Chapter 11
Section Review 11.1

1. B. -stomy
   RATIONALE: -ectasis means dilation, -cele means hernia, -lysis means release.

2. C. cheil/o
   RATIONALE: An/o means anus, cec/o means cecum, col/o means colon.

3. B. It conveys and stores bile.
   RATIONALE: The gall bladder is a sac-shaped organ located under the liver. It stores bile that is produced by the liver.

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

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

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

7. A. Mechanical and chemical
   RATIONALE: Digestion consists of two processes, mechanical and chemical. Mechanical digestion is chewing the food and your stomach and smooth intestine churning the food, but chemical digestion is the work the enzymes do when breaking large carbohydrate, lipid, protein and nucleic acid molecules down into their subcomponents - these and others are the nutrients.
8. B. Incisors, Cuspids, Molars

RATIONALE: There are three categories of teeth:

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

9. D. 5 ft. long

RATIONALE: The large intestine is about five feet long.

10. A. 4 lobes

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

Section Review 11.2

1. B. 530.81

RATIONALE: GERD is the definitive diagnosis. Chest pain and a dry cough are both symptoms of GERD and would not be reported separately. GERD is an acronym for gastroesophageal reflux disease. In the ICD-9-CM Index, look under disease, then gastroesophageal reflux (GERD), and you are guided to 530.81.

2. D. 564.1

RATIONALE: IBS is an acronym for irritable bowel syndrome, and can cause the intestinal tract to contract stronger and longer than normal. This may cause symptoms such as abdominal pain, constipation or diarrhea, and/or flatulence. To find IBS in the ICD-9-CM, look in the Index under Syndrome, then find irritable, then bowel, leading you to code 564.1. Because abdominal pain and diarrhea are symptoms of IBS, they would not be coded separately. Ulcerative colitis is a rule-out diagnosis, and therefore, should not be coded.

3. C. 455.6

RATIONALE: Hemorrhoids are dilated or enlarged varicose veins, which occur in and around the anus and rectum. The condition can be complicated by thrombosis, strangulation, prolapse, and ulceration. To find hemorrhoids in the ICD-9-CM, locate Hemorrhoids in the Index, which will guide you to 455.6. If there is a complication to the hemorrhoids, you will look further in the Index to locate the complication. For this record, there is no mention of complication, so the correct code would be 455.6.
4. B. 211.3

RATIONALE: The definitive diagnosis is polyps. Rectal bleeding is a sign of polyps in the colon, and therefore, not coded separately. In the ICD-9-CM Index, look under Polyps. Polyps can occur in a variety of locations, follow the Index to the site of the polyps, colon. You are directed to 211.3.

5. C. 250.60, 536.3

RATIONALE: Gastroparesis is also named delayed gastric emptying. Gastroparesis may occur when the vagus nerve is damaged and the muscles of the stomach and intestines do not work normally. Food then moves slowly or stops moving through the digestive tract. The most common cause of gastroparesis is diabetes. In this case, the physician did link the gastroparesis to the patient's diabetes; therefore, we can use the appropriate diabetic complication code, 250.6x. The correct fifth digit would be 0, because the physician did not document that the patient's diabetes was uncontrolled. To find this in the Index, look under Diabetes, gastroparesis, which leads to 250.6x [536.3]. The code in the slanted brackets always is a secondary code.

Section Review 11.3

1. B. 44204

RATIONALE: Even though a peritoneoscopy was performed, it is not separately reportable because it is incidental to the more extensive procedure of the laparoscopic colectomy and the anastomosis.

2. A. 41008

RATIONALE: The CPT® code 41008 is specifically for Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; submandibular space.

3. A. 48150

RATIONALE: The CPT® code 48150 is specifically for pancreatectomy, proximal subtotal with total duodenectomy, partial gastrectomy, choledochoenterostomy, and gastrojejunostomy (Whipple-type procedure); with pancreateojunostomy

4. A. 46200

RATIONALE: In the CPT® index, look up Anus/Fissure/Excision. You are referred to 46200. This is the correct code. There was a removal (excision) of a fissure, not fistula, without a sphincterotomy or hemorrhoidectomy.
5. **B. 49505-LT**

RATIONALE: In the CPT® index, look up Hernia Repair/Inguinal. You are referred to 49491, 49495–49500, and 49505. Review the codes to choose the appropriate service. 49505 is the correct code. The repair was through an incision (not by laparoscopy) on an initial inguinal hernia on a patient over five years of age. According to CPT® guidelines, "With the exception of the incisional hernia repairs (49560–49566), the use of mesh or other prosthesis is not separately reported." It would be inappropriate to code the mesh in this scenario.
Chapter 12

Section Review 12.1

1. **A. Kidneys**
   
   RATIONALE: The renal pelvis receives urine from the kidney, travels through the ureters on the way to the bladder, but urine is formed in the kidney.

2. **C. Urethra**
   
   RATIONALE: The urine travels from the kidneys to the ureters, to the bladder, where it is stored and expelled through the urethra.

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

4. **C. Spleen**
   
   RATIONALE: The organs making up the urinary system consist of the kidneys, bladder, urethra, and ureters.

5. **A. Prostate**
   
   RATIONALE: The prostate gland is the gland that is partly muscular and glandular.

Section Review 12.2

1. **C. 592.0**
   
   RATIONALE: Documentation of calculus of the kidney and ureter are very specific to the organ site involved. Though most stones are calcium based, coding a disorder of calcium metabolism would be incorrect. Calculus of the urethra and ureter are not correct because the documentation states “nephrolithiasis (kidney).” Kidney stones, or nephrolithiasis, is coded 592.0.

2. **C. 599.71**
   
   RATIONALE: Although there is documentation that the patient previously had a TURP, there is no documentation of continuing BPH (a condition for which a TURP routinely is performed). Because documentation states “gross” hematuria, microscopic or unspecified hematuria would be inappropriate codes. Gross hematuria 599.71 is the correct answer.
3. D. 866.00

RATIONALE: There is no specific information available regarding an "open" wound into the cavity; therefore, diagnosis 866.11 is not applicable. 866.0 is an incomplete code because a fifth digit is required for the codes within the 866 series. Because there is no documentation regarding a laceration of the kidney, the only other applicable code is 866.00. A diagnosis code within the "E" series also should be added.

4. D. 600.01

RATIONALE: Because urinary retention and enlarged prostate gland (BPH) are clearly defined, you would not code these separately. ICD-9-CM 600.01 describes BPH with urinary retention and therefore you would not code urinary retention (788.20) or BPH (600.01) separately. BPH with urinary retention is coded 600.01.

5. D. 594.0

RATIONALE: A prime example of (incorrectly) choosing a code from the index without accessing the tabular list, would be if you chose 562.10 diverticulosis. Bladder diverticulum 596.3 would be the correct code for bladder diverticulum, alone, and 594.1 describes a bladder stone within the bladder, but not within the bladder diverticulum. Calculi in diverticulae of the bladder is coded 594.0.

6. D. 590.10

RATIONALE: Acute pyelonephritis is coded 590.10, unless mention of a lesion of renal medullary necrosis is documented. You would not use chronic pyelonephritis because the documentation clearly states "acute;" nor would you use 590.0 because this is an incomplete code and must be coded to the fifth digit. Remember that all ICD-9-CM codes must be coded to the highest specificity.

7. D. 788.32

RATIONALE: Female stress incontinence is documented using ICD-9-CM 625.6 and is specific to the female gender. Incontinence unspecified is coded as 788.30; because documentation clearly states stress incontinence, this code would be inappropriate. Mixed urinary incontinence is a combination of urge and stress incontinence; because there is no mention of urge incontinence, this code would be incorrect. Male stress incontinence is coded using 788.32.

