2016

Medical Coding Training: Certified Outpatient Coder (COC™)

Volume 2—Answer Key

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Section Review 13.1

1. **Answer:** B. Removal of dead or damaged tissue as from a wound

   Rationale: Debridement is the process of removing dead tissue or eschar, dirt, foreign material, or debris from infected skin, a burn, or a wound to promote healing and prevent or control infection.

2. **Answer:** C. Cavity created by localized infection that contains a purulent exudate

   Rationale: An abscess is infection causing localization of pus and infected material in the skin.

3. **Answer:** D. S91.319A

   Rationale: The diagnosis is a cut (laceration) on the foot. Look in the ICD-10-CM Alphabetic Index for laceration/foot S91.319. There is no retained foreign body and code M79.5 is not valid. Verify code selection in the Tabular List, 7th character A is required to show that this is the initial encounter.

4. **Answer:** B. E11.621, L97.509

   Rationale: Look in the ICD-10-CM Alphabetic Index for Diabetes/type 2/with/foot ulcer E11.621. Look for this code in the Tabular List, there is a note under the code to use an additional code to identify the site of the ulcer (L97.4-, L97.5-). Therefore, the manifestation code is listed second. Reference the Tabular List for these 2 codes, code L97.509 is correct because the laterality is not specified nor is the severity.

5. **Answer:** C. T21.31XA, T22.30XA, T22.20XA, T31.30

   Rationale: Per ICD-10-CM coding guideline Section I.C.19.d.1, Sequence first the code that reflects the highest degree of burn when more than one burn is present. Look in the ICD-10-CM Alphabetic Index for Burn/chest wall /third degree T21.31; Burn/upper limb/third degree T22.30; Burn/upper limb/second degree T22.20. Reference all codes in the Tabular List; when assigning a code from these categories, your sixth character is a placeholder X because the 7th character A is required to show the initial encounter. Next, assign the code to reference the total budy surface involved, as per Guideline I.C.19.d.6 which states to use category T31 as an additional code for reporting purposes. Reference category T31 in the Tabular List. The total body surface area is 34% (9%+25%) making the correct 4th character 3 and 5th character is 0 for a complete code of T31.30.

Section Review 13.2

Match the surgical term to its correct definition.

1. **C** Avulsion	A. The use of heat or chemicals to burn or cut
2. **A** Cauterize	B. Instrument for direct electrical energy through tissues for lesion destruction
3. **D** Cryosurgery	C. The forceful tearing away of part of body

4.	**B** Electrocautery	D.	A procedure using low temperatures for lesion removal
5.	**H** Electrodessication	E.	Constriction of a body part to cut off blood or oxygen
6.	**F** Ligation	F.	A thread of a material (eg, cotton) used to tie off a lesion
7.	**E** Strangulation	G.	The process of peeling or shaving
8.	**G** Paring/Cutting	H.	The use of monopolar high frequency electrical current for lesion removal

Section Review 13.3

1. **Answer:** 11402

   Rationale: Look in the CPT® index for Excision/Lesion/Skin/Lesion, Benign and you are referred to code sets that are found in code range 11400–11471. This is a lesion of the trunk; therefore, you need to look at codes 11400–11406. Code 11402 is selected for a lesion of 1.4 cm.

2. **Answer:** 11603

   Rationale: Look in the CPT® index for Excision/Lesion/Skin/Lesion, Malignant and you are referred to code sets that are found in code range 11600–11646. This lesion is of the forearm; therefore, look at the range 11600–11606. Code 11603 is used for a 3 cm lesion of the forearm.

3. **Answer:** 11402, 11403

   Rationale: Each lesion is coded separately. Report 11402 for the 1.4 cm (1 cm + .2 cm margin + .2 cm margin) benign lesion excision of the lower back and 11403 for the benign lesion of the thigh measuring 2.1 cm (1.7 cm + .2 cm margin + .2 cm margin). Guidelines state each lesion is reported separately and in the outpatient hospital setting, modifier 51 is not allowed so a modifier is not reported.

Section Review 13.4

1. **Answer:** 11056

   Rationale: The key word here is paring. Look in the CPT® index for Paring/Skin Lesion/Benign Hyperkeratotic and you are referred to 11055–11057. The correct code is 11056 for the four warts removed.

2. **Answer:** 10081

   Rationale: Look in the CPT® index for Pilonidal Cyst/Incision and Drainage 10080–10081. Code 10081 reports a complicated I&D.

3. **Answer:** 11100, 11101

   Rationale: Look in the CPT® index for Biopsy/Skin Lesion 11100–11101.

4. **Answer:** 11643, 11602, 11602

   Rationale: This case involves malignant lesions; therefore, look in the CPT® index for Excision/Lesion/Skin/Malignant and you are referred to code sets that are found in code range 11600–11646. Highlight the anatomical areas in your CPT® book

to make reference easier. Code 11643 is chosen for the 2.1 cm lesion removed from the nose. Next look for chest, which is considered the trunk. Each lesion was 1.5 cm; therefore, code 11062 is then listed twice—each on a different line item. The instructions in the CPT® guidelines indicate to report each lesion excised separately; therefore, modifier 59 is not required.

5. **Answer:** 12032, 12013-59

Rationale: This is a repair of lacerations. Look in the CPT® Index for Skin/Wound Repair/Intermediate 12031–12057. Layered repair is noted in CPT® as an intermediate repair. The codes for intermediate repair of the arm start at 12031. This was a repair of 3.6 cm; therefore, 12032 is chosen. The lacerations of the cheek are simple repairs. As noted in the guidelines, these two laceration lengths are added 2.3 + 2.7 = 5.0 cm. Look in the Index Skin/Wound Repair/Simple for 12020–12021. Repairs of the face are listed starting at 12011. This is a simple repair of 5 cm; therefore, 12013 is correct.

The guidelines for reporting multiple repairs in CPT® direct the coder to append modifier 59 to the lesser of the codes. Payment is based on the APC assignment which is T and will reduce the second procedures by 50 percent.

Section Review 13.5

1. **Answer:** 17110

Rationale: Look in the CPT® index for Destruction/Lesion/Skin/Benign and you are referred to 17110–17111. There are three benign lesions. 17110 includes destruction of up to 14 lesions. Go to 17000 and HIGHLIGHT "premalignant" and go to 17110 and HIGHLIGHT "benign lesions other than skin tags or cutaneous vascular proliferative lesions."

2. **Answer:** 11981

Rationale: Look in the CPT® index for Drug Delivery Implant 11981.

3. **Answer:** 14041

Rationale: For this case you need to know that a Z-plasty is listed under Tissue Transfer and Rearrangement in your CPT® Book. Be sure to read the notes here. HIGHLIGHT that the excision of a lesion is included in these procedures. Look in the Index for Tissue/Transfer/Adjacent/Skin 14000–14350. The correct code for the repair of the forehead for a defect of 10.5 sq cm is 14041.

4. **Answer:** 15271

Rationale: Look in the Index for Skin Substitute Graft/Legs 15271–15274. In the guidelines for Skin Replacement Surgery, the coder is instructed to sum the surface area of all wounds when reporting multiple wounds for anatomic sites grouped together. The total of the skin grafts is 15.5 sq cm; therefore, 15271 is correct. Always choose the code by the recipient site, which in this case is the leg.

5. **Answer:** 15120, 11641

Rationale: Look in the CPT® index for Excision/Lesion/Skin/Lesion, Malignant and you are referred to code sets that are found in code range 11600–11646. Code 11641 reports a 0.8 cm lesion of the face. For the split skin graft reconstruction, look in the CPT® index for Skin Graft and Flap/Split Graft 15100–15101, 15120–15121. Code 15120 is necessary for an area

of 0.72 sq cm on the face. Multiply 0.8 cm x 0.9 cm to get 0.72 sq. cm.

Section Review 14.1

Using your medical dictionary, define the following:

1. **Answer:** Closed sac of fibrous tissue found between some tendons and the bones under them
2. **Answer:** Movement that causes the end of the bone to move in a circular motion
3. **Answer:** Tube-shaped sheath that lines the compartment where some tendons pass-through, such as those found around the ankle and wrist
4. **Answer:** Partial or complete removal of a limb or other protruding body part
5. **Answer:** Surgical repair of cartilage
6. **Answer:** Mucus filled cyst of the tendon sheath and most common in the wrist
7. **Answer:** Method used to reduce features by inserting a pin or wire through the bone and applying force or traction, usually by attaching weights
8. **Answer:** First repair immediately after injury
9. **Answer:** Displacement of a body part from its normal location
10. **Answer:** Fibrous material surrounding a gelatinous center, located in between the vertebrae that act as shock absorbers

Section Review 14.2

1. **Answer:** B. M70.31

   Rationale: In the Alphabetic Index for Bursitis/elbow M70.3-. In the Tabular List, fifth character 1 is reported for the right elbow. Correct code choice is M70.31.

2. **Answer:** A. S02.66XA

   Rationale: In the Alphabetic Index, look for Fracture/mandible/symphysis S02.66-. In the Tabular List, a seventh character is required. Report a a dummy placeholder X and a seventh character A for the initial encounter. Correct code choice is S02.66XA.

3. **Answer:** A. S22.42XA

   Rationale: In the Alphabetic Index, look for Fracture, traumatic/rib/multiple S22.4-. In the Tabular List, report 2 for the left side and seventh character A for the intial encounter. A dummy placeholder X is required to keep the seventh character in the seventh position. Correct code choice is S22.42XA.

4. **Answer:** B. Q65.01, Q65.32

   Rationale: In the Alphabetic Index, look for Dislocation/hip/congenital/unilateral Q65.0-. In the Tabular List, 1 is reported for the right side. Next, report the left side subluxation. Look in the Alphabetic Index for Subluxation/congenital/hip and you are directed to see Dislocation, hip, congenital, partial. Look in Alphabetic Index for Dislocation/ hip/congential/ partial/unilateral Q65.3-. In Tabular List, fifth character 2 is reported for left side. Correct code choice is Q65.32.

5. **Answer:** C. M24.312

Rationale: In the Alphabetic Index, look for Dislocation/pathological/shoulder M24.31-. In the Tabular List, sixth character 2 is reported for the left shoulder.

6. **Answer:** B. M96.2

   Rationale: In the Alphabetic Index, look for Complication/radiation/kyphosis M96.2. This can also be found by looking for Kyphosis/postradiation therapy M96.2. Verify in the Tabular List.

7. **Answer:** B. S72.041B

   Rationale: In the Alphabetic Index, look for Fracture, traumatic/femur, femoral/upper end/neck/base (displaced) S72.04. In the Tabular List, sixth character 1 is reported for the right side and seventh character B for open fracture. Correct code choice S72.041B.

8. **Answer:** A. M84.364A

   Rationale: In the Alphabetic Index, look for Fracture/stress/fibula M84.36-. In Tabular List, sixth character 4 is reported for the left fibula and seventh character A for initial encounter. Correct code choice is M84.364A.

9. **Answer:** B. M41.30

   Rationale: In the Alphabetic Index, look for Scoliosis/thoracogenic M41.30. Verify in the Tabular List.

10. **Answer:** D. S83.412A

    Rationale: In the Alphabetic Index, look for Tear, ligament - (see also Sprain, by site). Next look for Sprain, knee /collateral, (medial) S83.41-. In the Tabular List, 2 is reported for the left knee and seventh character A for initial encounter. Correct code choice is S83.412A.

Section Review 14.3

1. **Answer:** A. 27752

   Rationale: Look in the CPT Index for Fracture/Tibia/Shaft/with Manipulation 27752, 27760-27762, 27810. 27752 is correct code to report for the tibial shaft fracture.

2. **Answer:** B. 23655

   Rationale: Look in the CPT Index for Dislocation/Shoulder/Closed Treatment with Manipulation - 23650, 23655.

3. **Answer:** C. 24516

   Rationale: Look in the CPT Index for Fracture/Humerus/Shaft 24500-24505, 24516. 24516 is the correct code to report for using the intramedullary implant and locking screws.

