Medical Tests

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Question: 1

A patient is admitted for chemical burns caused by a leaky car battery. The physician diagnoses the patient with second- and third-degree burns on the right hand and second- degree burns on the left hand. The physician follows up with the patient 3 days later and performs a detailed examination. His findings include an infection that has developed on the right hand as a result of the burn. The patient is started on antibiotics. Code this encounter.

A. 99232, L08.9, T23.201S, T23.361S, T23.301S, T23.202A T54.2X4A
B. 99231, T23.201A, T23.361A T23.301A, T23.202A T54.2X4A L08.9
C. 99232, T23.701A, T23.662A T54.2XIA, L08.9
D. 99231, L08.9, T23.701S, T23.662A T54.2XIS

Answer: C

Explanation:
The physician's level of medical decision-making was moderate in complexity due to the acute, complicated injury/ illness, the minimal amount and complexity of data reviewed, and the issuance of a prescription drug. Because the patient has already been receiving care in a hospital setting for 3 days, the visit would be considered subsequent hospital care, making the level of inpatient service a 99232 and eliminating answers B and D. A burn caused by a chemical would be considered a corrosion because it is not caused by heat,
electricity, and/or radiation, thus eliminating the remaining choice of A. Additionally, when multiple burns on the same anatomic location and laterality are being treated, identify and code only the highest degree of burn recorded in the diagnosis. In this case, only the third-degree burns on the right hand and the second-degree burns on the left hand would be reported. Although the skin infection is a sequela, the seventh character in the corrosion code would remain "A" and sequenced first to indicate that the patient is still receiving active treatment for the reason of admission.

Question: 2

When it comes to documentation, which of the following is NOT an example of a moderate level of service?

A. A physician reviews the most recent X-Ray
B. A physician changes the frequency of chemotherapy
C. A nurse practitioner reviews CBC, CMP, and tumor markers
D. Anew patient presents with lymphoma while undergoing treatment for melanoma

Answer: A

Explanation:
If a physician were to only review the most recent X-ray, the physician is only meeting one of the nvo categories in the amount and/or complexity of data reviewed and analyzed. Meeting only one ofthe categories contributes to a low level of medical decision-making. On the other hand, altering a drug management program, reviewing several unique tests, and/or addressing an exacerbation of a chronic illness, all contribute to a moderate level of medical decision-making.

Question: 3

A 15-year-old male patient is seen in the emergency department due to a dislocated left elbow, caused by a fall from his skateboard. The physician performs a comprehensive physical evaluation to check for other injuries before manually realigning the dislocation and placing a splint from the shoulder to wrist. The patient is informed to follow up in 4 weeks. Which CPT and ICD-IO-CM codes should the emergency department report?

A. 24600-LT, S53.105A. VOO.131A
B. 99283, 24600-LT, VOO.131A
C. 24600-LT, 29105, S53.195AVOO.131A
D. 99282-57, 24600-LT, S53.105A VOO.131A

Answer: D

Explanation:
An E/M is always billed when a patient is seen in the emergency department because it is unscheduled and urgent. In this case, the documentation encompasses a straightforward level of decision-making (one acute, uncomplicated injury, minimal or no data reviewed, superficial dressings that result in minimal risk or morbidity of the patient), which lead the coder to 99282. Modifier 57 is appended to indicate that the decision for surgery was made just prior to the procedure and is not bundled. CPT coding crosswalk confirms that a closed treatment of a dislocated elbow is CPT code 24600. Application ofa splint is represented by CPT code 29105 but is not applicable when performed with a surgery to correct the dislocation. ICD-IO-CM crosswalk for dislocation of left elbow is S53.105A.

Question: 4

A surgeon performs a posterior fusion on the L2-L5 of the spine due to degenerative disc disease. CPT and ICD-IOOI code(s) should be reported?

A. 22612, 22614x2, MSI.36
B. 22800, M51.37
C. 22533, M51.37
D. 22612, 22614x 3, M51.36

Answer: A

Explanation:
The code for a joint fusion using a posterior approach is 22612. In this scenario, there are three fusion levels: L2-L3, L3-L4, and L4-L5. Following the primary code, 22614 would be billed tv;ice and with no modifier because it is an add-on code. ICD-IO-CM code M51.37 is for degenerative discs in the lumbosacral region; however, L2-L5 is considered the lumbar region.