8. B. 185

RATIONALE: Because this patient still has documented disease, V10.46 personal history of prostate cancer would not be correct. Unspecified neoplasm of the prostate, 239.5, would not be coded because there is a specific diagnosis of prostate cancer; therefore, 185 would be the correct code. Uncertain behavior of prostate neoplasm, as well as uncertain behavior of other neoplasms, should be coded only when the pathological report states "uncertain."
9. A. 223.0

RATIONALE: When assigning this code, you would look up oncocyto ma in the index of ICD-9-CM, which tells you to “see Neoplasm, by site, benign.” Neoplasm, kidney, benign is 223.0, which is the correct code to assign. Renal cancer, 189.0 and 189.1, would be incorrect because there is no documentation of malignancy and 223.1 is specific to the calyx, hilus and pelvis of the kidney.

10. D. 599.0

RATIONALE: Urinary hesitancy (788.41), urinary frequency (788.63) and dysuris (788.1) are all symptoms of a urinary tract infection. Because the diagnosis of UTI was confirmed by microscopic analysis, 599.0 urinary tract infection would be correct. If there was no confirmed diagnosis of UTI, the appropriate codes to note would be the presenting symptoms.

Section Review 12.3

1. D. 52224

RATIONALE: CPT® 52234 and 52235 describe a cystourethroscopy with fulguration or treatment of small (0.5 up to 2.0cm) and medium bladder tumors (2.0-up to 5.0cm), respectively. Because there is no mention of the size of the tumors treated, these codes would not be appropriate. CPT® 52204 describes a cystoscopy with biopsy and normally would be appropriate when “cold cup biopsy” is performed. But, the note states that all tumor sites are “cauterized” or fulgurated. Therefore, the correct code would be 52224, which describes cystourethroscopy with fulguration or treatment of MINOR (less than 0.5cm) lesion(s) with or without biopsy. Because of the description of CPT® 52224, the number of lesion(s) treated does not factor into the code selection.

2. B. 52630

RATIONALE: As a previous TURP was performed, CPT® 52601 would not be the appropriate because this code is used for the initial TURP. CPT® 52648 is described as laser vaporization of the prostate, and would not be coded. CPT® 52500 is described as “transurethral resection of bladder neck;” because the prostate was resected, not the bladder neck, this would not be appropriate. CPT® 52630 describes TURP of residual or regrowth of obstructive prostate tissue, which is the appropriate code. Had the patient needed a “repeat” TURP within the global period of his initial TURP, CPT® 52630 would be reported with modifier 78 appended.

3. B. 51040

RATIONALE: Aspiration of bladder with insertion of suprapublic catheter (51102) does not describe an “open” suprapubic tube insertion. Suprapubic catheter change is reported using CPT® 51705; therefore, this code would not be reported for an insertion procedure. Because 51045 describes a ureteral catheter or stent, this code would not be appropriate for a suprapubic catheter change. CPT® 51040 “Cystostomy, cystotomy with drainage” describes the suprapubic tube placement.
4. D. 51550

RATIONALE: Umbilical hernia repair codes are reported 49580-49587 and are differentiated by the age of the patient and whether the hernia is reducible, or incarcerated/strangulated. A reducible hernia is one that can be replaced to a normal position. An incarcerated or strangulated hernia is one that cannot be replaced to a normal position without surgical intervention. The description of CPT® 51550 “Excision of urachal cyst or sinus, with or without umbilical hernia repair” includes the umbilical hernia repair. Hernia repair would not be reported separately; therefore, CPT® 51550 is the correct answer.

5. B. 52005

RATIONALE: Placement of the ureteral catheters was performed via cystoscopy; therefore, CPT® 50605 would not be appropriate because this code is for an open insertion of indwelling stent into the ureter. CPT® 52332 describes the insertion of indwelling ureteral stents and would not be reported for temporary catheter insertion. CPT® 52310 describes the removal of ureteral stents, but does not cover the insertion of the catheters. CPT® 52005 “Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic services” would be the correct. There would be no additional code reported for removal of these catheters.

Section Review 12.4

1. D. 54060

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

2. C. 55250

RATIONALE: Although CPT® 55250 is the correct code to report, no modifiers would be reported with the vasectomy code because the descriptor clearly states “unilateral or bilateral;” therefore, modifier 53 and 52 are inappropriate. The procedure was not terminated due to the well-being of the patient (modifier 53), nor would you report a decreased service (modifier 52). You may add modifier RT to designate the side on which the procedure was performed.

3. A. 55250-58

RATIONALE: Using modifier 76 on the left vasectomy would not be appropriate because modifier 76 denotes a return to the operating room on the same day as the initial procedure. Modifier 58 would be appropriate because the vasectomy is a follow-up to the initial vasectomy (staged or related procedure). You might also append modifier LT to 55250.
4. **C. 54840**

RATIONALE: The spermatocele excision (spermatocelectomy) states, with or without epididymectomy; therefore, the epididymectomy codes would not be reported. Epididymectomy codes are described as unilateral (54860) or bilateral (54861). Because a lesion was not removed from the epididymis, CPT® 54830 would be incorrect.

5. **A. 55150**

RATIONALE: In the CPT® index, look for Circumcision, surgical excision, newborn. You are directed to 54150, 54160. A Plastibell is a type of clamp used in circumcision. Code 55150 is correct.

**Section Review 12.5**

1. **B. 52**

RATIONALE: Modifiers 52 is used to report reduced services. This would be used when a bilateral procedure is performed unilaterally.

2. **A. 76**

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

3. **A. TC**

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

4. **D. B or C**

RATIONALE: Depending upon the insurer, either modifier 50 or RT and LT would be appended to the surgical procedure.

5. **B. 53**

RATIONALE: When a procedure is terminated to preserve the well-being of the patient, modifier 53 is appended to the procedure code.
Chapter 13

Section Review 13.1

1. **D. Fallopian tubes and ovaries**
   RATIONALE: The word adnexa means “appendages.” The uterine appendages are the tubes and ovaries.

2. **A. Bartholin’s glands**
   RATIONALE: The Bartholin’s glands are the large glands located on either side of the vaginal introitus.

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

4. **C. Colposcopy**
   RATIONALE: The root word colp/o means vagina; colposcopy is examination of the vagina using a scope.

5. **C. Cervix**
   RATIONALE: The ovaries and salpinx (fallopian tubes) are found on both sides of the uterus. The Bartholin’s glands are found on both sides of the vaginal introitus. The cervix is singular, connecting the uterus to the vagina.

Section Review 13.2

1. **C. 233.32**
   RATIONALE: VIN III is coded as cancer in situ and VIN indicates a vulvar lesion.

2. **C. With forceps**
   RATIONALE: Code 650 is for a normal delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [rotation] or instrumentation [forceps] of spontaneous, cephalic, vaginal, full-term, single, live-born infant.
3. **B. Spontaneous abortion**

RATIONALE: ICD-9-CM and CPT® recognize three types of abortions, spontaneous (also called a miscarriage), induced (caused by a deliberate procedure), or missed. A missed abortion is when the fetus dies but the products of conception are retained.

4. **C. 642.02**

RATIONALE: Although the hypertension is pre-existing, it should be recoded in chapter 11 during the pregnancy and post-partum period. It is not necessary to add code 401.1 because the condition is already specified as benign. The fifth digit “2” is appropriate because the woman delivered during this episode of care but still has a condition that will carry over into the post-partum period.

5. **D. 627.1**

RATIONALE: This bleeding is after the end of the woman’s menses and should be described as postmenopausal.
Chapter 14

Section Review 14.1

1. B. Glands
   RATIONALE: The endocrine system is comprised of glands, located throughout the body, that produce various hormones.

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

3. A. Near the kidneys
   RATIONALE: Adrenal means near the kidneys since the adrenal glands sit directly atop of the kidneys, one per side.

4. C. Excision of the thymus by cutting into the chest
   RATIONALE: Thymectomy (partial or total) describes excision of the thymus. This may be achieved by a number of surgical approaches, including transcervical (via the neck), transthoracic or sternal split (via chest).

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

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

7. D. Sciatic
   RATIONALE: The largest nerve of the body is the sciatic nerve which divides into the tibial and common fibular (common peroneal) nerves.
8. C. Vertebra

RATIONALE: Vertebra is not a region of the spinal nerve segments since that is the cartilaginous segment that makes up the spinal cord. The lumbar region has five segments that form five pairs of lumbar nerves. The cervical region has seven segments that form eight pairs of cervical nerves. The coccygeal region has three segments forming one pair of coccygeal nerves.