4. **Answer:** A. 25431

   Rationale: Look in the CPT Index for Nonunion Repair/Carpal 25431, 25440. Code 25431 is correct to report for repaired of the carpal bone. Code 25440 is reported for nonunion repair of the scaphoid carpal, which was not mentioned.

5. **Answer:** B. 29075

   Rationale: Look in the CPT Index for Cast/Ambulatory/Short Arm - 29075. The removal of the cast applied by the same physician is not billable.

Section Review 15.1

1. **Answer:** D. Larynx

   Rationale: The larynx is also referred to as the voice box. It connects the nasopharynx to the trachea, and is covered by the epiglottis during swallowing to prevent aspiration.

2. **Answer:** B. Bronchioles

   Rationale: The passage of airflow to the lungs is via the nose, trachea, bronchi, bronchioles, to the alveoli.

3. **Answer:** A. Parietal pleura

   Rationale: The outer layer of the pleura is the parietal pleura. The inner layer of the pleura is the visceral pleura.

4. **Answer:** C. Diaphragm

   Rationale: Inhalation occurs when the diaphragm contracts or moves down: The air pressure in the thoracic cavity is reduced, allowing air to flow into the lungs. During exhalation, the diaphragm is relaxed and pushes air out of the chest.

5. **Answer:** A. Upper left quadrant of the abdomen

   Rationale: The spleen is located in the left upper quadrant of the abdomen.

Section Review 15.2

1. **Answer:** D. J44.9

   Rationale: Look in the Alphabetic Index for Disease/pulmonary/chronic obstructive J44.9 or Disease/lung/obstructive (chronic) J44.9. Verify in the Tabular List.

2. **Answer:** B. J21.9

   Rationale: Look in the Alphabetic Index for Bronchiolitis/with/bronchospasm or obstruction J21.9. Verify in the Tabular List.

3. **Answer:** B. J05.0

   Rationale: Look in the Alphabetic Index for Laryngitis/ obstructive J05.0. Verify in the Tabular List.

4. **Answer:** B. R09.01

   Rationale: Look in the Alphabetic Index for Asphyxia, asphyxiation R09.01. Verify in the Tabular List.

5. **Answer:** A. J45.909

   Rationale: Look in the Alphabetic Index for Asthma J45.909. Verify in the Tabular List.

6. **Answer:** B. C83.34

   Rationale: Look in the Alphabetic Index for Lymphoma/diffuse large cell. You are referred to C83.3- which requires a 5th character. Turn to subcategory C83.3 in the Tabular List. The fifth character to identify axilla is 4. The correct code is C83.34.

7. **Answer:** C. R04.0

   Rationale: Look in the Alphabetic Index for Epistaxis R04.0. Verify in the Tabular List.

8. **Answer:** B. I89.0

   Rationale: Look in the Alphabetic Index under Lymphedema (see also Elephantiasis). Look for Elephantiasis in the Index, I89.0. Verify in the Tabular List.

9. **Answer:** B. R06.01

   Rationale: Look in the Alphabetic Index for Orthopnea R06.01. Verify in the Tabular List.

10. **Answer:** D. R06.2

    Rationale: Look in the Alphabetic Index for Wheezing R06.2. Verify in the Tabular List.

Section Review 15.3

1. **Answer:** 31255, J01.21

   Rationale: The report shows bilateral ethmoidectomy performed using sinus endoscopy. Look in the CPT® Index for Sinus/Sinuses/Ethmoidectomy/Excision- 31254-31255. During this procedure the anterior and posterior ethmoids were removed which is defined as a total procedure, 31255. For the ICD-10-CM code look in the Alphabetic Index for Sinusitis/acute/ethmoidal/recurrent J01.21. Verify in the Tabular List. (Note: Recurrent acute is not the same as chronic)

2. **Answer:** 38510-50, 38525-50, C81.98

   Rationale: Biopsies are taken from the cervical and axillary nodes bilaterally. Look in CPT® Index for Biopsy/Lymph Nodes/Open-38500, 38510, 38520, 38525, 38530. The codes are selected based on the site of the biopsies. Report 38510 for the open, deep cervical biopsies. Report 38525 for the open, deep axillary biopsies. Append modifier 50 to both codes because the procedures were performed bilaterally. In the Alphabetic Index look up Granuloma/Hodgkin and you are referred to C81.9-. Refer to the Tabular List, fifth character "8" identifies multiple sites.

3. **Answer:** 31560, J38.02

   Rationale: Look in CPT® Index under Arytenoidectomy/Endoscopic 31560. Code 31560 describes the procedure. For the diagnosis, look in the Alphabetic Index to Diseases for Paralysis/vocal cord/bilateral J38.02. Verify in the Tabular List.

4. **Answer:** 30140-50, J34.89

   Rationale: Look in the CPT® Index for Turbinate/Excision 30130-30140. The procedure is reported with 30140. The incision is made on the inferior border of the turbinate and a submucous resection (redundant mucosa was then removed) is performed. An excision involves fracturing of the turbinates. The procedure was performed on both sides; therefore, modifier 50 is appended. In the Alphabetic Index, refer to Hypertrophy/nasal/turbinate J34.3. Verify in the Tabular List.

5. **Answer:** 31254-50, 31267-50, 31288-50, J32.4, J33.8

   Rationale: The report shows bilateral sphenoethmoidectomy and maxillary antrostomy by sinus endoscopy. Look in the CPT® Index for Sinus/Sinuses/Ethmoid/Excision/with Nasal/Sinus Endoscopy - 31254-31255. Also look in the same section for Maxillary/Antrostomy 31256-31267. A polyp was removed on both sides, so 31267 is assigned. Also note that tissue was removed from the sphenoid sinuses on both sides. Look in the CPT® Index for Sinus/Sinuses/Sphenoid/Incision/with Nasal/Sinus Endoscopy 31187, 31288. Code 31288 is used, because tissue was removed. Modifier 50 must be used for all codes, because all procedures were bilateral. For the diagnoses codes look in the Alphabetic Index for Pansinusitis J32.4 and Polyp, polypus/sinus J33.8. Verify your codes in the Tabular List.

Section Review 16.1

1. **Answer:** A. Coronary arteries

   Rationale: The coronary arteries are the network of blood vessels carrying oxygen and nutrient-rich blood to the heart.

2. **Answer:** B. Systemic

   Rationale: Systemic circulation supplies nourishment to tissue located throughout the body, with the exception of the heart and lungs.

3. **Answer:** D. SA node

   Rationale: The sinoatrial (SA) node is located in the right atrium by the superior vena cava and it is the normal pacemaker of the heart. It generates an impulse between 60–100 times per minute.

4. **Answer:** C. Tricuspid

   Rationale: The tricuspid valve is located between the right atrium and right ventricle.

5. **Answer:** A. Epicardium

   Rationale: The epicardium (or visceral pericardium) covers the heart's surface and extends to the great vessels.

Section Review 16.2

1. **Answer:** B. I34.1

   Rationale: Barlow's syndrome is mitral valve prolapse. It is not listed in ICD-10-CM, so be sure to list this in your codebook. In the Alphabetic Index, look for Prolapse/mitral (valve) I34.1. Verify code in the Tabular List. This is listed as nonrheumatic mitral valve prolapse.

2. **Answer:** B. I44.1

   Rationale: In the Alphabetic Index, look for Block/atrioventricular (incomplete)/types I and II, which directs you to I44.1. Verify code in the Tabular List I44.1. You will see that Mobitz block, type 2 and II is listed under I44.1.

3. **Answer:** D. Q24.6

   Rationale: In the Alphabetic Index, look for Block/heart/congenital which directs you to code Q24.6. Verify code in the Tabular List.

4. **Answer:** B. C38.0

   Rationale: In the Alphabetic Index, look for Malignancy (see also Neoplasm, malignant, by site). Next, go to the Table of Neoplasms and look for Neoplasm/Pericardium/Malignant Primary (column) which directs you to C38.0. Verify code in the Tabular List C38.0 Malignant neoplasm of heart. Malignant neoplasm of pericardium is listed under C38.0.

5. **Answer:** A. I50.31

   Rationale: In the Alphabetic Index, look for Failure, failed/heart (acute) (senile) (sudden)/diastolic/acute (congestive) which directs you to I50.31. Verify code in the Tabular List.

6. **Answer:** A. I50.21

   Rationale: In the Alphabetic Index, look for Failure, failed/heart/systolic (congestive)/acute (congestive) which directs you to I50.21. Verify code in the Tabular List.

7. **Answer:** C. I35.0

   Rationale: In the Alphabetic Index, look for Stenosis/aortic (valve) which directs you to I35.0. Verify code in the Tabular List.

8. **Answer:** B. I25.811

   Rationale: In the Alphabetic Index, look for Arteriosclerosis, arteriosclerotic/coronary (artery)/ transplanted heart which directs you to I25.811. Verify code in the Tabular List.

9. **Answer:** B. I48.91

   Rationale: In the Alphabetic Index, look for Fibrillation/atrial or auricular (established) I48.91. Verify code in the Tabular List.

10. **Answer:** A. I46.9

    Rationale: In the Alphabetic Index, look for Arrest, arrested/cardiac which directs you to code I46.9. Verify code in the Tabular List.

Section Review 16.3

1. **Answer:** 33228, T82.518A, I44.1

   Rationale: In the CPT® Index, look for Pacemaker, Heart/Replacement/Pulse Generator which directs you to codes 33227-33229. 33228 is the correct code to report for the replacement of a dual chamber pacemaker generator. Two diagnosis codes are reported. The first diagnosis code to report is the battery malfunction.

   In the Alphabetic Index, look for Complication/pacemaker (cardiac) — see Complications, cardiovascular device or implant, electronic. Next, look in this Index for Complication/cardiac/device, implant or graft/mechanical/breakdown/specified device NEC T82.518-. The second diagnosis code to report is the AV block. In the Alphabetic Index, look for Block/atrioventricular/type 1 and type 2 which directs you to code I44.1. Verify codes in the Tabular List. Report T82.518A. A seventh character A for initial encounter is added. Code I44.1 includes Wenckebach's block.

2. **Answer:** 33208, I47.1

   Rationale: In the CPT® Index look for Pacemaker, Heart/Insertion which directs you to codes 33206-33208. Code 33208 is correct for electrodes being placed in the both the atrium and ventricle. In the ICD-10-CM Alphabetic Index look for Tachycardia/paroxysmal/supraventricular which directs you to I47.1. Verify code in the Tabular List.

3. **Answer:** 33264, 33225, T82.518A, I50.9

   Rationale: In CPT® Index, look for Pacemaker, Heart/Insertion/Electrode which directs you to codes 33202, 33203, 33216, 33217, 33224, 33225. When reviewing the codes, 33225 is correct for the placement of the left ventricular pacing electrode at the time of the replacement of the generator. Next, look in the CPT® Index for Implantable Defibrillator/Replacement/Pulse Generator 33224, 33262-33264. Code 33264 describes the removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator, multiple lead system. Look under 33225 in CPT® and you will see that 33225 is to be used in conjunction with 33264. Two diagnosis codes are reported. The first diagnosis code is for the malfunction of the dual implantable defibrillator pulse generator. In the ICD-10-CM Alphabetic Index, look for Complication/cardiac/device, implant or graft/mechanical/breakdown/specified device NEC T82.518-. The second diagnosis code is for CHF. In the Alphabetic Index, look for Failure, failed/heart/congestive which directs you to I50.9. Verify codes in the Tabular List. Report T82.518A. The seventh character A is needed to indicate the initial encounter. The type of heart failure is not mentioned, so I50.9 is correct for unspecified heart failure.

Section Review 16.4

1. **Answer:** 34501, I73.9

   Rationale: In the CPT® Index, look for Valvuloplasty/Femoral Vein which directs you to code 34501. Verify the code. In the Alphabetic Index, look for Disease/peripheral/vascular NOS which directs you to I73.9. Verify code in the Tabular List.

