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How to Access and Implement Medical Coding Trainer Activities in MindTap: A Quick Start Guide for Instructors

What is Medical Coding Trainer?

MEDICAL CODING TRAINER is an application in Cengage's Medical Coding MindTaps that provides coding practice with real-world patient records. Medical Coding Trainer measures coding accuracy and speed so that students can become successful coders.

Features and Benefits of Medical Coding Trainer

- Coding practice from over 200 real, scrubbed patient records
- Coding practice assigning diagnosis and procedure codes
- Cases available in Basic, Intermediate, or Advanced levels of difficulty
- Select cases by difficulty level or subject area
- Track performance over time with an accuracy rating based on performance

Difficulty Levels in Medical Coding Trainer

- **Basic:** code diagnoses only; primary diagnosis must be entered exactly but any other codes can be in any order
- **Intermediate:** coding diagnoses and procedures, where the primary diagnosis and procedure codes must be entered exactly, but any additional codes can be entered in any order
- **Advanced:** coding diagnoses and procedures, where all codes must be entered in a determined order

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SECTION II

Answer Keys to Chapter Exercises and Reviews

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Overview of Coding

CHAPTER 1

EXERCISE 1.1 – CAREER AS A CODER

1. c
2. a
3. b
4. c
5. b

EXERCISE 1.2 – PROFESSIONAL ASSOCIATIONS AND DISCUSSION BOARDS

1. c
2. a
3. b
4. a
5. c

EXERCISE 1.3 – CODING OVERVIEW

1. b
2. a
3. a
4. a
5. a

EXERCISE 1.4 – OTHER CLASSIFICATION SYSTEMS AND DATABASES

1. c
2. g
3. a
4. h
5. f
6. j
7. b
8. e
9. d
10. i

EXERCISE 1.5 – DOCUMENTATION AS BASIS FOR CODING

1. a
2. b
3. b
4. b
5. b

EXERCISE 1.6 – HEALTH DATA COLLECTION

1. management
2. abstracting
3. CMS-1500
4. UB-04 (or CMS-1450)
5. medical

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REVIEW

Multiple Choice

1. a
2. d
3. c
4. b
5. b
6. c
7. c
8. d
9. a
10. a
11. c
12. a
13. c
14. b
15. b
16. d
17. b
18. a
19. b
20. c

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Introduction to ICD-10-CM and ICD-10-PCS Coding

CHAPTER 2

EXERCISE 2.1 – OVERVIEW OF ICD-10-CM AND ICD-10-PCS

1. 2015
2. Maintenance
3. National Center for Health Statistics (NCHS)
4. Modernization
5. subscription
6. encoder
7. diagnosis
8. necessity
9. chest pain
10. multiple lacerations

EXERCISE 2.2 – ICD-10-CM TABULAR LIST OF DISEASES AND INJURIES

1. Tabular List
2. Z
3. category or valid
4. invalid
5. placeholders

EXERCISE 2.3 – ICD-10-CM INDEX TO DISEASES AND INJURIES

1. Index
2. Drugs
3. alphabetical
4. alphabetical
5. boldfaced
6. nonessential

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7. essential
8. Asplenia
9. History

Note:

"Psychosis" is a type of mental disorder; thus, *History* is the main term in the ICD-10-CM index. Then, *personal* is the subterm and *mental disorder* is the 2nd qualifier. (Mental disorders is a broad category of conditions that include anxiety, depression, psychosis, and so on.) The diagnosis "history of affective psychosis" indicates that the patient no longer has the condition. Therefore, do not refer to main term *Psychosis* and subterm *affective*, which would result in an incorrect code assignment.

10. disease

EXERCISE 2.4 – ICD-10-PCS INDEX AND TABLES

1. ICD-10-PCS
2. inpatient
3. 7
4. O
5. 001U076

EXERCISE 2.5 – OFFICIAL GUIDELINES FOR CODING AND REPORTING

1. cooperating
2. NCHS
3. HIPAA
4. encounter
5. provider

EXERCISE 2.6 – ICD-9-CM LEGACY CODING SYSTEM

1. R11.11
2. A88.1
3. A74.89
4. 078.88
5. 078.89

REVIEW

Multiple Choice

1. a
2. b
3. b
4. b
5. a
6. d
7. b
8. a
9. a
10. d

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Matching

1. b
2. c
3. a
4. d
5. e

Coding Practice



Note:

Beginning with this coding practice answer key (and continuing through remaining chapters in this instructor's manual), the main term for each diagnosis or procedure/service is underlined to help instructors locate codes in the index of each coding manual.

Coding Practice – ICD-10-CM

K46.9 1. Abdominal hernia

R73.09 2. Abnormal nonfasting glucose tolerance test

H66.90 3. Acute otitis media

N85.00 4. Hyperplasia of endometrium

S42.301A 5. Traumatic fracture (closed), right humerus (Fracture, Traumatic) (initial encounter)

E84.9 6. Congenital fibrocystic disease of the lung (Fibrosis, Cystic)

M19.90 7. Degenerative arthritis (Osteoarthritis)

N60.11, N60.12 8. Fibrocystic disease of right and left breasts (Fibrocystic disease)

I78.0 9. Hereditary epistaxis

Z85.9 10. Personal history of cancer (History, personal (of))

Coding Practice – ICD-10-PCS

07B60ZX 1. Open biopsy, left axillary lymph node (Excision, Diagnostic in ICD-10-PCS)

0FT40ZZ 2. Open cholecystectomy, total (Resection, Gallbladder in ICD-10-PCS index)

0TJB8ZZ 3. Cystoscopy

0WJG0ZZ 4. Exploratory laparotomy, open (Inspection, Cavity, Peritoneal in ICD-10-PCS index)

BT1DZZZ 5. Intravenous right pyelogram (using fluoroscopy) (Fluoroscopy, Kidney in ICD-10-PCS index)

0DTJ0ZZ 6. Incidental appendectomy (open) (Resection, Appendix in ICD-10-PCS index)

09BT0ZX 7. Open biopsy of left frontal nasal sinus (Excision in ICD-10-PCS index)

0VB03ZX 8. Percutaneous biopsy of prostate (Excision in ICD-10-PCS index)

0N810ZZ 9. Right frontal craniotomy (open approach) (Division, Head and Facial Bones in ICD-10-PCS index)

0TBB7ZX 10. Transurethral biopsy of bladder (Excision in ICD-10-PCS index)

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ICD-10-CM and ICD-10-PCS Coding Conventions

CHAPTER 3

EXERCISE 3.1 – FORMAT AND TYPEFACE

Exercise 3.1A – ICD-10-CM

B88.0 1. Acariasis infestation

L44.0 2. Pityriasis rubra pilaris

Z44.109 3. Admission for adjustment of artificial leg

F43.22 4. Adjustment disorder with anxiety

F50.00 5. Anorexia nervosa

Exercise 3.1B – ICD-10-PCS

10D07Z5 1. High forceps delivery

BH31ZZZ 2. Magnetic Resonance Imaging (MRI) of Left Breast

10A07ZZ 3. Termination of pregnancy (by) dilation and curettage

02YA0Z0 4. Heart transplantation, allogenic

BW40ZZZ 5. Ultrasonography, abdomen

EXERCISE 3.2 – EPONYMS

ICD-10-CM

M26.69 1. Costen's complex

Q74.0 2. Madelung's deformity

H35.029 3. Coats' disease (In ICD-10-CM, *see* Retinopathy, exudative)

M12.10 4. Kaschin-Beck disease

H81.01 5. Meniere's disease, right ear

Note:

There are no eponyms or common procedure terms (e.g., appendectomy) in ICD-10-PCS.

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EXERCISE 3.3 – ABBREVIATIONS

ICD-10-CM

D69.2 1. Purpura

K41.90 2. Femoral hernia

I21.09 3. ST elevation myocardial infarction, anterior wall

E16.1 4. Hyperinsulinism

S05.31xA 5. Laceration, right eyeball (initial encounter)



Note:

The NEC and NOS abbreviations do not appear in ICD-10-PCS.

EXERCISE 3.4 – PUNCTUATION

ICD-10-CM

L83 1. Acquired acanthosis

B54 2. Malaria fever

A30.3 3. Dimorphous leprosy

E06.0 4. Acute pyogenic thyroiditis

E51.11 5. Neuritis due to beriberi



Note:

Punctuation is not an ICD-10-PCS coding convention.

EXERCISE 3.5 – BOXED NOTES

ICD-10-CM

G40.919 1. Pharmacoresistant epilepsy

G40.919 2. Treatment-resistant epilepsy

G40.911 3. Refractory epilepsy with status epilepticus

G40.911 4. Poorly controlled epilepsy with status epilepticus

C56.1 5. Malignant mesonephroma, right ovary (primary malignancy) (or Neoplasm Table, ovary, malignant)

C64.1 6. Malignant embryoma, right kidney (primary malignancy) (or Neoplasm Table, kidney, primary malignancy)

D04.9 7. Bowen's disease (or Neoplasm Table boxed note)

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EXERCISE 3.6 – TABLES

ICD-10-CM

D49.1 1. Ethmoid sinus tumor (Neoplasm Table)

C44.319 2. Basal cell carcinoma, skin of external cheek (Neoplasm Table)

C22.9 3. Carcinoma of liver (Neoplasm Table)

C61 4. Prostate cancer (Neoplasm Table)

T59.894A 5. Poisoning due to inhalation of paint fumes (Table of Drugs and Chemicals) (initial encounter)

Note:

In ICD-10-CM, codes from categories T51–T65 classify toxic effects, which occur when a harmful substance is ingested or comes in contact with a person. Toxic effect codes have an associated intent: accidental, intentional self-harm, assault, and undetermined. If stated, additional code(s) for all manifestations of the toxic effect (e.g., gastroenteritis, respiratory failure, and so on) are assigned and sequenced after the toxic effect code.

R57.9, T47.4x5A 6. Circulatory collapse due to therapeutic use of magnesium sulfate (oral) (Table of Drugs and Chemicals) (initial encounter)

Note:

In ICD-10-CM, categories T36–T50 are assigned to classify an adverse effect when the drug was correctly prescribed and properly administered. If stated, additional code(s) for manifestations of adverse effects (e.g., circulatory collapse, tachycardia, delirium, and so on) are assigned and sequenced before the adverse effect T code.

T43.201A 7. Accidental overdose of antidepressants (Table of Drugs and Chemicals) (initial encounter)

Note:

ICD-10-CM category codes T36–T50 are assigned to classify a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration). (Poisoning codes have an associated intent: accidental, intentional self-harm, assault, and undetermined.) If stated, additional code(s) for manifestations of poisonings (e.g., coma, respiratory distress, and so on) are assigned and sequenced after the poisoning T code.

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EXERCISE 3.7 – INCLUDES NOTES

ICD-10-CM

G04.90 1. Meningoencephalitis

I12.9, N18.9 2. Nephrosclerosis

K28.9 3. Anastomotic ulcer

I10 4. Hypertensive vascular degeneration

J02.9 5. Acute pharyngitis

Note:

Includes notes do not appear in ICD-10-PCS.

EXERCISE 3.8 – EXCLUDES1 AND EXCLUDES2 NOTES

ICD-10-CM

I25.10 1. Cardiovascular disease of native coronary artery

I77.6 2. Arteritis

N91.2 3. Absence of menstruation

L13.0 4. Herpetiformis dermatosis

Q24.0 5. Dextrocardia

A17.1, A17.81 6. Meningeal tuberculoma. Tuberculoma of brain and spinal cord.

Note:

The Excludes2 note for ICD-10-CM code A17.1 (meningeal tuberculoma) permits the assignment of code A17.81 when tuberculoma of the brain and spinal cord is also documented.

C01 7. Malignant neoplasm of dorsal surface of base of tongue. (Neoplasm table.)

E74.31, E73.0 8. Sucrase-isomaltase deficiency. Congenital lactase deficiency.

F28, F20.0 9. Psychotic disorder with hallucinations. Paranoid schizophrenia.

R04.1, R04.2 10. Hemorrhage from the throat. Hemoptysis.

Note:

Excludes notes do not appear in ICD-10-PCS.

EXERCISE 3.9 – INCLUSION TERMS

ICD-10-CM

A06.0 1. Acute amebic dysentery

B40.7 2. Disseminated blastomycosis

C94.20 3. Megakaryocytic (thrombocytic) leukemia, acute

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E75.09 4. GM2 gangliosidosis, juvenile

P37.1 5. Congenital toxoplasmosis

Note:

Inclusion terms are not used in ICD-10-PCS.

EXERCISE 3.10 – OTHER, OTHER SPECIFIED, AND UNSPECIFIED CODES

ICD-10-CM

K38.8 1. Intussusception of appendix

O00.90, Z3A.01 2. Ectopic pregnancy, week 6

O90.4 3. Hepatorenal syndrome (postpartum condition)

I75.89 4. Arterial atheroembolism

H40.9 5. Glaucoma

Note:

"Other, other specified, and unspecified codes" is not a coding convention in ICD-10-PCS.

EXERCISE 3.11 – ETIOLOGY AND MANIFESTATION RULES

ICD-10-CM

E20.9, H28 1. Tetanic cataract in hypoparathyroidism

D86.89 2. Cardiac sarcoidosis

N18.9, I32 3. Uremic pericarditis

A50.08, K67 4. Congenital syphilitic peritonitis

Note:

Reporting codes A50.08, K67 is a case of "trust the index." Go to main term ***Peritonitis,*** subterm syphilitic A52.74, and second qualifier congenital (early) A50.08 *[K67]* to report codes A50.08 and K67, in that order. The nature of the term congenital indicates means *at birth*. Sometimes congenital conditions don't present for many, many years, but they are still considered *at birth* conditions. ICD-10-CM codes A50.08 and K67 are also both reported because of the Excludes2 instruction, which indicates that the code and the excluded code can be reported together.

A01.05 5. Typhoid osteomyelitis

Note:

Etiology and manifestation rules are not used in ICD-10-PCS.

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EXERCISE 3.12 – AND

Exercise 3.12A – ICD-10-CM

A56.3 1. Venereal disease of the rectum due to chlamydia

C41.3 2. Malignant neoplasm of costal cartilage

E22.0 3. Acromegaly

J84.09 4. Parietoalveolar pneumopathy

D04.4 5. Carcinoma *in situ* of scalp (Neoplasm)

Exercise 3.12B – ICD-10-PCS

BH4CZZZ 1. Ultrasonography of head

0CHY7BZ 2. Insertion of oropharyngeal (mouth and throat) airway

0K880ZZ 3. Open division of muscle, left upper arm

0HQFXZZ 4. Repair of skin, right hand

0CBP0ZX 5. Open biopsy, tonsils (Excision in ICD-10-PCS)

EXERCISE 3.13 – DUE TO

ICD-10-CM

E83.01 1. Cirrhosis due to Wilson's disease

A57 2. Bubo due to *Hemophilus ducreyi*

E71.43 3. Carnitine deficiency due to hemodialysis

E89.0 4. Hypothyroidism due to irradiation therapy

J38.5 5. Airway obstruction due to laryngospasm

Note:

The *due to* subterm does not appear in the ICD-10-PCS Index.

EXERCISE 3.14 – IN

ICD-10-CM

O34.591, Z3A.12 1. Bicornis uterus in pregnancy, week 12

C18.9 2. Adenocarcinoma in adenomatous polyposis coli

O34.12, D25.9, Z3A.14 3. Uterine fibroid tumor in pregnancy (antepartum, second trimester, week 14)

Note:

ICD-10-CM tabular list category code O34 states *Use additional code for specific condition*, which means code D25.9 is assigned as a secondary code to classify the fibroid tumor. In ICD-10-CM, that condition requires the assignment of two (multiple) codes.

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B09 4. Keratoconjunctivitis in exanthema

A98.5 5. Nephrosis in epidemic hemorrhagic fever

Note:

ICD-10-PCS does not use the subterm *in*.

EXERCISE 3.15 – WITH

Exercise 3.15A – ICD-10-CM

K35.2 1. Appendicitis with perforation

E05.10 2. Thyrotoxicosis with uninodular adenomatous goiter

S27.2xxA 3. Traumatic hemothorax with pneumothorax

F43.22 4. Adjustment disorder with anxiety

Q00.0 5. Skull agenesis with anencephalus (or anencephaly)

Exercise 3.15B – ICD-10-PCS

8E0YXBG 1. Computer assisted procedure of the lower extremity with computerized tomography

0WU 2. Herniorrhaphy with synthetic substitute (*see* Supplement, Anatomical Regions, General)

4A02 3. Interrogation, cardiac rhythm related device, with cardiac function testing (*see* Measurement, Cardiac)

08R 4. Phacoemulsification of right lens, with intraocular lens implant (*see* Replacement, Eye)

0VL 5. Vasotomy with ligation (*see* Occlusion, Male Reproductive System)

Note:

There is limited use of subterm *with* in the ICD-10-PCS Index.