9. A. A single complete vertebral bone

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

10. D. Parietal lobe

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

Section Review 14.2

1. C. 242.31

RATIONALE: The diagnosis is indexed in the Alphabetical Index under Thyrotoxicosis, with goiter, nodular guiding you to code 242.3. Your fifth digit is a one to indicate the crisis. There is no documentation of the nodule being uninodular or multinodular.

2. B. 193.246.0

RATIONALE: When a patient has functional activity associated with any neoplasm such as thyrotoxicosis or disorders of thyrocalcitonin secretion, the neoplasm should be reported first and the functional activity caused by the neoplasm should be reported as a secondary code. There is no documentation of the patient having a history of cancer so it would be inappropriate to code the V code for this scenario. Thyroid cancer is indexed in the Neoplasm Table under thyroid (gland), Malignant, Primary (column) guiding you to code 193. The Tabular for 193 states “Use additional code to identify any functional activity.” The second diagnosis is indexed under Hypersecretion, calcitonin guiding you to code 246.0

3. A. 250.71, 785.4

RATIONALE: Diabetes with gangrene is found in the Alphabetical Index under Diabetes, gangrene, guiding you to code 250.7. Your fifth digit is one since the patient is a type I diabetic and there is no documentation of the diabetes being uncontrolled. In the Tabular section under subcategory code, 250.7, there is a note that states: Use additional code to identify manifestation as: diabetic: gangrene (785.4) which means gangrene will be coded as a secondary code. There is no documentation that the patient has secondary diabetes so it would be inappropriate to code that type of diabetes for this scenario.
4. C. 982.1, 323.72, E861.3

RATIONALE: Toxic myelitis is indexed under Myelitis, due to, toxic, guiding you to code 989.9 [323.72]. Note: Brackets are used in the Alphabetic Index to identify manifestation codes. In the Tabular listing code 989.9 is an unspecified substance, chiefly nonmedicinal as to source. In this scenario we do know the substance that poisoned the patient. In the Table of Drugs and Chemicals look for carbon, tetrachloride (vapor) guiding you to code 987.8. For the E code, we know that is an accidental poisoning since the substance was inhaled by putting out a fire guiding us to code E869.8. Code 323.72 will be reported as a secondary code. There is a Code first note under the subcategory code 323.7 that states: Code first underlying cause, as: carbon tetrachloride (982.1); however, this code represents poisoning by liquid carbon tetrachloride. The correct code is 987.8 for poisoning by carbon tetrachloride vapor.

5. B. 338.11, 723.1

RATIONALE: The scenario documents the patient of having acute pain due to being in a MVA accident (trauma). In the Alphabetical Index look under Pain, acute, due to trauma guiding you to code 338.11. The keywords to direct you to the codes in the 338 category are “acute pain” and there is no documentation on a definitive diagnosis on what is causing the pain. The Guidelines state that codes from 338 may be used in conjunction with codes that identify the site of pain; therefore, 723.1 Cervicalgia, is reported.

Section Review 14.3

1. D. 62362, 62350-51

RATIONALE: Patient is having an insertion of a programmable pump and an intrathecal catheter performed to infuse pain meds for pain management. Patient is not having an infusion of pain meds performed in this scenario. This is indexed in the CPT® manual under Infusion Pump, Spinal Cord guiding you to codes 62361–62362. The second code is indexed under Catheterization, Spinal Cord guiding you to codes 62350–62351.

2. C. 62270

RATIONALE: Patient is not having an injection or an aspiration of contents found in the nucleus pulposus, intervertebral disc, or paravertebral tissue. The procedure is a spinal puncture in the lumbar area for a diagnostic purpose of finding out if the patient has meningitis. This is indexed in the CPT® manual under Spinal Tap, Lumbar guiding you to code 62270.

3. B. 61154

RATIONALE: The keywords in the scenario to guide you to the correct code is burr hole, evacuation, hematoma and subdural. All those words are found in the code description of procedure code 61154. This is indexed in the CPT® manual under Burr Hole, Skull, Drainage, Hematoma guiding you to codes 61154–61156.
4. A. 63005

RATIONALE: Only a laminectomy and decompression is being performed in the scenario. There is no documentation of a facetectomy, foraminotomy, or discectomy being performed. This is indexed in the CPT® manual under Laminectomy or Decompression, Spinal Cord.

5. C. 95955-26

RATIONALE: The physician is using an EEG to record and measure the patient's brain electrical activity while performing thromboendarterectomy (not intracranial surgery). This is indexed in the CPT® manual under Electroencephalography, Intraoperative guiding you to code 95955.

Section Review 14.4

1. B. S2348

RATIONALE: This HCPCS code is indexed under Decompression, disc guiding you to code S2348.

2. B. 64721-53

RATIONALE: Modifier 53 is the appropriate modifier to append since the surgeon elects to terminate the surgical procedure due to the patient’s blood pressure dropping which is threatening the well being of the patient.

3. C. 57

RATIONALE: Modifier 57 is the appropriate modifier to append to the Evaluation and Management Service since the evaluation or examination of the child’s condition lead the surgeon to make a decision to perform surgery. The surgical procedure of draining the hematoma is a major procedure that has a 90 day global period. Modifier 25 is only appended to minor procedures which have a 0-10 day global period. Modifiers 22 and 54 are only appended to procedure codes not Evaluation and Management services.

4. C. 62258-78

RATIONALE: The baby is having a complete removal of the cerebrospinal fluid shunt system with a replacement. This is indexed in the CPT® Index under Shunt, Brain, Removal guiding you to codes 62256–62258. Modifier 78 is the appropriate modifier to append for two reasons: (1) The CSF shunt had a complication and the baby had to return to the operating room following the initial procedure during the post-operative period; (2) The same surgeon that performed the initial procedure is also performing the removal and replacement of the shunt.
5. A. 99212-24

RATIONALE: Even though the patient is in a post-operative period from a surgery, the physician can bill this E/M visit and append modifier 24. The reason is that the physician had to perform an examination that was unrelated to her surgery (repair of the nerve to her finger). Modifiers 55 and 54 are only appended to surgical procedure codes not Evaluation and Management services.
Chapter 15

Section Review 15.1

1. B. Balancing the strength of extraocular muscles
   RATIONALE: Strabismus in the CPT® index takes you to codes 67311-67399, a subsection entitled Extraocular Muscles. All of these codes involve the muscles that move the eyeball, and most address adjusting one or more ocular muscles to correct an imbalance in the muscles that causes the eye to be pulled too much in one direction, causing disorders like crossed or wandering eyes.

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

3. B. Air conduction
   RATIONALE: The hearing of a patient would be interrupted by impacted ear wax, called cerumen. The wax would interrupt the air conduction of sound as it traveled through the ear canal across the tympanic membrane to the middle and inner ear. Bone conduction would not be affected by ear wax buildup.

4. B. The middle ear
   RATIONALE: The three ossicles (malleus, incus and stapes) are found in the middle ear. When sound travels by air into the external auditory canal, it causes the tympanic membrane to vibrate. The sound is then transferred from the membrane to the tiny ossicles. From the stapes, the vibration is transferred to the oval window, and into the fluid of the inner ear. From there, the signal is transmitted through the cochlear nerve.

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

6. C. Surgical repair of the eyelid.
   RATIONALE: Blephar/o is a root word identifying the eyelid, and plasty indicates a surgical repair; therefore, the correct answer is C.

7. A. Cornea
   RATIONALE: Kerato/ is a root word identifying the cornea. In keratoconus, the cornea protrudes, causing a refraction error. Its cause is unknown, but it is thought to be hereditary.
8. D. The tympanic membrane is incised.

RATIONALE: Myring/a is a root word identifying the tympanic membrane and -otomy is a suffix indicating an incision, so D is the correct answer.

