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

Section Review 19.2

1. **Answer:** A. Problem Focused

   Rationale:

History				
HPI Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs & Symptoms	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)

ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete
PFSH Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient's family) Social history (an age appropriate review of past and current activities)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

CC: Follow up of hospitalization for pneumonia.

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

ROS: None

PFSH: None

2. **Answer:** C. Detailed

Rationale:

History				
HPI Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs & Symptoms	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, Mouth Endo	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete

PFSH Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient's family) Social history (an age appropriate review of past and current activities)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

CC: Asthma exacerbation

HPI: Duration—Two to three days

Associated signs and symptoms-cough

Quality—Productive cough

Severity—Getting worse

ROS: Constitutional—Denies fever or chills

Respiratory—Difficulty breathing

PFSH: Past History—Currently uses inhalers (current medication)

3. **Answer:** B. Expanded problem focused

Rationale:

History				
HPI Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs & Symptoms	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete

PFSH Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient's family) Social history (an age appropriate review of past and current activities)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

CC: Skin lesions

HPI: Location—Forehead and lateral to right eye

Duration—About a year

ROS: Integumentary—No other skin complaints

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

PFSH: Past, Family, and Social all reviewed as it relates to skin.

4. **Answer:** D. Comprehensive

Rationale:

History				
HPI Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs & Symptoms	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete

PFSH Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient's family) Social history (an age appropriate review of past and current activities)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

CC: Fever

HPI: Duration—Less than one day

Severity—High fever

Associated signs and symptoms—Decreased appetite

Modifying factor—Tylenol has been given which reduced the fever

ROS: GI—No vomiting or diarrhea

Resp—Parents unaware of any cough

Rest of review of systems reviewed and negative: Complete ROS

PFSH: Personal history—Current meds

Social history—Not exposed to second hand smoke

5. **Answer:** B. Expanded problem focused

Rationale:

History				
HPI Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs & Symptoms	Brief (1–3)	Brief (1–3)	Extended (4 or more)	Extended (4 or more)
ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo	None	Pertinent to problem (1 system)	Extended (2–9 systems)	Complete

PFSH Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient's family) Social history (an age appropriate review of past and current activities)	None	None	Pertinent (1 history area)	Complete (2 (est) or 3 (new) history areas)
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

CC: ATV accident

HPI: Context—ATV accident

Location—Lip and chin lacerations

ROS: GI—Negative for nausea and vomiting

Eyes— Negative for blurred vision

Neuro—Negative for headache

PFSH: Past history—surgeries and illnesses reviewed, current meds

Social history—Nonsmoker, moderate alcohol

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

Section Review 19.3

1. **Answer:** C. Detailed

   Rationale: Organ Systems: Constitutional, Skin, Respiratory, Cardiovascular, Gastrointestinal, and Musculoskeletal. There are six organ systems examined with detailed documentation. The level of exam is Detailed.

2. **Answer:** D. Comprehensive

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

3. **Answer:** D. Comprehensive

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

4. **Answer:** B. Expanded problem focused

   Rationale: Body Areas: Neck, Abdomen

   Organ Systems: Constitutional, ENMT, Respiratory

   There are three organ systems examined and two Body Areas. This is a limited exam of the affected body areas. The level of exam is Expanded Problem Focused.

5. **Answer:** D. Comprehensive

   Rationale: Organ Systems: Constitutional, Eyes, ENMT, Respiratory, Cardiovascular, Gastrointestinal, Integumentary, Neurologic, Lymphatic, Musculoskeletal. Ten organ systems were examined. The level of exam is Comprehensive.

Section Review 19.4

1. **Answer:** B. Low

   Rationale: The patient is in for follow up of chronic conditions. The conditions are both established and stable (two points). There is no data reviews and moderate risk (two stable chronic conditions). Medical decision making is Low.

2. **Answer:** D. High

   Rationale: New problem to examiner, additional workup—dialysis (four points); Labs, EKG, and X-ray reviewed (three points); risk is High (chronic illness posing a threat to life). The medical decision making is High.