EXERCISE 3.16 – CROSS-REFERENCES

Exercise 3.16A – ICD-10-CM

(*see also* Anomaly) 1. Abnormal, abnormality, abnormalities

(*see also* Toxemia) 2. Toxicosis

(*see also* Asphyxia, traumatic) 3. Strangulation, strangulated

see Cryptorchid 4. Undescended testis

see Proteinuria, gestational 5. Proteinuria complicating pregnancy

Exercise 3.16A – ICD-10-PCS

see Destruction 1. Ablation

see Repair, Tendons 0LQ 2. Achillorrhaphy

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see Repair, Eye 08Q

use Nerve, Lumbar Plexus

use Monitoring Device

3. Canthorrhaphy
4. Accessory obturator nerve
5. Cardiac event recorder

EXERCISE 3.17 – CODE ASSIGNMENT AND CLINICAL CRITERIA

J18.9
1. Patient admitted with difficulty breathing and fever. Physician's discharge diagnosis is pneumonia.

F32.9
2. Patient admitted with malaise. Physician's discharge diagnosis is depression.

G43.919
3. Patient admitted with severe headache. Physician's discharge diagnosis is intractable migraine.

K35.80
4. Patient admitted with abdominal pain and fever. Physician's discharge diagnosis is acute appendicitis.

S93.402A
5. Patient admitted with pain and swelling, left ankle. Physician's discharge diagnosis is sprain, left ankle.

REVIEW

Matching – ICD-10-CM

1. d
2. c
3. e
4. a
5. b

Multiple Choice – ICD-10-CM

1. d
2. d
3. b
4. b
5. a
6. c
7. a
8. d
9. c
10. c
11. b
12. d
13. c

Multiple Choice – ICD-10-PCS

1. a
2. c

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ICD-10-CM Coding Guidelines

CHAPTER 4

EXERCISE 4.1 – ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING

1. cooperating parties
2. encounter
3. provider
4. HIPAA
5. structure and conventions
6. principal diagnosis
7. additional diagnoses
8. comorbidities and complications
9. outpatient
10. present on admission (POA)

EXERCISE 4.2 – GENERAL ICD-10-CM DIAGNOSIS CODING GUIDELINES

1. F
2. F
3. T
4. T
5. F
6. T
7. F
8. T
9. T
10. F
11. F
12. T
13. T
14. F
15. F

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EXERCISE 4.3 – CERTAIN INFECTIOUS AND PARASITIC DISEASES

B20 1. AIDS
A05.1 2. Botulism
A69.20 3. Lyme disease
B05.2 4. Postmeasles pneumonia
A82.9 5. Rabies

EXERCISE 4.4 – NEOPLASMS

D06.9 1. Carcinoma *in situ,* cervix uteri (neoplasm)
C58 2. Choriocarcinoma (female patient)
D18.00 3. Hemangioma
C46.9 4. Kaposi sarcoma
D17.1 5. Lipoma, skin of abdomen



Note:

The index entry provides direction to code D17.39. Upon review of the tabular list, because the abdomen is part of the trunk, D17.1 is a more specific code.

EXERCISE 4.5 – DISEASES OF THE BLOOD AND BLOOD-FORMING ORGANS AND CERTAIN DISORDERS INVOLVING THE IMMUNE MECHANISM

D75.1 1. Acquired polycythemia
D62 2. Acute posthemorrhagic anemia
D70.9 3. Agranulocytosis
D53.9 4. Chronic simple anemia
D73.2 5. Chronic congestive splenomegaly

EXERCISE 4.6 – ENDOCRINE, NUTRITIONAL, AND METABOLIC DISEASES

E10.65 1. Diabetes mellitus, type 1, with hyperglycemia
E11.9 2. Diabetes mellitus, type 2
E22.1 3. Hyperprolactinemia
E66.01 4. Morbid obesity due to excess calories
E28.2 5. Polycystic ovaries

EXERCISE 4.7 – MENTAL, BEHAVIORAL, AND NEURODEVELOPMENTAL DISORDERS

G30.9, F02.80 1. Alzheimer's disease
F20.0 2. Paranoid schizophrenia

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F10.231 3. Alcoholic delirium tremens

F14.10 4. Episodic cocaine abuse

F33.9 5. Major depressive disorder, recurrent episode

EXERCISE 4.8 – DISEASES OF THE NERVOUS SYSTEM

G89.0 1. Central pain syndrome

G51.0 2. Bell's palsy

G89.11, M54.2 3. Acute pain due to trauma; cervicalgia

G80.8 4. Congenital quadriplegia

G06.1 5. Intraspinal abscess

EXERCISE 4.9 – DISEASES OF THE EYE AND ADNEXA

H40.11x11 1. Primary open-angle glaucoma, mild stage

H43.12 2. Vitreous hemorrhage, left eye

H44.23 3. Degenerative myopia, bilateral eyes

H50.15 4. Alternating exotropia

H35.353 5. Cystoid macular degeneration, bilateral eyes

EXERCISE 4.10 – DISEASES OF THE EAR AND MASTOID PROCESS

H60.331 1. Swimmer's ear, right ear

H65.02 2. Acute serous otitis media, left ear

H72.02 3. Central perforation of tympanic membrane, left ear

H81.43 4. Vertigo of central origin, bilateral

H95.122 5. Granulation of postmastoidectomy cavity, left ear

EXERCISE 4.11 – DISEASES OF THE CIRCULATORY SYSTEM

I21.19 1. Acute ST elevation myocardial infarction, inferolateral wall, initial episode of care

I01.1 2. Acute rheumatic endocarditis

I69.920 3. Aphasia, late effect of cerebrovascular disease

I10 4. Hypertension

I08.0 5. Mitral and aortic valve insufficiency

EXERCISE 4.12 – DISEASES OF THE RESPIRATORY SYSTEM

J01.10 1. Acute frontal sinusitis

J30.1 2. Allergic rhinitis due to pollen

J44.9 3. Chronic obstructive pulmonary disease

J98.11 4. Atelectasis

J05.0 5. Croup

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EXERCISE 4.13 – DISEASES OF THE DIGESTIVE SYSTEM

K50.90 1. Crohn's disease
K12.0 2. Canker sore
K28.1 3. Acute gastrojejunal ulcer, with perforation
K21.9 4. Gastroesophageal reflux
K40.90 5. Inguinal hernia

EXERCISE 4.14 – DISEASES OF THE SKIN AND SUBCUTANEOUS TISSUE

L63.9 1. Alopecia areata
L02.632 2. Carbuncle, left foot
L89.90 3. Decubitus ulcer
L01.00 4. Impetigo
L91.0 5. Keloid

EXERCISE 4.15 – DISEASES OF THE MUSCULOSKELETAL AND CONNECTIVE TISSUE

M79.642, M79.662, M25.572 1. Arthralgia, left hand, left lower leg, and left ankle
M21.532 2. Claw foot, left (acquired)
M24.552 3. Contracture of joint, left hip
M48.20 4. Kissing spine
M62.830 5. Muscle spasm, back

EXERCISE 4.16 – DISEASES OF THE GENITOURINARY SYSTEM

N45.4 1. Abscess of epididymis
N60.11 2. Chronic cystic mastitis, right breast
N41.1 3. Chronic prostatitis
N30.90 4. Diverticulitis of bladder (*see* Cystitis)
N92.0 5. Excessive menstruation with regular cycle

EXERCISE 4.17 – PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM

O41.1290 1. Amnionitis

Note:

ICD-10-CM index main term *Amnionitis* states see *Pregnancy, complicated by* where the subterm *Amnionitis* code is O41.129. Seventh-character 0 added to create valid O41.1290 code.

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O92.79 2. Engorgement of female breasts (postpartum)

O13.3 3. Gestational hypertension, third trimester

O62.4 4. Incoordinate uterine contractions

O71.3 5. Laceration of cervix (obstetric)

EXERCISE 4.18 – CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD

P28.2 1. Cyanotic attacks of newborn

P08.0 2. Exceptionally large baby

P11.3 3. Facial palsy, newborn

P92.9 4. Feeding problems in newborn

P50.9 5. Fetal blood loss

EXERCISE 4.19 – CONGENITAL MALFORMATIONS, DEFORMATIONS, AND CHROMOSOMAL ABNORMALITIES

Q25.46 1. Anomalies of aortic arch (tortuous)

Q24.6 2. Congenital heart block

Q03.9 3. Congenital hydrocephalus

Q11.0 4. Cystic eyeball, congenital

Q38.3 5. Fissure of tongue, congenital

EXERCISE 4.20 – SYMPTOMS, SIGNS, AND ABNORMAL CLINICAL AND LABORATORY FINDINGS, NOT ELSEWHERE CLASSIFIED

R29.2 1. Abnormal reflex

R27.0 2. Ataxia

R97.20 3. Elevated prostate specific antigen

R62.51 4. Failure to thrive (child)

R03.0 5. Elevated blood pressure reading

EXERCISE 4.21 – INJURY, POISONING, AND CERTAIN OTHER CONSEQUENCES OF EXTERNAL CAUSES

S02.621A 1. Closed fracture mandible, subcondylar, right (initial encounter)

S43.109A 2. Closed dislocation of clavicle (initial encounter)

S06.0x1A 3. Concussion with brief loss of consciousness (30 minutes) (initial encounter)

T25.222A 4. Foot burn, left, blisters, epidermal loss (second-degree) (initial encounter)

S26.020A 5. Heart laceration without penetration of heart chambers (initial encounter)

L50.0, T36.0x5A 6. Hives resulting from penicillin taken as prescribed (initial encounter)

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T42.3x2A, R40.20 — 7. Coma due to overdose of barbiturates during an attempted suicide (initial encounter)

T88.1xxA, T50.A15A — 8. Adverse reaction to pertussis vaccine (initial encounter)



Note:

The specific adverse reaction (e.g., rash, difficulty breathing, fever) is not stated. Therefore, ICD-10-CM code T88.1xxA is assigned.

T44.991A, T51.0x1A, I49.9 — 9. Cardiac arrhythmia due to interaction of prescribed ephedrine and ethyl alcohol intoxication (accident) (initial encounter)



Note:

Alcohol intoxication is associated with alcoholic beverages (e.g., beer, wine); thus, ethyl alcohol is the type. A code from ICD-10 category F10 can be added if the provider is queried to obtain a more complete diagnosis (e.g., acute alcohol intoxication); there is insufficient information in this diagnostic statement to assign the code.

T45.0x1A, R40.1 — 10. Stupor due to overdose of Nytol (accident) (initial encounter)

EXERCISE 4.22 – EXTERNAL CAUSES OF MORBIDITY

V00.131A, Y92.830 — 1. Fall from skateboard at public park (Place of occurrence) (initial encounter)

X05.xxxA, Y93.G3, Y92.020 — 2. Burning bedclothes resulting from cooking in kitchen of mobile home (Place of occurrence) (initial encounter)

V93.59xA — 3. Explosion in watercraft (initial encounter)

W11.xxxA — 4. Fall from ladder (initial encounter)

Y92.320 — 5. Left foot injury taking place on baseball field (accident) (initial encounter)

EXERCISE 4.23 – FACTORS INFLUENCING HEALTH STATUS AND CONTACT WITH HEALTH SERVICES

Z52.3 — 1. Bone marrow donor

Z51.11 — 2. Chemotherapy encounter

Z02.89 — 3. Examination for summer camp

Z20.89 — 4. Exposure to smallpox (laboratory)

Z82.3 — 5. Family history of stroke

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REVIEW

Multiple Choice

1. c
2. a
3. d
4. c
5. b
6. c
7. d
8. a
9. d
10. a
11. a
12. a
13. c
14. d
15. c
16. d
17. d
18. a
19. a
20. a

Coding Practice—Diseases

1. D66 — Classical hemophilia
2. Z45.018 — Fitting of cardiac pacemaker
3. P93.0, T36.2x5A — Gray syndrome from chloramphenicol administration in newborn as prescribed (initial encounter)
4. T14.90, Y23.0xxA — Injury by shotgun, undetermined whether accidental or intentional (shooting) (initial encounter)
5. K58.9 — Irritable bowel syndrome
6. C50.911 — Malignant neoplasm, right breast (female)
7. S83.136A — Medial dislocation of tibia, proximal end (initial encounter)
8. V09.20xA — Motor vehicle traffic accident involving a collision with a pedestrian (initial encounter)
9. F44.81 — Multiple personality
10. R11.2 — Nausea with vomiting
11. Z88.0 — Personal history of penicillin allergy
12. J15.3 — Pneumonia due to streptococcus, group B
13. M08.09 — Polyarticular juvenile rheumatoid arthritis, acute
14. Q61.19 — Polycystic kidney, autosomal recessive
15. E89.0 — Postsurgical hypothyroidism
16. I27.0 — Pulmonary arteriosclerosis
17. B88.1 — Sand flea infestation
18. O03.6 — Spontaneous abortion, complicated by excessive hemorrhage, complete
19. O60.14x1, O60.14x2, O30.003, Z37.2 — Preterm labor with preterm delivery of liveborn twins, third trimester
20. N81.2 — Uterine prolapse, first degree

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ICD-10-CM and ICD-10-PCS Hospital Inpatient Coding

CHAPTER 5

HOSPITAL INPATIENT CODING ANSWER FORM

Copy and provide the form to students for their use in assigning codes to hospital inpatient case scenarios and records. Using the form will facilitate students' understanding of diagnosis and procedure sequencing.

	Code(s)
Principal Diagnosis:	
Other (Additional) Diagnosis(es): (e.g., comorbidities, complications, and secondary diagnoses)	
Principal Procedure:	
Other Significant Procedure(s):	

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EXERCISE 5.1 – ACUTE CARE FACILITIES (HOSPITALS)

1. acute
2. ancillary
3. single hospitals
4. bed
5. short-term (or short term)
6. long-term (or long term)
7. four (or 4)

Note:

The month of May has 31 days. Count the day of admission, May 30, plus the remaining days through June 3 (May 31, June 1, and June 2). Do not count June 3 because it is the day of discharge.

8. nonacute
9. rehabilitation
10. specialty

EXERCISE 5.2 – INPATIENT DIAGNOSIS CODING GUIDELINES

1. b
2. h
3. f
4. a
5. g
6. i
7. d
8. j
9. e
10. c

EXERCISE 5.3 – INPATIENT PROCEDURE CODING GUIDELINES

1. UHDDS definitions
2. ICD-10-PCS
3. CPT
4. MS-DRGs
5. first
6. definitive
7. surgical in nature
8. five
9. 14
10. 24

EXERCISE 5.4 – ICD-10-PCS PROCEDURE CODING

0H0V0JZ 1. Bilateral augmentation mammoplasty using synthetic substitute, open approach (—*see* Alteration, Skin and Breast 0H0)

07BP3ZX 2. Percutaneous biopsy of spleen (—*see* Excision, Diagnostic)

3E0T3CZ 3. Injection of neurolytic agent (nerve block) into peripheral nerve (Block, nerve, anesthetic injection 3E0T3CZ)

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0UT14ZZ — 4. Laparoscopic oophorectomy, left (—*see* Resection, Female Reproductive System OUT)

06DS0ZZ — 5. Open stripping of varicose veins, left lesser saphenous vein (—*see* Extraction)

0VB00ZX — 6. Open biopsy of prostate (—*see* Excision, Diagnostic)

0DJ08ZZ — 7. Esophagoscopy

0GTQ0ZZ — 8. Parathyroidectomy, complete, via open approach (—*see* Resection, Endocrine System 0GT)

10D07Z5 — 9. Partial breech extraction with high forceps

0SRB0JZ — 10. Partial left hip joint replacement, synthetic substitute

Note:

Do not construct a separate code for resection of the original hip joint because *resection* is defined as cutting out or off, *without replacement*, all of a body part. Also, notice that the definition of *replacement* in ICD-10-PCS Table 0SR includes "putting in or on biological or synthetic material that physically takes the place and/or function of *all or a portion of* a body part." This means that Table 0SR is used to classify a complete or a partial joint replacement, and there is no separate character to assign to indicate *complete* or *partial* joint replacement.