9. A. The inner ear

RATIONALE: The inner ear is responsible for balance in addition to conduction of sound, and therefore A is the correct answer. Vertigo, or extreme dizziness, is often a symptom of inner ear disorders including Meniere's disease and vestibular neuronitis.

10. D. All of the above.

RATIONALE: All of the above are correct. The eye and ear both occur bilaterally, and their individual components occur bilaterally as well. Even within ophthalmology, you will find specialists in one area, for example, retinal specialists or ophthalmologists specializing in cataract surgery. The same is true for otorhinolaryngology: within that specialty, you will find subspecialists for hearing and vestibular disturbances. Because they are organs of communication, the eye and the ear are considered to be the most important sense organs in the body, and physicians work very hard to safeguard and optimize their patients' sight and hearing.

Section Review 15.2

1. B. 250.51, 362.04

RATIONALE: The note under 362.0 reads, “Code first diabetes (249.5, 250.5).” However, 250.5 is not a valid code. It requires a fifth digit. You should not code from the instructions or notes, but use these notes to guide you to the right codes. Under 250.5, you are instructed in ICD-9-CM to select a fifth digit based on the patient’s status as Type I or Type II and whether the patient is stated as uncontrolled. Reading the notes, we can see the correct diabetes code is 250.51, and that it should be sequenced first. Code 362.04 exactly matches the documentation: mild nonproliferative diabetic retinopathy. B is the correct answer.

2. D. 790.92

RATIONALE: Look at the chief complaint—the reason for the visit—when considering the primary diagnosis. In this case, the mother thought the son has a recurring ear infection because of the child’s excessive crying. D is the correct answer because it is the chief complaint and no other diagnosis was found. The V70 and V72 codes are inappropriate because these codes describe routine exams in asymptomatic populations. Code 380.22 would be wrong because as a rule-out diagnosis it was not validated in the exam.
3. C. 192.0

RATIONALE: Although an acoustic neuroma is indexed to 225.1 Benign neoplasm of cranial nerve, the descriptor, “malignant” changes the way we would report this disorder. A note at the beginning of the Table of Neoplasms discusses the classifications in the columns of the table, and advises, “the guidance in the index can be overridden if one of the descriptors ... is present.” Therefore, because the pathologist has said that this particular “acoustic neuroma” is malignant, the word “malignant” would override the index entry. Therefore, the correct code is 192.0 Malignant neoplasm of cranial nerves. It’s very important that we study and understand the information provided in the guidelines and notes within our code books. We don’t have to memorize the information, but we must be willing to look beyond the codes for the answers. Sometimes, the answers are in the instructional notes and guidelines.

4. D. 872.01, V03.7

RATIONALE: This is a simple open wound of the earlobe, reported with 872.01. Although you might consider an earring a “foreign body,” the earring was not part of the presenting problem; the wound was the presenting problem. The earlobe is clearly part of the auricle; therefore, nonspecific code 872.8 would be inappropriate. The patient needed tetanus prophylaxis, and this is reported with V03.7. There was no reported “exposure,” as is needed to report V01.89, but only a need for the vaccination. V06.5 reports tetanus in combination with another drug, which is not what was administered here. D is the correct answer.

5. A. 360.44

RATIONALE: Leucocoria is indexed to 360.44 and reports a symptom rather than an actual diagnosis. In leucocoria, a white mass behind the lens is visible to the physician upon examination of the eye. It can be indicative of retinoblastoma, a congenital retinal cancer, but until this diagnosis is confirmed, the symptom of leucocoria is the appropriate diagnosis to report.

6. B. 372.03

RATIONALE: Pink eye, a highly infectious form of mucopurulent conjunctivitis, is indexed to 372.03. Other mucopurulent conjunctivitis. This infection typically is accompanied by very bloodshot eyes and a heavy discharge.

7. D. 389.9

RATIONALE: Sometimes, the best we can do until we have more information is to report a nonspecific diagnosis. In this case, the patient has an unspecified hearing loss. No scientific study of the hearing loss was made, so 794.15 would not be appropriate. Instead, report the nonspecific loss with 389.9.
8. A. 996.69, 376.01, V43.0, V10.84

RATIONALE: A is the correct answer. It captures the entire story: The patient has an infection due to an implant (996.69) in her orbit (V43.0) causing cellulitis (376.01). The implant is the result of the patient's previous cancer (V10.84). A note under 996.6 states, "Use additional code to identify specified infections." Although we don't have documentation of the infective agent, we do know the patient has orbital cellulitis and we code that secondarily. The V codes are informational. We wouldn't report a foreign body because this is an implant, covered with 996.69. If you selected 996.63, infection due to nervous system implant, you probably didn't use your index to determine the code, or you didn't read the entire code set—"prosthetic orbital implant" is listed as an inclusion term under 996.69. If you selected cellulitis code 682.0, you neglected to review the "excludes" notes, which state orbital cellulitis is reported instead with 376.01.

9. C. 872.61

RATIONALE: The correct answer is C. Foremost, this is an acute injury. The codes in the 384.2 subcategory are for perforations that persist after an illness or injury is resolved. Excluded is "traumatic perforation (current injury)" Code 910.8 is for a superficial injury, but this isn't superficial because it is in the middle ear. Do not confuse "simple" with "superficial." Code 872.71 is "complicated," and this wound is simple, without a foreign body or sign of infection. You also could report E codes to describe the circumstance of the injury: E920.8 Cutting and piercing as cause of accident. Plant thorn is an inclusion term in this category. Also consider reporting E016.1 Accident occurring while gardening or landscaping and E849.0 Place of occurrence, home. These E codes help establish the proper insurer for the services provided.

10. A. 365.9

RATIONALE: We don't have a lot of information to work with here, so 365.9 Unspecified glaucoma is our best choice. In a medical office, you would have access to the entire patient record and to the physician to find out more about what type of glaucoma the patient has. The important thing to remember here is that the patient still has glaucoma, despite the normal (WNL is "within normal limits") IOP (intraocular pressure). Without medication, the patient has glaucoma. Therefore, V12.49 would be inappropriate because it reports a history of a resolved condition.

Section Review 15.3

1. B. 65275

RATIONALE: The presence of the foreign body has no bearing on code selection. Note that the code reads "with or without removal of foreign body." Key to code choice is the site of the injury (the cornea) and that it was a nonperforating injury. The topical anesthetic is bundled into the procedure, although the physician could bill separately for any IV sedation that was used or if a therapeutic contact lens was applied (92070).
2. B. 69105

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

3. A. 65420-50

RATIONALE: A pterygium is an overgrowth of conjunctiva that forms in the nasal aspect of the eye and grows outward toward the cornea. Pterygium are reported in ICD-9-CM with codes from 372.4; 372.44 reports recurrent pterygium and would be the correct choice here. Excision of pterygium is reported separately from other conjunctival disorders, with codes 65420 and 65426. Because this was repaired simply, 65420 is the correct code. Modifier 50 indicates a bilateral procedure was performed.

4. C. 69310

RATIONALE: Consider the goal of this procedure: to reduce the stenosis in the external auditory canal. This is called a "meatoplasty" and is reported with 69310 for an acquired condition, regardless of how simple or complex the reconstruction is.

5. C. 67318, 67331, 67335

RATIONALE: Code 67318 is the only code listed that describes a procedure on the superior oblique muscle. In addition to 67318, we would report add on codes for adjustable suture and also for a patient with a history of ophthalmic surgery (67331). The medical history of ocular surgery makes the procedure more risky and difficult, and use of this code helps the physician report this complexity. Modifier 51 never is applied to add-on codes.

6. A. 69799

RATIONALE: The correct answer is A, an unlisted procedure. Round window implants are a new technology not yet assigned CPT® a code. The word "transducer" should have alerted you to the hearing aid component of this procedure. There is no new technology code for this type of procedure, so an unlisted code is your best option. The round window is the barrier between the middle and inner ear, but is still considered middle ear.