3. **Answer:** B. Low

   Rationale: Established problem worsening (two points); ultrasound reviewed (one point); risk is moderate (simple mastectomy). The medical decision making is Low.

4. **Answer:** D. High

   Rationale: Three problems worsening (six points); labs reviewed (one point); chronic illnesses posing a threat to life (exacerbation of congestive heart failure, poorly controlled hypertension, worsening acute renal failure due to cardio-renal syndrome). The medical decision making is High.

5. **Answer:** C. Moderate

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

Section Review 19.5

1. **Answer:** B. 99213

   Rationale: Established patient codes require two of three key components be met to determine a level of visit. In this case, the expanded problem focused exam and low level of medical decision-making support a level 3 established patient office visit, 99213.

2. **Answer:** C. 99223

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

3. **Answer:** B. 99202

   Rationale: For a new patient visit, all three key components must be met:

   History—HPI (Extended), ROS (Extended), PFSH (none) = EPF

   Exam—Expanded problem focused (limited exam of ears, nose, throat, and neck)

   MDM—Moderate for the prescription drug management

   The documentation supports 99202.

4. **Answer:** C. 99309

   Rationale: For subsequent nursing facility care codes, two of three key components must be met.

   History—(Extended), ROS (Extended), PFSH (1-Pertinent) = Detailed

   Exam—Detailed exam of eyes, ENT, Neuro

   MDM—New problem with additional workup, lab ordered, moderate risk (undiagnosed new problem with uncertain prognosis) = moderate medical decision making

   The documentation supports 99309.

5. **Answer:** B. 99243

   Rationale: A consultation requires all three key components be met to support the level of visit.

   History—HPI (extended), ROS (Extended), PFSH (complete) = Detailed

   Exam—Detailed

   MDM—New problems no additional work-up, one data point given (review/order of test in medicine section) for the EMG or Nerve conduction study. The level of risk is moderate (elective major surgery).

   The documentation supports a 99243.

Section Review 20.1

1. **Answer:** B. 90375, 96372

   Rationale: Code for the product and the administration of rabies immune globulin. In the CPT® Index, see Immune Globulins/rabies, you are directed to 90375–90376. Because there is no mention of heat-treated, 90375 is the appropriate code. Reading the guidelines for immune globulins, a code from 96365–96372, 96374, or 96375 is reported as appropriate for the administration. This is an injection, and 96372 is the appropriate code. In the CPT® Index, look for Injection/Intramuscular/Therapeutic.

2. **Answer:** A. 90658, 90732, 90471, 90472

   Rationale: The patient received two vaccines: influenza and pneumonia. Each is charged separately. In the CPT® Index, look for Vaccines and Toxiods/Influenza/for Intramuscular Use. A review of the code choices indicates 90658 is the correct code. For the pneumonia vaccine look in the index for Vaccines/and Toxoids/Pneumococcal/23-valent (PPSV23). Code 90471 describes injection of one vaccine. The add-on code 90472 describes each additional vaccine. Add-on codes (+) may not be reported independently but are a composite of the basic code. In the CPT® Index look for Administration/Immunization One Vaccine/Toxoid and Administration/Immunization/Each Additional/Vaccine/Toxoid.

3. **Answer:** A. 90717, 90471

   Rationale: Code for both the vaccine and the administration. Codes 90717 and 90471 describe the yellow fever vaccine and the immunization administration for one vaccine. In the CPT® Index look for Vaccines and Toxoids/Yellow Fever and Administration/Immunization One Vaccine/Toxoid.

Section Review 20.2

1. **Answer:** C. 90847

   Rationale: A family therapy session with patient present is reported with 90847. The payer may request documentation of those present and areas of discussion. In the CPT® Index look for Psychotherapy/Family of Patient. Code choice is based on with or without the patient present, and time.