0TF33ZZ — 11. Percutaneous nephrostomy with fragmentation of stone in right kidney pelvis

099V3ZZ, 099U3ZZ — 12. Drainage of bilateral ethmoid sinuses for aspiration

Note:

Because there is no bilateral value for the body part, construct codes for the left and right ethmoid sinuses.

02HA0QZ — 13. Replacement of cardiac resynchronization defibrillator pulse generator device, heart, open approach (Insertion of device in)

08QTXZZ — 14. Repair of pterygium of conjunctiva, left eye

09Q87ZZ — 15. Left tympanoplasty (via natural opening)

EXERCISE 5.5 – CODING INPATIENT DIAGNOSES AND PROCEDURES

Note:

Procedure codes are not assigned for ancillary tests (e.g., laboratory tests and x-rays) in the case scenarios because such codes do not impact DRG assignment or the reimbursement amount for an inpatient case. However, because some hospitals do assign codes to ancillary tests (even though codes assigned do not impact the level of reimbursement received), students should be alerted to this practice.

B20, B59, B37.0, 3E1F88X — 1. AIDS-related *Pneumocystis jiroveci* and oral candidiasis. Diagnostic fiberoptic bronchoscopy with cell washings.

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Note:

Chapter-specific coding guidelines provide instruction to sequence ICD-10-CM code B20 (AIDS) as the principal diagnosis, with AIDS-related conditions sequenced as other additional diagnoses. The bronchoscopy procedure was performed for the purpose of taking cell washings as a type of biopsy. (Do not construct an ICD-10-PCS code for the bronchoscopy. Code only the diagnostic irrigation procedure.)

I63.232, I69.321, I69.351

2. Cerebral infarction with left carotid occlusion. Dysphasia. Right hemiparesis (dominant side).

S52.502A, W13.2xxA, Y92.018, Y93.h9, 2W3DX1Z

3. Closed fracture of distal radius, left. Fall from roof of his single-family house (place of occurence) while cleaning gutters (activity). Plaster splint was applied as a stabilizing device.

E10.40, E10.621, L97.524, E10.52, Z79.4, 0Y6N0Z0

4. Type 1 diabetic peripheral neuropathy. Diabetic toe (skin) ulcer, left, with gangrene of the bone. Long-term insulin use. Complete left foot amputation.

G40.219, Z79.899

5. Localization-related intractable epilepsy with complex partial seizures. Long-term use of phenobarbitol.

REVIEW

Multiple Choice

1. a
2. b
3. a
4. c
5. a
6. b
7. b
8. b
9. c
10. a
11. d
12. c
13. a
14. d
15. c
16. b
17. c
18. c
19. a
20. d

Coding Practice—Hospital Inpatient Cases



Note:

- Coding rationales are included for each case to provide direction about how to assign codes.
- Procedure codes are not assigned for ancillary tests (e.g., laboratory tests and x-rays) because they do not impact DRG assignment or the reimbursement amount for an inpatient case. However, because some hospitals do assign codes to ancillary tests (even though codes assigned do not impact the level of reimbursement received), students should be alerted about this practice.

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1. A41.51, E86.0, I11.0, I50.1

Note:

- A blood culture test was positive for *Escherichia coli*, and the physician documented septicemia as the principal diagnosis.
- Other diagnoses documented in the final diagnosis that are assigned codes include dehydration and hypertensive heart disease, which were treated with "routine medications" during the admission.
- Do not assign a code to the "positive blood culture, *Escherichia coli*" diagnosis because it is included in the septicemia diagnosis.
- To locate the code for acute pulmonary edema due to CHF (congestive heart failure), go to the Index to Diseases and Injuries and locate main term *edema,* subterm *lung*, 2nd qualifier *acute,* 3rd qualifier *with heart disease or failure,* and 4th qualifier *congestive.*

2. A41.01, R65.21, N17.9, E86.0, L22

Note:

- When septic shock is documented as a discharge diagnosis, report the code for septicemia as the principal diagnosis.
- This patient also was diagnosed as having septic shock, to which a separate code is assigned as an other (additional) diagnosis code.
- In addition, make sure you assign a code for any organ dysfunction; in this case, the organ dysfunction is acute renal failure.
- Then assign a code for dehydration and diaper rash.

3. C78.02, C25.0, E03.9, E11.9, 0BTJ0ZZ

Note:

- When a patient is admitted for a primary malignant neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm code is assigned as the principal diagnosis. The primary malignant neoplasm code is assigned as an other (additional) diagnosis code.
- In this case, codes for hypothyroidism and diabetes are also assigned.
- A procedure code is assigned for the left lower lobe lung resection (open) procedure.

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4. C18.7, C78.01, C78.02, J44.9, I25.10, I25.2

Note:

- Assign a code to carcinoma of sigmoid colon as the principal diagnosis. Carcinoma of the sigmoid colon is the primary site of cancer.
- Assign a code to probable metastatic bronchogenic carcinoma, bilaterally, as an other (additional) diagnosis because a suspected condition that receives inpatient treatment is coded as if confirmed. When a primary carcinoma metastasizes from its place of origin, the metastasized site is coded as the secondary site of cancer.
- Assign codes to chronic conditions that were medically managed during the hospitalization: chronic obstructive disease and coronary artery disease. Because documentation indicates that the patient has coronary artery disease with no history of coronary artery bypass surgery, assign a code for CAD of native coronary artery.
- "Previous MI" is a healed or old myocardial infarction, to which a code is also assigned.

5. E11.52, B96.5, B96.20, 0Y6Q0Z0

Note:

- Assign codes to classify *Pseudomonas aeruginosa* and *Escherichia coli* as bacterial agents.
- Assign a procedure code for metatarsal amputation of the left great toe.

6. E03.9, D63.8, K26.3

Note:

- Hypothyroidism is the condition established after study to be chiefly responsible for the patient's admission to the hospital. Thus, hypothyroidism is reported as the principal diagnosis.
- A code is assigned for the duodenal ulcer because it was treated during this admission.
- The transfusion of packed red blood cells does not impact the DRG reimbursement rate; therefore, do not assign a code for it.

7. D57.01, Z83.2
8. C50.911, D63.0, C79.51, C78.7, Z79.899

Note:

- The underlying chronic conditions are coded as other (additional) diagnoses: carcinoma of breast with metastases to bone and liver. These chronic conditions are underlying causes of the anemia. Also, assign a code for long-term current use of other medications (e.g., chemotherapy).
- The transfusion of packed red blood cells does not impact the DRG reimbursement rate.

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9. T39.312A, I47.2, F32.9, Z56.0, Z65.8, Y92.009

Note:

- When an overdose of a drug was intentionally taken, it is coded as a poisoning. Sequence the poisoning code first, followed by a code for the manifestation (paroxysmal ventricular tachycardia).
- Codes for unemployment and relationship problems provide additional information about the patient's status.
- External cause codes are also assigned in this case to indicate that the poisoning was a suicide attempt and that the incident occurred at home.
- A code for depression is also assigned as an other (additional) diagnosis.

10. F33.1, GZB4ZZZ

Note:

- Involutional psychotic reaction is assigned as the principal diagnosis.
- An other (additional) code for the depression is *not* assigned because it is implicit in the moderate involutional psychotic reaction, recurrent diagnosis.

11. G30.9, F02.81, J43.9, E11.9, Z91.83

Note:

- When coding Alzheimer's disease, assign an additional code for associated behavioral disturbances.
- Then assign other (additional) codes for emphysema and type 2 diabetes mellitus, controlled.
- To assign long-term (current) drug therapy for Orinase and albuterol, the coder would refer to the history report to determine whether long-term use applied.

12. G45.8, C54.1, N39.0, B96.1

Note:

- The patient was admitted with dizziness, weakness, and nystagmus, which are symptoms of the transient ischemic attack (TIA) diagnosed by the physician. The TIA is sequenced as the principal diagnosis. The symptoms are not coded because they are associated with the principal diagnosis of TIA.
- The patient is currently being treated for the endometrial carcinoma; therefore, an additional diagnosis is assigned for the endometrial carcinoma.
- Assign a code for the urinary tract infection, with an additional code to identify the organism, *Klebsiella pneumoniae.*
- The gait training physical therapy code does not impact the DRG reimbursement rate; therefore, that code is not assigned.

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13. I10, I74.5, I69.954, I69.920, I48.0

Note:

- Hypertension is reported as the principal diagnosis.
- Assign a code to possible iliofemoral emboli as an other (additional) diagnosis. For inpatient hospitalizations, conditions stated as "possible" are coded as established diagnoses. To assign an other (additional) diagnosis code for "possible femoral and popliteal artery embolism," the coder would query the physician because that diagnosis was not included in the list of final diagnoses.
- Assign an additional diagnosis code for atrial fibrillation.

14. I21.09, I10, E78.00, E66.01

Note:

- Assign a code to acute ST elevation anterior wall myocardial infarction as the principal diagnosis.
- Additional diagnosis codes for chest pain and diaphoresis are *not* assigned because they are considered components of the myocardial infarction. Such symptoms integral to a myocardial infarction are *not* coded.
- Assign a code to hypertension as an other (additional) diagnosis.
- Other (additional) diagnosis codes are also assigned for hypercholesterolemia and morbid obesity.

15. J20.5, D50.8, R11.2

Note:

- Acute bronchitis due to RSV is the principal diagnosis because pneumonia was ruled out.
- Do not code the cough because it is a sign of the bronchitis.
- The meningitis also is not coded because it is no longer being medically managed.
- Assign additional diagnosis codes for the nutritional anemia due to poor dietary iron intake and nausea and vomiting because they were treated during the hospitalization.

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16. J44.0, I25.110, I34.0

Note:

- The patient was admitted with shortness of breath and chest pain. The increasing chest pain was due to the chronic obstructive pulmonary disease with acute bronchitis; when acute bronchitis is documented with chronic obstructive pulmonary disease, code J44.0 is assigned and sequenced as the principal diagnosis.
- Do *not* assign an other (additional) diagnosis code for acute bronchitis. Do *not* assign a code for the respiratory distress because it is included in the principal diagnosis code.
- When the cause of the angina is clearly documented, sequence the cause before the appropriate angina code. In ICD-10-CM, a combination code (I25.110) classifies ASCVD of native artery with unstable angina (documented as progressive angina, which means unstable angina).
- Also assign a code for mitral insufficiency as an other (additional) diagnosis.

17. C18.7, G20, Z79.899, 0D1N0Z4

Note:

- In ICD-10-CM, the intestinal obstruction code contains an Excludes1 note that states, "intestinal obstruction due to specified condition—code to condition." Thus, just code C18.7 is assigned.
- Do *not* assign a code for the abdominal distention because it is a symptom of the bowel obstruction.
- Assign an other (additional) diagnosis code to Parkinson's disease, and a code for long-term use of Sinemet to treat the Parkinson's.
- Assign a procedure code to the loop colostomy. Do not assign a code to insertion of the nasogastric tube because it does not impact DRG reimbursement.

18. K26.3, K26.7, K44.9, K82.4, M81.0, M48.06

Note:

- If the same condition is described as both acute and chronic, code both the acute and chronic condition, sequencing the acute condition first.
- Do *not* assign a code for the abdominal pain because it is a symptom of the ulcer. Assign additional diagnosis codes for the hiatal hernia, gallbladder polyps, osteoporosis, and lumbar spinal stenosis because all conditions were medically managed during the inpatient stay.

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19. N17.9, E86.0, N18.6, D63.1

Note:

- When a patient is diagnosed with acute renal failure and dehydration and the only treatment is intravenous hydration, it is appropriate to assign the code for acute renal failure as the principal diagnosis. In most cases, intravenous hydration corrects the acute renal failure. The fact that the renal function was not investigated does not affect the code assignment.
- Assign an other (additional) diagnosis code for the dehydration.
- Assign an other (additional) diagnosis code for the anemia due to end-stage renal disease. Go to index main term *Anemia*, subterm *in*, and third qualifier *end stage renal disease* to assign code D63.1.
- The transfusion of packed red blood cells code does not impact the DRG reimbursement rate; therefore, that code is not assigned.

20. N40.1, R39.16, R39.12, M53.3, I10, 0VB07ZZ

Note:

- Assign benign prostatic hyperplasia with urinary obstruction and other lower urinary tract symptoms [LUTS] as the principal diagnosis.
- Assign an other (additional) diagnosis code for coccygodynia, which was evaluated and treated during the patient's stay.
- Assign a diagnosis code for the hypertension that was under medical management.
- Assign a procedure code for the transurethral resection of the prostate.

21. N83.202, D25.9, N80.9

Note:

- When two or more interrelated conditions meet the definition of principal diagnosis, either condition may be sequenced first as long as official coding guidelines do not indicate otherwise. Because it was determined that both the ovarian cyst and the uterine fibroid resulted in the patient's admission, either condition may be sequenced as the principal diagnosis.
- Assign an other (additional) diagnosis code for the possible endometriosis. If a diagnosis at the time of hospital discharge is qualified as "possible," code the condition as if it were an established diagnosis.

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22. O03.1, 10D17ZZ

Note:

- The principal diagnosis is spontaneous abortion with excessive bleeding.
- A procedure code is assigned for dilatation and curettage following an abortion (miscarriage) to remove retained products of conception.

23. O65.4, O62.2, Z37.0, 10D00Z1

Note:

- When a patient undergoes a cesarean delivery, the reason for the cesarean delivery is sequenced as the principal diagnosis. In this case, the cause is "obstructed labor."
- A code is assigned for failure to progress as an other (additional) diagnosis.
- A code for outcome of delivery is always reported on maternal delivery records. It is always sequenced as an other (additional) diagnosis. In this case, the code indicates that the outcome of delivery was a single liveborn.
- Assign a procedure code for the low cervical cesarean section.

24. M67.431, L72.3, Z30.2, 0XBG0ZZ, 0HB1XZZ, 0VBQ0ZZ

Note:

- Ganglion cyst of joint is the principal diagnosis because it is the condition after study that occasioned the admission to the hospital.
- Assign a code for the other (additional) diagnosis of sterilization.
- Assign a code for the other (additional) diagnosis of cyst, skin of the nose.
- Assign procedure codes for excision of ganglion cyst, bilateral vasectomy, and excision, lesion, skin of nose. In ICD-10-PCS, index main term *Ganglionectomy* and subterm *Excision of lesion* directs you to *see Excision*; then, main term *Excision* and subterm *Wrist Region, Right* directs you to table 0XB. Main term *Vasectomy* directs you to see *Excision, Male Reproductive System 0VB.* Main term *Excision* and subterm *Skin* directs you to table 0HB.

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25. L89.624, I96, B95.61, 0Y6G0ZZ

Note:

- Decubitus ulcer of the heel is the principal diagnosis. It is a stage IV decubitus ulcer.
- A code is assigned to gangrene as an additional diagnosis to identify its presence.
- Assign an additional diagnosis code to identify the *Staphylococcus aureus* infection.
- Assign a procedure code for the below-the-knee amputation as the principal procedure.
- The whirlpool physical therapy treatment does not impact the DRG reimbursement rate; therefore, that code is not assigned.

26. T84.84xA, I95.81, T81.4xxA, B96.20, Y83.1, 0SP904Z

Note:

- Diagnosis "painful Gouffon pins" is coded as a complication due to presence of other internal fixation device.
- Do *not* assign ICD-10-CM code G89.18 for "pain" because its Excludes1 note lists code T84.84.
- Assign an external cause code as an other (additional) diagnosis code to indicate that this complication was due to the surgical procedure, implant of an internal orthopedic device.
- Assign an other (additional) diagnosis code for postoperative hypotension.
- Assign an other (additional) diagnosis code for the postoperative wound infection, and assign a code for *Escherichia coli* as an other (additional) diagnosis to indicate the organism.
- Assign an external cause code as an other (additional) diagnosis to classify the complications due to surgical operation for the removal of the pin.
- Assign the principal procedure code for removal of the pin.
- The gait training with a walker code does not impact the DRG reimbursement amount; therefore, that code is not assigned.

27. M17.11, 0SRC0JZ

Note:

- Main term *Osteoarthritis* includes the *See also* osteoarthritis instruction. Thus, main term *Osteoarthrosis,* subterm localized (because osteoarthritis of the knee means the condition is localized, as opposed to generalized), and second qualifier primary provides direction to code M17.1- in the index. Reviewing the tabular list leads to code M17.11 because the knee is part of the lower leg.
- Assign a code for total knee replacement as the principal procedure.
- The gait training with a walker code does not impact the DRG reimbursement amount; therefore, that code is not assigned.

