Chapter 4
   a. 284.09    c. 285.9, 288.00, 287.5
   b. 284.89    d. 288.00, 287.5, 285.9

Chapter 6
Page 526  EXERCISE 12.6
6. Percutaneous medial fasciotomy tenotomy for treatment of tennis elbow, right.

Chapter 8
Page 359  34. A patient presents to the emergency department (ED) following an accident in his garage. The patient was working under his car when the jack failed, and the car fell on the patient’s chest. The patient requires 65 minutes of critical care time during which he is evaluated and undergoes emergency endotracheal intubation and stabilized. The patient is found to have a hemothorax, and a chest tube is inserted by the ED attending physician. The patient undergoes surgery for an is admitted as an inpatient and scheduled for exploratory laparotomy with possible splenectomy. Codes 99291 and 31500 are reported for the ED visit. Refer to code 31500 32020 and explain the meaning of the forbidden (⊙) symbol that precedes the code.

Chapter 9
Page 400  EXAMPLE: The physician participated in a 30-minute interdisciplinary team medical conference of mental health professionals to discuss a 49-year-old patient’s plan of care. Report code 99361 99367.

Case Management Services
47. A 72-year-old patient with a history of breast cancer has a suspicious mass in her uterus. A biopsy was done. The determination was that the patient had a carcinoma in situ of the uterus. The physician who conducted the surgery called a face-to-face meeting with his fellow surgeons and discussed the case and the patient’s outcome for 30 minutes.

48. A 14-year-old boy twisted his ankle while playing soccer. He was taken to his PCP, received level 3 E/M services from his physician the next morning. The physician ordered an x-ray of the ankle, area was taken, and the child left the office after the x-ray but did not see the physician. Later that afternoon the physician called and spoke to the patient’s mother about the x-ray results and treatment of the patient’s sprain. Medical discussion was 10 minutes in duration.

Chapter 10
Page 438  TABLE 10-8 Coding Rules Associated with Spine and Spinal Cord Subsection Anesthesia Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Coding Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>00600</td>
<td>When anesthesia services for myelography and diskography diagnostic and therapeutic percutaneous image-guided spine and spinal cord procedures are provided, report codea 01905 01935-01936 instead of 00600.</td>
</tr>
<tr>
<td>445</td>
<td>When anesthesia services for myelography and diskography therapeutic percutaneous image-guided procedure on the spine and spinal cord procedures are provided, report code _______________.</td>
</tr>
</tbody>
</table>

Chapter 11
Page 463  EXAMPLE: A physician performed a thoracentesis for pleural effusion. Later that same day the patient’s condition required a second thoracentesis. Report codes 32421 and 32421-76 32000 and 32000-76.
Chapter 12

Incision

Thoracentesis (Figure 12-17) (32421-32422 32000–32002) is the surgical puncture of the chest wall with a needle to obtain fluid from the pleural cavity. It is performed to make a diagnostic evaluation or to drain excess fluid from a patient with severe pleural effusion (Figure 12-17) (fluid in the pleural cavity prevents the lung from fully expanding, making it very difficult for the patient to breathe).

Chapter 13

CODING TIP: When blood is collected from a partially or completely implantable venous access device, report code 36591 36540.

Chapter 14

EXAMPLE: The following codes are reported for gastrostomy procedures (Figure 14-5). Their code descriptions differ based on the surgical approach (underlined in each code description below) used to perform the gastrostomy.

• 43653 Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g., Stamm procedure) (separate procedure)
• 43750–43246 Percutaneous placement of gastrostomy tube via upper gastrointestinal endoscopy
• 43830 Gastrostomy, open; without construction of gastric tube (e.g., Stamm procedure) (separate procedure)
• 49440 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance

619 Codes 43750–43761 are reported for placing, repositioning, and changing gastrostomy tubes (e.g., feeding tube and PEG tube) (Figure 14-12). Naso or orogastric tube placement (43752) that requires a physician’s skill and fluoroscopic guidance is reported when the nursing staff are unable to successfully insert the tube. Code 43752 is not reported when nursing staff insert the tube.

Chapter 17

Unlisted Service or Procedure

A service or procedure that is provided for which there is no CPT code is reported with an “unlisted service or procedure” code. Pathology and laboratory unlisted service and procedure codes include:

• Unlisted urinalysis procedure (81099).
• Unlisted chemistry procedure (84999).
• Unlisted hematology and coagulation procedure (85999).
• Unlisted antigen, each (86586 86486).
• Unlisted immunology procedure (86849).
• Unlisted transfusion medicine procedure (86999).
• Unlisted microbiology procedure (87999).
• Unlisted necropsy [autopsy] procedure (88099).
• Unlisted cytopathology procedure (88199).
• Unlisted surgical pathology procedure (88399).
• Unlisted miscellaneous pathology test (89240).

