Basic’s for the Test

- Practice, Practice and Practice
- Grade Yourself
- What did you get wrong?
- Why? What info are you missing?
- TIME Yourself...150 questions, 5hr 40min...2.25 min per question
- Time Management
- Know Your Books

Anatomy

- Competency: Identify the structures of the upper respiratory system.
  - What do we need to know?
    - The structures of the upper respiratory system
    - Check CPT and ICD10 manuals for images of upper respiratory system.
      - CPT: front pages xix-xxii “List of illustrations”
      - HCPCS: pg. 25-60
      - ICD10: throughout the tabular; specific to diagnostic chapters
Anatomy
Which of the following structures is part of the upper respiratory system?
A. Carpus
B. Trachea
C. Pylorus
D. Coccyx
Look at your reference in the CPT pg 178

Diagnosis
- Competency: Apply ICD10 coding conventions and guidelines to accurately report diseases of the genitourinary system and cardiovascular system.
- What do we need to know?
  - ICD-10-CM Hypertension guidelines (pg. 13; I.C.9.a)
  - ICD-10-CM Chronic Kidney Disease guidelines (pg. 17; I.C.14.a)
  - How to use the ICD-10-CM Index to Diseases to locate a code (pg. 3; I.A.1-13)
  - How to apply ICD-10-CM conventions and guidelines (pg. 4; I.B.1-18)

Diagnosis
A patient with hypertensive stage 5 chronic kidney disease, and secondary hyperparathyroidism receives peritoneal dialysis. The provider evaluates the patient once before dialysis begins. What ICD-10-CM codes are reported?
A. I10, N18.5, Z99.2, N25.81
B. I12.0, N25.81
C. I12.0, N18.6, Z99.2, N25.81
D. I12.0, N18.5, Z99.2
## HCPCS Level II

- What do we need to know?
  - How to identify the type of service
  - How to identify the payer and who can report the S codes (pg. 8)
  - When reporting the S codes is appropriate
  - How to locate a HCPCS Level II code in the HCPCS Level II code book (pg. 5)

## A patient with private insurance has laser in situ keratomileusis (LASIK) surgery performed. The private insurance requires the use of HCPCS codes, when available. Which code properly reports this encounter?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>A. 65760</td>
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<tr>
<td>B. S0800</td>
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<tr>
<td>C. S0810</td>
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<tr>
<td>D. 65400</td>
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</tbody>
</table>

## Modifiers

- Competency: Accurately apply modifiers to report professional, technical, and global services given a scenario or medical record.
- What do we need to know?
  - How to tell if it is a global, technical (-TC) or professional service(-26).
  - The definitions of the modifiers. (HCPCS front and back covers)
The patient comes into the hospital for chest pain. The hospital radiology technician takes a frontal view chest X-ray in the office (radiologist is not employed by the hospital and does not own the equipment). The radiologist reads the X-ray and interprets that the patient has pneumonia. How should the radiologist bill the interpretation of the chest X-ray?

A. 71045-26
B. 71045-26-TC
C. 71045-TC
D. 71045

Cardiovascular System

- Competency: Apply CPT guidelines to accurately report cardiac catheterization services.
- What do we need to know?
  - Distinguish the difference between selective and non-selective catheterizations
  - CPT guidelines for catheterizations
  - How to identify orders of arteries
  - How to use Appendix L

The cardiologist advances a 6 French catheter into the left renal artery via a right common femoral puncture. It is selectively catheterized and angiographic films are taken. The catheter was then removed and a diagnostic guiding type, RDC catheter was used and the left renal artery was selectively engaged. A 0.014 Supracore wire was used and the lesion was crossed. A 6.0 X 18 mm balloon expandable Racer stent was introduced. This was expanded around 8 atmospheres of pressure which is nominal. Angiography revealed excellent results with no residual stenosis.

A. 36245-LT, 75625-26, 37236
B. 36245-LT, 37236
C. 36245-LT, 36251, 37236
D. 36246-LT, 37236
Cardiovascular System

- ANS: B
- Rationale: The left renal artery is a first order vessel as noted in Appendix L of the CPT® codebook (36245-LT). To locate the selective catheterization, look in the CPT® Index for Artery/Abdomen/Catheterization 36245-36248. Angiography of the left renal vessel was performed; however, there is no mention in the report of the results of the angiography. This is not a diagnostic angiography, rather it is angiography for mapping (checking out known stenosis). The stent was deployed (37236) in the left renal artery; this code also includes the radiologic supervision and interpretation. In the CPT® Index look for Stent/Placement/Transcatheter/Intravascular which directs the coder to 37215-37218, 37236-37239. Follow-up renal angiography is bundled with the stent procedure.