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28. Z38.00, Q91.7, P05.18, Q37.0, Q69.0, Q54.1, Q76.6, Q76.49, Q63.2

Note:

- The appropriate ICD-10-CM Z38 category code is sequenced as the principal diagnosis. In this case, the principal diagnosis code is Z38.00 for single liveborn, baby born in the hospital, and no cesarean section.
- When congenital condition(s) are diagnosed during the hospital episode in which an infant is born, appropriate code(s) from the Congenital Malformations . . . chapter of the coding manual are assigned as other (additional) diagnoses. The following other (additional) diagnoses are assigned codes.
  - Trisomy 13
  - Small for dates
  - Cleft lip and hard palate, complete
  - Accessory finger, left hand
  - Hypospadias
  - Extra rib
  - Hemivertebra
  - Dextroversion malrotation, left kidney

29. Q20.0, R55, Y93.61, Y92.321

Note:

- Persistent truncus arteriosus is the principal diagnosis.
- Assign a code to syncope as an other (additional) diagnosis.
- Do not assign codes for the shortness of breath, fatigue, and vague chest pain because they are symptoms of (and included in) the principal diagnosis code.
- Assign the activity code for football and the place of occurrence code for football field.

30. Z38.00, P07.17, P07.35, P96.1

Note:

- The principal diagnosis is single liveborn, born in the hospital, spontaneous vaginal delivery.
- Assign a diagnosis code for “premature infant.”
- Assign an additional code for the “weeks of gestation.”
- Assign an other (additional) diagnosis code for withdrawal symptoms due to the mother’s drug addiction.

31. Z38.01, P59.9, 6A600ZZ

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Note:

- The principal diagnosis is single liveborn, born in hospital via cesarean section.
- Assign a code to hyperbilirubinemia as an other (additional) diagnosis.

32. R56.00, H65.01

Note:

- Assign febrile seizure as the principal diagnosis because it is the condition that occasioned the admission to the hospital.
- Do *not* assign a code to the fever because it is included in the febrile seizure code.
- Assign a code for the acute serous otitis media, right ear, as an other (additional) diagnosis.

33. R10.31

Note:

The patient was admitted to the hospital due to her abdominal pain, and a definitive diagnosis was never made for the cause of the abdominal pain. Therefore, the principal diagnosis is right lower quadrant abdominal pain.

34. T22.211A, T21.27xA, T24.211A, T24.212A, T31.0, X10.0xxA, Y92.009

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Note:

- The principal diagnosis code reflects the highest degree of burn when a patient is admitted with more than one burn. Because the patient's burns were all second degree, sequence the second-degree burn of the forearm, second-degree burn of the vulva, or second-degree burn of the thigh as the principal diagnosis.
- Then assign a code to classify "burns according to extent of body surface involved." This code is assigned when it is necessary to provide data for evaluating burn mortality.
- Assign an external cause code to indicate that the burn was due to a hot liquid and another external cause code to indicate that the accident occurred at home.
- The nonexcisional debridement of burns does not impact the DRG reimbursement amount; therefore, that code is not assigned.
- Do *not* assign a code for the placement of dressings.

35. S82.252C, S82.452C, S52.531A, S01.512A, V27.0xxA, Y92.481, 0QSH04Z, 0QSK04Z, 0CQ7XZZ, 2W38X2Z



Note:

- Codes for multiple fractures are sequenced according to severity, and the code for an open fracture is sequenced before a closed fracture. For this case, sequence the open fracture as the principal diagnosis.
- Assign an other (additional) diagnosis code for closed fracture of the distal radius.
- Assign an other (additional) diagnosis code for tongue laceration. (ICD-10-CM does not classify complications with laceration codes.)
- Assign an external cause code to indicate that the patient was the driver of a motorcycle that collided with a parked vehicle. Then, assign an external cause code to indicate that the place of occurrence was a parking lot.
- Assign open reduction, internal fixation of tibia/fibula as the principal procedure code(s). (In ICD-10-PCS, two codes are assigned.) Also assign a code immobilization using cast, right upper extremity.
- Assign a code for the suture repair of the tongue laceration. In ICD-10-CM, assign an *external* approach value for the 5th character because the tongue is located in the oral cavity, which is an orifice visible and does not require an incision or use of instrumentation (e.g., endoscope).

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ICD-10-CM Outpatient and Physician Office Coding

CHAPTER 6

EXERCISE 6.1 – OUTPATIENT CARE

1. outpatient (or ambulatory)
2. primary
3. primary care provider
4. ambulatory
5. ambulatory surgery
6. emergency department (or emergency care) (or emergency room)
7. observation
8. triage
9. clinic
10. referred

EXERCISE 6.2 – DIAGNOSTIC CODING AND REPORTING GUIDELINES FOR OUTPATIENT SERVICES: HOSPITAL-BASED AND PHYSICIAN OFFICE

1. skin lesion
2. shortness of breath
3. fractured humerus
4. gastroenteritis
5. urinary frequency
6. acute bronchitis
7. back pain
8. diabetes mellitus
9. outpatient chemotherapy
10. acute cholecystitis with cholelithiasis

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REVIEW

Multiple Choice

1. d
2. a
3. b
4. d
5. a
6. a
7. c
8. d
9. c
10. c
11. c
12. d
13. d
14. c
15. d
16. c
17. c
18. d
19. a
20. b

Coding Practice

Note:

- Coding rationales are included to provide direction about assigning codes.
- ICD-10-PCS codes are *not* assigned to procedures or services because HCPCS level II and CPT codes are assigned to outpatient procedures and services. (ICD-10-PCS procedure codes are assigned to inpatient cases, as discussed in textbook Chapter 5.)

Coding Practice — Ambulatory Surgery Center (ASC)

1. E03.9, E04.9, Z87.09
2. K31.7, Z83.79
3. Z30.2, E66.01
4. K40.90
5. Z30.2, Z64.1, Z87.891

Coding Practice — Chiropractic Office

1. M50.10, Y93.H3, Y92.014, Y99.0
2. S13.4xxA, W51.xxxA, Y93.67, Y92.310, Y92.213, Y99.8

Note:

Do not assign codes for the neck pain and stiffness because those are symptoms of the definitive diagnosis, acute cervical sprain.

3. S16.1xxA, M79.1, Y93.C1, Y92.214, Y99.0

Note:

The numbness and tingling in her left arm is due to the cervical neck strain; therefore, do not assign codes for these symptoms.

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4. M47.892

Note:

Index main term *Osteoarthritis* and subterm *Spine* contains a *see* Spondylosis cross-reference, which directs you to the appropriate code. This condition did not result from a work-related or other injury, so external cause codes are not assigned.

5. S13.9xxA

Note:

Assign a code for the neck sprain only. To assign codes for shoulder and back pain, and headaches, you would generate a physician query to ask the chiropractor to document additional conditions if appropriate.

Coding Practice — Hospital Emergency Department

1. R51

Note:

Assigning a code for the headache only is appropriate even though physical examination indicated abnormalities of the eyes. The patient's current symptoms in light of his past history may have prompted the ED visit.

2. M25.511, Y93.H2, Y92.007, Y99.8

Note:

The shoulder is a joint. Therefore, in the Index to Diseases and Injuries, go to main term *Pain*, subterm *joint*, and 2nd qualifier *shoulder* to assign the code. Probable strain, deltoid muscle, and possibly the deeper muscles of the anterior shoulder area is a qualified diagnosis, which is not coded for outpatient (e.g., ED) care.

3. J40, J18.9

Note:

- There is no documentation of the infectious organism; therefore, do not assign a code for the type of infection. (If performed, sputum culture results would document the infectious organism.)
- Do not assign a code to the "chest pain" symptom because a definitive diagnosis of "pneumonia" was documented.

4. S93.402A, Y93.64, Y92.320, Y99.8
5. S61.235A, W26.0xxA, Y92.9, Y99.9

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Coding Practice — Hospital Outpatient Department

1. Z13.6, Z82.49



Note:

- The patient's EKG was negative, which means she was not diagnosed as having cardiovascular disease. The nonspecific T-wave changes were explained as probably due to anxiety and positional changes during the procedure. Therefore, go to main term *Screening* and subterm *cardiovascular disorder*.
- Assign code Z82.49 for *family history of cardiovascular disease*.
- Do not assign code Z03.89 because the patient did not present with cardiovascular symptoms. This patient underwent a screening EKG because of a family history of cardiovascular disease.

2. M32.9
3. I25.10



Note:

- There is no past history of coronary artery bypass graft surgery; therefore, assign the ASHD code that describes "native coronary artery" as the type of vessel.

4. I50.9, Z71.3
5. T86.12, Q60.0, Z76.82, Y83.0



Note:

Query the physician to request documentation of chronic kidney disease and its severity (e.g., Stages I–V) and/or end-stage renal disease (ESRD), which are not documented in the case study.

Coding Practice — Hospital Same Day Surgery

1. J35.3



Note:

Do not report ICD-10-CM code J35.9 because *hypertrophied tonsils and adenoids* results in a more specific code (J35.3).

2. N40.1, N18.9, N39.0, B95.2, R35.0, R39.15

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Note:

Report code N40.1 (not code N40.0) because the provider documented lower urinary tract symptoms. Also report codes R35.0 and R39.15 per the "Use additional code for associated symptoms, when specified:" instruction located below code N40.1.

3. K60.2, K64.0

Note:

- Although *obesity* is likely a contributing factor to the development of the anal fissure and hemorrhoids, there is no documentation that this condition was medically managed. Therefore, do not assign a code for obesity.

4. E04.9, D34

Note:

- There is no documentation as to type of *nodular colloid goiter*, which means the unspecified code is assigned.
- Degenerating follicular adenoma, right lobe *of thyroid* is a benign neoplasm of the thyroid gland.

5. O02.1

Coding Practice — Physician Office

1. S05.32xA, W50.4xxA, Y92.214, Y99.8

Note:

In ICD-10-CM, main term *Laceration* and subterm *eye(ball)* lists code S05.3-.

2. S81.032A, W22.8xxA, Y92.9, Y99.9

Note:

Go to main term *Puncture* and subterm *knee* to assign the code.

3. N43.3
4. S61.112A, W29.8xxA, Y92.9, Y99.9

Note:

- In ICD-10-CM, main term *Laceration*, subterm *thumb*, 2nd qualifier *left*, 3rd qualifier *with*, and 4th qualifier *damage* to *nail* lists code S61.112A.

5. M79.89, M79.642, W22.8xxA, Y92.010, Y99.8

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Note:

- Main term *Swollen* contains the instruction to *"see* Swelling.*"* Therefore, go to main term *Swelling* and subterm *hand* to assign the code.
- Go to main term *Pain* and subterm *hand* to assign the code for "hand . . . painful to touch."

Coding Practice — Stand-Alone Radiology Center

1. N18.9, T82.898A

Note:

- An *occluded dialysis access graft* is a complication of the access graft, which needs surgical repair (to clear the occlusion). In ICD-10-CM, go to main term *Complication*, subterm *graft*, 2nd qualifier *vascular*, and 3rd qualifier *specified complication NEC* to assign code T82.898A.
- An occluded graft is *not* a mechanical complication of the blood vessel graft, which would be assigned a different code to describe the mechanical complication (e.g., torn graft or twisting of graft).

2. K82.8

Note:

Do not assign a code to *moderate hypertrophic change of lumbar spine* because the purpose of the outpatient encounter was for a cholecystogram, which resulted in a related diagnosis.

3. K86.1

Note:

Do *not* assign a code to stomach *pain* because that is a symptom of recurrent pancreatitis.

4. R32

Note:

The first-listed diagnosis is urinary incontinence, and there are no secondary diagnoses.

5. M25.461, S83.241A

Note:

- Go to main term *Effusion,* subterm *joint,* and 2nd qualifier *knee* to assign the first-listed code.
- In ICD-10-CM, go to main term *Tear,* subterm *meniscus,* 2nd qualifier *medial,* and 3rd qualifier *specified type NEC* to assign the secondary code.

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Coding Practice — Stand-Alone Urgent Care Center

1. S50.811A, S50.812A, S80.811A, S80.812A, S51.012A, S93.401A, S83.91xA, V29.9XXA, Y92.9, Y99.9

Note:

- In ICD-10-CM, the *see also* cross-reference instruction for main terms *Abrasion* and *Laceration was* removed, which makes it easier to locate the appropriate codes.
- In ICD-10-CM, there is no *lower leg* 2nd qualifier for main term *Sprain* and subterm *knee.* However, separate codes are assigned for the ankle sprain and the knee sprain.

2. L03.113, W20.8xxA, Y92.9, Y99.9, Z86.2
3. M46.1

Note:

Go to main term *Inflammation*, subterm *joint*, and 2nd qualifier *sacroiliac* to assign the code.

4. L72.3

Note:

Go to main term *Cyst* and subterm *sebaceous* to assign the code. There is no 2nd qualifier for "infected" or "right cheek."

5. R04.0, W50.0xxA, Y92.9, Y99.9

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HCPCS Level II National Coding System

CHAPTER 7

EXERCISE 7.1 – OVERVIEW OF HCPCS

1. national
2. durable medical equipment, prosthetics, orthotics, supplies (DMEPOS)
3. level I
4. five
5. A–V

EXERCISE 7.2 – HCPCS LEVEL II NATIONAL CODES

1. CMS HCPCS Workgroup
2. Medicare Carriers Manual (MCM)
3. Medicare National Coverage Determinations Manual
4. CMS HCPCS Workgroup
5. CMS-1500
6. DMEPOS dealer
7. January 1 annual
8. -AE
9. -50
10. modifiers

EXERCISE 7.3 – ASSIGNING HCPCS LEVEL II CODES

1. infusion or injection, medication
2. two
3. one
4. supplies
5. Medicare
6. medications
7. table of contents

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8. alphabetical first character
9. commercial payers
10. CPT

EXERCISE 7.4 – DETERMINING PAYER RESPONSIBILITY

1. HCPCS level II
2. billing
3. fraudulent
4. primary MAC, DME MAC
5. certificate of medical necessity (CMN)

REVIEW

Multiple Choice

1. c
2. d
3. b
4. a
5. a
6. d
7. c
8. d
9. a
10. d
11. d
12. c
13. a
14. c
15. c
16. c
17. a
18. b
19. d
20. c

Coding Practice I

1. A0433-PH
2. A0225-HH
3. A0429-RH
4. A0422-NH
5. A0130-EP
6. A4208-AG
7. A4246-TD
8. A4261
9. A4282-NU
10. A6410

Note:

According to Encoder Pro Expert, code A4261 is exempt from adding a modifier to identify the type of practitioner who performed the procedure.

11. A9526
12. A9300-RR
13. A9528, A9528
14. A9700
15. A9152
16. B4224, B4224
17. B4155

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18. B9002-NU
19. B4036-NU
20. B4083
21. C1717-AF
22. C1764-SC
23. C1789
24. C8905-LT
25. C1752-RT
26. E0910
27. E0455
28. E0202
29. E0570
30. E0135-NU
31. G0307
32. G0127
33. G9016, G9016
34. G0104
35. G0252
36. H0004-HJ, H0004-HJ
37. H0035
38. H2013
39. H0045, H0045, H0045
40. H2032-GP, H2032-GP
41. J0706
42. J1460, J1460, J1460, J1460, J1460, J1460, J1460, J1460, J1460, J1460
43. J2501
44. J3265
45. J9000
46. K0072-RB, K0072-RB
47. K0105
48. K0038, K0038
49. K0012-RR
50. K0603
51. L0160
52. L0220
53. L0830
54. L3310, L3310
55. L1960-AV
56. L5150

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57. L7007
58. L5000
59. L6895 (or L6890-RT)
60. L8030
61. M0100
62. M0075
63. M0300
64. M0301
65. M0076
66. P9612
67. P3000
68. P9045
69. P9019, P9019
70. P9010, P9010
71. Q0083
72. Q3031
73. Q2017
74. Q4023
75. Q0112
76. R0075-US
77. R0076-UR
78. R0075-UN
79. S2142
80. S2202
81. S3708
82. S0400
83. S2055
84. T1027
85. T2101
86. T1502-TE
87. T1000-TD, T1000-TD
88. T2035
89. V2208, V2208
90. V2025
91. V2744, V2744
92. V2785
93. V2626
94. V5010

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95. V5140
96. V5245
97. V5240
98. V5268

Coding Practice II

1. J0456
   R0070



Note:

Code R0070 is reported by the mobile x-ray service.