Chapter 18

CODING TIP

• Report code 36550 36593 for declotting a catheter or port using a fibrinolytic agent (e.g., recombinant tissue plasminogen activator, also known as tPA or alteplase).
• Code 36550 36593 is not reported for the routine flushing of vascular access devices with saline or heparin. For example, this type of flushing is considered integral to chemotherapy administration and is not separately coded and reported.
Workbook to Accompany 3-2-1 Code It!

Chapter 4

   a. 388.12    c. 389.20
   b. 388.2     d. 389.9

Chapter 5

Page 64  13. Admission diagnoses include weight loss, hypotension, and weakness. Final diagnosis is adrenal hypofunction. Which code is reported?
   a. 071.6    c. 255.5
   b. 255.41   d. 255.6

Chapter 8

Page 97  19. Which code is an add-on category III code?
   a. 0055T 0016T    c. 0089T
   b. 0060T     d. 4011F

  103  4. In which subcategory of the E/M section would you find a code for prolonged patient services with direct face-to-face contact?
   a. 99354-99357    c. 99361-99362 99366-99368
   b. 99358-99359   d. 99450-99456

Chapter 9

Page 115  11. Mrs. Johnson underwent a cervical biopsy two weeks ago after a Pap smear tested positive. Dr. Smith called Mrs. Johnson today to inform her that her test results were positive for Human Papilloma virus and that she should come to the office for follow-up within 90 days. Medical discussion was 10 minutes in duration.

Chapter 10

Page 127  32. A 35-year-old male with type 2 diabetes and back pain underwent therapeutic percutaneous image-guided spine and spinal cord diskography under general anesthesia, which was administered by the CRNA under medical direction by an anesthesiologist.

Chapter 11

   a. 19140    c. 19140-51
   b. 19140-50  d. 19180-50
   a. 19300    c. 19300-51
   b. 19300-50  d. 19303-50

Chapter 12

Page 135  5. A patient with pleural effusion underwent stab incision thoracentesis, which allowed the placement of an aspirating needle into the pleural space. 10 cc of fluid was drained from the space.

  137 ASSIGNMENT 12.1

  3. PREOPERATIVE DIAGNOSIS: Retained hardware, left hip, status post closed reduction and percutaneous subcutaneous pinning of the subcapital fracture of her left hip.
    POSTOPERATIVE DIAGNOSIS: Same.
    OPERATION PERFORMED: Percutaneous Subcutaneous removal of hardware.
    The patient was taken to the operating room and placed in the supine position. After adequate general anesthesia was administered, the left hip was prepped and draped in usual sterile fashion. The previous incision was used to make a 2.0 cm incision. A guidewire was used to get into the screws
5. **PREOPERATIVE DIAGNOSIS:** Mass of lung.  
**POSTOPERATIVE DIAGNOSIS:** Carcinoma of the right lung.  
**OPERATION PERFORMED:** Bronchoscopy and right upper lobectomy.  
The patient was brought into the operating room; and after the administration of anesthesia, the patient was prepped and draped in the usual sterile fashion. The patient was placed in the left lateral decubitus position. A thoracotomy incision was made. This exposed the chest muscles, which were incised and retracted. The fourth and fifth ribs were visualized and transected to allow entrance to the chest. A tumor mass was noted. This mass measured 7.0 cm in diameter, involving the right lung upper lobe. The mass was excised in its entirety, and a biopsy of the mass was taken and sent for frozen section to determine if lymph nodes around the pulmonary artery and trachea needed to be excised at this time. The frozen section revealed squamous cell carcinoma. Nodes were then dissected around the pulmonary artery and the trachea. The nodes were sent for frozen section. The nodes were identified as negative per pathology. Saline was irrigated into the chest. It was noted that the liver and diaphragm appeared to be normal with no lesions seen. After verification that the sponge count was correct, chest tubes were placed for drainage. The surgical wound was closed in layers with chromic catgut and nylon. The patient tolerated this portion of the procedure well.

The patient was then placed in the supine position for the bronchoscopy. The patient was still under anesthesia. A flexible fiberoptic bronchoscope was inserted. Patent bronchi were noted bilaterally. The scope was withdrawn. The patient was awakened and sent to the recovery area in stable condition.

8. Percutaneous needle biopsy of the lung.
   a. 32000 32421  
   b. 32400  
   c. 32402  
   d. 32405

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**Chapter 16**

Page 177  
7. Patient is a 45-year-old female and presents for her first mammography. The patient has no family history of cancer, and personal medical history includes only hypertension. The mammography is negative for the presence of any carcinoma and shows only mild fibrocystic disease in the left breast.
   a. 76091 77056  
   b. 76092 77057  
   c. 76093 77058  
   d. 76094 77059

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**Chapter 18**

Page 190  
9. A 20-year-old construction worker stepped on a needle at work. The needle went through his work boot and punctured the skin of the bottom of his foot. The patient removed the needle and has it with him. He has a small amount of bleeding at puncture site. The patient presents to the clinic for a tetanus vaccine, which is **injected administered IM** into his upper left arm.