Digestive System

- Competency: Apply CPT guidelines and coding conventions to accurately report Endoscopic Retrograde Cholangiopancreatography (ERCP) when given a scenario or operative report.
- What do we need to know?
  - CPT guidelines for ERCP
  - How to locate a CPT code

Digestive System

A surgeon exchanges one stent is in the biliary duct and one stent in the pancreatic duct during the same surgery session. How is this reported?
- A. 43276 x 2
- B. 43276-50
- C. 43276
- D. 43276, 43276-59
Digestive System

- Competency: Apply CPT guidelines and conventions to accurately report hernia repair.
- What do we need to know?
  - Hernioplasty, Herniorrhaphy, and Herniotomy guidelines
  - Different type of hernia repairs
  - When mesh is reported
  - How to apply guidelines and parenthetical statements

A general surgeon performs laparoscopic surgery for a recurrent strangulated incisional hernia repair, on a 36-year-old. Because this is a recurrent problem, the provider inserts mesh. According to the hernia repair guidelines, how is this hernia repair reported?

A. 49655
B. 49655, 49568
C. 49657, 49568
D. 49657
A morbidly obese patient has gastric restriction by gastric band laparoscopically. The patient is appropriately prepped and anesthetized. The provider makes a small incision in the lower abdomen and insufflates the abdominal cavity. A scope is inserted. The provider then places an adjustable band around the top of the stomach and fastens it into place. Tubing is placed from the band to an access port in the abdominal wall. The instruments are removed, and the incision is closed.

A. 43771  
B. 43842  
C. 43770  
D. 43644

A patient is diagnosed with multiple bladder tumors. The provider performs a cystourethroscopy and resects a 1 cm tumor and a 2.5 cm tumor from the bladder. How is this reported?

A. 52234, 52235  
B. 52234 x 2  
C. 52235  
D. 52235 x 2
### Radiology

- **Competency:** Apply CPT guidelines and conventions to accurately report ultrasound services on the abdomen and retroperitoneum given a scenario or operative report.

- **What do we need to know?**
  - CPT guidelines for ultrasounds of the abdomen and retroperitoneum
  - ICD-10-CM guidelines for signs and symptoms vs definitive diagnosis

### Radiology

A patient with abdominal pain has an ultrasound of the complete abdominal aorta to rule out an abdominal aortic aneurysm. What diagnosis and procedure codes are reported for this encounter?

A. 76706, Z13.6 not a screening  
B. 76770, R10.9  
C. 76775, R10.9…  
D. 76700, I71.4…aneurysm

### Pathology & Laboratory

- **Competency:** Accurately report an occult blood test given a scenario or pathology report.

- **What do we need to know?**
  - Collection methods for an occult blood test.
    - Clinical Responsibility (AAPC Coder)
    - The lab analyst performs all technical steps to test for the presence or absence of occult blood in a nonfecal specimen. Samples may be from any source in the body to test for microscopic amounts of blood. The most common, other than feces, is from the upper gastrointestinal tract.
    - These sources can include gastric lavage contents, esophageal swabs, etc.
  - How to locate a CPT code.
  - How to determine a screening vs. diagnostic test.
Pathology & Laboratory

A lab analyst receives an esophageal swab from a provider and performs an occult blood test. The test is performed for colorectal cancer screening. Which occult blood test is reported?
A. 86768
B. 82272
C. 82271
D. 82270

Pathology & Laboratory

• Competency: Accurately report surgical pathology services given a scenario or pathology report.
• What do we need to know?
• How to identify the specimen
• How to identify the type of service
• How to identify the approach and intent
• CPT guidelines for surgical pathology

Pathology & Laboratory

A provider performs a total resection of the larynx, including the regional lymph nodes and sends it to pathology. What CPT code is reported for the gross and microscopic examination performed on the specimen?
A. 88300, 88307
B. 88300, 88309
C. 88307
D. 88309
### Evaluation and Management

#### Competency: Apply CPT guidelines to accurately report observation services given a scenario or operative report.

- What do we need to know?
  - CPT E/M categories
  - CPT Observation, outpatient, and inpatient guidelines
  - How to identify hospital status
  - How to level an observation code

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### Evaluation and Management

A patient calls her family physician at 10 pm with pain in her abdomen. The on-call physician meets her at the hospital and admits her to observation care. The physician performs a comprehensive history, comprehensive examination, and medical decision making of moderate complexity. The patient is discharged from observation the next day. What CPT® code reports the admission to observation?

- A. 99219
- B. 99222
- C. 99284
- D. 99235

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### Evaluation and Management

- Competency: Apply CPT E/M guidelines to accurately report an office or other outpatient visit.