2. J1670
   E0112



Note:

Do not assign HCPCS level II code to the pHisoHex solution, sterile gauze, or paper tape. Those supplies are included in the provision of the evaluation and management (E/M) service, which would be assigned a separate CPT code for this case.

Do not assign HCPCS code J2001 for Xylocaine. Although lidocaine HCl is the generic name for Xylocaine, code J2001 is assigned only when lidocaine HCl is injected for intravenous infusion.

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Introduction to CPT Coding

CHAPTER 8

EXERCISE 8.1 – HISTORY OF CPT

1. b
2. e
3. a
4. d
5. c

EXERCISE 8.2 – OVERVIEW OF CPT

1. providers
2. payer
3. necessity
4. II
5. III

EXERCISE 8.3 – ORGANIZATION OF CPT

1. six
2. specialties
3. Anesthesia
4. vesiculotomy; complicated
5. Laparoscopy, surgical; cholecystectomy with cholangiography

EXERCISE 8.4 – CPT INDEX

1. T
2. F
3. F
4. T
5. F

EXERCISE 8.5 – CPT APPENDICES

1. d
2. a
3. f
4. k
5. o
6. b
7. n
8. g
9. i
10. c
11. j
12. e
13. h
14. m
15. l

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EXERCISE 8.6 – CPT SYMBOLS

1. a
2. d
3. e
4. f
5. c
6. b
7. j
8. h
9. i
10. g

EXERCISE 8.7 – CPT SECTIONS, SUBSECTIONS, CATEGORIES, AND SUBCATEGORIES

1. F
2. F
3. T
4. T
5. F

EXERCISE 8.8 – CPT MODIFIERS

1. -80 or 80
2. -79 or 79
3. -25 or 25
4. -57 or 57
5. -56 or 56
6. -55 or 55
7. -76 or 76
8. -51 or 51
9. -50 or 50
10. -32 or 32

EXERCISE 8.9 – NATIONAL CORRECT CODING INITIATIVE

1. B
2. Editor
3. mutually exclusive
4. Benefits
5. unbundling

REVIEW

Multiple Choice

1. d
2. c
3. a
4. b
5. c
6. b
7. c
8. d
9. d
10. b
11. b
12. c
13. d
14. d
15. b
16. b
17. a
18. a
19. d
20. b

Note:

Modifier -26 is added to the code because “interpretation only” was performed. Without modifier -26, reimbursement from the payer would be higher than allowed.

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CPT Index

1. Main term — a. Debridement
   Subterm — b. Skin
   2nd qualifier — c. Subcutaneous tissue
   3rd qualifier — d. Infected
   Code range — e. 11004–11006, 11008
2. Main term — a. Arthrodesis
   Subterm — b. Elbow
   Code range — c. 24800–24802

   - or -

   Main term — a. Elbow
   Subterm — b. Arthrodesis
   Code range — c. 24800–24802
3. Main term — a. Kocher pylorectomy
   Cross-reference — b. *See* Gastrectomy, partial
   Main term — c. Gastrectomy
   Subterm — d. Partial
   Code range — e. 43631–43635, 43845, 48150, 48152
4. Main term — a. Hysterectomy
   Subterm — b. Abdominal
   2nd qualifier — c. Resection of ovarian malignancy
   Code range — d. 58951, 58953–58954, 58956
5. Main term — a. PET
   Cross-reference — b. *See* Positron emission tomography
   Main term — c. Positron emission tomography (PET)
   Subterm — d. Brain
   Code range — e. 78608–78609

CPT Symbols

1. approval
2. add-on
3. telemedicine
4. -51 (or 51)
5. subsequent

CPT Modifiers

1. -51 (or 51)
2. -50 (or 50)
3. -26 (or 26)
4. -76 (or 76)
5. -77 (or 77)

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CPT Evaluation and Management

CHAPTER 9

EXERCISE 9.1 – OVERVIEW OF EVALUATION AND MANAGEMENT SECTION

1. Preventive
2. Emergency
3. examination
4. 5
5. place
6. type
7. office
8. office
9. Office
10. established

EXERCISE 9.2 – EVALUATION AND MANAGEMENT SECTION GUIDELINES

1. established
2. new
3. established
4. fractured
5. numbness

EXERCISE 9.3 – LEVELS OF EVALUATION AND MANAGEMENT SERVICES

1. a. 99204
   b. 99211
   c. 99222
   d. 99345
   e. 99283

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2. a. yes
   b. 99284-25

Note:

Modifier -25 was added to facilitate reimbursement of both the E/M service and procedure performed (reduction of fracture). Students will learn to code procedures starting with Chapter 11 of *3-2-1 Code It!*

3. a. no
   b. no code

Note:

Instead of an E/M code, a CPT surgery code is assigned for the suture repair of the laceration and CPT Medicine codes are assigned for the intramuscular administration of the tetanus toxoid as well as the tetanus toxoid agent that was injected.

4. making
5. three
6. two out of three
7. time
8. a. Established
   b. 99213
9. To assign the E/M code, the following is determined:
   a. established
   b. expanded problem focused

Note:

Chief complaint is "follow-up for evaluation and management type 2 diabetes mellitus and hypertension." According to the 1997 E/M documentation guidelines, two elements of the history of present illness (HPI) were documented: quality (stable) and severity (home monitoring), which means that a brief HPI was performed. Documentation of the review of system (ROS) included five body areas/systems (chest pain—cardiovascular; headache—neurologic; extremities—musculoskeletal; shortness of breath—respiratory; and visual changes—eyes), making this an extended ROS. Since there is no documentation of past, family, or social history, the highest extent of history that can be selected is expanded problem focused.

   c. detailed

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Note:

According to the 1997 E/M documentation guidelines, general multisystem exam elements are counted as follows: constitutional (1) (blood pressure, weight, and pulse count as one element); eyes (1) (pupils equal, round, and reactive to light and accommodation); ears, nose, and throat (2) (external auditory canals/tympanic membranes negative; oropharynx benign); neck (2) (supple; no bruits, jugular venous distention, or thyromegaly) (maximum of two elements can be identified for neck); respiratory (2) (breath sounds clear to auscultation and percussion; auscultation, or listening to the lungs, revealed no rubs, rales, rhonchi, or wheezing) (maximum of four elements can be identified for respiratory); cardiovascular (3) (no click, gallop, irregularity, murmur, or rub; distal pulses intact; no edema); musculoskeletal (1) (no cyanosis, clubbing); and neurologic (2) (deep tendon reflexes within normal limits and symmetrical; no decreased lower extremity sensation noted). A total of 14 elements in this general multisystem exam were documented, which means that a detailed examination was performed.

d. moderate complexity

Note:

The number of diagnoses and management options documented is multiple because two diagnoses and management options must be considered. The amount and complexity of data to be reviewed are minimal because just lab tests are considered. The risk of complications and/or morbidity or mortality is moderate because of the documented prescription drug therapy for two stable chronic illnesses. Since the complexity of medical decision making is determined by the two highest of the three options, the level for this encounter is moderate complexity.

e. 99214

Note:

An expanded problem-focused history, a detailed examination, and moderate complexity of medical decision making were documented. Because two of three key components determine the E/M level for an established patient visit, assign 99214. Code selection is based on extent of examination and complexity of medical decision making. (No contributory components, such as counseling or coordination of care, were documented.)

10. 99344

EXERCISE 9.4 – EVALUATION AND MANAGEMENT CATEGORIES AND SUBCATEGORIES

1. F
2. F
3. T
4. F
5. T
6. F
7. F
8. T
9. T
10. F
11. T
12. T
13. F
14. T
15. F
16. T
17. F
18. T
19. F
20. T
21. F
22. T
23. F
24. T
25. T
26. T
27. F
28. F
29. F
30. T

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REVIEW

Multiple Choice

1. a
2. b
3. a
4. c
5. c
6. b
7. a
8. c
9. b
10. c
11. c
12. d
13. d
14. c
15. c
16. a

Note:

The nursing facility patient is "recovering," which means that code 99307 is reported.

17. a
18. b
19. a
20. b

Coding Practice

1. 99213

Note:

An established patient requires two out of three key components be met or exceeded for a particular level of E/M service to be assigned. In this case, a problem-focused history was performed. (It is part of code 99212.) The examination and medical decision making are level 3 (code 99213). Since just two key components need to be met, the level 3 E/M code is assigned.

2. 99202

Note:

For a new patient, three out of three key components must be met or exceeded to assign an E/M code. Code 99202 requires an expanded problem-focused history and examination and straightforward medical decision making.

3. 99219

Note:

For initial hospital observation care, three out of three key components must be met or exceeded for a level to be assigned. In this case, documentation warrants assignment of a level 2 initial observation code.

4. 99218 (5/7), 99217 (5/8)

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Note:

Two codes are assigned to this case: one for initial observation care and one for observation care discharge. For the initial observation care, three out of three key components must be met or exceeded to assign a level. For the discharge care, the physician must document a final exam, patient instructions, and discussion of the hospital stay.

5. 99222 (10/10), 99232 (10/11), 99232 (10/12), 99238 (10/13)

Note:

Four codes are required for this case. 99222 is the E/M code for initial hospital care level 2, 99232 reflects subsequent hospital care level 2, and 99238 reflects discharge day management 30 minutes or less.

6. 99233

Note:

For an established patient, two out of three key components are required. For this case, the coder can use the detailed physical examination and the MDM of a high level. The detailed history does not have to be used to assign a subsequent hospital care E/M code.

7. 99242

Note:

For office consultations with new patients, three out of three key components must be met or exceeded for a level to be assigned. For 99242, an expanded problem-focused history, expanded problem-focused exam, and medical decision making of a straightforward nature are the requirements.

8. 99255

Note:

Initial inpatient consultation codes require three out of three key components be met in order to assign a specific level. A comprehensive history, comprehensive exam, and MDM of high level would code to 99255.

9. 99285

Note:

The presenting problem in this patient warrants a high E/M level. The diagnoses of shortness of breath and chest pain are critical medical issues. Since no time was documented by the physician, critical care service code 99291 or 99292 could not be used.

10. 99288

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11. 99284 –25, 99291

Note:

ED is the abbreviation for emergency department, and MDM is the abbreviation for medical decision making. The presenting problem of this patient and the fact that critical services were provided for 70 minutes requires the coding of 99291. The patient is unable to provide history due to his medical condition; however, time is the component used to assign a critical care code and the fact that the patient's medical problem is of a critical nature. The lack of history documentation does not prevent the use of code 99291 in this case.

12. 99291, 99292, 99292, 99292, 99292

Note:

Three hours of critical care support equals 180 minutes, which is coded to 99291 and 99292 × 4. The criteria for critical care code assignment are the documentation of time by the physician and the patient's medical illness/condition being of a critical nature.

13. 99304

Note:

For initial nursing facility care, all three key components must be met for a specific level to be assigned. Based on the history, exam, and MDM levels in this case, 99304 is the only E/M code that can be assigned. The physician exceeds the MDM requirement for this level but does not meet the comprehensive examination requirement to be able to assign the next highest level, 99305.

14. 99308

Note:

For the subcategory of subsequent nursing facility care, two out of three key components must be met to assign a specific level. The exam noted in this case meets the requirement of 99308. The MDM meets the requirement of 99309. However, the case does not document that either the history or exam requirement for 99309 are met. Therefore, E/M code 99308 is assigned.

15. 99324

Note:

The code range for domiciliary, rest home, or custodial care services is 99324 to 99328 for new patients. As with other new patient codes, three out of three key components must be met for a specific level to be assigned.

16. 99335

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Note:

Only two out of three key components must be met for this established patient. A problem-focused history is part of level 1, an expanded problem-focused exam is part of level 2, and an MDM of moderate complexity is part of level 3. The only level where two key components were met or exceeded was level 2. The physician met the exam requirement and exceeded the MDM requirement.

17. 99348

Note:

For the subcategory of established patient, home services, two out of three key components must be met or exceeded to assign a specific level. An expanded problem-focused history and problem-focused examination were performed, and MDM was of moderate complexity. Thus, code 99348 is assigned.

18. 99343

Note:

For a new patient in the category of home services, all three key components must be met or exceeded for a specific level to be assigned. For 99343, the requirements are a detailed history, a detailed examination, and MDM of moderate complexity.

19. 99214, 99354, 99355

Note:

First, determine the established patient office visit level based on the documentation. Then given the information of two hours of service, prolonged physician service codes are added. Based on information in CPT, 99214 has a typical time of 25 minutes. (120 minutes minus 25 minutes equals 95 minutes.) 99354 covers 60 of the 95 minutes, which leaves 35 minutes unaccounted for. 99355 is assigned for the remaining 35 minutes. Both 99354 and 99355 are add-on codes; therefore, no modifier is needed. Prolonged services of less than 15 minutes beyond the final 30 minutes are not reported separately.

20. 99360

Note:

99360 is assigned for standby (non-face-to-face) service. This code is assigned based on full units of 30 minutes.

21. 99367

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Note:

Code 99367 is assigned for a medical team conference of 30 minutes' duration or more with participation by the physician. Team conferences are typically face-to-face meetings of health professionals from the same discipline or from various medical specialties.

22. 99366



Note:

Code 99366 is assigned for a medical team conference with an interdisciplinary team of health care professionals who have face-to-face direct contact with the patient and/or family, 30 minutes of duration or more.

23. 99375
24. 99378
25. 99384



Note:

A preventive medicine service E/M code should be assigned in this case. These codes are assigned by age of the patient.

26. 99397
27. 99441
28. 99444
29. 99455



Note:

Work-related or medical disability evaluation services is the subcategory of E/M codes that should be used in this case. The requirements for the assignment of an E/M from this category are the completion of a history, exam, the forming of a diagnosis, the development of a treatment plan, and the completion of a report. No special level of key components is required.

30. 99460 (7/8), 99462 (7/9)

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CPT Anesthesia

CHAPTER 10

EXERCISE 10.1 – ANESTHESIA TERMINOLOGY

1. b
2. e
3. c
4. d
5. a
6. d
7. c
8. a
9. e
10. b

EXERCISE 10.2 – OVERVIEW OF ANESTHESIA SECTION

1. monitoring
2. -59 (or 59)
3. False
4. monitored
5. -QS (or QS)

EXERCISE 10.3 – ANESTHESIA SECTION GUIDELINES

1. c
2. e
3. a
4. d
5. b
6. a
7. b
8. a
9. a
10. b
11. T
12. T
13. T
14. F
15. F
16. T
17. T
18. T
19. T
20. F

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Note:

- For number 15, the statement is False because if the patient requires anesthesia services after discharge from the receovery room, the CRNA or anesthesiologist will provide such services (e.g., ICU, patient hospital room).
- Regarding number 20, the anesthesia time unit is 4 because 60 ÷ 15 = 4. The anesthesia code's base unit value is 5, and the physical status modifier's relative value is 0; thus, (5 + 4 + 0) × $17.45 = 9 × $17.45 = $157.05.

21. b
22. c
23. a
24. d
25. e

EXERCISE 10.4 – ANESTHESIA SUBSECTIONS

1. add-on
2. -59 (or 59)
3. False

Note:

The code description for 00326 includes the phrase, ". . . in children younger than 1 year of age." Therefore, code 99100 is not reported in addition to code 00326.

4. 00406
5. -QS (or QS)
6. 01935–01936
7. 00796
8. 01990
9. 01922–23
10. 01953

REVIEW

Multiple Choice

1. d
2. a
3. d
4. a
5. b
6. b
7. a
8. d
9. d
10. a
11. a
12. a
13. b
14. b
15. c
16. b
17. b
18. b
19. c
20. b

Coding Practice I—Modifiers

1. 01961-P1-AA, 99140, 62326-59

Note:

Modifier -P1 is assigned for a healthy patient. Modifier -AA is a HCPCS modifier that is assigned to reflect anesthesia performed by an anesthesiologist. Modifier -59 is assigned to indicate that a distinct procedural service was provided in addition to anesthesia services.

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2. 01832-P2-QX, 01996, 62324-59

Note:

CRNA is the abbreviation for certified registered nurse anesthetist (CRNA). The physical status anesthesia modifier -P2 is assigned due to the patient being a diabetic. Modifier -QX is assigned to reflect CRNA service under medical direction of a physician. Modifier -59 is assigned to indicate that a distinct procedural service was provided in addition to anesthesia services.