   1. IM injection of varicella-zoster immune human globulin.
      a. 90716  
      b. 90396, 90471  
      c. 90396, 90772  
      d. 90716, 90772

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**Appendix E: Mock CPC Examination**

Page 579  
113. A 54-year-old patient underwent an annual physical examination, which was performed by his primary care physician.

   a. 99362 99213  
   b. 99386  
   c. 99396  
   d. 99412
Multiple Choice
Question: Insertion of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator, a garment-type automatic external defibrillator with integrated electrocardiogram analysis.

Correct Answer: G0300 K0606
Feedback: Correct! Code G0300 K0606 is reported.
Incorrect Answer: G0297 K0607
Feedback, 1st try: Incorrect. Code G0297 K0607 classifies “Insertion of single chamber pacing cardioverter defibrillator pulse generator” a replacement battery for a garment-type automated external defibrillator. Try again.
Feedback, 2nd try: Code G0300 K0606 is reported.
Incorrect Answer: G0298 K0608
Feedback, 2nd try: Code G0300 K0606 is reported.
Incorrect Answer: G0299 K0609
Feedback, 1st try: Incorrect. Code G0299 classifies “Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator,” replacement electrodes for use with an automated external defibrillator. Try again.
Feedback, 2nd try: Code G0300 K0606 is reported.

Fill-in-the-Blank
Question: Assign E/M code(s) to the following: A patient, who had been taking a prescribed medication for the past 2 weeks, was concerned about side effects she was experiencing with a prescription medication she was taking. She spoke with her physician on the phone to describing her symptoms. The physician decided to change her medication, and he told advised her that he would call in a new prescription to her pharmacy and she was to schedule an appointment to see him 7 days from today. The medical discussion between patient and physician via telephone was 12 minutes in duration.

Correct Answer: 99372 99442
Feedback: Code 99372 99442 is reported.
Incorrect Answers:
Feedback, 1st try: This telephone service provided was 12 minutes in duration is an intermediate service.
Feedback, 2nd try: Code 99372 99442 is reported.

True/False
Question: When anesthesia services for myelography and diskography percutaneous image-guided spine and spinal cord procedures are provided, report code 01905 01935-01936 instead of 00600.

Correct Answer: True
Feedback: When anesthesia services for myelography and diskography percutaneous image-guided spine and spinal cord procedures are provided, report code 01905 01935-01936 instead of 00600.

Multiple Choice
Question: Tube thoracostomy with water seal, for hemothorax.

Correct Answer: 32020 32551
Feedback: Correct! Code 32020 32551 is reported.
Incorrect Answer: 32035
Feedback, 1st try: This is not the correct code. Try again.
Feedback, 2nd try: Code 32020 32551 is reported.
Chapter 14

Multiple Choice Question: Intracatheter aspiration of bladder.
Correct Answer: 51005 51101
Feedback: Correct! Code 51005 51101 is reported.
Incorrect Answer: 51000 51100
Feedback, 1st try: This is not the correct code. Try again.
Feedback, 2nd try: Code 51005 51101 is reported.
Incorrect Answer: 51010 51102
Feedback, 1st try: This is not the correct code. Try again.
Feedback, 2nd try: Code 51005 51101 is reported.
Incorrect Answer: 51700
Feedback, 1st try: This is not the correct code. Try again.
Feedback, 2nd try: Code 51005 51101 is reported.

StudyWare Coding Cases

StudyWare Coding Cases
Outpatient - Emergency Department (Respiratory)
Case 2

Art: [Figure 2]
Art Caption: Pneumothorax

Narrative:

Patient Name: Jason DuPonte
Diagnosis: Spontaneous pneumothorax
Procedures: Tube thoracostomy, chest x-ray

A 40-year-old male arrived in the emergency department by ambulance. He complained of a sudden onset of sharp chest pain, dyspnea, and dry hacking cough. Physical findings during the comprehensive history and exam included tympany on percussion, diminished tactile fremitus, and diminished motion on the left side of chest. A complete chest x-ray showed a collapsed left lung with mediastinum shift to the right. The patient was diagnosed with spontaneous pneumothorax. Tube thoracostomy was performed with water-sealed drainage to permit egress of air from pleura, but not permitting air to enter the space. Vital signs, responses and pain assessment were checked and recorded regularly. The patient was stabilized within one hour, and he remained in the ED awaiting consultation with the on-call surgeon for possible inpatient admission. Medical decision making was of high complexity.

Instructions: Assign ICD and CPT codes for this case.

ICD Correct Answers: 512.8
ICD Correct Feedback: That is correct!
ICD General Wrong Feedback: That is incorrect. Assign 512.8 for spontaneous pneumothorax.

CPT Correct Answers: 99285, 32020 32551-LT, 71030
CPT Correct Feedback: That is correct!
CPT General Wrong Feedback: That is incorrect. Assign 99285 for E/M services, 32020 32551-LT for the tube thoracostomy, and 71030 for complete chest x-ray.