7. C. 68520

RATIONALE: The stone was embedded in the sac, which was removed. Therefore, you cannot bill for both removal of the stone and removal of the sac. Only 68520 would be reported. This is an unbundle that typically will be documented with payers, but logic should let coders know these two codes wouldn’t be reported together. The lacrimal gland is located near the eyebrow; the lacrimal sac is the upper dilated end of the lacrimal duct, aligned with the nostril. Don’t confuse the two sites.
8. D. 69637

RATIONALE: When you are looking at operative notes, use a highlighter to note the key words on the note. Here, we note the approach, mastoidotomy. Most important to code selection, though is the use of a prosthetic implant, reported with 69637.

9. C. 67120

RATIONALE: If you didn’t know that an aqueous shunt is implanted material in the extraocular posterior segment, you could come to that understanding by reviewing all the aqueous shunt codes in the Eye and Adnexa section of CPT®. Within the aqueous shunt subsection is the parenthetical note, “For removal of implanted shunt, use 67120.”

10. C. 92012

RATIONALE: Intermediate ophthalmological services are described in CPT® as the evaluation of a new or existing condition of the eye not requiring comprehensive services. This would be reported with 92002 for a new patient, or 92012 for an existing patient. This service is for an existing patient, so 92012 is the correct code. Documentation does not support any level of E/M.
Chapter 16

Section Review 16.1

1. A. 00528

RATIONALE: Thoracoscopy in the Index provides the above four choices. All of these codes are related to thoracoscopy. The coder must review the codes in the anesthesia section to determine that 00528 describes a diagnostic procedure, without an indication of one-lung ventilation utilization.

2. D. 00406

RATIONALE: Mastectomy is not listed in the Index. The coder must look under “Breast,” which provides a range of three choices. The coder must review the codes in the anesthesia section to determine that 00406 is the appropriate code selection.

3. B. 00790

RATIONALE: A cholecystectomy is the surgical removal of the gallbladder. If a coder is not familiar with this surgery or terminology, look under “Cholecystectomy” in the Index and review the surgical section under 47562. The surgery is described as removal of the gallbladder—identifying the anatomical area as upper abdomen. Reference the Index for Anesthesia, Abdomen, Intraperitoneal, and you are directed to 00790, which describes this procedure including laparoscopy.

4. A. 01622

RATIONALE: Diagnostic arthroscopy is not listed in the Index. The coder must either look under “Arthroscopic Procedures, Shoulder” or “Shoulder.” Both provide a range of code choices. The coder must review the codes in the anesthesia section to determine that 01622 is the appropriate code selection.

5. D. 01638, 64416-59

RATIONALE: In this example, it is quickest to look at the two anesthesia code selections first. 01630 is not a total shoulder replacement. Since the brachial plexus was requested for postoperative pain management, it is appropriate to report separately. However, 64415 describes a single injection and 01996 is reported with epidurals—not brachial plexus blocks, as noted below the description of 64415. Therefore, the correct answer is 01638, 64416-59. Modifier 59 is appended because nerve blocks are bundled with anesthesia codes. In this case, the block is for postoperative pain and is reported separately.
6. B. 01967

RATIONALE: The continuous epidural catheter from the surgical section (62319) is a flat-fee code and does not accurately describe the anesthesia service. 01961 describes a cesarean delivery. Reference the Index for “Anesthesia, Childbirth, Vaginal Delivery.” The description of 01967 includes replacement of the catheter during labor. Because the code includes any repeat needle placement or replacement of the epidural during labor, it is not reported twice.

Section Review 16.2

1. A. 577.9

RATIONALE: Pancreas is not listed in the Index under “Mass;” however, “Mass, specified organ NEC” indicates the coder must look under Disease of specified organ or site. “Disease, pancreas” is coded correctly as 577.9. The coder should not default to the Neoplasm Table because the term “mass,” unless otherwise stated, should not be coded as a neoplasm.

2. D. 218.9

RATIONALE: The preoperative diagnosis is disregarded in this case because a more definitive diagnosis was determined following surgery. Although “Fibroid” under the Alphabetic Index indicates see also “Neoplasm, connective tissue, benign—uterus” is listed under Fibroid as 218.9, which takes precedence over the Neoplasm Table.

3. C. 374.84, V15.80

RATIONALE: The reason for the anesthesiologist’s involvement for the MAC in the surgery is the patient’s history of failed sedation. The eye cyst is first-listed as it is the medical necessity for the anesthesia care and V15.80 is an additional diagnosis to explain the need for anesthesia care. Also, as noted in the Tabular, V15.80 cannot be listed as a primary diagnosis.

4. B. 719.96

RATIONALE: The patient’s previous surgery has no relevance to the anesthesia for the knee surgery. DJD, using either Degeneration or Disease of joint leads the coder to Osteoarthrosis. The coder should not assign 715.96 without checking the numeric index. As indicated in the Tabular at the beginning of Chapter 13, the fifth digit “6” includes the knee joint.

5. C. 823.00

RATIONALE: A linear fracture identifies this as a closed fracture (See Notes above Fracture). Using the Alphabetic Index under “Fracture, tibia, proximal end” sends the coder to upper end. The fifth digit “0” identifies the tibia alone.
Section Review 16.3

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

2. B. When the anesthesiologist begins to prepare the patient
   RATIONALE: Anesthesia time begins when the anesthesia provider begins to prepare the patient for the induction of anesthesia, as listed in the Anesthesia Guidelines.

3. A. The anesthesia code representing the most complex procedure is reported
   RATIONALE: Only the anesthesia code representing the most complex procedure is reported. The most complex procedures are usually the highest base unit value service.

4. D. P1
   RATIONALE: A normal healthy patient is reported as P1 as listed in the Anesthesia Guidelines. No additional value is recognized.

5. D. None of the above
   RATIONALE: Qualifying circumstances may not be separately reported if the anesthesia code already takes difficulty into consideration. Anesthesia code 00562 indicates, “Do not report 00562 in conjunction with code +99116 or +99135.” No code is separately billed.

6. B. 93503
   RATIONALE: Coder may look under either “Insertion” or “Catheterization” to find the Flow Directed (93503) catheter code listed under Cardiac. This service may not be reported as a right heart catheterization (93451) because it is a diagnostic procedure performed to assess right heart function. Catheterization of the pulmonary artery (93503) is a right heart catheterization which is performed for monitoring purposes.

7. D. 31500
   RATIONALE: The anesthesiologist is not providing an intubation for a patient undergoing anesthesia. An emergency intubation is correctly reported as 31500.

8. C. -74
   RATIONALE: Although not typically reported by physicians, insurance companies may require specific modifiers. The 74 modifiers best describes an anesthesia service that was discontinued after administration of anesthesia (complications were during surgery) in an ASC.
Section Review 16.4

1. C. 00142-AA-QS

RATIONALE: An anesthesiologist who is performing personally reports her service to Medicare with an "AA" modifier. Because the service was performed under MAC, a "QS" modifier is also reported.

2. B. 01961-QK and 01961-QX

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

3. D. AD and QX

RATIONALE: An anesthesiologist who is medically supervising reports his/her service separately from the CRNA, depending on the number of concurrent cases. Because there are five concurrent cases, the appropriate modifiers to report are AD for the physician claims and QX for the CRNA claims. Reporting a QZ modifier indicates a case performed by a CRNA without medical direction by a physician. Only one claim is filed for the case (the CRNA claim).

4. B. QZ

RATIONALE: A CRNA without medical direction is reported appropriately with a "QZ" modifier.

5. C. G9

RATIONALE: Anesthesia care for a patient who is undergoing MAC and has a history of severe cardiopulmonary disease is reported appropriately with a G9 modifier. The additional modifier QS is not necessary because the description for G9 includes monitored anesthesia care.
Chapter 17

Section Review 17.1

1. D. Superior and inferior

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

2. C. At an angle, neither frontal or lateral

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

3. A. AP

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

4. D. Coronal

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

5. B. Projection

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

Section Review 17.2

1. B. 611.72

RATIONALE: When a test is ordered for a sign or symptom, and the outcome of the test is a normal result with no confirmed diagnosis, the coder will report the sign or symptom that prompted the physician to order the test. Because the test was ordered for a lump in the breast, but the outcome is normal, the lump in the breast (611.72) is reported as the diagnosis.