2. **Answer:** B. 90882

   Rationale: The services performed by the psychotherapist include environmental interventions by communicating with the social agency. In the CPT® Index locate Psychiatric Treatment/Environmental Intervention. Code 90882 describes intervention on a psychiatric patient's behalf with agencies, employers, or institutions.

3. **Answer:** D. 90834

   Rationale: Code 90834 describes a 45-minute outpatient/office encounter for psychotherapy. In the CPT® Index look for Psychotherapy/Individual Patient.

Section Review 20.3

1. **Answer:** A. 90911

   Rationale: Code 90911 describes biofeedback training for the urethral sphincter. In the CPT® Index, look for Biofeedback Training/Anorectal.

Section Review 20.4

1. **Answer:** A. 90937

   Rationale: Code 90937 describes hemodialysis requiring physician re-evaluation with or without substantial revision of dialysis. In the CPT® Index, look for Hemodialysis/Procedure/with Evaluation.

2. **Answer:** C. 90969 x 25

   Rationale: Code 90969 describes ESRD related services for dialysis less than a full month of service per day, for patients 12–19 years of age. This was not a full month of ESRD related services and 90969 is reported per day with 25 units, 1 unit for each day. See the example in CPT® under End Stage Renal Disease Services. In the CPT® Index, look for End Stage Renal Disease Services/Less than a full month.

3. **Answer:** C. 90989

   Rationale: Code 90989 describes a completed course of dialysis training for the patient and a helper. In the CPT® Index, look for Dialysis/Patient Training/Completed Course.

Section Review 20.5

1. **Answer:** D. 93926

   Rationale: Code 93926 describes duplex scan, limited or unilateral study, of the lower extremity arteries, including digits. Swelling was present in the left foot and the only extremity scanned. In the CPT® Index, look for Duplex Scan/Arterial Studies/Lower Extremity.

2. **Answer:** D. 93990

   Rationale: Code 93990 describes a scan of hemodialysis access and includes arterial inflow, body of access, and venous outflow. In the CPT® Index, look for Hemodialysis/Duplex Scan of Access.

3. **Answer:** B. 93975

   Rationale: Code 93975 describes a complete scan of arterial inflow and venous outflow of the abdominal, pelvic, scrotal contents, and/or retroperitoneal organs. In the CPT® Index, look for Duplex Scan/Arterial Studies/Visceral.

Section Review 20.6

1. **Answer:** A. 95004 x 12

   Rationale: Code 95004 describes scratch tests with allergenic extracts, immediate type of reaction. The code includes interpretation and report. Report the code with the correct number of units for the number of tests. In the CPT® Index, look for Allergy Tests/Skin Tests/Allergen Extract.

2. **Answer:** C. 95130

   Rationale: Code 95130 describes provision of allergenic extract and injection of a single stinging insect venom. In the CPT® Index, look for Allergen Immunotherapy/Allergenic Extracts/Injection and Provision/Insect Venom.

3. **Answer:** B. 95144 x 4

   Rationale: Code 95144 describes preparation and provision of antigen for immunotherapy in single dose vials. Report 4 vials. In the CPT® Index, look for Allergen Immunotherapy/Antigens/Preparation and Provision.

Section Review 20.7

1. **Answer:** D. 96040 x 3

   Rationale: Code 96040 describes genetic counseling by a qualified counselor for each 30 minutes of face-to-face time. Report three units for the session lasting 1.5 hours. Report E/M codes if counseling is provided by a physician. In the CPT® Index, look for Medical Genetics.

Section Review 20.8

1. **Answer:** B. 96150 x 8

   Rationale: Code 96150 describes the clinical interview and behavior observation and assessment, face-to-face per 15 minutes. The encounter lasted 2 hours. The code is reported with 8 units. Time should be documented in the psychologist's report. In the CPT® Index, look for Health Behavior—*See* Evaluation and Management/Health Behavior/Assessment.

2. **Answer:** C. 96112

   Rationale: Code 96112 describes testing for developmental assessment, including interpretation and report. In the CPT® Index, look for Developmental Testing. Because the physician spent one hour, 96112 is reported.