- What do we need to know?
  - E/M Categories
  - E/M Guidelines
  - How to tell the difference between new and established patients.
  - How to level an E/M code when given the level of history, exam, and medical decision making.
A patient being seen for the first time in a provider’s office complains of a high fever and body aches during flu season. The provider performs an expanded problem focused history, expanded problem focused exam, and medical decision making of moderate complexity. What E/M code is reported for this service?

A. 99204
B. 99202
C. 99213
D. 99214

Evaluation and Management

- Competency: Apply CPT conventions and guidelines to accurately report newborn E/M services.
- What do we need to know?
  - E/M Categories
  - E/M Newborn services guidelines
  - How to identify and apply parenthetical statements
  - E/M NICU guidelines

An OB/GYN requested a pediatrician to be present for a vaginal delivery for possible fetal distress. The pediatrician attended the delivery at the request of the obstetrician. At delivery, the nuchal chord was wrapped around the neonate’s neck. The nuchal chord was removed from the neck and the pediatrician stabilized the neonate and placed the neonate in the NICU. What CPT® coding is reported for the pediatrician?

A. 99465
B. 99464
C. 99465, 99477
D. 99464, 99477
Evaluation and Management

- Competency: Apply CPT guidelines and coding conventions to accurately report critical care services.

- What do we need to know?
  - E/M Categories
  - How to calculate critical care time.
  - E/M critical care guidelines – what is included in critical care services and what can be reported separately.

A 68-year-old patient is brought into the ED department cardiac dysrhythmia requiring emergent treatment. The ED physician performs an emergency endotracheal intubation. A 2-view chest X-ray is performed, and pulse ox is monitored. The physician spends 2 hours in critical care time with the patient. How is this reported?
A. 99291, 99292, 31500, 71046, 94760
B. 99291, 99292 x 2, 31500
C. 99291, 99292 x 2, 31500, 71046
D. 99291, 99292 x 2

Evaluation and Management

Medicine

- Competency: Apply CPT guidelines and conventions to accurately report vaccinations.

- What do we need to know?
  - How to identify the payer
  - How to identify the vaccination
  - How to identify the route of administration
  - Vaccination administration guidelines
  - Reason for the injection
Medicine
A Medicare patient is seen by the nurse for a Fluzone high-dose (enhanced immunogenicity) vaccination. The nurse administers the flu vaccine in the right deltoid. The physician reviews the chart and signs off on the nurse’s note.
What procedure and diagnosis codes are used for Medicare?
A. 90471, 90662, Z23
B. G0008, 90662, Z23
C. 99211-25, G0008, 90685, Z28.09
D. G0009, 90685, Z23

Medicine
• Competency: Apply CPT guidelines and conventions to accurately report moderate conscious sedation services.
• What do we need to know?
  • How to identify the type of sedation
  • MCS guidelines
  • How to identify the administering provider and monitoring provider/clinician
  • How to calculate the time

Medicine
A ten-year-old is brought to the orthopedic clinic after colliding with another player on the soccer field. Due to the patient’s hysteria, the provider is unable to get a clear X-ray. The provider applies moderate conscious sedation, with the nurse acting as an independent observer, and obtains a 2-view X-ray of the shin. The patient is under sedation for 45 minutes. What CPT codes are reported for the services?
A. 99152, 99153 x 2, 73590
B. 99151, 99153 x 2, 73592
C. 99155, 99157 x 2, 73592
D. 99155, 99157 x 2, 73590
Medicine

- Competency: Apply CPT guidelines and conventions to accurately report percutaneous transluminal balloon angioplasty.
- What do we need to know?
  - CPT guidelines for coronary therapeutic procedures.
  - Artery modifiers

Medicine

Intracoronary stents are placed percutaneously in the right coronary and left anterior descending arteries for a patient with stenosis. Percutaneous transluminal balloon angioplasty is performed on the left circumflex coronary artery. Choose the correct CPT® codes for this procedure.
A. 92928-RC, 92928-LD, 92920-LC
B. 92928-RC, 92929-LD, 92920-LC
C. 92933-RC, 92934-LD, 92934-LC
D. 92928-RC, 92920-LD, 92920-LC

Medicine

- Competency: Apply CPT and HCPCS Level II guidelines and conventions to accurately report administration of injections given a scenario or medical record.
- What do we need to know?
  - How to identify the service given
  - How to identify the reason for the service
  - How to locate the HCPCS code for the drug and calculate units
A 30-year-old male cut his right hand on a nail. He was given 1,200,000 units of Bicillin CR for cellulitis. How is this reported?
A. 90460, J0558 x 12
B. 90471, J0558
C. 96372, J0561 x 12
D. 96372, J0558 x 12

THANK YOU

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