Question: 5

A provider places a catheter on the right side of the heart chamber via an incision made on the lower left side of the patient's chest while performing a transcatheter mitral valve replacement. How should this encounter be coded?

A. 33430
B. 0483T, 93451
C. 0484T, 93451-59
D. 0484T

Answer: D

Explanation:
0484T describes a transcatheter mitral valve replacement via a thoracic approach. CPT code 33430 describes a mitral valve replacement in which cardiopulmonary bypass is initiated. CPT code 0483T describes a transcatheter mitral valve replacement with a percutaneous approach: however, the documentation identifies a transthoracic incision. Catheterization is bundled into the procedure and is not separately identifiable unless the provider documents extenuating circumstances (i.e,„ no prior study available, inadequate visualization, etc.).

Question: 6

A 92-year old female with Medicare part A coverage receives ongoing hospice care due to dementi a. She goes to a physician's office to receive closed treatment of a hip dislocation following a fall. No anesthesia was used. How should the provider submit this claim?

A. 27250, S73.003A, W19XXXA
B. 27250-GW, S73.003A, W19XXXA
C. 27250-GW, 99202-25, S73.003Æ W19XXYuA
D. 27250, 99213-25, S73.003A

Answer: B

Explanation:
When a patient is receiving hospice care, Medicare will not reimburse the physician for services rendered that are unrelated to the terminal illness unless submitted with modifier GW. In Answers C and D, a separate, identifiable E/M is not to be billed because the procedure is considered minor (1- to 10-day global period) and includes an inherent E/M component.

Question: 7

If a provider documents in an assessment that a patient is obese, but the BMI extracted from the chart is consistent with morbid obesity, what should be reported on the claim?

A. Morbid obesity
B. Morbid obesity and the appropriate BMI
C. Obesity
D. Obesity and the appropriate BMI

Answer: D

Explanation:
The diagnosis is always based on the provider's documentation, which in this case would be obesity. Coding guidelines also state that if there is a reportable diagnosis related to weight, "the BMI can be assigned from documentation of someone other than the patient's provider, such as nursing notes."

Question: 8

Code the excision of a large goiter extending into the chest cavity using a transthoracic approach.

A. 32900
B. 32140
C. 21602
D. 60270

Answer: D

Explanation:
A goiter is an abnormal enlargement of the thyroid gland. The removal of that gland is a thyroidectomy, represented by CPT codes 60240-60271. CPT 60270 is selected based on the approach used. CPT codes 21602 and 32900 are obtained by using the coding crosswalk for resection ofthe chest wall and describe the removal of a tumor and one or more ribs. CPT 32140 is a thoracotomy, which involves pulling apart the ribs to reach and remove a lung cyst.

Question: 9

Which is NOT a type of injection through which contrast is administered?

A. Intramuscular
B. Intravascular
C. Intra-articular
D. Intrathecal

Answer: A

Explanation:
Per CPT guidelines, administration of contrast materials is given through the following routes: intravascular, intra-articular, and intrathecal. Alternate routes also include orally and/or rectally; however, the "contrast administration alone does not qualify as a study 'with contrast'"

Question: 10

Modifier 50 is not an appropriate modifier to append on CPT code 52000.

A. True
B. False

Answer: A

Explanation:
The statement is true. In general, modifier 50 is not appended on cystourethroscopies because human anatomy has only one bladder. However, if the descriptor includes "with ureteral catherization," the procedure can be performed tvvice and billed once with modifier 50 because there are two ureters. CPT 52000 does not include this descriptor.

Question: 11

A patient underwent catheter thoracentesis aspiration of the pleural cavity with ultrasound guidance. What code(s) should be used to report this procedure?

A. 32554, 76942
B. 32555, 76942
C. 32555
D. 32557

Answer: C

Explanation:
This patient had fluid drained from the chest using a catheter, and the procedure was performed with ultrasound guidance. Searching CPT Index for Aspiration, Chest, Thoracentesis with Imaging Guidance directs to 32555. CPT 32555 does define the procedure in the question.
CPT code 32554 describes the procedure without any imaging guidance.
CPT code 32557 describes pleural drainage with an indwelling catheter using imaging guidance. An indwelling catheter is a scenario where the catheter is left in the patient, which is not documented in this question.