2. **Answer:** 35876, T82.868A

   Rationale: In the CPT® Index look for Thrombectomy/Bypass Graft/Other than Hemodialysis Graft or Fistula, which directs you to 35875, 35876. Code 35876 is correct, because a revision of the arterial graft was performed. This is a complication of the graft. Look in ICD-10-CM for Complications/ graft (bypass) (patch)/femoral artery (bypass) — see Complication, extremity artery (bypass) graft. Look next in the ICD-10-CM Index for Complication/extremity artery (bypass) graft/thrombosis T82.868-. Verify in the Tabular List. Report T82.868A. The seventh character A is required to indicate the initial encounter.

Section Review 16.5

1. **Answer:** 37220, 75710-59, I70.412

   Rationale: The report states that images were taken for diagnostic angiogram and possible angioplasty. Code 37220 includes catheterizing the vessel, the angioplasty, and the imaging performed. In the CPT® Index look for Angioplasty/Iliac Artery/Intraoperative 37720, 37722. The diagnostic angiography was performed prior to the decision for angioplasty; therefore, it is reported separately. The access from the left femoral artery is a nonselective catheterization of the left external iliac (36140). In the CPT® Index look for Catheterization/Extremity Artery 36140. The same approach was used for the angioplasty, so 36140 is not reported. Report 75710-59 for the left extremity angiogram with modifier 59 to show it is separate (diagnostic) from 37220. In the CPT® Index look for Angiography/Leg Artery 73706, 75635, 75710-75716. 75710 is reported for the angiography performed on one leg. In the ICD-10-CM Alphabetic Index, look for Stenosis, stenotic/artery/extremities and you are directed to see Arteriosclerosis, extremities. Look for Arteriosclerosis/extremities/leg/left/with/intermittent claudication I70.412. Verify in the Tabular List.

2. **Answer:** 36223-LT, I65.23

   Rationale: The left common carotid artery is first order off the aorta. In the CPT® Index look for Catheterization/Carotid Artery directing you to codes 36100, 36221–36224, 36227–36228. Code 36223-LT is correct for the selective catheterization of the left common carotid artery and angiography including the extracranial carotid circulation and intracranial carotid circulation and cervicocerebral arch. In the ICD-10-CM Alphabetic Index, look for Stenosis, stenotic/cerebral and you are directed to see Occlusion, artery, cerebral. Look for Occlusion, occluded/artery/carotid I65.2-. In the Tabular List, The documentation indicates that there was significant stenosis on the right side as well as the left. Fifth character 3 is reported for bilateral for a complete code I65.23.

3. **Answer:** 37606, I72.0

   Rationale: In the CPT® Index look for Ligation/Artery/Carotid directing you to codes 37600–37606, 61610–61612. 37606 is the correct code for ligation of the common carotid artery with gradual occlusion. In the ICD-10-CM Alphabetic Index look for Aneurysm/carotid artery (common) (external)/internal/extracranial portion directing you to code I72.0. Verify in the Tabular List.

Section Review 17.1

1. **Answer:** B. Right upper quadrant

   Rationale: The gallbladder is located in the right upper quadrant of the abdominal cavity.

2. **Answer:** B. Liver

   Rationale: Bile is produced by the liver and aids in the digestive process.

3. **Answer:** A. Cardia, fundus, body, and antrum

   Rationale: The stomach has four sections: Cardia, fundus, body and antrum. The stomach plays a large part in the secondary digestion process.

4. **Answer:** B. Opening into the duodenum

   Rationale: The pyloric sphincter is the opening between the stomach and duodenum.

5. **Answer:** D. Cholecystectomy

   Rationale: The root word cholecyst means gallbladder and the suffix ectomy means excision or surgical removal.

Section Review 17.2

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

   Rationale: GERD is the acronym for gastroesophageal reflux disease. In the Alphabetic Index look for Disease, diseased/gastroesophageal reflux (GERD) K21.9. Verify code in the Tabular List.

2. **Answer:** D. K40.20

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hernia/inguinal/bilateral K40.20. Go to the Tabular List for verification.

3. **Answer:** B. K81.9

   Rationale: Look in the ICD-10-CM Alphabetic Index for Cholecystitis K81.9. Verify code in the Tabular List.

4. **Answer:** B. K63.5

   Rationale: In the ICD-10-CM Alphabetic Index look for Polyp, polypus/colon K63.5. Verify code in the Tabular List.

5. **Answer:** B. K41.90

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hernia/femoralK41.90. Verify in the Tabular List.

6. **Answer:** A. K85.9

   Rationale: In the ICD-10-CM Alphabetic Index look for Pancreatitis/acute K85.9. Verify code in the Tabular List.

7. **Answer:** B. K40.90

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hernia/inguinal; sliding is a nonessential modifier. You are directed to K40.90. Verify code selection in the Tabular List.

8. **Answer:** B. Q79.2

   Rationale: Look in the ICD-10-CM Alphabetic Index for Omphalocele Q79.2. Verify the code in the Tabular List.

9. **Answer:** C. K43.6

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hernia/spigelian which states to see Hernia, ventral. Hernia/ventral/with/obstruction leads to K43.6. Verify in the Tabular List.

10. **Answer:** C. K64.8

    Rationale: Look in the ICD-10-CM Alphabetic Index for Hemorrhoids/internal K64.8. Verify code selection in the Tabular List.

Section Review 17.3

1. **Answer: A.** 42821

   Rationale: Look in the CPT Index for Tonsillectomy 42820-42826. Check the range of codes and you will see 42821 Tonsillectomy and adenoidectomy; age 12 and over.

2. **Answer:** D. 42220. 42826

   Rationale: Look in the CPT® Index for Palatoplasty 42145, 42200–42225. Check the range of codes and you will see 42220 Palatoplasty for cleft palate; secondary lengthening procedure. Look in the CPT® Index for Tonsillectomy 42820–42826. Check the range of codes and you will see 42821 Tonsillectomy and adenoidectomy; age 12 and over.

3. **Answer:** C. 43213

   Rationale: Look in the CPT® Index for Esophagus/Dilation/Endoscopic 43195-43196, 43212-43214, 43220, 43226, 43229, 43233, 43248-43249. This is a retrograde dilation, which means that the patient must have a gastrostomy. Check the range and you will see 43213 Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance when performed).

4. **Answer: B.** 43220

   Rationale: Look in the CPT® Index for Endoscopy/Esophagus/Dilation 43195, 43196, 43212-43214, 43220, 43226, 43229, 43233, 43248–43249. Check the range of codes and you will see that 43220 *Esophagoscopy flexible transoral; with transendoscopic balloon dilation (less than 30 mm diameter)* is the correct code.

5. **Answer: A.** 45380

   Rationale: Look in the CPT® Index for Colonoscopy/Flexible/Biopsy and you are directed to 45380, 45392. 45392 includes transendoscopic ultrasound guidance which was not performed making 45380 the correct code. There is also a code for control of bleeding (45382); however, this is only to be reported if the bleeding occurs spontaneously or as a result of traumatic injury. When the bleeding is due to the biopsy, this code is not reported separately.

Section Review 17.4

1. **Answer: D.** 43251

   Rationale: EGD is the acronym for esophagogastroduodenoscopy; also known as an upper gastrointestinal endoscopy, examining the esophagus, stomach and duodenum. Look in the CPT® Index for Endoscopy/Gastrointestinal/Upper/Removal 43247, 43250–43251. Check the range of codes and 43251 is for an EGD with removal of polyps by snare technique.

2. **Answer: B.** 46250

   Rationale: Find in your CPT® Index look for Hemorrhoids/Excision—*See* Hemorrhoidectomy. Hemorrhoidectomy/External Complete 46250. Verify: 46250 *Hemorrhoidectomy, external, 2 or more columns/groups.*

3. **Answer: C.** 42700

   Rationale: Look in the CPT® Index for Incision and Drainage/Abscess/Tonsil 42700. Verify: 42700 *Incision and drainage abscess; peritonsillar.*

4. **Answer: C.** 43249

   Rationale: EGD is the acronym for esophagogastroduodenoscopy; also known as an upper gastrointestinal endoscopy. Look in the CPT® Index for Endoscopy/Gastrointestinal/Upper/Dilation 43245, 43248–43249. 43249 is correct for balloon dilation of esophagus less than 30 mm diameter. A diagnostic endoscopy (43235) is always included in a surgical endoscopy.

Section Review 18.1

1. **Answer:** C. Bladder

   Rationale: The bladder is a hollow, muscular, expandable organ collecting urine.

2. **Answer:** A. Scrotum

   Rationale: The scrotum holds the testicles outside the body.

3. **Answer:** C. Urethra

   Rationale: At the time of urination, the bladder muscles will tighten and squeeze urine from the bladder into the urethra. The urethra is the outlet for urine to exit the body.

4. **Answer:** D. Vas deferens

   Rationale: The vas deferens is a muscular tube that transports semen from the epididymis into the pelvis.

5. **Answer:** A. Prepuce

   Rationale: Prepuce (foreskin) is surgically removed during circumcision.

Section Review 18.2

1. **Answer:** D. N15.1

   Rationale: Look in the ICD-10-CM Alphabetic Index for Abscess/kidney N15.1. Verify in the Tabular List.

2. **Answer:** A. Q61.3

   Rationale: Look in the ICD-10-CM Alphabetic Index for Disease/polycystic kidney Q61.3. Verify in the Tabular List.

3. **Answer:** D. A59.02

   Rationale: Look in the ICD-10-CM Alphabetic Index for Prostatitis/trichomonal A59.02. Verify code selection in the Tabular List.

4. **Answer:** C. Z94.0

   Rationale: Look in the ICD-10-CM Alphabetic Index for Transplant(ed) (status), kidney Z94.0. Verify in the Tabular List.

5. **Answer:** C. N20.0

   Rationale: Look in the ICD-10-CM Alphabetic Index for Calculus/kidney N20.0. Verify in the Tabular List.

6. **Answer:** B. C61

   Rationale: Look in the ICD-10-CM Alphabetic Index for Neoplasm, neoplastic and you are directed to the Table of Neoplasms. Look in the Table of Neoplasms for Prostate (gland)/Primary Malignant (column) C61. Verify in the Tabular List.

7. **Answer:** A. N13.4

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hydroureter N13.4. Verify in the Tabular List.

8. **Answer:** B. Q60.1

   Rationale: Look in the ICD-10-CM Alphabetic Index for Absence/kidney(s)/congenital/bilateral Q60.1. Verify in the Tabular List.

9. **Answer:** C. N25.1

   Rationale: Look in the ICD-10-CM Alphabetic Index for Diabetes/due to/insipidus/nephrogenic N25.1. Verify in the Tabular List.

10. **Answer:** B. I12.9, N18.3

    Rationale: Look in the ICD-10-CM Alphabetic Index for Nephrosclerosis and you are referred to see also Hypertension, kidney. Look for Hypertension/complicating/kidney I12.9. Check the Tabular List and you are instructed to code use an additional code to identify the stage of chronic kidney disease, N18.3 is for Stage 3. Verify in the Tabular List.

Section Review 18.3

1. **Answer:** C. 50945, N20.1

   Rationale: CPT®: Look in the CPT® Index for Ureterolithotomy/Laparoscopy 50945. Verify in the listing.

   ICD-10-CM: Look in the ICD-10-CM Alphabetic Index for Calculus/ureter N20.1. Verify in the Tabular List.

2. **Answer:** D. 50430, N13.722, Z93.6

   Rationale: CPT®: Look in the CPT® Index for Nephrostogram 50430, 50431. 50430 is reported for existing access. The code includes supervision and interpretation and imaging guidance. 74425 is not reported separately.

   ICD-10-CM: Look in the ICD-10-CM Alphabetic Index for Reflux/vesicoureteral/with/nephropathy/without hydroureter/bilateral N13.722; ICD-10-CM codes are not reported with modifiers. Z93.6 can be added for status nephrostomy tube. This is found in the Alphabetic Index under Status/nephrostomy. Verify in the Tabular List.

3. **Answer:** A. 50080, 76000, N20.0

   Rationale: CPT®: Look in the CPT® Index for Kidney/Removal/Calculus and you are referred to a range of codes. Review the codes in the listing, code 50080 reports removal of a stone up to 2 cm percutaneously (needle). There is a parenthetical

note that directs you to report 76000, 76001 for fluoroscopic guidance. Code 76000 is used because there is no mention of fluoroscopy time.

