CHAPTER 1: YOUR CAREER AS A MEDICAL CODER

Answers to Checkpoint Questions

Checkpoint 1.1
In your opinion, is each of the following diagnoses and procedures correctly linked to show medical necessity? Why or why not?
1. Diagnosis: deviated septum  
Procedure: nasal surgery Yes, nasal surgery is medically necessary for treating that condition once other options such as medication have been provided.
2. Diagnosis: mole on a female patient’s cheek, questionable nature  
Procedure: surgical removal and biopsy Yes, once a mole is considered of questionable nature it is medically necessary to biopsy it to determine if it is a malignancy.
3. Diagnosis: male syndrome hair loss  
Procedure: implant hair plugs on scalp. No, this would be considered a cosmetic procedure and would not be covered by insurance.
4. Diagnosis: probable broken wrist  
Procedure: comprehensive full-body examination, with complete set of lab tests, chest x-ray, and ECG No, a probably broken wrist would not require such an extensive workup. The physician would most likely do an examination and possibly an x-ray of the wrist. The other services would not be medically necessary.

Checkpoint 1.2
In which type of environment would you prefer to be employed? Why?
The answers will vary, but in a medical school physician group the opportunities for learning all aspects of coding and reimbursement are available and the potential for advancement to higher career levels are also available.

Checkpoint 1.3
The following chart note contains typical documentation abbreviations and shortened forms for words.

65-yo female; hx of right breast ca seen in SurgiCenter for bx of breast mass. Frozen section reported as benign tumor. Bleeding followed the biopsy. Reopened the breast along site of previous incision with coagulation of bleeders. Wound sutured. Pt adm. for observation of post-op bleeding. Discharged with no bleeding recurrence.
Final Dx: Benign neoplasm, left breast.

Research each abbreviation using an online resource and record their meanings on the lines provided.
1. yo Year old
2. hx History
3. ca Cancer
4. bx Biopsy
5. Pt Patient
6. adm Admitted
7. op Operative
8. Dx Diagnosis
Checkpoint 1.4

Consider medical ethics, and answer the questions that follow.

1. Sallie Smith, who works for the Clark Clinic, ordered medical office supplies from her cousin, David Hand. When the supplies arrived, David came to the office to check on them and to take Sallie out to lunch. Is Sallie’s purchase of supplies from her cousin ethical? Why or why not? No. 
   Rationale: This is a conflict of interest. No attempt was made to find the best price for the supplies, and there is a personal relationship with the supplier and an implied benefit to the employee.

2. Davon Singh is a medical coder in the practice of Dr. Karen Kline. During the past few weeks, Dr. Kline has consistently written down codes that stand for 1-hour appointments, but Davon knows that these visits were all very short, no longer than 15 minutes each. Is it ethical for Davon to code these visits as hour-long appointments? No. 
   Rationale: A medical coder would approach the physician or review the documentation to determine why the physician used those codes. If the visit was 15 minutes and based on time because it was for a discussion with the patient, the appropriate 15-minute code would be used. If the visit was based on the key components the coder would review the documentation to determine if the key components met the criteria for the higher code. This issue is covered in more detail in chapters 13 and 14.

Checkpoint 1.5

1. Visit AHIMA’s website for information about certification (www.ahima.org/certification), and review the criteria for applying for the CCS versus the CCA examinations. Report on the major differences in their requirements.

   ANS: The CCA candidate requires a U.S. high school diploma or equivalent.

   The CCS candidate must have one of the following criteria:
   By Credential: RHIA®, RHIT®, or CCS-P®
   OR
   By Education: Completion of a coding training program that includes anatomy and physiology, pathophysiology, pharmacology, medical terminology, reimbursement methodology, intermediate/advanced ICD diagnostic/procedural and CPT coding;
   OR
   By Experience: Minimum of two (2) years of related coding experience directly applying codes; OR
   By Credential With Experience: CCA® plus one (1) year of coding experience directly applying codes;
   OR
   Other Coding credential from other certifying organization plus one (1) year coding experience directly applying codes.

2. Visit the AAPC website to learn more about certification (www.aapc.com/certification), and report on three of the certifications that are offered.

   ANS: CPC certified professional coder
   CPC-H: certified professional coder—outpatient hospital
   CPC-P: certified professional coder—payer

Answers to Review Questions

Matching

A. health information management (HIM)
B. ethics
C. provider
D. medical necessity
E. code set
F. compliance
G. diagnosis code
H. certification
I. documentation
J. medical coding

1. B Standards of conduct based on moral principles
2. I The systematic, logical, and consistent recording of a patient’s health status—history, examinations, tests, results of treatments, and observations in chronological order in a patient’s medical record
3. E A coding system used to encode elements of data
4. F The completion of actions that follow and satisfy official guidelines and requirements
5. G Number assigned to a patient’s documented illness or condition
6. H Process of earning a credential through a combination of education and experience followed by successful performance on a national examination
7. C Person or entity that supplies medical or health services and bills for or is paid for the services in the normal course of business; may be a professional member of the health-care team such as a physician, or a facility such as a hospital or skilled nursing home
8. J The process of analyzing the documentation of patients’ diagnoses and procedures and assigning accurate, compliant codes based on HIPAA-mandated code sets
9. D Payment criterion of payers that requires medical treatments to be appropriate and provided in accordance with generally accepted standards of medical practice
10. A Department in a facility that manages patients’ medical records to ensure quality of data

True/False
1. T The terms outpatient and ambulatory have the same meaning.
2. T The particular tests, services, and treatments a patient receives are assigned procedure codes based on the medical record.
3. F The medical billing process is called the resource cycle.
4. F An inpatient is usually released from a facility within 15 to 18 hours.
5. F Providers work only in the hospital setting.
6. F Medical coders work only for hospitals.
7. T Information technology, communications, and coding skills are needed for success as a medical coder.
8. F Compliance can involve actions that ignore regulations.
9. T The fourth step in the medical coding process is to assign accurate, complete diagnosis and procedure codes.
10. T Most successful coders need professional certification to advance in their careers.

Multiple Choice
1. The correct link between a patient’s condition and the services a provider performed demonstrates the
   A. Minimum necessary standard
   B. HIPAA Security Rule
   C. Medical necessity of the services for payment
   D. Release of information
   **ANS: C**

2. Coding credentials that can be earned include
   A. CCP-A, CPC, CCS, and CCS-P
   B. RHIT, RHIA, and MBA
   C. CHS, ROI, and MRN
   D. None of the above
   **ANS: A**

3. Skills required for medical coding include knowledge of
   A. Anatomy and physiology
   B. Disease processes
C. Medical terminology  
D. All of the above  

ANS: D  

4. Medical necessity means the patient’s treatments/services are  
A. Reasonable  
B. Required for the diagnosis  
C. Not experimental  
D. All of the above  

ANS: D  

5. The major types of payers are  
A. Private, self-funded, and government sponsored  
B. Medicare, Medicaid, and TRICARE  
C. TRICARE and CHAMPVA  
D. None of the above  

ANS: A  

6. The health information management department may also be known as  
A. The clinical area  
B. The medical records department  
C. Human resources  
D. Registration  

ANS: B  

7. The medical billing process is aimed at  
A. Effective charge capture  
B. Efficient use of facility resources  
C. Documentation improvement  
D. Increasing information technology use  

ANS: A  

8. In the second step of the medical coding process, the coder determines the appropriate  
A. Diagnosis and procedure  
B. Supply use and place of service  
C. Prognosis, provider, and payer  
D. Provider, patient type, place of service, and payer  

ANS: D  

9. Which of the following is an example of using information technology?  
A. Using encoder products  
B. Using empathy  
C. Gaining certification  
D. Ethical actions  

ANS: A  

10. Earning certification as a medical coder requires  
A. Education  
B. Experience  
C. Successful completion of an examination  
D. All of the above  

ANS: D
CHAPTER 2: THE REGULATORY ENVIRONMENT OF CODING

Answers to Checkpoint Questions

Checkpoint 2.1

A. The following chart note is on file for a female patient:

SUBJECTIVE: The mother brought in this 1-month-old female. The patient is doing very well. They have been using the phototherapy blanket. She is thirsty, has good yellow stooling, and continues on formula. Her alertness is normal. Other pertinent ROS is noncontributory.

OBJECTIVE: Afebrile. Comfortable. Jaundice is only minimal at this time. No scleral icterus. Good activity level. Normal fontanel. TMS, nose, mouth, pharynx, neck, heart, lungs, abdomen, liver, spleen, and groin are normal. Good extremities.

ASSESSMENT: Resolving physiological jaundice on phototherapy.

PLAN: Will stop phototherapy and do a bilirubin level for a couple of days to make sure there is no rebound. The patient is to be seen in 1 week. Push fluids. Routine care was discussed.

MD/xx

1. Identify the patient: One-month-old female
2. What abnormal condition does the patient have? Physiological jaundice
3. Is the abnormal condition getting better or worse? Resolving (better)
4. What test is ordered? Blood test for bilirubin level

B. This letter is in the patient medical record of John W. Wu:

Nicholas J. Kramer, MD
2200 Carriage Lane
Currituck, CT 07886
Consultation Report
on John W. Wu
(Birth date 12/06/1942)

Dear Dr. Kramer:

At your request, I saw Mr. Wu today. This is a 65-year-old male who stopped smoking cigarettes 20 years ago but continues to be a heavy pipe smoker. He has had several episodes of hemoptysis; a small amount of blood was produced along with some white phlegm. He denies any upper respiratory tract infection or symptoms on those occasions. He does not present with chronic cough, chest pain, or shortness of breath. I reviewed the chest x-ray done by you, which exhibits no acute process. His examination was normal. A bronchoscopy was performed, which produced some evidence of laryngitis, tracheitis, and bronchitis, but no tumor was noted. Bronchial washings were negative. I find that his bleeding is due to chronic inflammation of his hypopharynx and bronchial tree, which is related to pipe smoking. There is no present evidence of malignancy.

Thank you for requesting this consultation.

Sincerely,

Mary Lakeland Georges, MD

1. What is the purpose of the letter? The letter is a record of the consultation provided by Dr. Georges at the request of Dr. Kramer.
2. How does it demonstrate the use of a patient medical record for continuity of care? Patient was referred for hemoptysis (coughing up blood) and the letter shows the findings of Dr. Georges’ examination and the bronchoscopy performed. The letter becomes part of the patient’s medical record.
Checkpoint 2.2
In each of the following cases of release of PHI, was the HIPAA Privacy Rule followed?
1. A laboratory communicates a patient’s medical test results to a physician by phone. Yes
2. A physician mails a copy of a patient’s medical record to a specialist who intends to treat the patient. Yes
3. A hospital faxes a patient’s health-care instructions to a nursing home to which the patient is being transferred. Yes
4. A doctor discusses a patient’s condition over the phone with an emergency department physician who is providing the patient with emergency care. Yes
5. Bedside, a doctor orally discusses a patient’s treatment regimen with a nurse who will be involved in the patient’s care. Yes
6. A physician consults with another physician by e-mail about a patient’s condition. Yes
7. A hospital shares an organ donor’s medical information with another hospital that is treating the organ recipient. Yes
8. A medical assistant answers a health plan’s questions about a patient’s dates of service on a submitted health claim over the phone. Yes

Checkpoint 2.3
Read the following case and answer the questions.
Gloria Traylor, an employee of National Bank, called Marilyn Rennagel, a medical coder who works for Dr. Judy Fisk. The bank is considering hiring one of Dr. Fisk’s patients, Juan Ramirez, and Ms. Traylor would like to know whether he has any known medical problems. Marilyn, in a hurry to complete the call and get back to work on this week’s charts, quickly explains that she remembers that Mr. Ramirez was treated for depression some years ago, but that he has been fine since that time. She adds that she thinks he would make an excellent employee.
1. In your opinion, did Marilyn handle this call correctly? No
2. What problems might result from her answers? The medical coder did not have authorization to release medical information for Mr. Ramirez, which is a violation of the HIPAA Privacy Rule and would open the practice to HIPAA sanctions.

Checkpoint 2.4
Use the letter from Dr. Georges to Dr. Kramer provided in Checkpoint 2.1 to answer the following questions.
1. Identify and define the patient’s symptom using clinical terms:
   ANS: The patient has hemoptysis, which is defined as coughing up blood.
2. What procedure did Dr. Georges perform?
   ANS: Bronchoscopy

Checkpoint 2.5
Read the following case and answer the questions.
Mary Kelley, a patient of the Good Health Clinic, asked Kathleen Culpepper, the employee who handles medical coding and billing, to help her out of a tough financial spot. Her medical insurance authorized her to receive four radiation treatments for her condition, one every 35 days. Because she was out of town, she did not schedule her appointment for the last treatment until today, which is 1 week beyond the approved period. The insurance company will not reimburse Mary for this procedure. She asks Kathleen to change the date on the record to last Wednesday so that it will be covered, explaining that no one will be hurt by this change and, anyway, she pays the insurance company plenty.
1. What type of action is Mary asking Kathleen to do? Medical fraud
2. How should Kathleen handle Mary’s request? She should deny Mary’s request and keep the correct
date on the record.

**Checkpoint 2.6**

As a medical coder, do you think that ongoing training will be important to you? **There is no question that ongoing training is essential to medical coders. The codes change every year, both diagnostic and procedural, and no one person knows everything about all the codes. The training is needed to maintain efficiency, accuracy, and professionalism.**

**Answers to Review Questions**

**Matching**

<table>
<thead>
<tr>
<th>A. Joint Commission</th>
<th>G. protected health information (PHI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. HIPAA Privacy Rule</td>
<td>H. treatment, payment, and health-care operations (TPO)</td>
</tr>
<tr>
<td>C. HIPAA Security Rule</td>
<td>I. meaningful use</td>
</tr>
<tr>
<td>D. informed consent</td>
<td>J. covered entity</td>
</tr>
<tr>
<td>E. minimum necessary standard</td>
<td></td>
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<tr>
<td>F. Affordable Care Act</td>
<td></td>
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</table>

1. **B** HIPAA law regulating the use and disclosure of patients’ protected health information—individually identifiable health information that is transmitted or maintained by electronic media
2. **I** Using certified EHR technology to improve quality, efficiency, and patient safety in the health-care system
3. **E** Principle that individually identifiable health information should be disclosed only to the extent needed to support the purpose of the disclosure
4. **J** Under HIPAA, a health plan, clearinghouse, or provider who transmits any health information electronically
5. **H** Under HIPAA, the purposes for which patients’ protected health information may be shared without authorization
6. **G** Individually identifiable health information that is transmitted or maintained by electronic media
7. **A** Organization that accredits and certifies hospitals and other health-care organizations/programs.
8. **C** HIPAA law that requires covered entities to establish administrative, physical, and technical safeguards to protect health information
9. **D** Process by which a patient authorizes a planned treatment following discussion concerning its nature and risks
10. **F** Common name for the 2010 health system reform legislation that provides significant patient benefits

**True/False**

1. **F** When a state law and the federal HIPAA provision both cover a particular situation the state law is followed.
2. **F** Fraud is not intentional.
3. **F** The chief complaint is usually documented using clinical terminology.
4. **T** Electronic health records have advantages over paper records.
5. **T** A compliance plan includes measures to ensure that coders are trained in current code sets.
6. **T** Business associates of providers must follow the same privacy rules as the providers they work for.
7. **T** Protected health information includes the various numbers assigned to patients, such as their medical record numbers.
8. **F** The minimum necessary standard does not refer to the patient’s health history.
9. **F** Patients do not have the right to access, copy, inspect, and request amendment of their medical records.
10. F A patient’s authorization is needed to disclose protected information for payment purposes.

**Multiple Choice**

1. Health information that does not identify an individual is referred to as
   A. Protected health information
   B. Authorized health release
   C. Statutory data
   D. De-identified health information
   **ANS: D**

2. An encounter is
   A. An operation
   B. An office visit
   C. A chemotherapy infusion
   D. All of the above
   **ANS: D**

3. A patient’s PHI may be released without authorization to
   A. Local newspapers
   B. An anesthesiologist who will anesthetize the patient during a scheduled surgery
   C. Friends who visit the patient during a hospital stay
   D. A lawyer who calls for information
   **ANS: B**

4. Which government group has the authority to enforce the HIPAA Privacy Rule?
   A. FBI
   B. OIG
   C. OCR
   D. Medicaid
   **ANS: C**

5. When PHI is correctly requested, what is the only information the HIM department releases?
   A. De-identified information
   B. Code set data
   C. Minimum necessary data
   D. A copy of the entire file
   **ANS: C**

6. The authorization to release information of an unsecured breach of PHI must specify the
   A. Number of pages to be released
   B. Social Security number of the patient
   C. Entity to whom the information is to be released
   D. Name of the treating physician
   **ANS: B**

7. The main purpose of the HIPAA Security Rule is to
   A. Regulate bank transactions
   B. Protect research data
   C. Control access to protected health information
   D. Protect medical facilities from break-ins and robbery
   **ANS: C**

8. The________codes used in the United States are based on the International Classification of Diseases (ICD).
   A. Diagnosis
   B. Treatment
   C. Procedure
   D. Transaction
ANS: A
9. Medical coders assign codes based on the requirements of the
A. HIPAA Privacy Rule
B. HIPAA Security Rule
C. HIPAA Electronic Health Care Transactions and Code Sets standards
D. Health Care Fraud and Abuse Control Program
   ANS: C
10. Patients’ protected health information may be released for
A. Treatment
B. Payment
C. Operations
D. All of the above
   ANS: D
CHAPTER 3: ICD-10-CM BASICS

Answers to Checkpoint Questions

Checkpoint 3.1
A. Identify the purpose of ICD-10-CM coding in the following case scenarios as research (R), quality (Q), communication (C), payment (P), or administrative (A).
1. A hospital board would like to develop a chemotherapy marketing campaign because the hospital has had a reduction in services to patients during the past year. A
2. A physician reported the wrong ICD-10-CM codes to Medicare and was reimbursed incorrectly; the codes had to be resubmitted on a new health-care claim. P
3. A hospital wants to send a patient survey to all patients to determine whether the services they received were satisfactory. Q
4. A trend showed an increase in hospital postoperative complications, and a hospital wanted to investigate this trend. Q
5. A company wants to determine whether its new drug for the treatment of diabetes is effective. R
B. Identify which coding system (ICD-9-CM and/or ICD-10-CM) is referenced in the following statements.
6. Classifies laterality. ICD-10-CM
7. Contains a separate classification for external causes of injury (E codes). ICD-9-CM
8. Contains 21 chapters. ICD-10-CM
9. The code 410.11 is a sample from this system. ICD-9-CM
10. GEMs help transition which coding system(s)? ICD-9-CM and ICD-10-CM

Checkpoint 3.2
Using the entire ICD-10-CM Index to Diseases and Injuries, identify which specific section in the Index—the Index to Diseases (A), the Neoplasm Table (N), the Table of Drugs and Chemicals (T), or the Index to External Causes (E)—the coder would reference for the following main terms.
1. Carbon monoxide T
2. Chronic obstructive pulmonary disease A
3. Parachuting E
4. Tylenol T
5. Infection A
Underline the main term in the following examples that the coder would use to begin the coding process.
6. Burn of the hand BURN
7. Fall from tree FALL
8. Poisoning from cocaine Poisoning or Cocaine
9. Chronic cystitis Cystitis
10. Automobile accident Accident
11. Acute appendicitis Appendicitis
12. Malignant neoplasm of the colon Neoplasm
13. Allergic reaction to shellfish Reaction
14. Closed fracture of the lateral condyle of the left humerus Fracture
15. Struck by lightning Struck
Answer the following using the Index to Diseases and Injuries.
16. What is the first subterm under the main term edema? With nephritis
17. What is the first subterm under the main term drowning? (Hint: See the Index to External Causes.) Assault
18. What is the first subterm under the main term pain? Abdominal
19. Is there a carryover line at the main term pneumonia? **Yes**

20. What is the first sub-subterm under the main term accident, subterm transport? **18 wheeler**

Using the Index, code the following:

21. Urinary tract infection **N39.0**

22. Progressive atrophic paralysis **G12.22**

23. Insomnia due to alcohol abuse **F10.182**

24. Ski lift accident **V98.3**

25. Regional enteritis with complication of intestinal obstruction **K50.912**

**Checkpoint 3.3**

Find the following codes in the ICD-10-CM Tabular List of Disease and state their meaning.

1. M26.02 **Maxillary hypoplasia**
2. H92.02 **Otalgia, left ear**
3. W59.02xA **Struck by nonvenemous lizards, initial encounter**
4. Z62.891 **Sibling rivalry (problems related to upbringing**
5. R71.0 **Precipitous drop in hematocrit**
6. D23.71 **Other benign neoplasm of the skin of the right lower limb, including hip**
7. K56.1 **Intussusception**
8. B35.3 **Tinea pedis**
9. S09.21xA **Traumatic rupture of the right ear drum, initial encounter**
10. O40.2xx2 **Polyhydramnios, second trimester, fetus 2**

**Checkpoint 3.4**

1. What is the block associated with code N36.41? **Other diseases of the urinary system (N30–N39)**
2. What does the sixth digit classify in code H10.423? **Sixth digit classifies laterality (bilateral)**
3. What does the fourth digit classify in code N70.11? **Chronic salpingitis and oophoritis**
4. Is code S00.252 reported at the highest level of specificity? **No, code S00.252 requires a seventh character.**
5. What chapter is represented by code O9A.312? **Pregnancy, Childbirth, and Puerperium (Chapter 15)**

**Checkpoint 3.5**

Match the following terms.

- A. a three-digit code
- B. a character that maintains the seven digits
- C. the last digit in an ICD-10-CM code
- D. a fourth, fifth, or sixth digit is assigned
- E. a range of codes
- F. a group of codes within a chapter

1. Chapter **E**
2. Block **F**
3. Category **A**
4. Subcategory **D**
5. Placeholder character **B**
6. Seventh character **C**

**Checkpoint 3.5**

Code the following medical conditions in ICD-10-CM and identify the convention that applies from the Index to Diseases and Injuries: NEC or NOS.

<table>
<thead>
<tr>
<th>Code</th>
<th>Convention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z30.8</td>
<td>NEC</td>
</tr>
<tr>
<td>D17.9</td>
<td>NOS (unspecified)</td>
</tr>
<tr>
<td>A08.4</td>
<td>NEC (gastroenteritis) Note: Viral enteritis NOS in Tabular List at A08.4</td>
</tr>
</tbody>
</table>
4. Accidental food poisoning, initial encounter  
   T62.91xA NEC Note: Toxic effect of unspecified noxious substance eaten as food, accidental NOS convention in Tabular List

Explanation: The food poisoning is a poisoning NEC, the type of food is NOS NEC

5. Specified malformation of the heart  
   Q24.8

Checkpoint 3.6

Answer the following questions using all sections of ICD-10-CM.

1. What does the note at Chapter 13 instruct the coder to do? **Use an External Cause code following the code, if applicable, to identify the cause of the musculoskeletal condition.**

2. What is the cross-reference used to code Crohn's disease? **See Enteritis, regional**

3. What does the note refer to at category G43? **Defines the terms equivalent to intractable (i.e., treatment resistant)**

4. Which cross-reference should the coder follow when coding depressive psychosis? **See Disorder, depressive**

5. What does the note specify at code S45? **Code also any associated open wound and a seventh character should be assigned for all codes beginning with S45**

6. Is the diagnosis of fainting classified as code R55? **Yes (see includes note)**

7. Does code R68.11 include excessive crying of a child? **No—Excessive crying of a child is coded as R45.83.**

8. Which conditions are excluded (NOT CODED HERE) when reporting the code false labor (O47)? **Preterm labor**

9. Can codes N40.0 (enlarged prostate without lower urinary tract symptoms (LUTS)) and C61 (malignant neoplasm of the prostate) both be reported when documented for the same visit of the same patient? **Yes—Excludes 2 note (both can be present if documented)**

10. Can Baker's cyst of the right knee, without rupture, be classified using code M66.0? **No—Code M71.21**

Checkpoint 3.7

Apply the ICD-10-CM punctuation and typeface conventions to answer the following questions.

1. Would the diagnosis of tropical sprue be classified to code K90.1? **Yes**

2. Which two codes should be reported when coding Lewy body dementia? **(Hint: Report in the correct sequence.) G31.83 and F02.80 (both codes required and sequenced in this order)**

3. When reporting the external cause of injury as “cutting,” does the specific body part cut impact the code assignment? **(Hint: See the Index to External Causes.) No, cutting of any body part is coded here**

4. When looking up the main term Stenosis, subterm colon, in the Index, does the documentation need to support that this is a congenital disorder when assigning code Q42.9? **Yes, the cross-reference requires that the subterm congenital be documented.**

5. Would the diagnosis of acute coronary embolism without myocardial infarction be classified to code I24.0? **Yes**

6. Does code L97.101 include a chronic topical ulcer of unspecified thigh limited to breakdown of skin? **Yes (see Includes note at Category L97)**

7. Can alcoholic cirrhosis of the liver be reported using code K74.3? **No, alcoholic cirrhosis is excluded.**

8. Code poorly controlled diabetes mellitus, type 2. **E11.65 (poorly controlled is reported by specified type of diabetes with hyperglycemia)**

9. What is the significance of the terms in parentheses located at the main term bronchitis? **These terms are nonessential terms and do not have to be present to assign code J40.**
10. Code anterior dislocation of the lens, left eye. **H27.122**

**Checkpoint 3.8**

Using all sections of ICD-10-CM, indicate whether each of the following statements is true or false.

1. **F** The sequencing of the following codes is correct: L24.0, T49.0x5A.
   - **Rationale:** Correct sequencing is T49.0x5A, L24.

2. **F** Solar urticaria due to ultraviolet radiation is reported using code L56.3.
   - **Rationale:** An additional code is required to identify the source of ultraviolet radiation.

3. **T** Moderate persistent asthma with acute exacerbation due to exposure to secondhand tobacco smoke is reported using codes J45.41 and Z77.22.

4. **F** Code F04 should always be listed first.
   - **Rationale:** See Code first note.

5. **F** The instruction “code also” dictates sequencing of codes.

6. Acute cystitis due to *Escherichia coli* (E coli) **N30.00, B96.2**
   - **Rationale:** See the main term Infection, subterm Escherichia (E) coli, as cause of disease classified elsewhere to report the additional code to the organism.

7. Benign prostatic hypertrophy with lower urinary tract symptom of urinary retention. **N40.1, R33.8**
   - **Rationale:** Use additional code as instructed.

8. Alcohol abuse with uncomplicated intoxication, blood alcohol level is 65 mg/100 mL **F10.120, Y90.3**
   - **Rationale:** See the Use additional code note at category F10.

9. Bilateral Kearns-Sayre syndrome with heart block. **H49.813, I45.9**
   - **Rationale:** Code the manifestation as instructed at H49.81.

10. Encounter for adequacy testing for hemodialysis in a patient with end-stage renal disease. **Z49.31, N18.6**

**Checkpoint 3.9**

Using the ICD-10-CM, answer the following questions.

1. Which type of term is used as a subterm in the neoplasm table: site, etiology, or manifestation? **Site**

2. What is the code for benign neoplasm of the left lower female breast? **D24.2**

3. What is the accidental poisoning code for aspirin seen for the initial encounter? **T39.011A**

4. Starting with the main term Sarcoma, report the code for sarcoma of the left arm. **C49.12**

5. How would an underdose of digoxin be reported (subsequent encounter)? **T46.0x6D**

**Checkpoint 3.10**

Using the coding resources listed in Table 3.6, identify a resource that could be used to find the medical information below.

1. The meaning of CHF **Abbreviation book**

2. Coding advice regarding a patient who has uncontrolled diabetes **AHA Coding Clinic for ICD-10-CM**

3. The medical indications for the drug Zantac **Drug reference**

4. The ICD-10-CM code changes effective October 1, 2015 **Centers for Medicare and Medicaid Services (CMS) website**

5. The signs and symptoms of gastric ulcer **Pathophysiology book**

6. In which part of the body the talus is located **Anatomy book**

7. The code for sleep apnea effective October 1, 2005 **National Center for Health Statistics website**

8. The latest technology for heart transplants **Medical Internet site**


10. Medical term for gallbladder removal **Medical dictionary**
Answers to Review Questions

Matching
Match the key terms with their definitions.

A. WHO
B. cooperating parties
C. *ICD-10-CM Official Guidelines for Coding and Reporting*
D. External Cause of Injury Index
E. brackets
F. block
G. includes note
H. subcategory
I. colon
J. letter “x”

1. E Coding convention that encloses codes that should be reported second; these codes represent manifestation of a disease
2. A Organization responsible for maintaining ICD-9 and ICD-10
3. J Character used as a placeholder
4. H An ICD-10-CM code with five digits
5. C Publication that contains rules on ICD-10-CM coding and sequencing
6. F A range of codes within a chapter
7. I A coding convention that combines a term on the left with a term on the right
8. G A coding convention that instructs the coder that these conditions are not excluded
9. B The group of organizations that includes representatives from the NCHS, CMS, AHIMA, and AHA
10. D A portion of ICD-10-CM, the Index to Diseases and Injuries

True/False
Decide whether each statement is true or false.

1. F A coder is finished coding once a code is found in the Index.
   *Rationale: The coder must verify the code in the Tabular List of Diseases.*
2. F ICD-10-CM codes are never used for health-care reimbursement.
   *Rationale: ICD-10-CM codes are used for reimbursement.*
3. T HIPAA legislation mandates the use of ICD-10-CM.
4. F ICD-10-CM codes are updated annually on January 1.
   *Rationale: ICD-10-CM codes are updated October 1.*
5. F A Z code can never be used as a principal diagnosis.
   *Rationale: These are codes to report factors influencing health care and can be first listed.*
6. T The first step in assigning an ICD-10-CM code is reviewing complete documentation.
7. T When coding to the highest level of specificity, the coder must assign a code using the most digits available.
8. F The comma is a convention used in ICD-10-CM to list nonessential modifiers.
   *Rationale: The parentheses enclose nonessential modifiers.*
9. F An encoder can replace a knowledgeable coder.
   *Rationale: An encoder cannot replace the knowledge of a coder.*
10. F The Tabular List of ICD-10-CM has 20 chapters.
    *Rationale: There are 21 chapters in the Tabular List.*

Multiple Choice
Select the letter that best completes the statement or answers the question.

1. Which codes would be used to classify an individual with insulin-dependent type 2 diabetes with diabetic polyneuropathy?
   A. E11.42
   B. E11.610, Z79.4
   C. E11.42, Z79.4
   D. E11.40, Z79.4
ANS: C
2. Which convention instructs the coder to go to a different word in the Index?
A. Bold typeface
B. Parentheses
C. See
D. Code first
ANS: C
3. Which of the following codes are invalid? (may be more than one)
A. I22.9
B. I11.9
C. S84.11XA
D. S89.019
ANS: D
4. Which codes represent initial encounter for open fracture of the distal tibia due to fall from a ladder at home?
A. S82.90xB, W11.xxxA, Y92.9
B. S82.309, W19.xxxA, Y92.9
C. S82.899A, W19.xxxA, Y92.009
D. S82.309B, W11.xxxA, Y92.009
ANS: D
5. Which codes represent acute pyelonephritis due to pseudomonas in a patient with a history of urinary tract infections?
A. N10, B96.5, Z87.410
B. N11, B95.0, Z80.59
C. N10, B95.0, Z80.59
D. N10, B96.5, Z87.440
ANS: D
6. Code A54.00 describes which disease?
A. Gonorrhea not otherwise specified
B. Acute gonococcal infection of the lower genitourinary tract
C. Gonococcal urethritis
D. All of the above
ANS: B
7. Which code or codes represent acute and chronic cholecystitis with choledocholithiasis?
A. K81.2, K80.66
B. K80.44
C. K80.46
D. K80.50, K81.2
ANS: C
8. Which codes represent hypertension with stage V chronic kidney disease?
A. I13.11, N18.5
B. I12.0, N18.5
C. I12.9, N18.5
D. I13.0, N18.5
ANS: B
9. Which E code would be assigned when coding an initial encounter for suicide attempt by morphine?
A. T40.2x1A
B. T40.2x5A
C. T40.2x2A
D. T40.2x3A
ANS: C

10. Which of the following represents pyrophosphate crystal-induced arthritis of the left knee?
A. M11.879
B. M11.859
C. M11.862
D. M11.869
ANS: C
CHAPTER 4: ICD-10-CM CODING GUIDELINES

Answers to Checkpoint Questions

Checkpoint 4.1
Using the Tabular List of the ICD-10-CM, determine whether the following codes are coded to their highest level of specificity (the most number of digits available). If not, identify which digit(s) are missing.
1. C4A.1 No, need a fifth digit
2. I10 Yes
3. I69.81 No, needs a fifth and sixth digit
4. M80.051 No, needs a seventh character
5. S30.1 No, needs a fifth and sixth placeholder and seventh character

Checkpoint 4.2
For the following diagnostic statements, identify the sign or symptom and whether the sign or symptom is integral to the underlying disease.
1. Subdural hemorrhage resulting in a comatose state Sign: comatose state, not integral to the subdural hemorrhage
2. Shortness of breath due to pulmonary embolism Symptom: shortness of breath, integral to pulmonary embolism
3. Hematuria due to bladder cancer Sign: hematuria, integral to bladder cancer
4. Acute stroke with aphasia and weakness Sign and symptom: aphasia and weakness, not integral to acute stroke (report weakness as hemiplegia when associated with stroke per AHA Coding Clinic 1Q 2015)
5. Wrist pain due to recent fracture Symptom: wrist pain, integral to the fracture
Code the following using ICD-10-CM.
6. Acute gastritis, with hemorrhage K29.01
7. Closed fracture of the left wrist, initial episode of care, with wrist pain S62.102A
8. Acute idiopathic pancreatitis with abdominal ascites K85.00, R18.8
9. Acute asthma exacerbation with hypoxia J45.901, R09.02
10. Urinary tract infection with dysuria N39.0

Checkpoint 4.3
Code the following diagnostic statements using ICD-10-CM.
1. Acute cystitis with hematuria due to pseudomonas infection N30.01, B96.5
2. Autonomic dysreflexia due to fecal impaction G90.4, K56.41
3. Benign prostatic hypertrophy with urinary obstruction and urinary frequency N40.1, R35.0, N13.8
4. Prolapsed posterior vaginal wall with fecal incontinence N81.6, R15.9
5. Septic shock due to E coli sepsis with acute hypoxic respiratory failure A41.51, R65.21, J96.01
6. Diabetes due to chronic pancreatitis K86.1, E08.9
7. Pseudobulbar affect caused by amyotrophic lateral sclerosis G12.21, F48.2

Checkpoint 4.4
Code the following diagnostic statements using ICD-10-CM
1. Acute and chronic cystitis N30.00, N30.20
2. Acute and chronic cholecystitis K81.2
3. Acute appendicitis with perforation K35.2
4. Postoperative hematoma of skin following cardiac catheterization I97.630
5. Chronic bronchitis due to tobacco smoking \textit{J41.0, F17.200}  
6. Type 1 diabetes, cataract left eye \textit{E10.36}

\textbf{Checkpoint 4.5}

Underline the residual condition in the following diagnostic statements and then code using ICD-10-CM.

1. Painful scar due to old burn injury, left leg \textit{L90.5, T24.0025}  
2. Leg paralysis due to previous poliomyelitis \textit{G83.10, B91}  
3. Sequela of hyperalimentation \textit{E68}  
   \textit{Note: There is no residual condition to code; thus, code only the sequela.}

4. Normal pressure hydrocephalus due to previous encephalitis \textit{G91.9, G09}  
5. Malunion of displaced left tibial pilon fracture (traumatic) \textit{S82.872P}  
   \textit{Note: The seventh character reflects the injury as a malunion, which is a sequela of the fracture.}

\textbf{Checkpoint 4.6}

Code the following diagnostic statements using ICD-10-CM.

1. Threatened abortion \textit{O20.0}  
2. Impending delirium tremens \textit{F10.239}  
3. Impending gangrene of the right heel due to stage 4 decubitus ulcer \textit{L89.614}  
   \textit{Note: I96 is not coded as the gangrene is an impending condition (not present).}

4. Impending respiratory failure due to chronic obstructive pulmonary disease (COPD) exacerbation \textit{J44.1}  
   \textit{Note: J96.90 is not coded as the respiratory failure is an impending condition (not present).}

5. Impending myocardial infarction \textit{I20.0}

\textbf{Checkpoint 4.7}

Identify the sign/symptom and definitive diagnosis for each of the following diagnostic statements.

<table>
<thead>
<tr>
<th>Sign/Symptom</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>Gastritis</td>
</tr>
<tr>
<td>Hematuria due to renal calculus</td>
<td>Calculus</td>
</tr>
<tr>
<td>Cerebrovascular accident (CVA) with aphasia</td>
<td>CVA</td>
</tr>
<tr>
<td>Sprained knee with pain</td>
<td>Sprained knee</td>
</tr>
<tr>
<td>Cirrhosis of the liver with ascites</td>
<td>Cirrhosis of the liver</td>
</tr>
</tbody>
</table>

\textbf{Checkpoint 4.8}

Indicate whether the following scenarios meet the criteria under which the coder may sequence either code first when two conditions are either related or unrelated.

1. Mary presents to the hospital with chest pain and shortness of breath. Further study confirms both pneumonia and congestive heart failure. Mary is treated equally using medications and respiratory therapy. \textit{Yes}

2. Joseph presents with atrial fibrillation. After admission, he develops syncope due to a medication. \textit{No}

3. Pamela is admitted due to epigastric pain. Further evaluation by an upper endoscopy is positive for both gastritis and esophagitis. \textit{Yes}

\textbf{Checkpoint 4.9}

Code the following diagnostic statements using ICD-10-CM. Also note which guideline applies.

<table>
<thead>
<tr>
<th>Diagnostic Statement</th>
<th>Codes(s)</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Chest pain due to anxiety and reflux esophagitis</td>
<td>\textit{F41.9, K21.0, R07.9}</td>
<td>Comparative and contrasting conditions, code also the chest as chest pain is not integral.</td>
</tr>
</tbody>
</table>
2. Upper GI bleeding due to antral and duodenal ulcer: K25.4, K26.4
   Either condition may be sequenced first—this scenario represents comparative and contrasting conditions.

3. Hypotension versus hypoglycemia: I95.9, E16.2
   Either condition may be sequenced first—this scenario represents comparative and contrasting conditions.

4. Pneumonia versus congestive heart failure: J18.9, I50.9
   Either condition may be sequenced first—this scenario represents comparative and contrasting conditions.

5. Sprain and dislocation of the left knee: S83.92XA, S83.105A
   Report both injuries separately.

**Checkpoint 4.10**
Code the following diagnostic statements using ICD-10-CM, sequencing the code(s) in order. Verify all codes in the Tabular List, and read all coding notes and conventions. Do not assign External Cause codes.

1. Post-op urinary retention: N99.89
2. Loosening of a left prosthetic hip joint replacement (sequela): T84.031S
3. Postoperative seroma of skin of abdominal wall following digestive surgery: L76.34
4. Infected urethral catheter with cystitis, initial encounter: T83.51XA, N30.90
5. Mechanical breakdown (complication) of a pacemaker electrode, initial encounter: T82.110A

**Checkpoint 4.11**
Correctly code and sequence the following scenarios using ICD-10-CM.

1. Joe is admitted to the hospital from observation after his unstable angina does not improve with medications: I20.0
2. Karen is admitted to the hospital due to post-op atelectasis following outpatient bronchoscopy for lung mass: J95.89, J98.11, R91.8
3. After outpatient carotid angiography for syncope, Larry’s hypertension is uncontrolled, requiring admission to the hospital: I10, R55
4. Laura is admitted for rehabilitation services following treatment of right femoral shaft fracture: S72.301D
5. Maxine undergoes cystoscopy with a biopsy for hematuria as an outpatient. She then goes to observation for pain control. In observation, Maxine develops chest pain, which requires her hospitalization: R07.9, R31.9

**Checkpoint 4.12**
Underline the conditions in the following scenarios that would be reported as additional diagnoses, and identify which criteria for reporting were met (1, 2, 3, 4, and/or 5). Note: Your answer may include more than one criterion.

1. Clinical evaluation
2. Therapeutic treatment
3. Diagnostic procedures
4. Extended length of hospital stay
5. Additional nursing care and monitoring

Following is an example: Monica is admitted to the hospital for treatment of breast cancer. She is also treated with medication for her hypertension and diabetes. **Criterion 2, therapeutic treatment**
6. Joseph develops hypokalemia on the second day of his hospital stay. This condition requires laboratory monitoring and potassium supplements. **Criterion 1, clinical evaluation, and Criterion 2, therapeutic treatment**

7. Kevin needs to stay in the hospital one additional day because he becomes dehydrated. **Criterion 4, extended length of hospital stay**

8. Marlene undergoes an echocardiogram due to a heart murmur heard on examination. The physician documents mitral valve prolapse as the cause of the murmur and prescribes antibiotics prior to surgery. **Criterion 2, therapeutic treatment, and Criterion 3, diagnostic procedures**

9. Paul becomes dizzy once he is able to get out of bed. The nursing staff is ordered to monitor Paul’s blood pressure closely during the next 12 hours due to his dizziness. **Criterion 5, additional nursing care and monitoring**

10. After admission, Beth develops chest pain. The chest pain is evaluated by ECG and is treated with nitroglycerin. **Criterion 2, therapeutic treatment, and Criterion 3, diagnostic procedures**

**Checkpoint 4.13**

Correctly code and sequence the following scenarios using ICD-10-CM.

1. Monica is admitted for acute CVA. After admission, follow-up lab work shows abnormal liver function tests, which are documented and evaluated by the attending physician. The cause of these abnormal findings is not determined. I63.9, R94.5

2. The patient is admitted for acute renal failure. The patient had an appendectomy 3 years earlier. N17.9

3. Documentation of the discharge diagnoses states the following: congestive heart failure, gouty arthritis, abnormal ECG, history of nicotine dependence. I50.9, M10.00, R94.31, Z87.891

4. Bonnie is admitted for treatment of breast cancer. The face sheet documentation supports the following diagnoses: carcinoma of the left breast (center portion), estrogen receptor positive status, hyponatremia, and possible allergic dermatitis. C50.112, Z17.0, E87.1, L23.9.

   **Rationale:** The Official Guidelines under Section III. Reporting Additional Diagnosis C. Uncertain Diagnosis, which states that probable diagnoses can be used at discharge, is in relation to inpatient facility coding and cannot be used for physician coding. The hospital would code the allergic dermatitis, not the physician.

5. In the outpatient setting, the patient presents to the hospital for an outpatient x-ray due right ankle pain. Ankle x-ray interpretation by the radiologist supports the diagnosis of osteoarthritis M19.07 Note: In the outpatient setting, the radiology interpretation may be reported. Osteoarthritis is considered primary type, unless otherwise stated.

**Checkpoint 4.14**

Assign the present on admission (POA) indicators for all of the diagnoses in the following scenarios.