3. 01402-P1-AA

Note:

P1 is the anesthesia modifier assigned to a healthy patient, and -AA is the HCPCS modifier assigned when services are provided by an anesthesiologist.

4. 01400-P1-AA, 64447-59

Note:

Modifier -59 is assigned to indicate that a distinct procedural service was provided in addition to anesthesia services.

5. 00540-P2-QZ, 62324-59

Note:

The physical status anesthesia modifier of P2 is assigned due to this patient's chronic asthma condition. The HCPCS modifier QZ is assigned for CRNA services not under the direction of a physician. Modifier -59 is assigned to indicate that a distinct procedural service was provided in addition to anesthesia services.

Coding Practice II—Anesthesia

1. 00142-P2-AA, 99100

Note:

The physical status anesthesia modifier of P2 is assigned due to the fact that this patient has controlled diabetes mellitus. Qualifying circumstances code 99100 is reported because the patient is over age 70.

2. 00120-P1-AA
3. 00326-P5-AA, 99140

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Note:

The physical status anesthesia modifier of P5 is assigned to reflect the severity of the patient's cardiopulmonary state. Code 99140 is reported to indicate emergency conditions of treatment. Qualifying circumstance code 99100 is not assigned, per the note located below code 00326 in the CPT coding manual.

4. 00320-P2-AA

Note:

The physical status anesthesia modifier of P2 is assigned in this case due to the nature of the patient's condition, thyroid tumor.

5. 00400-P1-AA
6. 00474-P2-AA

Note:

The patient's chest pain, shortness of breath, and possible lordosis are symptoms of pectus excavatum. While most patients with pectus excavatum are asymptomatic, this patient exhibited symptoms that interfered with physiologic functioning. Therefore, the physical status modifier is -P2. (If the patient had remained untreated and his symptoms had worsened, resulting in heart and/or respiratory disease, physical status modifier -P3 would have been assigned.)

7. 00524-P3-AA, 99100

Note:

The qualifying circumstance code of 99100 is assigned due to the patient's age being over 70. The physical status anesthesia modifier -P3 is assigned for the systemic disease of pneumonia and the severity that caused the patient to have drainage of fluid (pneumocentesis).

8. 00530-P3-AA
9. 00600-P2-AA
10. 00635-P2-AA
11. 00756-P2-AA
12. 00702-P1-AA
13. 00802-P1-AA

Note:

This patient has no medical history or chronic conditions; therefore, the physical status anesthesia modifier -P1 is assigned.

14. 00851-P1-AA
15. 00952-P1-AA

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16. 00921-P1-AA
17. 01112-P1-AA
18. 01170-P1-AA
19. 01230-P2-AA

Note:

Type 2 diabetes mellitus is a systemic disease that is under control in this patient. Therefore, the physical status modifier -P2 is assigned.

20. 01214-P3-AA, 99100

Note:

The physical status modifier -P3 is assigned due to the admitted condition of the patient.

21. 01392-P1-AA
22. 01400-P1-AA
23. 01462-P2-AA

Note:

The physical status modifier -P2 is assigned in this case due to the patient's preexisting condition of Down syndrome.

24. 01462-P1-AA

Note:

The fact that this patient is a smoker does not warrant a higher-level physical status modifier. There is no documentation of any disease process or condition; therefore, modifier -P1 is assigned. Do not assign CPT code 01490 because the cast application was not performed as a separate procedure.

25. 01620-P1-AA
26. 01636-P1-AA
27. 01710-P1-AA
28. 01716-P1-AA
29. 01810-P1-AA
30. 01830-P1-AA
31. 01920-P2-AA
32. 01922-P3-AA
33. 01952-P3-AA, 01953-P3-AA, 01953-P3-AA, 01953-P3-AA

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Note:

01952 covers 9 percent of this patient's 35 percent total body burn. Thirty-five percent minus 9 percent equals 26 percent (35 − 9 = 26). 01953 is added × 3 to reflect the remaining 26 percent. 01953 is an add-on code; therefore, no -51 modifier is required. In CPT, the 9% described in code 01953 is interpreted as "up to 9%," which is why code 01953 is reported × 3.

34. 01952-P2-AA
35. 01960-P1-AA
36. 01961-P2-AA
37. 01996-P1-AA
38. 01990-P6-AA
39. 01996-P1-AA
40. 01999-P2-AA, 99100



Note:

Qualifying code of 99100 is assigned because the child is under the age of 1 year.

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CPT Surgery I

CHAPTER 11

EXERCISE 11.1 – OVERVIEW OF SURGERY SECTION

1. major body area or organ system
2. diagnostic
3. therapeutic
4. a. urinary system
   b. urinary bladder
   c. endoscopic
   d. biopsy
   e. cystourethroscopy with biopsy
   f. 52204

Note:

Combination code 52204 includes cystourethroscopy with biopsy. No incision is made to access the urinary bladder because the cystourethroscope is inserted through the urethra into the urinary bladder.

5. a. digestive system
   b. large intestine (colon)
   c. laparotomy (incision)
   d. excision
   e. partial colon resection (colectomy) with anastomosis
   f. 44140

Note:

Do not code the lysis of adhesions or exploratory laparotomy. The lysis of adhesions is incidental to the colon resection procedure, and the exploratory laparotomy is the surgical approach. To find the code, refer to the CPT index and locate main term *Colon*, subterm *Excision*, and 2nd qualifier *Partial*. Review the range of codes to select 44140 (Colectomy, partial; with anastomosis). (Since there is no mention of laparoscopic approach in the case study, do not report code 44204.)

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EXERCISE 11.2 – SURGERY GUIDELINES

1. F
2. T
3. T
4. F
5. F
6. T
7. T

Note:

When a diagnostic procedure (e.g., diagnostic esophagogastroduodenoscopy) is performed and the provider performs follow-up evaluation and management (E/M) services, the E/M service(s) are separately coded and reported. (If the patient had undergone a therapeutic procedure, such as a partial gastrectomy to remove that part of the stomach that had ulcers, and the physician provided follow-up E/M services, a separate code would not be reported. Such follow-up E/M services are part of the global period and, therefore, included in the procedure code that was initially reported.)

8. F
9. T
10. T
11. March 15
12. October 14
13. -24
14. -50
15. Once (because the description states *15 or more lesions*).

EXERCISE 11.3 – GENERAL SUBSECTION

1. 10021
2. 10022, 76942-RT

EXERCISE 11.4 – INCISION AND DRAINAGE

1. 10180-78
2. 10140
3. 10120
4. 10040
5. 10061

EXERCISE 11.5 – LESION REMOVAL

1. 11401

Note:

Do not report modifier -LT with CPT integumentary system codes because the skin is not a paired organ. The procedure in #1, above, was performed on the "skin" of the left forearm. Simple repair is included in lesion excision and is not coded and reported separately.

2. 11100, 11101
3. 11643, 11602-59, 11602-59
4. 11056
5. 11442

EXERCISE 11.6 – NAILS

1. 11719

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Note:

Do not add modifier -50 to the code because the code description includes the phrase any number.

2. 11762-T1
3. 11730-T5, 11732-T6, 11732-T7, 11732-T8, 11732-T9
4. 11740-F1
5. 11765-T7

EXERCISE 11.7 – PILONIDAL CYST

1. 11772
2. 11770
3. 11771
4. 10080
5. 10081

EXERCISE 11.8 – INTRODUCTION

1. 11980
2. 11900
3. 11954
4. 11976
5. 11901

EXERCISE 11.9 – REPAIR (CLOSURE)

1. 12002
2. 99212
3. 16020
4. 15200, 15002
5. 15780

EXERCISE 11.10 – DESTRUCTION

1. 17000, 17003, 17003

Note:

Report code 17003 twice because of the word *each* in the CPT code description.

2. 11200, 11201

Note:

Report code 11201 in addition to 11200 because a total of 17 skin tags were removed. Code 11200 is reported for the first 15 skin tags removed, and code 11201 is reported for up to the next 10 skin tags removed.

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3. 17110
4. 17000, 17003
5. 11200
6. 17274
7. 17262
8. 17276
9. 17280
10. 17263

EXERCISE 11.11 - BREAST

1. 19125-RT, 19126-RT
2. 19367-RT
3. 19301-LT
4. 19302-RT
5. 19081-LT

REVIEW

Multiple Choice

1. d
2. b
3. a
4. d
5. c
6. b
7. b
8. c
9. c
10. a
11. c
12. c
13. c
14. b
15. b
16. d
17. b

Note:

Modifier -LT is not added to any codes in question #17 because the surgery was performed on skin, which is not considered a paired organ.

18. d
19. a
20. d

Coding Practice

1. 10021
2. 10022, 77012
3. 11404
4. 11771

Note:

Code 11771 is reported for extensive excision of a pilonidal cyst, which is one that is over 2 cm in size, is recurrent, and/or requires subcutaneous or layer closure. For this case, a 5.0-cm pilonidal subcutaneous cyst was removed and layered closure was required.

5. 10060
6. 15100, 11606

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Note:

Do not report modifier -LT for general skin procedures because the skin is not considered a paired organ.

7. 13132-F1

Note:

For this case, surgical debridement and depth of the repair indicate the complex closure of a traumatic laceration.

8. 16020
9. 11730-T5, 11732-TA

Note:

Code 11730 is assigned for removal (or avulsion) of one nail plate, and code 11732 is assigned for removal of the second nail plate of the left great toe. HCPCS level II modifiers are added to the codes to indicate the digits on which the procedures were performed. (-T5 is added to indicate surgery on the right foot, great toe. -TA is added to indicate surgery on the left foot, great toe.)

10. 12002

Note:

Per CPT notes, wound repairs of the same anatomical group and same level of repair have lengths added together to determine the code assignment. In this case, the lengths of the neck and scalp wounds are totaled. (3.0 + 2.0 = 5.0 cm.) Both repairs are simple, and the correct code is 12002. (Do not assign codes 12002 and 12001.)

11. 15740
12. 15840

Note:

Obtaining the fascial graft is included in code 15840. Do not report a separate code for obtaining the graft.

13. 17273

Note:

Surgical curettement is a type of destruction, and a code from range 17000–17286 is assigned.

14. 19301-LT
15. 19000-RT

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CPT Surgery II

CHAPTER 12

EXERCISE 12.1 – MUSCULOSKELETAL SYSTEM NOTES

1. body area
2. open or closed fractures and joint injuries
3. treatment
4. normal, uncomplicated follow-up care
5. manipulation

EXERCISE 12.2 – GENERAL

1. 20005
2. 20101

Note:

Surgical exploration and enlargement of the wound, debridement removal of a foreign body, and ligation of subcutaneous tissue is included in 20101; do not report separate codes.

3. 20240

Note:

Even though this procedure was performed on the left femur, do not add modifier -LT to code 20240. Its code description does not represent a procedure performed on paired organs because the sternum and spinous process is listed as an example. They are not paired organs.

4. 20612-RT
5. 20553
6. 20692-RT
7. 20816-F6

Note:

Do not report modifier -RT. Modifier -F6 specifies the right second (index) finger. MCP is the abbreviation for metacarpophalangeal (joint).

8. 20920
9. 22590, 20931
10. 20975

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EXERCISE 12.3 – HEAD

1. 21010-50
2. 21026

Note:

Report code 21026 just once because the code description includes the term *bone(s)*.

3. 21084
4. 21121
5. 21150
6. 21198
7. 21270
8. 21401

Note:

There is no mention of the term *blowout*; therefore, do not report a code from 21385–21395.

9. 21440
10. 21465

EXERCISE 12.4 – NECK (SOFT TISSUES) AND THORAX AND BACK AND FLANK

1. 21510
2. 21685
3. 21820
4. 21600
5. 21627
6. 20206

Note:

The parenthetical note below code 21550 provides instruction to report code 20206 for a needle biopsy of (any) soft tissue.

7. 21930
8. 21935, 13101-51

Note:

A radical resection includes excision of the tumor; therefore, do not report code 21930 in addition to code 21935. Due to complex closure (repair), add code 13101-51.

9. 21920
10. 21925

EXERCISE 12.5 – SPINE (VERTEBRAL COLUMN)

1. 22630

Note:

Just one interspace was fused; therefore, report code 22630. Also, code 22630 includes laminectomy and discectomy when performed to prepare the vertebral interspace for fusion.

2. 22505

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Note:

Report code 22505 just once even though three spinal regions were manipulated under anesthesia.

3. 22220
4. 22595, 22841
5. 22800, 20937

EXERCISE 12.6 – ABDOMEN, SHOULDER, HUMERUS (UPPER ARM) AND ELBOW, FOREARM AND WRIST, AND HAND AND FINGERS

1. 22900
2. 23000-LT
3. 23900-RT

Note:

An interthoracoscapular amputation (forequarter) is the surgical amputation of the arm, including disarticulation (separation at the joint) of the humerus and removal of the scapula and outer part of the clavicle (collarbone).

4. 23333-LT
5. 24075-RT
6. 24357-RT
7. 24300-LT
8. 25606-LT
9. 25246-RT
10. 26121-LT

EXERCISE 12.7 – PELVIS AND HIP JOINT, FEMUR (THIGH REGION) AND KNEE JOINT, LEG (TIBIA AND FIBULA) AND ANKLE JOINT, AND FOOT AND TOES

1. 27097
2. 27125-RT

Note:

If the patient returns in the future for replacement of the prosthetic device (e.g., broken device), report code 27236.

3. 27372-LT
4. 27327-LT
5. 27357-LT

Note:

Code 27357 includes obtaining (harvesting) graft, such as femur tissue, when performed during the same operative episode.

6. 27498-RT
7. 27650-RT
8. 27604-LT
9. 28296-RT
10. 28110-RT

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EXERCISE 12.8 – APPLICATION OF CASTS AND STRAPPING AND ENDOSCOPY/ARTHROSCOPY

1. 29830-LT
2. 29065-LT

Note:

Do not report code 29705-LT because the same physician who applied the first cast removed the wet cast and applied the new cast.

3. 29086-F9

Note:

The proximal interphalangeal (PIP) joint is part of the finger. Therefore, add modifier -F9 (not -RT) to the code.

4. 29445-LT
5. 29125-LT
6. 29892-RT
7. 29901-RT
8. 29824-LT
9. 29807-RT
10. 29881-LT

EXERCISE 12.9 – NOSE

1. 30200

Note:

Do not add modifier -50 to code 30200 because its description indicates turbinate(s), indicating surgery performed on multiple and bilateral turbinates.

2. 30110-LT

Note:

Do not report a code for single-layer closure, which is a simple closure that is included with code 30110.

3. 30100-LT
4. 30118-LT

Note:

The CPT index entry for "Rhinotomy, lateral" lists code 30118 and 30320. No foreign body was removed; therefore, report code 30118 with the appropriate directional modifier.

5. 30462

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EXERCISE 12.10 – ACCESSORY SINUSES

1. 31200
2. 31238
3. 31255-LT, 31256-51-LT
4. 31237
5. 31276-LT

Note:

Do not report a code for diagnostic endoscopy (31231) because it is included in the surgical endoscopy code.

EXERCISE 12.11 – LARYNX

1. 31500
2. 31365
3. 31587
4. 31502
5. 31365, 38720-59

Note:

- For a total laryngectomy with bilateral radical neck dissection (31365), do not add modifier -50 to the code. The larynx is a single midline organ, and it is not appropriate to add modifier -50 to code 31365. (A laryngectomy cannot be performed bilaterally.)
- Instead, report code 31365 for the total laryngectomy and radical neck dissection on one side. Then, report code 38720-59 for the radical neck dissection on the other side (even though the description of code 38720 is "Cervical lymphadenectomy (complete)").
- Add modifier -59 to indicate a distinct procedural service.

EXERCISE 12.12 – TRACHEA AND BRONCHI

1. 31603
2. 31717
3. 31635-LT
4. 31624
5. 31623, 31625-51, 31635-51

EXERCISE 12.13 – LUNGS AND PLEURA

1. 32551
2. 32997
3. 32405, 10021-51
4. 32663-LT

Note:

Do not report code 32601 because diagnostic thoracoscopy is included in the code for surgical thoracoscopy.

5. 32851, 32850, 35216, 32855

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REVIEW

Multiple Choice

1. b
2. a
3. b
4. c
5. d
6. d
7. a
8. c

Note:

C3–C4 contains just one interspace; therefore, report code 22554 just once (with modifier -62 added to indicate that two surgeons were required to perform the procedure).