ICD-10-CM: Look in the ICD-10-CM Alphabetic Index for Calculus/kidney N20.0. Verify in the Tabular List.

4. **Answer:** C. 50060, N20.0

   Rationale: CPT®: Look in the CPT® Index for Nephrolithotomy 50060-50075. Review the codes in the listing, code 50060 is the correct code to report a surgical removal of the stone performed through an incision in the kidney.

   ICD-10-CM: Look in the ICD-10-CM Alphabetic Index for Calculus/kidney N20.0. Verify in the Tabular List.

5. **Answer:** A. 55700, 76942, R97.2

   Rationale: CPT®: Look in the CPT® Index for Prostate/Biopsy 55700-55706. 55700 is the correct because needle biopsy was performed without transperineal, stereotactic template. Code 55700 is only reported once for the three biopsies, because the code description is for single or multiple biopsies taken. There is a parenthetical note under code 55700 that instructs if imaging guidance is performed, use 76942. Ultrasound guidance is used, code 76942 is reported.

   ICD-10-CM: In the ICD-10-CM Alphabetic Index look for Elevated, Elevation/prostate specific antigen (PSA) R97.2. Verify in the Tabular List.

Section Review 19.1

1. **Answer:** C. Uterus

   Rationale: Root words metr/o and metri/o mean uterus.

2. **Answer:** B. Skene's glands

   Rationale: Bartholin's glands (greater vestibular glands) are located slightly inferior and to either side of the vaginal introitus. Skene's glands (lesser vestibular glands or paraurethral glands) are located on the anterior wall of the vagina around the lower end of the urethra.

3. **Answer:** B. An oocyte or egg

   Rationale: The fimbriae, or fingers, near the ovaries, help capture the ovum (egg or oocyte) at ovulation as it makes its way into the tube, and to the uterus.

4. **Answer:** A. Opening in the cervix

   Rationale: The opening in the cervix communicates with the vagina and is known as the os or external os.

5. **Answer:** D. Vagina

   Rationale: The vagina is a tubular, muscular canal leading from the uterus to outside the body.

Section Review 19.2

1. **Answer:** B. Z30.2

   Rationale: Look in the ICD-10-CM Alphabetic Index for Encounter (with health service) (for)/Sterilization, Z30.2. Verify in the Tabular List.

2. **Answer:** C. C50.312

   Rationale: Look in the ICD-10-CM Alphabetic Index for Malignancy - see Neoplasm, by site, malignant. Look in the Neoplasm Table for Neoplasm/breast/lower-inner quadrant/Primary C50.3-. Verify in Tabular List. The additional character 1 is reported for female and character 2 for left breast. The correct code choice is C50.312.

3. **Answer:** C. O10.213, I12.9, N18.9, Z3A.29

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hypertension, hypertensive/complicating/pregnancy/with/pre-existing/renal disease, O10.21-. In the Tabular List, add the additional character 3 to indicate third trimester. There is a note under category O10.2, to use an additional code from category I12 to identify the type of hypertensive chronic kidney disease. Because the documentation does not indicate the type of kidney disease, use I12.9 to indicate unspecified chronic kidney disease. An instructional note at I12.9 states to use an additional code for the stage of CKD, which is not documented so N18.9 is reported. At the beginning of Chapter 15, there is a note to report an additional code for the weeks of gestation. In the Alphabetic Index, look for Pregnancy/weeks of gestation/29 weeks Z3A.29.

4. **Answer:** D. O26.812, Z3A.26

   Rationale: Look in the ICD-10-CM Alphabetic Index for Pregnancy/complicated (by)/fatigue O26.81-. Look in the Tabular List for the 6th character; 2 is reported to indicate the second trimester. The correct code choice is O26.812. At the beginning of Chapter 15, there is a note to report an additional code for the weeks of gestation. In the Alphabetic Index, look for Pregnancy/weeks of gestation/26 weeks Z3A.26.

5. **Answer:** A. O30.203, Z37.52, Z3A.30

   Rationale: Look in the ICD-10-CM Alphabetic Index for Pregnancy/quadruplet O30.20-. In the Tabular List, additional characters are required to indicate the number of placenta and the number of amniotic sacs. Because you do not have that documentation, unspecified is reported. An additional character 3 is reported to indicate third trimester. The complete code is O30.203. Next, look in the ICD-10-CM Alphabetic Index for Outcome of Delivery/multiple birth/all liveborn/quadruplets Z37.52. Verify in Tabular List. The last code indicates the number of weeks. Documentation indicates she is at her 30th week. Look in the Alphabetic Index for Pregnancy/weeks of gestation/30 weeks Z3A.30.

Section Review 19.3

1. **Answer:** B. Surgical repair of the vagina

   Rationale: Colporrhaphy is the surgical repair of the vagina. The "-rrhaphy" part of the word comes from the Greek "raphe" meaning suture. Colporrhaphy may be performed for cystocele, rectocele, and endocele.

2. **Answer:** B. Hysteroscopies

   Rationale: All hysterscopies are allowed in the outpatient hospital and in an ASC. Open abdominal hysterectomies are considered inpatient only procedures. Not all vaginal hysterectomies are allowed in the outpatient hospital setting.

3. **Answer:** D. 57288

   Rationale: If the tendons supporting the urethra have been stretched, an additional procedure may be needed to create a sling to support the urethra (coded from the vagina section if performed transvaginally [57288].

4. **Answer:** B. 57461

   Rationale: Loop excision is also referred to as loop electrosurgical excision procedure, or LEEP. A LEEP conization with colposcopy is 57461. When performing a LEEP, the physician will use a loop electrode to remove a portion of the cervix. The procedure is both a biopsy and a treatment for dysplasia following an abnormal Pap smear. Documentation should indicate whether colposcopy is used. Documentation of LEEP alone is insufficient to assign a code.

5. **Answer:** C. 58100

   Rationale: Endometrial biopsy is sampling of the endometrial lining. Code 58100 reports an endometrial biopsy without dilation.

Section Review 20.1

Match the gland to the anatomical location with the aid of an anatomy book.

1.	**E**	Adrenal glands	A.	In a small bony cavity at the base of the brain
2.	**D**	Parathyroid gland	B.	Anterior neck below the skin and muscle layer
3.	**A**	Pituitary gland	C.	In the mediastinum of the chest
4.	**C**	Thymus gland	D.	Posterior side of the thyroid gland and imbedded in the connective tissue
5.	**B**	Thyroid gland	E.	On top of each kidney

Rationale: The adrenal (or suprarenal) glands sit directly atop the kidneys, one per side (adrenal means near the kidneys). There are four parathyroid glands. They are found on the posterior surface of the thyroid gland. The pituitary gland (hypophysis cerebri) is located just under the hypothalamus of the brain, which controls it. The thyroid gland is located anteriorly in the neck, just below the thyroid cartilage, or Adam's Apple.

Match the gland to its function with the aid of an anatomy reference or a medical dictionary.

6.	**C**	Adrenal medulla	A.	Exerts chemical control over the human body by maintaining homeostasis
7.	**D**	Thyroid gland	B.	Control of the body's calcium levels
8.	**A**	Neuroendocrine glands	C.	The main function of this gland is the secretion of adrenaline (epinephrine). It acts by raising blood glucose levels; increases blood pressure, heart rate, sweating, respiratory rate and other activities regulated by the sympathetic nervous system.
9.	**E**	Pituitary gland	D.	Regulate the body's overall metabolism
10.	**B**	Parathyroid glands	E.	Control the activity of many other endocrine glands

Rationale: Each portion (and sub-portion) of the adrenal glands performs a distinct function. The adrenal glands are responsible primarily for releasing stress hormones, including cortisol from the cortex and adrenaline and norepinephrine from the medulla, among other hormones. The thyroid gland controls how quickly the body uses energy, makes proteins, and determines sensitivity of the body to other hormones. Parathyroid glands maintain the body's calcium level for proper

functioning of the nervous and muscular systems. In some instances, the endocrine and nervous systems monitor and adjust each other's activities to create desired changes in the body. The term neuroendocrine system is sometimes used to describe the cooperation of both systems towards regulation of bodily functions. The pituitary gland is considered the master gland and regulates a wide variety of functions including: growth, metabolism, milk production and uterine contractions in pregnant women.

Section Review 20.2

1. **Answer:** D. E27.1

   Rationale: Look in the ICD-10-CM Alphabetic Index for Addison's/disease (bronze) or syndrome and you are directed to E27.1. Code selection is confirmed in the Tabular List.

2. **Answer:** D. E21.0

   Rationale: Look in the ICD-10-CM Alphabetic Index for Hyperparathyroidism/ primary and you are directed to E21.0. Code selection is confirmed in the Tabular List.

3. **Answer:** B. E21.0

   Rationale: In the ICD-10-CM Alphabetic Index for Hyperplasia, hyperplastic/parathyroid (gland) and you are directed to E21.0. Code selection is confirmed in the Tabular List.

4. **Answer:** D. E11.40

   Rationale: In the ICD-10-CM Alphabetic Index look for Diabetes, diabetic/with/neuropathy and you are directed to E11.40. There is no mention of the type of diabetes, so the default is Type 2. Verify in the Tabular List.

5. **Answer:** A. E11.311

   Rationale: Look in the ICD-10-CM Alphabetic Index for Diabetes/type 2/with/retinopathy/with macular edema E11.311. Verify in the Tabular List.

Section Review 20.3

1. **Answer:** C. M54.2

   Rationale: In the ICD-10-CM Alphabetic Index look for Cervicalgia or Pain(s)/neck NEC and you are directed to M54.2. Code selection is confirmed in the Tabular List.

2. **Answer:** B. G91.1

   Rationale: In the ICD-10-CM Alphabetic Index look for Hydrocephalus/obstructive G91.1. Verify code in the Tabular List.

3. **Answer:** A. M47.12

   Rationale: In the ICD-10-CM Alphabetic Index look for Spondylosis/with/myelopathy NEC/cervicalregion and you are directed to M47.12. Code selection is confirmed in the Tabular List.

4. **Answer:** D. M50.00

   Rationale: In the ICD-10-CM Alphabetic Index look for Disorder/disc/with/myelopathy/cervical region and you are directed to M50.00. There is a note to code the most superior level of disorder. Code selection is confirmed in the Tabular List.

5. **Answer:** B. G43.109

   Rationale: In the ICD-10-CM Alphabetic Index look for Migraine/classical and you are directed to see Migraine, with aura. Migraine/with/aura leads to G43.109. There is no mention of intractable migraine or status migrainosus. Code selection is confirmed in the Tabular List.

Section Review 20.4

1. **Answer:** B. 60271, D34

   Rationale: Look in the CPT® Index for Thyroidectomy/Total/Cervical Approach and you are directed to 60271. Verification of this code confirms it includes substernal thyroid and that it is performed via cervical approach. In the ICD-10-CM codebook, look in the Neoplasm Table for Neoplasm/thyroid (gland) and select the code from the Benign column, D34. Verify in the Tabular List.

2. **Answer:** D. 60100, E04.1

   Rationale: Look in the CPT® Index for Thyroid Gland/Needle Biopsy and you are directed to 60100. Verification of this code confirms it is for a percutaneous needle biopsy of the thyroid. Look in the ICD-10-CM Alphabetic Index for Cyst/thyroid (gland) and you are directed to E04.1. Verification in the Tabular List confirms code selection.

3. **Answer:** A. 60502, E83.52

   Rationale: Look in the CPT® Index for Parathyroid Gland/Exploration and you are directed to code range 60500-60505. Code 60502 indicates a re-exploration and is approved for OPPS. It is not approved for the ASC. Look in the ICD-10-CM Alphabetic Index for Hypercalcemia, hypocalciuric, familial and you are directed to E83.52. Verification in the Tabular List confirms code selection.