1. A patient is admitted for a diagnostic workup of syncope. The final diagnosis is Sick Sinus Syndrome, and the patient undergoes pacemaker insertion. Y

2. A patient presents with difficulty breathing. The diagnosis is acute asthma exacerbation. Y

3. A patient falls in the ED, sustaining a fractured hip. The patient is subsequently admitted due to hip fracture. Y

4. A patient is admitted to the hospital for knee replacement due to osteoarthritis of the knee. After surgery, the patient develops acute blood loss anemia. **Osteoarthritis Y and acute blood loss anemia N**

5. A patient in active labor is admitted. During the stay, a breast abscess is noted when the patient starts breastfeeding the baby. The provider is unable to determine whether the abscess was present on admission. **Breast abscess W**

6. A single, live newborn born in the hospital via cesarean section, develops feeding problems after birth. **Birth (Exempt), feeding problems N**

7. A pregnant woman presents to the hospital and undergoes a normal delivery. **Delivery Y**
8. A patient presents with nausea and vomiting. The physician documents the discharge diagnosis as possible viral gastroenteritis. Viral gastroenteritis Y
9. A patient presents to the ED after a motor vehicle collision. He requires admission due to fractured ribs and a fractured wrist. After admission and surgery, he develops a wound infection. Fractured ribs Y, Fractured wrist Y, Wound infection N, Motor vehicle collision Exempt
10. A homeless patient is admitted with acute renal failure. After admission, the patient develops syncope. The physician documents the diagnoses as acute renal failure and possible cardiogenic syncope. Acute renal failure Y, Cardiogenic syncope N, and homeless Exempt.

Answers to Review Questions

Matching
Match the key terms with their definitions.

A. uncertain diagnosis  
B. secondary diagnoses  
C. abnormal findings  
D. CC  
E. IPPS  
F. integral  
G. chapter-specific guidelines  
H. code first  
I. late effect  
J. acute condition

1. F The fact that a symptom is a component part of a disease process
2. J A medical condition that develops suddenly and resolves quickly
3. G A set of rules specific to a chapter in ICD-10-CM
4. H An instructional notation about which code should be listed before another
5. I A circumstance in which a residual condition is present
6. D A comorbidity or complication
7. A Condition that is probable, suspected, likely, questionable, possible, or still to be ruled out
8. C Test results that are outside of normal ranges
9. B Other conditions in addition to the primary condition that are documented, coded, and reported
10. E The Medicare payment system used for inpatients

True/False
Decide whether each statement is true or false.

1. F The *ICD-10-CM Official Guidelines for Coding and Reporting* apply only to the inpatient setting.
2. T The statement “scar from previous burn” would be coded as a sequela.
3. T The coder must verify all codes in the Tabular List.
4. F When coding the presence of a disease that is both acute and chronic, the code for the chronic condition is sequenced first.
5. T The patient has abdominal pain, which represents a symptom.
6. F The UHDDS definitions apply to outpatient visits only.
7. F The coder should review each laboratory test and x-ray in order to code the results.
8. F All signs and symptoms should be coded.
9. T An External Cause code may be required to report complications of a medical or surgical treatment.
10. F A patient is admitted due to urinary incontinence. After admission, the patient develops chest pain. The POA indicator for the chest pain is W.

Multiple Choice
Select the letter that best completes the statement or answers the question.

1. Which codes would be reported for a patient with a seizure disorder from previous viral encephalitis?
   A. G40.909, B94.1
   B. G40.909, B94.8
   C. G40.901, B94.1
2. Which instruction at code L86 directs the coder to assign a mandatory code for the underlying cause of acquired keratoderma?
A. Code first the underlying disease  
B. Excludes  
C. Use additional code to identify the underlying disease  
D. None of the above  
\textbf{ANS: A}

3. Which codes report the initial episode of a traumatic open fracture, type 1, of the right distal tibia due to collision on the highway with another motor vehicle?
A. S82.302B, V43.51XA  
B. S82.301A, V43.92XD  
C. S82.301B, V43.92XA  
D. S82.301B, V43.51XA  
\textbf{ANS: C}

4. Joseph presented with fever, tachycardia, chest pain, and headache. Which complaint(s) represents a symptom?
A. Fever  
B. Fever and tachycardia  
C. Chest pain, headache, and tachycardia  
D. Chest pain and headache  
\textbf{ANS: D}

5. Which code or codes are reported for type 1 diabetes, with diabetic ketoacidosis?
A. E10.10  
B. E10.11  
C. E11.00  
D. E08.10  
\textbf{ANS: A}

6. Which documents in the medical record should be reviewed when coding?
A. Physician progress notes  
B. Physician orders  
C. Discharge summary  
D. All of the above  
\textbf{ANS: D}

7. Under which circumstance may a sign or symptom be sequenced as the principal diagnosis?
A. When the underlying condition is documented  
B. When the sign or symptom is followed by comparative or contrasting conditions  
C. When the underlying cause of the sign or symptom is unknown  
D. Both B and C  
\textbf{ANS: D}

8. Which of the following statements represents an uncertain diagnosis?
A. Myocardial infarction ruled out  
B. Possible myocardial infarction  
C. Myocardial infarction  
D. Chest pain due to myocardial infarction  
\textbf{ANS: B}

9. Marlene presents with chest pain. After study, the attending physician determines that the chest pain is due to coronary artery disease. Marlene also has hypertension, which is treated with medication during her stay. What is the principal diagnosis?
A. Chest pain
B. Coronary artery disease
C. Hypertension
D. Either chest pain or coronary artery disease

ANS: B

10. What should the coder do when documentation supports positive test results, signs and symptoms of a disease, and treatment, but the physician does not document any corresponding diagnosis (for example, the patient has low potassium levels on laboratory tests and is treated with supplemental potassium)?
A. Code the abnormal test results.
B. Query the physician to seek clarification.
C. Do not code the lab results.
D. Code the abnormal test results, and write the diagnosis on the chart.

ANS: B
CHAPTER 5: ICD-10-CM: CHAPTERS 1 THROUGH 5: A00–F99

Answers to Checkpoint Questions

Checkpoint 5.1
Correctly code and sequence the following statements using ICD-10-CM.
1. HIV-related infection B20
2. HIV positive Z21
3. Screening for HIV infection Z11.4
4. Pneumocystis carinii pneumonia (PCP), due to HIV infection B20, B59
5. Nonspecific serology of HIV, type 2 R75
6. Asymptomatic HIV infection Z21
7. Suspected carrier of HIV infection, counseled during this visit Z22.8, Z71.7
8. Exposure to HIV infection Z20.6
9. AIDS with cytomegaloviral disease B20, B25.9
10. Pregnancy second trimester with HIV positive status O98.712, Z21
11. Screening for HIV due to symptoms of headache and night sweats R51, R61

Checkpoint 5.2
Correctly code and sequence the following statements using ICD-10-CM.
1. SIRS due to infectious origin (Hint: SIRS due to infection can also be termed sepsis) A41.9
2. Strep B sepsis A40.1
3. Gangrenous sepsis A41.9
4. Acute cellulitis of the abdominal wall due to Pseudomonas (Hint: To code the organism look for the main term infection) L03.311, B96.5
5. Streptococcus pneumoniae sepsis due to stage II decubitus ulcer of the sacrum (Hint: This case is an example of a localized infection causing systemic infection.) A40.3, L89.152
6. MRSA sepsis with septic shock A41.02, R65.21
7. Acute renal failure with tubular necrosis due to severe sepsis A41.9, R65.20, N17.0
8. SIRS due to enterobacter-infected urinary catheter (initial encounter) (Hint: SIRS equals sepsis and the infected catheter is a complication) T83.51xA, A41.81
9. SIRS due to acute pancreatitis (Hint: This case is an example of systemic inflammatory response syndrome, not due to infection) K85.9, R65.10
10. Urosepsis, after physician query documentation supports acute candida cystitis (Hint: See the main term candidiasis.) B37.41
11. Peritonsillar abscess due to Streptococcus, resistance to penicillin J36, B95.5, Z16.11
12. Acute upper respiratory infection, MSSA nasal swab positive (Hint: See the main term carrier) J06.9, Z22.321

Answer the following questions on MSRA
13. The code J14 reflects a combination code: True
14. MRSA colonization is the same as MRSA infection: False
15. Code acute MRSA pyelonephritis:
   A. N10
   B. B95.62
16. When coding for an additional organism, the coder uses the main term infection, subterm for the organism, as cause of disease classified elsewhere: True
Checkpoint 5.3
Code the following statements using ICD-10-CM. Remember to locate the main term for the morphology or histological type first.
1. Fibrous histiocytoma of the right leg D23.71
2. Endometrial sarcoma C54.1
3. Left renal cell carcinoma C64.2
4. Islet cell adenocarcinoma of the pancreas C25.4
5. Melanoma of the right external ear C43.21
6. Adenocarcinoma of the areola of the left breast (female) with brain metastasis C50.012, C79.31
7. Liver metastasis from gastric adenocarcinoma C16.9, C78.7
8. Carcinoma of the lower left lobe of the lung with left pleural metastasis C34.32, C78.02
9. History of colon cancer, now with omental metastasis Z85.038, C78.6
10. Cervical lymph gland metastasis C77.0, C80.1

Indicate the primary and secondary sites for the following diagnostic statements.
11. Bladder cancer with pelvic lymph node metastasis
   a. Primary Bladder
   b. Secondary Lymph node
12. Prostate cancer with bone, brain, and liver metastasis
   a. Primary Prostate
   b. Secondary Bone, brain, liver
13. Cervical lymph node metastasis from laryngeal carcinoma
   a. Primary Larynx
   b. Secondary Lymph node
14. Lung metastasis from previously resected and treated gallbladder adenocarcinoma
   a. Primary Gallbladder
   b. Secondary Lung
15. Metastatic endometrial carcinoma
   a. Primary Endometrium
   b. Secondary Unspecified

Checkpoint 5.4
Code the following statements using ICD-10-CM.
1. Male patient presents with symptoms of obstructive uropathy and urinary retention. Prostate biopsy is positive for adenocarcinoma.
   A. Prostate cancer C61
   B. Obstructive uropathy N13.8
   C. Urinary retention R33.8
2. The same patient is now seen for his second radiation therapy treatment for prostate adenocarcinoma.
   A. Z51.0
   B. Prostate cancer C61
3. Five months later, this patient presents with weakness and pain in his hip. Bone scan is positive for bone metastasis. *[Hint: The hip pain code is not reported as the symptom is integral to the bone metastasis.]*
   A. C79.51
4. The patient receives additional radiation and chemotherapy for the prostate cancer that is delivered in the outpatient setting. After his chemotherapy, he is extremely dehydrated and requires inpatient services for rehydration. Documentation supports dehydration due to chemotherapy. *[Hint: Remember to report the code from the Table of Drugs and Chemicals for the adverse effect of chemotherapy [antineoplastic drug].]*
A. Dehydration E86.0
B. C61
C. T45.1x5A

5. This patient presents with new symptoms of seizures. An MRI of the brain is positive for metastasis from previous prostate cancer. Palliative chemotherapy is given. (Hint: Code diagnoses only.)

A. C79.31, R56.9, Z85.46
B. C80
C. K81.1, K83.1

6. Dysphagia from carcinoma of the esophagus C15.9, R13.10

7. New pathological fracture of left radius due to osteosarcoma M84.534A, C40.02

8. Admission for antineoplastic immunotherapy of malignant melanoma of the stomach Z51.12, C49.4

9. Bowel obstruction due to peritonei carcinomatosis C78.6, K56.69

10. Biliary duct obstruction due to metastatic carcinoma of the gallbladder, unknown primary C78.89, C80.1, K83.1

11. Pregnancy in the third trimester complicated by newly diagnosed left ovarian cancer O9A.113, C56.2

12. The patient presents with carcinoma of the middle and third portion of the esophagus (overlapping site). C15.8

13. The patient presents with anemia related to chronic disease of carcinoma of the uterus. C55, D63.0

Checkpoint 5.5

Code the following statements using ICD-10-CM.

1. Hypochromic anemia in chronic illness D63.8, D50.9

2. Refractory sideroblastic anemia D46.1

3. Diverticulitis of the large intestine with hemorrhage, anemia K57.33, D64.9

4. Other postoperative anemia D64.9

5. Acute blood loss anemia D62

6. Hb-C sickle-cell anemia with sickle-cell crisis D57.219

7. Chest pain syndrome with sickle-cell crisis D57.01

8. Chronic anemia from end-stage renal disease N18.6, D63.1

9. Acute posthemorrhagic anemia D62

10. Microcytic hypochromic anemia D50.9

Checkpoint 5.6

Code the following statements using ICD-10-CM. Do not assign procedure codes.

1. Diabetic bilateral proliferative retinopathy with macular edema E11.3513

2. Type 2 diabetes mellitus and peripheral angiopathy E11.51

3. Diabetic left foot ulcer due to diabetic neuropathy E11.40, E11.621, L97.529

4. Chronic osteomyelitis of the right femur and diabetes mellitus type 2, with hyperglycemia M86.651, E11.65

5. Type 2 diabetes with associated Charcot’s joint E11.610

6. Nephropathy with type 2 diabetes mellitus E11.21

7. Visit for adjustment of an insulin pump titration with type 1 diabetes mellitus Z46.81, E10.9

8. Insulin overdose due to insulin pump failure in an individual with type 1 diabetes T85.614A, T38.3x1A, E10.9

9. Infected insulin pump in an individual with type 1 diabetes (Hint: See complication, insulin pump.) T85.72xA, E10.9

10. Insulin overdose resulting in hyperglycemia in an individual with type 1 diabetes T38.3x6A, E10.65

11. Diabetes secondary to cystic fibrosis E84.9, E08.9

12. Steroid-induced diabetes with diabetic neuropathy T38.0x5A, E09.40

13. Severe malnutrition in a 35-year-old patient with BMI of 18. 0 E43, Z68.1
**Checkpoint 5.7**

Code the following statements using ICD-10-CM.

1. Delirium tremens, alcohol dependence. The patient drinks one pint of vodka per day. F10.231
2. Alcohol-induced dementia. This alcoholic patient has stopped drinking for 3 years and is known to be in remission. F10.27, F10.21
4. Patient admitted for treatment of alcoholic cirrhosis. The patient is intoxicated with a blood alcohol level of 180 mg/100 mL. The patient is alcohol dependent and abuses cocaine twice per month. K70.30, F10.229, Y90.6, F14.10
5. Alcohol and drug abuse. F10.10, F19.10
6. Alcohol abuse, admitted for counseling. Z71.41, F10.10
7. Moderate alcohol use disorder. F10.20

**Answers to Review Questions**

**Matching**

Match the key terms with their definitions.

A. bacteremia
B. BMI
C. type 1 diabetes
D. secondary diabetes
E. physician query
F. morphology code
G. neoplasm
H. SIRS
I. metastasis
J. methicillin-resistant *Staphylococcus aureus*

1. H Also known as severe sepsis
2. E Process of asking for additional documentation by a physician
3. J Very-difficult-to-treat staph infection
4. C A type of diabetes in which insulin is not produced
5. A Disease described as an infection in the blood
6. B A measurement using height and weight
7. F A code used to identify the histological type and behavior of a neoplasm
8. I Movement of cancer cells to a secondary site
9. G An abnormal growth of cells
10. D A type of diabetes due to an underlying process

**True/False**

Decide whether each statement is true or false.

1. F When coding infectious diseases, two codes are always required.
2. T The principal diagnosis for patients admitted with AIDS-related illness is B20.
3. F The coding of sepsis always requires two codes.
4. T When assigning codes for diabetes, the type of diabetes impacts code assignment.
5. T The diagnostic statement of “diabetic retinopathy” indicates a causal relationship between the diabetes and retinal disease.
6. F All neoplasms are malignant.
7. F When coding the diagnostic statement “prostate cancer with bone metastasis,” the primary site of cancer is the bone.
8. T The physician should be queried when documentation in the nutrition consult states BMI of 40.3 and the diagnosis of obesity is not stated.
9. F Acute blood loss anemia is coded the same as postoperative anemia.
10. T A history of malignant neoplasm code is assigned when the neoplasm is no longer present or being
Multiple Choice
Select the letter that best completes the statement or answers the question.

1. Which of the following affects code assignment for infectious disease?
   A. Site of infection
   B. Infectious agent
   C. Both a and b
   D. Neither a nor b
   **ANS: C**

2. The diagnosis of positive HIV test would be reported as
   A. B20
   B. Z21
   C. Z71.7
   D. R75
   **ANS: B**

3. Which components should be included in a physician query?
   A. Leading questions
   B. Reference to documentation
   C. Request for yes or no answer
   D. Statement indicating reimbursement increase
   **ANS: B**

4. Acute blood loss anemia due to epistaxis. The patient was admitted and treated for anemia with blood transfusions. Epistaxis occurred during hospitalization but did not require packing. Which codes are reported?
   A. R04.0, D62
   B. D62, R04.0
   C. D50.0, R04.0
   D. D50.0, I78.0
   **ANS: B; R04.0, D50.0**

5. Hb-SD sickle-cell acute chest syndrome with crisis is coded as
   A. D57.811
   B. D57.01
   C. D57.00
   D. D57.00, R07.89
   **ANS: A**

6. A neoplasm assigned the code C53.9 is
   A. Benign
   B. A secondary malignancy
   C. A primary malignancy
   D. An in situ carcinoma
   **ANS: C**

7. In the diagnosis adenocarcinoma of the pancreas with extension to the duodenum and metastasis to the liver and mesenteric lymph nodes, the primary site is the
   A. Duodenum
   B. Liver
   C. Pancreas
   D. Mesenteric lymph node
   **ANS: C**

8. A female patient was discharged from the hospital with the diagnosis of brain metastasis with unknown primary. Which code or codes are reported?
A. C79.31
B. C79.31, C79.9
C. C71.9
D. C79.9, C71.9

**ANS: B**

9. Type 2 diabetes, Chronic kidney disease, stage 3, long term insulin use
A. E11.22, N18.3, Z79.4
B. E10.22, N18.9, Z79.4
C. E11.9, N18.3, Z79.4
D. E08.9, N18.9

**ANS: A**

10. Alcoholic induced depression and alcoholic fatty liver.
A. F10.20, F32.9, K70.0
B. F10.24, F32.9, K70.0
C. F10.49, K76.0
D. F10.24, K70.0

**ANS: D**
CHAPTER 6: ICD-10-CM CHAPTERS 6 THROUGH 10: G00–J99

Answers to Checkpoint Questions

Checkpoint 6.1
Code the following pain cases, using ICD-10-CM. Keep sequencing guidelines in mind.
1. Acute postoperative neck pain, admitted for pain control G89.18, M54.2
2. Chronic back pain from lumbar stenosis, patient admitted for laminectomy M48.06
3. Chronic post-thoracotomy pain G89.22
4. Chronic pain due to bone metastasis, admitted for pain control G89.3, C79.51
5. Chronic low back pain M54.5, G89.29

Checkpoint 6.2
Code the following statements using ICD-10-CM.
1. Acute cerebral infarction due to embolism of middle cerebral arteries with resulting aphasia I63.419, R47.01
2. Intraventricular hemorrhage with resulting left lower leg monoplegia in right-handed patient I61.5, G83.14
3. Acute stroke with neurogenic dysphagia and spastic hemiplegia I63.9, R13.19, G81.10
4. Admission for therapy due to previous cerebral hemorrhage with resulting spastic right-sided hemiplegia in right-handed patient I69.151
5. Congenital spastic paraplegia G80.1
6. Symptomatic localized epilepsy with complex partial seizures G40.209
7. Complex febrile seizure R56.01
8. Intractable petit mal seizures with status epilepticus G40.411
9. Seizure disorder G40.909
10. Grand mal epilepsy, with status epilepticus G40.401
11. Poorly controlled (poorly controlled = intractable) idiopathic generalized epilepsy G40.319

Checkpoint 6.3
Code the following visual impairment cases using ICD-10-CM.
1. Acquired night blindness H53.62
2. Blindness in the left eye with low vision in the right eye H54.12
3. Acute atopic conjunctivitis of the left eye H10.12
4. Nuclear sclerotic cataract of the right eye H25.11
5. Intermittent angle-closure glaucoma of the right eye, moderate and borderline glaucoma of the left eye H40.231, H40.002
6. Primary bilateral open-angle, low-tension glaucoma, indeterminate stage H40.1234

Checkpoint 6.4
Code the following statements using ICD-10-CM.
1. Elevated blood pressure without a diagnosis of hypertension R03.0
2. Hypertensive carditis I51.89, I10
3. Hypertensive urgency, hypertensive chronic diastolic heart failure I16.0, I11.0, I50.32
4. Hypertension due to ureteral calculus I15.8, N20.1
5. Chronic renal failure, stage 3, hypertension I12.9, N18.3
6. Hypertensive cardiomegaly with acute renal failure with tubular necrosis I11.9, N17.0
7. Hypertensive emergency with acute renal failure. Patient has hypertension and CKD stage IV I16.1, N17.9, I12.9, N18.4
Checkpoint 6.5
Code the following statements using ICD-10-CM.
1. Anterior cerebral artery embolism with infarction and convulsions I63.429, R56.9
2. Old (sequelae) cerebral embolism with infarction with residual ataxia I69.393
3. Left-sided carotid artery stenosis with infarction I63.232
4. A ruptured cerebral aneurysm I60.7
5. History of TIA Z86.73
6. Acute ST elevation myocardial infarction of the anterior wall I21.09
7. Acute subendocardial myocardial infarction I21.4
8. Admission to skilled nursing facility 2 weeks after treatment of nontransmural myocardial infarction and patient requires continued treatment I21.4
9. Admission to Hospital B for inferior wall STEMI 2 weeks after treatment of an acute ST-elevated lateral wall myocardial infarction I22.1, I21.29
10. Postmyocardial infarction syndrome I24.1

Checkpoint 6.6
Code the following statements using ICD-10-CM.
1. Coronary artery disease of an autologous vein bypass graft I25.810
2. Unstable angina due to CAD (no previous history of coronary artery bypass graft or surgery) I25.110
3. Patient is admitted with impending myocardial infarction due to CAD of an autologous arterial bypass. The patient had an MI 5 years ago I25.720, I25.2
4. Patient presents with coronary arteriosclerosis due to lipid-rich plaque I25.83
5. Rheumatic congestive heart failure I09.81, I50.9
6. Acute on chronic diastolic and systolic congestive heart failure I50.43
7. Ischemic cardiomyopathy with acute congestive heart failure I50.9, I25.5
8. Congestive heart failure with tricuspid regurgitation I07.1, I50.9
9. Aortic and mitral insufficiency with rheumatic chronic diastolic congestive heart failure I08.0, I09.81, I50.32

Checkpoint 6.7
Code the following statements using ICD-10-CM.
1. COPD with hypoxemia J44.9, R09.02
2. COPD with emphysema J44.9
3. COPD exacerbation with emphysema J44.1
4. Acute exacerbation of moderate, persistent asthma, status asthmaticus J45.42
5. Bronchiolitis due to respiratory syncytial virus (RSV) J21.0
6. COPD with asthma exacerbation J45.901, J44.9
7. Acute asthmatic bronchitis J45.909

Checkpoint 6.8
Code the following statements using ICD-10-CM.
1. Acute respiratory failure due to pneumonia J96.00, J18.9
2. Hypercapnia with acute respiratory failure due to cerebral embolism with infarction I63.40, J96.02
3. Severe sepsis with septic shock and acute respiratory failure A41.9, R65.21, J96.00
4. Patient admitted with COPD exacerbation and developed acute hypoxic respiratory failure after admission J44.1, J96.01
5. COPD with acute pneumonia with exacerbation of moderate persistent asthma J44.0, J18.9,
J45.41
6. Aspiration pneumonia with hypoxemia J69.0, R09.02
7. Pneumonia in candidiasis B37.1
8. Bacterial pneumonia due to *Streptococcus* group B and Serratia J15.3, J15.6
9. Bronchiolitis obliterans with organizing pneumonia (BOOP) J84.89
10. Pneumonia with COPD J44.0, J18.9

**Answers to Review Questions**

**Matching**

Match the key terms with their definitions.

<table>
<thead>
<tr>
<th></th>
<th>A. systolic heart failure</th>
<th>B. end-stage renal disease</th>
<th>C. diastolic heart failure</th>
<th>D. status asthmaticus</th>
<th>E. chronic pain</th>
<th>F. acute on chronic</th>
<th>G. acute myocardial infarction</th>
<th>H. causal relationship</th>
<th>I. hypertensive emergency</th>
<th>J. unstable angina</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>H. Cause and effect</td>
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<td>2.</td>
<td>J. Pre-infarction heart pain</td>
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<td>3.</td>
<td>C. Condition in which the heart muscle is either overgrown or stiffened, drastically reducing blood flow</td>
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<td>4.</td>
<td>I. Sudden, severe elevation of blood pressure in which the patient typically suffers organ damage or even death</td>
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<td>5.</td>
<td>E. Long-term pain</td>
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<td>6.</td>
<td>A. Condition in which the left ventricle of the heart is weakened and cannot put out a sufficient volume of blood</td>
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<td>7.</td>
<td>G. Sudden partial or total reduction in the blood supply to the heart</td>
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<td>8.</td>
<td>B. Renal disease stage requiring transplantation or dialysis</td>
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<td>9.</td>
<td>D. Patient’s failure to respond to therapy administered during an asthmatic episode</td>
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<tr>
<td>10.</td>
<td>F. Description of sudden serious exacerbation of a patient’s chronic condition</td>
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</table>

**True/False**

Decide whether each statement is true or false.

1. **F** A causal relationship between hypertension must be documented in order to assign codes for chronic hypertensive kidney disease.
2. **T** A patient would have native CAD if he or she never had a coronary artery bypass graft (CABG).
3. **T** The correct code assignment for rheumatic CHF is I09.81, I50.9.
4. **T** Hyperkalemia is one condition that can be associated with acute renal failure.
5. **F** A woman presented with acute COPD exacerbation with status asthmaticus. The principal diagnosis should be COPD exacerbation
6. **F** Coding of COPD and coding of emphysema result in the assignment of two codes.
7. **T** Glaucoma of different stages in both eyes always requires two codes.
8. **F** If a patient has a cerebral embolism, the individual is assumed to have had a cerebral infarction.
9. **F** If a patient is right handed and hemiplegia is noted on the left-hand side, this patient has dominant-sided hemiplegia.
10. **T** The sequencing of acute respiratory failure depends on chapter-specific guidelines.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. Carotid artery stenosis is coded as
   A. I65.21
   B. I63.139
2. Acute brainstem hemorrhagic CVA. Aphasia resolved, and hemiplegia on the left side remained. The codes are
A. I61.3, R47.01, G81.94
B. I61.3, I69.120
C. I61.9, R47.01, I69.159
D. I61.3, I69.120, R69.154

ANS: C

3. Acute bronchitis with COPD and hypoxemia is coded as
A. J20.9, R09.02
B. J44.0, R09.02
C. J44.0, J20.9, R09.02
D. J20.9

ANS: C (use additional code to identify respiratory infection – acute bronchitis)

4. Pre-senile nuclear cataract is coded as
A. H26.039
B. H26.009
C. H25.10
D. Q12.0

ANS: A

5. What is the correct code(s) for bilateral open-angle glaucoma, mild stage in left eye and mild stage in right eye?
A. H40.213
B. H40.10x1
C. H40.212, H40.211
D. H40.10x0

ANS: B

6. Coronary artery disease, status post-coronary artery angioplasty. The patient has chronic total occlusion of the native coronary vessel. The codes are
A. I25.110, I25.82
B. I25.10, I25.83, Z98.61
C. I25.119, I25.83, Z98.61
D. I25.10, I25.82, Z98.61

ANS: D

7. Arteriosclerosis of autologous vein bypass with unstable angina is coded as
A. I25.701
B. I25.710
C. I20.0
D. I25.720

ANS: B

8. Sequelae of cerebral infarction to include dysarthria, cognitive deficits, and convulsions are coded as
A. I69.322, I69.31, I69.398, R56.9
B. I69.822, I69.81, I69.898, R56.9
C. I69.322, I69.31, I69.398
D. I69.90, R47.1, R41.89, R56.9

ANS: A

9. The condition of varicose veins of the left lower leg with ulcer and inflammation is coded as
A. I83.229, L97.909
B. I83.228  
C. I83.92, L97.929  
D. I83.229, L97.929  

ANS: D

10. Food aspiration pneumonia with methicillin-resistant *Staphylococcus aureus* (MRSA) pneumonia is coded as  
A. J69.1, J15.211  
B. P24.31, J15.212  
C. J69.0, J15.212  
D. J69.0, J15.20  

ANS: C
Answers to Checkpoint Questions

Checkpoint 7.1
Code the following cases using ICD-10-CM.
1. The patient presented with rectal bleeding. A colonoscopy is positive for second-degree bleeding internal hemorrhoids and non-bleeding sigmoid diverticulosis. K64.1, K57.30
2. Acute large and small intestine diverticulitis with hemorrhage. K57.53
3. Arteriovenous malformation (angiodysplasia) of the duodenum with hemorrhage. K31.811
4. Rectal bleeding, negative colonoscopy in a patient with alcoholic gastritis. K62.5, K29.20, F10.20 (Code the alcoholism as unspecified per “use additional code” note at K29.2.)
5. Acute gastric ulcer with hemorrhage and perforation. K26.4
6. Melena due to chronic duodenal ulcer. K25.2
7. Bleeding esophageal varices. I85.01
8. Positive Hemoccult fecal occult blood test (blood in stool) with negative endoscopic studies. (Hint: See main term occult.) R19.5
9. Upper GI bleeding due to Barrett’s esophagus. K22.70, K92.2
10. Diverticulosis, internal hemorrhoids, and upper GI bleeding, with cause of GI bleeding undetermined. K92.2, K57.90, K64.8

Checkpoint 7.2
Code the following statements using ICD-10-CM.
1. Alcoholic cirrhosis of the liver (patient has alcoholism) K70.30, F10.20
2. History of hepatitis B Z86.19
3. Chronic hepatitis C B18.2
4. Acute hepatic encephalopathy with liver cirrhosis K72.00, K74.60
5. Acute liver failure with alcoholic hepatitis (patient abuses alcohol) K72.00, K70.10, F10.10
6. Left, recurrent, incarcerated inguinal hernia K40.31
7. Paraumbilical hernia with gangrene K42.1
8. Recurrent abdominal wall hernia K43.2
9. Strangulated incisional hernia K43.0
10. Bilateral femoral hernia with gangrene K41.10

Checkpoint 7.3
Code the following statements using ICD-10-CM.
1. Group B streptococcus cellulitis of the face L03.211, B95.1
2. Open wound of the right lesser toe with cellulitis of the right toe (initial episode) S91.104A, L03.031
3. Acute lymphangitis of the skin of the jaw L03.212
4. Gangrenous cellulitis of a left ankle wound (initial episode) S91.002A, I96
5. Cellulitis of the right shoulder due to postoperative wound infection (initial encounter) T81.4xxA, L03.113

Checkpoint 7.4
Code the following statements using ICD-10-CM.
1. Type 2 diabetic ulcer of the left foot E11.621, L97.529
2. Chronic ischemic ulcer of the left calf with bone necrosis L97.224
3. Venous stasis ulcer in a patient without varicose veins I87.2 (the exact site of the ulcer is not described here, thus no code from L97)
4. Stage II decubitus ulcer of the buttock (left) L89.322
5. Type 1 diabetic ulcer of the left midfoot due to diabetic neuropathy E10.621, E10.40, L97.429

**Checkpoint 7.5**

Code the following statements using ICD-10-CM.
1. Pathological fracture of the left distal radius due to postmenopausal osteoporosis, initial encounter M80.032A
2. Fracture of the distal right tibia due to chronic osteomyelitis, initial encounter M80.861A
3. Nonunion of pathologic fracture of right humerus M84.421K
4. Aftercare of healing pathological fracture of the left femur M84.452D
5. Traumatic arthritis of the left ankle M12.572 (no seventh character required)

**Checkpoint 7.6**

Code the following statements using ICD-10-CM.
1. Acute osteomyelitis of the mandible M27.2
2. Subacute osteomyelitis of the right radius M86.231
3. Osteomyelitis of the toe due to typhoid A01.05 (Note that this code is assigned from the infectious chapter.)
4. Sclerosing, nonsuppurative osteomyelitis of the hip M86.8x5
5. Chronic osteomyelitis of the left third toe with draining sinus M86.472

**Checkpoint 7.7**

Code the following statements using ICD-10-CM.
1. Benign hypertension, end-stage renal disease; patient is on renal dialysis I12.0, N18.6, Z99.2
2. Person with type 1 diabetes CKD stage 4 E10.22, N18.4
3. Acute renal failure due to obstructive uropathy from prostatic hyperplasia N17.9, N13.8, N40.1
4. Cystocele and rectocele with stress urinary incontinence N81.10, N81.6, N39.3
5. Chronic renal failure, hyper tension I12.9, N18.9
6. Hematuria due to calculus of the bladder N21.0
7. Adenofibromatous hypertrophy of the prostate with urinary frequency, and urinary hesitancy N40.1, R35.0, R39.11
8. Acute renal failure, dehydration, and hyperkalemia N17.9, E86.0, E87.5
9. Acute pyelonephritis due to ureteral calculus with hydronephrosis N13.2
10. Urethral stricture N35.9
11. Solitary renal cyst Q61.01
12. Phimosis N47.1
13. Monilial cystitis (Hint: Monilial infection is coded to candidiasis.) B37.41
14. Endometriosis of the fallopian tubes and ovaries N80.2, N80.1
15. Infertility due to adhesions of the fallopian tubes N97.1
16. Acute pelvic inflammatory disease due to Staphylococcus N73.0, B95.8
17. Encysted hydrocele N43.0
18. Premenopausal menorrhagia N92.4
19. Male bladder prolapsed N32.89
20. Kinking of the ureter N13.5
21. UTI with acute pyelonephritis N10
22. Acute cystitis due to E coli N30.00, B96.20
23. Chronic UTI; patient taking prophylactic antibiotics (Hint: Note code as history of UTI and long-term use of antibiotics.) Z87.440, Z79.2t
24. Acute urethritis due to urethral catheter (Hint: See complication due to catheter.) T83.098, N34.2
Answers to Review Questions

Matching

Match the key terms with their definitions.

A. end-stage renal disease
B. cellulitis
C. unstageable
D. stage 3 CKD
E. gangrene
F. hematochezia
G. pressure ulcer

H. ischemic ulcer
I. causal relationship
J. stage III pressure ulcer
K. stress fracture
L. osteomyelitis
M. pathological fracture

1. A Renal disease stage requiring transplantation or dialysis
2. D A form of kidney disease where the GFR is between 30 and 59
3. F Passage of fresh blood in the stool
4. H An ulcer caused by lack of blood flow
5. I Cause and effect
6. B An infection of the skin
7. C A pressure ulcer that cannot be assigned a stage due to the way it presents
8. E The death of tissue
9. G Also called decubitus ulcer
10. M A fracture that is due to osteoporosis
11. J Full-thickness skin loss due to pressure
12. L An infection of the bone
13. K A fracture that is due to repetitive injury

True/False

Decide whether each statement is true or false.
1. F A causal relationship between hypertension must be documented in order to assign codes for hypertensive kidney disease.
2. T Hyperkalemia is one condition that can be associated with ARF.
3. F A patient presented with a GI bleeding. Colonoscopy was positive for diverticulosis. The code assigned is diverticulosis with hemorrhage.
4. F Coding of COPD and coding of emphysema result in the same code.
5. F Melena refers to bloody vomitus.
6. T The code for stress incontinence should be reported separately when coding vaginal prolapse.
7. F There are a total of three different stages of pressure (decubitus) ulcers.
8. T If a fracture is due to trauma, a pathological fracture code would not be assigned.
9. F In the statement “dysuria due to possible urinary tract infection,” the infection code would be assigned as the primary diagnosis in the outpatient setting.
10. F Two codes are required to report a stage II pressure ulcer.
11. T When coding a venous stasis ulcer of the calf (no mention of varicose vein), only one code is assigned.

Multiple Choice

Select the letter that best completes the statement or answers the question.
1. Vaginal prolapse with rectocele is coded as
   A. N81.10, N81.6
   B. N81.12, N81.6
   C. N81.2
D. N81.12, N81.2

ANS: A

2. Arteriosclerotic peripheral vascular disease with left heel ulcer is coded as
A. I70.244
B. I70.744, L97.429
C. I70.244, L97.429
D. L97.429

ANS: C

3. Hematuria due to renal calculus with hydronephrosis is coded as
A. N13.2, R31.9
B. N20.0, N13.30
C. N20.0
D. N13.2

ANS: D

4. Angiodysplasia of the large intestine with hemorrhage is coded as
A. K55.20
B. K31.811
C. K55.21
D. K31.819

ANS: C

5. Bleeding esophageal varices with related cirrhosis of liver and chronic hepatitis C is coded as
A. K74.60, I85.11, B18.2
B. I85.11, B19.20
C. K74.60, B18.2
D. I85.11, K74.60, B19.20

ANS: A

6. Acute cholecystitis with cholelithiasis and choledocholithiasis is coded as
A. K81.0, K80.50, K80.20
B. K80.42
C. K80.00
D. K80.62

ANS: D

7. Decubitus ulcer of the sacrum, stage III, with gangrene. The patient also had cellulitis with lymphangitis of the left lower shin. What are the correct codes?
A. L89.153, L03.116
B. L89.153, I96, L03.116, I89.1
C. L89.152, I96, L03.116
D. I96, L03.116, I89.1

ANS: B
CHAPTER 8: ICD-10-CM CHAPTERS 15 THROUGH 17: O00–Q99

Answers to Checkpoint Questions

Checkpoint 8.1
Identify the trimester represented in the following cases.
1. The patient is 34 weeks pregnant. **Third**
2. The patient is 12 weeks pregnant. **First**
3. The patient is 14 3/7 weeks pregnant. **Second**
4. The patient is admitted in the third trimester and developed gestational diabetes at 26 weeks requiring oral hypoglycemics. **Third**
5. The patient was admitted at 27 weeks with pregnancy-induced hypertension and was discharged during the 29th week. **Second**
6. Which trimester character should rarely be used? **Nine (9 = unspecified)**
7. Is the trimester character assigned when there is an “in childbirth” option? **No**
8. Code O33.6xx2 reflects a multiple gestation pregnancy with a problem with the second fetus, true or false? **True**
9. When reporting code O33.5xx, what is the seventh character assigned for a single newborn? **Zero (0)**
10. What is the seventh character assigned when it is not clinically possible to determine the fetus affected when assigning code O40.3xx? **Zero (0)**

Checkpoint 8.2
Code the following statements using ICD-10-CM.
1. A patient presents to the hospital during the 12th week due to insulin controlled gestational diabetes **O24.419, Z3A.12**
2. A patient delivers a single liveborn infant at 39 weeks. The patient has preexisting hypertension. **O10.92, Z3A.39, Z37.0**
3. A patient presents with chorioamnionitis at 37 weeks and delivers a single liveborn infant. **O41.1230, Z3A.37, Z37.0**
4. A patient presents for a routine outpatient prenatal visit at 13 weeks during a normal first pregnancy. **Z34.01, Z3A.13**
5. A patient presents to the physician office during a first pregnancy for a routine high-risk prenatal visit. The patient is high-risk due to her age of 40 (elderly primagravida). Her visit is during week 22. **O09.512, Z3A.22**

Checkpoint 8.3
Code the following statements using ICD-10-CM. (No need to report weeks of gestation or outcome of delivery)
1. A mother delivers a single liveborn infant at 39 weeks. The mother has gestational diabetes controlled with diet and is dependent on cigarettes. **O24.420, O99.334, F17.210**
2. A patient who is HIV positive presents for a routine high-risk antepartum visit at 12 weeks. **O98.711, Z21**
3. A mother presents to the office due to a single gestation fetal chromosomal abnormality at 25 weeks. **O35.1xx0**
4. A mother presents full-term at 39 weeks and delivers (in childbirth) a single liveborn infant. Her pregnancy was complicated by preexisting type 2 diabetes that requires long-term insulin use. **O24.12, E11.8, Z79.4**
5. A patient presents with sepsis complicated the postpartum period. **O85**
6. A patient experiences a normal delivery of a single liveborn at 39 weeks. **O80, Z3A.39, Z37.0 (if
7. A patient was treated for a urinary tract infection during the 12th week of pregnancy. This resolved and the patient was admitted at 40 weeks when she delivered a single liveborn without complications. O80, Z3A.40, Z37.0 (if requested by instructor to report weeks and outcome; current visit is without complication as UTI is resolved.)

8. A patient returns to the hospital 2 weeks postpartum for breast engorgement. O92.79

9. A patient delivered her full-term newborn at home and presents immediately after delivery for routine postpartum care. Z39.0

10. A patient presents at 38 weeks and requires induction of labor due to pregnancy-associated cardiomyopathy. She delivers a single liveborn. O99.42, Z3A.38, Z37.0

Checkpoint 8.4

Code the following statements using ICD-10-CM. Do not assign the additional code for weeks of gestation for these questions.

1. The patient presents with spontaneous incomplete abortion complicated by hemorrhage. O03.1
2. The patient presents 1 week after complete spontaneous abortion with defibrination syndrome. O03.6
3. The patient presents with retained products of conception following spontaneous abortion. O03.4
4. The patient presents with a missed abortion. O02.1
5. The patient presents with an elective abortion complicated by pelvic peritonitis. O07.0
6. The patient experiences a spontaneous abortion due to premature rupture of membranes at 15 weeks. O03.9, O42.912
7. The patient presents with a failed complete abortion with acute renal failure. O07.32
8. The patient has an elective termination of pregnancy. Z33.2

Checkpoint 8.5

Code the following cases using ICD-10-CM.

1. Single full-term liveborn infant was born via cesarean section. Z38.01
2. Twin A was born vaginally at 33 weeks; mate was also liveborn. Twin A weighed 2,181 grams and was born from a mother with diabetes. Diabetes in the baby was ruled out. Z38.30, P07.18, P07.36
3. Twenty-day-old infant presents with urinary tract infection due to *Escherichia coli* (*E. coli*). P39.3, B96.20
4. Newborn health check, physician office visit. Z00.111
5. Baby was transferred to hospital B due to hyaline membrane disease after being delivered via cesarean section at hospital A. P22.0
6. Newborn (vaginal delivery in hospital) evaluated for sepsis, not found. Mother was septic. Z38.00, P00.2
7. Newborn (vaginal delivery in hospital) evaluated for sepsis, with fever; sepsis was not found. Z38.00, P81.9
8. Large-for-gestational-age newborn was born via cesarean section with transitory tachypnea. Z38.01, P08.1, P22.1
9. A newborn presents to the office and is fussy according to the mom who suspects a gastroenteritis. The provider states healthy newborn, gastrointestinal disorder ruled out. Z05.5

Checkpoint 8.6

Code the following cases using ICD-10-CM.