2. D. 823.82

RATIONALE: The final diagnosis is available at the time of reporting so the final diagnosis should be used instead of the sign or symptom. The final diagnosis of a fracture of the tibia and fibula should be reported as the diagnosis.
3. B. 793.0, 473.9, 478.30

RATIONALE: The findings of the CT were nonspecific and would not be considered a final diagnosis. The first diagnosis reports the nonspecific findings. Because the findings were inconclusive, you also would report the signs and symptoms for which the CT was ordered.

4. C. V72.5

RATIONALE: For encounters for routine radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign V72.5. Because there were no signs or symptoms for the chest X-ray, and it was routinely performed as part of a preventive medicine exam, ICD-9-CM V72.5 is reported.

5. D. V72.83

RATIONALE: The pre-operative exam is a general preoperative exam. When an X-ray is performed as part of a general preoperative exam, ICD-9-CM code V72.83 should be used.

Section Review 17.3

1. D. 70390, 527.4

RATIONALE: A contrast radiography of the salivary gland and ducts is considered sialography. Code 70390 describes sialography supervision and interpretation.

2. C. 74150, 72192

RATIONALE: Both a CT of the abdomen and of the pelvis was obtained; thus, requiring two codes to report the service. "Without contrast" codes would be used.

3. B. 76010

RATIONALE: In the index, look up "X-ray." Then, find "nose to rectum, Foreign body." The index guides you to 76010. Turning to 76010, you will find this code is applicable to a child only. This is due to the length of the nose to rectum in a child, versus the length in an adult.

4. C. 70150

RATIONALE: Three views of the facial bones (Waters view, Caldwell view, and lateral view) were ordered. Looking in the index, "X-ray, facial bones" guides you to 70140–70150. Code 70150 is for a complete, minimum three view X-ray of the facial bones.
5. D. 72156

RATIONALE: In the CPT® Index, “magnetic resonance imaging, spine, cervical” guides you to codes 72141–72142, 72156–72158. Because both without contrast and with contrast were used for this cervical MRI, CPT® code 72156 would be selected.

Section Review 17.4

1. B. 76705

RATIONALE: Ultrasound of the abdomen includes the liver, gall bladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava. Because the ultrasound was of only the liver, it would be considered a limited abdominal ultrasound.

2. D. 76815

RATIONALE: The position of the fetus is the reason for the test; therefore, the ultrasound is limited. The description of 76815 includes 1 or more fetuses and thus the code would be reported once only.

3. B. 76775

RATIONALE: In the CPT® index, “Ultrasound, Kidney” guides you to range 76700-76776. CPT® code 76776 is an ultrasound for a transplanted kidney, including real-time and duplex Doppler with image documentation. In our scenario, duplex Doppler of the kidney is not performed. The parenthetical instruction under CPT® 76776 indicates to report 76775 for an ultrasound of transplanted kidney without duplex Doppler. Therefore, the correct code is 76775.

4. C. 77055, 77051

RATIONALE: The physician has ordered a unilateral diagnostic mammogram. CPT® 77055 is the code for a unilateral diagnostic mammography. The use of computer aided detection software is reported by the add-on code 77051 for a diagnostic mammogram.

5. A. 76506

RATIONALE: In the CPT® index, echoencephalography guides you directly to 76506.
Section Review 17.5

1. B. 77427

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

2. D. 76499

RATIONALE: Dual energy X-ray absorptiometry (DEXA) studies are found in the code range 77080-77082. Under this range of codes is a parenthetical instruction stating to use 76499 for a DEXA body composition study.

3. A. 77777

RATIONALE: In this case, brachytherapy is performed using interstitial radiation seeds. The code is determined based on the number of radioactive sources. In this case there are nine, which is reported as intermediate with code 77777. Review the CPT® coding guidelines for the definition of simple, intermediate, and complex for clinical brachytherapy.

4. D. 19102-RT, 77031-26

RATIONALE: In this case a needle biopsy is performed on the right breast using stereotactic imaging guidance. You need to select the code for the biopsy. In this case, it is a needle biopsy. 19102 is the correct code to report a biopsy obtained using imaging guidance. There is a parenthetical note following 19102 that states to report the imaging guidance. In this case, it is stereotactic which is reported with 77031. Modifier RT is used to indicate the right breast. Modifier 26 is appended to report the professional component.

5. A. 77080

RATIONALE: DEXA is dual-energy X-ray absorption. The site is of the spine, which is part of the axial skeleton. From the CPT® index, look up “bone density/axial skeleton.” In this case one site (spine) is involved in the study. The correct code is 77080.
Chapter 18

Section Review 18.1

1. C. Disease
   RATIONALE: The word root path means "disease". The suffix -logy is "study of".

2. D. Microbiology
   RATIONALE: The root words micro (small) and bio (life) combined with -logy describe the study of small life forms.

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

4. B. Quantitative
   RATIONALE: A quantitative test determines the amount of a substance that is present in a specimen.

5. C. Quantitative
   RATIONALE: A quantitative test determines the amount of a substance found in the specimen. A qualitative test determines the presence or absence of the substance.

Section Review 18.2

1. C. V01.5
   RATIONALE: The codes in category V01 are for exposure to a disease without signs or symptoms of infection.

2. C. 174.9
   RATIONALE: Always code the most specific diagnosis that is known. When a diagnosis of carcinoma of the breast has been confirmed, it is inappropriate to code a less specific diagnosis, no matter what reason was for the original test.
3. B. 714.0, V58.64

RATIONALE: Code both the arthritis and the long-term use of NSAIDs. Although the use of the NSAID is the reason for the test, the codes in category V58.6 cannot be used alone or as the first diagnosis code. Note: Code 714.0 indicates that an additional code is to be used to identify manifestation.

Myopathy (359.6)
Polyneuropathy (357.1)

These codes would be used only if the manifestation was indicated in the report.

4. B. V10.46

RATIONALE: Once cancer has been excised and there is no further treatment directed toward the cancer site without recurrence, code a personal history of malignancy code. In this case, use V10.46.

5. D. 795.09

RATIONALE: Choose a code that identifies unspecified previous abnormal findings on cervical Pap smear. Although the second test results came back normal, the previous abnormal finding supports the need for a repeat test.

Section Review 18.3

1. A. 85530

RATIONALE: PTT stands for protamine tolerance test. This can be found in the Index.

2. C. 81002-QW

RATIONALE: 81000 is for dipstick urinalysis. Modifier 26 is not needed in the physician office but QW is required as this is a CLIA waived test.

3. B. 80076, 82565

RATIONALE: Code the panel anytime all of the tests listed in the panel are completed. If additional tests are also performed, they are coded separately.

4. C. 88040

RATIONALE: Services related to legal investigations and trials are forensic examinations.
5. **D. 86359**

RATIONALE: Code 86359 is for total T-cell count. If other studies were performed, they were not ordered and may not be billed, no matter how seemingly appropriate.
Chapter 19

Section Review 19.1

1. C. Outpatient consultation

RATIONALE: Dr. Smith has sent the patient for a consultation to Dr. Parker. Dr. Parker evaluates the patient and provides a written report back to the requesting physician. An evaluation and management code from outpatient consultation should be selected.

2. B. Preventive medicine, established patient

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

3. D. Initial observation care

RATIONALE: The patient came through the Emergency Department. However, the patient was admitted to observation. The guidelines for Initial Observation Care tell us that all services provided by the admitting physician for the same date of service are included in the initial hospital care, such as emergency department services. If the patient was discharged on the same date of service, a code from Observation or Inpatient Care Services (Including Admission and Discharge Services) would be selected.

4. C. Nonbillable

RATIONALE: The follow up visit from the neurosurgeon is to follow up with care given during the surgery; therefore, it would not be considered a consultation. Postoperative care after the removal of cancer from the spinal cord is bundled in the surgical procedure. Because it would be within the global period, it would not be separately reported.