9. d
10. c
11. c
12. c
13. b
14. a
15. d
16. c
17. c
18. a
19. b
20. d

Coding Cases

1. 20100

Note:

Codes 20100–20103 are reported for wound exploration resulting from penetrating trauma (e.g., penetrating gunshot or stab wound). These codes include surgical exploration, extension of dissection, debridement, removal of foreign bodies, and ligation/coagulation of minor subcutaneous/muscular blood vessels (not requiring thoracotomy or laparotomy). Do not report simple, intermediate, or complex repair (closure) codes from the Integumentary subsection with a wound exploration (trauma) code.

2. 21179

Note:

Do not report a separate code for the bone allograft.

3. 27506-RT

Note:

Do not report a separate code for placement of the cast. The cast application is included in the code for the open fracture treatment.

4. 27301-RT
5. 27570-LT
6. 29345-LT

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Note:

For cast reapplication, assign a code from 29000–29799. Do not code the cast removal. Cast removal is coded only when performed by a different physician.

7. 29730-LT
8. 29830-LT
9. 26080-F6

Note:

The incision was made between the first and second bones of the right index finger, which is an interphalangeal joint. Code 26080 is assigned. (Do not mistakenly assign code 26075, which involves surgery on the metacarpophalangeal joint, which is located between the first bone of the finger and bones of the wrist.)

10. 25600-RT

Note:

Do not report a separate code for application of the cast. The cast application is included in the code for the open fracture treatment.

11. 31231

Note:

Do not add modifier -50 to the code. The code descriptor states that this code is applied to unilateral or bilateral procedures. There is no need to apply the -50 modifier.

12. 31510

Note:

An indirect laryngoscopy uses a mirror to visualize the larynx.

13. 31576
14. 32656

Note:

The insertion of a chest tube is a common component of this procedure and is not separately coded.

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15. 31628
16. 31561



Note:

Do not report a separate code for use of the operating microscope (69990).

17. 30520
18. 30100
19. 30300
20. 30460

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CPT Surgery III

CHAPTER 13

EXERCISE 13.1 – HEART AND PERICARDIUM

1. 33410
2. 33824
3. 33533, 33517

Note:

Do not report modifier -51 with code 33517.

4. 33920
5. 33207, 33225

Note:

Do not report modifier -51 with code 33225.

6. 33031
7. 33282 (May 1), 93285 (May 16)
8. 33702
9. 33261
10. 33922
11. 33010, 76930
12. 33215
13. 33250
14. 33510, 33508
15. 33690
16. 33464
17. 33496
18. 33512
19. 33533, 33572
20. 33606
21. 33641

Note:

Do not report separate codes for the cardiopulmonary bypass or patch. Code 33641 includes repair of the defect, cardiopulmonary bypass, and placement of the patch.

22. 33852
23. 33780
24. 33647
25. 33860

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EXERCISE 13.2 – ARTERIES AND VEINS

1. 37211
2. 75710-RT, 36120-RT
3. 36200, 75605, 75625, A9698
4. 36555
5. 75831-LT, 36010, 36011-LT, 36012-LT

EXERCISE 13.3 – HEMIC AND LYMPHATIC

1. 38572
2. 38204
3. 38242
4. 38208
5. 38221
6. 38205, 38207
7. 38100
8. 38115
9. 38200, 75810
10. 38100
11. 38120
12. 38700
13. 41155, 38724-59

Note:

Do not report directional modifiers -LT and -RT because each side of the neck is not considered a paired organ.

14. 31365, 38720-59

Note:

When a total laryngectomy with bilateral radical neck dissection (31365) is performed, code 31365 is reported for the total laryngectomy and radical neck dissection on one side. (There is just one larynx, which means that modifier -50 cannot be added to code 31365.) Code 38720-59 is reported for the radical neck dissection on the other side. (Modifier -59 is added to indicate a distinct procedural service.) (Do not report directional modifiers -LT and -RT because each side of the neck is not considered a paired organ.) (A radical neck dissection removes all lymphatic tissue along with the spinal accessory nerve, (SAN), sternocleidomastoid muscle (SCM), and internal jugular vein (IJV). Thus, modifier -50 cannot be added to code 38720 (cervical lymphadenectomy, complete) because that code does not completely describe the procedure as performed.)

15. 38792, 78195

REVIEW

Multiple Choice

1. d
2. a
3. c
4. d
5. d
6. b
7. b
8. d
9. c
10. d
11. c
12. d
13. b
14. b
15. c
16. b
17. d
18. d
19. d
20. c

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Coding Practice

1. 37722-50, 37718-51-LT

Note:

The patient had bilateral long saphenous vein stripping, which is reflected with CPT code 37722; modifier -50 identifies this as a bilateral procedure. The patient had short veins stripped of the left leg. Modifier -51 is added to code 37718 to reflect multiple procedures reported on the same date of service. HCPCS modifier -LT is added to reflect that the procedure of stripping short veins was done on the left side of the patient's body.

2. 33430
3. 33208

Note:

33208 includes insertion of the pulse generator and electrodes into the atrial and ventricular areas.

4. 33820
5. 36425
6. 36830
7. 35301-LT

Note:

EEG is the abbreviation for electroencephalogram. The EEG done during the operation is a common component of this procedure and is not separately coded or reported. To do so would be unbundling.

8. 33263

Note:

This case documents the insertion of a replacement dual-lead system. The original leads were not replaced.

9. 33050
10. 33510
11. 38221
12. 38100
13. 38555
14. 38770-50
15. 38520
16. 38120
17. 38790-RT, 75805-RT

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Note:

Code 38790 is reported for the injection, and code 75805 is reported for the radiologic procedure.

18. 38382

Note:

Chyle in the pleural cavity is a condition called chylothorax.

19. 38204

20. 38300

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CPT Surgery IV

CHAPTER 14

EXERCISE 14.1 – MEDIASTINUM AND DIAPHRAGM

1. 39561
2. 39010
3. 39501
4. 39402
5. 39540

EXERCISE 14.2 – ORAL CAVITY

1. 41874
2. 40500
3. 40810
4. 41010

Note:

Do *not* report code 40819, which classifies an excision of the frenum.

5. 42330

Note:

Do *not* report code 42405, which classifies an incisional biopsy.

6. 42953
7. 42700
8. 42820
9. 42960-78
10. 42826

Note:

Do *not* report code 42821, which classifies a tonsillectomy and adenoidectomy. This patient underwent tonsillectomy only.

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EXERCISE 14.3 – ESOPHAGUS AND STOMACH

1. 43217
2. 43045



Note:

Do not report code 43101, which classifies excision of a lesion from the esophagus. This patient underwent foreign body removal from the esophagus through an incision in the chest wall and esophagus (esophagotomy).

3. 43460
4. 43116-52-62 (Dr. Smith), 43496-62 (Dr. Jones)
5. 43250, 43251-59
6. 43520
7. 43848
8. 43761, 76000



Note:

Do not report code 43752, which classifies the original placement of a nasogastric or orogastric tube. Because fluoroscopic guidance is not included in code 43761, report code 76000.

9. 43644



Note:

Do not report code 43645, which classifies small intestine reconstruction to limit absorption in addition to the gastric bypass procedure.

10. 49440

EXERCISE 14.4 – INTESTINES (EXCEPT RECTUM), MECKEL'S DIVERTICULUM, MESENTERY, APPENDIX, RECTUM, AND ANUS

1. 44955
2. 44005
3. 44120, 44121



Note:

Two segments of small intestine were resected and anastomosed. Therefore, report primary code 44120 and add-on code 44121. Do not report code 44625, which classifies the closure of an enterostomy with resection and anastomosis.

4. 44850
5. 44206
6. 45000
7. 45114

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Note:

Do *not* report code 45135, which classifies an excision of rectal procidentia, with anastomosis, abdominal and *perineal* approach.

8. 45300
9. 45333
10. 45384

EXERCISE 14.5 – LIVER, BILIARY TRACT, PANCREAS, ABDOMEN, PERITONEUM, AND OMENTUM

1. 47010
2. 47141
3. 47380

Note:

Do not report code 47370, which is performed via laparoscopy. The procedure for this case was performed via open laparotomy.

4. 47564

Note:

Do not report code 47610, which is performed via open incision (not laparoscopy).

5. 47480
6. 49084
7. 49002
8. 49650

Note:

Do not report a code for use of the mesh. (A code for the use of mesh is reported for incisional or ventral hernia repair only.)

9. 49560, 49568
10. 49495

Note:

Do not report code 52640, which is performed for a postoperative bladder neck contracture.

EXERCISE 14.6 – URINARY

1. 50020
2. 50590-LT
3. 50060-RT
4. 50432
5. 50542-LT
6. 50600-LT
7. 50953-50
8. 50727-RT
9. 50684-LT, 74425-LT
10. 50605-LT
11. 52640

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Note:

Do not report code 49496, which classifies an incarcerated or strangulated hernia.

12. 52325
13. 52700
14. 51102

Note:

Do not report code 51045, which classifies a cystotomy (incision made into the urinary bladder) with insertion of ureteral catheter or stent.

15. 52214, 52320-51
16. 53440
17. 53600
18. 53400
19. 53850
20. 53200

REVIEW

Multiple Choice

1. b
2. b
3. a
4. d
5. c
6. d
7. b
8. a
9. a
10. c
11. b
12. d
13. c
14. b
15. a
16. b
17. b
18. a
19. b
20. c

Coding Practice

1. 39200

Note:

MRI is the abbreviation for magnetic resonance imaging.

2. 39540
3. 39545

Note:

Imbrication is the overlapping of diaphragm tissue.

4. 39501
5. 39402
6. 43840
7. 40510
8. 43611
9. 42821
10. 49553
11. 47562
12. 45331
13. 47100
14. 41015
15. 42410

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Note:

Do not report code 42415 because there is no documentation of "nerve dissection." The mass was dissected free; however, the facial nerve was not dissected.

16. 52214
17. 52310
18. 52235
19. 49405
20. 50590-RT
21. 52332-RT

Note:

Do not report code 52000-LT in addition to 52332-RT even though the cystourethroscope was also passed into the left ureter to visualize it. Because the cystourethroscope had already been passed through the urethra to visualize the right ureter (and to facilitate inserting the double-J stent), third-party payers will not consider passing the cystourethroscope into the left ureter a separate procedure. (After using the cystourethroscope to insert the double-J stent, the surgeon withdraws the instrument from the right ureter and inserts it into the left ureter. The instrument did not have to be completely withdrawn from the urethra and reinserted through the urethra to then visualize the left ureter.)

22. 51535, 51702
23. 50200-RT
24. 50060-LT
25. 53400

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CPT Surgery V

CHAPTER 15

EXERCISE 15.1 – MALE GENITAL SYSTEM SUBSECTION

1. 55150
2. 55520-LT
3. 54550-RT

Note:

Do not report code 55110, which classifies scrotal exploration.

4. 55812
5. 54065

EXERCISE 15.2 – REPRODUCTIVE SYSTEM PROCEDURES AND INTERSEX SURGERY SUBSECTION

1. 55920, A9699
2. 55970
3. 55980-58

EXERCISE 15.3 – FEMALE GENITAL SYSTEM SUBSECTION

1. 58605 (in addition to vaginal delivery code)
2. 57020

Note:

Colpocentesis involves making an incision in the vaginal wall to drain peritoneal fluid from the area behind the vagina. This case did not mention the presence of a peritoneal abscess; therefore, do not report code 57010.

3. 58970
4. 58300
5. 58662

EXERCISE 15.4 – MATERNITY CARE AND DELIVERY SUBSECTION

1. 59120
2. 59000, 76946
3. 59012, 76941
4. 59025
5. 59426, 59430

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EXERCISE 15.5 – ENDOCRINE SYSTEM SUBSECTION

1. 60300
2. 60225

Note:

- The total thyroid lobectomy was performed on the right, and a contralateral subtotal lobectomy including isthmusectomy was also performed during the same operative episode, which means it was performed on the left side. Code 60225 is assigned because it states, "Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy."
- Do *not* assign directional modifiers to code 60225 because the thyroid gland is a single organ (with two lobes).
- Do *not* assign code 60220 in addition to code 60225 because that would be considered overcoding. Code 60225 includes all elements of the procedure performed.

3. 60260
4. 60100
5. 60000
6. 60650
7. 60500, 60512

Note:

The parenthetical note below code 60512 instructs the coder to report that code with 60500, 60502, 60505, 60212, 60225, 60240, 60252, 60254, 60260, 60270, and 60271.

8. 60540
9. 60500
10. 60600

EXERCISE 15.6 – NERVOUS SYSTEM SUBSECTION

1. 61305

Note:

Per the parenthetical note below code 61253 in CPT, do not report code 61253 with code 61305 when burr holes are drilled into the infratentorial area prior to craniectomy during the same operative session.

2. 61210
3. 61215
4. 62252
5. 61070
6. 63012
7. 62270
8. 63740
9. 62361
10. 63064

Note:

T1 represents one thoracic vertebral segment. Therefore, code 63064 is reported. If more than one thoracic vertebral segment was decompressed, code 63066 would be reported for each additional segment.

11. 64410
12. 64493-50, 64494-50
13. 64420
14. 64786
15. 64550

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EXERCISE 15.7 – EYE AND OCULAR ADNEXA SUBSECTION

1. 65222-RT
2. 65275-LT
3. 65125
4. 65265-RT
5. 65205-E3
6. 65450-LT
7. 65820-RT, 66990-RT

Note:

Report add-on code 66990 as an additional code to indicate the use of an ophthalmic endoscope during the goniotomy procedure.

8. 66985-58-RT

Note:

Modifier -58 indicates that a staged or related procedure was performed.

9. 65400-LT
10. 66984-LT
11. 67015-RT
12. 67220-RT, 92235-RT
13. 67227-50

Note:

Do not report code 67101, which classifies repair of retinal detachment.

14. 67255-LT
15. 67141-LT
16. 67415-RT
17. 67312-50
18. 67805-E1-E3
19. 67311-RT, 67318-LT
20. 67312-RT, 67320-RT

Note:

Report code 67320 just once because its description does not specify “each” muscle.

21. 68200-LT
22. 68761, 68761, 68761, 68761

Note:

There are four puncta, two associated with each eye. Reporting code 68761 four times classifies surgery performed on the puncta of both eyes.

23. 68810-50
24. 68705-LT, 68705-LT

Note:

Two puncta are associated with each eye. Therefore, report code 68705-LT twice to classify surgery performed on two puncta of one eye.

25. 68020-RT

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EXERCISE 15.8 – AUDITORY SYSTEM SUBSECTION

1. 69000-LT
2. 69200-LT
3. 69300-RT
4. 69220-RT
5. 69090-50
6. 69424-50
7. 69436-50
8. 69450-RT
9. 69710-LT
10. 69650-LT
11. 69720
12. 69930-50
13. 69610-RT
14. 69642-LT
15. 69676-LT
16. 69970-LT
17. 69955
18. 69960-RT
19. 69805
20. 69950

EXERCISE 15.9 – OPERATING MICROSCOPE SUBSECTION

1. 69610

Note:

Operating Microscope notes state that code 69990 is not reported for visualization with magnifying loupe or corrected vision.

2. 31526

Note:

The description for code 31526 states "with operating microscope," which means that code 69990 is not reported separately.

3. 19301-RT, 69990
4. 54901, 69990
5. 61548

Note:

Do not add code 69990 because below code 61548 is a parenthetical note that states, "(Do not report code 69990 in addition to code 61548.)"

REVIEW

Multiple Choice

1. d
2. b
3. b
4. b
5. a
6. a
7. d
8. b
9. d
10. c
11. c
12. d
13. a
14. b
15. b
16. d
17. d
18. c
19. b
20. b

Coding Practice

1. 55700
2. 55041

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Note:

The code description for 55041 states that it is a bilateral code. Do not add modifier -50 to the code.

3. 54057
4. 54150
5. 54520-50
6. 55250
7. 55815
8. 54600-LT
9. 54840
10. 54300
11. 58240

Note:

Due to this patient's diagnosis of gynecologic malignancy, the code assignment is different than that of a non-gynecologic abdominal hysterectomy (58150). Also, this patient had a pelvic exenteration, or removal, of the contents of the cavity.