1. The patient presents with renal artery anomaly. Q27.2
2. The patient presents with patent ductus arteriosus with atrial tachycardia. Q25.0
3. The patient presents with bilateral cleft palate with unilateral cleft lip. Q37.9
4. Single newborn born via vaginal delivery in the hospital with esophageal atresia. **Z38.00, Q39.0**
5. The patient is diagnosed with congenital hydrocephalus with lumbar spina bifida. **Q05.2**

**Answers to Review Questions**

*Matching*

Match the key terms with their definitions.

<table>
<thead>
<tr>
<th>A. antepartum period</th>
<th>F. perinatal period</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. obstetrical period</td>
<td>G. abortion</td>
</tr>
<tr>
<td>C. congenital anomaly</td>
<td>H. prematurity</td>
</tr>
<tr>
<td>D. peripartum</td>
<td>I. primigravida</td>
</tr>
<tr>
<td>E. elderly primigravida</td>
<td>J. postpartum</td>
</tr>
</tbody>
</table>

1. **C** Condition that a child is born with
2. **J** Period from delivery of placenta to 6 weeks after birth
3. **E** A patient who is 35 years old at the time of delivery
4. **F** The time period from birth to 28 days
5. **B** Period from conception to 6 weeks after birth
6. **A** The period of conception through complete delivery
7. **D** Period from last month of pregnancy to 5 months postpartum
8. **G** Termination of pregnancy
9. **H** Period of birth to 37 weeks
10. **I** First pregnancy

*True/False*

Decide whether each statement is true or false.

1. **F** According to the ICD-10-CM classifications, all abortions are considered legal abortions.
2. **T** A code from category Z38 can be assigned only on a newborn record.
3. **T** A code from category Z38 can be assigned only once and is always the principal diagnosis when a baby is born alive.
4. **F** It is appropriate to assign code O80 with a pregnancy complication code.
5. **T** An outcome of delivery code should be assigned on the mother’s record for an encounter in which the baby is born.
6. **F** An additional code for weeks of gestation is assigned for all newborns delivered.
7. **T** A code from the congenital anomalies chapter can be assigned, if appropriate, regardless of patient age.
8. **T** Code Z34.91 is assigned for a routine prenatal visit in the first trimester.
9. **T** A baby who exhibits any sign of life is considered a liveborn.
10. **F** Codes from the perinatal chapter are for mothers and their babies.

*Multiple Choice*

Select the letter that best completes the statement or answers the question.

1. Incomplete spontaneous abortion with severe sepsis and acute kidney failure is coded
   A. O07.37, R65.20, N17.9  
   B. O03.37, R65.20  
   C. O03.37, R65.20, N17.9  
   D. O03.37, N17.9  
   **ANS: C**

2. One week after a legal abortion, the patient now presents for a visit with a laceration of the bladder. This is coded
   A. O04.84  
   B. O07.34
C. 003.84  
D. 003.34

**ANS: B**

3. Which of the following code pairs could be assigned for the same encounter?  
A. O80, Z37.2  
B. O80, Z37.0  
C. P05.06, P07.16  
D. O24.013, O24.02

**ANS: B**

4. Which of the following main terms would *not* be used to code a mother’s record?  
A. Pregnancy  
B. Delivery  
C. Outcome  
D. Newborn

**ANS: D**

5. Single premature newborn is born via vaginal delivery at 35 weeks of gestation. The newborn weight is 2,323 grams. Which of these codes would be reported?  
A. O80, Z37.0, P07.38  
B. Z38.00, P07.18  
C. Z38.00, P07.18, P07.38  
D. Z38.01, P07.18, P07.38

**ANS: C**

6. A full-term newborn was delivered via cesarean section two weeks ago. The newborn is now admitted with neonatal jaundice and feeding problems. Which of these codes would be reported?  
A. P59.3, P92.8  
B. Z38.01, P59.9, P92.9  
C. P59.9, P92.9  
D. Z38.01, P55.9, P92.9

**ANS: C**

7. A 23-year-old female presents with premature rupture of membranes (PROM) and she delivers a single liveborn infant at 39 weeks of gestation. The mother has morbid obesity with BMI of 45 and smoked cigarettes (dependence throughout her pregnancy). Which of these codes would be reported?  
A. O42.92, O99.214, E66.01, Z68.42, O99.334, F17.210, Z37.0  
B. O42.92, O99.213, E66.01, Z68.42, O99.333, F17.210, Z37.0  
C. O42.90, O99.214, E66.9, Z68.42, O99.334, Z37.0  
D. Z38.00, O42.92, O99.213, O99.333, F17.210

**ANS: A**

8. A 20-year-old female presented in labor at 38 weeks. Cesarean section is required due to obstructed labor from compound presentation for this twin pregnancy. Diachorionic/diamniotic twin girls were born alive. Which of these codes would be reported?  
A. O64.5xx9, O30.043, Z37.2, Z3A.38  
B. O64.5xx0, O30.043, Z37.2, Z3A.38  
C. O64.5xx0, Z37.0, Z3A.338  
D. O64.5xx9, Z37.0, Z3A.38

**ANS: B**

9. A 34-year-old female delivers a single liveborn at 34 weeks of gestation. The patient develops breast engorgement after delivery. Which of these codes would be reported?  
A. O60.2xx0, Z37.0, O92.79, Z3A.34  
B. O60.14x0, O92.79, Z3A.34  
C. O60.10x0, Z37.1, O92.79, Z3A.34
D. O60.14x0, Z37.0, O92.79, Z3A.34

ANS: D

10. A 30-year-old female presents for repeat low transverse cesarean section and delivers a single liveborn girl. The mother also has an elective sterilization during this visit. Which of these codes would be reported?

A. O80, Z30.2, Z37.0, Z3A.37
B. O34.211, Z30.2, Z37.0, Z3A.37
C. O34.211, Z37.0, Z3A.37
D. O34.211, Z30.2, Z38.00, Z3A.37

NS: B
CHAPTER 9: ICD-10-CM CHAPTERS 18 THROUGH 21: R00–Z99

Answers to Checkpoint Questions

Checkpoint 9.1
Which of the following signs and symptoms are integral to the underlying condition?
1. Chest pain due to myocardial infarction
2. Abdominal pain due to gastric ulcer
3. Dysuria due to renal calculus
4. Dyspnea due to lung cancer
5. Fever due to sepsis

Checkpoint 9.2
Code the following cases using ICD-10-CM.
1. Abnormal coagulation profile
2. Chronic fatigue syndrome
3. Hospital ED (outpatient): chest pain probably due to angina versus gastroesophageal reflux
4. Physician office: fever, cough, and shortness of breath probably related to pneumonia
5. Coma secondary to acute subdural hemorrhage. At hospital admission coma scale reflected eyes open to pain, no verbal response, and patient responds with flexion withdrawal
6. Hospital ED (outpatient): cardiac arrest, possible acute myocardial infarction as the cause
7. Hospital inpatient: cardiac arrest, possible acute myocardial infarction as the cause; patient expired 8 hours after admission
8. Abdominal pain due to gastritis and hernia
9. Hydronephrosis due to obstructing renal calculus
10. Fever and leukocytosis, infection ruled out

Checkpoint 9.3
Code the following cases using ICD-10-CM. (Do not assign external cause of injury codes at this point.)
1. Traumatic hemothorax with (3) left rib fractures (initial episode of care)
2. Subdural hematoma with occipital skull fracture, loss of consciousness for 45 minutes (initial episode of care)
3. Subcapital traumatic fracture of the left femur (initial episode of care)
4. Blister of the right hand (initial episode of care)
5. Initial episode of treatment for Grade II liver laceration (moderate)
6. Traumatic bucket-handle tear of left medial meniscus (initial episode of care)
7. Compound bimalleolar fracture of the left ankle and fracture of the multiple nasal bones (initial episode of care)
8. Nonunion of traumatic greenstick fracture of right ulnar shaft
9. Delayed healing fracture of the facial bone
10. Insect bite of the right leg (initial episode)
11. Laceration of the lip and scalp. Left ring finger laceration with embedded glass in the wound (subsequent encounter)
Checkpoint 9.4
Code the following cases using ICD-10-CM. (Do not assign External Cause codes.)
1. Sunburn of the face L55.9
2. Burn with blisters of the right buttock T21.25xA (Burn with blisters is a second-degree burn.)
3. Bee sting with cellulitis of the right hand T63.441A, L03.113
4. Full-thickness infected burn of the left ear T20.312A
5. Second- and third-degree burns of the left foot T25.322A
6. Second-degree burns of the chin, cheek, and head T20.29xA (multiple sites of the head, face, and neck)
7. Accidental acid chemical burn of the left cornea T54.2x1A, T26.62xA
8. Inhalation burn of the left lung T27.1xxA
10. Second-degree burns of the left hand and third-degree burns of both arms; total extent of the burns is 20%, 18% third-degree burns T22.392A, T22.391A, T23.202A, T31.21
11. Painful scar contracture from previous burn of the back L90.5, T21.04xS

Checkpoint 9.5
Code the following cases using ICD-10-CM.
1. Drug rash from taking penicillin as prescribed. L27.0, T36.0x5A
2. Wife took her husband's oxycodone by mistake, and as a result of the drug she developed nausea and vomiting. T40.2x1A, R11.2
3. Burns of the esophagus from accidentally swallowing bleach. T54.91xA, T28.6xxA
5. Mild mental retardation from a previous suicide attempt. The patient took an overdose of fentanyl. F70, T40.4x25 (This is a sequelae from a previous attempt.)
6. Abnormal coagulation profile due to Coumadin taken as prescribed. R79.1, T45.515A
7. Suicide attempt. The patient took 30 Percodan tablets with 1 pint of whiskey. T40.2x2A, T51.0x2A
8. A baby accidentally swallowed cleaning detergent. T65.891A
9. Carbon monoxide poisoning from car exhaust (car not in transit) in a suicide attempt. Patient had resulting acute respiratory failure. T58.02xA, J96.00
10. Neutropenia due to chemotherapy. D70.1, T45.1x5A

Checkpoint 9.6
Code the following cases using ICD-10-CM and include External Cause codes where appropriate.
1. Postoperative wound infection with abdominal wall cellulitis; the patient recently underwent colon resection with anastomosis. T81.4XXA, L03.311, Y83.2
2. Infected arteriovenous fistula used for renal dialysis with end-stage CKD. T82.7XXA, N18.6, Y83.2
3. Chronic pain due to internal orthopedic fixation device (nail). T84.84XA, G89.28, Y83.1
4. Malfunctioning insulin pump in an individual with type 1 diabetes, with resulting under-dosing. T85.694A, T38.3X6A, E10.9
5. Dislocation of prosthetic right knee. T84.022A, Z96.651, Y83.1
7. Ulcer of large intestinal anastomosis. K91.89, K63.3
8. Postoperative seroma; patient underwent hernia repair. L76.22, Y83.8
9. Sponge (foreign body) accidentally left in abdominal cavity after gastric bypass surgery. T81.500A, Y65.8, Y83.2, Z98.84 (status post gastric bypass surgery)
10. Renal transplant rejection resulting in CKD, stage 5. T86.11, N18.5, Y83.0
11. Ventilator-associated Klebsiella pneumonia. **J95.851, B96.1**
12. *Staphylococcus aureus* infection occurs in left lower leg amputation stump. **T87.44, B95.61, Y83.5**

**Checkpoint 9.7**
Define the following using the definitions located in the beginning of Chapter 20 in the Tabular List.
1. Tricycle **A pedal cycle**
2. Rowboat **Watercraft**
3. Interurban streetcar **Streetcar**
4. Bulldozer **A special construction vehicle**
5. Person riding a skateboard **A pedestrian**

Assign only external cause codes to the following.
6. Fall from tree at home in yard, initial encounter **W14.XXXA, Y92.017**
7. Kicked by horse in the barn while horseback riding **W55.82, Y92.71, Y93.52**
8. Fall from baseball stadium steps **W10.9, Y92.320**
9. Struck in the head by falling object at work (in factory) **W20.8, Y92.63, Y99.0**
10. Child neglect (did not feed child) by father, unintentional **X58, Y07.11**
11. Fall from ATV motor vehicle (driver) **V86.55**
12. Burned by fall into bonfire at beach **X03.3, Y92.832**
13. Hand cut by lawn mower blade at apartment building residence **W28, Y92.038**
14. Cut by electric knife at grocery store while preparing food as an employee **W29.1, Y92.512, Y93.51, Y99.0**
15. Bicyclist hit by car in traffic, bicyclist injured (initial encounter) **V13.4XXA**

**Checkpoint 9.8**
Code the following cases using ICD-10-CM.
1. Exposure to venereal disease **Z20.2**
2. Group B streptococcus carrier **Z22.330**
3. Vaccination not carried out due to acute illness **Z28.01**
4. Family history of coronary artery disease **Z82.49**
5. Insufficient prenatal care, patient in third trimester **O09.33**
6. Status post bone marrow transplant **Z94.81**
7. Attention to colostomy **Z43.3**
8. Awaiting heart transplant **Z76.82**
9. Prophylactic breast removal; family history of breast cancer **Z40.01, Z80.3**
10. Admission for routine pacemaker pulse generator change **Z45.010**
11. Aftercare following traumatic fracture of the left humerus **S42.302D**
12. Visit for dressing change **Z48.00**
13. Admission for removal of vascular catheter, no complications **Z45.2**
14. Hospice care (palliative care) for patient with end-stage congestive heart failure **Z51.5, I50.9**
15. High-risk sexual behavior, HIV positive **Z72.51, Z21**
16. Visit for preemployment exam **Z02.1**
17. Observation following car accident; no injuries noted **Z04.1**
18. Body mass index of 35.4 (adult), obesity **E66.9, Z68.35**
19. Visit for routine hearing test **Z01.10**
20. Kidney donor **Z52.4**

**Answers to Review Questions**

*Matching*
Match the key terms with their definitions.

A. screening Z code  
B. observation Z code  
C. poisoning  
D. counseling Z code  
E. adverse effect  
F. displaced  
G. external cause code  
H. status Z code  
I. fracture aftercare  
J. history Z code  
K. sign  
L. symptom  
M. pathological fracture  
N. stress fracture

1. **A** Type of code that reports testing for disease in a seemingly well individual  
2. **L** A subjective condition the patient reports, such as abdominal pain  
3. **D** Type of code used when a patient or family member receives assistance in the aftermath of an illness or injury  
4. **H** Type of code used when a patient has the sequelae of a past disease or condition  
5. **N** A fracture that is due to repetitive injury  
6. **E** Patient’s negative reaction to a drug correctly prescribed and administered  
7. **C** Occurs when prescribed substances are taken (ingested) incorrectly  
8. **F** Bone break in which the bone ends are not aligned  
9. **I** Cast changes, cast removal, removal of fixation devices, medication adjustment, or any follow-up visits  
10. **M** A fracture that is due to osteoporosis  
11. **G** A code that can never be used first  
12. **B** Type of code that is assigned when a suspected condition is ruled out  
13. **J** Type of code that reports that a medical condition no longer exists and that no treatment is being provided for it, but that it merits continued monitoring  
14. **K** An objective condition, such as a fever

**True/False**
Decide whether each statement is true or false.

1. **F** Mixing alcohol with prescribed medication is considered an adverse reaction.  
2. **T** When sequencing injury codes, the most severe injury is sequenced first.  
3. **F** Follow-up codes are assigned for the second visit when a disease is treated.  
4. **F** An encounter for radiation therapy Z code is always a secondary code.  
5. **F** A screening code is assigned for a patient presenting with signs and symptoms of the disease.  
6. **T** When reporting burn codes, report only the highest degree of burn for the same anatomical site.  
7. **T** Routine and administrative examination codes are assigned for routine visits, school physicals, pre-operative examinations, or routine health checks.  
8. **F** A code for rehabilitation is assigned as a secondary code when the encounter is for rehabilitation.  
9. **T** The diagnosis of prosthetic fracture is considered a complication.  
10. **T** A patient history code is assigned when the medical condition no longer exists or is under no longer treatment.  
11. **T** The seventh character “D” is used to describe a fracture that is healing for which treatment was provided previously.  
12. **F** A symptom code can never be the principal diagnosis.  
13. **T** If a fracture is due to trauma, a pathological fracture code would not be assigned.  
14. **F** In the statement “dysuria due to possible urinary tract infection,” the infection code would be assigned as the primary diagnosis in the outpatient setting.  
15. **T** Weakness is a symptom that is integral to anemia.  
16. **T** A symptom code may be the principal diagnosis when the cause of the symptom is unknown.

**Multiple Choice**
Select the letter that best completes the statement or answers the question.
1. Which of the following code pairs reflects a follow-up colonoscopy in a patient with a history of colon cancer, no recurrence found?
   A. Z08, Z85.038
   B. Z85.038, Z08
   C. Z08, Z80.0
   D. Z12.11, Z85.038
   **ANS: A**

2. Status post motor vehicle accident, initial observation for suspected head injury, none found, is coded.
   A. Z04.1, S09.90xA
   B. Z04.3
   C. S09.90xA
   D. Z04.1
   **ANS: D**

3. Initial treatment was for a compound sub-capital fracture of the left femur. The patient also sustained a laceration of the left eyebrow after tripping and falling on the carpet at her house in the bedroom. Which codes are reported?
   A. S72.011A, S01.111A, W18.09xxA, Y92.019
   B. S72.012A, S01.112A, W18.09xxA, Y92.003
   C. M84.452, S01.110A, W22.8xxA, Y92.003
   D. S72.012A, S01.112A, W22.8xxA, Y92.042
   **ANS: B**

4. A patient with right lung cancer is admitted for chemotherapy. How is this coded?
   A. C34.90, Z51.11
   B. Z51.11, C34.91
   C. Z51.11
   D. C34.91
   **ANS: B**

5. A patient accidentally took Tegretol as prescribed and then drank three martinis, which resulted in a syncopal episode. Which codes are reported?
   A. T42.1x1A, R55
   B. T42.1x1A, T51.0x1A
   C. T42.1x1A, T51.0x1A, R55
   D. R55, T42.1x4A
   **ANS: C**

6. Postoperative ileus following resection of colon with anastomosis is coded
   A. K91.89, Y83.6
   B. K56.7, Y83.6
   C. K91.840, Y83.2
   D. K91.89, K56.7, Y83.2
   **ANS: D**

7. Acute chest pain due to gastroesophageal reflux and anxiety is coded
   A. R07.9, K21.9, F41.9
   B. K21.9, F41.9
   C. K21.9, F41.9, R07.9
   D. F41.9, K21.9, R07.9
   **ANS: B**

8. Epigastric pain due to gastritis is coded
   A. K29.00
   B. K29.70
C. R10.13, K29.70
D. K29.70, R10.13

**ANS: B**

9. Routine child health check is coded
A. Z02.89
B. Z00.121
C. Z00.129
D. Z00.00

**ANS: C**

10. Physician office visit with diagnosis of dyspnea, shortness of breath, and rule out pneumonia is coded
A. J18.9
B. R06.00, R06.02, J18.9
C. J18.9, R06.00, R06.02
D. R06.00, R06.03

**ANS: D**

11. Initial care for fracture of the second lumbar vertebra secondary to idiopathic osteoporosis is coded
A. M80.88xA
B. M81.8, M80.88xA
C. M80.88xA, M81.8
D. S32.029A, M81.8

**ANS: A**

12. Initial treatment for infected urinary catheter causing acute *E. coli* pyelonephritis is coded
A. N10, B96.20
B. T83.51xA, N10, B96.20, Y84.6
C. T83.51xA, N10, Y84.6
D. N10, T83.51xA, Y84.6

**ANS: B**

13. Initial encounter is for a patient with infected puncture wound of the left ring finger with cellulitis due to *pseudomonas*. Patient has a history of breast cancer. Which codes are reported?
A. S61.235A, A49.8, L03.012, Z85.3
B. A61.235A, L03.010, Z85.3
C. L03.012, B96.5, Z85.3
D. S61.235A, L03.012, B96.5, Z85.3

**ANS: D**

14. Initial aftercare is provided for nonunion of left tibial shaft fracture with ankle pain. Patient was a driver in a car when the car collided with a bus. Report code(s)
A. S82.202K
B. S82.200K
C. S82.202K, V49.9
D. S82.202A, V44.5

**ANS: D**

15. Underdosing of Lasix resulting in acute on chronic diastolic congestive heart failure is coded
A. T50.1x6A, I50.31
B. T50.1x6A, I50.33
C. T50.1x5A, I50.33
D. T50.1x6A, I50.9

**ANS: B**
CHAPTER 10: ICD-10-CM OUTPATIENT CODING GUIDELINES

Answers to Checkpoint Questions

Checkpoint 10.1
Indicate whether the diagnostic coding for the following patient services would follow the inpatient or outpatient guidelines.
1. A patient presents to the hospital ED for a wrist sprain and goes home. **Outpatient**
2. A patient visits the physician’s office for an annual physical. **Outpatient**
3. A patient is transferred from the hospital to a nursing home after being in the hospital for 3 days. **Inpatient**
4. A patient stays in the psychiatric unit at the hospital for 30 days. **Inpatient**
5. A patient receives physical and occupational therapy in the outpatient clinic for 2 hours. **Outpatient**
6. A patient goes to the hospital laboratory to have blood drawn to determine cholesterol level. **Outpatient**
7. A patient is admitted to the hospital and dies the same day. **Inpatient**
8. A patient goes from the ED to the observation unit due to asthma. **Outpatient**
9. A patient visits the orthopedic clinic to have a cast removed. **Outpatient**

Checkpoint 10.2
Code the following cases using ICD-10-CM for outpatient encounters, keeping the outpatient coding guidelines in mind.
1. Shortness of breath and fever, with possible pneumonia **R06.02; R50.9 (Do not report pneumonia in the outpatient setting.)**
2. Screening for malignant neoplasm of the colon **Z12.11**
3. Visit for poliomyelitis vaccination **Z23**
4. Nausea and vomiting **R11.2**
5. Well-child examination **Z00.129**

Checkpoint 10.3
Code the diagnoses for the following outpatient case scenarios. Sequence the first-listed diagnosis code first using the outpatient coding guidelines.
1. A patient presents to the outpatient department for a cholecystogram with the diagnosis of possible gallstone. The radiologist interprets the cholecystogram and lists the diagnosis of cholelithiasis. **K80.20**
2. At the time of a visit to a physician’s office, the documented diagnosis is epigastric pain, nausea, and vomiting, rule out gastritis. **R10.13, R11.2**
3. A patient presents to the outpatient department for a screening colonoscopy for malignancy. The colonoscopy reveals the finding of external hemorrhoids. **Z12.11, K64.4**
4. A patient has had right shoulder pain for months. His physician documents the presence of a chronic rotator cuff tear. The patient now presents for rotator cuff repair in the hospital ambulatory surgery department. After surgery, he requires observation services for chest pain. **M75.11, R07.9**
5. A patient presents at the ED with chest pain, fever, and shortness of breath. After ECG, blood work, and chest x-ray, the ED physician documents the diagnosis of pneumonia.
   a. Which code or codes are reported by the hospital as the reason(s) for the visit? **R07.9, R50.9, R06.02**
   b. Which code is reported as the first-listed condition? **J18.9**
6. A patient presents for coronary angiography due to an abnormal stress test. After the angiography, postoperative documentation supports coronary artery disease of the native coronary arteries. What is the code for the first-listed condition? **I25.10**
7. A patient visits her obstetrician for prenatal care in the sixth month. This is her second pregnancy with no complications. Z34.82
8. A patient presents to the hospital outpatient department for a barium enema due to lower GI bleeding. The barium enema is normal. K92.2
9. A patient presents to the hospital outpatient laboratory for thyroid hormone level test. The patient has hypothyroidism, according to the physician order. E03.9
10. A patient presents to the outpatient surgery center for treatment of ureteral calculus. After preparation for surgery, he develops noncardiac chest pain, which requires the cancellation of surgery. N20.1, Z53.09, R07.89

Checkpoint 10.4
Assign the appropriate ICD-10-CM diagnosis codes for the following case scenarios.
1. A patient presents to the hospital for chemotherapy to treat his cancer of the cecum. He has a family history of colon cancer. Z51.11, C18.0, Z80.0
2. A patient presents to the ED and is evaluated and treated for acute cystitis. She is also currently being treated for chronic gout. N30.00, M1A.9
3. A patient sees the dermatologist due to a painful scar. Complete examination also reveals rosacea and seborrheic keratosis. Medications are ordered, and the patient is to return for excision of the scar the next week. L90.5, L71.9, L82.1
4. A patient visits his physician every 3 months due to his type 2 diabetic polyneuropathy. During each visit, his other chronic conditions are evaluated. These include osteoarthritis of the lumbar spine, benign hypertension, and asthma. E11.42, M47.816, I10, J45.909
5. A patient sees her cardiologist for preoperative clearance for laparoscopic vaginal hysterectomy due to menometrorrhagia. The cardiologist examines the patient and clears her for surgery. Documentation supports the presence of native coronary artery disease and congestive heart failure as cardiac conditions. Z01.810, N92.1, I25.10, I50.9

Answers to Review Questions

Matching
Match the key terms with their definitions.
A. OPPS APC status indicator
B. ambulatory surgery
C. APC
D. patient’s reason for visit
E. visit
F. freestanding facility
G. history codes
H. therapeutic services
I. coexisting condition
J. hospital-based facility

1. C The payment group in the Medicare Facility Outpatient Prospective Payment System
2. F A facility not owned or managed by a hospital
3. G Codes representing factors influencing health status
4. J A facility owned or managed by a hospital
5. D ICD-10-CM code assigned to the patient’s chief complaint
6. A Letter connected to a code that shows whether the procedure is payable under the OPPS APC system
7. B Services performed for an outpatient in an operating room
8. E Another term for encounter
9. H Special services provided to treat a patient
10. I Documented conditions that are present at the time of the visit that require or affect patient care, treatment, or management

True/False
Decide whether each statement is true or false.
1. **F** The UHDDS definition of principal diagnosis applies to the outpatient setting.

2. **T** An interpretation by a radiologist of an x-ray can be used to assign a diagnosis code in the emergency department.

3. **F** Signs and symptoms codes are never used in the outpatient setting.

4. **T** A patient goes to get a lab test. This is considered an outpatient visit.

5. **F** A visit to an observation unit in a hospital is always reported with an “admit for observation” code as the first-listed diagnosis.

6. **F** In the diagnosis statement “chest pain due to suspected coronary artery disease,” the primary diagnosis in the outpatient setting is coronary artery disease. **Do not report** “suspected” conditions in the outpatient setting.

7. **T** Chronic conditions that have no bearing on the current outpatient visit should not be reported.

8. **T** When a patient presents to the physician’s office for an annual physical without abnormal findings the diagnosis code of Z00.00 is reported.

9. **F** There is no difference in coding rules for a hospital inpatient visit and for a hospital outpatient visit.

10. **F** The hospital completes the 837P or CMS-1500 form when providing services to a patient who undergoes an upper endoscopy in the outpatient unit.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. Which of the following is considered an outpatient visit?
   A. A two-day stay in a hospital intensive care unit
   B. A hospital emergency department visit
   C. A baby born in the hospital
   D. All of the above
   **ANS: B**

2. Which is an example of a diagnostic procedure in the outpatient setting?
   A. Colonoscopy
   B. Appendectomy
   C. Cataract extraction
   D. Coronary stent insertion
   **ANS: A**

3. Which of the following represents a symptom?
   A. Pneumonia
   B. Syncope
   C. Diverticulosis
   D. Peripheral vascular disease
   **ANS: B**

4. Which of the following would be reported for a patient visit to the physician’s office with a diagnosis of abdominal pain probably due to gastroenteritis?
   A. R10.9
   B. K52.9
   C. A04.9, R10.9
   D. K52.9, R10.9
   **ANS: A**

5. A patient presents to the ambulatory surgery unit for left inguinal hernia repair. After surgery, the patient goes to observation for acute postoperative pain due to surgery. Which codes would be reported?
   A. K40.90, G89.19, R52
   B. K40.91, R52
   C. K40.90, G89.18
   D. R52, K40.90
   **ANS: A**
6. A patient presents to the physician’s office for an influenza vaccination. Which of the following would be reported?
   A. Z23
   B. Z23, Z00.01
   C. Z00.00, Z23
   D. None of the above
   **ANS: A**

7. For the visit in question 6, which coding system would be used to report the flu shot?
   A. ICD-10-CM
   B. CPT
   C. UB-04
   D. APC
   **ANS: B**

8. What should the coder do when documentation in an ED record states ‘injury to the wrist, rule out fracture,’” and the radiologist interprets the x-ray with the diagnosis of wrist fracture?
   A. Code only the wrist fracture.
   B. Query the ED physician to seek clarification.
   C. Code the wrist injury.
   D. Report both the wrist injury and wrist fracture codes.
   **ANS: A**

9. If a patient who is pregnant with her third child presents to the physician’s office for a routine obstetrical exam in the second trimester, what code(s) would be reported?
   A. Z34.02
   B. Z34.82
   C. O80
   D. Z34.82, O80
   **ANS: B**

10. If a pediatric patient presents to the pediatrician’s office for evaluation of obesity and the physician documents obesity with body mass index of the ninetieth percentile, which codes would be reported?
    A. E66.9, Z68.33
    B. E66.01, Z68.23
    C. E66.01, Z68.53
    D. E66.9, Z68.53
    **ANS: D**
CHAPTER 11: ICD-10-PCS OVERVIEW AND FORMAT

Answers to Checkpoint Questions

Checkpoint 11.1
Identify which coding system (A-D) is described in the following statements:
   A. ICD-10-PCS
   B. ICD-9-CM Volume 3
   C. ICD-10-CM
   D. CPT
1. B Classifies hospital inpatient procedures prior to October 1, 2015
2. D Classifies hospital outpatient and physician procedures
3. A Used to classify hospital inpatient procedures effective October 1, 2015
5. C Used to report diagnoses, injuries and medical condition beginning October 1, 2015
6. B Maintained by NCHS
7. B Uses a three- or four-digit numeric format
8. A Uses a flexible table format
9. A Contains seven alphanumeric characters
10. C Classifies external causes of diseases effective October 1, 2015

Checkpoint 11.2
Answer the following questions.
1. When was ICD-10-PCS implemented? October 1, 2015
2. Which legislation mandates the use of ICD-10-PCS? HIPAA
3. Who is required to use ICD-10-PCS codes? Acute hospital inpatient facilities
5. How many ICD-10-PCS procedure codes are there effective October 1, 2017? 78,705

Matching
Match the resource to the following statements:
   A. Official Guidelines: Conventions
   B. Reference Manual
   C. Official Guidelines: Selection of Principal Procedures
   D. AHA Coding Clinic for ICD-10-CM/PCS
   E. Device key
6. D Contains articles offering practical information to improve data quality
7. B Provides the primary source for coding instructions and clarification
8. E Provides a device and substance classification
9. C Contains the rules for principal procedure selection
10. A Instructs the coder that the same row of an ICD-10-PCS table must be used to assign a valid code

Checkpoint 11.3
Answer the following questions:
1. How many possible values are there for each character in ICD-10-PCS? 34
2. Which character values are not used in ICD-10-PCS? The letters I and O
3. The first character value of B in an ICD-10-PCS code represents which section? Imaging
4. What is the main term in Box 11.2? Excision
5. What is the term used in ICD-10-PCS that directs the coder to an alternative main term? See
Using Box 11.7 (ICD-10-PCS Sample Index) answer the following questions.
6. Which body part should be reported for the gastric plexus? **Abdominal sympathetic nerve**
7. What are the first characters of the ICD-10-PCS code for a sleeve gastrectomy? **ODY6**
8. What is the ICD-10-PCS code for a gastroduodenoscopy? **0DJ08ZZ**
9. Gastric pacemaker lead is considered what type of device in ICD-10-PCS? **Stimulator generator**
10. Which two cross-references are used to code a gastrojejunostomy? **See bypass, See drainage**

**Checkpoint 11.4**

Based on the code structure of ICD-10-PCS, identify the meaning of each character space in the ICD-10-PCS code.
1. First: **Section**
2. Second: **Body system**
3. Third: **Root operation**
4. Fourth: **Body part**
5. Fifth: **Approach**
6. Sixth: **Device**
7. Seventh: **Qualifier**

**True/False**
8. T Medical and surgical procedure codes have a first character of 0.
9. F T83.4567 is a valid ICD-10-PCS code.
   *Rationale: There are no codes that start with the letter T and no decimal points are used in ICD-10-PCS codes.*
10. T The character 8 is used as a value for the operative approach.
11. T The letter B represents the section for imaging.
12. T The first three characters of a code define the table.

**Matching**

Match the root operation with the appropriate definition.
A. dilation  
B. excision  
C. resection  
D. inspection  
E. repair  
F. extirpation  
G. removal  
H. restriction  
I. supplement  
J. fragmentation
13. E Restoring a body part to its normal anatomic structure or function
14. C Cutting out or off, without replacement, all of a body part
15. B Cutting out or off, without replacement, a portion of a body part
16. I Putting in or on biological or synthetic material that physically reinforces a body part
17. A Expanding an orifice or lumen of a tubular body part
18. G Taking out or off a device from a body part from an abnormal physical constraint
19. D Visually exploring a body part
20. H Partially closing an orifice or the lumen of a tubular body part
21. F Taking or cutting out solid matter from a body part
22. J Breaking solid matter in a body part into pieces

Use Boxes 11.2 to 11.6 and Figures 11.1 to 11.3 to answer the following questions.
23. What are the first four characters in the code for repair of the left acetabulum? **0QQ5**
24. What is the ICD-10-PCS classification for the body part left upper femur? **Femoral head**
25. What is the value for the percutaneous approach in table 0DB? **3**
26. What is the code for a CT scan of the mandible using low osmolar contrast? **BN261ZZ**
27. What main term would be used to find the table 0XM? **Reattachment**
Answers to Review Questions

Matching
Match the key terms with their definitions using the ICD-10-PCS Body Part Key and Device Key. (Hint: Access these files from the downloaded PCS code book, page 1, Introduction).

A. Physiomesh™ flexible composite mesh  
B. stent, intraluminal  
C. medical canthus  
D. cubital nerve  
E. hip joint liner  
F. lap-band  
G. otic ganglion  
H. ischium  
I. trifecta valve  
J. pinna

1. B Intraluminal device  
2. G Head and neck sympathetic nerve  
3. D Ulnar nerve  
4. I Zooplastastic tissue in heart and great vessels  
5. E Liner in lower joints  
6. J External ear  
7. A Synthetic substitute  
8. C Lower eyelid  
9. H Pelvic bone  
10. F Extraluminal device

Multiple Choice
Select the letter that best completes the statement or answers the question. Use the ICD-10-PCS online tools when necessary.

1. Which of the following describes the structure of ICD-10-PCS?  
A. Multi-axial  
B. Based on disease process  
C. Limited in expansion capabilities  
D. Allows for use of letters only  
ANS: A

2. How many possible values are there for each character in an ICD-10-PCS code?  
A. 16  
B. 36  
C. 26  
D. 34  
ANS: D

3. Which of the following is an invalid code?  
A. 06H033T  
B. 06H233Z  
C. 06H003T  
D. 06H14DZ

ANS: A (The coder must stay in the same row and only choose values allowed in that row.)

4. Which of the following codes is an invalid code?  
A. 3E0F37Z  
B. 3E0F87Z  
C. 3E0F03D  
D. 3E0F3SF  
ANS: C

5. Which following root operation describes taking or cutting out solid matter from a body part?  
A. Drainage
B. Extirpation  
C. Excision  
D. Removal  

ANS: B

6. Posterior lumbar fusion (posterior approach, anterior column) of L2–L4 with insertion of CAGES-style interbody fusion devices and use of morphogenic bone graft would be coded
A. 0SG00AJ, 0SG00AJ  
B. 0SG10A0  
C. 0SG30J1  
D. 0SG10AJ  

ANS: D

7. Colonoscopy with a biopsy of the sigmoid and cecum would be coded
A. 0DBG7ZX  
B. 0DBH8ZX, 0DBN8ZX  
C. 0DBH8ZZ, 0DBN8ZZ  
D. 0DBH4ZX, 0DBN4ZZ  

ANS: B  
Rationale: Two codes required as two separate body parts biopsied.

8. Percutaneous left renal biopsy followed by open wedge resection of the left kidney would be coded
A. 0TB13ZZ  
B. 0TB13ZZ, 0TB10ZZ  
C. 0TB10ZZ  
D. 0TB13ZX, 0TB10ZZ  

ANS: D  
Rationale: Code the biopsy/excision and resection.

9. Percutaneous endoscopic coronary angioplasty (dilation) of the left anterior descending and left circumflex arteries with insertion of two drug eluting stents would be coded
A. 02713DZ  
B. 027245Z  
C. 027145Z  
D. 027044Z, 027044Z  

ANS: C

10. Percutaneous needle core biopsy of the left and right breast would be coded (Hint: See excision, and a biopsy is considered diagnostic.)
A. 0HBV3ZX  
B. 0HBT3ZX, 0HBU3ZX  
C. 0HBV0ZZ  
D. 0HBV3ZZ  

ANS: A

11. Laparoscopic cholecystectomy followed by total open cholecystectomy (converted procedure) would be coded
A. OFJ44ZZ  
B. OFT44ZZ  
C. OFT44ZZ, OFJ44ZZ  
D. 0FT40ZZ  

ANS: D  
Rationale: Code inspection for the laparoscopy and resection with open approach for the cholecystectomy.

12. Right ankle joint amputation would be coded
A. 0Y9K00Z
B. 0Y6M0Z0
C. 0Y6M0Z9
D. 0Y6N0Z0

ANS: B

13. Laser destruction of four warts on the left hand and two warts on the right hand would be coded
A. 0H5GXZD, 0H5FXZD
B. 0H5GXZZ, 0H5FXZZ
C. 0HBGXZX, 0HBFXZX
D. 0HDGXZZ, 0HDFXZZ

ANS: A

14. Laparoscopy with ablation of endometriosis of the endometrium and endometriosis of bilateral fallopian tubes would be coded (Hint: Laparoscopy is a percutaneous endoscopic approach)
A. 0U5B3ZZ, 0U573ZZ
B. 0U5B4ZZ, 0U574ZZ
C. 0U558ZZ, 0U68ZZ
D. 0U5B8ZZ, 0U578ZZ

ANS: B

15. Endoscopic lithotripsy of the left and right ureteral calculus would be coded
A. 0TF38ZZ, 0TF48ZZ
B. 0TC68ZZ, 0TC78ZZ
C. 0TF64ZZ, 0TF74ZZ
D. 0TF68ZZ, 0TF78ZZ

ANS: D
CHAPTER 12: CPT BASICS

Answers to Checkpoint Questions

Checkpoint 12.1
Locate each term in the CPT index, and then indicate which type of term it is—an abbreviation, an anatomical site, an eponym, or a procedure. Record the codes that are listed for it. The first one is completed as an example.
1. Epstein-Barr virus **Eponym 86663–86665**
2. Evisceration **Procedure 65093, 65091, 49900**
3. ETOH **Abbrev See Drug Assay, Drug Procedure, Definitive Drug Class, Alcohols**
4. Nasolacrimal duct **Anat. Site 68816, 68810, 68811, 68816, 68815, 21340, 70170**
5. Myringotomy **Procedure 69420, 69421**
6. Tetralogy of Fallot **Eponym 33692–33697, 33924**

Checkpoint 12.2
List the name of the CPT section in which each of the following codes is located.
1. 99212 **E/M**
2. 90389 **Medicine**
3. 75630 **Radiology**
4. 00820 **Anesthesia**
5. 80055 **Pathology**
6. 0071T **Category III**
7. 35180 **Surgery**
8. 4000F **Category II**

Checkpoint 12.3
Answer the following questions.
1. What is the common portion of code 46760? **Sphincteroplasty, anal, for incontinence, adult**
2. What is the unique portion of code 46942? **Subsequent**
3. What is the complete code description of 54326? **One-stage distal hypospadias repair (with or without chordee or circumcision), with urethroplasty by local skin flaps and mobilization of urethra**
4. If a diagnostic flexible colonoscopy is performed in a physician’s endoscopy suite and the physician supplies the IV sedation, is it appropriate to report both code 45378 and code 99152? **Yes, if the patient is 5 years or older, if there was an independent trained observer, and the time frame is 15 minutes.**
5. In the CPT manual you are using, identify three new codes (indicated by a bullet), three revised codes (indicated with a triangle), and three codes with new or revised text (indicated by facing triangles). **NOTE TO THE INSTRUCTOR: THIS WILL CHANGE EACH YEAR. CHECK CURRENT BOOK.**

Checkpoint 12.4
Provide the correct modifier for each of the following descriptions.
1. Multiple modifiers −99
2. Distinct procedural service −59
3. Co-surgery −62
4. Staged procedure −58
5. Assistant surgeon −80
6. Discontinued procedure after sedation was started; service is being reported by a hospital outpatient facility −74
7. Repeat procedure by same physician – 76
8. Unusual anesthesia – 23
9. Mandated services – 32
10. Surgical team – 66

**Checkpoint 12.5**
Determine whether the following codes are ICD-10-CM or CPT codes.
1. I10 **ICD-10**
2. 99283 **CPT**
3. Z85.3 **ICD-10**
4. W61.01 **ICD-10**
5. 1002F **CPT**
6. S31.110A **ICD-10**
7. 19318 **CPT**
8. 0075T **CPT**

**Checkpoint 12.6**
List all possible index entries for locating the service listed, and then assign the code. The first entry has been completed as an example.