5. A. Office visit, new patient

RATIONALE: Consultations performed at the request of a patient are coded using office visit codes. Because she had not seen Dr. Howard before, this would be considered a new patient visit.
Section Review 19.2

1. B. Expanded problem focused

RATIONALE:

<table>
<thead>
<tr>
<th>History</th>
<th>Brief (–3)</th>
<th>Brief (1–3)</th>
<th>Extended (4 or more)</th>
<th>Extended (4 or more)</th>
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<tbody>
<tr>
<td><strong>HPI</strong></td>
<td>Location Severity Timing Modifying Factors Quality Duration Context Assoc Signs &amp; Symptoms</td>
<td>(–3)</td>
<td>(1–3)</td>
<td>(4 or more)</td>
</tr>
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<td><strong>ROS</strong></td>
<td>Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo</td>
<td>None</td>
<td>Pertinent to problem (1 system)</td>
<td>Extended (2-9 systems)</td>
</tr>
<tr>
<td><strong>PFSH</strong></td>
<td>Past history (current meds, past illnesses, operations, injuries, treatments) Family history (a review of medical events in the patient’s family) Social history (an age appropriate review of past and current activities)</td>
<td>None</td>
<td>None</td>
<td>Pertinent (1 history area)</td>
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</tbody>
</table>

**CC:** Follow-up of hospitalization for pneumonia.

**HPI:** Quality—doing well

**ROS:** Respiratory—hosp for six days, IV antibiotics, Singulair®, doing well with breathing since.

**PFSH:** None
2. **B. Expanded problem focused**

**RATIONALE:**

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<th>Brief (1–3)</th>
<th>Extended (4 or more)</th>
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**CC:** Asthma exacerbation

**HPI:** Duration—2–3 days

Severity—difficulty breathing

Assoc S & S: cough

Quality—maybe has slight productive cough

**ROS:** Constitutional—denies fever or chills

Respiratory—has not been able to locate inhalers for a week

**PFSH:** None
3. B. Expanded problem focused

RATIONALE:

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<th>History</th>
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CC: skin lesions

HPI: Location—forehead & lateral to right eye
Duration—about a year

ROS: Integumentary—history of squamous cell carcinoma
Stated “Otherwise well,” but this is not an indication that all other systems were reviewed.

PFSH: Past, Family, and Social all reviewed as it relates to skin.
4. **B. Expanded problem focused**

**RATIONALE:**

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<td>ROS Const GI Integ Hem/lymph Eyes GU Neuro All/Immuno Card/Vasc Musculo Psych All other negative Resp ENT, mouth Endo</td>
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**CC:** Fever

**HPI:** Duration—less than one day

Severity—high fever

Associated S & S—decreased appetite

**ROS:** GI—no vomiting or diarrhea

Resp—parents unaware of any cough

Rest of review of systems reviewed and negative: Complete ROS

**PFSH:** Personal history—current meds

Social history—not exposed to second hand smoke
5. B. Expanded problem focused

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CC: ATV accident

HPI: Context—ATV Accident
Location—Lip and chin lacerations

ROS: GI—unremarkable for nausea & vomiting
Eyes—unremarkable for blurred vision
Neuro—unremarkable for headache

PFSH: Past history—surgeries and illnesses reviewed, current meds
Social history—nonsmoker, moderate alcohol

Note: only 2 of 3 PFSH are needed for complete for Emergency Department, but all three are needed for a complete PFSH for a hospital admit.
Section Review 19.3

1. C. Detailed
   
   RATIONALE:
   
   Organ Systems: Constitutional, Skin, Respiratory, Cardiovascular. There are four organ systems examined with detailed documentation. The level of exam is Detailed.

2. C. Detailed
   
   RATIONALE:
   
   Organ Systems: Constitutional, Genitourinary, Gastrointestinal. There are three organ systems examined with detailed documentation. The level of exam is Detailed.

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

4. B. Expanded problem focused
   
   RATIONALE:
   
   Body Areas: Neck, Abdomen
   Organ Systems: Constitutional, ENMT, Respiratory
   
   There three organ systems examined and two Body Areas. This is a limited exam of the affected body areas. The level of exam is Expanded Problem Focused.

5. D. Comprehensive
   
   RATIONALE: Organ Systems: Constitutional, Eyes, ENMT, Respiratory, Cardiovascular, Gastrointestinal, Integumentary, Neurologic, Lymphatic, Musculoskeletal. Ten organ systems were examined. The level of exam is Comprehensive.
Section Review 19.4

1. B. Low
RATIONALE: The patient is in for follow up of chronic conditions. The conditions are both established and stable (two points). There is no data reviews and moderate risk (two stable chronic conditions). Medical Decision Making is Low.

2. D. High
RATIONALE: New problem to examiner, additional workup—dialysis (four points); Labs, EKG, and X-Ray Reviewed (three points); Risk is High (chronic illness posing a threat to life). The medical decision making is high.

3. B. Low
RATIONALE: Established problem worsening (two points); Ultrasound reviewed (one point), Risk is moderate (simple mastectomy). The medical decision making is Low.

4. D. High
RATIONALE: Three problems worsening (four points); Labs reviewed (one point); Chronic illness posing a threat to life (Exacerbation of Chronic Heart Failure, Poorly Controlled Hypertension, Worsening Acute Renal Failure due to cardio-renal syndrome). The medical decision making is high.

5. C. Moderate
RATIONALE: Two problems worsening (4 points). No data reviewed with moderate risk (elective major surgery). The medical decision making is Moderate.

Section review 19.5

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

2. C. 99223
RATIONALE: Initial hospital care codes require all three key components be met to determine a level of visit. In this case, the comprehensive history and exam, and the high level of medical decision making support a 99223.
3. **B. 99202**

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

- **History—HPI (Extended), ROS (Extended), PFSH (none) = EPF**
- **Exam—Expanded problem focused (limited exam of ears, nose, throat, and neck)**
- **MDM—Moderate for the prescription drug management.**

The documentation supports 99202.

4. **C. 99309**

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

- **History—(Extended), ROS (Extended), PFSH (1-Pertinent) = Detailed**
- **Exam—Detailed exam of Eyes, ENT, Neuro.**
- **MDM—New problem with additional workup, lab ordered, moderate risk (undiagnosed new problem with uncertain prognosis) = moderate medical decision making.**

The documentation supports 99309.

5. **B. 99243**

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

- **History—HPI (extended), ROS (Extended), PFSH (complete) = Detailed**
- **Exam—Detailed**
- **MDM—New problems, no credit given in the EM for the EMG or Nerve conduction study because they will be billed with a separate CPT® code. The level of risk is moderate (elective major surgery).**

This supports a 99243.
Chapter 20

Section Review 20.1

1. **B. 90375, 96372**
   RATIONALE: Code for the product and the administration for rabies immune globulin. In the CPT® Index, look for Immune Globulin, rabies and you are directed to 90375–90376. Since there is not mention of heat-treated, 90375 would be the appropriate code. Reading the guidelines for immune globulins, codes 96365-96368, 96372, 96374, or 96375 should be reported as appropriate for the administration. This is an injection so 96372 would be the appropriate code.

2. **A. 90658, 90732, 90471, 90472**
   RATIONALE: The patient received two vaccines: influenza and pneumonia. Each is charged separately (90658, 90732), depending upon the age category. Code 90471 describes injection of one vaccine. The add-on code 90472 describes each additional vaccine. Add-on codes (+) may not be reported independently, but are a composite of the basic code.

3. **A. 90717, 90471**
   RATIONALE: Code for both the vaccine and the administration. Codes 90717 and 90471 describe the yellow fever vaccine and the immunization administration for 1 vaccine.

Section Review 20.2

1. **C. 90847**
   RATIONALE: A family therapy session with patient present is reported with 90847. The payer may request documentation of those present and areas of discussion.