CPT code 76942 describes needle placement guidance using ultrasound. The main procedure code for this procedure includes the imaging guidance.

Question: 12

A total wrist replacement was performed on an 80-year-old patient. Which anesthesia code(s) would work best?

A. 01780
B. 01832
C. 01832, 99100
D. 01810, 99100

Answer: C

Explanation:
In the index of the CPT book, you will look up anesthesia, replacement, wrist, which gives you the code 01832. Turning to the Anesthesia section, where this code is located, you will see that this code is for anesthesia for open/surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints, total wrist replacement. The patient also falls into the "extreme age" category when it comes to anesthesia, so you would add code 99100 as well. Since this is what the question is asking for, these codes would be the correct answer.Code 01810 is for anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of forearm, wrist, and hand. The question states that a wrist replacement was done, which is a different procedure, so this would not be the correct answer. Code 01780 is for anesthesia for procedures on veins of the upper arm and elbow, not otherwise specified. This is not what the question is asking for, so this would also be an incorrect answer.

Question: 13

After a patient complains of poor vision and pain, the ophthalmologist performs a B-scan ultrasound in order to see behind the left eye. This reveals some blood behind the eye, which the ophthalmologist will treat accordingly.
How would the radiological aspect of this visit be billed?

A. 76512-LT
B. 76510-LT
C. 76516
D. 76513-RT

Answer: A

Explanation:
In the index of the CPT book, you will look up ophthalmology, diagnostic, ultrasound. This gives you the code range 76510-76529, which can be found in the Radiology section. The difference between the codes in this range is which kind of ultrasound is performed. In the case of this question, the physician performs a B-scan ultrasound only. Code 76512 is for a B-scan only. Also, the physician specifies that the

left eye was viewed. Therefore, code 76512 with an LT modifier would be the correct answer to this question.
Code 76510 is for an A-scan and B-scan, performed during the same patient encounter. This is more than what the question is asking for, so this would not be the correct answer. Code 76513 is for an anterior segment ultrasound, immersion B-scan or high-resolution biomicroscopy. This is not what the question is asking for, so this would be incorrect. Code 76516 is for ophthalmic biometry by ultrasound echography, A-scan. This is not what the question is asking for, so this would also be incorrect.

Question: 14

If a patient has a case of active tuberculosis of the lungs, which ICD-10 code would be correct to code?

A. A19.8
B. A15.0
C. A15.8
D. Z86.11

Answer: B

Explanation:
In the alphabetic index of the ICD-10 book, you will look up tuberculosis, pulmonary. This gives you the code A15.0, which can be found in Chapter 1: Certain Infectious and Parasitic Diseases. This code directly correlates to tuberculosis of the lung, which is exactly what the question asks for. Code A15.0 does not need any more characters to complete it, so this would be the correct answer to this question.
Code A15.8 is for other respiratory tuberculosis. Since there is an actual code for the type of tuberculosis the question asks for, this would not be the correct answer. Code A19.8 is for other military tuberculosis. This is not what the question is asking for, so this is incorrect. Code Z86.11 is for personal history of tuberculosis. The question states the patient has an active infection of tuberculosis, not a personal history of tuberculosis, so this would be incorrect.

Question: 15

If a patient receives a monaural assistive listening device system, how would it be billed?

A. V5273
B. V5281
C. V5282
D. V5298

Answer: B

Explanation:
In the index of the HCPCS book, you would look up assistive listening device, system, monaural. This gives you the code V5281, which is located in the Hearing Services section. Here, you will see that this code is for an assistive listening device, personal FM/DM system, monaural. This matches what the question is asking for, so this will be the correct answer.

Code V5282 is for an assistive listening device system as well, but for a binaural. Since the question asks for a monaural system, this is not the correct answer. Code V5273 is for an assistive listening device, for use with cochlear device. This is not what the question is asking for, so this would be incorrect. Code V5298 is for hearing aid, not otherwise specified. This is also not what the question is asking for, so this would be an incorrect answer.

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