<table>
<thead>
<tr>
<th>Index Entry</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excision, mucous cyst</td>
<td>26160</td>
</tr>
<tr>
<td><strong>Endoscopy, nose, biopsy</strong></td>
<td>31237</td>
</tr>
<tr>
<td>Arthroscopy-surgical, knee-meniscectomy, meniscectomy</td>
<td>29880, 29881</td>
</tr>
<tr>
<td>Drainage, salivary gland</td>
<td>42310</td>
</tr>
<tr>
<td><strong>Cystourethroscopy, lithotripsy-ureter</strong></td>
<td>52353</td>
</tr>
</tbody>
</table>

**Answers to Review Questions**

**Matching**
Match the key terms with their definitions.

A. special report  
B. significant procedure  
C. separate procedure  
D. Category III codes  
E. surgical package  
F. postoperative period  
G. Category II codes  
H. add-on code  
I. unlisted code  
J. modifier

1. **B** A major professional service  
2. **D** Temporary codes for emerging technology, services, and procedures  
3. **E** Procedure code that groups related procedures under a single code  
4. **I** A service that is not listed in CPT and requires a special report  
5. **F** The period of care following a surgical procedure  
6. **G** CPT codes that are used to track performance measures
7. **A** Information that must accompany the reporting of an unlisted code
8. **C** A procedure usually done as an integral part of a surgical package, but that may be reported if performed alone, or on a separate site, or during a separate session
9. **H** A secondary procedure that is performed with a primary procedure and that is indicated in CPT by a plus sign (+) next to the code
10. **J** A two-character addition to a CPT code indicating that special circumstances were involved with a procedure, such as a reduced service or a discontinued procedure

**True/False**

Decide whether each statement is true or false.
1. **F** Inclusion of a code in CPT indicates that it is covered by insurance.
2. **F** Specific guidelines are found at the end of each section of the CPT manual.
3. **F** CPT codes listed as “(separate procedure)” must be coded separately from the primary procedure.
4. **T** The unique portion of a CPT code follows a semicolon.
5. **F** Codes that begin with “99” are unlisted Medicine section codes.
6. **F** CPT codes cannot be located in the index by looking up a diagnosis as the main term.
7. **F** CPT codes are submitted to insurance companies only for services provided by a physician.
8. **T** Unlisted procedure codes can never be reported to Medicare.
9. **F** It is permissible to code directly from the index in situations where only one code choice is listed.
10. **F** Modifiers are used to indicate when a procedure was modified and the description changed.
11. **F** Category III codes are not required for reporting because they are for emerging technology and are considered temporary codes.
12. **T** Under HIPAA, HCPCS codes are used for all payers.
13. **F** CPT codes are reported for inpatient procedures only.
14. **T** All payers recognize all HCPCS Level I and Level II modifiers.
15. **T** One of the CPT appendixes contains clinical examples of the codes in the E/M section.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.
1. Add-on codes can be identified by the following criteria:
   A. They can never stand alone and must be reported with another service.
   B. The code describes additional anatomical sites where the same procedure is performed.
   C. The code is marked with a ● in the codebook.
   D. The code can be used with a –51 modifier.
   E. All of the above.
   F. A and B only.
   G. A, B, and D only.

   **ANS: A**

2. Which of the following is the symbol for a new CPT code?
   A. ☺
   B. ☻
   C. ●
   D. ☐

   **ANS: C**

3. Which of the following contains a complete list of modifier –51 exempt codes?
   A. Appendix F
   B. Appendix A
   C. Index
   D. Appendix E

   **ANS: D**
4. Review the code range 20526–20610. What is the correct code assignment for injection of a carpometacarpal joint?
A. 20550  
B. 20600  
C. 20526  
D. 20610  
**ANS: B**

5. Which of the following symbols signifies a revised code?
A. ☞  
B. ⊗  
C. ♦  
D. ▲  
**ANS: D**

6. Which of the following would be considered a Medicine code?
A. 99212  
B. 72100  
C. 0126T  
D. 93745  
**ANS: D**

7. What is the correct code assignment for removal of impacted cerumen from both ears?
A. 69200–50  
B. 69210–50  
C. 69210  
D. 69210–RT, –LT  
**ANS: B**

8. Which modifier would the physician assign to indicate that only a portion of a planned procedure was completed?
A. –22  
B. –53  
C. –26  
D. –52  
**ANS: D**

9. Additions, deletions, and revisions of codes from the prior year are listed in which appendix?
A. B  
B. A  
C. G  
D. H  
**ANS: A**

10. Which modifier is assigned to the code for postoperative care only following right inguinal hernia by another surgeon?
A. –78  
B. –55  
C. –54  
D. –24  
**ANS: B**
CHAPTER 13: CPT: EVALUATION AND MANAGEMENT CODES

Answers to Checkpoint Questions

Checkpoint 13.1

Read the following cases and answer the questions.

A 47-year-old patient was seen last month in the physician office for intermittent chest pain. He is seen today in the office to follow-up on the results of medication prescribed during last month’s visit and to follow-up on the chest pain complaint.

1. Who is the patient? Established; adult
2. What is the place of service? Office
3. What is the patient’s status? Follow-up on the resolved chest pain
4. What type of service is being provided? Established patient office visit

A family with a 3-year-old child has moved 200 miles to a new home. The child became ill with a fever, and the parents have contacted a pediatrician so that the child can be evaluated and treated.

5. Who is the patient? New; child
6. What is the place of service? Office
7. What is the patient’s status? Feverish
8. What type of service is being provided? New patient office visit

Checkpoint 13.2

What differentiates an expanded problem-focused history from a detailed history? List each element, and indicate whether it is different or the same. The chief complaint remains the same for both. History of present illness changes from brief to extended. System review changes from problem-pertinent to extended. Pertinent past, family, and/or social history directly related to the patient’s problem is added.

Checkpoint 13.3

Read the following cases and answer the questions.

The physician determines that there are multiple diagnoses, limited data, and low risk based on the review of the history and performance of the examination.

1. What is the level of MDM?
   Multiple diagnoses = moderate MDM
   Limited data = low MDM
   Low risk = low MDM

   Two of the three elements of MDM must be met or exceeded to determine the level of MDM. Two elements are at the low level of MDM; the one moderate element does not change the level of MDM. Low is the correct answer.

   A patient who suffered a hip dislocation presents with leg and hip pain and chronic abdominal pain radiating into the chest. After obtaining the patient’s history and performing an examination, the physician reviews an x-ray and blood work that was ordered and determines that the femur was injured in the course of treating the hip dislocation. The patient has been taking too much ibuprofen for the pain and now has gastroesophageal reflux. The physician prescribes physical therapy for the leg problem and medication for the reflux problem.

   2. Assess the three measurements of MDM, and give the level of MDM.
   Multiple diagnoses = moderate MDM
   Limited data = low MDM
Moderate risk = moderate MDM. The two elements (multiple and moderate) are at the moderate complexity of MDM.

NOTE: The answers are based on the MDM requirement that two of the three elements must be met or exceeded.

Checkpoint 13.4
Determine the level of service in the following scenario using both new patient and established patient criteria.

<table>
<thead>
<tr>
<th>Key Components</th>
<th>New Patient LOS</th>
<th>Established Patient LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded problem-focused history</td>
<td>99202</td>
<td>99213</td>
</tr>
<tr>
<td>Detailed exam</td>
<td>99203</td>
<td>99214</td>
</tr>
<tr>
<td>Moderate MDM</td>
<td>99204</td>
<td>99214</td>
</tr>
</tbody>
</table>

Rationale: For the new patient scenario, the answer is 99202; the lowest key component controls the level of service when the code requires all three key components. The LOS is 99214. Established patient services allow for disregarding the lowest key component and basing the LOS on the lowest key component of the remaining two key components. In this scenario, the remaining two key components are at the same level: 99214.

Checkpoint 13.5
Read the following case and answer the questions.

A patient has been treated for diabetes for 4 years and was most recently seen 2 weeks ago. During today’s visit, after reviewing the lab results and examining the patient, the physician determines that the patient will have to start insulin treatment immediately. The patient is upset because her mother was severely affected by long-term insulin use. The physician discusses the effects of insulin and its impact on lifestyle and health. The exam is EPF, and the MDM is moderate. The physician spends 15 minutes of the 25-minute visit counseling the patient.

1. What is the correct established patient code for the scenario? 99214
2. Explain how you determined that level of service. The visit was documented as a duration of 25 minutes, with 15 minutes spent in counseling, which is greater than 50% of the visit time. Therefore, the total time of the visit determines the level of service and code.

Checkpoint 13.6
Read the following case and answer the question.

A patient with long-term hypertension sees her internist. Her previous visit was 2 years ago, and the patient is concerned that her hypertension has escalated since her last visit. The history is detailed, the exam is detailed, and the medical decision making is low. The physician submits a claim for code 99213.

1. Is the claim correct? Explain your answer. No. 99214 is the correct code based on the detailed history and examination. Established patient services require only two of three key components.

Checkpoint 13.7
Read the following case and answer the questions.

An internal medicine physician sees a patient for stomach pain. The physician documents a brief history and low medical decision making. The physician examines the gastrointestinal system, the respiratory system, and the cardiovascular system.

1. Based on the 1995 guidelines, which system is the symptomatic system and which are the related systems? The symptomatic system is gastrointestinal. The related systems are respiratory and cardiovascular. The physician would check both related systems based on the chief complaint of stomach pain.
2. What is the level of service for the exam? The level of the examination is EPF. There was nothing in the question to indicate an extended examination; therefore, you would default to the limited level,
which is EPF.

**Checkpoint 13.8**

Read the following case and answer the question.

A patient sees her cardiologist for follow-up of her hypertension and coronary artery disease. The patient reports intermittent chest pain and some dizziness. Based on the patient’s symptoms, the cardiologist is not comfortable sending the patient home, but, based on the examination and blood work, the patient’s condition is not severe enough for admission to the hospital. The physician sends the patient to the hospital for observation and then subsequently sees the patient later at the hospital in observation and reevaluates her. The cardiologist reports a code from the 99212–99215 category and another code from the 99218–99220 category of codes.

1. Have the correct code categories been used? Explain your answer. **It is not correct to report both categories of codes. Based on the roll-up rule, once the patient was sent for observation care in the hospital, the physician should report only the observation care codes. This answer is based on the cardiologist having gone to the hospital and re-evaluated the patient while in observation. If the physician had not gone to the hospital he would have reported the office visit code only.**

**Checkpoint 13.9**

Read the following case and answer the question.

A patient is seen in her physician’s office, is sent to the hospital for observation, and is discharged from observation care on the same day.

1. What code range would be reported? Explain your answer. **99234–99236. The patient was sent for observation care and was discharged from observation care on the same date. The observation care codes would not be used; the appropriate codes are the same-day admission and discharge codes as indicated in the observation care guidelines.**

**Checkpoint 13.10**

Are the following cases correctly described as consultations? (Disregard Medicare guidelines.)

1. A family physician has been treating a patient with diabetes and is concerned that the patient may develop diabetic retinopathy. The patient is sent to an ophthalmologist for his opinion about whether this condition has developed or may develop. The ophthalmologist examines the patient and sends an opinion on the potential for diabetic retinopathy to the family physician. **Yes; the consultation requirements have been met: request for an opinion is clearly identified, the service was rendered, and the report sent to the requesting physician.**

2. An internist has been treating a patient for many years. The patient now presents with urinary difficulties, and the physician is concerned that the problem may be related to an enlarged prostate. The internist sends the patient to a urologist to obtain an opinion on what is causing the urinary problem and to determine whether the patient is a candidate for surgery. The urologist examines the patient and sends his findings in writing to the internist. **Yes; the consulting physician was asked for an opinion on the patient’s condition and whether surgery is needed; the consultant’s opinion was sent in writing to the referring physician.**

3. A patient goes to the ED with severe leg pain. He is seen and evaluated by the ED physician, who suspects muscle deterioration that cannot be explained. The ED physician recommends that the patient see an orthopedist the next day or as soon as possible. The patient is able to get an appointment the next day with an orthopedist. **No, the orthopedist will take on the care of the muscle condition. He will not just provide an opinion and report back to the ED physician. The ED physician’s role ended the previous day.**

4. In case 3, if the orthopedist had seen the patient at the ED and admitted the patient to the hospital, should the consultation code or the admission code be billed? Can both be billed? **The physician should report the admission code only (roll-up rule).**
Checkpoint 13.11

Read the following cases and answer the questions.

1. The physician spent 1 hour and 10 minutes at the patient’s bedside providing critical care. He also spent 20 minutes reviewing films on the unit and documenting the care he provided. What code(s) would the physician report? **99291 for the first hour; 99292 for the additional 30 minutes because the time spent reviewing films and documenting on the unit where the patient is located can be counted in as critical care time.**

2. In the above case, the physician also performed cardiopulmonary resuscitation (CPR) just prior to the 1 hour and 10 minutes of critical care. Can the physician report the CPR in addition to the critical care? **Yes; CPR is not included in critical care.**

Checkpoint 13.12

Indicate whether the following statements are true or false, and explain why.

1. **F** Prolonged services codes are the only codes reported when counseling and coordination of care are greater than 50% of the patient services provided on that day.
   
   **Rationale:** Coders can use the E/M codes 99201–99215 for the counseling and coordination of care scenarios. Under certain circumstances, the prolonged services codes are also applicable to these scenarios in addition to the E/M codes.

2. **T** Prolonged services codes are never billed alone.
   
   **Rationale:** They are add-on codes, which are never billed alone.

3. **F** Codes 99234–99236 cannot be reported with codes 99356–99357.
   
   **Rationale:** Prolonged care services for the inpatient and observation settings can be reported together as indicated in the parenthetical note following code 99356 and 99357.

4. **F** The difference between direct and nondirect services is the place of service.
   
   **Rationale:** They are differentiated by face-to-face versus non-face-to-face services.

Checkpoint 13.13

Read the following case and answer the question.

A neurologist asks a neurosurgeon to stand by during neurological testing performed in the operating room because there is concern about the stability of the patient to withstand the testing, and surgery might be required on an emergency basis. The neurosurgeon stands by for 35 minutes.

1. What is the appropriate code for this service? **99360**—This accurately describes a standby service.

Checkpoint 13.14

Read the following case and answer the question.

A physician is responsible for the care of an 84-year old man with many complex health-care issues, who is currently in a nursing facility. She has seen this patient at the nursing home, and she also takes the calls from the nursing home for required changes in care plans and about lab studies and tests that are required to maintain the patient’s health, as well from the patient’s daughter, who visits her father daily. The physician discusses treatment with the nurses in charge of her patient’s care at the facility on a regular basis. Her office documentation indicates that she has spent 40 minutes on such oversight this month.

1. What code should be reported for this month’s time? **99380**—Care plan oversight code. The patient was in a nursing facility, and the physician provided more than 30 minutes of care plan oversight during that month.

Checkpoint 13.15

Read the following case and answer the question.

The pediatrician treated the newborn in the hospital after delivery and during the 2 days the baby remained in the hospital after the delivery date.

1. What codes should the pediatrician report for the hospital services? **On the day of delivery, the**
pediatrician will report 99460 for the initial care of the newborn. On the two subsequent days, 99462 for each day of subsequent care.

Checkpoint 13.16
Read the following case and answer the question.
A 3-day-old infant became critically ill. The physician admitted the infant to the critical care unit and spent 2 hours with the infant, including a discussion with the family regarding the infant’s prognosis.
1. What code(s) would be reported? Report code 99468 only. The inpatient neonate critical care codes are per-day codes. The time spent is not an issue.

Checkpoint 13.17
Read the following case and answer the questions.
A dermatologist has been treating a patient for skin lesions. At the patient’s fifth visit, the dermatologist explains that the right arm lesion will need to be incised and drained at the next visit unless it resolves from the application of medication. At the next visit, the lesion is unchanged, and the incision and drainage are performed. However, the patient has developed several similar lesions in other body areas. The dermatologist reports an E/M service with modifier –25 and the incision and drainage code.
1. Did the dermatologist report his services correctly? Yes
2. Explain why or why not. The patient returned with new lesions, which justifies the “significant and separately identifiable” requirement for the use of modifier –25 on the E/M code in addition to the incision and drainage procedure on the initial lesion.

Answers to Review Questions

Matching
A. admitting physician
B. category
C. chief complaint
D. consultation
E. contributory component
F. direct care
G. new patient
H. observation care
I. preventive medicine
J. roll-up rule
1. C Patient’s explanation to the physician of why he or she needs to be seen
2. D The situation in which a physician provides an opinion or advice on a patient and does not take over the care of the patient
3. G Patient who has not been seen by the physician for 3 years
4. E Nature of the presenting problem
5. H The situation in which a patient is sent to the hospital for care, but is not admitted to the hospital
6. J Guideline for a coding situation in which, after being treated in the office, the patient is sent to the hospital to be admitted, and only an admission code is reported for service provided at both locations
7. F Type of face-to-face care provided by a physician to a pediatric patient in transport from one facility to another
8. B Type of E/M grouping called office or outpatient consultations
9. I Type of care for a patient who is evaluated by a physician without a specific diagnosis, illness, or condition being reported for that evaluation
10. A A physician who is allowed to bill the initial hospital care codes 99221–99223

Multiple Choice
1. Which code is used for the initial office visit of a patient with a 2-day history of lower abdominal pain and occasional vomiting in which the physician obtains a detailed history and detailed examination and does low MDM?
A. 99204
2. An internist asks an endocrinologist to give an opinion on a diabetic patient’s bilateral lower extremity neuropathy. In his office, the endocrinologist provides a detailed history, an expanded problem-focused exam, and moderate medical decision making. The endocrinologist writes a letter to the internist indicating his findings. Which code is used?
   A. 99203  
   B. 99243  
   C. 99242  
   D. 99254 
   **ANS: C**  
   **Rationale:** Answers A and D are automatically incorrect because 99203 is a new patient code and 99254 is an inpatient consultation code. The student is left with deciding between B and C. Remembering that the lowest key component controls the level of service, an EPF examination mandates the 99242 code. The detailed history and moderate MDM lead to the 99243 code, but the reported code can be no higher than the lowest key component—the examination.

3. An established patient has diabetes and hypertension and is morbidly obese. The physician provides an expanded problem-focused history and exam and moderate MDM. Blood work reveals that the patient must start on insulin, and the patient is counseled for 15 minutes regarding the insulin regimen and risks. The total time for the visit is 25 minutes. Which code is used?
   A. 99213  
   B. 99214  
   C. 99243  
   D. 99244 
   **ANS: B**  
   **Rationale:** The consultation code answers C and D are immediately eliminated because none of the consultation requirements were indicated in the question. The answer is based on time because counseling was greater than 50% of the time spent with the patient. Once a question provides the total visit time and time spent in counseling, the students should evaluate the answers based on time versus the key components. The total visit time of 25 minutes is represented by code 99214.

4. An internist sends a patient with long-term back pain to a spine specialist for treatment of the problem. The spine specialist provides an expanded problem-focused history and exam and low MDM. The patient discusses his years of stress-related pain and his dissatisfaction with his previous care. The physician spends a total of 35 minutes with the patient. Which code is used?
   A. 99202  
   B. 99243  
   C. 99203  
   D. 99244 
   **ANS: A**  
   **Rationale:** The correct answer cannot be a consultation code, which eliminates B and D. The question specifically states that the patient was sent to the spine specialist for treatment, not for an opinion. The remaining issues for the student are whether to base the code on the key components or on time. Because only the total visit time was documented, without mention of the counseling and/or coordination of care time, the correct answer must be based on the key components.

5. A pediatrician examines a newborn right after birth but is called away during the examination. The pediatrician returns later that day and completes the visit. The total time spent during that day is 25
minutes. Which code is reported?
A. 99460
B. 99221
C. 99201
D. 99462

ANS: A
*Rationale: This is initial newborn care. These codes are per-day codes; time is not a factor.*

6. A physician provides 75 minutes of inpatient critical care for a 30-day-old infant. Which code(s) will be reported?
A. 99460
B. 99468
C. 99471
D. 99291, +99292

ANS: C
*Rationale: A 30-day-old patient is a pediatric patient, not a neonate. The correct code for inpatient critical care of a pediatric patient is 99471.*

7. An ED physician evaluates a patient in the ED. The patient’s internist is called in to admit the patient to the hospital. What service does each physician report?
A. ED physician reports ED code; internist reports initial hospital care for the admission.
B. ED physician reports initial hospital care; no codes reported by internist.
C. ED physician reports ED code and initial hospital care; no codes reported by internist.
D. ED physician does not report any services; internist reports initial hospital care.

ANS: A
*Rationale: The ED physician reports an ED code; the internist reports the initial hospital care code.*

8. A 54-year-old established patient is seen for an annual examination. The physician provides a comprehensive physical and spends 15 minutes discussing the patient’s anxiety. Which code is used?
A. 99205
B. 99386
C. 99396
D. 99401

ANS: C
*Rationale: Answer is based on the patient’s age and his status as an established patient. Counseling is included in the preventive medicine codes.*

9. A cardiologist asks a surgeon to stand by during a procedure. The surgeon sees patients in the hospital while on standby, but is available via beeper. The procedure takes 1.5 hours. Which code(s) are used?
A. 99360
B. 99360 × 3
C. 99360, 99356
D. This is not a reportable service

ANS: D
*Rationale: This is not a reportable service. One requirement for reporting the standby codes is that the physician not be engaged in any other patient activity during the standby period.*

10. A patient is in the hospital for a total hip replacement. The patient also has coronary artery disease and develops symptoms. The orthopedic surgeon puts a request in the patient’s hospital chart for a cardiologist to see the patient and give his opinion on the severity of the problem. The cardiologist sees and evaluates the patient and puts his findings in the patient’s chart. What code does the cardiologist report?
A. Consultation code.
B. New patient code
C. Subsequent hospital care code
D. This is a professional courtesy; no codes are reported.
ANS: A

Rationale: This is a request for an opinion, not a transfer of care. All consultation requirements have been met.

11. An internal medicine physician asks a local endocrinologist to evaluate a diabetic patient’s ongoing bilateral lower extremity neuropathy. He needs an opinion on whether the patient’s problem is related to the diabetes or if there is another problem. The endocrinologist performs a detailed history, a detailed exam, and moderate medical decision making. The endocrinologist writes a letter to the requesting physician indicating his findings. This is a Medicare patient who has never seen the endocrinologist before. Which code does the endocrinologist report?
A. 99203
B. 99243
C. 99204
D. 99254
ANS: A

Rationale: The services provided are consistent with consultation services, but Medicare does not accept the consultation codes. Because the patient is new to the endocrinologist, the new patient codes are required.

12. An established patient is seen in his physician’s office for a chief complaint of persistent cough. The physician performs a brief history and examines the respiratory system. MDM is straightforward. Which code does the physician use?
A. 99211
B. 99201
C. 99213
D. 99212
ANS: D

Rationale: A brief history is applicable to both a problem-focused and expanded problem-focused LOS; an examination of one system relates to a problem-focused LOS.

13. At an initial office visit by a patient with a 5-day history of right leg pain, swelling, and a hot spot on the right leg, the physician provides a detailed history and detailed exam, and MDM is moderate. The patient is concerned about thrombophlebitis because there is a family history of this problem. The physician counsels the patient for 40 minutes. The entire visit takes 65 minutes. Which code does the physician use?
A. 99203
B. 99204
C. 99205
D. 99202
ANS: C

Rationale: The LOS is based on time. Although the key components meet the requirement for 99203, time becomes the determining factor based on the documentation of the total visit time and the time spent in counseling.

14. A neonatologist is requested to attend a delivery due to concerns about the infant’s possible respiratory problems. The pediatrician stabilizes the infant while still in the delivery room. What E/M code(s) does the pediatrician report?
A. 99291
B. 99460
C. 99464, 99465
D. 99464
ANS: D

Rationale: The attendance at delivery code includes stabilization of the infant.
15. A pediatrician stood by for 30 minutes during delivery by an obstetrician for a high-risk patient. The obstetrician delivered the baby and the pediatrician performed resuscitation. Which code(s) would be used for the pediatrician’s services?
A. 99464, 99460  
B. 99464  
C. 99465, 99360  
D. 99360

**ANS:** C  
**Rationale:** Both services are separately reportable.

16. A 60-year-old patient recently moved to Phoenix and is seeing a new internist there. The patient has a long history of gouty arthropathy but presents today for his annual preventive medicine visit. The physician provides a comprehensive H&P, counsels the patient on diet, and orders exercise and blood work. Which code(s) would be used?
A. 99205  
B. 99386  
C. 99396  
D. 99386, 99402

**ANS:** B  
**Rationale:** Although the patient has gouty arthropathy, his visit is for preventive medicine services. Those services include counseling.

17. An ED physician sees a patient who was in a motor vehicle accident. The patient has scrapes, contusions, and two dislocations. The ED physician performs a comprehensive exam, a detailed history, and moderate MDM. Which code should be reported?
A. 99243  
B. 99244  
C. 99284  
D. 99283

**ANS:** C  
**Rationale:** The lowest key component controls the LOS. The comprehensive examination equates to 99285 but both the detailed history and moderate MDM equate to 99284.
CHAPTER 14: CPT EVALUATION AND MANAGEMENT AUDITING

Answers to Checkpoint Questions

Checkpoint 14.1
Answer the following questions.
1. What information must be documented for an expanded problem-focused history in addition to that documented in a problem-focused history? A problem-focused history requires documentation of a brief history of present illness (HPI) only. To report an EPF history there must be documentation of the brief HPI plus a problem pertinent review of systems (ROS).
2. The physician evaluated an established patient and documented an expanded problem-focused history and examination and straightforward MDM. The physician reported code 99213. Is the physician correct? What concept was used to correctly answer this question? Code 99213 is correct and it reflects the lowest key component concept as applied to established patients. The straightforward MDM is disregarded and the LOS is based on the remaining two key components.

Checkpoint 14.2
Answer the following questions.
1. How has Medicare reimbursement been calculated since 1992? As of 1992, Medicare reimbursement is based on the resource-based relative value system (RBRVS), which is a cost- and geography-based system.
2. What is the main difference between the 1995 and the 1997 documentation guidelines? The examination key component is the main difference.
3. Are physicians allowed to use both the 1995 and 1997 documentation guidelines, or do they have to limit themselves to choosing one or the other? Physicians are allowed to select either the 1995 or 1997 DGs, whichever one best benefits the physician for the particular service provided.

Checkpoint 14.3
Read the following scenarios and answer the questions.
1. The physician assistant (PA) sees an established patient who is covered by Medicare to review his blood pressure status and lipid profile since the last visit a month ago. This protocol was established by the physician on the patient’s last visit. The physician was present in the office during the encounter. The billing for this visit went out under the physician’s name and provider number to Medicare. This is an example of what type of billing? Incident-to. This is a Medicare patient and the incident-to rules are applicable. The patient is established (not new) and the physician is present in the office during the encounter.
2. If the above patient was new to the practice and was seen by the PA, could the service be reported under the physician’s name and provider number? No, new patients are not reportable under the incident-to guidelines. The PA would have to report the service under his or her own provider number if the provider had one. If not, the service is not reportable to Medicare.
3. In giving a history of her present illness, a patient states that she hurt her arm a week ago when she fell down a few stairs. Which elements of HPI are represented by that statement? Location — arm; context — fell down

Checkpoint 14.4
Read the following case and answer the question.
In the ROS the physician documented that the patient’s chief complaint was chest pain. In talking with the patient, the physician also asked about muscle pain and headaches. She replied no to muscle pain and yes to headaches.
1. The physician counted both systems in the ROS. Is that correct? Yes, a negative response is still
considered a review of that system.

**Checkpoint 14.5**

Read the following case and answer the question.

A patient was previously seen 2.5 years ago and is now seen for a worsening of her asthma. The physician did an extended HPI and ROS and documented that he asked if there had been any changes in the patient’s medical history, or if she had changed jobs.

1. The physician notated that he had obtained a complete PFSH. Is the physician correct? **Yes, for an established patient, if the physician documents two of the three PFSH elements, it is considered a complete PFSH. The two PFSH elements are past and social history.**

**Checkpoint 14.6**

Answer the following questions.

1. What is meant by a “modifying factor” in the HPI? **Modifying factor represents any action taken by the patient to modify the condition for which he or she is being seen.** For example, taking ibuprofen for muscle pain is considered a modifying factor.

2. Can past problems and medications be counted in the ROS? **No, past problems and medications are part of the patient’s past medical history.**

3. Which E/M services require all three key components? **New patient services for office/outpatient, initial nursing facility, domiciliary, home; initial observation care services; initial hospital care services; consultations; emergency department services.**

**Checkpoint 14.7**

Answer the following question.

1. In what areas do the 1997 general multisystem exam requirements differ from the 1997 musculoskeletal exam requirements? **It is in the detailed and comprehensive levels that the guidelines differ. General multisystem specifies the number of areas/systems that must be accounted for by bullets. The musculoskeletal guidelines require a specific number of bullets but do not specify the areas/systems.**

**Answers to Review Questions**

*Matching*

A. audit  
B. body areas  
C. brief  
D. constitutional  
E. data review  
F. documentation guidelines (DGs)  
G. downcoding  
H. extended  
I. external audit  
J. general multisystem examination requirements  
K. history of present illness (HPI)  
L. internal audit  
M. organ systems  
N. overall risk  
O. past, family, and/or social history (PFSH)  
P. prospective audit  
Q. retrospective audit  
R. review of systems (ROS)  
S. specialty examination requirements  
T. upcoding

1. **D** An element listed in both the ROS in history and in the examination key component
2. **E** An element of the 1995 and 1997 DG medical decision-making criteria
3. **N** Complications, morbidities, and mortalities associated with the patient’s condition
4. **A** Determining whether the physician’s documentation matches the level of service reported by an E/M code
5. **T** Reporting a level of service that is higher than the level documented
6. **K** A history element that identifies the chronology of the patient’s illness or complaint
7. **H** A listing of four or more elements of HPI or two to nine elements of ROS
8. **F** Criteria established in 1992 as to how physicians can determine whether their documentation matches a level of service
9. **C** A listing of one to three elements of HPI
10. **L** An audit initiated by a medical practice to determine whether the codes selected are appropriate to the services documented
11. **G** An inventory of body systems presented by the patient in response to questions
12. **O** An element of the history key component that relates to previous illnesses and family history
13. **I** Audits performed by payers or government agencies to determine whether a medical practice is adhering to documentation standards
14. **M** Part of the examination elements
15. **J** A refinement of the 1995 DGs
16. **B** An element of the 1995 and 1997 DG exam criteria that includes the neck
17. **P** An audit conducted prior to sending out claims to a payer
18. **S** One of the choices offered by the 1997 DGs at the request of specialty physicians
19. **Q** An audit conducted after claims have been sent to the payer

**True/False**
1. **F** It is appropriate to use the 1995 DGs for the bullet method of determining the LOS for an E/M encounter.
2. **F** If the ROS has fewer than four elements documented, the ROS is considered brief.
3. **T** To qualify for a comprehensive exam, the physician must document an examination of eight organ systems.
4. **T** Question 3 relates to the 1995 documentation guidelines.
5. **F** As long as the chief complaint is documented, clarity about the presenting problem is not necessary.
6. **F** Past history includes a recitation of the relevant illnesses and surgeries of family members.
7. **F** The detailed levels of service under the 1997 general multisystem examination guidelines are the same as the 1997 single-organ system examination guidelines.
8. **F** Documentation of any key component at the highest level means that the patient encounter qualifies as the highest level E/M service.
9. **T** Historically speaking, the need for documentation guidelines resulted from the RBRVS program.
10. **T** Emergency department codes require only two elements of PFSH to qualify as the comprehensive LOS of the history key component.
11. **T** For the MDM key component, only two elements must be in the same column to select the level of MDM.
12. **F** All specialty physicians are required to use the specialty-specific 1997 documentation guidelines.
13. **F** Once the constitutional information is obtained for ROS, it can also be part of the constitutional requirement in the examination.
14. **T** In the physician’s documentation, indicating an abnormal finding without elaboration is insufficient.
15. **T** The audit result will be affected by whether the E/M code requires three or two key components.

**Multiple Choice**
1. Jane Robins, an established patient, presents with a chief complaint of a productive cough for 5 days after exposure to a friend who was ill with pneumonia. She has not had a fever. She is wheezing but has no muscle aches, dizziness, or headaches. What is the level of this patient’s history?
   A. 99203
   B. 99212
   C. 99213
   D. 99242
ANS: C

Rationale: Patient is established and there is no documentation of consultation; therefore, a and d are incorrect, leaving B or C. The HPI has four elements documented (quality, duration, context, and associated signs and symptoms), this is an extended HPI. There is documentation of three systems reviewed (musculoskeletal, respiratory, neurological), this is an extended ROS. No PFSH is documented, this is an EPF history.

2. The physician examined Jane Robins’ lungs and ears, nose, and throat (ENT). What is the level of this examination?

A. 99203  
B. 99212  
C. 99213  
D. 99242  

ANS: C

Rationale: An examination of the respiratory system and ENT qualifies as an EPF examination.

3. After examining Jane Robins, the physician determined that she had bronchitis but sent her for a chest x-ray to rule out the possibility of pneumonia due to her previous exposure. What is the level of medical decision making?

A. Straightforward  
B. Low  
C. Moderate  
D. High  

ANS: B

Rationale: This is a new problem with an additional workup ordered (4), a chest x-ray was ordered (1), and the risk is low based on the presenting problem.

4. Using the three key components chosen for Questions 1–3, what E/M code should the physician report using the 1995 documentation guidelines?

A. 99203  
B. 99212  
C. 99213  
D. 99242  

ANS: C

Rationale: History is EPF, examination is EPF, and MDM is low.

5. Using the 1995 documentation guidelines, what E/M code would the physician report if Jane Robins was a new patient?

A. 99202  
B. 99203  
C. 99204  
D. 99205  

ANS: A

Rationale: EPF history for a new patient is 99202. EPF examination for a new patient is 99202. Low MDM for a new patient is 99203. The lowest key component controls the level of service.

6. The physician examined new patient Jane Robins’ lungs and ENT. What is the level of this examination using the 1997 general multisystem guidelines?

A. 99201  
B. 99212  
C. 99213  
D. 99242  

ANS: A

Rationale: Problem-focused: The notation that the lungs are clear to auscultation is one bullet, the reference to the neck and thyroid counts as two bullets. Three bullets under the general multisystem
guidelines is a problem-focused examination.

7. Using the findings in Question 6, what will be the result once all three key components for new patient Jane Robins are considered under the 1997 general multisystem guidelines versus the 1995 guidelines?

A. The LOS does not change.
B. The LOS is higher.
C. The LOS is lower.
D. The LOS is higher if Jane Robins is a new patient and lower if she is an established patient.

ANS: A

Rationale: The LOS does not change, it is still 99201. The examination component controls the level of service because all three key components must be considered for a new patient visit and the problem-focused examination is the lowest key component; it controls the level of service.

8. Arthur Martin, an established patient, has had difficulty walking due to pain in his right leg for the last 3 months. He has less pain when he stops walking. He denies pain while at rest; he has no other musculoskeletal pain and has no problems with impotence or urination. He denies any family history related to this problem that he knows of. Assess the level of history for this patient under the 1995 documentation guideline and select the correct E/M code.

A. 99212
B. 99213
C. 99214
D. 99215

ANS: C

Rationale: Four elements of HPI are documented—location, quality, timing, and duration = extended HPI. There are two systems reviewed and documented—musculoskeletal and genitourinary = extended ROS. Family history is documented by the mention of nothing relevant in the family history = pertinent PFSH.

9. The physical examination of Arthur Martin reveals a temperature of 98.1°F and BP of 135/76. The right leg is without any deformity and the skin on the right foot is cool and mottled. The neurological examination shows Arthur to be alert and oriented but with decreased sensation below the right knee. Both his cardiovascular and respiratory examinations are normal. Assess the level of examination under the 1995 documentation guidelines and assign the correct E/M code.

A. 99212
B. 99213
C. 99214
D. 99215

ANS: C

Rationale: The respiratory, cardiovascular, neurological, musculoskeletal, integumentary, and constitutional systems were documented = a detailed examination that requires 5 to 7 body areas or organ systems to be examined.

10. Using Arthur Martin’s details from Question 9, assess the level of examination for Arthur Martin under the 1997 general multisystem guidelines and assign the appropriate E/M code.

A. 99212
B. 99213
C. 99214
D. 99215

ANS: B

Rationale: Seven bullets are accounted for under the 1997 guidelines:

Constitutional—1
Musculoskeletal—2
Neurological—1
Cardiovascular — 1
Respiratory — 1
Integumentary — 1

11. Arthur Martin has peripheral vascular disease, needs to begin a monitored walking program, and will need prescribed medication. He also has to stop smoking for his condition to resolve. A follow-up visit is to be scheduled for 1 month. Assess the level of medical decision making using the 1995 documentation guidelines and assign the appropriate E/M code.

A. 99212
B. 99213
C. 99214
D. 99215

ANS: C

*Rationale:* This is a new problem with no additional workup (3), no data review, and moderate overall risk based on the prescribed medication. MDM is moderate.

12. Combining the three key component levels for Arthur Martin, what code will the physician report for this patient encounter using the 1995 documentation guidelines?

A. 99212
B. 99213
C. 99214
D. 99215

ANS: C

*Rationale:* Detailed history, detailed examination, moderate MDM.

13. Sixteen-year-old Sandra Katz comes to the emergency department for right lower quadrant abdominal pain that started 4 hours ago. The pain was sudden onset and has remained steady. She is not nauseous and has not vomited. Her last menstrual period was normal, and she has not had any injury to account for this pain. Sandra has not had any surgeries, is not on any medications, and has no allergies. Her parents are in good health without any significant medical history. She does not drink or use drugs, and she denies sexual activity. What is the history level for this patient using the 1995 documentation guidelines?

A. 99243
B. 99253
C. 99283
D. 99284

ANS: D

*Rationale:* Four HPI elements, three systems reviewed, all three PFSH.

14. The examination of Sandra Katz shows slightly hyperactive bowel sounds in the abdomen, no hepatosplenomegaly, no palpable masses, and some tenderness to deep palpation. The pelvic exam shows tenderness in the right adnexa but no adnexal masses; the cervix is not tender. Using the 1995 documentation guidelines, which code should be reported?

A. 99243
B. 99253
C. 99283
D. 99284

ANS: C

*Rationale:* Examination of two organ systems, gastrointestinal and genitourinary = expanded problem-focused.

15. Continuing with Sandra Katz, urinalysis is done and is normal. The complete blood count (CBC) shows a low hematocrit level with mildly elevated white blood cell count. An independent review of the pelvic ultrasound shows no masses but some fluid in the deep pelvis. The onset of pain and the history are not typical for appendicitis. Possible options are a ruptured ovarian cyst or ovarian torsion. If pain persists, Sandra may need a laparoscopy. Her CBC is to be repeated. Using the 1995 documentation
guidelines, which code should be reported?
A. 99282
B. 99283
C. 99284
D. 99285
ANS: D

Rationale: New problem with additional workup (4), data review shows clinical laboratory tests, ordering ultrasound, and independent review of both (4), overall risk is moderate based on the presenting problem of an undiagnosed new problem with uncertain prognosis.

16. Combining the three key component levels for Sandra Katz, what code will this physician report for this patient encounter using the 1995 documentation guidelines?
A. 99243
B. 99253
C. 99283
D. 99284
ANS: C

Rationale: History is 99284, examination is 99283, MDM is 99285. The lowest key component controls the level of service and in the ED, and all three key components must be considered.

17. Helen Daniels, an established patient, sees her dermatologist due to recurrence of a rash on her forearm 4 days ago. The rash is itchy. The dermatologist’s examination shows a 3- by 5-cm rash on the midforearm with scaly, erythematous, raised papules. He diagnoses the condition as recurrent eczematous dermatitis and prescribes 1% cortisone cream, an over-the-counter medication. What is the code for this encounter using the 1995 documentation guidelines?
A. 99212
B. 99213
C. 99214
D. 99215
ANS: A

Rationale: History is brief (problem-focused) with three elements: location, duration, and quality. There is no ROS, no PFSH. The examination was of the skin (problem-focused).

18. If the MDM is straightforward, how does it affect the code selection for Helen Daniels’s encounter?
A. There is no impact because both the history and examination are at the same code level as straightforward MDM.
B. There is no impact because MDM is not required for an established patient encounter.
C. It will impact the code selection because MDM controls the level of service.
D. It will impact the code selection because straightforward MDM is the lowest level MDM and will lower the level of service.
ANS: A

Rationale: There is no impact because both the history and examination are at the same code level as straightforward MDM.

19. If the MDM for Helen Daniels’s encounter is low, how does it affect the code selection?
A. There is no impact because both the history and examination are at the same code level as low MDM.
B. There is no impact because the lowest key component controls the level of service.
C. It will impact the code selection because MDM controls the level of service.
D. It will impact the code selection because low MDM is at a higher level than the history and examination key components.
ANS: B

Rationale: There is no impact because even if one of the lowest key components is dropped the lowest key component of the remaining two will still control the level of service.

20. HISTORY: Maxine Lee, a patient with unrelenting shoulder pain and decreased range of motion in
the shoulder, is referred to a rheumatologist for an opinion about the diagnosis and about how to treat the condition once determined. In the rheumatologist’s office, she tells the physician that the pain started 6 weeks ago after she lifted heavy suitcases during a family vacation. Motrin was used to alleviate the pain. There is no family history of rheumatoid arthritis, but Maxine is having increased difficulty with daily activities. She denies any respiratory or cardiovascular symptoms, has not been nauseous, and has no constipation problems or allergies. All other systems are negative as well. The patient had a knee arthroscopy 2 years ago, and she does smoke and drink occasionally. She is divorced with two children.

EXAMINATION: Musculoskeletal exam of the shoulders shows a very limited range of motion.

MEDICAL DECISION MAKING: X-rays of the shoulders were taken and reviewed. The patient has arthralgia of the shoulders and will need physical therapy and a stronger anti-inflammatory available only by prescription. If Maxine is not better in 2 weeks, her internist will consider cortisone injections and/or an MRI. Which code should be reported for this patient encounter using the 1995 documentation guidelines?

A. 99241
B. 99242
C. 99243
D. 99244

ANS: A

Rationale: This is a consultation. The lowest key component controls the level of service. History is comprehensive, which is appropriate for 99244/99245. Examination is problem-focused, which is appropriate for 99241. Medical decision making is moderate, which is appropriate for 99244.
CHAPTER 15: CPT: ANESTHESIA CODES

Answers to Checkpoint Questions

Checkpoint 15.1

Use Table 15.1 and the definition of a complete anesthesia service to determine the code(s) that can be reported for the following case.

A 43-year-old patient requires fusing of the lumbar spine due to traumatic injury. The surgeon asks the anesthesiologist to place an epidural for continuous infusion of pain medication for postoperative pain management. The possible codes are 22612 and 62326.

1. Which code(s) can be assigned? The surgeon will report 22612 and the anesthesiologist will report 62326.

2. Is a modifier needed to indicate that two distinct procedural services were performed? No modifier is used because each physician reports his or her own service.

Checkpoint 15.2

Append all modifiers applicable to the anesthesia code in the following case.

1. A Medicare patient undergoes a radical hysterectomy for cervical cancer. The anesthesiologist is supervising two cases simultaneously. The CRNA provides the general anesthesia.

00846-QX, 00846–QK

Rationale: The coder would report 00846 QX for the CRNA's services and 00846 QK for the anesthesiologist's services. QK represents the work of the anesthesiologist who is directing anesthesia care provided by qualified individuals in 2–4 cases.

Checkpoint 15.3

Refer to Figure 15.1 to answer the following questions.

1. What type of anesthesia was provided? General

2. What surgical procedure was performed? Hemicolecotmy

3. What was the total anesthesia time? 1 hr, 47 min.

4. Who provided the anesthesia care? Vauhn

5. If a CRNA provided the care, did a physician supervise the work? Yes

6. What is the anesthesia code for this procedure? 00840

Rationale: Review the Anesthesia section and find the lower abdomen header where codes start with 00800. Code 00840 is correct—the hemicolecotmy is intraperitoneal and is not specified in any of the indented codes.