Section Review 20.5

1.	**L**	Optic (II)	A. Sense of smell
2.	**K**	Trochlear (IV)	B. Controls movement of four of the six muscles of the eyeball, the upper eyelid, and the muscles that constrict the pupils
3.	**J**	Abducens (VI)	C. Responsible for chewing, biting, and sideways movement of the jaw; sensations of pain, temperature, and touch on the face, scalp, sinuses, and interior of the nose and mouth
4.	**H**	Glossopharyngeal (IX)	D. Controls facial muscles around the eyes, forehead, external ear, and mouth; sensation of taste; and certain salivary and lacrimal (tear) glands
5.	**G**	Accessory (XI)	E. Responsible for sensations and movements for all of the organs of the chest and abdomen as well as the larynx, pharynx, and palate
6.	**F**	Hypoglossal (XII)	F. Responsible for tongue movements affecting speech and swallowing

7.	**E**	Vagus (X)	G. Responsible for shoulder movements, head rotation, swallowing, visceral movements, and voice production
8.	**I**	Acoustic (VIII)	H. Responsible for swallowing, secretion of saliva, sensations of the throat and taste sensations for the back of the tongue
9.	**D**	Facial (VII)	I. Responsible for hearing and balance (vestibulocochlear nerve)
10.	**C**	Trigeminal (V)	J. Controls movement of the lateral rectus muscle of the eye, one of the six muscles of the eyeball
11.	**B**	Oculomotor (III)	K. Controls movement of the superior, oblique muscle of the eyeball
12.	**A**	Olfactory (I)	L. Vision, extends from the retina to the optic chiasma

Section Review 20.6

1. **Answer:** B. 64420, G89.3, C79.51, C61

   Rationale: Look in the CPT® Index for Intercostal Nerve/Injection/Anesthetic and you are directed to 64420–64421. We know to look for anesthetic because it is a nerve block. An injection of a neurolytic agent is used for destruction. 64420 indicates a single nerve. Look in the ICD-10-CM Alphabetic Index for Pain(s)/due to cancer G89.3. ICD-10-CM Guideline I.C.6.b.5. states to code the pain as the primary diagnosis when the reason for the visit is pain control management. Both the primary and secondary cancers also need to be coded. Look in the Alphabetic Index for Metastasis, metastatic/cancer/ to specified site—see Neoplasm, secondary, by site. Look in the Neoplasm Table for Neoplasm/rib/Malignant Secondary column C79.51. The rib metastasis C79.51 is reported first before the primary cancer because the pain control is for the secondary cancer. Next, report the primary prostate cancer. Look in the Neoplasm Table for Neoplasm/prostate (gland) and use the code from the Malignant Primary column C61. Verify in the Tabular List.

2. **Answer: C.** 64493-50, 64494-50, M54.5

   Rationale: Look in the CPT® Index for Injection/Paravertebral Facet Joint/Nerve/with Image Guidance and you are directed to code range 64490-64495. L1-L2 and L2-L3 indicates two levels. 64493 is reported for the first level, and 64494 is reported for the second level. Parenthetical instructions below the heading of Paravertebral Spinal Nerves and Branches indicate to add a modifier 50 if the procedure is performed bilaterally. Fluoroscopic guidance is not reported because it is included in the code description. Look in the ICD-10-CM Alphabetic Index for Pain/lumbar region and you are directed to M54.5. Verification in the Tabular List confirms code selection.

3. **Answer: B.** 64493-50, G89.29, M51.36, M51.37

   Rationale: Look in the CPT® Index for Injection/Paravertebral Facet Joint/Nerve/with Image Guidance and you are directed to code range 64490-64495. Only one facet joint is mentioned, the joint between L4 and L5. Parenthetical instructions below the heading of Paravertebral Spinal Nerves and Branches indicate to add a modifier 50 if the procedure is performed bilaterally. Fluoroscopic guidance is not reported because it is included in the code description. The reason for the encounter is for pain control/pain management. The ICD-10-CM guideline for category code G89, Section I.C.6.b.1.(a), is followed. Look in the ICD-10-CM Alphabetic Index for Pain(s)/chronic G89.29. Look in the ICD-10-CM Alphabetic Index for Degeneration, degenerative/disc disease which states to see Degeneration, intervertebral disc. Degeneration/ intervertebral disc/lumbar directs you to M51.36 and lumbosacral M51.37. Verification in the Tabular List confirms code selection.

For questions 4–10, match the term to the definition.

4.	**D**	Syrinx	A. A drug or substance used to eliminate the sensation of pain
5.	**F**	Malformation	B. Part of the peripheral nervous system
6.	**B**	Somatic nerve	C. A network of nerves
7.	**E**	Cauda equina	D. A synonym for syringomyelia, a cyst within the spinal cord
8.	**C**	Plexus	E. The end of the spinal cord, including the nerve roots of those nerves below the first lumbar nerve
9.	**A**	Anesthetic agent	F. Failure of proper or normal development
10.	**G**	Decompression	G. Removal of pressure

Section Review 21.1

1. **Answer:** Sclera

   Rationale: Sclera is the white outer skin of the eye, and is covered with a thin protective layer of conjunctiva.

2. **Answer:** Six

   Rationale: Each eye has six muscles that work in tandem to direct the gaze up and down and from side to side as we focus on an object.

3. **Answer:** Limbus

   Rationale: The cornea meets the sclera in a ring called the limbus, also known as the sclerocorneal junction. Often, physicians will reference the limbus when describing the site of incision in eye surgery.

4. **Answer:** Malleus, incus, and stapes

   Rationale: The tympanic membrane vibrates to telegraph its message to the middle ear, where the malleus picks up the vibration, and transfers it to the incus and stapes. These three tiny bones, the ossicles, carry the message to the oval window and creates waves in the perilymph of the scala vesibuli of the cochlea, the round window membrane moves, which causes movement of the endolymph inside the cochlear duct. This causes the basilar membrane to vibrate, which in turn causes the organ of Corti (inner hair cells) to send electrical impulses along the auditory nerve to the brain.

5. **Answer:** Sound waves

   Rationale: In the context of the ear, conduction refers to the transfer of sound waves.

Section Review 21.2

1. **Answer:** D. H53.133

   Look in the ICD-10-CM Alphabetic Index for Loss/vision, visual/sudden. Note in alpha section indicates to see Disturbance/vision/subjective, loss/sudden, H53.13-. In the Tabular List, 3 is reported to indicate bilateral. The complete code is H53.133.

2. **Answer:** A. H52.512

   Look in the ICD-10-CM Alphabetic Index for Ophthalmoplegia/internal (complete) (total) H52.51-. This listing refers you to see also strabismus; however, nothing listed there is pertinent. In the Tabular List, 2 is reported to indicate the left eye. The complete code choice is H52.512.

3. **Answer:** C. H25.031

   Look in the ICD-10-CM Alphabetic Index for Cataract/senile/polar/ subcapsular/polar/anterior H25.03-. In the Tabular List, 1 is reported to indicate the right eye. The complete code choice is H25.031.

4. **Answer:** B. H10.33

   Look in the Alphabetic Index for Conjunctivitis/acute H10.3-. In the Tabular List, an additional character 3 is reported to indicate bilateral. The complete code choice is H10.33.

5. **Answer:** A. H53.022

   Look in the ICD-10-CM Alphabetic Index for Amblyopia/refractive H53.02-. In the Tabular List, add a 2 to indicate left eye. The complete code choice is H53.022.

Section Review 21.3

1. **Answer:** B. H70.011

   Rationale: Look in the Alphabetic Index for Abscess/mastoid which directs you to see Mastoiditis, acute. See mastoiditis/acute/subperiosteal H70.01-. In the Tabular List a 1 is added to indicate the right side. The complete code choice is H70.011.

2. **Answer:** D.H65.33

   Rationale: Look in the Alphabetic Index for Otitis/media/nonsuppurative/chronic/mucoid H65.3-. In the Tabular List, add a 3 to indicate bilateral. The complete code choice is H65.33.

3. **Answer:** C. H60.333

   Rationale: Look in the ICD-10-CM Alphabetic Index for Swimmer's/Ear H60.33-. In the Tabular List, add a 3 for bilateral. The complete code choice is H60.333.

4. **Answer:** B. H83.12

   Rationale: Look in the ICD-10-CM Alphabetic Index for Fistula/labyrinth (inner ear). Instructions are to see subcategory H83.1. In the Tabular List, add a 2 for the left ear. The complete code choice is H83.12.

5. **Answer:** B. H90.11

   Rationale: Look in the ICD-10-CM Alphabetic Index for Deafness/conductive/unilateral H90.1-. In the Tabular List, instructions are to add a 1 to indicate the right side. The complete code choice is H90.11.

Section Review 21.4

1. **Answer:** A. 67311, H50.9

   Rationale: When a muscle is detached and re-attached, it is considered a resection procedure. The lateral rectus muscle is a horizontal muscle and in this case the only muscle performed on. Strabismus surgery is performed to correct missalignment of the eye muscles. Look in the CPT® Index for Eye Muscles/Repair/Strabismus/See Strabismus. Under Strabismus/Repair/One Horizontal Muscle and you are directed to 67311. Look in the ICD-10-CM Alphabetic Index for Strabismus H50.9. Verify in the Tabular List.

2. **Answer:** D. 66984-LT, H26.9

   Rationale: Look in the CPT® Index for Phacoemulsification/Removal/Extracapsular Cataract and you are directed to 66982, 66984. There is no mention of complex devices or techniques, making 66984 the correct code. Code 66984 includes the lens implant. Modifier LT is used to report the left eye. Look in the ICD-10-CM Alphabetic Index for Cataract and you are directed to H26.9. There is no further specification on the cataract making H26.9 the correct code. Verification in the Tabular List confirms code selection.

3. **Answer:** B. 67107-LT, H33.22

   Rationale: This is repair of a detached retina. In the CPT® Index, look under Retina/Repair/Detachment/Scleral Dissection 67107. You can also find this code under Retina/Repair/Detachment/Cryotherapy. Refer to the codes. Lamellar scleral dissection with cryotherapy is reported with 67107. Look in the ICD-10-CM Alphabetic Index for Detachment/retina and you are directed to H33.2-. In the Tabular List, add a 2 for the left eye. The complete code choice is H33.22. Sudden loss of vision is a sign/symptom of the retinal detachment (H53.132) and is not reported.

4. **Answer:** C. 68761-50, H04.123

   Rationale: The inferior puncta is part of the lacrimal system. Look in the CPT® Index for Lacrimal Punctum/Closure/by Plug and you are directed to 68761. Because this is a bilateral procedure, modifier 50 is added. Remember, in the facility, when a procedure is performed on both the right and left sides, instead of using RT and LT modifiers, the procedure is reported on one line item with modifier 50. Look in the ICD-10-CM Alphabetic Index for Syndrome/dry eye H04.12-. In the Tabular List, add a 3 for bilateral. The complete code choice is H04.123.

5. **Answer:** C. 65275-LT, S05.8X2A, T15.02XA

   Rationale: Look in the CPT® Index for Cornea/Repair/Wound/Nonperforating and you are directed to 65275. Looking at the description of the code, 65275, the removal of the metal is included. There is also a parenthetical note under code 65222 that indicates for repair of corneal laceration with foreign body, use 65275. In the ICD-10-CM Alphabetic Index look for Wound, open/ocular/specified S05.8X-. In the Tabular List, add a 2 for the left eye and an A for the initial encounter. The complete code choice is S05.8X2A. Next code the foreign body. Look in the Alphabetic Index for Foreign body/cornea. T15.0-. In the Tabular List, a 2 is added for the left eye, a dummy placeholder X and then an A are is added for initial encounter. The complete code choice is T15.02XA. The laceration of the cornea was superficial not penetrating.

Section Review 21.5

1. **Answer: B.** 69300-50, Q17.5

   Rationale: The procedure involves the surgical repair of prominent ears. Look in the CPT® Index for Otoplasty or Ear/Reconstruction/Protruding Ear 69300. Append modifier 50 because the procedure is performed bilaterally. In the ICD-10-CM Alphabetic Index, look for Prominence/auricle (congenital) (ear) Q17.5. Verify in the Tabular List.