3. **Answer:** D. 96130, 96131 x12

   Rationale: Code 96130 describes multiple testing, face-to-face time with the patient, and time interpreting and preparing the report, first hour of time. 96131 Is to be reported with the 96130 for each additional hour. Number of units reported is 12. The time must be documented in the psychologist's record. In the CPT® Index, look for Neuropsychological Testing/Evaluation Services.

Section Review 20.9

1. **Answer:** A. 96360, 96361

   Rationale: Codes 96360 and 96361 describe hydration infusion for two hours. Code 96360 is the first hour and 96361 is the second hour. The add-on code 96361 cannot be reported independently, but only in addition to 96360. The fluids infused are separately reported, using the appropriate code from HCPCS Level II. In the CPT® Index, look for Infusion/Hydration.

2. **Answer:** B. 96522

   Rationale: Code 96522 describes refill and maintenance of an intra-arterial or intravenous implanted pump for drug delivery. The drug is separately reported with HCPCS Level II codes. In the CPT® Index, look for Infusion Pump/Maintenance or Drug Delivery Implant/Maintenance and Refill/Intravenous.

3. **Answer:** D. 96450

   Rationale: Code 96450 describes intrathecal delivery of chemotherapy agents. The code includes the spinal puncture. The drugs are separately coded using HCPCS Level II codes. Spinal catheter placement is included in the technique. In the CPT® Index, look for Spine Chemotherapy/Administration.

Section Review 20.10

1. **Answer:** A. 97161-GP, 97110-GP x 4

   Rationale: The therapist evaluates the patient and problem at the first visit and determines a treatment. Code 97161 is reported for an uncomplicated injury with low clinical decision making. In the CPT® Index, look for Physical Medicine/Therapy/Occupational Therapy/Evaluation/Physical Therapy. Code 97110 describes exercises performed to develop strength and range of motion, per 15 minutes. For one hour, report four units. In the CPT® Index, look for Physical Medicine/Therapy/Occupational Therapy/Procedures/Therapeutic Exercises.

2. **Answer:** C. 97161-GP, 97110-GP x 3, 97116-GP

   Rationale: The therapist evaluates the patient and problem at the first visit and determines a treatment plan. Gait training will be necessary and will likely increase in time at subsequent therapy sessions. Code 97161 is reported for an uncomplicated condition with low clinical decision making. In the CPT® Index, look for Physical Medicine/Therapy/Occupational Therapy/Evaluation/Physical Therapy. Code 97110 is for the exercises. In the CPT® Index, look for Physical Medicine/Therapy/Occupational Therapy/Procedures/Therapeutic Exercises. And, 97116 for the gait training. In the CPT® Index, look for Physical Medicine/Therapy/Occupational Therapy/Procedures/Gait Training. Report three units for the exercises to cover 45 minutes.

3. **Answer:** A. 97760

   Rationale: Code 97760 describes Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes. Report the orthotic device separately using HCPCS Level II codes. In the CPT® Index, look for Orthotics/Management and Training.

Section Review 20.11

1. **Answer:** C. 97802 x 2

   Rationale: Code 97802 describes the initial medical nutrition assessment interview per 15 minutes of face-to-face time. Report two units for the 30-minute session. In the CPT® Index, look for Nutrition Therapy/Initial Assessment.

Section Review 20.12

1. **Answer:** C. 97813

   Rationale: Code 97813 describes a 15-minute encounter with one-on-one patient contact using acupuncture with electrical stimulation. In the CPT® Index, look for Acupuncture/with Electrical Stimulation.

Section Review 20.13

1. **Answer:** B. 98925

   Rationale: Code 98925 describes manipulation of one to two body regions. Both feet were manipulated during the session. In the CPT® Index, look for Osteopathic Manipulation.

Section Review 20.14

1. **Answer:** A. 98943

   Rationale: Code 98943 describes extraspinal manipulation, one or more regions. In the CPT® Index, look for Manipulation/Chiropractic.