7. What physical status modifier should be appended? P2

Rationale: The patient's diagnosis of ulcerative colitis would be considered a mild systemic disease. The physical status is not “normal healthy patient” nor “severe systemic disease.”

Checkpoint 15.4

Assign the anesthesia code and any applicable modifiers and qualifying circumstances for the following scenarios.

1. Radical prostatectomy for a Medicare patient. The anesthesiologist performs the anesthesia. 00865 AA

Rationale: Review the Anesthesia section and find the lower abdomen header where codes start with 00800. The prostate is extraperitoneal and code 00865 identifies a radical prostatectomy procedure.

2. Correction of tetralogy of Fallot congenital heart defect with pump oxygenator in a 1-year-old girl.

00562

Rationale: Review the Anesthesia section and find the Intrathoracic header where codes start with 00500. You are looking for a code for anesthesia for procedures on the heart with pump oxygenator.
3. Emergency appendectomy in a 28-year-old female who is otherwise healthy. **00840-P1+99140**
   *Rational: Review the Anesthesia section and find the lower abdomen header where codes start with 00800. An appendectomy is an intraperitoneal procedure. The P1 status modifier is correct because the patient is identified as otherwise healthy. The qualifying circumstance modifier is needed because it was an emergency procedure.*

4. Hammertoe repair in a 66-year-old female with diabetes under MAC. The CRNA administered the anesthesia unsupervised. **01480-QZ, QS, P2**
   *Rational: Review the Anesthesia section and find the lower leg header where codes start with 01462. This procedure is on the toe (foot). The –QZ modifier represents the services of the CRNA unsupervised and the –QS modifier represents the monitored anesthesia care.*

5. A liver biopsy of a 42-year-old patient with cirrhosis of the liver under MAC in an ambulatory surgery center. **00702-QS-P2**
   *Rational: Review the Anesthesia section and find the upper abdomen header where codes start with 00700.*

**Answers to Review Questions**

**Matching**

<table>
<thead>
<tr>
<th>A. conscious sedation</th>
<th>B. postoperative anesthesia service</th>
<th>C. qualifying circumstances</th>
<th>D. monitored anesthesia care</th>
<th>E. physical status modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>F. general anesthesia</td>
<td>G. spinal anesthesia</td>
<td>H. preoperative anesthesia service</td>
<td>I. regional anesthesia</td>
<td>J. analgesic</td>
</tr>
</tbody>
</table>

1. G An anesthetic injection into the subarachnoid space
2. F The patient is rendered unconscious and is under constant attendance and monitoring
3. J Type of anesthesia that relieves pain without causing loss of consciousness
4. A Moderate anesthesia carried out by injecting a sedative and/or analgesic intravenously to relieve pain and anxiety during a medical procedure
5. C Add-on codes used to indicate operative conditions and/or unusual risk factors
6. I Part of the body is numbed without inducing unconsciousness
7. B Monitoring a patient for immediate postoperative complications
8. D The patient is not completely anesthetized and can respond to questions and directions
9. E Codes used with anesthesia codes to indicate patient’s health conditions
10. H Obtaining the patient’s medical and surgical history and medications

**True/False**

1. T Physical status modifiers are assigned with anesthesia codes.
2. F An anesthesiologist’s history and physical exam are separately reportable with an E/M code in addition to the anesthesia code for the same day of service.
3. T Qualifying circumstances codes may be assigned for anesthesia services.
4. T Use modifier –47 when the surgeon provides both the anesthesia and the surgical procedure.
5. F Use qualifying circumstance modifier –99100 with code 00834 for patients younger than 1 year of age.
6. F Once anesthesia has been provided, the anesthesiologist has no other responsibilities to the patient.
7. T Use HCPCS modifier –QY for the anesthesiologist medically directing a CRNA.
8. F Modifier –P3 is appended to the surgery code whenever a patient has severe systemic disease.
9. F Anesthesia time begins when the patient is fully anesthetized.
10. F To find the anesthesia code in the CPT index, go to the anatomical site of the surgery.

**Multiple Choice**
1. Which modifier is never used with anesthesia codes?
   A. –22
   B. –32
   C. –47
   D. –59
   **ANS: C**

2. Surgeons who administer their own anesthesia use which modifier with the surgical code they submit?
   A. –23
   B. –32
   C. –47
   D. –22
   **ANS: B**

3. Physical status modifiers are assigned for anesthesia services based on
   A. The payer
   B. The patient’s age
   C. The patient’s health
   D. Open versus closed procedure
   **ANS: C**
   **Rationale:** Review of the physical status modifiers shows this.

4. Anesthesia was provided to a normal, healthy 75-year-old patient for a needle biopsy of the thyroid. What is the applicable code(s)?
   A. 00326–P2
   B. 00326–P1, 99100
   C. 00322–P1, 99100
   D. 00322–P2
   **ANS: C**
   **Rationale:** The correct answer must have the –P1 modifier because the patient is identified as normal and healthy—answers A and D are eliminated. The choice is between 00326 and 00322. Code 00322 specifically identifies the thyroid but also note that 00326 is for a patient younger than 1 year of age. The qualifying circumstance modifier –99100 is required because the patient is over 70 years old.

5. A patient who has diabetes, controlled by diet and exercise, undergoes a transurethral resection of the prostate. What is the applicable code(s)?
   A. 00910–P2
   B. 00914–P2
   C. 00914–P3
   D. 00920–P3
   **ANS: B**
   **Rationale:** Controlled diabetes indicates a physical status of mild systemic disease and only answers A and B have that modifier. The choice is between 00910 and 00914. Code 00914 is specific to transurethral resection of the prostate.

6. An 82-year-old patient slipped on ice while crossing the street, sustaining a femoral neck fracture. Open treatment of the fracture with prosthetic replacement was performed. What is the applicable code?
   A. 01220
   B. 01230
   C. 01480
   D. 01462
   **ANS: B**
   **Rationale:** Answer A is incorrect because that code is for a closed fracture. Answer C is incorrect because it relates to bones of the lower leg and the femur is in the upper part of the leg. Answer D is incorrect because it is for a closed procedure and the lower leg.
7. A CRNA provides anesthesia on a patient during a radical mastectomy under the medical direction of an anesthesiologist. Code for the CRNA and the anesthesiologist.
   A. CRNA 00406–QY, Anesth. 00404–QY
   B. CRNA 00406–QX, Anesth. 00406–QX
   C. CRNA 00404–QX, Anesth. 00406–QY
   D. CRNA 00404–QX, Anesth. 00404–QY
   **ANS: D**
   *Rationale: The correct answer must have the –QX modifier on the CRNA’s code and the QY on the anesthesiologist’s code—that eliminates A and B. Answer C has two different anesthesia codes, which is incorrect. Both the CRNA and anesthesiologist would report the same code.*

8. An anesthesiologist provides anesthesia for an open lung biopsy on a patient with congestive heart failure. What is the applicable code(s)?
   A. 00540–P3
   B. 00540–P4
   C. 00560–P2
   D. 00560–P3
   **ANS: A**
   *Rationale: Congestive heart failure is a severe systemic disease; the correct answer must have the –P3 modifier, eliminating B and C. Code 00540 is specific to the lungs, whereas 00560 is not.*

9. Anesthesia is provided for repair of a ruptured Achilles tendon without graft. What is the applicable code?
   A. 01462
   B. 01470
   C. 01472
   D. 01480
   **ANS: C**
   *Rationale: The procedure is specific to a ruptured Achilles tendon; the only code that is specific to that condition is 01472.*

10. How do you report anesthesia services for multiple surgical procedures during the same session?
    A. Report the most complex procedure first, followed by the second procedure.
    B. Report the most complex procedure first, and report only half the time for the second procedure.
    C. Report the most complex procedure code and also report the time for all the procedures combined.
    D. Report only the most complex procedure code.
    **ANS: C**
    *Rationale: Review the anesthesia guidelines specific to separate or multiple procedures.*
CHAPTER 16: CPT: SURGERY CODES

Answers to Checkpoint Questions

Checkpoint 16.1
Using Table 16.3 and the Reimbursement Review, answer the following questions.
1. Is code 11471 a major or minor procedure? Major
2. Is 11446 a major or minor procedure? Minor
3. Can 36640 be reported separately from 00100? Yes

Checkpoint 16.2
Use Box 16.4 to answer the following questions.
1. Was there an assistant surgeon in this case? No
2. Was the procedure performed via an open or endoscopic approach? Endoscopic
3. What type of anesthesia was provided? General, scalene block, and local at the surgical spots
4. Did the patient have any synovitis? No
5. Which shoulder was operated on? Left
6. Would the arthroscopy of the glenohumeral joint be coded separately from the procedures described for procedure #3? No

Checkpoint 16.3
Assign the applicable modifiers to the following scenarios.
1. Physician performs cautery of the nose for epistaxis. Patient goes home and 6 hours later comes back with the nose bleeding again. Physician takes the patient back to the OR to perform further cautery and packing. –78
2. Patient is prepped for surgery and is taken to the OR. Anesthesia is administered. Patient’s extremity is scrubbed and the physician notes an infected fingernail. Physician terminates the procedure for fear of infecting the operative site. You are coding for the facility here and not the doctor. –74
3. Surgeon performs an ectropion repair of the left lower lid. –E2
4. Surgeon removes impacted cerumen by irrigation from the left ear only. None
5. Child has a speech delay and requires an auditory evoked potentials test of the central nervous system. Because the child would not sit still, the child was taken to an outpatient facility and placed under general anesthesia. What modifier will the anesthesiologist append to the procedure code? –23
6. Physician performs tendon procedure on the left hand. He also performs both local and regional anesthesia. What modifier(s) would be assigned to the procedure code? –LT, –47
7. Surgeon performs a bilateral carpal tunnel release. –50

Checkpoint 16.4
Assign CPT codes for the following statements
1. Excision of malignant lesions, 1.1 cm, upper arm; 0.1 cm, foot 11602, 11620–51
2. Needle core biopsy of both breasts (not using imaging guidance) 19100–50
3. Simple incision and removal of foreign body, subcutaneous tissue 10120

Checkpoint 16.5
Use the CPT book to assign codes to the following statements. Do not forget to append modifiers if needed.
1. Humeral osteotomy 24400
2. Closed treatment of sesamoid fracture 28530
3. Open treatment of right talus fracture 28445–RT
4. I&D of left foot bursa 28001–LT
5. Right elbow joint arthrodesis **24800–RT**

**Checkpoint 16.6**

Use the CPT book to assign codes to the following statements. Don’t forget to append modifiers if needed. Some of the following procedures require two codes. *(Hint: For endoscopic procedures, read the notes before this code group carefully.)*

1. Surgical thoracoscopy with excisions of pericardial and mediastinal cysts **32661, 32662–51**
2. Surgical nasal/sinus endoscopy with left maxillary antrostomy **31256–LT**
3. Planned tracheostomy on infant **31601**
4. Hematoma drainage from nasal septum **30020**
5. Laser destruction of two intranasal lesions, internal approach **30117×2**

**Checkpoint 16.7**

Use the CPT book to assign codes to the following statements. Don’t forget to append modifiers if needed. Some of the following procedures require two codes. *(Hint: For endoscopic procedures, read the notes before this code group carefully.)*

1. Ligation of secondary varicose veins, left and right legs **37785–50**
2. Excision of infected abdominal graft, surgical care only **35907–54**
3. Patient is placed on heart/lung bypass and the main pulmonary artery is opened in order to remove the blockage and interior lining of the artery. The artery was then sutured closed and the pulmonary endarterectomy was accomplished. **33916**
4. Insertion of transvenous electrode for dual chamber pacing cardioverter-defibrillator **33217**

**Checkpoint 16.8**

Use the CPT book to assign codes to the following statements. Don’t forget to append modifiers if needed. Some of the following procedures require two codes. *(Hint: For endoscopic procedures, read the notes before this code group carefully.)*

1. Secondary adenoidectomy, 10-year-old patient **42835**
2. Endoscopic placement of gastrostomy tube with radiological S&I **43246, 74235**
3. Simple ileostomy revision **44312**

**Checkpoint 16.9**

Use the CPT book to assign codes to the following statements. Do not forget to append modifiers if needed.

1. Discontinued contact laser vaporization of prostate **52648–53**
2. Incisional biopsy of testis followed by radical orchietomy for tumor, inguinal approach **54530**
3. Simple electrodesiccation of four lesions on penis **54055**
4. Radical perineal prostatectomy **55810**

**Checkpoint 16.10**

Use the CPT book to assign codes to the following statements. Do not forget to append modifiers if needed.

1. Routine obstetric care/vaginal delivery, previous cesarean delivery **59610**
2. Missed abortion surgically completed in first trimester **59820**
3. Cesarean delivery, including postpartum care, and total hysterectomy following attempted vaginal delivery; patient had previous cesarean delivery **59622, 59525**
4. D&C, postpartum hemorrhage **59160**
5. Simple destruction of four lesions, vulva **56501**

**Checkpoint 16.11**

Assign the CPT code and applicable modifier to the following statements.
1. Extracapsular cataract removal with insertion of intraocular lens prosthesis, mechanical technique, left 66984–LT
2. Excision of scleral right lesion 66130
3. Chalazion excision right eye during the global period of a strabismus surgery 67800–79
4. Impacted cerumen removed from both ears 69210–50

Answers to Review Questions

True/False
1. F Being aware of payer coding and reporting requirements is unnecessary because it does not influence correct coding.
2. F CPT modifiers are the same for both physician and outpatient facilities.
3. T The modifier –51 for multiple procedures can be used in the Radiology section.
4. F The modifier –50 for bilateral procedures is used to describe bilateral views (x-rays) taken of both knees (see code 73565).
5. F All HCPCS Level I and II modifiers are appropriate to use for coding in all settings.
6. F CPT does not have a way to capture the charges for the technical component of a procedure or service.
7. F A special report is only required when submitting a claim with an unlisted procedure code.
8. F The Neurology section of CPT is dedicated solely to neurologists and neurosurgeons and codes from this section should not be reported by physicians of other specialties.
9. F If the procedure note indicates that the physician utilized magnifying loupes to visualize blood vessels, code 69990 is reported in addition to the procedure code.

Multiple Choice
1. CMS provides a Change Request transmittal that lists types of add-on codes without any primary procedure codes. Which type is correct?
   A. Type I
   B. Type II
   C. Type III
   D. Type IV
   ANS: B
2. A designated separate procedure may be reported when (choose two answers)
   A. It is the only procedure performed.
   B. It is reported with modifier 59.
   C. It is performed in a separate site during the associated procedure.
   D. It is an incidental procedure performed during the associated procedure.
   ANS: A, C
3. The Medicare Physician Fee Schedule is a tool to help the coder do the following (select all that apply):
   A. Look up codes without having to use the CPT book
   B. Determine if a code has a physician or technical component
   C. Determine if a code can be billed bilaterally
   D. Obtain the global days for a procedure
   E. Sequence codes in highest value code order
   ANS: B, C, D, E
4. Select the correct code for the removal of both tonsils and adenoids in a 12-year-old patient.
   A. 42836
   B. 42826
   C. 42825
   D. 42821
ANS: D
5. Select the correct code for biopsy of lesion of the earlobe.
A. 11440
B. 11100
C. 69100
D. 69105

ANS: C
6. Select the correct code for removal of a foreign body of the left deep calf muscle.
A. 20525
B. 20103
C. 20520
D. 11043

ANS: A
7. Select the correct code for excision of two nasal polyps in the physician’s office.
A. 30300
B. 30110
C. 30115
D. 30110, 30110–51

ANS: B

ANS: B
8. Select the correct code for drainage of a cervical lymph node abscess.
A. 38308
B. 38505
C. 38300
D. 38510

ANS: C
9. Select the correct code for cystotomy with excision of ureterocele, bilateral.
A. 51530
B. 51535–50
C. 51065
D. 51535

ANS: B
CHAPTER 17: INTEGUMENTARY SYSTEM

Answers to Checkpoint Questions

Checkpoint 17.1
Assign codes to the following procedures. Include any necessary modifiers.
1. A patient has been complaining of a nonhealing surgical wound. The patient underwent an arthroplasty of the left index finger proximal interphalangeal (PIP) joint. The skin over the joint has been chronically infected. The physician debrides the skin surface. **11000**
   
   Rationale: CPT provides debridement codes specific to infected skin based on body percentage affected. Without specific documentation of the body percentage use the lowest percentage code.
2. A patient presents to the office with a tender 2.0-cm cyst located in the right axilla. The patient says she has had this for 2 weeks and thinks it is from an ingrown hair. The physician uses a scalpel to puncture the cyst and proceeds to drain the pustule. **10060**
3. A patient was hit in the left upper arm with an 85-mph fastball while playing baseball. Over the course of the day, the arm became bruised and began to swell. Two days later, he went to the physician, who diagnosed him with a hematoma and recommended draining the pooled blood. The patient tolerated the procedure well. **10140**
4. A women is seen in the dermatologist’s office for a chronic rash with raised lesions on her stomach. The physician examines the rash under magnification and decides to biopsy two lesions. He stretches the skin perpendicular to the tension lines and inserts the trephine to sample the skin to rule out lupus. **11100, +11101**
5. A patient presents to the office with two dermatofibroma on her right leg and one on her left. The nurse practitioner uses liquid nitrogen to destroy them. **17110**
6. Laser destruction of four premalignant lesions. **17000, 17003 × 3**

Checkpoint 17.2
Assign codes to the following procedures. Include any necessary modifiers.
1. A 7-year-old boy fell from his tree house, lacerating his forehead, right hand, and left forearm. He was taken to the ED. The ED physician used Dermabond and butterflies to close the superficial 2.0-cm laceration of the forehead. The 2.5-cm laceration of the skin and subcutaneous tissue of the left forearm required a layered closure using a Vicryl suture. The 3.0-cm laceration of the right hand had bark debris that had to be washed out before suturing the skin and subcutaneous tissue. **12042, 12031–59, 12011–59**
   
   Rationale: 12042 represents the 3.0 cm intermediate repair to the right hand even though the repair included the subcutaneous, which is a simple repair. The repair included removal of particulate matter. 12031–59 represents the layered (intermediate) repair of the 2.5 cm forearm. The Dermabond repair to the forehead is also coded. If it had been the only, or sole repair provided, it would be part of an E/M service and would not be reported with a repair code.
2. A 19-year-old patient goes to the physician complaining of two warts on the left index and middle fingers. He wants these removed. The physician applies Verruca-Freeze for 1 minute to each wart. **17110**
3. A 63-year-old female noticed a purplish irregular lesion on her lower leg. She has already had a basal cell carcinoma removed from her left shoulder. The 1.7-cm lesion was removed with a 0.2-cm margin. Simple repair was performed. Pathology confirmed basal cell carcinoma. **11603**
   
   Rationale: The 0.2 cm margin is doubled to equal 0.4 and added to the 1.7 cm lesion diameter for a total of 2.1 cm.
4. A patient has been complaining of a nonhealing surgical wound. The patient underwent an arthroplasty of the left index finger PIP joint. The skin over the joint has been chronically infected. The physician debrides 10 sq. cm of skin and subcutaneous tissue and performs a complex layered closure. **11042, 13132**.
Rationale: The physician debrides 10 sq.cm so we must assume that 10 sq.cm is the size of the repair unless otherwise indicated. Code 11042 is used here because debridement was performed on the skin and subcutaneous tissue. Because the repair codes are in centimeters not square centimeters, conversion must be done: 10 sq cm = a little more than 3 cm. Note that this question is similar to question 1 from checkpoint 17.1 but the difference (subcutaneous tissue) is what to watch for in similar coding scenarios.

5. A 3.0-cm, full-thickness benign lesion is removed from the patient’s upper back. A second benign lesion is also removed from the midback measuring 2.2 cm. The physician uses Vicryl to repair the subcutaneous layer and Monocryl to close the skin in both sites. 11403, 11403–59, 12032

Checkpoint 17.3
Assign codes to the following procedure. Include any necessary modifiers.
1. A patient is treated for a chronic venous stasis ulcer of the lower calf. The patient has been managed in the wound care clinic for 8 weeks with debridement, whirlpool therapy, and compression dressings and is now ready today for graft closure. A skin substitute graft is applied to the 5 cm x 12 cm ulcer site. 15271, 15272 x 2
2. Split-thickness autograft, 80 cm², lower leg, staged procedure. 15100–58

Checkpoint 17.4
Assign codes to the following procedure. Include any necessary modifiers.
1. The patient was burned on his upper arm and now suffers pain from the burn scar (eschar) in that area. The surgeon makes three incisions around the scar to release the constriction and pain caused by the scar. 16035, +16036 x 2

Checkpoint 17.5
1. A patient is being treated for injuries sustained in a motor vehicle accident earlier in the day. Debridement is necessary on his right foot down to the muscle and on his right hand down to the subcutaneous tissue. 11043, 11042–59
   Rationale: Without any documentation of sq cm the codes are chosen based on the depth of the debridement at the lowest sq cm (first 20 sq cm).
2. The surgeon performed Mohs surgery on an upper extremity malignancy. He performed a first-stage excision with seven tissue blocks. The frozen section examined by the surgeon revealed tumor was still present. A second-stage excision was performed with four tissue blocks and tumor was still present. A third-stage excision with four tissue blocks revealed no tumor present in the margins. 17313, +17314 x 2, +17315 x 2.
   Rationale: Code 17313 represents the first stage excision which includes 5 tissue blocks. Because 7 were performed the add-on code 17315 is coded x 2. Code 17314 represents the 2nd and 3rd stage excisions, which include 5 tissue blocks and therefore reported x 2. The 2nd and 3rd stage excision had 4 tissue blocks each, which are included in the 5 tissue blocks in the code.

Checkpoint 17.6
Assign codes to the following procedures. Include any necessary modifiers. In some cases, more than one code is required.
1. A 47-year-old female patient underwent a routine mammogram. The patient has had chronic fibrocystic disease, but this mammogram showed a small calcification not palpable to the touch. The radiologist performed an ultrasound-guided percutaneous needle core biopsy of this lesion of the right breast. 19083.
   Rationale: The ultrasound is included in code 19083
2. A patient undergoes a lumpectomy of the right breast for biopsy suspicious for malignancy. The 4.0-cm lesion with 0.2-cm margins was sent for frozen section. The pathologist confirmed the specimen to be malignant and that the margins were clear. 19301
3. Surgical removal of excess skin and tissue, upper arm and hand. **15836, 15837–51**
4. Rhytidectomy of glabellar frown lines. **15826**

**Answers to Review Questions**

**Matching**

A. paring  
B. dermabrasion  
C. dorsal  
D. shaving  
E. incisional biopsy  
F. excision  
G. proximal  
H. excisional biopsy  
I. debridement  
J. intermediate repair

1. **D** Slicing a raised lesion or mole entirely off at skin level  
2. **A** Trimming or gradual reduction in size by slicing  
3. **H** Surgically removing or cutting out part or all from body  
4. **I** Removal of dead, necrotic tissue  
5. **G** Closest to where that point attaches to the trunk of the body  
6. **C** Toward the backside of the body  
7. **F** Entire lesion or tumor is removed  
8. **J** Layered closure/repair of wound  
9. **E** Portion or a sample of the lesion or tumor is removed through an incision  
10. **B** Scraping away the outermost layer of skin with a motorized instrument

**True/False**

Decide whether each statement is true or false.

1. **F** I&D of abscess of the left thigh would always be coded as 27301; the code is specific to the thigh region.  
2. **T** Excision of a 3.0-cm hyperkeratosis of the scalp is coded as 11423.  
3. **F** Needle cauterization of subungal hematoma is coded as 11740.  
4. **F** Suture repair of a 12.0-cm laceration of the right lower leg in which fascia, subcutaneous layer, and skin are closed is coded 13121 and 13122.  
5. **F** The dermis is the thick, outer layer of the skin.  
6. **T** Layered closure is an example of intermediate wound repair.  
7. **F** Debridement is never coded as a separate procedure.  
8. **T** A shallow wound in the epidermis that could be repaired with a simple repair required extensive cleaning due to contamination. An intermediate wound repair code should be assigned.  
9. **F** Before you can assign a code for shaving a lesion, you must know if the lesion was benign or malignant.  
10. **F** One 0.5-cm benign lesion of the hand was removed and another 0.5-cm benign lesion of the foot was removed. Multiple lesions were excised and both anatomical areas are grouped into the same code descriptor, so the diameters of the lesions are added together.  
11. **T** When coding for skin grafts, simple closure of the donor site is included in the service for the graft and is not coded separately.  
12. **F** Simple closure is not included in the excision of a lesion.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. In which of these cases would the coder add the lengths of the defects?  
   A. Removal of benign lesions from neck  
   B. Simple closure of lacerations on the trunk  
   C. Intermediate closures of lacerations on arm and face  
   D. Excision of lesion on left leg with simple repair and excision of lesion on back with intermediate repair
ANS: B.
Rationale: Response A is incorrect because each lesion excision is coded separately; C is incorrect because while both closures are intermediate they are in different parent codes; D is incorrect because different types of repairs cannot be added together.

2. Wound exploration does not include which of the following?
A. Laparotomy
B. Debridement
C. Foreign body removal
D. Wound enlargement
ANS: A

3. The physician excised a benign lesion on the face measuring 2.0 cm × 0.6 cm × 3.0 cm. The correct code would be
A. 17000
B. 11444
C. 11643
D. 11443
ANS: D.
Rationale: Response A is a destruction code; B is for 3.1-4.0 cm, C is a malignant lesion excision code.

4. When coding wound repairs with varying complexity, which of the following is true?
A. The codes are listed with the largest repair size listed first
B. Only the most complex repair code is listed.
C. The most complex repair code is listed first followed by the other repairs
D. The order in which the codes are listed does not matter.
ANS: C

5. Per CPT guidelines, if a lesion is biopsied and the remainder of the lesion is removed, what code(s) is (are) assigned?
A. Code for the biopsy and the lesion excision with a −59 modifier on the excision code.
B. Code for the lesion excision only.
C. Code for the biopsy only.
D. Code for the biopsy and the lesion excision with a −59 modifier on the biopsy code.
ANS: B.
Rationale: The biopsy and excision of the same lesion requires that only the excision code is reported.

6. Which of the following procedures describes destruction of a lesion?
A. Paring
B. Shaving
C. Removal
D. Laser removal
ANS: D

7. A patient is seen in the ED after cutting his hand with a band saw. The ED physician indicates that the wound required extensive cleansing and multiple-layer closure. What kind of wound repair was done?
A. Intermediate
B. Simple
C. Tissue rearrangement
D. Complex
ANS: A

8. For a superficial incision and drainage of the shoulder, the code would be assigned from which range?
A. 21501–21510
B. 23030–23031
C. 10040–10180
D. None of the above
ANS: C.
Rationale: A superficial incision and drainage would be coded from the integumentary system code range.

9. In an excision of a 3.0- x 2.5-cm lipoma of the back, the incision was carried down to and through the subfacial fascia. Layered closure was performed with 2-0 Vicryl and 1-0 Monocryl. Which codes apply to this procedure?
A. 11403, 12032
B. 21932, 12032
C. 21925, 12031
D. 21930, 12031
ANS: B.
Rationale: The correct answer would have a code from the musculoskeletal system because of the depth of the excision. Subfascial depth and 3.0 cm indicates code 21932. Layered closure is an intermediate repair.

10. In a suture repair of a 9.0-cm laceration of the left lower leg, fascia, subcutaneous layer, and skin were closed. Which code(s) apply(ies) to this procedure?
A. 12034
B. 13121, 13122
C. 12004
D. 13120, 13121
ANS: A
Rationale: The correct answer is an intermediate repair code. Review of the complex repair guidelines shows that this repair is not complex. Answer C code 12004 is a simple repair code.

11. A patient has two benign lesions on the left leg, one is 2 cm, the other is 2.5 cm. The surgeon will use chemosurgery to perform destruction of the lesions. Which code(s) apply to this procedure?
A. 17263, 17262–51
B. 17000x2
C. 17000, +17003
D. 17110
ANS: D
Rationale: Destruction codes are delineated by premalignant, benign, and malignant. The correct codes for benign lesions start with code 17110, which includes destruction of up to 14 lesions.

12. A patient was treated at the ambulatory surgery center for a 3.3-cm lesion on his cheek. A previous biopsy indicated the lesion was a malignant melanoma and the patient is now seen for Mohs surgery. The lesion required three stages of excision with four blocks in the first stage, three blocks in the second stage, and two blocks in the third stage. Which codes apply to this procedure?
A. 17311, +17312 x 2, +17315 x 9
B. 17311, +17312 x 2
C. 17313, +17314 x 2, +17315 x 9
D. 17313, +17314 x 2
ANS: B
Rationale: Any answer with code 17315 is incorrect, none of the 3 stages went beyond 5 tissue blocks. That leaves answers B and D. Answer D has the incorrect body site for the Mohs procedure.

13. A layered closure is an example of which type of repair?
A. Skin graft
B. Intermediate closure
C. Rotation flap
D. Adjacent tissue transfer
ANS: B

14. What is the code or codes for suction lipectomy of the right and left thighs?
A. 15877, 15878
B. 15878, 15877  
C. 15879–50  
D. 15879  
ANS: C

15. What is the code for mastectomy with removal of right axillary lymph nodes including the pectoralis minor muscle but not the pectoralis major?  
A. 19305  
B. 19307  
C. 19303  
D. 19306  
ANS: B.  
Rationale: Answer A includes removal of both the minor and major pectoral muscles; Answer C does not include removal of any pectoral muscles; Answer D includes removal of both pectoral muscles plus the internal mammary lymph nodes.

16. A surgeon performs three percutaneous needle core biopsies on the right breast and two percutaneous needle core biopsies on the left breast. One incision was made on each breast. The surgeon supervised and interpreted the ultrasound imaging. The biopsies were performed in the outpatient surgery setting. Which codes apply to this procedure?  
A. 19100, 19100–59  
B. 19081, +19082  
C. 19083, +19084  
D. 19085, +19086  
ANS: C  
Rationale: As indicated in the guidelines, report the add-on code when performing biopsies on the contralateral breast. Codes 19083 and 19084 have the correct imaging guidance.

17. Mohs surgery was provided to a patient with a malignancy on his head. The surgeon provided both the surgery and the pathology services. There was a first-stage excision with 10 tissue blocks and a second stage excision with 6 tissue blocks. Which codes apply to this procedure?  
A. 17311, 17312, 17315 × 6  
B. 17311 × 2, 17315 × 6  
C. 17313, 17314, 17315  
D. 17313, 17314, 17315 × 6  
ANS: A

18. A patient has a squamous cell carcinoma on his left thigh. The 2.1-cm lesion is excised and simple repair is performed to repair the resulting defect. The total defect size for both defects is 10.1 cm². Which code(s) apply(ies) to this procedure?  
A. 14021  
B. 11603  
C. 14001  
D. 11603, 14001  
ANS: B.  
Rationale: Code 11603 represents the correct body site and dimension of the lesion. This is a malignant lesion so the correct answer must start with a 116xx code. There is no documentation of an ATT therefore code 14001 would not be reported.

19. A patient with insulin-dependent diabetes has a 4- x 4-cm (16-sq. cm) ulcer involving the skin and subcutaneous tissue of the left foot. The surgeon debrides the area. Which code(s) apply(ies) to this procedure?  
A. 11042  
B. 11403  
C. 11044
20. A patient suffered burns on the arm, torso, and leg. The surface size of the area to be excised involves 20 sq cm of the arm, 80 sq cm on the torso, and 30 sq cm on the leg. The total area to be excised is 130 sq cm. Treatment included excision of burn eschar and then placement of a split-thickness skin graft to each of the three areas. Which codes apply to this procedure?

A. 15002, 15003, 15100, 15101
B. 15002, 15003, 15100, 15100, 15100
C. 15100, 15101
D. 15002, 15002, 15002, 15100, 15100, 15100

ANS: A.

Rationale: The correct answer must include the surgical preparation codes 15002 and +15003 to represent the 130 sq cm. This eliminates answers C and D. Code 15100 represents a split thickness skin graft to the trunk, arms and legs, first 100 sq cm. To account for the additional 30 sq cm a coder would report the add-on code 15101, not 15100 three times.

21. A male patient was treated at the ambulatory surgery center for a 3.3-cm lesion on his cheek. It was excised, found to be basal cell carcinoma, and a full-thickness skin graft is excised from his shoulder and placed on the 10-sq cm defect. Which codes apply to this procedure?

A. 15240, 11646
B. 15240, 15000
C. 15350, 15000, 11644
D. 15240, 11644

ANS: D.

Rationale: The correct answer requires code 15240 for the full thickness graft and an excision of malignant lesion code representing the cheek and 3.3 cm. Answer D. is the only answer with those codes.
CHAPTER 18: CPT: MUSCULOSKELETAL SYSTEM

Answers to Checkpoint Questions

Checkpoint 18.1
Assign codes to the following procedures for the physician. Include any necessary modifiers.
1. A 6-year-old child was helping his father clear out brush and small trees from their yard and got a large splinter embedded in his right hand that required removal. The splinter was located deep in the palm of the hand. **20525**
2. A data entry operator has been suffering from chronic tendonitis in the right index finger. The physician injects the finger with 0.5 mL lidocaine and 0.25 mL Celestone Soluspan. **20551**
3. A patient suffers a nasty fall from the top flight of the stairs. The patient is complaining of neck and left shoulder pain. The physician identifies three trigger points—the right trapezius, the right deltoid, and the right levator scapulae muscles—and injects these with a mixture of lidocaine and Marcaine. **20553**
4. Diagnosis: Soft tissue tumor of the back. Procedure: Excision of soft tissue tumor. Patient presents with tumor on the upper right back. Skin is incised down through the deep dermal layers to the deep subcutaneous tissue. The cyst was removed en bloc. The cyst measured 5.5 x 2.7 x 1.2 cm. **21931**

Checkpoint 18.2
Using Pinpoint the Code 18.2 as a guide, assign codes to the following procedures for the physician. Include any necessary modifiers. In some cases, more than one code may be required.
1. A 19-year-old girl was playing soccer when she was accidentally kicked in the left knee. She suffered a displaced tibial plateau fracture. Open reduction with screw placement was performed under fluoroscopy. **27535–LT**
2. A patient was involved in a four-wheeler accident 2 days ago. He was taken to the ED where he was seen by the orthopedic surgeon on call. X-rays were obtained revealing a fracture of the left femoral shaft. Two days later the surgeon performed an ORIF with internal fixation of the left femoral shaft fracture. Code for the fracture repair. **27507–LT**
3. A patient was water skiing and while crossing a wake was unable to keep his legs square beneath his shoulders. His right leg was drawn outward when his ski did not disengage. He felt a pop in his right hip. He was taken to the ED where an x-ray was obtained confirming a traumatic hip dislocation. The patient was taken to the OR for reduction of hip dislocation under anesthesia. **27275–RT**

Checkpoint 18.3
Assign codes to the following procedures for the physician. Include any necessary modifiers. In some cases, more than one code may be required.
1. What modifier is needed when a diagnostic scope was performed and results in the decision to do an open procedure? **–59 modifier**
2. Can you use a –59 modifier when an attempted arthroscopic procedure cannot be accomplished and an open procedure is done instead? **No**
3. The standard medial and inferior lateral portals were established and diagnostic arthroscopy was carried out. The meniscus was then contoured back medially and laterally. **29883**
4. Code for a synovial biopsy and diagnostic arthroscopy of the left hip. **29860–LT**
5. Code for a surgical arthroscopy of the left ankle with removal of foreign body. **29894–LT**

Checkpoint 18.4
Assign codes to the following procedures for the physician. Include any necessary modifiers. In some cases, more than one code is required.
1. The patient is a 20-year-old minor league baseball player with chronic left elbow pain. The patient throws side-arm, and after an MRI of the left elbow is diagnosed with a medial collateral ligament tear.
He undergoes a repair of the ligament with local tissue. **24345–LT**

2. A patient is diagnosed with a rotator cuff tear. MRI confirms the diagnosis and the patient undergoes a left arthroscopic repair of the rotator cuff. **29827–LT**

3. A patient has chronic right lateral epicondylitis. He is taken to the OR and an incision is made over the lateral epicondyle. The underlying bone is noted to have a very sharp ridge. An osteotome is used to remove this ridge down to healthy smooth bone. **24357–RT**

4. Procedure: Excision of right volar ganglion cyst, radial side. Keith is a 34-year-old man with a work-related injury to the left wrist. He had a painful right volar ganglion cyst, which continued to increase in size, giving him pain and some numbness and tingling in the thumb and index finger. The ganglion cyst was excised. **25111–RT**

5. Nine months after a right humeral fracture repair a patient returns to his physician with pain in the fracture area. The patient had not returned before this time for fracture care follow-up and now has a nonunion of the humeral fracture. The surgeon does an iliac graft to repair the nonunion. **24435–LT**

**Checkpoint 18.5**

Assign codes to the following procedure for the physician. Include any necessary modifiers. More than one code may be required.

1. The patient is a 65-year-old female with a firm lump over the volar aspect of her right hand. The mass is consistent with Dupuytren's contracture. The right extremity is prepped and an incision is made over the fifth ray. Dissection was carried down through the subcutaneous layers. The pretendinous fascia was excised over the fifth ray approximately 3 cm in length. The same procedure was repeated and fascia was also removed from the fourth ray. **26045**

**Checkpoint 18.6**

Assign codes to the following procedure for the physician. Include any necessary modifiers.

1. A patient was running and felt a sharp pain in his hip. His right leg collapsed and he was taken to the ED, where an x-ray confirmed a traumatic tear to the labrum of his right hip. The patient was taken to the OR for arthroscopic labral repair under anesthesia. **29916**

**Checkpoint 18.7**

Assign codes to the following procedures for the physician. Include any necessary modifiers. In some cases, more than one code is required.

1. A patient sustained a twisting injury to the left knee after getting the heel of her shoe caught in a sidewalk crack. MRI confirmed an anterior horn medial meniscus tear. The surgeon performs arthroscopic meniscal repair and synovectomy of the medial compartment. **29882**

2. A patient with long-standing osteoarthritis undergoes chondroplasty on the right knee to repair damage to the articular cartilage. Cartilage is debrided using a microdebrider device until bright red bleeding bone is encountered. **29879**

**Checkpoint 18.8**

Assign codes to the following procedures for the physician. Include any necessary modifiers. In some cases, more than one code is required.

1. An avid runner has been experiencing chronic plantar fasciitis. She has already tried conservative methods including anti-inflammatories, injections, and rest. She is also experiencing numbness of the fourth toe on the left foot. The physician performs a partial fasciectomy and removal of Morton’s neuroma on the left foot. **28080**

   **Rationale:** The partial fasciectomy (28060) is a designated separate procedure and cannot be reported with another more major procedure in the same area.

2. A patient has been suffering from large bony bunion prominence of the right great toe for 2 years. She has changed footwear and still has pain with activity. She wants to have this bunion removed. Her great toe has severely deviated toward her other toes. The physician performs a first metatarsal osteotomy and
fixation with screw. 28296
3. A patient contracted osteomyelitis of the fourth left toe. A skin incision was made along the lateral border of the fourth metatarsal and carried down to the subcutaneous tissue. Dissection was carried down to the base of the metatarsal where an osteotomy was made. The bone was delivered from the wound and sent to pathology. There was erosion of the head consistent with osteomyelitis. The toe was amputated. 28810

Answers to Review Questions

Matching

A. external fixation  F. arthroplasty
B. lysis          G. replantation
C. fusion         H. trigger point injection
D. arthrotomy     I. chondroplasty
E. casting        J. traction

1. H A procedure involving injections used to treat painful knots of muscle that form when muscles do not relax
2. E Immobilization of a bone or joint with a plaster or fiberglass molded support that remains on (usually) 4 to 6 weeks
3. G Reattachment of a body part that was traumatically removed in its entirety from the body
4. F Realigning or reconstructing a dysfunctional joint
5. J Force applied by weights or other devices to treat bone injuries or muscle disorders
6. A Any means of securing or fixing bone ends or fragments in proper anatomical alignment from outside the body without nailing, wiring, rodding, screwing, or plating the bones together on the inside
7. B The decompression or loosening of a tendon, muscle, or nerve from surrounding tissue that is binding or impeding movement
8. D Surgical incision into a joint as an approach to a therapeutic surgery
9. C The permanent joining together of bones by mechanical implant such as screws or wire or by graft to make them immobile
10. I Debridement of articular cartilage

True/False

Decide whether each statement is true or false.
1. F Debridement is never coded as a separate procedure.
2. F Removal of biplane external fixator from the humerus under general anesthesia is assigned 20693.
3. F A synovectomy is always included in a surgical arthroscopy and is never coded separately.
4. F An ED physician examines a boy’s arm and determines that the radial shaft is broken. She places a cast on the arm and refers him to the orthopedic surgeon for fracture reduction. The correct code for the ED physician’s service is 25500.
5. F Arthroscopic thermal capsulorrhaphy of the left shoulder and manipulation under anesthesia is coded 23700–RT, 29999.
6. T A labrum is a piece of bone that encircles the glenohumeral joint.
7. F A shoulder manipulation and a shoulder arthroscopy should both be coded when performed at the same time.
8. T The correct code for the excision of a recurrent ganglion cyst of the wrist is 25112.
9. T Fluoroscopy is included in fracture treatment and is not coded separately.
10. T A patient sustained a fracture of the radial shaft. Six weeks after the fracture reduction, x-rays demonstrate a nonunion requiring a fracture re-reduction. The same surgeon performed both procedures within 6 weeks of each other. The physician should append the –76 modifier to the re-reduction code.

Multiple Choice
Select the letter that best completes the statement or answers the question.

1. Select the correct code(s) for closed treatment of a distal radial fracture with manipulation and external fixator application.
   A. 25605, 20690
   B. 25600, 25611–51
   C. 25607
   D. 25600, 20690
   **ANS: A**

2. Select the correct code(s) for injection of lidocaine and Depo-Medrol to the left knee and right great toe.
   A. 20550
   B. 20600, 20610
   C. 20526, 20600–51
   D. 20612, 20612–59
   **ANS: B**

3. Select the correct code(s) for arthroscopy of the right knee with synovectomy of the medial compartment and meniscectomy of the medial and lateral compartments.
   A. 29876–RT, 29880–RT–51
   B. 29875–RT, 29880–RT–51
   C. 29876–RT, 27333–RT–51
   D. 29880–RT
   **ANS: D**

4. Select the correct code(s) for when a patient has two hammertoes repaired, one on the left third toe and the second on the left fourth toe.
   A. 28285–50
   B. 28285–LT, 28285–59
   C. 28285–LT, 28285–LT–51
   D. 28285–T2, 28285–T3
   **ANS: D**

5. An excision of bone is an
   A. Exostectomy
   B. Ostectomy
   C. Osteotomy
   D. Arthrodesis
   **ANS: B**

6. Select the correct code for wound exploration of the shoulder.
   A. 20120
   B. 20610
   C. 20103
   D. 21501
   **ANS: C**

7. Select the correct codes for excision of a 3.0- x 2.5-cm lipoma of the back, where the incision was carried down to and through the superficial fascia and a layered closure was performed with 2-0 Vicryl and 1-0 Monocryl.
   A. 11403, 12032
   B. 21931, 12032
   C. 21925, 12031
   D. 21931, 12031
   **ANS: B**

8. Cast codes are not coded when
A. An ED physician applies the cast for support and refers the patient to an orthopedist.
B. A physician is reapplying a cast at a follow-up appointment.
C. A doctor performs fracture care.
D. A doctor applies a splint in the office after performing a detailed examination, reviewing a CT scan of the wrist, and coordinating rehab services.