2. **B. 90882**
   RATIONALE: The services performed by the psychotherapist include environmental interventions by communicating with the social agency. To locate the correct code, look for "Psychiatric Treatment" in the index, and find environmental intervention. Code 90882 describes intervention on a psychiatric patient’s behalf with agencies, employers of institutions.

3. **D. 90806**
   RATIONALE: Code 90806 describes a 45-50 minute outpatient/office encounter for behavior modification and support, insight directed.
Section Review 20.3

1. A. 90911

RATIONALE: Code 90911 describes biofeedback training for urethral sphincter.

Section Review 20.4

1. A. 90935

RATIONALE: Code 90935 describes the hemodialysis procedure requiring physician re-evaluation with or without substantial revision of dialysis.

2. C. 90969 x 25

RATIONALE: Code 90969 describes ESRD related services for dialysis less than a full month of service per day, for patients 12–19 years of age. In this case, the patient is 18 years old and she was hospitalized on the 26th day of the month. This was not a full month of ESRD related services; therefore, 90969 is reported with 25 units for each day. See the example in CPT® under End-Stage Renal Disease Services.

3. C. 90989

RATIONALE: Code 90989 describes a completed course of dialysis training for the patient and a helper.

Section Review 20.5

1. D. 93926

RATIONALE: Code 93926 describes duplex scan, limited or unilateral study, of the lower extremity arteries, including digits. Swelling was only present in the left foot, which was the only extremity that was scanned.

2. D. 93990

RATIONALE: Code 93990 describes a scan of hemodialysis access and includes arterial inflow, body of access and venous outflow.

3. B. 93975

RATIONALE: Code 93975 describes a complete scan of arterial inflow and venous outflow of the abdominal, pelvic, scrotal contents, and/or retroperitoneal organs.
Section Review 20.6

1. A. 95004 x 12
   RATIONALE: Code 95004 describes scratch tests with allergenic extracts, immediate type of reaction. Code includes interpretation and report. Report the code with the correct number of units for the number of tests.

2. C. 95130
   RATIONALE: Code 95130 describes provision of allergenic extract and injection of a single stinging insect venom.

3. B. 95144 x 4
   RATIONALE: Code 95144 describes preparation and provision of antigen for immunotherapy in single dose vials. Show number of vials in unit field.

Section Review 20.7

1. D. 96040 x 3
   RATIONALE: Code 96040 describes genetic counseling by a qualified counselor for each 30 minutes of face-to-face time. Report three units for the session lasting 1.5 hours. Report E/M codes if the counseling is provided by a physician.

Section Review 20.8

1. B. 96150 x 8
   RATIONALE: Code 96150 describes the clinical interview and behavior observation and assessment, face-to-face per 15 minutes. The encounter lasted 2 hours. The code is reported with 8 units. Time should be documented in the psychologist’s report.

2. C. 96111
   RATIONALE: Code 96111 describes extensive testing for developmental assessment, including interpretation and report.

3. D. 96101 x 13
   RATIONALE: Code 96101 describes multiple testing, face-to-face time with the patient and time interpreting and preparing the report, per one hour of time. Number of units reported is 13, and the time must be documented in the psychologist’s record.
Section Review 20.9

1. A. 96360, 96361
   RATIONALE: Codes 96360 and 96361 describe hydration infusion for two hours. Code 96360 covers the first hour and 96361 covers the second hour. The add-on code 96361 cannot be reported independently, but only in addition to 96360. The fluids that are infused are separately reported, using the appropriate code from HCPCS II. Dehydration is the diagnosis code to support the medical necessity of the infusion.

2. B. 96522
   RATIONALE: Code 96522 describes refill and maintenance of an intra-arterial or intravenous implanted pump for drug delivery. The drug is separately reported with HCPCS II codes.

3. D. 96450
   RATIONALE: Code 96450 describes intrathecal delivery of chemotherapy agents. The code includes the spinal puncture. The drugs are separately coded using HCPCS II codes. Spinal catheter placement is included in the technique.

Section Review 20.10

1. A. 97001-GP, 97110-GP x 4
   RATIONALE: At the first visit, the therapist typically evaluates the patient and problem and determines a suitable series of exercises to achieve the goal. Code 97001 is reported for the physical therapy evaluation and 97110 describes exercises performed to develop strength and range of motion, per 15 minutes of time. For one hour, report four units.

2. C. 97001-GP, 97110-GP x 3, 97116-GP
   RATIONALE: The therapist evaluates the patient and problem at the first visit and determines the best exercises to use. Gait training will be necessary and will likely increase in time at subsequent therapy sessions. Code 97001 is reported for the evaluation, 97110 for the exercises and 97116 for the gait training. Report three units for the exercises to cover 45 minutes.

3. A. 97760
   RATIONALE: Code 97760 describes orthotic management and fitting for the lower extremity per 15 minutes of time. Report the orthotic device separately using HCPCS II codes.
Section Review 20.11

1. C. 97802 x 2

RATIONALE: Code 97802 describes the initial medical nutrition assessment interview per 15 minutes of face-to-face time. Report two units for the 30-minute session.

Section Review 20.12

1. C. 97813

RATIONALE: Code 97813 describes a 15-minute face-to-face encounter using acupuncture with electrical stimulation.

Section Review 20.13

1. B. 98925

RATIONALE: Code 98925 describes manipulation of 1–2 body regions. Both feet were manipulated during the session.

Section Review 20.14

1. A. 98943

RATIONALE: Code 98943 describes extraspinal manipulation, one or more regions.

2. C. 98940

RATIONALE: Code 98940 describes manipulation of 1-2 spinal regions.

3. A. 98941

RATIONALE: Three regions of the spine were manipulated. Code 98941 describes manipulation of 3–4 regions.

Section Review 20.15

1. D. 98962 x 3

RATIONALE: A Registered Dietitian is a nonphysician practitioner that is qualified to educate at risk patients in diet management. Code 98962 describes 5–8 patients. Report 3 units for 90 minutes.
2. B. 98960 x 2

RATIONALE: Code 98960 describes face-to-face education and training with one patient for each 30 minutes. Report two units for one hour.

Section Review 20.16

1. D. 98967

RATIONALE: Code 98967 describes a telephone discussion with a qualified health care professional lasting 11–20 minutes not leading to an appointment within the next 24 hours or the soonest available appointment nor relating to an E/M service within the previous seven days.

2. D. 98969

RATIONALE: Code 98969 describes an on-line medical evaluation with a qualified health care professional not relating to a management and assessment service within the previous seven days and not leading to the next urgent care appointment: 21–30 minutes.

Section Review 20.17

1. D. 99075

RATIONALE: Physicians may be called upon to give a medical opinion about cause of death in a court proceeding. Code 99075 is designated for medical testimony.

2. B. 99027 x 13

RATIONALE: Code 99027 describes mandated on call personnel that are out of the hospital, but must return upon notification.

3. A. 99000

RATIONALE: Physicians often contract with an outside laboratory to handle specimens and provide reports. The laboratory will arrange for courier pick up and charge the physician a handling fee.

4. D. 99050

RATIONALE: Code 99050 describes services provided on holidays & weekends that are outside of normal business hours.
Section Review 20.18

1. D. 99175

RATIONALE: Code 99175 describes administration of ipecac to induce emesis for emptying the stomach.

2. B. 99170

RATIONALE: Code 99170 describes an anogenital examination with colposcopic magnification on a child for suspected trauma.

Section Review 20.19

1. D. 99507

RATIONALE: Patients often discharge to home when they no longer need the hospital level of care, but still need some assistance. The physician typically arranges the care with a home care agency that sends a qualified person to the patient’s home. Code 99507 describes home care for maintenance of catheters.

2. A. 99505

RATIONALE: Code 99505 describes a home care visit from a nonphysician practitioner to manage stomas and ostomies.

3. D. 99601

RATIONALE: Code 99601 describes home infusion of a specialty drug per visit, up to two hours.

Section Review 20.20

1. D. 99606, 99607

RATIONALE: Code 99606 describes the initial 15-minute consultation with a pharmacist for an established patient. Code 99607 describes an additional 15 minutes. Both are reported for the 23-minute encounter.