2. **Answer: A.** 42830, 69436-50, J35.2, H65.23

   Rationale: In the CPT® Index, look for Adenoids/Excision 42830-42836. The procedure involves the adenoids only. The age of the patient is required for proper code choice. Code 42830 is correct for an initial adenoidectomy, which is a primary procedure, for a child under 12 years of age. The insertion of the ventilation tubes requires the creation of an opening which is a tympanostomy. Code selection is determined based on the type of anesthesia. In the CPT Index, look for Tympanostomy/General Anesthesia 69436. Append modifier 50 because the procedure is performed bilaterally. In the ICD-10-CM Alphabetic Index, look for Hypertrophy, hypertrophic/adenoids (infective) J35.2. Verify in Tabular List. In the Alphabetic Index, look for Otitis/media/non-suppurative/chronic/serous H65.2-. In the Tabular List, a 3 is added for bilateral. The complete code choice is H65.23.

3. **Answer:** D. 69436-RT, H69.91

   Rationale: A myringotomy is an insertion in the eardrum. In this case the opening is created to insert a ventilating tube which is reported as a tympanostomy. Look in the CPT® Index for Tympanostomy/General Anesthesia 69436. Modifier RT is appended to report the procedure in the right ear. ETD is Eustachian tube dysfunction. In the Alphabetic Index, look for Disorder/Eustachian tube H69.9-. In the Tabular List, a 1 is added for the right ear. The complete code choice is H69.91.

4. **Answer: D.** 69660-LT, H90.12

   Rationale: Look in the CPT® Index for Stapedotomy/without Foreign Material. You are referred to 69660. The procedure does not involve a revision of a prevision procedure or a footplate drill out. 69660 is the correct code. Modifier LT is reported because the procedure is performed on the left ear. The use of the operating microscope is bundled because this is a microscopic procedure. See notes above code 69990. In the ICD-10-CM Alphabetic Index, look for Deafness/conductive unilateral H90.1-. In the Tabular List, a 2 is added for the left side. The complete code choice H90.12.

5. **Answer: A.** 69930-LT, H91.93

   Rationale: In the CPT® Index look for Cochlear Device/Implantation 69930. The use of the operating microscope is a bundled procedure. Modifier LT is appended because the procedure is performed on the left ear. In the ICD-10-CM Alphabetic Index, look for Deafness H91.9-. There is not a subterm for profound. Verify the default code in the Tabular List. Add 3 for bilateral. The complete code choice is H91.93.

Section Review 22.1

1. **Answer:** Anteroposterior (AP) and posteroanterior (PA) are positioning terms for radiology services and the description of the direction an X-ray travels through the body.
2. **Answer:** Body part is rotated so that it does not produce an AP/PA projection. The X-ray beam enters at an angle.
3. **Answer:** Lying down on a horizontal surface on the right or left side; central ray is parallel to the surface.
4. **Answer:** Side of the patient that is closest to the film.
5. **Answer:** Forearm or hand is turned so that the palm is directed downward. Prone also means lying face down on the front of the body (ventral recumbent).

Section Review 22.2

1. **Answer:** C. Telephone order without a written order

   Rationale: Orders for X-rays may be received in multiple formats. A written order may be written as a prescription, or it may be a radiology requisition form, a fax, or a progress note. A telephone order may be called in by the treating physician or his office staff. The treating physician may send an email to the radiology department or facility. Even if a telephone order is sent and received, both parties must follow-up in writing on the patient's medical record to ensure that both the requesting and performing physicians approve the imaging study.

2. **Answer:** B. Z12.31, Z80.3

   Rationale: Look in the ICD-10-CM Alphabetic Index for Mammogram/routine Z12.31. The code for family history of breast cancer is also coded. Look in the Alphabetic Index for History of/family/malignant neoplasm/breast Z80.3. Verification in the Tabular List confirms code selection.

3. **Answer:** C. N73.6, N97.1

   Rationale: Look in the ICD-10-CM Alphabetic Index for Adhesions/peritubal N73.6. Then look in the ICD-10-CM Alphabetic Index for Infertility/female/origin/tubal N97.1. Verify both codes in the Tabular List.

4. **Answer:** A. M81.0, Z79.890

   Rationale: Look in the ICD-10-CM Alphabetic Index for Osteoporosis/postmenopausal M81.0. Next, look in the Alphabetic Index for Therapy/drug/hormone replacement (postmenopausal) Z79.890. Verification in the Tabular List confirms code selection.

5. **Answer:** B. Z01.818, M16.11, Z86.11

   Rationale: This is a chest X-ray for pre-operative clearance. Look in the ICD-10-CM Alphabetic Index for Examination/pre-procedural/specified NEC Z01.818. The surgery is being performed for osteoarthritis. Look in the ICD-10-CM Alphabetic Index for Osteoarthritis/hip directs you to M16.1-. The Tabular List indicates a fifth character of 1 is required to show the right hip: M16.11. The history of tuberculosis is also coded. Look in the Alphabetic Index for History of/personal/infectious/tuberculosis Z86.11. Verification in the Tabular List confirms code selection. Check the Official Guidelines for Coding and Reporting in Section IV. M. Code first the Z code, followed by the reason for the surgery, and lastly the findings related to the preoperative evaluation.

Section Review 22.3

1. **Answer:** When contrast medium is administered either rectally or orally it does not qualify as with contrast for coding selection.

2. **Answer:** Scout films may be performed prior to an actual imaging study with contrast or delayed imaging. Scout films are not coded separately as they are considered part of the basic procedure.

3. **Answer:** MRI—imaging, and MRA—angiography. MRI is used to study the joints, soft tissues, injuries to bone, tumors, etc. MRA is used to study the vessels and heart.

4. 73650, S92.009A, W13.2XXA, Y92.009

Rationale: Look in the CPT® Index for X-ray/Heel 73650. Look for the code 73650 and it includes a minimum of 2 views of the calcaneus. For the ICD-10-CM, look in the Alphabetic Index for Fracture/traumatic heel bone and you are directed to see Fracture/tarsal/calcaneus S92.00-. Reference this in the Tabular List; a 6th character of 9 indicated unspecified heel, and a 7th character of A indicates this is the initial encounter: S92.009A. The patient fell off of his roof. Look in the Index to External Causes for Fall, falling/from, off/roof W13.2. Reference the Tabular List; a 7th character is needed therefore the final code is W13.2XXA Look in the Index to External Causes for Place of occurance/residence/home Y92.009. Verification in the Tabular List confirms code selection.

5. **Answer:** 73222, S46.011A, V00.321A, Y93.23, Y92.59

Rationale: Look in the CPT® Index for Magnetic Resonance Imaging (MRI)/Diagnostic/Joint/Upper Extremity and you are directed to 73221-73223. 73222 indicates an MRI with contrast. Look in the ICD-10-CM Alphabetic Index for Tear, torn/ rotator cuff (traumatic) S46.01-. Verification in the Tabular List shows a 6th character of 1 is needed for the right shoulder and a 7th character of A shows this is the initial encounter: S46.011A. Next, in the Index to External Causes find Accident/ transport/pedestrian/conveyance/skis/fall V00.321, which will also require a 7th character of A: V00.321A. In the same index, find Activity/skiing (alpine) (downhill) Y93.23. In the same index, find Place of occurance/trade area/hotel Y92.59. Verify in the Tabular List.

Section Review 22.4

1. **Answer:** 76700

Rationale: Look in the CPT® Index for Ultrasound/Abdomen and you are directed 76700–76705. 76700 represents a complete ultrasound of the abdomen.

2. **Answer:** 72126

Rationale: Look in the CPT® Index for CT Scan/with Contrast/Spine/Cervical and you are directed to 72126. Verify.

3. **Answer:** 62269, 77002

Rationale: Look in the CPT® Index for Biopsy/Spinal Cord/Percutaneous or Needle 62269. Look up this code and you will see below 62269 the codes for radiological supervision and interpretation. Report 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device).*

4. **Answer:** 76801, 76802, Z34.00

Rationale: Look in the CPT® Index for Ultrasound/Pregnant Uterus 76801-76817. Look at this range of codes. Code 76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester, (<14 weeks 0 days) transabdominal approach; single of first gestation is reported. Use add-on code 76802 to report the ultrasound for the second fetus. In the ICD-10-CM, look in the Alphabetic Index for Pregnancy/complicated by/ twins/ unspecified number of placenta and unspecified number of amniotic sacs O30.00-. Verification in the Tabular List shows a 6th character of 1 is needed for the first trimester. O30.001, Twin pregnancy with unspecified number of placenta and amniotic sacs, first trimester is correct. Use an additional code for the weeks of gestation, Z3A.00 as weeks are not specified.

5. **Answer:** 32555, J93.9

Rationale: Look in the CPT® Index for Thoracentesis/with Imaging Guidance 32555. 32555 is reported for thoracentesis performed with imaging guidance. The flouroscopic guidance is included in code 32555 and note reported separately. Look in the ICD-10-CM Alphabetic Index for Pneumothorax J93.9. Verification in the Tabular List confirms code selection.

Section Review 22.5

For questions 1–5, match the term with the definition.

1.	**D** Field	A.	Blocks placed between the radiation source and the patient to reduce exposure
2.	**E** Fractionation	B.	Radiation dosage in million electron volts = maximum energy level of the X-ray beam
3.	**B** MeV	C.	Use of three or more fields to deliver dosage
4.	**C** Multifield	D.	Geometric area defined by a collimator at the skin surface
5.	**A** Shaped field	E.	Division of total planned dose into number of smaller doses given over a period of time

6. **Answer:** C8918, N94.9

   Rationale: Look in the CPT® Index for Magnetic Resonance Angiography (MRA)/Pelvis and you are directed to 72198. Remember that some of the MRIs and MRAs have specific C codes to be used for OPPS. In this case, the Medicare Carriers Manual states to use a code from C8918 - C8920 in place of CPT® code 72198. Looking in the HCPCS Level II codebook, C8918 is for an MRA of the pelvis with contrast. For the ICD-10-CM, the reason for the MRA is a mass in the right adnexa. Look in the ICD-10-CM Alphabetic Index for Mass/specified site NEC and you are directed to see Disease, by site. Disease/genital organs/female directs you to N94.9. Verification in the Tabular List confirms code selection.

7. **Answer:** 77086, M81.0, W19.XXXA

   Rationale: Look in the CPT® Index for DXA-See Dual X-ray Absorptiometry (DXA). Dual X-ray Absortiometry (DXA)/ Vertebral Fracture 77085, 77086. 77086 is the correct code because the scan is just for the vertebral fracture assessment. For the diagnosis, look in the ICD-10-CM Alphabetic Index for Osteoporosis M81.0. Verify in the Tabular List. Fracture code is not reported because the reason for scan is to find out if there is a fracture. Next look in the external cause index for Fall/accidental leading to W19-. Verify in the Tabular List. A 7th character of A and XXX placeholders are needed.

8. **Answer:** 76819, Z36

   Rationale: Look in the CPT® Index for Fetal Biophysical Profile and you are directed to 76818-76819. Non-stress testing is not performed making 76819 the correct code. Look in the ICD-10-CM Alphabetic Index for Screening/antenatal, of mother Z36. Verify in the Tabular List.

9. **Answer:** 78013

   Rationale: Look in the CPT® Index for Thyroid Gland/Nuclear Medicine/Imaging with Flow directs you to code 78013. Verify in the listing.

Section Review 23.1

1. **Answer:** Hemat/o is the root word for blood.

2. **Answer:** The Latin term in vivo refers to studies performed within the living body. In contrast, *in vitro* refers to studies performed on components of an organism that have been isolated from their usual biological surroundings. Ex vivo studies are conducted on functional organs that have been removed from the body.

3. **Answer:** Cyto = cell. Cytopathology is the study and diagnosis of diseases on a cellular level.

4. **Answer:** Molecular diagnostics is the measurement of DNA (deoxyribonucleic acid), RNA (ribonucleic acid), proteins, or metabolites to detect genotypes, mutations, or biochemical changes.

5. **Answer:** Definitve. Tests may be identified as presumptive or definitive. Presumptive testing determines the presence or absence of a drug class(es) only and may be followed by a definitive test. Because presumptive testing does not identify a specific drug the definitive testing identifies specific drugs and associated metabolites. Definitive testing may be qualitative (the presence or absence of the drug in the patient's system), quantitative (how much of the drug is present in the patient's system), or a combination.