**ANS: C**

9. Select the correct code(s) for a percutaneous repair of a ruptured Achilles tendon on the patient’s left foot, with application of a short leg cast.
A. 27650–LT
B. 27652–RT
C. 27654–RT
D. 27650–RT, 29405–RT

**ANS: A**

10. If an arthroscopic rotator cuff repair is performed, but it cannot be completed under this technique and is converted to an open procedure
A. Only the open procedure is reportable.
B. Both the open and arthroscopic procedures are reported.
C. Both the open and arthroscopic procedures are reported with the –59 modifier appended to the open procedure code.
D. Both the open and arthroscopic procedures are reported with the –52 modifier appended to the open procedure code.

**ANS: A**

11. Casting/splinting/strapping should not be reported separately if a____________________ is also performed.
A. Restorative treatment
B. E/M service
C. Treatment to afford comfort to the patient
D. All of the above

**ANS: A**

12. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report
A. An E/M service
B. A casting/splinting/strapping CPT code, an E/M code, and a casting supply code
C. A cast/splint/strap HCPCS supply code
D. A fracture reduction care code with a –54 modifier

**ANS: B**

13. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture, or for any other purpose during another more major procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is
A. Separately reportable
B. Reported with a –59 modifier
C. Not reported separately
D. Reported separately with 23700 for shoulder dislocation

**ANS: C**

14. Select the correct code(s) for a left shoulder arthroscopy, arthroscopic subacromial decompression, open rotator cuff repair, and repair of a SLAP lesion.
A. 23412, 29826, 29807
B. 23412
C. 29807, 29826, 29827–51
D. 23412, 29826–51, 29807–51

ANS: D

15. Select the correct code(s) for a right knee arthroscopy with medial and lateral meniscectomies and chondroplasty of the patellofemoral joint.
A. 29877–RT
B. 29880–RT
C. 29881–RT, 29877–RT
D. 29880–RT, 29877–RT–59

ANS: B

16. Select the correct code(s) for a posterior lumbar arthrodesis at L3-L5.
A. 22614 × 3
B. 22612
C. 22600
D. 22612, 22614

ANS: D

Rationale: A represents and add on code for 2 additional vertebral segments. B represents 1 vertebral segment. C represents the cervical spine. To see how CPT answers a similar question refer to the guidelines under the Spine header.

17. Arthrodesis is performed using a metal cage; a hole is drilled in the interspace and a metal cage is placed in the hole. Another metal cage is placed in the same interspace and filled with autogenous, morselized bone graft from a separate incision. Code for the application of the metal cages and the bone graft.
A. 22851, 20937–51
B. 22851 × 2, 20937–51
C. 22851
D. 22851, 20937

ANS: D
CHAPTER 19: CPT: RESPIRATORY SYSTEM

Answers to Checkpoint Questions

Checkpoint 19.1

Assign codes to the following procedures. Include any necessary modifiers.

1. Bilateral inferior turbinate reduction. **30130–50**
3. Removal of a Lego from a child’s nose under anesthesia. **30310**
4. Diagnosis: right nasal polyp. Procedure: excision of nasal mass. An incision was made along the dome-like polyp just posterior to the nasal sill. This continued laterally underneath the right inferior turbinate. The lesion was bluntly dissected. It was removed in its entirety. **30117**
5. Diagnosis: deviated septum with hypertrophic turbinates. Procedure: septoplasty and submucous resection of inferior turbinates. The deviated parts of the quadrilateral cartilage were resected. A nasal speculum was then used to expose the inferior turbinate on the right. The soft tissues were elevated off the inferior turbinate bone, which was then resected. A Bovie suction was placed in the resected cavity to shrink it. The same procedure was carried out on the opposite side. The mucoperichondrium of the septum was re-approximated with 4-0 catgut. **30520, 30140–51**
6. Diagnosis: intranasal tumor. Procedure: removal of nasal tumor. A right intercartilaginous incision was made and the entire nasal dorsum was exteriorized. There was a tumor on the lateral nasal bone measuring 1–2 cm. A retractor was placed in the nose. The tumor was removed down to the underlying bone. A Denver splint was applied to the nose. **30118**
7. Diagnosis: persistent epistaxis. Procedure: nasal endoscopy with cautereization. During the past few days patient has had persistent brisk bleeding. The scope was inserted into the nose and the nasal passages were suctioned of blood clots. A very brisk bleeding arteriole was located on the left floor of the nose. It was cauterized. A similar arteriole was encountered on the right side and was also cauterized. **31238–50**
8. Diagnosis: pansinusitis; nasal polyposis. Procedure: shaver-assisted intranasal polypectomy with ethmoidectomies. The patient had huge polyps present exuding from the middle meati bilaterally. The bulk of the polyps were snared. The remaining polyps were debrided. Anterior–posterior ethmoidectomies were accomplished. **30115–50, 31201–51**

Checkpoint 19.2

Assign codes to the following procedures. Include any necessary modifiers.

1. Direct diagnostic laryngoscopy and tracheoscopy with operating microscope. **31526**
2. Bronchoscopy with biopsy of bronchus and transbronchial biopsy of lung. **31625, 31628–51**
3. Insertion of tube for tube thoracostomy for drainage of hemothorax. **32551**
4. Planned tracheostomy on infant. **31601**
5. Microlaryngoscopy with biopsy of posterior larynx. **31536**
6. A patient developed a cough with thick sputum production along with dyspnea on exertion. Bronchoscopy was ordered. The flexible bronchoscope was inserted. Forceps were advanced through the suction channel of the scope into the left lower lobe bronchus and bronchioles. Significant infiltrate was encountered in the tracheobronchial tree and aspirated. The fluoroscope was utilized and the biopsy forceps were advanced into the bronchiole. Six biopsies were obtained from the bronchus and bronchioles and the forceps and scope were removed. **31625**
7. A 73-year-old man with a history of asbestos exposure was admitted for increasing dyspnea and dry cough. He denied fever, chills, sweats, or hemoptysis. X-rays showed large effusion. Thoracentesis with removal of 2 L of fluid was performed. The next day under ultrasound guidance, a French pigtail drainage catheter was placed, and 7 L of fluid was removed. Fluid continued to drain and 2 days later he had a thoracoscopy with pleurodesis and decortication. Code for the last procedure(s). **32650, 32651–51**
Answers to Review Questions

Matching

A. antrum  F. pneumonectomy
B. concha bullosa  G. radiofrequency ablation
C. lobectomy  H. segmentectomy
D. osteomeatal complex  I. thoracotomy
E. ostium  J. turbinates

1. G Method of surgically removing turbinates
2. A The paranasal cavities
3. H Removal of one of the divisions of a lobe
4. B A nasal bone that has become filled with air
5. C Removal of a single lobe of the lung
6. D Middle meatus
7. F Removal of the entire lung
8. I Performed to gain access to the thoracic organs
9. J Bones located inside the nose shaped like a shell
10. E Openings that connect the paranasal cavities to the nasal cavity

True/False

1. F The sphenoid sinus opens into the osteomeatal complex.
2. F Middle turbinate procedures can never be reported at the same time as an ethmoidectomy on the same side.
3. F A sleeve pneumonectomy is reported with 32486.
4. T Articnoid cartilage is part of the larynx.
5. F Separate codes are used for harvesting a lung from a live versus a cadaver donor.
6. T Lobectomies and wedge resections can be performed endoscopically.
7. T The uncinate process is part of the ethmoid.
8. T An endoscopic segmentectomy can be performed by a pulmonologist.
9. F There are three different kinds of turbinates: inferior, anterior, and superior.
10. F There are five sinus cavities: maxillary, sphenoid, ethmoid, paranasal, and frontal.
11. F Each lung has three lobes: superior, middle, and inferior.
12. F Codes 31020 and 31256 can be reported together when both are performed.
13. T A flexible fiber-optic laryngoscopy is routinely performed in under topical anesthesia.
14. F All nasal endoscopies are unilateral.

Multiple Choice

1. A patient undergoes nasal endoscopy with bilateral partial ethmoidectomies. What procedure does this describe?
   A. 31255–50
   B. 31237–50
   C. 31231
   D. 31254–50

   **ANS: D**

2. A patient had an endoscopic exam of the left nasal cavity and left ethmoid sinus with removal of polyp. On the right side, the physician examined the nasal cavity and performed a partial anterior ethmoidectomy. What procedure does this describe?
   A. 31254–RT, 31237–59
   B. 31254–RT, 31237–LT
   C. 31254–50
   D. Both A and B
ANS: A
3. A patient with liver carcinoma with bilateral pulmonary metastasis is seen for surgical excision. Incision was made between the fourth and fifth ribs and carried through the deeper tissues. The fifth rib was transected and a rib spreader was placed. Exploratory thoracotomy was conducted locating a mass in the apical segment of the LUL. An apical segmentectomy was performed. What procedure does this describe?
   A. 32503  
   B. 32484  
   C. 32505  
   D. 32442

ANS: B
4. The natural ossea was enlarged to create an opening for draining of the maxillary sinus. What procedure does this describe?
   A. 31256  
   B. 31237  
   C. 31267  
   D. 31231

ANS: A
5. A perpendicular plate of the anterior ethmoid was found to be causing severe septal deviation. It was elevated off the mucoperiosteum and the bone was removed in pieces with forceps. What procedure does this describe?
   A. 31237  
   B. 31255  
   C. 31254  
   D. 31020

ANS: C
6. A patient has adenocarcinoma of the upper lobe of the left lung. Two intercostal incisions were made in the chest wall and advanced into the chest cavity. A trocar was inserted into the first incision. The chest cavity was examined through direct visualization. Images were obtained of the lesion. Blood vessels and bronchial tubes were clamped at the segments of the lung containing the mass. The mass was removed by dividing the vessel and bronchial tubes and removing the segment. Trocars were removed. What code describes this procedure?
   A. 32666  
   B. 32484  
   C. 32480  
   D. 32663

ANS: B
7. A patient was in an altercation 3 months ago where his nose was broken. It was reduced in the ED. He is seen for major repair of the septum because of chronic sinusitis and a feeling of fullness in the nose. The physician performs reconstruction rhinoplasty with major repair of the septum. What procedure does this describe?
   A. 21335  
   B. 21336  
   C. 30420  
   D. 30450

ANS: C
8. A patient with hemoptysis is treated with bronchoscopy. The bronchoscope is inserted, noting any abnormalities. The vocal cords are visualized with the structure and function noted. The bronchoscope is then inserted through the upper airway and into the tracheobronchial tree. The patient has mild erythema throughout. In the right lower lobe, blood is seen coming from the right posterior basilar segment. Sterile
saline washings of this bronchus are obtained and sent for culture and cytological examination. What procedure does this describe?
A. 31623  
B. 31623–50  
C. 31622  
D. 31622–50  
ANS: C

9. A patient was seen in the ED due to a stab wound to the chest that lacerated a lung. He was taken to the OR after an emergency thoracotomy was performed in the ED with insertion of a chest tube. The chest was entered through the thoracotomy incision and the pleura was dissected off the area of bleeding. The arterial intercostal space artery was bleeding. This was repaired with 3-0 Prolene. The laceration was identified in the lowermost portion of the upper left lobe posteriorly. The stapling device was placed over this laceration and repaired. What procedure does this describe?
A. 32110  
B. 32503, 32110  
C. 32480  
D. 32480, 32110  
ANS: A

10. A 33-year-old male who worked as a chemical operator presented for evaluation of sinus problems and nasal congestion that had plagued him for many years. Clinical examination was significant for a severely deviated anterior septum and bilateral inferior turbinate hypertrophy. The patient underwent a nasal septoplasty combined with partial resection of the inferior turbinates. What procedure does this describe?
A. 30520, 30140–50  
B. 30520, 30130–50–51  
C. 30520, 30140–52–50  
D. 30520–22  
ANS: B

11. A patient had a CT scan 1 week ago due to increasing shortness of breath and persistent cough. Lesions were noted and surgery was scheduled. The right upper and lower lobes were removed through an intercostal incision between the fourth and fifth ribs. A wedge resection was performed on the middle lobe and frozen section pathology revealed it was positive for malignancy. The patient was diagnosed with non–small-cell carcinoma of the right lung. What procedure does this describe?
A. 32480x2  
B. 32482  
C. 32482, 32505  
D. 32480, +32507  
ANS: C

12. What code(s) would be assigned for diagnostic bronchoscopy with bronchial biopsy?
A. 31622, 31625  
B. 31625  
C. 31662  
D. 31662, 31625–59  
ANS: B

13. A patient has laryngeal cancer and has had a tracheostomy for over a year. The patient requires a revision of the stoma with reconstruction with the local flap due to irritation and breakdown from the artificial larynx device. What procedure does this describe?
A. 31613  
B. 31750  
C. 31614
14. A patient is diagnosed with three lesions on the right lung. Bronchoscopy was performed and two transbronchial lung biopsies were done on one lobe and another transbronchial lung biopsy was done on the second lobe. What procedure does this describe?
A. 31628, +31632
B. 31628x3
C. 31628
D. 31625
ANS: A

15. A surgical thoracoscopy with excisions of pericardial and mediastinal cysts was performed. What procedure does this describe?
A. 32661–22
B. 32661, 32662–51
C. 32662–22
D. 32659
ANS: B
Answers to Checkpoint Questions

Checkpoint 20.1
Assign the CPT code(s) for the following situation.

A 70-year-old male patient with a history of coronary artery disease presents with chest pain and indications of myocardial infarction. A pacing catheter is passed into the right ventricle with attachment to an external pulse generator. 33210
Rationale: When the electrodes are placed and attached to an external generator, it indicates a temporary pacemaker was provided. The checkpoint specified one electrode, which is a single chamber temporary pacemaker.

Checkpoint 20.2
Assign the CPT code(s) for the following situations.
1. A patient’s original pulse generator has reached the end of its life and needs to be replaced. The physician will remove the old generator and put in a new one. The existing two electrodes will remain in place. 33228
   Rationale: This code is selected because CPT provides codes 33227–33229 for removal and reinsertion of pacemaker generators when the existing leads are left in place. The pacemaker generator was specified as a dual-chamber generator.
2. Subcutaneous removal of pacing cardioverter-defibrillator pulse generator, electrodes removed by thoracotomy. 33243, 33241–51
   Rationale: Code 33243 specifically states that the removal is by thoracotomy.

Checkpoint 20.3
Assign the CPT code(s) for the following situations.
1. Coronary artery bypass graft ×3 was performed, and during the same session the surgeon performed tissue ablation and reconstruction of the left atrium. Will the surgeon report code 33254 or 33257 with the CABG code? +33257
   Rationale: The guidelines for this range of codes and the parenthetical note following codes 33254–33256 specify that these codes cannot be reported with the CABG codes and further indicate that add-on codes are provided when these services are provided in addition to CABG services.
2. Valvuloplasty of tricuspid valve with ring insertion. 33834

Checkpoint 20.4
Assign the CPT code(s) for the following situation.
1. A 64-year-old patient has blockages in three coronary arteries. The surgeon will use the saphenous vein as graft material for one of the blocked arteries and the left internal mammary artery (LIMA) will be used to provide graft material for the two remaining blocked arteries. The cardiothoracic surgeon performs CABG×3 using a saphenous vein graft to the right coronary artery (RCA) and left internal mammary artery grafts to the left anterior descending (LAD) and left circumflex arteries. 33534, +33517
   Rationale: When reporting combined artery and vein coronary artery bypass grafts, coders must report the artery-only codes first (33533–33536) and the special combined artery and vein codes (+33517 to +33523) second. The patient received two arterial bypass grafts and one venous graft.

Checkpoint 20.5
Assign the CPT code(s) for the following situations.
1. A patient with severe finger pain and diminished finger blood pressures needs a bypass graft from the brachial artery to the ulnar artery using a vein for the graft. 35523
Rationale: To code for non-coronary bypass grafts, the coder needs to confirm what material was used for the graft based on the three types—vein, in situ vein, or other than vein. Once the coder identifies that vein was the material used, they would review the code descriptions in that section to find one that identifies brachial-ulnar.

2. Patient is placed on heart/lung bypass and the main pulmonary artery is opened to remove the blockage and interior lining of the artery. The artery was then sutured closed and the pulmonary endarterectomy was accomplished. 33916

Checkpoint 20.6

Assign the CPT code(s) for the following situations.
1. Due to the need for repeated IV infusions, a 64-year-old patient requires placement of a central venous access device. Local lidocaine is administered and the subclavian/jugular vein is punctured. The guidewire is passed centrally and the central venous catheter is placed. The catheter is sutured in position, dressed in standard fashion, and attached to IV infusion fluids. 36556
   Rationale: To code for placement/insertion of a central venous access device, the coder must determine the patient’s age and whether or not the catheter was tunneled or non-tunneled, and whether or not a port or pump was provided. Code 36556 is correct for older than 5 years, non-tunneled, without port or pump.

2. Central venous non-tunneled catheter inserted in patient 40 years old. 36556

Checkpoint 20.7

Assign the CPT code(s) for the following situations.
1. A 56-year-old patient is diagnosed with bladder and prostate carcinoma and must undergo chemotherapy. A Hickman catheter venous access device is inserted for anticipated chemotherapy administration. A guidewire was placed at an entry point in the skin and a tunneling tool was used to reach the venotomy site. The catheter was brought out through the skin near the left collarbone. 36558
   Rationale: The description specified a tunneled procedure, the device was central, not peripheral, and the patient’s age was over 5 years.

2. A dialysis patient is experiencing loss of bruits in the right AV fistula. Doppler demonstrates presence of a thrombus. The patient undergoes an open AV fistula revision with thrombectomy. 36833
   Rationale: For revision of an arteriovenous fistula, carefully read the code descriptions to capture both the revision and the thrombectomy. Code 36832 has the revision but without thrombectomy. Code 36833 has both procedures.

Checkpoint 20.8

Assign the CPT code(s) for the following situations.
1. A patient with slowly enlarging varicose veins in the left leg has now presented with pain and difficulty walking. The physician performed 15 stab phlebectomies. 37765

2. How would you report this procedure if fewer than 10 stab phlebectomies were performed? 37799
   Rationale: Review of the stab phlebectomy codes shows specificity in the number of stabs associated with each code and a parenthetical note that leads the coder to the unlisted procedure code 37799 for any number less than 10.

Checkpoint 20.9

Assign the CPT code(s) for the following situations.
1. A patient presents for a persistently enlarged left posterior (deep) cervical lymph node. The complete node was excised by sharp dissection and sent to pathology. 38510
   Rationale: Go to the CPT index under excision, lymphatic system, nodes and review the codes listed. Another method is to go directly to the Lymphatic System section in CPT and review the codes under the excision header. The scenario specifies deep and cervical; therefore, the correct code is 38510.
2. A patient sustained an impelling injury to the diaphragm. The surgeon performed an emergent acute diaphragmatic hernia repair. **39540**

*Rationale:* Go to the CPT index under repair, diaphragm, hernia and review the codes listed. Another method is to go directly to the Diaphragm section in CPT and review the codes under the repair header. The correct code must reflect the acute status of the repair.

3. A patient suffered a severe injury to the diaphragm necessitating resection with a muscle flap. **39561**

*Rationale:* Go to the CPT index under repair, diaphragm, hernia and review the codes listed. Another method is to go directly to the Diaphragm section in CPT and review the codes under the repair header. The correct code must reflect the use of the muscle flap.

**Answers to Review Questions**

*Matching*

| A. arteriovenous graft | F. revascularization |
| B. arteriovenous fistula | G. CABG |
| C. anastomosis | H. nonselective catheterization |
| D. cannula | I. selective catheterization |
| E. angioplasty | J. ligation |

1. **F** Reestablishing the blood supply to the heart or within a blood vessel
2. **D** An external tube used in dialysis and ECMO procedures
3. **A** An external catheter that connects an artery and a vein
4. **I** Placement of a catheter into a branch off the main vascular conduit
5. **J** Vein tied off to cut off blood flow, making the vein less visible
6. **C** Rejoining a blood vessel
7. **G** Coronary bypass procedure using a vein and/or artery graft
8. **E** The surgical repair or reconstruction of a blood vessel
9. **H** Placement of a catheter into the main vascular conduit
10. **B** Surgically created connection between an artery and a vein

*True/False*

1. **F** When reporting placement of a transcatheter intravascular stent into a lower extremity artery, report code 37236.

*Rationale:* Review of code description shows that this code is “except for lower extremity.”

2. **F** A left ventricular electrode must be placed at the time of the insertion of the pacemaker or implantable defibrillator.

*Rationale:* The left ventricular electrode can be placed at the time of the pacemaker insertion or at a time following the pacemaker insertion—code 33224 versus +33225.

3. **T** A needle bone marrow biopsy from the left iliac crest is coded with 38221–LT.

4. **T** If a catheter is placed into the femoral artery, then into the aorta, and then into the left common carotid artery, it is considered a selective catheterization.

*Rationale:* Once the catheter leaves the main trunk of a vascular system (the aorta) and moves into the first branch off of the main trunk, the catheterization is considered selective.

5. **F** Coders can report a mitral valve replacement procedure without cardiopulmonary bypass.

*Rationale:* There is no code for mitral valve replacement without cardiopulmonary bypass.

6. **F** Always remember to report modifier –51 with the combined CABG codes 33517–33523.

*Rationale:* These are add-on codes and modifier –51 is never reported with an add-on code.

7. **T** The inferior and superior vena cava (IVC, SVC) carry deoxygenated blood to the heart.

*Rationale:* The SVC and IVC carry deoxygenated blood to the heart. Arteries carry the oxygenated blood to the body.

8. **F** The endovascular revascularization codes 37220–37235 are divided into three territories and each
territory is divided into three vessels.

*Rationale: The femoral popliteal territory is not divided into territories.*

9. **F** The central venous access codes are all age based.

*Rationale: Only the insertion codes are age based.*

10. **F** Report code 37216 when placing a stent into the cervical carotid artery with distal embolic protection.

*Rationale: Code 37216 specifies “without embolic protection.”*

**Multiple Choice**
Select the letter that best completes the statement or answers the question.

1. A patient has a long-standing history of varicose veins and elects to have ligation, division, and stripping of the greater saphenous vein from the saphenofemoral junction of the left leg. Additionally, the physician performed ligation, division, and stripping of the short saphenous vein of the right leg. Which codes are reported?

A. 37700–LT, 37780–RT–59  
B. 37718–RT, 37722–LT, 37785–LT  
C. 37700–LY, 37718–RT–59  
D. 37722–LT, 37718–RT–59

**ANS:** **C**

*Rationale: Review the first code in each answer. Only code 37700 provides the correct description of the procedure performed. That eliminates answers B and D. In choice A, code 37780 represents work done at the saphenopopliteal junction, which is not specified in the procedure description.*

2. A patient is evaluated for anemia and the blood work and evaluation show that the patient needs a bone marrow biopsy. Multiple passes of the needle are taken from the iliac crest. Report the bone marrow biopsy. Which code or codes are reported?

A. 38221  
B. 38220, 38221–59  
C. 38220  
D. 38230

**ANS:** **A**

*Rationale: Code 38221 represents a bone marrow biopsy. The other answers represent aspiration or harvesting procedures.*

3. A 75-year-old patient is seen today for an enlarged deep cervical lymph node. The patient has had the problem for 2 weeks. Open excision of the lymph node is performed and a sample is sent for four-color flow cytometry. Which code is reported?

A. 38500  
B. 38520  
C. 38510  
D. 38562

**ANS:** **C**

*Rationale: Code 38510 is specific to a deep cervical lymph node. Answers A and B are superficial, and choice D is for the pelvic area.*

4. A patient with a dual-chamber pacemaker that was inserted 9 days ago now needs the atrial electrode repositioned. Which code is reported?

A. 33216  
B. 33212  
C. 33218  
D. 33215

**ANS:** **D**

*Rationale: Code 33215 is specific to repositioning. Answer A is for electrode insertion, B is for a
generator insertion, and C is a repair code.

5. A 73-year-old patient with an existing dual-chamber pacemaker now requires a biventricular pacemaker. The right atrial and ventricular leads are retained and a left ventricular lead is inserted. Which code or codes are reported?
   A. 33216, +33225
   B. 33224
   C. 33224, +33225
   D. 33214, 33224

   **ANS:** B

   **Rationale:** The patient has an existing pacemaker and now requires the left ventricular electrode. Answer B specifies that scenario. Answer A represents the insertion of two electrodes, one of which is left ventricular. Answer C represents the insertion of the left ventricular electrode twice under two different circumstances, and D represents a pacemaker upgrade and insertion of the left ventricular electrode.

6. A patient received a heart/lung transplant at a hospital in New York. The donor heart was obtained at a hospital in Missouri. Code for the services of the donor cardiectomy/pneumonectomy.
   A. 33930, 33933, 33935
   B. 33935, 33933
   C. 33940
   D. 33930

   **ANS:** D

   **Rationale:** Code 33930 represents the donor cardiectomy/pneumonectomy, which is what the question specified. Answer A represents the removal of the heart/lung plus the backbench work and the transplant. Answer B has the removal and the transplant; C is for the heart removal only.

7. Which term describes a slow heartbeat?
   A. Tachycardia
   B. Cardiomegaly
   C. Bradycardia
   D. Myocardial infarction

   **ANS:** C

   **Rationale:** Tachy is the prefix for fast or rapid. Cardiomegaly is an enlarged heart. Brady is the prefix for slow, and myocardial infarction represents blockage to the heart muscle.

8. Which valve is located between the right atrium and right ventricle?
   A. Tricuspid
   B. Mitral
   C. Aortic
   D. Pulmonary

   **ANS:** A

   **Rationale:** Tricuspid is the valve between the right and left atrium. Mitral valve is on the left, aortic is from the left ventricle to the aorta, and the pulmonary valve is from the right ventricle to the pulmonary artery.

9. A patient undergoes a coronary artery bypass graft times three using the saphenous vein, an upper extremity vein, and the left internal mammary artery. Which codes are reported?
   A. 33533, +35500
   B. +33518, +35500
   C. 33533, +33518, +35500
   D. 33533, 33511, +35500

   **ANS:** C

   **Rationale:** The question specifies that both veins and arteries were used as bypass graft material plus
the use of an upper extremity vein. The correct answer must start with the artery bypass graft (33533), and then the combined vein/artery bypass graft code (33518) and then the upper extremity vein code (33500). Answer A has no vein code, answer B has no artery code, and answer D has the incorrect vein code (33511).

10. A patient with aortic stenosis needs a valve replacement procedure using a mechanical valve and cardiopulmonary bypass. Which code is reported?
   A. 33405
   B. 33411
   C. 33406
   D. 33400
   
   **ANS: A**

   **Rationale:** Answer B is for aortic valve replacement with aortic annulus enlargement, which is not specified in the question. Answer C is for replacement with an allograft (not mechanical), and D is for valvuloplasty, which is a repair, not a replacement.
CHAPTER 21: CPT: DIGESTIVE SYSTEM

Answers to Checkpoint Questions

Checkpoint 21.1

Assign the CPT code(s) for the following situations.

1. A 4-year-old boy suffers from left inguinal hernia and left scrotal hydrocele. Procedure: Hernia repair. An incision was made in the left groin. The external oblique aponeurosis was opened and the hernia sac identified. The sac was opened, transected, and ligated high. The tunica vaginalis was opened and a small amount of hydrocele fluid was removed. A small portion of the hydrocele sac was removed. A trocar was inserted and the abdomen was filled with CO₂. A 120-degree lens was inserted and the right groin appeared normal. The CO₂ was removed. An ilioinguinal nerve block was applied using 10 cc of 0.25% Marcaine with 1:200,000 epinephrine. **49500−LT**

   Check the NCCI edits and indicate if you are permitted to code for the ilioinguinal nerve block. **No**

2. The patient presents with a gallstone. Procedure: laparoscopic cholecystectomy. Trocar was inserted and the patient had dense adhesions around the gallbladder, making it difficult to reach and requiring dissection. Cholangiogram was attempted. I could not get any flow of contrast out of the gallbladder itself. The gallbladder was manipulated and dye still would not spill. The plan changed to dissect the gallbladder out and then do a transcystic cholangiogram. The gallbladder was freed and the cystic duct was opened. Cholangiogram was performed. The gallbladder was taken out through one of the trocar sites. **47563. The physician can also report 74300−26. Facilities would report 47563 and 74300−TC.**

3. The patient is a 65-year-old man who for at least the past 30 years has experienced intermittent hemorrhoidal symptoms, which have become progressively worse. On examination, he was found to have a moderate-sized edematous left lateral external hemorrhoid with a large prolapse, left lateral internal hemorrhoidal column, containing several small thromboses. A hemorrhoidopexy by stapling was indicated. Beginning posteriorly, a #2-0 Prolene suture was placed in a purse-string fashion along the submucosal plane approximately 4 to 5 cm above the dentate line. When this was completed, the Fansler retractor was removed. The PPH anal canal dilator and obturator were then placed over the purse-string suture and carefully positioned to protect the anal sphincter complex. The PPHO3 stapler was then fully opened and the purse-string suture was secured around the shaft of the anvil, then retrieved through the barrel of the stapler with a suture threader. The suture was secured upon itself and retracted as the stapler was then fully closed. The stapler was kept closed for 30 seconds, fired, released, removed, opened, and inspected. **46947**

4. The patient was seen in the ambulatory surgery center (ASC) for removal of a tongue mass. A submucosal mass was located on the left anterior third of the tongue. 1% xylocaine with epinephrine was used to infiltrate the tongue. Incision was made, the submucosal tissue was divided, and the lesion was bluntly dissected. The wound was then closed with 4-0 chromic. **41112**

5. Diagnosis: 25-year-old patient with chronic hypertrophic adenotonsillitis. Procedure: adenotonsillectomy. The nasopharynx was visualized with a laryngeal mirror. The adenoids were removed with Barnhill Jones curette. The tonsils were removed by blunt dissection and snare technique. Bleeding was controlled with 2-0 gut loop ties. **42821**

6. A 2-year-old boy fell and hit his mouth on the coffee table, sustaining a traumatic mucocele. An 8-mm firm mucocele was located on the midportion of the mucosal surface of the lower lip. The lesion was excised sharply with scissors. The base was cauterized with the Bovie. **40810**

7. The patient is experiencing anal pain in the posterior midline. She was diagnosed with fistula in ano in the posterior midline. The anus was examined and there were Grade I internal hemorrhoids without significant external hemorrhoidal tissue. She had a fistulous opening that was probed. It was superficial above the sphincter muscle. Fistulotomy was performed, opening this area with Bovie cautery. **46270**

8. Diagnosis: 36-year-old male with umbilical hernia. Procedure: umbilical hernia repair. There was a 1-cm umbilical hernia fascial defect. No incarceration was noted. An infraumbilical incision was made, and
the umbilical skin was elevated from the hernia sac, which was excised. The fascia was closed with interrupted sutures of 3-0 silk. **49585**

9. The patient has a recurrent femoral hernia that is strangulated this time. Ten years ago, the patient underwent repair. The physician performs this by making a 4-cm incision in the femoral area and inserting a PerFix mesh patch. **49557**.

**Rationale:** A HCPCS supply code for the mesh is not separately reported by the physician or the facility. The cost of the mesh is bundled into the facility’s APC payment.

**Checkpoint 21.2**

Assign the CPT and HCPCS code(s) if necessary for the following situations.

1. A 65-year-old is admitted for a screening colonoscopy. The patient had no symptoms but does have a family history of colon cancer. The physician finds diverticulosis on examination. Assign the procedure code. **G0105**
2. A patient had been experiencing chronic constipation, nausea and vomiting, and left lower quadrant abdominal pain. Upon testing, there was blood in the stool and upper GI x-ray showed sigmoid volvulus. A flexible sigmoidoscopy with decompression of the volvulus was carried out. **45337**
3. A 3-year-old boy is seen in the emergency department (ED) for suspected foreign body in the throat. His parents state that he was playing with his army action figure and put the figure in his mouth, swallowing the helmet. A flexible esophagoscope with foreign body removal is performed. **43215**
4. A 4-year-old is operated on for her second-stage operation for a bilateral cleft lip. Her first primary repair was performed at 1 year of age. **40720–50**
5. A patient is seen in follow-up for Barrett’s esophagus. A scope was passed into the esophagus under direct visualization to the gastroesophageal (GE) junction at 37 cm in the distal esophagus. Barrett’s was seen. Multiple biopsies were obtained. The scope was passed into the stomach, which appeared normal. The scope was then advanced into the duodenum, which was also normal. **43239**
6. A patient is seen for screening colonoscopy. The patient is complaining of hematochezia. A scope is inserted and two sessile polyps are located in the ascending colon, each measuring 2 mm in size. Biopsies were taken with cold biopsy forceps, essentially removing the polyps. One additional polyp was found in the transverse colon. This polyp measured 5 mm and was removed by hot snare. **45380, 45385–59**
7. A patient with rectal cancer was seen in follow-up for flexible sigmoidoscopy with submucosal tattooing (10 mL of India ink) of mid to upper rectal cancer. It was recommended to him that he undergo flexible sigmoidoscopy with tattooing of the cancer to facilitate proper identification and subsequent laparoscopic resection. The scope was passed proximal to the lesion into the distal sigmoid colon at approximately 25 cm and slowly withdrawn, where at 12 cm a sessile villous appearing lesion was located. Multiple photographs were taken. Ten milliliters of India ink were injected in three separate quadrants just distal to the lesion. The scope was withdrawn. **45335**
8. A patient underwent colonoscopy for chronic constipation. The patient was fully prepped for the study. A scope was inserted and advanced to the sigmoid colon. The prep was totally inadequate. The scope was unable to pass beyond the sigmoid due to obstruction with firm stool. **45378–53**

**Checkpoint 21.3**

Assign the CPT and HCPCS code(s) if necessary for the following situations.

1. A 37-year-old patient suffers from morbid obesity and, despite 10 years of various diets, his condition remains the same. He also suffers from hypertension, hypercholesterolemia, and diabetes. The surgeon has decided to perform a vertical banded gastroplasty. **43842**
2. A 40-year-old female patient presents with a body mass index of 48. She is hypertensive and diabetic. She has a history of dieting that has been unsuccessful. She is here today for laparoscopic adjustable gastric band and subcutaneous port placement. **43770**
3. The patient from Question 2 returns 1 year after placement of the adjustable gastric band. She has not had a good result from the procedure and has not felt well since its placement. She is here for removal of...
the device and port components. **43774**

**Answers to Review Questions**

**Matching**

Match the key terms with their definitions.

A. cholecystectomy  
B. esophagoscopy  
C. diagnostic  
D. incidental appendectomy  
E. colonoscopy  
F. bariatric surgery  
G. polyp  
H. snare  
I. volvulus  
J. cleft lip

1. **H** A wire loop with an electric current  
2. **J** A type of birth defect involving a separation of the lip  
3. **I** A twisting of the intestines  
4. **A** Surgical removal of the gallbladder  
5. **C** The type of endoscopy that is included in a surgical endoscopy  
6. **B** Placing a scope into the esophagus  
7. **D** May or may not be separately reportable from other intra-abdominal procedures  
8. **G** A tumor on a pedicle  
9. **F** A gastric restrictive procedure  
10. **E** Scope placement from the anus to the cecum

**True/False**

Decide whether each statement is true or false.

1. **F** EGD is the abbreviation for esophagogastroduodenoscopy.  
2. **F** With respect to polyps, biopsy and polypectomy are synonymous.  
3. **T** If an esophageal dilation using a Savary dilator was performed, the dilation was carried out using a guidewire.  
4. **F** If a screening colonoscopy is scheduled but during the procedure a polyp is found and removed, a code for the screening should still be submitted because this was why the case was originally scheduled.  
5. **T** To report a colonoscopy, the physician passes the scope beyond 50 cm of the large intestine.  
6. **F** An EGD with Maloney dilation is reported with 43235 and 43450.  
7. **T** An incidental appendectomy is coded separately when performed with other abdominal procedures on the digestive system.  
8. **T** Placement of an anal seton cannot be reported separately from other rectal procedures.  
9. **F** The use of hot biopsy forceps does not constitute ablation technique.  
10. **F** Medicare accepts either the diagnostic colonoscopy CPT code or the HCPCS code for screening colonoscopies.  
11. **T** Suture of diaphragm due to traumatic multiple stab wounds is assigned to 39501.  
12. **T** Inflammation of the bile ducts is referred to as cholangitis.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. A patient is seen for a screening colonoscopy. The patient is 75 years old and has a family history of colon cancer. During the colonoscopy, a polyp is discovered in the proximal sigmoid. The polyp is snared with cold biopsy forceps. Which code(s) should be reported?
A. 45385, G0105  
B. 45385  
C. 45338  
D. G0105  

**ANS: B**

2. Colonoscopy is performed in a 46-year-old patient. Biopsy was taken of the terminal ileum. A scope was withdrawn into the cecum and multiple biopsies were taken of several suspicious-looking areas. At the area of the hepatic flexure, a polyp was removed with snare technique. Which code(s) should be reported?  
A. 45385, 45380, 45385–59  
B. 45385, 45380–59  
C. 45385×2, 45380–59  
D. 45385, 45380×2  

**ANS: B**

3. A 53-year-old patient exhibits hernias of the left inguinal canal and of the umbilicus. The inguinal canal was repaired 5 years ago. At this episode, the physician uses mesh to repair the inguinal hernia. Both hernias are repaired laparoscopically under general anesthesia. Which codes should be reported?  
A. 49520, 49585  
B. 49650, 49659, 49568  
C. 49585, 49651–51  
D. 49651, 49652  

**ANS: D**

4. A 47-year-old patient complaining of persistent right upper quadrant nagging pain undergoes an ERCP with removal of stent and sphincterotomy. Which code(s) should be reported?  
A. 43260, 43262–51  
B. 43274  
C. 43275, 43262–51  
D. 43275, 43260–59  

**ANS: C**

5. A 56-year-old patient complaining of difficulty swallowing and persistent indigestion undergoes an endoscopy with biopsies and dilation of an esophageal stricture. The physician inserted the scope into the esophagus and at 20 cm noted esophagitis. The scope was advanced into the stomach and to the second portion of the duodenum. Biopsies were taken of the stomach and esophagus. A 20-mm balloon was used to dilate the esophagus. Which codes should be reported?  
A. 43249, 43239–59  
B. 43213, 43239–51  
C. 43202, 43220–51  
D. 43249, 43239–51  

**ANS: D**

6. A 47-year-old with a 10-year history of chronic alcoholism reported to the physician-owned endoscopy suite with abnormal liver function tests and vomiting blood. The physician performed an endoscopy with injection of esophageal varices. Once the endoscopy procedure was completed, under fluoroscopic guidance, a hollow-bore needle was inserted between the ribs on the patient’s right side and the liver was biopsied. Which codes should be reported?  
A. 43204, 47000, 77002  
B. 43243, 47001–51  
C. 43201, 47000  
D. 43204, 47000–51, 77003  

**ANS: A**

7. A patient had a right recurrent ventral hernia repaired with Marlex mesh. Which codes should be
8. A patient is seen in follow-up for polypectomy. A polyp was removed 1.5 years ago. She is scheduled for a colonoscopy. A scope was inserted and at about 38 cm a polyp was found. It was removed with a snare. Which code should be reported?

A. 45378
B. 45385
C. 45338
D. 45315

**ANS: B**

9. An elderly patient has a history of pancreatic cancer and now needs an ERCP procedure to place a biliary stent due to recurrent jaundice 4 months after a previous ERCP procedure. Which code(s) should be reported?

A. 43266
B. 43274
C. 43275
D. 43260, 43274–51

**ANS: B**

10. A 41-year-old female patient has been experiencing right flank pain radiating to the shoulder and irregular bowel movements. Ultrasound showed a 4+ gallbladder with two large stones. The patient undergoes a laparoscopic cholecystectomy with common bile duct exploration. Which code should be reported?

A. 47562
B. 47563
C. 47564
D. 47579

**ANS: C**

11. A patient presents with long-standing history of abdominal pain and now presents with acute rebound tenderness of the right lower quadrant. Exploratory laparotomy with appendectomy is performed. Which code(s) should be reported?

A. 49000, 44955
B. 49010, 44950
C. 44970
D. 44950

**ANS: D**

12. A 4-year-old boy presents with a bulge in the left inguinal area and an associated hydrocele on examination. The surgeon performs an open inguinal hernia repair with hydrocelectomy. Which code(s) should be reported?

A. 49505, 55500
B. 49520, 55000
C. 49495
D. 49500

**ANS: D**

13. This 4-year-old swallowed a small toy that got stuck in her throat. A flexible esophagoscopy was performed to remove the toy. Which code should be reported?