12. 58558
13. 58671
14. 57454
15. 57135
16. 56740
17. 57513
18. 58770-RT
19. 58974
20. 58925
21. 55980-58
22. 55970-58
23. 59050

Note:

Fetal monitoring during labor by the attending obstetrician is not a separately billable or reportable service. The service done in this case is performed by a specialist, or neonatologist, which is billable and reportable per CPT guidelines.

24. 59618

Note:

This patient requested a VBAC (vaginal birth after cesarean). However, due to fetal distress, this request could not be granted, and the mother had a repeat C-section. Attempted VBAC that is unsuccessful is reported with 59618, not 59610. 59610 is the code used to report a successful VBAC.

25. 59866
26. 59812
27. 59414
28. 59120
29. 59400

Note:

Per CPT guidelines, the performing of an episiotomy during a delivery is not a separately billable or reportable procedure. To do so is unbundling. This code also reflects antepartum and postpartum care.

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30. 59425
31. 59400, 59412-51

Note:

CPT code 59400 reflects normal antepartum care, vaginal delivery, and routine postpartum care. CPT code 59412 reflects the turning of the fetus from a breech presentation to a cephalic presentation. Modifier -51 is added to reflect multiple procedure codes being reported.

32. 60100
33. 60220
34. 60540-50
35. 60281
36. 60500
37. 60650-LT
38. 60220

Note:

Do not assign modifier -LT because the thyroid gland is not a paired organ. It is one organ with two lobes.

39. 60254

Note:

The patient has a thyroid malignancy, which requires the assignment of code 60254 for a total excision, not code 60240.

40. 60260
41. 60545-LT
42. 62360
43. 64402

Note:

A nerve block is the terminology used to identify the injection of an anesthetic agent into a nerve.

44. 64831-LT
45. 64553
46. 63700
47. 62270
48. 61150
49. 61680

Note:

AV is the abbreviation for arteriovenous.

50. 64712
51. 63744
52. 65222-LT
53. 67312-LT

Note:

Each eye has four extraocular muscles: superior rectus, inferior rectus, lateral rectus, and medial rectus. In this case, two muscles were surgically treated.

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54. 67800-E1
55. 68520-RT
56. 65400-RT
57. 66761-LT
58. 67145-RT
59. 67938-E4
60. 68550-LT
61. 66984-LT

Note:

- *IOL* is the abbreviation for intraocular lens.
- The use of the operating microscope is included in the code because it is an integral part of cataract surgery. Assigning a separate code for use of an operating microscope (69990) in addition to the code for the eye surgery is unbundling.
- The injection of an antibiotic is considered an integral part of the procedure, and a separate code is *not assigned.*

62. 69210-50
63. 69300-LT
64. 69200-LT
65. 69105-RT
66. 69641-LT

Note:

The removal of the cholesteatoma is an incidental part of this procedure, and it is not separately coded.

67. 69540-LT
68. 69020-RT
69. 69420-50
70. 69552-LT

Note:

The tegmen is part of the mastoid bone; it is the roof the mastoid sinuses.

71. 69220-LT
72. 69801-RT, 69990
73. 42600-LT, 69990
74. 39503, 69990
75. 34501-LT, 69990
76. 26548-F4, 69990
77. 35207-F2, 69990
78. 64865, 69990
79. 42808, 69990
80. 31420, 69990
81. 26415-F1, 69990
82. 69424-50, 69990

Note:

Modifier -50 is added to the procedure code to reflect that it is a bilateral procedure.

83. 51500, 69990
84. 26850-F6, 69990
85. 24495-RT, 69990

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CPT Radiology

CHAPTER 16

EXERCISE 16.1 – RADIOLOGY TERMINOLOGY

1. d
2. a
3. c
4. b
5. b
6. d
7. a
8. c
9. g
10. c
11. d
12. e
13. f
14. a
15. b

EXERCISE 16.2 – OVERVIEW OF RADIOLOGY CODING

1. type of service; anatomical site; use of contrast material
2. technical
3. professional
4. global service
5. evaluation and management (E/M)

EXERCISE 16.3 – RADIOLOGY SECTION GUIDELINES

1. separate
2. unlisted
3. a. Surgical component: 36200
   b. Radiological component: 75625
4. intravascular, intra-articular, or intrathecal
5. False

EXERCISE 16.4 – DIAGNOSTIC RADIOLOGY (DIAGNOSTIC IMAGING)

1. 77012
2. 70350
3. 75658-LT

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Note:

The surgeon would report the catheterization code (e.g., 36140-LT).

4. 72220
5. 76390

EXERCISE 16.5 – DIAGNOSTIC UTRASOUND, RADIOLOGIC GUIDANCE, BREAST MAMMOGRAPHY, AND BONE/JOINT STUDIES

1. 76700
2. 76801
3. 76818
4. 76705
5. 76514
6. 47000, 77002
7. 61751
8. 20982-LT
9. 19081-LT
10. 77074

EXERCISE 16.6 – RADIATION ONCOLOGY

1. 77321
2. 77620
3. 77280
4. 77401
5. 77789

EXERCISE 16.7 – NUCLEAR MEDICINE

1. 79101
2. 78195
3. 79403
4. 78582
5. 78428

REVIEW

Multiple Choice

1. a
2. d
3. a
4. a
5. c
6. a
7. c
8. d
9. b
10. b
11. d
12. d
13. b
14. b
15. b
16. c
17. c
18. d
19. a
20. a

Coding Practice

1. 74000

Note:

AP is the abbreviation for anteroposterior.

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2. 74270
3. 74290
4. 74245
5. 74250
6. 71020
7. 71100
8. 70250
9. 73120-LT
10. 71010
11. 74410
12. 70240
13. 72040
14. 73080-LT

Note:

A complete elbow x-ray includes a minimum of three views.

15. 73562-50
16. 73100-LT
17. 74010
18. 78635, 61026
19. 70120-50
20. 78215
21. 76805
22. 77402
23. 76870
24. 70491

Note:

CT is the abbreviation for computed tomography.

25. 72131
26. 73030-RT
27. 78811

Note:

PET is the abbreviation for positron emission tomography.

28. 73610-LT
29. 75557

Note:

MRI is the abbreviation for magnetic resonance imaging.

30. 78306

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CPT Pathology and Laboratory

CHAPTER 17

EXERCISE 17.1 – OVERVIEW OF PATHOLOGY AND LABORATORY SECTION

1. professional
2. methods
3. chargemaster
4. specimen
5. phlebotomy
6. 36415
7. 36400–36410
8. -26
9. -90
10. Clinical Laboratory Improvement Act of 1988 (CLIA)

EXERCISE 17.2 – PATHOLOGY AND LABORATORY SECTION GUIDELINES

1. specimen
2. twice

Note:

When multiple specimens are received for pathological examination, each specimen is considered a single unit of service and each is reported with a separate code. Thus, code 88302 is reported twice.

3. date of service
4. unlisted service or procedure; special report
5. -91; -51

EXERCISE 17.3 – PATHOLOGY AND LABORATORY SUBSECTIONS

1. 81000
2. 36415, 80162
3. 80051
4. 88331, 88331-59, 88332, 88305, 88305-59

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Note:

- The frozen section of the first specimen is reported with code 88331.
- The first frozen section on the second specimen is reported with code 88331-59, and the second frozen section for this specimen is reported with code 88332.
- Code 88305 is reported twice to classify the two separately identified basal cell carcinomas for surgical pathology (definitive examination). Modifier -59 is added to the second code (88305-59).

5. 81025
6. 36600, 82800
7. 82310, 82374, 82435, 82565, 84295, 84520

Note:

Do not report code 80048 (Basic metabolic panel) because potassium and glucose levels were not performed. A code for each laboratory test performed is reported separately: calcium (82310), carbon dioxide (82374), chloride (82435), creatinine (82565), sodium (84295), and urea nitrogen (BUN) (84520).

8. 88331, 88309
9. 85730
10. 36416, 82948
11. 88331, 88305

Note:

- The frozen section of this specimen is reported with code 88331.
- Surgical pathology evaluation of the breast biopsy is reported with code 88305.

12. 80061, 82947

Note:

- Code 80061 is reported for the lipid panel.
- Code 82947 is reported for the quantitative glucose test.

13. 80050

Note:

Code 80050 includes a hemogram (or complete blood count). Therefore, a separate code is not reported for the hemogram.

14. 82374, 82435, 82565, 82947, 84132, 84295, 84520

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Note:

- Do not report code 80053 (Comprehensive Metabolic Panel) because albumin, bilirubin (total), calcium, phosphatase (alkaline), protein (total), and transferase (alanine and aspartate amino) tests were not performed.
- Instead, each test is reported separately: carbon dioxide (82374), chloride (82435), creatinine (82565), glucose (82947), potassium (84132), sodium (84295), and urea nitrogen (BUN) (84520).

15. 86021
16. 87172
17. 88304



Note:

Although surgical pathology evaluation of appendix tissue is also included below code 88302, that code is for an incidental appendectomy (e.g., appendix removed incidentally during another procedure). For this case, the appendix was abnormal (due to acute appendicitis), which means that code 88304 is reported.

18. 87181
19. 89230
20. 88331, 88332, 88331-59, 88332-59, 88332-59, 88307, 88307-59, 88309



Note:

- The frozen section of two blocks from the right specimen are reported with codes 88331 and 88332.
- The frozen section of three blocks from the left specimen are reported with codes 88331-59, 88332-59, and 88332-59.
- Surgical pathology evaluation of right and left obturator lymph node resections are reported with codes 88307 and 88307-59.
- Surgical pathology evaluation of prostate tissue (as the result of radical prostatectomy) is reported with code 88309.

REVIEW

Multiple Choice

1. a
2. b
3. c
4. c
5. d
6. a
7. c
8. b
9. b
10. b
11. a
12. a
13. b
14. c
15. d
16. c
17. d

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Note:

ABO, Rh, and MN blood typing are just 3 of 27 blood-typing systems used to describe the absence or presence of antigens. (Many are named after the patients in whom they were initially encountered.)

- ABO testing results in the determination of four principal blood group types: A, B, AB, and O.
- Blood tested for the presence or absence of a Rhesis (Rh) blood protein results in Rh-positive (Rh+) or Rh-negative (Rh-) status.
- The MN system tests for blood types M, N, or MN, which is useful in maternity and paternity testing.

18. d 19. b 20. a

Coding Practice

1. 80055

Note:

- The combination of these eight blood laboratory tests constitutes an obstetric panel. Assigning a separate code to each test is incorrect.
- Rh(D) is the terminology used to identify a group of antigens on the surface of red blood cells.
- ABO is the medical terminology used to classify blood types: A, B, AB, and O.
- CBC is the abbreviation for complete blood count.
- WBC is the abbreviation for white blood count.

2. 80069, 85027

Note:

- The 10 tests—albumin, carbon dioxide, calcium, sodium, glucose, chloride, creatinine, urea nitrogen, potassium, and phosphorus inorganic—constitute a renal function panel.
- Because a CBC is not a part of a renal function panel, a separate code (85027) is assigned.

3. 81001 4. 89260

Note:

Code 89260 is reported for the sperm isolation procedure and semen analysis.

5. 80418, 96372

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Note:

- These seven tests are done for suppression testing, and they are coded as a pituitary evaluation panel code.
- ACTH is the abbreviation for adrenocorticotropic hormone.
- HGH is the abbreviation for human growth hormone.
- TSH is the abbreviation for thyroid-stimulating hormone.
- LH is the abbreviation for luteinizing hormone.
- FSH is the abbreviation for follicle-stimulating hormone.
- Code 96372 is reported from the CPT Medicine section for administration of the agent used to evoke the tests.

6. 87265
7. 83009
8. 85014
9. 82810
10. 88331, 88305
11. 87220

Note:

KOH is the abbreviation used to identify the method of using potassium hydroxide prep.

12. 84443, 84479
13. 80307
14. 86038

Note:

- ANA is the abbreviation for antinuclear antibodies.
- SLE is the abbreviation for systemic lupus erythematosus.

15. 88309
16. 86771
17. 84478
18. 86631

Note:

- The gross and microscopic exam of radically resected prostate tissue is coded to level VI under the Surgical Pathology subsection.
- TURP is the abbreviation for transurethral resection of the prostate.

19. 88305

Note:

The gross and microscopic exam of this type of tissue is classified as level IV below the Surgical Pathology subsection under sinus, paranasal biopsy.

20. 86485
21. 86901
22. 84153

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Note:

PSA is the abbreviation for prostate-specific antigen.

23. 86359

24. 88304

Note:

The examination of this type of tissue is classified as level III below the Surgical Pathology subsection under nerve, biopsy. Morton's neuroma is the thickening of tissue around the nerve located between the third and fourth metatarsals.

25. 86200

Note:

CCP is the abbreviation for cyclic citrullinated peptide.

26. 88029

27. 88142

28. 89050

29. 81401

30. 88037

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CPT Medicine

CHAPTER 18

EXERCISE 18.1 – OVERVIEW OF MEDICINE SECTION

1. noninvasive
2. minimally invasive
3. can
4. diagnostic and therapeutic
5. procedure-oriented

EXERCISE 18.2 – MEDICINE SECTION GUIDELINES

1. notes
2. separate
3. plus
4. separate procedure
5. HCPCS level II

EXERCISE 18.3 – MEDICINE SUBSECTIONS

1. 90473
2. 90837
3. 92928-LD, 92929-RC
4. 90968, 90968, 90968, 90968, 90968, 90968, 90968, 90968, 90968, 90968

Note:

Code is reported for each day when less than a full month (e.g., 30 days) of ESRD services are provided to a patient between age 2 and 11 years.

5. 96374

Note:

Neither of the IV flush procedures is coded and reported because an IV flush is integral to the infusion/injection service provided. HCPCS level II code J0696 is reported for each 250-mg dosage.

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REVIEW

Multiple Choice

1. b
2. d
3. d
4. a
5. c
6. a
7. b
8. c
9. d
10. a
11. a
12. d
13. d
14. b
15. a
16. b
17. d
18. a
19. b
20. a

Coding Practice

1. 92341
2. 96120
3. 92002
4. 91030
5. 93886
6. 92579
7. 94667
8. 93797
9. 90911
10. 93288
11. 93303
12. 98941
13. 90636, 90471
14. 97535, 97535
15. 95813
16. 91132
17. 92516
18. 90371, 96372
19. 90832
20. 93000
21. 92920, 92921



Note:

The procedure described in this note is a percutaneous transluminal coronary angioplasty (PTCA). Two vessels were treated, requiring assignment of codes 92920 and 92921. CPT code 92921 is an add-on code; therefore, do not add modifier -51.

22. 93015
23. 91034
24. 99503
25. 97001
26. 95125
27. 96920
28. 90375, 96372
29. 90960
30. 96413, 96415

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Insurance and Reimbursement

CHAPTER 19

EXERCISE 19.1 – THIRD-PARTY PAYERS

1. Medicare administrative contractors
2. Centers for Medicare & Medicaid Services (or Centers for Medicare and Medicaid Services)
3. UB-04
4. clearinghouse
5. hold
6. TRICARE
7. Medicaid
8. Medicare
9. managed
10. fee-for-service (or fee for service)

EXERCISE 19.2 – HEALTH CARE REIMBURSEMENT SYSTEMS

Exercise 19.2A – Health Care Reimbursement (Completion)

1. 300 (or $300)
2. 4500 (or $4500)
3. chargemaster
4. inpatient
5. ambulatory payment classifications

Exercise 19.2B – Matching Payment Systems with Types of Prospective Rates

1. a
2. a
3. b
4. b
5. a

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Exercise 19.2C – Matching POA Indicators with Case Scenarios

1. a
2. a
3. b
4. b
5. a

Note:

Present on admission (POA) "U" was not an answer for any of the case scenarios because, in practice, coders query physicians to determine POA status. POA indicator "U" should not be reported.

EXERCISE 19.3 – IMPACT OF HIPAA ON REIMBURSEMENT

Exercise 19.3A – Matching Reimbursement Terms with Definitions

1. a
2. b
3. b
4. a
5. a

Exercise 19.3B – Impact of HIPAA on Reimbursement (Completion)

1. national health plan identifier
2. national standard employer identifier number
3. national provider identifier
4. electronic data interchange
5. security

REVIEW

Multiple Choice

1. c
2. a
3. b
4. d
5. c
6. b
7. b
8. b
9. d
10. d
11. d
12. c
13. b
14. c
15. b
16. b
17. b
18. d
19. c
20. c
21. b
22. b
23. a
24. d
25. c

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