Section Review 23.2

1. **Answer:** A. C44.319

   Rationale: Look in the Alphabetic Index for Carcinoma/basal cell (see also Neoplasm, skin, malignant) C44.91. Go to Neoplasm/skin/cheek which shows C44.309; however this does not indicate basal cell carcinoma. See reference here - see also Neoplasm, skin, face. If you got to Neoplasm/skin/face/basal cell carcinoma/Primary Malignant C44.310. In Tabular List, C44.310 is for unspecified part of face. Look further and see C44.319 is correct as Basal cell carcinoma of skin or other part of face.

2. **Answer:** A. C67.9

   Rationale: The laboratory should report code C67.9, malignant neoplasm of bladder, part unspecified. It is appropriate to code the carcinoma, in this instance, because the cytology reports the pathologist authenticated the services as confirmation of the cell type, similar to a pathology report. In the Alphabetic Index for Carcinoma - see also Neoplasm, by site, malignant. Look in the Neoplasm Table for Neoplasm/bladder (urinary)/Malignant/Primary C67.9. Verify in the Tabular List.

3. **Answer:** A. C43.62

   Rationale: There is a confirmed diagnosis of malignant melanoma. Look in the ICD-10-CM Alphabetic Index for Melanoma (malignant)/skin/arm C43.6-. In the Tabular List, fifth character 2 is reported for the left uppper limb.

4. **Answer:** B. Z12.4, Z87.410

   Rationale: The Pap smear is negative. This patient has had cervical dysplasia in the past. So the reason for the test, is a screening Pap test, because of a past history of cervical dysplasia; therefore, the need for another Pap smear. Look in the Alphabetic Index for Screening/neoplasm (malignant) (of)/cervix Z12.4. Look in the Alphabetic Index History/personal (of)/cervical dysplasia Z87.410.

5. **Answer:** A. Z11.51, Z86.19

   Rationale: This patient has a normal Pap; however she has been tested again because she had a positive HPV test in the past. This is a screening. Look in the Alphabetic Index for Screening/human papillomavirus Z11.51. Look in the Alphabetic Index for History/personal (of)/disease or disorder (of)/infectious/specified NEC Z86.19. Verify in the Tabular List.

Section Review 23.3

Fill in the blanks with the proper panel code and title:

1. **Answer:** hepatic function panel (80076)

2. **Answer:** lipid panel (80061)

3. **Answer:** renal function panel (80069)

4. **Answer:** acute hepatitis panel (80074)

5. **Answer:** electrolyte panel (80051)

Section Review 23.4

1. **Answer:** D. 80502

   Rationale: Regular consultation codes from the E/M section of CPT® are not used, because the pathologist did not evaluate the patient. The pathologist fulfilled the requirements of the code in following the request and preparing the report. Look in the CPT® Index for Consultation/Clinical Pathology 80500-80502. Check the codes. Code 80500 does not include a review of the patient's history and medical records; therefore, the correct code is 80502.

2. **Answer:** D. 80303, 80345, 80361

   Rationale: Look in the CPT® Index for Drug Assay/Drug Procedure/Presumptive Drug Class/Drug Class List A/Opiates (80300, 90301, 90303, 80304) and Barbiturates (80300, 80301, 80303, 80304). Code 80303 is for TLC for single or multiple drug classes and is reported only once per date of service. Next, look in the CPT® Index for Drug Assay/Drug Procedure/Definitive Drug Class/Opiates, 1 or more (80361) and Barbiturates (80345).

3. **Answer:** B. 85610, Z51.81, Z79.01, I48.91

   Rationale: PT/INR is a prothrombin time test. Look in the CPT® Index for Prothrombin Time and you are directed to 85610-85611. There is no mention of substitution making 85610 the correct code. Coumadin is an anticoagulant. Look in the ICD-10-CM Alphabetic Index for Admission (with health services) (for)/therapeutic drug level monitoring Z51.81. In the Tabular List, under code Z51.81, it states to use additional code for any long-term (current) drug therapy (Z79.-). In the Alphabetic Index, look for Long-term (current) (prophylactic) drug therapy/anticoagulants Z79.01. Look in the ICD-10-CM Alphabetic Index for Fibrillation/atrial or auricular (established) I48.91. Verification in the Tabular List confirms code selection.

4. **Answer:** D. 84436, 84443, R63.4, R00.0, R45.0

   Rationale: Look in the CPT® Index for T4 Total and you are directed to see Thyroxine, Total. Looking for Thyroxine/Total, you are directed to 84436. Look in the CPT® Index for Thyroid Stimulating Hormone (TSH) and you are directed to 80418, 80438, 80439, 84443. 84443 is for the TSH. The other codes referred to include other tests or multiples of TSH. The patient is suspected of having hyperthyroidism, but this is not confirmed. The symptoms should be coded. Look in the ICD-10-CM Alphabetic Index for Loss/weight (abnormal) (cause unknown) R63.4. Then, look for Rapid/heart (beat) or Tachycardia and you are directed to R00.0. Last, look in the Alphabetic Index for Nervousness R45.0. Verification in the Tabular List confirms code selection.

5. **Answer:** B. 84153, R31.9

   Rationale: PSA is a Prostate Specific Antigen. Look in the CPT® Index for Prostate Specific Antigen and you are directed to code range 84152-84154. 84153 is for a PSA total. Look in the ICD-10-CM Alphabetic Index for Hematuria and you are directed to R31.9. Verification in the Tabular List confirms code selection.

Section Review 23.5

1. **Answer: A.** 87181

   Rationale: In the CPT® Index look for Pathology and Laboratory/Microorganism Identification/Sensitivity Studies directs you to codes 87181–87190. 87181 is correct because of the agar dilution method.

2. **Answer: C.** 88040

   Rationale: In the CPT® Index look for Necropsy/Forensic Exam directs you to code 88040. Verify.

3. **Answer: C.** 88304

   Rationale: In the CPT® Index look for Pathology and Laboratory/Surgical Pathology/Gross and Micro Exam which lists Levels I-VI, which are codes 88302–88309. Review the codes. 88304 is the correct code because Appendix removed was not incidental.

4. **Answer: B.** 89230

   Rationale: In the CPT® Index look for Pathology and Laboratory/Sweat Collection/Iontophoresis for 89230. Verify.

5. **Answer: A.** 89050

   Rationale: In the CPT® Index look for Pathology and Laboratory/Cell Count/Body Fluid 86152–86153, 89050–89051 or look for Cell Count/Body Fluid/Other than Blood 89050–89051. 89050 is correct because there is no mention of the test being performed with differential count.

Section Review 24.1

1. **Answer:** A. 28192, 90703, 90471, S91.341A, W45.0XXA, Y92.69, Y93.01, Z23

   Rationale: The patient had a nail removed from deep in the foot. Look in the CPT® Index for Removal/Foreign Body/Foot and you are directed to code range 28190-28193. There is no mention of complication. There is mention that it was deep. 28192 is the correct code. For the vaccination, look in the CPT® Index for Vaccines/Tetanus and Diphtheria Toxoid and you are directed to 90714. The administration of the tetanus toxid is also reported. Look in the CPT® Index for Administration/Immunization/One Vaccine/Toxoid and you are directed to 90471, 90473. The injection was given intramuscular (IM) making 90471 the correct administration code.

   Look in the ICD-10-CM Alphabetic Index for Puncture/foot/right/with foreign body S91.341-. In the Tabular List, a seveth character is required. Seventh character A is reported for the initial encounter. In the Index to External Cause of Injuries Index look for Contact (accidental)/with/nail W45.0-. In the Tabular List, W45.0 requires a seventh character; A is reported for the intial encounter. The patient also receives an immunization. Placeholders are used to keep the seventh character in the seveth position. Look in the ICD-10-CM Alphabetic Index for Immunization/encounter for Z23. Also look for Place of of occurrence/construction area and you are directed to see Place of occurrence, industrial and construction area. Look for Place of occurrence/industrial and construction area (Y92.69). Then, look for Activity/walking (on level or elevated terrain) Y93.01. Verification in the Tabular List confirms code selection. In the ICD-10-CM Alphabetic Index see Immunization/Encounter for Z23.

2. **Answer:** D. 99283-25, 90675, 90471, 90375, 96372, S51.809A, Z23, W54.0XXA

Rationale: The ED visit is mid-level (99283). This is found in the CPT® Index under Evaluation and Management/Emergency Department 99281-99288. The wound cleaning is included in the ED visit. Look in the CPT® Index for Vaccines/Rabies and you are directed to code range 90675-90676. 90675 reports intramuscular use. The administration of the rabies vaccination is also reported. Look in the CPT® Index for Administration/Immunization/One Vaccine/Toxoid and you are directed to 90471, 90473. The injection was given intramuscular (IM) making 90471 the correct administration code. Look in the CPT® Index for Immune Globulins/Rabies and you are directed to code range 90375-90376. Because there is no mention of the immunoglobulin being heat-treated, 90375 is the correct code. The coding guidelines preceding the codes for the immunoglobulin state to report the administration using codes 96365-96368, 96372, 96374, 96375. Report the injection based on route. The immunoglobulin injection given intramuscularly is reported with 96372. Modifier 25 is appended to the E/M code because other procedures were performed (vaccination and injection).

Look in the ICD-10-CM Alphabetic Index for Bite/forearm S51.85-. In Tabular List, an additional character 1 is added for the right forearm and the seveth character A for an initial encounter. The immunization code is not reported because the immunzation is performed for a bite. Next, look in the External Cause if Injuries Index for Bite, bitten by/dog, W54.0-. Verify in Tabular Index. Add two dummy placeholders X and an A for the initial encounter. Correct code choice is W54.0XXA. We do not have the activity of the person or the location where the patient was when bitten so additional external cause codes cannot be reported. Next, in the ICD-10-CM Alphabetic Index for Immunization/Encounter for and see Z23.

Section Review 24.2

1. **Answer: D.** 90791, F41.1

   Rationale: Look in the CPT® Index for Psychiatric Diagnosis/ Evaluation and you are directed 90791. There is no mention of this being interactive making 90791 the correct code. Look in the ICD-10-CM Alphabetic Index for Disorder/anxiety/generalized and you are directed to F41.1. Verification in the Tabular List confirms code selection.

2. **Answer: B.** 90834, F22

   Rationale: Look in the CPT® Index for Psychotherapy/Individual Patient/Family Member and you are directed to 90832-90834, 90836-90838. There is no mention of an E/M visit and the visit lasts 45 minutes making the correct code 90834. Look in the ICD-10-CM Alphabetic Index for Psychosis/paranoid and you are directed to F22. Verification in the Tabular List confirms code selection.

Section Review 24.3

1. **Answer: A.** 90911, R15.9

   Rationale: Look in the CPT® Index for Biofeedback Training/Anorectal and you are directed to 90911. Look in the ICD-10-CM Alphabetic Index for Incontinence/feces, and you are directed to R15.9. Verification in the Tabular List confirms code selection.

2. **Answer: D.** 99284-25, G0378 x 13, G0257, R07.9, N18.6, Z99.2

   Rationale: Dialysis provided to ESRD patients may be reported by a non-certified ESRD facility when the patient misses dialysis due to an unrelated medical emergency. This scenario meets this definition. G0257 is reported for the hospital to receive payment under OPPS. This is found in the HCPCS Level II Index under Dialysis/emergency treatment G0257. Level 4 ED visit in a Type A ED is reported with 99284. This is found in the CPT Index under Evaluation and Management/Emergency Department 99281-99288. Look in the HCPCS Index for Observation service/per hour G0378. Modifier 25

is needed to show that the resources used for the ED visit were separate from those used for dialysis and the observation services. The patient is admitted to observation for 13 hours which is reported with 13 units of G0378.

Look in the ICD-10-CM Index to Diseases for Pain/Chest R07.9. We do not have any further information about the chest pain. Look in the Index to Diseases for Disease/renal/end-stage (failure) N18.6. Verify in the Tabular List to see an Instructional note to use an additional code to identify dialysis status, Z99.2.