A. 43200
14. Assign the appropriate code(s) for EGD with biopsies of the stomach and duodenum and injection of implant material into the muscle of the lower esophageal sphincter. Which code(s) should be reported?
A. 43235, 43239
B. 43239, 43236
C. 43239, 11900
D. 43239
ANS: D

15. A 40-year-old male has had severe GERD for almost a year. After a previous endoscopy of the esophagus and a barium swallow, the physician determines that he will perform a laparoscopic Nissen procedure. Code for the Nissen procedure. Which code(s) should be reported?
A. 43280
B. 43328
C. 43327
D. 43279, 43280–51
ANS: A

16. A 48-year-old man went to the ED complaining of vomiting coffee-ground material several times within the past hour. He had abdominal pain and had been unable to eat for the past 24 hours. He was dizzy and light-headed. His stools today have been black and tarry. While in the ED he vomited bright red blood and some coffee-ground material. After evaluating the patient, a consult was requested. The GI physician took the patient to the endoscopy suite and performed an upper GI endoscopy for diagnostic purposes. Which code(s) should be reported?
A. 99255–57, 43235
B. 43235
C. 43200, 43235
D. 43243
ANS: B

17. An endoscope was inserted into the esophagus, and the stomach was entered. The pyloric channel was traversed, showing a pyloric stenosis. The endoscopy was then introduced into the second portion of the duodenum, which showed normal mucosa. A 15-mm balloon was placed across the stenosis and dilated and then withdrawn. Which code should be reported?
A. 43205
B. 42400
C. 43204
D. 43245
ANS: D

18. A diagnostic colonoscopy and a diagnostic EGD are performed on the same patient by the same physician on the same day but not during the same session. Code for both procedures.
A. 45378, 43235–59
B. 45378, 43235–51
C. 45530, 43200–51
D. 45530, 43200–59
ANS: B

19. A child’s gestational age at birth was 34 weeks. Fourteen weeks later she had an initial inguinal hernia repair done. Which code should be reported?
A. 49491
B. 49491–63
C. 49495
D. 49495–63

**ANS: A**

20. A patient with Crohn’s disease has been on drug therapy to treat the condition. She is now seen for extreme pain. An x-ray is taken, showing small-bowel obstruction. The patient is taken immediately to surgery and a partial colectomy is performed with an end-to-end anastomosis. Which code(s) should be reported?
A. 44020, 44120–51
B. 44020
C. 44120
D. 44120, 45136

**ANS: C**
CHAPTER 22: CPT: URINARY SYSTEM

Answers to Checkpoint Questions

Checkpoint 22.1
Answer the following questions.
1. What are the six major anatomical sites associated with the urinary system? **Two kidneys, two ureters, one bladder, one urethra**
2. What are the minor related procedures included in cystourethroscopy for the female urethral syndrome? **Internal urethrotomy and bladder neck fulguration**
3. What is the code for a complex cystometrogram with urethral pressure profile studies? **51727**

Checkpoint 22.2
Answer the following questions.
1. Which part of the urinary system is particularly susceptible to structuring as a result of infection, trauma, or previous surgery? **Urethra**
2. Code for the complicated removal of a ureteral stent via cystourethroscopy. **52315**
3. Which code represents the most common retropubic suspension procedure for supporting the bladder neck (also known as the Burch procedure)? **51840**

Checkpoint 22.3
Assign codes to the following procedures. Include any necessary modifiers. In some cases, more than one code is required.
1. EMG studies of urethral sphincter. **51784**
2. Cystourethroscopy with double J stent. **52332**
3. Simple bladder irrigation. **51700**
4. Renal endoscopy through nephrotomy, right. **50570–RT**
5. Patient was placed on his right side on a water cushion and shock waves were used to crush a right renal calculus. **50590–RT**
6. The Surgeon performed a cystoscopy with biopsy of the trigone and dilation of ureteral stricture. **52204**
7. A urologist needs to examine both ureters and the bladder. She inserts a scope into the ureter(s), making an incision in the opening of the ureters to the bladder (meatotomy), and completes the examination. **52290**
8. Repair hypospadias second stage, greater than 3-cm diversion. **54312**

Answers to Review Questions

Matching
Match the key terms with their definitions.

- **A. litholapaxy**
- **B. cystourethroscopy**
- **C. cortex**
- **D. extracorporeal shock wave lithotripsy**
- **E. urodynamics**
- **F. incontinence**
- **G. bladder neck**
- **H. calculus**
- **I. stricture**
- **J. stent**

1. **A** The crushing of a calculus located in the bladder
2. **G** Where the bladder narrows to connect to the urethra
3. **H** Stones that form in the urinary tract
4. **B** Endoscopic procedure where the scope is inserted into the urethra and the bladder, ureters, and kidney
5. **J** Used to keep the ureter open for the passage of urine
6. **E** The assessment of bladder function
7. **D** A method of treatment for kidney stones (nonoperative)
8. **C** Outermost layer of the kidney
9. **I** Functional blockage urine
10. **F** Loss of bladder control

**True/False**

Decide whether each statement is true or false.
1. **F** Lithotripsy is assigned to 50590 regardless of where the stones are located or the approach.
2. **T** The fact that a patient has had prior surgery on the bladder with scarring present would justify choosing a complicated removal of ureteral stent code (52315).
3. **T** Cyst and vesic are both prefixes for the bladder.
4. **F** Urethral calibration can be reported separately from transurethral resection of the prostate.
5. **F** The placement of an indwelling ureteral stent is included in cystourethroscopy.
6. **T** Nephrolithotomy represents the services of removing a stone from the kidney.
7. **F** Hematuria is a urinary tract infection.
8. **F** The backbench work during a kidney transplant includes cold preservation.
9. **F** TURP is the acronym for transurinary resection of prostate.
10. **F** The code range for a laparoscopic nephrectomy is 50220–50240.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. Contrast is instilled and a voiding urethrocystography is conducted in the outpatient department. Which code should be reported?
   A. 51610  
   B. 51600  
   C. 51728  
   D. 74430  
   **ANS:** B

2. A 29-year-old female with interstitial cystitis, frequency, and urethral itch diagnosed with urethral syndrome undergoes cystoscopy with urethral dilation, urethral meatotomy, and hydrodistention of the bladder under general anesthesia. Which code(s) should be reported?
   A. 52260  
   B. 52260, 52285  
   C. 52270, 52260, 52281  
   D. 52281, 52260  
   **ANS:** B

3. The urologist performed a cystourethroscopy to remove two bladder tumors by fulguration. The tumors measured 1.7 cm each. Which code should be reported?
   A. 52234  
   B. 52234–50  
   C. 52234x2  
   D. 52234–22  
   **ANS:** A

4. The surgeon performed a nephrolithotomy and removed a large staghorn calculus. Which code should be reported?
   A. 50060  
   B. 50070  
   C. 50065  
   D. 50075
ANS: D
5. The urologist performed a cystectomy with urinary diversion by connecting the ureters to a ureteroileal conduit on a patient diagnosed with malignant neoplasm of the bladder. Which code should be reported?
A. 51595
B. 51580
C. 51590
D. 51565
ANS: C
6. A physician dilates a male patient’s urethra under local anesthesia using a urethral dilator. This is the initial session for this patient. Which code should be reported?
A. 53600
B. 53660
C. 53605
D. 53620
ANS: A
7. A male patient with urinary retention, urinary stenosis, and vesical neck stenosis. The urologist performs a meaotomy, urethral dilation, and TURP. Which code(s) should be reported?
A. 52500, 53605–51
B. 52601, 52501–51
C. 52500, 52601
D. 52601
ANS: D
8. A patient presents with vesicouterine fistula and the urologist performs a closure of the fistula. Which code should be reported?
A. 51920
B. 51900
C. 51925
D. 51900–50
ANS: A
9. The urologist performs a cystourethroscopy with removal of ureteral calculus and insertion of an indwelling right ureteral stent. Which code(s) should be reported?
A. 52332
B. 52320
C. 52320, 52332–59
D. 52320, 52332–51
ANS: D
10. A donor kidney is available to a patient who has been on dialysis for 3 years. His sister has agreed to donate a kidney to her brother. The transplant team is sent to the donor’s hospital to retrieve the kidney. They transport it to the recipient patient’s hospital where backbench work is provided and the kidney is transplanted into the recipient. The recipient’s own kidney was removed several years ago. Provide the codes that represent this set of services.
A. 50320, 50325, 50360
B. 50320, 50323, 50365
C. 50300, 50325, 50365
D. 50300, 50323, 50360
ANS: A
CHAPTER 23: CPT: MALE GENITAL SYSTEM

Answers to Checkpoint Questions

Checkpoint 23.1
Assign codes to the following procedures. Include any necessary modifiers. In some cases, more than one code is required.
1. Spermatocele excision 54840
2. Simple electrodesiccation of four lesions on penis 54050
3. Bilateral vasectomy 55250
4. Incision and drainage (I&D), abscess of epididymis 54700
5. Removal of foreign body, scrotum 55120
6. A patient presents with symptoms of deformity of his penis and painful erection. The physician diagnosed Peyronie’s disease and performed an injection and then excision of penile plaque. 54110
7. A couple is trying to conceive, and they decide to have a testicular biopsy to extract sperm from the tubules of the epididymis to be artificially inseminated into the wife. The epididymis is isolated through a 0.5-inch incision made in the scrotal skin. An operating microscope is used to open a dilated tubule, and the fluid is collected. All of the sperm-containing fluid is collected and sent to the lab for processing. 54505
8. A 2-year-old boy has had a hydrocele on the left that seems to come and go. The patient’s mother requests a hydrocelectomy. A small incision is made in the skin fold of the groin. The hydrocele “sac” is identified. The surgeon empties the fluid from the sac. The sac is removed. 55040–LT
9. A 39-year-old patient noticed a lump in his right testicle. The surgeon recommended removal, because 95% of testicular masses are malignant. A 4-inch incision was made along the “bikini line” through the lower abdomen on the right side. The surgeon pushed the testicle up through the pelvic region and removed it. 54530–RT

Checkpoint 23.2
Assign codes to the following procedures. Include any necessary modifiers.
1. Completion (second stage) of transurethral electrosurgical prostate resection during global period of first stage of resection 52601–58
2. A patient had suffered from frequent urination, pressure, and pain in the bladder. Upon examination, the physician found a prostate mass. Due to the size and specific location of the mass, an incisional biopsy of the prostate was performed to determine if the mass was benign or malignant. 55705
3. A 70-year-old patient was seen for chronic urinary urgency. The urologist’s examination revealed an enlarged prostate that was most likely the cause of the problem. Testing determined that the patient did not have prostate cancer, and drug therapy was prescribed initially. The patient’s problem was not alleviated and surgery was recommended. The urologist performed an electrosurgical resection of the prostate using a transurethral approach and internal urethrotomy. 52601
4. Discontinued contact laser vaporization of prostate 52648–53
5. Incisional biopsy of testis followed by radical orchiectomy for tumor, inguinal approach 54530
6. Radical perineal prostatectomy 55810

Answers to Review Questions

Matching
Match the key terms with their definitions.
A. orchiectomy
B. PSA
C. hydrocele
D. spermatocele
E. BPH
F. PIN
G. undescended testicle
H. TUNA
I. torsion
J. TUMT

1. **I** Twisting of the spermatic cord
2. **J** Uses microwave thermotherapy to destroy prostate tissue
3. **E** Benign prostatic hyperplasia
4. **H** Uses radio frequency to destroy prostate tissue
5. **B** Prostate-specific antigen
6. **F** Dysplasia of prostate
7. **G** Congenital condition where the testis is not in the correct anatomical location
8. **A** Surgical removal of part of or the entire testis
9. **C** Fluid collection in the scrotum around the testicle
10. **D** Cystic accumulation of fluid that usually contains dead sperm arising from the epididymis

**True/False**

Decide whether each statement is true or false.

1. **T** Simple left orchietomy with insertion of prosthesis using scrotal approach is coded as 54520–LT.
2. **T** The prostate gland completely encircles the male urethra.
3. **F** Circumcision involves removal of the glans penis.
4. **F** A retropubic radical prostatectomy is coded as 55831.
5. **F** Transurethral microwave treatment performed in the office is assigned code 53850.
6. **F** Dorsal slit is the simplest circumcision technique.
7. **T** Torsion is the twisting of the spermatic cord.
8. **F** Chordee is the unnatural curvature of the penis upward.
9. **F** Orchiopexy is the repair of testicular rupture.
10. **F** Peyronie’s disease is a hereditary disease of the penis.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. A 15-year-old male with inadequate circumcision undergoes surgical circumcision. Which code should be reported?
   A. 54150
   B. 54160
   C. 54162
   D. 54163
   **ANS: D**

2. A patient has a bilateral vasovasostomy reversal with operating microscope. Which code(s) should be reported?
   A. 55400–50, 69990–51
   B. 55400–50, 69990
   C. 55400, 69990
   D. 55400
   **ANS: B**

3. A sexually active male patient presents with numerous condyloma on the base and shaft of the penis varying in size and shape. Laser destruction of the numerous lesions was performed under general
anesthesia. Which code(s) should be reported?
A. 54057  
B. 54065  
C. 17000, 17003  
D. 54110  
**ANS: B**

4. A patient is seen for transrectal ultrasonic guided prostate biopsy. Two biopsies were taken from each side. Which code should be reported?
A. 55700×4  
B. 55705  
C. 52450  
D. 55700  
**ANS: D**

5. The__________ is a tunnel-like structure where the nerves and vessels travel from the abdomen to the scrotum.
A. Spermatic cord  
B. Epididymis  
C. Tunica vaginalis  
D. Seminal vesicle  
**ANS: A**

6. A physician injected the penis on the dorsal side to break up scarring that was causing painful erection. Which code should be reported?
A. 54235  
B. 54231  
C. 54230  
D. 54200  
**ANS: D**

7. A urologist performs three needle biopsies of the prostate gland using ultrasonic guidance in the hospital. Which code(s) should be reported?
A. 55700×3  
B. 55700×3, 76942  
C. 55700, 76942–26  
D. 55700, 76942–51  
**ANS: C**

8. A urologist performs a meatotomy, urethral dilation, and TURP on a male patient with urinary retention, urethral stenosis, and vesical neck stenosis. Which code(s) should be reported?
A. 52500, 53605–51  
B. 52601, 52500–51  
C. 52500, 52601  
D. 52601  
**ANS: D**

9. A physician dilates the urethra, which passes through the prostate, using a urethral dilator under general anesthesia. Which code should be reported?
A. 53600  
B. 53660  
C. 53605  
D. 52344  
**ANS: C**

10. A patient was born with distal hypospadias and has had two prior surgeries to correct the abnormality.
The patient now presents with urethral fistula and urethral diverticulum, both of which are complications of his previous hypospadias condition. During the repair procedure, the urethra was explored and found to be dilated and required tapering. A long urethral plate was ready for tubularization. The proximal urethral plate was at the urethra and was tapered proximal to the fistula. Unroofing the distal urethra and incision on either side of the urethra distally formed the distal urethral plate. Excess shaft skin was trimmed off in order to have sufficient skin to wrap around the penis. Which code(s) should be reported?

A. 54344
B. 54304–80
C. 54344–62
D. 54304–50

ANS: A
CHAPTER 24: CPT: FEMALE GENITAL SYSTEM AND MATERNITY CARE AND DELIVERY

Answers to Checkpoint Questions

Checkpoint 24.1
Assign code(s) to the following procedure. Include any necessary modifiers.
1. A 29-year-old female is being treated for CIN II. A speculum is inserted into the cervix. The surgeon bathes the cervix with Monsel’s solution. A laser is used to cut around the opening in the cervix and remove a cone-shaped piece of tissue. 57520

Checkpoint 24.2
Assign code(s) to the following procedure. Include any necessary modifiers.
1. A 45-year-old patient presents with three vulvar lesions that were previously biopsied and pathology testing has determined they were condyloma. The lesions were removed by laser ablation with no complicating factors. 56501

Checkpoint 24.3
Assign code(s) to the following procedure. Include any necessary modifiers.
1. The physician performed a radical, partial vulvectomy. Provide the code and a definition of radical and partial in terms of vulvectomy procedures. 56630.
   *Rationale: A radical procedure removes skin and deep subcutaneous tissue. A partial procedure removes less than 80% of the vulvar area.*

Checkpoint 24.4
Assign code(s) to the following procedure. Include any necessary modifiers.
1. The patient presented with three intramural myomas weighing 210 grams. The surgeon performed a myomectomy via abdominal approach. 58140

Checkpoint 24.5
Assign code(s) to the following procedure. Include any necessary modifiers.
1. Code for a total abdominal hysterectomy without removal of tubes and ovaries. 58150

Checkpoint 24.6
Assign code(s) to the following procedure. Include any necessary modifiers.
1. Cesarean delivery, including postpartum care, and total hysterectomy following attempted vaginal delivery; patient had previous cesarean delivery. 59618, +59525

Checkpoint 24.7
Assign code(s) to the following procedure. Include any necessary modifiers.
1. Spontaneous incomplete miscarriage surgically completed in first trimester. 59812

Checkpoint 24.8
Assign codes to the following procedures. Include any necessary modifiers. In some cases, more than one code is required.
1. Laser destruction of vaginal lesions (extensive). 57065
2. Laparoscopically assisted vaginal hysterectomy (uterus less than 250 grams). 58550
3. Routine obstetrical care plus vaginal delivery after previous cesarean delivery. 59610
4. An elderly woman without any prior history of cancer is diagnosed with an extensive malignant vaginal cancer, requiring vaginectomy and complete removal of the vaginal wall. 57110
5. An obstetrician has been seeing this patient starting with her first visit to determine that she is pregnant.
She recently performed the vaginal delivery, and the patient is now being seen in the office for her last postpartum visit. How will the obstetrician code for her services? 59400

6. A patient has a hysterotomy to remove a hydatidiform mole as well as tubal ligation during the same surgical session. 59100, +58611

7. A patient is pregnant with her fourth child and is having contractions that are rapidly coming closer together. She and her husband leave for the hospital, but the baby is born in the car before reaching the hospital. Once the baby is secured by emergency medical technicians, the patient is admitted and her physician delivers the placenta. 59414

**Answers for Review Questions**

**Matching**

Match the key terms with their definitions.

- A. antepartum
- B. blighted ovum
- C. colpocleisis
- D. colpopexy
- E. hydrosalpinx
- F. hysteroscopy
- G. pessary
- H. LMP
- I. menometrorrhagia
- J. endometriosis

1. **H** Last menstrual period
2. **A** Time period between onset of pregnancy and delivery
3. **G** A synthetic or rubber device intended to take up space within the vagina
4. **D** Suture repair of prolapsed vagina
5. **E** Fallopian tube fills with fluid as a result of adhesions
6. **F** The use of a scope that is inserted through the cervix into the uterus, to visualize the uterine cavity
7. **J** Tissue lining of uterus found elsewhere
8. **C** Procedure performed to correct vaginal prolapse
9. **B** A fertilized egg that fails to develop
10. **I** Excessive uterine bleeding during monthly menstrual cycles and at other irregular intervals

**True/False**

Decide whether each statement is true or false.

1. **F** The inner lining of the uterus is called the ectometrium.
2. **F** A pelvic examination performed in conjunction with a gynecological surgery is coded in addition to the surgery.
3. **T** If a physician only sees a pregnant patient for one to three antepartum visits, E/M codes should be assigned instead of a maternity care code.
4. **T** Antepartum care begins with conception and ends at delivery.
5. **T** The maternity package may be broken up when necessary to capture services of multiple providers.
6. **T** Abortions can be initiated by inserting vaginal suppositories.
7. **F** CPT code 59510 is assigned twice in the case of twin delivery.
8. **F** Cryosurgery on nine vaginal warts is assigned 57061.
9. **F** When reporting maternity care services, codes are assigned for antepartum, delivery, and postpartum services in order to capture all components of the maternity package.
10. **F** Complete level ultrasound is considered part of the global maternity package and is not reimbursed separately.
11. **T** The —50 modifier is appended to code 58672.
12. **T** A couple suffers from infertility and the physician utilizes electroejaculation to secure a sperm sample from the male to inseminate his partner. Sperm was injected into the cervix after washing. Codes submitted would be 58321, 58323.

**Multiple Choice**

Select the letter that best completes the statement or answers the question.

1. A LEEP procedure is
   A. A vaginal conization technique
   B. A method of performing cervical conization
   C. A method of removing endometrial polyps
   D. A type of cauterization

   **ANS:** B

2. If a single area is biopsied and excised
   A. Only code the biopsy
   B. Code the biopsy and the excision
   C. Only code the excision
   D. Assign the excision code with a —22 modifier

   **ANS:** C

3. A missed AB refers to
   A. A miscarriage
   B. An incomplete abortion
   C. A missed appointment
   D. Failure to expel a dead fetus

   **ANS:** A

4. The physician performs an exploratory laparoscopy with bilateral salpingo-oophorectomy. What is the correct code assignment?
   A. 58661
   B. 49000, 58661
   C. 49000, 58720
   D. 58720

   **ANS:** A

5. What is the correct CPT code assignment for hysteroscopy with lysis of intrauterine adhesions?
   A. 58555, 58559
   B. 58559, 58740
   C. 58559
   D. 58555, 58559, 58740

   **ANS:** C

6. What is the correct code assignment for version or breech presentation, successfully converted to cephalic presentation with normal spontaneous delivery?
   A. 59400
   B. 59612, 59412
   C. 59409
   D. 59409, 59412

   **ANS:** D

7. A woman is rushed to the hospital by a friend. While en route, she delivers in the vehicle. The husband cut the cord before arrival at the hospital, leaving the emergency department (ED) physician to deliver the placenta in the ED. What is the correct code assignment?
   A. 59409
   B. 59430
   C. 59414
D. 59899

**ANS: C**

8. The OB who provided Lilly’s obstetrical care performed a C-section and ligation of the fallopian tubes at the time of delivery. She also saw Lilly for her 6-week postpartum visit. What is the correct code assignment?
   A. 59515, 58671
   B. 58670, 59510
   C. 59510, 58611
   D. 59510, 59525

   **ANS: C**

9. A perimenopausal patient undergoes a colposcopy with an endometrial biopsy in the office. What is the correct code assignment?
   A. 58100
   B. 57456
   C. 57421
   D. 57420, 58110

   **ANS: D**

10. Routine obstetrical care is provided by Dr. Hugh with subsequent C-section delivery. The patient elected to change physicians and goes to Dr. May in another practice for her post-op follow-up. What code(s) will Dr. Hugh report to the insurance carrier?
    A. 59400
    B. 59426, 59514
    C. 59510
    D. 59514

    **ANS: B**
CHAPTER 25: CPT: ENDOCRINE AND NERVOUS SYSTEMS

Answers to Checkpoint Questions

Checkpoint 25.1
Assign codes to the following procedures. Include any necessary modifiers. In some cases, more than one code is required.

1. A 63-year-old female patient fell 2 weeks ago and struck her head on a coffee table. She did not lose consciousness but has had headaches and some dizziness. A CT scan showed a subdural hematoma. A burr hole was placed and the hematoma was evacuated. 61154
   
   *Rationale: The beginning of the nervous system CPT section has the codes for burr hole procedures. Alternatively, find “burr hole, for drainage, hematoma” in the index and review codes 61154, 61156. Code 61156 is incorrect because it is for aspiration of hematoma, not evacuation of hematoma.*

2. A patient has a primary neoplasm in the ethmoid sinus and, due to the many risks associated with this surgery, the craniofacial extradural approach without maxillectomy including lateral rhinotomy will be performed by an otolaryngologist. The definitive procedure, an intradural excision including dural repair of the neoplasm at the base of the anterior cranial fossa, will be performed by a neurosurgeon. 61580, 61601
   
   *Rationale: This exercise is an example of skull base surgery. To answer correctly, you must define the approach procedure and the definitive procedure. Go to the Skull Base Surgery section of the nervous system and review the guidelines. You have to be able to find the location of the neoplasm to find the correct approach. In the exercise, the neoplasm is at the base of the anterior cranial fossa; that code range is 61580–61586. The approach is specifically craniofacial, which narrows the code range to 61580–61583. Code 61580 is the correct approach. For the definitive procedure, the code range is 61600 or 61601. Code 61601 is correct because it is the intradural procedure.*

3. A coder is attempting to provide the correct code for an endovascular temporary balloon occlusion of an intracranial artery. The surgeon has indicated that the procedure code for the surgery is 61623 and has asked the coder to add a code for the selective catheterization and the RSI for the angiography. The coder is hesitant to do this based on the CPT code description. Is the coder correct? **Yes, code 61623 includes selective catheterization of the vessel to be occluded.**

4. Due to an aneurysm in the carotid artery, the surgeon performed intracranial and cervical occlusion of the carotid. 61705
   

5. A 3.5-cm cranial lesion was treated with stereotactic radiosurgery (gamma ray). Report the code(s) for the neurosurgeon. 61798
   
   *Rationale: Find “radiosurgery, brain, lesion” in the index and review code range 61796–61800 and the guidelines. A 3.5-cm cranial lesion is considered a complex lesion.*

Checkpoint 25.2
Assign codes to the following procedures. Include any necessary modifiers. In some cases, more than one code is required.

1. A patient experiences chronic unilateral muscle spasms of the face. The patient is injected with Botox type A, 1 unit. 64612, J0585
   
   *Rationale: The injection of a neurolytic agent (Botox) is considered chemodenervation. Find “chemodenervation, facial muscle” in the index and review codes 64612, 64615 for the correct code. When you study the HCPCS chapter, you will find code J0585 is the correct code for the supply of Botox.*

2. A patient suffers from intractable hiccups due to his advanced lung cancer. The physician performs a
A patient with cerebral palsy has received many treatments for spasticity with no significant relief. A patient is being followed for suspected multiple sclerosis. The patient has long-standing chronic back pain. Conservative measures only provide limited relief. The neurosurgeon feels that neurostimulator insertion for long-term therapy is a viable option. The patient is placed in the prone position and a laminotomy midline incision is made overlying the affected vertebrae. The surgeon places the inductive electrode pads in the epidural space proximal to the dura. The tubing was connected to the pump and anchored with sutures. The pump was placed into a pocket in the right lower quadrant of the abdomen 1 inch below the skin. Five milliliters of 0.5% bupivacaine were injected. 64410  
Rationale: Find “phrenic nerve, injection, anesthetic” in the index.
3. A patient lacerates her finger on a windowsill. She follows up with her doctor and is found to have numbness in the right index finger. She is referred to a surgeon, and neuroplasty of the finger is performed. 64702–F6  
Rationale: Find “neuroplasty, digital nerve” in the index and review codes 64702, 64704. Code 64702 is correct, because the neuroplasty is performed on a nerve in the digit itself, not in the hand. Modifier –F6 identifies the right hand, second digit.
4. A patient has carpal tunnel syndrome and undergoes left carpal tunnel release and left ulnar nerve decompression. 64721–LT, 64719–LT–51  
Rationale: Neuroplasty is also nerve decompression; find “neuroplasty, peripheral nerve, median at carpal tunnel” and also “neuroplasty, peripheral nerve, ulnar at wrist” in the index.
5. An anesthesiologist performs a bilateral femoral nerve block. Check the physician fee schedule to determine if this code is reportable as a bilateral code (see www.cms.hhs.gov/pfslookup). Choose Medicare Physician Fee Schedule Look-Up Tool, Start Search, and then select Payment Policy Indicators. Enter the code for femoral nerve block. Can this code be reported with a –50 modifier? 64447  
Rationale: Yes, find “femoral nerve, injection, anesthetic” and review codes 64447–64448. Do not select code 64448, because it represents a continuous infusion, not an injection. Once you have done the look-up for code 64447, you will see that the modifier indicator equals one that allows the use of the modifier –50.

Assign codes to the following procedures. Include any necessary modifiers.
1. A patient has long-standing chronic back pain. Conservative measures only provide limited relief. The neurosurgeon feels that neurostimulator insertion for long-term therapy is a viable option. The patient is placed in the prone position and a laminotomy midline incision is made overlying the affected vertebrae. The surgeon places the inductive electrode pads in the epidural space proximal to the damaged spinal segment. The pulse generator is sutured over the muscles and the skin is closed. 63655, 63685–51  
Rationale: This is a neurostimulator coding exercise via laminectomy. Find “laminectomy, for implantation of electrodes.” Next, find “insertion, pulse generator, spinal cord” and review 63685.
2. A patient is being followed for suspected multiple sclerosis. A diagnostic lumbar puncture is performed. 62270  
Rationale: If you look up “lumbar puncture” in the index, it refers you to “spinal tap, lumbar.”
3. A patient with cerebral palsy has received many treatments for spasticity with no significant relief. He agrees to proceed with implantation of a nonprogrammable baclofen spinal cord pump. The patient’s back was prepped and the incision was made in the skin at the L3–L4 level. A catheter was inserted into the subarachnoid space. The catheter tubing was then anchored to the fascia with 2-0 silk. A second incision was made in the right lower quadrant of the abdomen 1 inch below the skin. The pump was placed into this pocket. The tubing was connected to the pump and anchored with sutures. 62361, 62350–51  
Rationale: In this exercise, the procedure to code is the placement of the pump and the catheter. 
Searching the CPT index is not straightforward, because using “implantation” as the search term does not work. Find "infusion pump, spinal cord" in the index and review code 62361 for the pump placement. For the catheter placement, find "catheter, spinal cord” in the index and review codes 62350, 62351. Code 62351 is incorrect because it requires a laminectomy, which is not in the exercise.
4. A 6-month-old infant is brought to the emergency department. It is determined that she is suffering from hydrocephalus secondary to subarachnoid hemorrhage associated with shaken baby syndrome. A VP shunt was placed to drain the fluid from her brain. 62223  
Rationale: Find “shunt, brain, creation” in the index and review codes 62180–62223.
Checkpoint 25.4

Assign codes to the following procedures. Include any necessary modifiers.

1. The neurosurgeon performed a laminotomy with partial facetectomy and excision of a herniated disc for C3–C4 and C5–C6. **63020, 63035**
   
   *Rationale:* You will not find laminotomy in the index; use the term “hemilaminectomy” and review codes 63020–63044. Code 63020 includes the disc excision but represents only one cervical interspace. C3–C4 is one interspace; C5–C6 is a second interspace. You will need the add-on code 63035 for the additional interspace.

2. A vertebral corpectomy procedure with decompression of the cauda equine was performed on three segments, using a thoracolumbar approach. **63087, 63088**
   
   *Rationale:* Searching for “corpectomy, vertebral” will not work; find “decompression, cauda equine” and then review the code ranges given. The other code ranges offered are incorrect, because they are for laminectomy or laminotomy, not vertebral corpectomy.

3. Code for a laminectomy with facetectomy and foraminotomy, bilateral, with decompression of the spinal cord, two thoracic segments. **63046, 63048**
   
   *Rationale:* Find “laminectomy, for decompression, thoracic” and review the code ranges. Codes 63003, 63016 are incorrect because they specify “without laminectomy, etc.” Category III code 0274T is incorrect because it is a percutaneous procedure.

   
   *Rationale:* Find hemilaminectomy and review codes 63020–63044.

Answers to Review Questions

**Matching**

Match the key terms with their definitions.

| A. meninges          | F. islet cells of pancreas            |
| B. neurorrhaphy      | G. nerve block                        |
| C. plexus            | H. skull base surgery                 |
| D. cerebrum          | I. rhizotomy                          |
| E. corpectomy        | J. discectomy                         |

1. **E** Partial or complete removal of solid round portion of the vertebra
2. **B** Suture of the nerve
3. **J** Procedure performed to decompress spinal cord
4. **C** A network of nerves
5. **D** The largest portion of the brain
6. **A** Lining of the brain and spinal cord
7. **H** Procedure performed on an area between the brain and the floor of the skull
8. **G** Procedure performed for pain control
9. **I** Radio-frequency ablation technique
10. **F** A gland within the endocrine system

**True/False**

Decide whether each statement is true or false.

1. **T** The neurostimulator insertion/removal codes 63661–63664 do not include evaluative testing, programming, or reprogramming.
2. **T** Destruction of the trigeminal nerve with iced saline is coded as 64600.
3. **T** Secretion of hormones is a function of the endocrine system.
4. **F** Nerve blocks can be performed by a single injection and continuous infusion of analgesic and are
both administered for short-term pain control by inserting a catheter.
5. F When reporting 62290 at the same session as 62291, a –59 modifier is necessary to prevent bundling.
6. F Skull base surgery always requires the services of two or three surgeons.
7. F Never report codes from the musculoskeletal and nervous systems together.
8. F The meninges consist of the dura mater, the subarachnoid, and the pia mater.
9. T Nerve grafts, nerve wrapping, and suture repair are all part of the nerve repair services.
10. F Discectomy is always included in the laminectomy procedures.

Multiple Choice
Select the letter that best completes the statement or answers the question.
1. A patient is status post inguinal hernia repair and is having chronic pain into the groin. The surgeon suspects nerve entrapment. The patient is referred for an ilioinguinal nerve block. Which code(s) should be reported?
   A. 64421
   B. 49505, 64425
   C. 64450
   D. 64425
   **ANS: D**
2. Which of the following is not true about lumbar puncture?
   A. Contrast material is used during the fluoroscopy.
   B. It is used as a diagnostic test.
   C. Fluid is removed from between two vertebrae.
   D. It may have side effects.
   **ANS: A**
3. A patient presented with nerve compression of the left hand secondary to entrapment of the nerve in scar tissue from previous hand surgery. Decompressive neuroplasty was performed with external neurolysis. Which code should be reported?
   A. 64722–LT
   B. 64704–LT
   C. 64702–LT
   D. 64834–LT
   **ANS: B**
4. A patient is seen for total removal of implanted spinal neurostimulator pulse generator. Which code should be reported?
   A. 63661
   B. 63746
   C. 63685
   D. 63688
   **ANS: D**
5. A patient suffers from pseudotumor cerebri and undergoes a lumbar puncture to reduce the CSF pressure. Which code should be reported?
   A. 62287
   B. 62272
   C. 62270
   D. 62273
   **ANS: B**
6. A patient suffers from muscle spasms of the face. Chemodenervation is provided via injection of Botox type A, 1 unit. Provide the CPT code for the injection and the HCPCS code for the drug.
   A. 64612, J0585
   B. 64616, J0587
   C. 20552, J0585
D. 64612, J0587

ANS: A

7. A patient is being treated for cervical radiculopathy. The physician performs a left greater occipital nerve root block. Which code should be reported?
   A. 64415
   B. 64405
   C. 64450
   D. 64418

   ANS: B

8. Vertebral corpectomy was performed via a thoracolumbar approach to levels T12, L1, and L2 with discectomy. Which code(s) should be reported?
   A. 63087x2
   B. 63087, 63088x2
   C. 63081, 63082
   D. 63081, 63077–51

   ANS: B

9. A patient has a malignant neoplasm of the brainstem. An otolaryngologist performs the approach via a transtemporal posterior cranial fossa and decompression of the sigmoid sinus. The neurosurgeon then excises the neoplastic lesion, extradural, from the brainstem. The neurosurgeon closes the operative field. Which codes should be reported?
   Otolaryngologist       Neurosurgeon
   A. 61590, 61605 61605–62
   B. 61590 61605
   C. 61595 61615
   D. 61595, 61615 61615–62

   ANS: C

10. A patient is suffering from an intracranial hemorrhage resulting from an intracranial aneurysm in the right carotid artery. Emergent microdissection of the aneurysm is performed via an intracranial approach. Which code(s) should be reported?
    A. 61700, 69990
    B. 61700
    C. 61697
    D. 61697, 69990

   ANS: A

11. The regions of the spine are
    A. Sacral, lumbar, brachial, pia
    B. Sacral, cervical, lumbar, thoracic
    C. Pia, arachnoid, vertebral, lumbar
    D. Lumbar, cervical, pia, thoracic

   ANS: B

12. A patient is diagnosed with spondylolisthesis, lumbosacral, without myelopathy. The surgeon performs a bilateral laminotomy via posterior approach. The nerve roots are decompressed, and a partial facetectomy is performed for interspace L4–L5. Which code should be reported?
    A. 63040
    B. 63040–50
    C. 63030–50
    D. 63030

   ANS: C
CHAPTER 26: CPT: EYE AND EAR

Answers to Checkpoint Questions

Checkpoint 26.1
Assign the CPT code(s) to the following procedure.
1. The physician performed an extracapsular cataract removal by phacoemulsification, with insertion of an IOL prosthesis. This was a complex procedure due to the density of the cataract. The patient had undergone prior intraocular surgery 6 months ago. 66982

Checkpoint 26.2
Assign CPT code(s) to the following procedures. Some scenarios also require HCPCS code assignment.
1. A Medicare patient is status post cataract extraction 5 years ago. He is seen today for insertion of a replacement Alcon SN60WS intraocular lens, right eye, with ophthalmic endoscope. 66986–RT, 66990
   Rationale: Q1003 is used instead of HCPCS A2632 because it is listed as a new technology lens.
2. A patient is seen in the office with decreased vision in the right eye 3 months after a cataract extraction. The eye is examined and it is determined that the patient has secondary opacification. The physician makes an incision at the limbus to remove the posterior lens membranous capsule. 66830–RT
3. A patient is seen in the office for his annual eye examination. He states he has decreased vision in his left eye where he had a cataract removed the previous year. The doctor examines the eye and discovers that the lens has become dislodged. The patient is taken to the operating room the next day and the IOL is repositioned. 66825–LT

Checkpoint 26.3
Assign the CPT code(s) to the following procedure.
1. A surgeon performed a repair of a retinal detachment by scleral buckling of the right eye. The patient previously underwent scleral buckling on the left eye approximately 4 months ago. 67107–RT

Checkpoint 26.4
Assign the CPT code(s) to the following procedure.
1. An ophthalmologist performs a pars plana vitrectomy with focal endolaser photocoagulation immediately following an ophthalmic endoscopy that revealed severe proliferative diabetic retinopathy with hemorrhage in the left eye. The patient is 26 years old. 67039–LT, 66990

Checkpoint 26.5
Assign CPT code(s) to the following procedures.
1. A patient is seen in the office for decreased vision. Upon ophthalmoscopic examination, the patient is found to have vitreous hemorrhage in the right eye. The following day, the patient receives a subtotal mechanical vitrectomy. 67010–RT
2. A patient suffered head trauma from an off-road accident. The patient complains of seeing white spots and some flashes of light for the past few days. Upon examination, the doctor determined that the patient has a retinal detachment of the left eye. The patient is seen in the ASC 2 days later for treatment of retinal detachment with scleral buckling and vitrectomy. 67108–LT
3. Excision of three chalazions from the right eye. Two were removed from the top lid and one from the lower lid. 67805
4. A 37-year-old male who has had diabetes for 20 years is seen for an eye examination. The right eye illustrates classic signs of proliferative diabetic retinopathy (PDR). After speaking with the patient, he agreed to proceed with pan retinal photocoagulation and pars plana vitrectomy. 67040–RT

Checkpoint 26.6
Assign CPT code(s) to the following procedures. Some scenarios also require HCPCS code assignment.
Assign codes for the physician and the surgical center (facility).
2. Tympanoplasty and mastoidectomy, radical, both ears. **Physician: 69645–50. Facility: 69645–50**
3. A patient has otosclerosis of the left ear. The patient is admitted for stapedectomy. The middle ear is entered and the ossicles palpated. The stapes footplate is visualized and found to be thickened. Small and large Buckingham mirrors are used to drill out the stapes footplate. Once completed, a Schuknecht piston prosthesis is placed into position. **Physician: 69661–LT Facility: 69661–LT, L8699**
5. A 3-year-old child with adhesive otitis media is placed under general anesthesia. The right ear is examined and debris and fluid are encountered. A PE tube is placed. The left ear is thoroughly examined and the previous tube is still intact. **Physician: 69436–RT, 92502–59–LT Facility: 69436–RT, 92502–59–LT**
6. Tympanic membrane repair on right with operating microscope. Payer follows CPT guidelines and does not have a separate policy for microscope use. **Physician: 69610–RT, 69990 Facility: 69610–RT, 69990**
8. Impacted cerumen is removed from both ears using instrumentation. **Physician: 69210–50 Facility: 69210–50**
9. A senile elderly patient in a nursing home placed an earring in her ear that is now lodged in the right external auditory canal. The patient’s tendency to flail her arms whenever she is examined requires that general anesthesia be used to extract the earring. Once the patient has been anesthetized, the physician is able to visualize the earring and extract it with forceps and suction. **Physician: 69205–RT Facility: 69205–RT**

**Answers to Review Questions**

**Matching**
Match the key terms with their definitions.

A. tympanostomy  F. phototherapeutic keratectomy
B. keratoplasty  G. photocoagulation
C. pneumatic retinopexy  H. pseudophakia
D. trabeculectomy  I. photorefractive keratectomy
E. myringotomy  J. aphakia

1. **C** Procedure in which a gas bubble is injected directly inside the vitreous cavity of the eye to push the detached retina against the back outer wall of the eye
2. **F** Laser treatment that removes layers of corneal clouding and clears patients’ vision
3. **A** Involves incising the tympanic membrane and inserting ventilation tubes
4. **B** Removal of the central portion of a diseased cornea and replacement with a matched donor
5. **D** Incisional procedure that creates a drain for the aqueous
6. **J** Status of eye that had a lens removed surgically or by trauma
7. **E** Incision of the tympanic membrane
8. **I** Use of a laser to reshape the surface of the cornea to correct vision
9. **G** A laser that emits green waves to coagulate tissue by sealing off blood vessels
10. **H** Eye that had the natural lens removed and replaced with a synthetic one

**True/False**
Decide whether each statement is true or false.
1. **F** A vitrectomy is separately reported when performed during a cataract extraction.
2. **F** Report 65130 for the insertion of an IOL after cataract removal surgery.
3. **F** All codes necessary for reporting procedures on the eye or ear are located in the Eye and Ocular Adnexa and Auditory System sections of CPT.
4. **F** A chalazion is an abnormal growth of the conjunctiva.
5. **F** All codes located within the Eye and Ocular Adnexa and Auditory System sections can be appended with modifier –50 because the eye and ear are paired body organs.
6. **T** Incision and drainage of a conjunctival cyst is assigned code 68020.
7. **T** Removal of a rock from a patient’s ear under anesthesia with a microscope is assigned to 69205.
   
   **Rationale:** CCI edits indicate the code for the microscope (69990) cannot be reported with 69205
8. **F** An intracapsular cataract is considered a complex cataract.
9. **F** Removal of existing PE tubes is coded separately from the insertion of new tubes because the doctor has to make a new incision in the tympanic membrane.

**Multiple Choice**
Select the letter that best completes the statement or answers the question.
1. A patient undergoes extracapsular cataract extraction OD with phacoemulsification and IOL insertion. Which code should be reported?
   
   A. 66982–RT
   B. 66940–LT
   C. 66850–RT
   D. 66984–RT
   
   **ANS:** D

2. A patient had a cataract removed 70 days ago on the right eye. The ophthalmologist finds opacification and incises the posterior capsule with a YAG laser. Which code should be reported?
   
   A. 66850–RT
   B. 66821–RT
   C. 66830–RT
   D. 66821–78–RT
   
   **ANS:** D

3. An anterior capsulorrhexis was performed. The lens nucleus was hydrodissected and then removed by phacoemulsification. Cortical material was removed with irrigation. What procedure(s) was performed?
   
   A. Phacoemulsification of cataract
   B. Extracapsular cataract extraction
   C. Intracapsular cataract extraction
   D. Both A and C
   
   **ANS:** A

4. A patient complains of pain and swelling in the right eye. He says he was tearing out drywall without safety glasses. The physician removed the conjunctival foreign body. Which code should be reported?
   
   A. 65220–RT
   B. 65235–RT
   C. 65210–RT
   D. 65205–RT
   
   **ANS:** D

5. A 9-year-old Down syndrome patient with previous tympanostomies is seen for examination under anesthesia and debridement. The canal was debrided and an extruded tube was noted on the right and removed. On the left, a perforation is noted and there was granulation tissue and the tympanic membrane was debrided. Which codes should be reported?
   
   A. 69424–RT, 69799–LT
   B. 69220–LT, 69222–RT
   C. 69222–LT, 69799–RT
D. 69424–RT, 69222–LT

ANS: A

Rationale: The level of debridement performed in the left ear does NOT constitute a mastoidectomy (69220/69222). The mastoid is a bony extension of the ear canal. The debridging was of the tympanic membrane to remove granulation tissue, but no repair was performed nor was there a tube removed from the left ear. There isn’t a code that accurately describes the simple debridging of the tympanic membrane where the hole exists from the previously placed PE tube, which is why 69799-LT is required.