2. **Answer:** C. 98940

   Rationale: Code 98940 describes manipulation of one to two spinal regions. In the CPT® Index, look for Manipulation/Chiropractic.

3. **Answer:** A. 98941

   Rationale: Three regions of the spine were manipulated. Code 98941 describes manipulation of three to four regions. In the CPT® Index, look for Manipulation/Chiropractic.

Section Review 20.15

1. **Answer:** D. 98962 x 3

   Rationale: A Registered Dietician is a nonphysician practitioner that is qualified to educate at-risk patients in diet management. Code 98962 describes five to eight patients. Report three units for 90 minutes. In the CPT® Index, look for Special Services/Group Education/Self-Management.

2. **Answer:** B. 98960 x 2

   Rationale: Code 98960 describes face-to-face education and training with one patient for 30 minutes. Report two units for one hour. In the CPT® Index, look for Special Services/Individual Education/Self-management.

Section Review 20.16

1. **Answer:** D. 98967

   Rationale: Code 98967 describes a telephone discussion with a nonphysician qualified healthcare professional for 11–20 minutes. The discussion did not lead to an appointment within the next 24 hours or the soonest available appointment and was not related to an E/M service within the previous seven days. In the CPT® Index, look for Telephone/Evaluation and Management/Nonphysician.

2. **Answer:** D. 98969

   Rationale: Code 98969 describes an on-line medical evaluation with a nonphysician qualified healthcare professional not relating to a management and assessment service within the previous seven days and not leading to the next urgent care appointment. In the CPT® Index, look for Evaluation and Management/Online Services.

Section Review 20.17

1. **Answer:** D. 99075

   Rationale: Physicians may be called upon to give a medical opinion about cause of death in a court proceeding. Code 99075 is designated for medical testimony. In the CPT® Index, look for Medical Testimony.

2. **Answer:** B. 99027 x 13

   Rationale: Code 99027 describes mandated on-call service, out of the hospital, per hour. In the CPT® Index, look for Mandated Services/On Call Services.

3. **Answer:** A. 99000

   Rationale: Physicians often contract with an outside laboratory to handle specimens and provide reports. The laboratory will arrange for courier pick up and charge the physician a handling fee. In the CPT® Index, look for Handling/Specimen Transport.

4. **Answer:** D. 99050

   Rationale: Code 99050 describes services provided on holidays and weekends that are outside of normal business hours. In the CPT® Index, look for After Hours Medical Services.

Section Review 20.18

1. **Answer:** D. 99175

   Rationale: Code 99175 describes administration of ipecac to induce emesis for emptying the stomach. In the CPT® Index, look for Ipecac Administration/for Poisoning.

2. **Answer:** B. 99170

   Rationale: Code 99170 describes a magnified anogenital examination on a child for suspected trauma. In the CPT® Index, look for Anogenital Region—*See* Perineum. Locate Perineum/Anogenital Examination/with Magnification and Image/Recording.

Section Review 20.19

1. **Answer:** D. 99507

   Rationale: Patients discharged from hospital care may still need some assistance with their medical condition. The physician typically arranges the care with a home care agency by sending a qualified person to the patient's home to provide that assistance. Code 99507 describes home care for maintenance of catheters. In the CPT® Index, look for Home Services/Catheter Care.

2. **Answer:** A. 99505

   Rationale: Code 99505 describes a home care visit from a nonphysician practitioner to manage stomas and ostomies. In the CPT® Index, look for Home Services/Stoma Care.

3. **Answer:** D. 99601

   Rationale: Code 99601 describes home infusion of a specialty drug per visit, up to two hours. In the CPT® Index, look for Home Services/Home Infusion Procedures.

Section Review 20.20

1. **Answer:** D. 99606, 99607

   Rationale: Code 99606 describes the initial 15-minute consultation with a pharmacist for an established patient. Code 99607 describes an additional 15 minutes. Both are reported for the 23-minute encounter. In the CPT® Index, look for Medication Therapy Management/Pharmacist Provided.