Section Review 24.4

1. **Answer**: D. 93886, R56.1, S09.90XS

   Rationale: Look in CPT® Index for Doppler Scan/Intracranial Arteries/Complete Study. You are referred to 93886. The patient is diagnosed with seizure disorder caused by a severe head injury, which happened six months ago. Look in the ICD-10-CM Alphabetic Index for Seizure/post traumatic, and you are referred to R56.1. The seizure disorder is a result of a severe intracranial head injury which makes this a late effect. Late effects of the injury are coded to the injury with a seventh character S is reported. Look in the ICD-10-CM Alphabetic Index for Injury/head S09.90-. In the Tabular List, seventh character S is reported (S09.90XS).

2. **Answer: D.** 95180 x 3, T78.40XA

   Rationale: Look In CPT™ Index to Diseases for Allergen Immunotherapy/Rapid Desensitization. You are referred to 95180. The code description includes "each hour" so the code is reported with 3 units. For the diagnosis, look in the ICD-10-CM Alphabetic Index for Hypersensitivity and you are referred to see also Allergy. Under Allergy, allergic (reaction) (to)/drug, medicament & biological T78.40-. In the Tabular List, a seveth character is required. A is reported for the initial encounter because it is active treatment. Verify the code description in the Tabular List.

Section Review 24.5

1. **Answer:** B. G0463, 96372, J2510, J18.9

   Rationale: A low level, established patient E/M service is reported with G0463. This is found in the HCPCS Index under Clinical visit/encounter/hospital outpatient. Through OPPS all outpatient facility clinic visit are billed with G0463. Look in the CPT® Index for Injection/Intramuscular/Therapeutic and you are directed to 96372, 99506. 99506 is for a home visit and is not applicable for this case. 96372 is the correct code for an intramuscular injection. Modifier 25 is used on the E/M service to show that the resources used were separate from the injection service. Also report the Penicillin. Look in the HCPCS Level II Table of Drugs for Penicillin G Procaine. 600,000 units given IM. This is reported with HCPCS Level II code J2510. Look in the ICD-10-CM Alphabetic Index for Pneumonia and you are directed to J18.9. Verification in the Tabular List confirms code selection.

2. **Answer: C.** 96365, J3489 x 5, M81.0

   Rationale: Look in the CPT® Index for Infusion/Intravenous/Diagnostic/Prophylactic/Therapeutic and you are directed to 96365–96368, 96379. 96365 is for the first hour. The drug should also be coded. Look in the HCPCS Level II Table of Drugs for Reclast®. 1 mg given IV directs you to J3489. This is for 1 mg and 5 mg were given so 5 units should be reported. The guidelines for Infusions state the flush of saline is included and not reported separately. Look in the ICD-10-CM Alphabetic Index for Osteoporosis/postmenopausal and you are directed to M81.0. Verification in the Tabular List confirms code selection.

Section Review 24.6

1. **Answer:** B. 97035 x 2, M48.06

   Rationale: Look in the CPT® Index for Physical Medicine/Therapy/Occupational Therapy/Modalities/Ultrasound and you are directed to 97035. The code reflects 15 minutes so 2 units are reported. Look in the ICD-10-CM Alphabetic Index for Stenosis/spinal/lumbar and you are directed to M48.06. Verification in the Tabular List confirms code selection.

2. **Answer:** A. 97003, H54.3

   Rationale: Look in the CPT® Index for Occupational Therapy/Evaluation and you are directed to 97003-97004. 97003 is for the initial evaluation. Look in the ICD-10-CM Alphabetic Index for Impaired, impairment/vision/both eyes H54.3. Verification in the Tabular List confirms code selection.

Section Review 25.1

1. **Answer:** D. Create a PPS for outpatient facility services

   Rationale: When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital specific costs. To encourage more efficient delivery of medical care and to ensure that Medicare pay appropriately for services, Congress mandated replacement of the cost-based payment methodology with a prospective payment system (PPS).

2. **Answer:** A. OR, recovery room, and anesthesia

   Rationale: The costs for the OR, recovery room and anesthesia are packaged in the surgical fee. Separate payment is not made for these services.

3. **Answer:** D. Incidental services, packaging, procedures or services, medical visits, and multiple procedure discounting, and ancillary tests and procedures

   Rationale: Basic concepts for APCs include procedures or services, medical visits, ancillary tests and procedures, incidental services, packaging, composite packaging and multiple procedure discounting.

4. **Answer:** B. False

   Rationale: Packaged services are reported on the claim but are not paid separately. The cost is included in the APC for the surgical or medical procedure performed that is assigned an APC.

5. **Answer:** A. Control hospital reimbursement for outpatient services

   Rationale: The primary objective of the OPPS is to simplify payment, encourage hospital efficiency, and to ensure payments are adequate to compensate hospitals for legitimate costs.

Section Review 25.2

1. **Answer:** A. Status indicator methodology

   Rationale: Payments for outpatient hospital services are paid using a status indicator methodology. The status indicator determines under what payment system the services are paid.

2. **Answer:** B. Grouping of outpatient services that are similar clinically and require similar resources

   Rationale: Services within an APC are similar clinically and require similar resources to perform the services and/or procedures.

3. **Answer:** C. Paid under OPPS; separate APC payment

   Rationale: Status Indicator G is for pass-through drugs and biologicals which are paid under OPPS; separate APC payment.

4. **Answer:** A. Surgical thoracoscopy, laminectomies, enterostomies, risky invasive procedures

   Rationale: In the chapter there are examples listed for inpatient only procedures. Included on the list are surgical thoracoscopy, laminectomies, enterostomies and risky invasive procedures.

5. **Answer:** D. Recovery room, routine supplies, drugs considered integral part of procedure, anesthesia

   Rationale: Packaged items include routine supplies, anesthesia, recovery room and drugs integral of a surgical procedure.

Section Review 25.3

1. **Answer:** D. Provide additional payment for extremely high cost services

   Rationale: Outlier payment adjustments provide additional payment for extremely high cost cases. The OPPS Pricer calculates outlier payments based on each individual service.

2. **Answer:** A. Must exceed 1.75 times the APC payment plus a fixed dollar threshold of $2,775

   Rationale: To qualify for an outlier payment for outpatient hospitals for 2016, the cost of the service must exceed 1.75 times the APC payment rate plus the $3,250.00 fixed dollar threshold that equals 50 percent of the amount by which the cost of furnishing the services exceeds.

3. **Answer:** B. is equal to the amount of which 95 percent of the AWP for the drug exceeds the portion of the APC payment

   Rationale: The pass-through payment for a drug or biological is equal to the amount by which 95 percent of the average wholesale price (AWP) for the drug exceeds the portion of the APC payment determined to be associated with the drug or biological.

4. **Answer:** If two procedures with status indicator S are performed, then both procedures will be paid at 100 percent. When multiple T procedures are performed, the first procedure of highest value is paid at 100 percent and the additional procedures with status indicator T are paid at 50 percent.

   Rationale: The definition for CCR can be found in the chapter with an example of the CCR for various states.

5. **Answer:** This item does not qualify for an outlier payment.

   Rationale: Because the total cost does not exceed the 1.75 or $3,250 threshold, this service does not qualify for an outlier payment.

Procedure charge:	$12,000.00
Times CCR	x 0.336
Total cost	$4,032.00
APC payment	$3,450.00
OPPS outlier threshold	x 1.75
Total	$6,037.50
Fixed dollar threshold	$3,250.00
Plus APC payment	+ $3,450.00
Total exceeds	$6,700.00

Section Review 27.1

1. **Answer:** 3M HIS

   Rationale: The Centers for Medicare & Medicaid Services (CMS), the agency responsible for maintaining the inpatient procedure code set in the U.S., contracted with 3M Health Information Systems in 1993 to design and develop a procedural classification system that would replace Volume 3 of ICD-9-CM.

2. **Answer:** 1998

   Rationale: The Centers for Medicare & Medicaid Services (CMS), the agency responsible for maintaining the inpatient procedure code set in the U.S., contracted with 3M Health Information Systems in 1993 to design and develop a procedural classification system that would replace Volume 3 of ICD-9-CM. ICD-10-PCS was initially released in 1998.

3. **Answer:** 7

   Rationale: All codes in ICD-10-PCS are seven characters long. Each character in the seven-character code represents an aspect of the procedure, as shown in the following diagram of characters from the main section of ICD-10-PCS, called medical and surgical.

1	2	3	4	5	6	7
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

4. **Answer:** procedure, section

   Rationale: The first character in the code determines the broad procedure category, or section, where the code is found.

5. **Answer:** 17

   Rationale: ICD-10-PCS is composed of 17 sections, represented by the numbers 0–9 and the letters B–D and F–H. The broad procedure categories contained in these sections range from surgical procedures to substance abuse treatment.

6. **Answer:** 0

   Rationale: The first section, medical and surgical, contains the great majority of procedures typically reported in an inpatient setting. All procedure codes in the medical and surgical section begin with the section value 0.

7. **Answer:** medical, surgical

   Rationale: Sections 0–9 of ICD-10-PCS comprise the medical and surgical related sections. These sections include obstetrical procedures, administration of substances, measurement and monitoring of body functions, and extracorporeal therapies.

8. **Answer:** seven

   Rationale: In sections 1 and 2, all seven characters define the same aspects of the procedure as in the medical and surgical section.

9. **Answer:** multiaxial

   Rationale: The key attribute that provides the framework for all other structural attributes is multiaxial code structure. Multiaxial code structure makes it possible for the ICD-10-PCS to be complete, expandable, and to provide a high degree of flexibility and functionality.

10. **Answer:** semi-independent axis

    Rationale: A character's position can be understood as a semi-independent axis of classification that allows different specific values to be inserted into that space, and whose physical position remains stable. Within a defined code range, a character retains the general meaning that it confers on any value in that position. For example, the fifth character retains the general meaning "approach" in sections 0–4 and 7–9 of the system.

Section Review 27.2

1. **Answer:** B. The anatomic region of the procedure

   Rationale: The fourth character defines the body part or specific anatomical site where the procedure was performed. The body system (second character) provides only a general indication of the procedure site. The body part and body system values together provide a precise description of the procedure site.

2. **Answer:** A. Root operation performed or inspection of the body part or anatomical region inspected

   Rationale: If the intended procedure is discontinued, code the procedure to the root operation performed. If a procedure is discontinued before any other root operation is performed, code the root operation Inspection of the body part or anatomical region inspected.

3. **Answer:** C. Control

   Rationale: Control is used to represent a small range of procedures performed to treat postprocedural bleeding. If performing Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection is required to stop the bleeding, then Control is not coded separately.

4. **Answer:** A. Resection, anatomical subdivision

   Rationale: Resection is similar to Excision, except Resection includes all of a body part, or any subdivision of a body part that has its own body part value in ICD-10-PCS, while Excision includes only a portion of a body part.

5. **Answer:** B. A separate procedure is coded

   Rationale: If a separate procedure is performed to harvest autograft tissue, it is coded to the appropriate root operation in addition to the harvest.

6. **Answer:** C. If the inspection procedure is performed using a different approach than the root operation

   Rationale: When both an Inspection procedure and another procedure are performed on the same body part during the same episode, if the Inspection procedure is performed using a different approach than the other procedure, the Inspection procedure is coded separately.

7. **Answer:** C. Reposition

   Rationale: Reduction of a displaced fracture is coded to the root operation Reposition and the application of a cast or splint in conjunction with the Reposition procedure is not coded separately.

8. **Answer:** B. If the device remains after the procedure is completed, regardless of the length of time it remains in place

   Rationale: A device is coded only if a device remains after the procedure is completed. If no device remains, the device value No Device is coded.

9. **Answer:** A. Open

   Rationale: Procedures performed using the open approach with percutaneous endoscopic assistance are coded to the approach Open.

10. **Answer:** D. Logic Driven

    Rationale: Because ICD-10-PCS codes are constructed of individual values rather than lists of fixed codes and text descriptions, the unique, stable definition of a code in the system is retained. New values may be added to the system to represent a specific new approach or device or qualifier, but whole codes by design cannot be given new meanings and reused.