6. Removal of FB from right cornea using slit lamp. The physician also repairs the corneal laceration. Which code(s) should be reported?
A. 65222–RT, 65270–RT
B. 65220–RT, 65285–RT
C. 65275–RT
D. 65280–RT

ANS: C

7. A patient is diagnosed with otitis media of the right ear with ossicular damage and erosion. The TM was totally perforated. Right tympanoplasty and canal split-thickness skin graft are performed. A posterior ear canal skin flap was made and then a postauricular incision. A temporalis fascia graft was harvested. Which code should be reported?
A. 15770
B. 20926
C. 69631
D. 69620

ANS: C

8. A patient has cataract surgery that involves using iris hooks and an endocapsular ring. Which code should be reported?
A. 66984–22
B. 66850–22
C. 66984
D. 66982

ANS: D

9. A patient is taken to the operating room for removal of retained foreign bodies of the left ear with chronic infection. The operating microscope was used and the canal was cleaned of infected debris. The ventilation tube was removed and a new one placed. The edges of the myringotomy were freshened and a paper patch applied. The patient has Cigna insurance, which utilizes the NCCI. Which code(s) should be reported?
A. 69610–LT
B. 69424–LT, 69436–LT
C. 69436–LT
D. 69631–LT

ANS: A

Rationale: Code 69436 bundles into code 69610 on the same ear. Code 69424 bundles into code 69436 on the same ear.

10. A patient has three chalazions removed under general anesthesia. Two were removed from the upper right eyelid and the third from the upper left eyelid. Which code should be reported?
A. 67808
B. 67805
C. 67808–50
D. 67801

ANS: A
CHAPTER 27: CPT: RADIOLOGY CODES

Answers to Checkpoint Questions

Checkpoint 27.1
Assign the correct procedure code and appropriate modifiers to the following, based on whether the code is for the facility or the physician.
1. Venography supervision and interpretation (S&I) of the right leg, facility **75820–RT, –TC**
2. Physician use of fluoroscopic guidance for left wrist injection **77002–26**
3. MRI of the heart, without contrast, followed by with contrast material for morphology and function **75561–TC, 75561–26 (physician reporting)**
4. Upper GI imaging with KUB **74241–TC, 74241–26 (physician reporting)**
5. Ultrasound of the gallbladder **76705–TC, 76705–26 (physician reporting)**
   - **Rationale:** Because only one organ, the gallbladder, is documented in the exercise, it is a limited ultrasound.
6. Ultrasound-guided needle placement for thoracentesis **76942–TC, 76942–26 (physician reporting)**
7. CT scan of chest, without contrast **71250–TC, 71250–26 (physician reporting)**
8. MRI of the brain with contrast **70552–TC, 70552–26 (physician reporting)**
   - **Rationale:** Facility would also report a HCPCS code for the contrast agent.
9. Mammography of the right breast, facility **77065–RT–TC**

Checkpoint 27.2
Assign codes to the following procedures. Include any necessary modifiers.
1. A 5-year-old boy closed his right hand in the car door. His thumb was clearly stuck in the door. After freeing it, the parents drove him to the ED where x-rays of the hand with one view and thumb (three views) were obtained. **73120–52, 73140**
2. A patient has been experiencing right hip and lower back pain for several weeks. Lumbar spine and hip x-rays were inconclusive. Myelography S&I was performed at the lumbosacral region by injecting Iopamidol at the L5–S1 interspace to rule out disc herniation or nerve impingement. Code for the injection and the S&I. **62284, 72265–26**
   - Use Box 27.1 to answer the following questions.
3. What type of radiological service was performed? Was it a diagnostic, screening, or therapeutic service? **Bilateral diagnostic mammogram**
4. Was clinical data or a preliminary diagnosis provided by the referring physician? If so, is it adequate to allow you to assign the findings by Dr. Tucker? **Yes, the findings indicate a history of lumpectomy on the right and left breasts.**
5. Provided that the clinical data are adequate, what CPT code is assigned by the radiologist? **77066–26**
What code is assigned by the facility? **77066–TC**

Checkpoint 27.3
Assign codes to the following procedures provided by the physician in the facility setting. Assign the S&I code. Include any necessary modifiers. Remember, S&I codes are assigned for each vessel accessed diagnostic and therapeutic.
1. Access: right common femoral. Catheter is advanced into the aorta and contrast is injected for aortography. **36200, 75600–26**
2. A 73-year-old patient with a history of pulmonary embolism (PE) complains of acute shortness of breath. She undergoes selective bilateral main (R) and (L) pulmonary arteriograms. **75743**
3. Selective catheter placement was provided into the left common carotid. Will the physician code for the S&I portion of the procedure? If so, what modifier will be used? **No, none.**
Rationale: The code for selective catheter placement into the common carotid artery is 36222 and it includes the S&I services. A radiology code is not reported.

Checkpoint 27.4

Assign codes to the following procedures. Include any necessary modifiers.
1. A radiation oncologist reviews the port films, dosimetry, dose delivery, and treatment parameters, and also does a medical evaluation each week for a patient who receives eight treatments in a period of 2 weeks. Code for the radiation oncologist’s services related to the eight treatments. 77427, 77427
   * Rationale: Code 77427 represents five treatments, but code 77427 can be reported again in this scenario because three treatments at the end of the course of treatment are allowed.

2. Before the patient’s course of radiation treatment, the radiation oncologist sets up intermediate simulation procedures. 77285
   * Rationale: The index doesn’t really help in finding this code. It’s best to go to the Radiology section for radiation oncology. The simulation codes 77280–77290 follow the clinical treatment planning codes 77281–77283 even though there is no header to identify them that way.

3. A patient diagnosed with a primary endometrial carcinoma receives intracavitary brachytherapy using 10 sources with applicators left in place for 2 days. 77762
   * Rationale: Review the definitions preceding those codes; intermediate is defined as five to ten sources/ribbons.

Checkpoint 27.5

Assign codes to the following procedures. Include any necessary modifiers.
1. PET tumor imaging, whole body 78813
2. SPECT myocardial imaging 78469
3. Diagnostic nuclear medicine procedure, gastrointestinal, unlisted 78299
4. Multiple determinations of thyroid uptake 78012
5. High-dose rate brachytherapy, remote afterloading, 11 channels 77771
6. A radiation oncologist provides clinical treatment planning services to patients who are receiving radiation therapy for cancer. Code for the clinical treatment planning that encompasses a single treatment area in a single port with no blocking. 77261
7. How would you report the CPT code for the study in Box 27.3? 78811
8. A patient is status post chemotherapy and radiation treatment for lung cancer 1 month ago. He is here today for PET scan follow-up to evaluate response to therapy and any distant metastatic lesions. A whole-body PET scan was performed. Radiopharmaceutical: 15.0 mCi F-18 FDG i.v. Findings: Images of the body show a photopenic focus with a rim of minimal FDG uptake in the left lower lobe. 78813
9. A 79-year-old male was brought to the imaging center by his daughter who states that he is becoming very lethargic, forgetful, and less able to care for himself. He got lost driving home from the grocery store. PET scan shows hypometabolism in the temporoparietal and reduced glucose uptake in the cranial portion of both frontal lobes. The radiologist confirms Alzheimer’s disease. 78608
10. A 53-year-old man with a history of end-stage renal disease (ESRD) underwent kidney transplant 2 years ago. His post-transplant creatinine has remained elevated and has increased to 2.8. A nuclear medicine diagnostic study was provided for kidney function imaging with vascular flow.
   78701

Answer to Review Questions

Matching
Match the key terms with their definitions.
A. fluoroscopy
B. nuclear medicine
C. vascular family
D. ultrasound
E. selective catheter placement          H. technical component
F. magnetic resonance angiography       I. portal
G. charge description master            J. retrograde

1. D Uses ultrahigh-frequency sound waves for diagnostic scanning
2. H Encompasses the allocation of staff or use of equipment
3. A Uses a continuous low-level x-ray beam to view the body in motion
4. J Against the normal flow pattern
5. E Placement of a catheter into a branch off the main conduit of a vascular system
6. G A computerized master list of hospital services with associated fees and codes
7. C All arteries or veins branching off of the main conduit of a vascular system
8. F An MRI study of the blood vessels
9. I Entry point for a radiation beam
10. B The use of computers, detectors, and radioactive substances for diagnosis or therapy

True/False
Decide whether each statement is true or false.
1. T The diagnostic ultrasound definition of an A-mode implies a one-dimensional ultrasonic measurement procedure.
2. F The time descriptors for fluoroscopic examination codes apply to the actual time the fluoroscopic unit is turned on.
3. T When the physician owns the equipment and provides the S&I, the global x-ray service has been provided.
4. T Nuclear medicine involves imaging that uses injection or infusion of radioelements to allow visualization of a specific area.
5. F The abbreviation PC stands for professional charge.
6. F For situations in which contrast is provided orally, codes with contrast are chosen.
7. T There is a separate unlisted procedure code for diagnostic ultrasounds.
8. F The –26 modifier reports the professional and technical component of a procedure.
9. F In radiation oncology the consultation with a radiation oncologist is part of the clinical management of the patient during treatment.
10. T Selective catheter placement includes nonselective catheter placement.

Multiple Choice
Select the letter that best completes the statement or answers the question.
1. What does the abbreviation S&I mean?
A. Search and intervention
B. Supervision of iodine
C. Supervision and interpretation
D. Supervision of injection
ANS: C

2. Two views of the thumb and two views of the second digit on each hand are coded as
A. 73140–RT, 73140–LT
B. 73120–FA, 73120–F5, 73140–F1, 73140–F6
C. 73120–50, 73140–50
D. 73120–LT–RT, 71340–LT–RT
ANS: A

3. When a diagnostic mammogram is performed on the same day as a screening mammogram, which modifier is used on the diagnostic mammogram?
A. –76
B. –GA
C. –22
4. Diagnostic ophthalmic ultrasound of the eye with quantitative A scan only is coded as
   A. 76511
   B. 76513
   C. 76516
   D. 76519
   **ANS: A**

5. A physician not employed by the hospital provides a shoulder arthrography S&I to an inpatient. What is the code?
   A. 73020–26
   B. 73050–TC
   C. 73040–26
   D. 73040–TC
   **ANS: C**

6. A complete cervical x-ray with flexion and oblique views is coded as
   A. 72082
   B. 72052
   C. 72050
   D. 72040
   **ANS: D**

7. An x-ray of the paranasal sinuses, two views is coded as
   A. 70160
   B. 70250
   C. 70210
   D. None of the above
   **ANS: C**

8. A CT scan of the lumbar spine without contrast and with contrast is coded as
   A. 72131, 72132
   B. 72120
   C. 72100
   D. 72133
   **ANS: D**

9. A hysterosalpingography, S&I is coded as
   A. 74740
   B. 58340
   C. 58345
   D. 74742
   **ANS: A**

10. A barium enema with KUB is coded as
    A. 74246
    B. 74270
    C. 74280
    D. 74241
    **ANS: B**
CHAPTER 28: CPT: PATHOLOGY AND LABORATORY CODES

Answers to Checkpoint Questions

Checkpoint 28.1
Read the following scenario and answer the question.
1. An internal medicine physician did a venipuncture to obtain blood for laboratory analysis and then sent the blood specimen to an outside laboratory for testing. The laboratory will bill the patient for the testing. How will the internal medicine physician’s services be reported? **36415.**
   
   **Rationale:** The physician cannot report the laboratory if the analysis is not performed onsite by physician office staff.

Checkpoint 28.2
Read the following scenario and answer the question.
1. Evocative/suppression testing was done to determine adrenal insufficiency and cortisol was administered twice in the course of testing. The laboratory reported 82533, 82533–91. Is the laboratory correct? **No, the laboratory is incorrect.**
   
   **Rationale:** The evocative/suppression guidelines specify that cortisol is to be administered twice for correct determination. Do not use modifier –91.

Checkpoint 28.3
Read the following scenario and answer the question.
1. The laboratory performs the following tests: total calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and blood urea nitrogen (BUN). Can a panel code be used? If so, which one? **Use panel code 80048.**
2. Is an additional code required? **No**

Checkpoint 28.4
Read the following scenario and answer the question.
1. An elderly patient has been taking digoxin for many years but now appears sleepy all the time. The physician is concerned that the patient is not able to excrete the digoxin and has increased levels in her blood. The patient’s blood is drawn and sent to the laboratory for testing. Report the laboratory’s CPT code for the test. **80162.**
   
   **Rationale:** This is a therapeutic drug assay service. The physician is checking for how much (quantitative) digoxin is in the blood.

Checkpoint 28.5
Read the following scenario and answer the question.
1. A patient presents with fatigue, dyspnea on exertion, and easy bruising. The patient’s hemogram shows leukocytosis anomalies. Bone marrow is submitted for NPM1 exon 12 mutation testing. Assign the CPT code and any applicable modifier reported by the laboratory. **81310**

Checkpoint 28.6
Read the following scenario and answer the question.
1. A specimen of a portion of the lung from a left lower segmental resection is sent for gross and microscopic examination. Assign the CPT code and any applicable modifier reported by the laboratory. **88309**

Checkpoint 28.7
Assign codes to the following procedures. Include any necessary modifiers.
1. hCG, quantitative **84702**
2. Cholesterol, HDL, triglycerides, LDL 80061, 83721
3. Rubella screen (antibody testing) 86762
4. Cryopreservation of five cell lines 88240×5
5. HGH antibody 86277
6. Comprehensive clinical pathology consultation with history and record review 80502
7. Mandated alcohol screen (single drug class) 80305–32
8. A cardiologist suspects a blockage in the coronary arteries and needs to do a cardiac catheterization. One test that the hospital will need both before and after surgery is the test that shows how long it takes for the blood to clot (bleeding time). Code for this test. 85002
9. After his most recent chemotherapy treatment, a patient was quite weakened. His oncologist ordered a complete CBC, automated. 85025
10. A patient with chronic edema, despite years of treatment with diuretics, is considered to have a pituitary gland problem that may be secreting excessive amounts of vasopressin, an antidiuretic hormone. Code for the ADH test. 84588

Answers to Review Questions

Matching
Match the key terms with their definitions.

- A. analyte
- B. antibody
- C. antigen
- D. assay
- E. block
- F. coagulation
- G. gross examination
- H. panel code
- I. qualitative
- J. quantitative

1. E Portion of frozen tissue from a specimen
2. C Substance that causes a reaction in the body
3. J Measurement of how much of a substance is present in the body
4. A A substance that is being measured or analyzed
5. H One code that represents a group of tests
6. I Measurement of whether a substance is present in the body
7. G Pathology examination with eyes only
8. F A measurement of how fast the blood will clot
9. D Analysis of a substance in the body
10. B The body’s response to an antigen

True/False
Decide whether each statement is true or false.
1. T Unlisted procedure codes are listed under their specific subsections.
2. F The −26 modifier reports the professional and technical component of a procedure.
3. T Multiple procedures that are rendered on the same date should be reported as separate entries.
4. T When a panel code is reported and an additional test not listed in the panel code is performed, the test should be reported separately in addition to the panel code.
5. F Pathology and laboratory services are provided by a physician only.
6. T The codes in the Surgical Pathology subsection represent levels of difficulty of the particular specimen examined.
7. F A physician office with an in-house laboratory draws blood and performs a TSH. The physician would report code 84443 and no other code.
8. F The organ and disease panels located in CPT are clinical parameters for such.
9. F Confirmation of a drug assay is only coded once per drug class per procedure.
10. F Surgical pathologists do not ever examine people but rather specimens obtained from people.
Multiple Choice
Select the letter that best completes the statement or answers the question.

1. Your laboratory offers a hepatic function panel with the following components: albumin, bilirubin (total and direct), alkaline phosphatase, total protein, SGOT, SGPT, and GGT. Which code(s) should be reported?
   A. 80076
   B. 80076, 82977
   C. Code separately each test
   D. 80076–52
   ANS: B

2. Code a nonautomated microscopic examination of urine by dipstick performed in a physician’s office. A Clinical Laboratory Improvement Act (CLIA) waiver is on file.
   A. 81000
   B. 81000–26
   C. 81002
   D. 81025
   ANS: A

3. The source of the specimen for a chemistry test coded to 82000 through 84999 is
   A. Urine
   B. Blood
   C. Sputum
   D. Any source
   ANS: D

4. Code for a glucose tolerance test, four specimens taken.
   A. +82952
   B. 82951
   C. 82950
   D. 82951, +82952
   ANS: D

5. A patient is being tested for the presence of cocaine in his system. The laboratory used the single drug class procedure and also confirmed its findings. What code(s) would the laboratory report?
   A. 80305
   B. 80305, 80353
   C. 80353
   D. 82542
   ANS: B

6. A urine pregnancy test was performed in the office using Hybritech ICON (visual color comparison). Which code(s) should be reported?
   A. 84703
   B. 81025, 36415
   C. 84702
   D. 81025
   ANS: D

7. Which code should be reported for a stool culture for Salmonella?
   A. 87102
   B. 87046
   C. 87045
   D. 86768
   ANS: C

8. Which code should be reported for a Pap smear, screening by automated system with manual
rescreening under physician supervision?
A. 88166
B. 88153
C. 88175
D. 88148

ANS: D

9. Which code should be reported for a pathological gross and microscopic examination of the entire left testicle?
A. 88302
B. 88304
C. 88305
D. 88307

ANS: C

10. Which code should be reported for a pathology consultation in which the physician reviews complete medical records and provides a written report?
A. 88355
B. 80500
C. 88321
D. 80502

ANS: D
CHAPTER 29: CPT: MEDICINE CODES

Answers to Checkpoint Questions

Checkpoint 29.1
Assign codes to the following procedures for the physician.

1. A patient was injured while cutting sheet metal. He went to his physician and received an injection of 250 units of human tetanus immune globulin IM. 90389, 96372
   
   Rationale: The correct answer requires two codes, one for the administration and the other for the immune globulin product. The correct administration codes are found in the immune globulin guidelines.

2. A 6-year-old patient is seen in the pediatrician office for her well-child checkup and immunizations. The physician performs the examination and talks to the child’s mother about the girl’s development. The mother indicates her concern about the side effects of the vaccines scheduled for today’s visit. The physician counsels the mother about each component of the vaccines being given, and she agrees to the vaccinations. The patient receives the meningococcal MCV4 and DTaP vaccines. 90460, 90461×3, 90700, 90734
   
   Rationale: The correct administration codes are those that incorporate counseling. The administration codes must represent each vaccine component that is administered and counseled. The meningococcal vaccine is one component. The DTaP is three components: diphtheria, tetanus, and acellular pertussis, for a total of four components. There are several vaccine codes that incorporate diphtheria so coders should carefully review their descriptions. The description for 90460 includes “first or only component of each vaccine or toxoid” CPT Changes for 2011 and 2012 clarify this; code 90640 can be reported only once per day of service.

3. A 25-year-old patient seen in the office requests the flu vaccine. Because the patient is afraid of needles, the nurse administers the FluMist nasal vaccine. Code for the administration of the vaccine. 90473

4. A patient with known idiopathic thrombocytopenic purpura is seen for full-dose injection of Rho(D) immune globulin to help maintain proper platelet count. The patient receives the injection in the left buttock. 90384, 96372
   
   Rationale: Again, you need two codes for administration and product.

Checkpoint 29.2
Assign codes to the following procedures for the physician. Include any necessary modifiers.

1. A nurse sees a patient in the outpatient dialysis clinic for dialysis training. The nurse educates the patient on how to keep the catheter site clean, how to connect and disconnect the dialysis tubing, and what to do in an emergency. The patient completes the course. 90989
   
   Rationale: There are dialysis training codes, one for the completed course, the other for when the full course is not completed. That code is reported times the number of training sessions.

2. A patient receives hemodialysis in the hospital and is evaluated by her physician for her renal disease, respiratory issues, and chronic leg pain. Can the physician report an E/M service? Explain your answer.
   
   Yes, the patient’s respiratory illness and chronic leg pain can be considered as separate and distinct from the renal disease.

Checkpoint 29.3
Assign codes to the following procedures for the physician. Include any necessary modifiers.

1. A patient was seen in the office, and the cardiologist performed an echocardiogram (ECG) with interpretation and report, with an office visit. Due to an abnormal ECG finding, the cardiologist also does a limited transthoracic echocardiogram that same day. What codes should be reported? Are any modifiers
needed? 93308, 93000–59
   Rationale: Code 93308 is correct because it represents a limited echocardiogram as specified in the exercise. The ECG would also be reported with the modifier –59. It is separate and distinct from the echocardiogram, and it provided the information necessary to perform the echocardiogram.

2. A patient was seen in the outpatient cardiology clinic for a real-time maximal stress ECHO. The patient walked for a total of 10 minutes and achieved 91% of age-predicted maximal heart rate. The test was stopped early due to fatigue. Baseline ECG showed normal sinus rhythm. Exercise ECG showed the same. Pre-exercise heart wall motion was normal. Post-exercise wall motion showed increase in ejection fraction. 93351
   Rationale: This code incorporates both the cardiovascular stress test and the stress echocardiogram. Refer to the parenthetical notes under code 93351 in CPT.

3. A patient was admitted for 23-hour observation for elective cardioversion. Oral medications had not been successful in maintaining his rhythm. The patient’s A-fib was putting him at risk for stroke. The patient was sedated, and 300 synchronized joules were conducted through the electrodes by placing the paddles on the chest. Normal sinus rhythm was achieved, and cardioversion was successful. 92960
   Rationale: The question describes an elective external cardioversion.

4. A combined left heart catheterization and retrograde right heart catheterization were performed with right ventricular angiography and selective coronary angiography, including imaging supervision and interpretation. 93460, +93566
   Rationale: When a cardiac catheterization description indicates that coronary angiography was provided, the correct range of codes to refer to is 93454–93461. Code 93454, the parent code, provides for the coronary angiography and the imaging supervision and interpretation. The indented code 93460 includes the services in code 93454 plus the left and right heart catheterizations. You need the add-on code +93566 for the right ventriculography.

Checkpoint 29.4

Assign codes to the following procedures for the physician.

1. A patient complaining of pain in the thumbs and numbness of both hands is seen in the neurologist’s office. The physician performs needle myography of bilateral forearms. 95861
   Rationale: Needle electromyography codes are per-extremity codes. Code 95861 correctly represents the work done on two extremities, the right and left forearms.

2. A patient reports to her physician that for the past three summers she has caught a cold that turns into a sinus infection. She says that she does not have this problem year-round. The physician decides that allergy testing is warranted. The patient is tested for mold, ragweed, and grass pollen. Intradermal testing immediate-type reaction is performed with allergenic extracts. 95024×3
   Rationale: The allergy testing range of codes is 95004–95071 and is differentiated by immediate-type reaction versus delayed-type reaction and if the test is sequential and incremental. Question #2 indicated the immediate-type reaction without mention of sequential and incremental; therefore, 95024 is the correct code. These codes also indicate “specify number of tests.” The patient was tested for three types of allergens.

3. The previous patient’s allergy tests show she is allergic to ragweed. She has agreed to immunotherapy. She returns to the allergist’s office and receives an injection of the antigen. The serum to determine tolerance is prepared and provided by the allergist in a single-dose vial. 95144, 95115
   Rationale: To answer this question correctly, you must find the code that specifies single-dose vials and code separately for the injection. There is only one code that specifies single-dose vials for allergen immunotherapy: 95144.

4. A patient was status post insertion of deep-brain neurostimulator to combat tremors from Parkinson’s disease. The system generator was tested, the battery was tested, and the parameters were also adjusted because the patient was still experiencing some tremor. Electronic analysis and programming of the
single-array generator were performed. The overall session lasted 2 hours. $95978, 95979 \times 2$

Rationale: The deep-brain neurostimulator codes are found within the code range 95970–95981. The code for electronic analysis of a deep-brain neurostimulator is 95978 for the first hour and the add-on code 95979 $\times 2$ is needed to represent each additional 30 minutes.

Checkpoint 29.5

Assign codes to the following procedures for the physician.

1. A patient receives an infusion of a noncancer drug (including hydrating solutions) for 3 hours 27 minutes. $96365, +96366\times 2$

Rationale: The infusion codes are 96365–96371. The question represents continuous infusion for 3 hours 27 minutes. Report code 96365 for the first hour and 96366 $\times 2$ for each additional hour. The 27 additional minutes do not meet the criteria of greater than 30 minutes beyond the 1-hour increments needed to report 96366 $\times 3$.

2. A patient receives a 2-hour infusion of a hydrating solution to which a cancer drug has been added. Documentation does not have a specific order for the hydration. $96413, +96415$

Rationale: You do not code for the hydration; it is included in the administration of the cancer drug for 2 hours.

3. A cancer patient receives an antiemetic given by infusion over 10 minutes before chemotherapy. Chemotherapy starts at 10:00 a.m. and ends at 12:30 p.m. $96413, +96415, 96374$

Rationale: The administration of the antiemetic is considered a push technique because it lasted for fewer than 15 minutes. Code 96415 is not reported times two because the infusion lasted for 2 hours 30 minutes. It would have to go beyond 30 minutes to justify reporting 96415 $\times 2$.

Checkpoint 29.6

Assign codes to the following procedures for the physician.

1. A patient is seen in the OB/GYN oncology office for nonhormonal chemotherapy injection. $96401$

2. An established patient with a history of rhinitis leading to sinusitis calls the physician to discuss new acute sinusitis symptoms. The nurse speaks to the patient for 15 minutes to obtain a history via telephone and assess the patient’s condition, then talks to the physician. The physician decides to call in an order for an antibiotic rather than have the patient come to the office for examination. $98967$

Rationale: This code represents the non-face-to-face, non-physician services. The guidelines for these services are met, and the remaining factor is time. This is the correct code based on time.

3. A 65-year-old patient needs to have a percutaneous gastrostomy tube inserted with fluoroscopic guidance in the outpatient surgery center. The physician does the procedure and provides moderate sedation, and a qualified trained nurse is present to monitor the patient during the procedure. The physician reports codes 49440, 99151, 99153 $\times 3$ for the 45-minute procedure. The physician spent an additional 20 minutes in pre- and post-service work. Is the physician correct? Explain your answer. No.

Rationale: Codes 49440 and 99151 are correct, but code 99153 is reported $\times 2$ only. The pre- and post-service work is included in performing the procedure. The correct codes are 49440, 99151, 99153 $\times 2$.

4. A patient is seen for the first chemotherapy session for recently diagnosed bone cancer. An infusion of 100 mcg of Kytril is provided. Kytril is infused at 1:15 p.m. and ends at 1:35 p.m. The registered nurse (RN) administering the infusion is continuously present for the infusion. Code for the administration. $96409$

Rationale: This code is an IV push code and is correctly used here, because the question specified that the RN administering the infusion was continuously present.
Answers to Review Questions

Matching
A. intravenous push  F. electroencephalogram
B. percutaneous transluminal coronary G. immunization
    intervention, angioplasty  H. percutaneous transluminal coronary
C. angiography  I. electromyography
D. antigen  J. immune globulin
E. infusion

1. C Injecting contrast medium and imaging the contrast in the vessel
2. G Helps the body develop protection against certain diseases by injecting a small amount of antigen
3. D A foreign substance in the body
4. E Therapy in which medication is dripped into a patient’s vein over a course of time
5. B Physician threads a balloon-tipped catheter from the groin or the arm to the site of a narrow or
    blocked artery
6. H Inserting a balloon catheter into the vein to remove a clot
7. A Infusion of 15 minutes or less.
8. J Produce antibodies before exposure to the disease
9. F Recording brain activity
10. I Recording of the electrical properties of muscles and the action generated by the muscle cells

True/False
1. T If the patient receives an infusion of a single drug that lasts 1 hour 45 minutes, the physician reports
   code 96365 for up to 1 hour and code +96366 for the additional 45 minutes.
   Rationale: As the guidelines indicate and as is also explained in the parenthetical notes below codes
   96365, +96366, code 96365 represents the first hour of infusion and code 96366 represents each
   additional hour of the same drug if at least 30 additional minutes of infusion occurred beyond the first
   hour.
2. T A pregnant mother is seen in the OB/GYN office for an injection of the RhoGAM because she is a
   different blood type than the baby. CPT code 96372 should be submitted.
3. T Code 99026 from the Medicine section may be assigned to indicate a postoperative follow-up
   office visit.
   Rationale: Code 99026 is for hospital-mandated on-call services; code 99024 is the correct code for
   postoperative follow-up.
4. T ESRD codes include monitoring of nutrition, assessment of growth and development, and parental
   counseling for patients under the age of 20 years.
   Rationale: The ESRD code descriptions for codes 90951, 90954, and 90957 are different from the code
   descriptions for patients 20 years and older.
5. F Moderate sedation is a form of anesthesia in which the patient is awake but still needs assistance in
   breathing.
   Rationale: In the guidelines for moderate sedation, it specifies that “no interventions are required to
   maintain a patent airway, and spontaneous ventilation is adequate.”
6. T Separate cardiac catherization codes exist for pulmonary artery angiography.
   Rationale: In the CPT index under angiography, the pulmonary artery is specified by code 93568,
   which is part of the cardiac catheterization injection codes.
7. T Hierarchy rules for the complexity of percutaneous coronary therapeutic services and procedures
   state that if an angioplasty, atherectomy, and stent procedure are done on the same vessel, only the stent
   procedure is reported.
   Rationale: The guidelines for codes 92920–92944 specify the hierarchy of these services.
8. T Medicare considers CPT codes 95120–95134 to be invalid and does not recognize them.

9. T The lightning bolt symbol located in CPT alerts the coder that this is a highly reimbursable product.  
Rationale: As indicated in CPT’s symbol guidelines and also within the guidelines preceding the Medicine section codes, the lightning symbol represents that an immunization product is pending FDA approval.

10. F CPT codes 90957 and 90959 can be reported together for the same month.  
Rationale: Code 90957 represents ESRD-related services per month, with four or more physician visits. Code 90959 is for the same services with one physician visit per month. Code 90957 includes 90959.

Multiple Choice
Select the letter that best completes the statement or answers the question.

1. A patient receives an antiemetic via IV infusion for 10 minutes, followed by 2 hours 30 minutes of chemo infusion. Report codes
A. 96413, +96415, +96367  
B. 96413 x 2, 96365  
C. 96372, 96413, +96415  
D. 96413 x 2, +96367  
ANS: A  
Rationale: Coding for chemotherapy and antiemetic infusions requires that the initial service is the primary code, followed by other services. The initial service is defined as the primary reason for the encounter, which would be chemotherapy. The correct answer must start with code 96413, which eliminates answer c. The chemotherapy was administered for 2.5 hours; code 96413 represents 1 hour, and add-on code 96415×2 is reported for the additional 1 hour. Add-on code 96415 cannot be reported more than once, to report it times 2 the time would have to be more than 2.5 hours. Code +96372 represents the antiemetic infusion. It is reported as an IV push because the infusion was for less than 15 minutes.

2. A patient arrives in the ED with a 2-day history of gastroenteritis, nausea, and vomiting. IV hydration is begun at 100 mL/hour at 0300 hours. The patient receives one IV push Versed, and IV is continued until the patient is discharged at 0435. Report codes
A. 96365, +96366, 96374  
B. 96360, +96361, 96375  
C. 96360, 96374  
D. 96365, 96360  
ANS: B  
Rationale: Answers A and D are incorrect, because code 96365 does not represent infusion for hydration. The correct code for hydration is 96360, and the add-on code 96361 should be reported for the total of 1 hour 35 minutes (0300–0435). The only answer with both codes is B, and code +96375 is reported for the IV push.

3. A patient receives one antibiotic infusion for 45 minutes. The patient requires two different antibiotics, but the two drugs cannot be administered simultaneously. The second antibiotic is infused for an additional 25 minutes. What is the correct code assignment?
A. 96365, 96376  
B. 96365 x 2  
C. 96365, 96367  
D. 96365  
ANS: C  
Rationale: Answer A is incorrect, because code 96366 is for each additional hour of the same drug. The correct add-on code is 96367, representing a sequential infusion of a different drug. Answer B is incorrect, because code 96365 represents only up to 1 hour of infusion and cannot be reported times 2. Answer D would cover only 1 hour of infusion.
4. A young child’s behavior has dramatically changed over a period of weeks. Her internist has recommended that she see a psychiatrist. The child is unable to speak, even though she is 8 years old and capable of speech. The first visit with the patient goes well, and the psychiatrist recommends psychotherapy. Code for the initial visit with the child.

A. 90791  
B. 90791, +90785  
C. 90792  
D. 90792, +90785  

ANS: B  
Rationale: The first code in each answer is either 90791 or 90792. Both are for diagnostic evaluations, but 90792 includes medical services that are not indicated in the question. The correct answer could be either A or B, but answer A is incorrect, because the code that represents interactive complexity, +90785, is missing.

5. A 45-year-old patient received outpatient ESRD-related services for 5 days and then was admitted to the hospital for inpatient dialysis and evaluation. The patient remained in the hospital for 4 days and returned to resume his outpatient dialysis for the rest of the month. Once back in outpatient dialysis, he had two face-to-face visits with the physician but no complete assessment was provided during that month. What code(s) will be reported for the outpatient services provided during that month?

A. 90961  
B. 90961 X 26  
C. 90967  
D. 90970 X 26  

ANS: D  
Rationale: Dialysis coding is based on age, number of physician visits, and whether or not the services are provided monthly or per day. Because the patient was admitted to the hospital during the month of dialysis care and because there was no complete assessment during that month, the correct code must be a per-day code. In the per-day code range, 90967–90970, the code choice is based on age and then times the number of days per month minus the days in the hospital. The patient was in the hospital for 4 days; the month is always considered as 30 days.

6. Percutaneous transluminal coronary thrombectomy and percutaneous coronary atherectomy performed in the left circumflex artery are coded as

A. 92924  
B. 92924, +92973  
C. 92924–22  
D. 92933, +92973  

ANS: B  
Rationale: Code 92924 represents atherectomy with angioplasty. Code 92933 represents atherectomy with stent and angioplasty; therefore, the correct answer must start with 92924. The question indicates that transluminal coronary thrombectomy was also provided, and code +92973 represents those services.

7. What is the correct code assignment for bilateral electromyography (EMG) of cranial nerves?

A. 95867  
B. 95867–50  
C. 95868  
D. 95868–50  

ANS: C  
Rationale: The code choices are 95867 or 95868. Code 95867 is unilateral; 95868 is bilateral and is the correct answer.

8. Moderate sedation codes are based on
A. Age of patient and duration of service  
B. Duration of service, location  
C. Age of patient, duration of service, provider of service, location  
D. Age of patient, type of agent used, duration of service  

ANS: C  
*Rationale: Review of the moderate sedation guidelines indicates that age, duration, provider, and location are all required. Type of agent is not part of the code choice.*

9. A 2-year-old patient is seen for his measles, mumps, and rubella vaccine. The patient’s parents are very concerned about the side effects of vaccination and ask to consult with the physician before the vaccination administration. The parents then agree to the vaccine, and it is administered subcutaneously. What is the correct code assignment?  
A. 90707, 90704, 90460  
B. 90707, 90471  
C. 90707, 90460, +90461  
D. 90707, 90460, 90461x2  

ANS: D  
*Rationale: The correct answer must have the 90460, 90461 combination of codes, because counseling was provided; therefore, B is incorrect. In the counseling administration codes 90460, 90461, the codes are based on the number of vaccine components administered. In the exercise, there were three: mumps, measles, and rubella. The correct answer must have 90461x2 in addition to 90460.*

10. For left heart catheterization with coronary angiography, left ventriculography, and pulmonary angiography, the physician reports codes  
A. 93452, 93454, +93568  
B. 93458, +93568  
C. 93458  
D. 93452  

ANS: B  
*Rationale: When coronary angiography is provided with a left heart catheterization, the correct answer must start with the 93454–93461 range of codes; answers A and D are incorrect. In answer A, both 93452 and 93454 are reported which is incorrect. Code 93458 includes codes 93452 and 93454 (the left heart catheterization and coronary angiography); therefore, B is the correct answer, because 93458 includes the coronary angiography, the left heart catheterization, and the left ventriculography. Add-on code 93568 is required for the pulmonary angiography.*

11. Coronary thrombolysis by IV infusion is coded as  
A. 92977  
B. 92975  
C. 92977, 92975  
D. 92977–22  

ANS: A  
*Rationale: Answer B is incorrect, because it is an intracoronary infusion, not intravenous. Answer C is incorrect, because you would not report those two services together. Answer D is incorrect, because there is no documentation of an unusual or greater service.*

12. What does C mean?  
A. The code cannot append a –51 modifier.  
B. Conscious sedation is separately reportable.  
C. The code is likely to be audited.  
D. Conscious sedation is included in the surgical service and not separately reported.  

ANS: A  
*Rationale: As indicated in Appendix A in the CPT, the modifier descriptor appendix, A is correct.*
CHAPTER 30: HCPCS

Answers to Checkpoint Questions

Checkpoint 30.1
Determine whether the following codes are CPT HCPCS (Level I) or HCPCS (Level II) codes. Two are given as examples.
28285 CPT A4649 HCPCS
1. 15002 CPT 4. J0520 HCPCS
2. A0430 HCPCS 5. 69990 CPT
3. 72040 CPT 6. E0992 HCPCS

Checkpoint 30.2
Using a current HCPCS codebook, write the notation(s) that appear for each code. Code J1960 is filled out for you with generic symbols and color coding as an example. Indicate the action taken by Medicare in the first column. Look at the color coding, symbols, and instructional notes to determine if information on coverage is supplied and list it in the second column. Alert/Action is the notification that Medicare has given or action taken since the last publication.

Alert/Action: Coverage:
J9160 APC Status Indicator for Outpatient PPS Yellow highlight means coverage at carrier
Quantity Alert discretion
SNF Excluded

Note to Instructor: Depending on the publisher of the HCPCS manual, symbols and color coding may vary.
Coverage: Blue highlight indicates Special Coverage Instructions from Medicare Pub. 100.
2. L3217 Alert/Action: Quantity Alert, Female Only, Age Edit, Items, Codes and Services Not Covered by any Outpatient Benefit Based on Statutory Exclusion.
Coverage: Not Covered by or Invalid for Medicare.
3. A6206 Alert/Action: Quantity Alert, Packaged into APC.
Coverage: Blue highlight indicates Special Coverage Instructions from Medicare Pub. 100.
4. G0105 Significant Procedure, Multiple Reduction Applies, Surgical Procedure Added to ASC List in CY 2007; Payment Based on OPPS Relative Payment weight, SNF Excluded, Physician Quality Reporting. AHA: 2Q, ’09, 1.
Coverage: Blue highlight indicates Special Coverage Instructions from Medicare Pub. 100.

Checkpoint 30.3
In which sections are the following HCPCS services located?
1. E Motorized wheelchair
2. A Alcohol wipes, box
3. G PET imaging, whole body
4. A Ambulance waiting time
5. V Contact lens, gas permeable

Checkpoint 30.4
Indicate which Level II modifier applies to the following scenarios.
1. Physician assistant, nurse practitioner, or clinical nurse specialist services for assistance at surgery AS
2. Outpatient occupational therapy service GO
3. Medicare beneficiary elected to purchase an item **BP**
4. Service is not reasonable and necessary **GZ**
5. Office performed CLIA-waived test **QW**

**Checkpoint 30.5**

Assign the HCPCS Level I or II codes for the following scenarios. Append any HCPCS Level II modifiers as needed.

1. Blood glucose monitor with integrated lancing **E2101**
2. Injection Depo-Estradiol Cypionate, 2.5 mg **J1000**
3. Thoracic lumbar sacral orthosis back brace **L1200**
4. LPN nursing care in the home, per diem **T1031**
5. Blood glucose reagent strips for home blood glucose machine **A4253**
6. Injection of Cordarone IV, 45 mg **J0282**
7. Patient received 1 hour of outpatient speech therapy by a speech pathologist in the office **92507-GN**
8. Prostate-specific antigen screening in a 69-year-old patient **G0103**

**Answers to Review Questions**

**Matching**

Match the key terms with their definitions.

- A. durable medical equipment (DME)
- B. HCPCS
- C. Medicare Carriers Manual (MCM)
- D. permanent national codes
- E. temporary national codes
- F. Level II modifiers
- G. Pub100-03
- H. CMS HCPCS Workgroup

1. **D** HCPCS Level II codes that are maintained for the use of all payers
2. **C** Reference containing guidelines established by Medicare related to covered services in HCPCS Level II
3. **E** HCPCS Level II codes that are used by individual payers for items not covered in permanent national codes
4. **G** Reference containing information whether specific medical items, services, treatment procedures, or technologies are payable under Medicare
5. **B** Code set providing national codes for supplies, services, and products
6. **A** Reusable medical equipment for use in the home
7. **F** Two-character codes that are assigned to clarify Level II codes
8. **H** Government committee that maintains and advises on HCPCS Level II codes

**True/False**

Decide whether each statement is true or false.

1. **F** HCPCS Level II codes have six digits.
2. **F** HCPCS Level II codes are used only by hospitals.
3. **T** HIPAA mandates the use of HCPCS codes.
4. **F** CPT modifiers and HCPCS Level II modifiers are the same.
5. **F** HCPCS permanent national codes can be altered or deleted by a single payer alone.
6. **T** HCPCS permanent national codes are issued on January 1 of each year and must be used as of their effective date.
7. **T** HCPCS codebooks use symbols to show new, revised, and deleted codes and descriptors.
8. **T** Coding drugs involves paying attention to both the method of administration and the quantity administered.
9. **T** DME supplies are located in the K section of the main listing.
10. **F** Private payers are not permitted to use HCPCS codes; use is restricted to government programs.
Multiple Choice
Select the letter that best completes the statement or answers the question.
1. Transportation services are HCPCS__________ codes.
   A. A
   B. B
   C. C
   D. D
   **ANS: A**

2. Vision and hearing services are HCPCS__________ codes.
   A. D
   B. E
   C. H
   D. V
   **ANS: D**

3. Temporary codes are HCPCS__________ codes.
   A. D
   B. Q
   C. T
   D. V
   **ANS: B**

4. DME codes are HCPCS__________ codes.
   A. D
   B. E
   C. H
   D. V
   **ANS: B**

5. Prosthetic procedures are HCPCS__________ codes.
   A. D
   B. E
   C. H
   D. L
   **ANS: D**

6. Temporary national codes for private insurers to identify drugs, services, supplies, and procedures that are not reimbursable under Medicare are HCPCS__________ codes.
   A. D
   B. E
   C. S
   D. V
   **ANS: C**

7. Diagnostic radiology services are HCPCS__________ codes.
   A. R
   B. E
   C. H
   D. V
   **ANS: A**

8. Chemotherapy drugs are HCPCS__________ codes.
   A. D
   B. E
   C. H
   D. J
ANS: D
9. Laboratory and pathology are HCPCS__________codes.
A. D
B. E
C. P
D. V

ANS: C
10. Modifiers –A1 through –A9 are
A. Anatomical modifiers
B. Reported with wound care services
C. Anesthesia modifiers
D. Accepted by all payers

ANS: A