## CHAPTER 1 Health Insurance Specialist Career

### ANSWERS TO REVIEW

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

## CHAPTER 2 Introduction to Health Insurance

### ANSWERS TO REVIEW

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

## CHAPTER 3 Managed Health Care

### ANSWERS TO REVIEW

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

## CHAPTER 4 Processing an Insurance Claim

### ANSWERS TO REVIEW

1. b  
2. d  
3. d  
4. a  
5. a  
6. b  
7. d  
8. b  
9. b  
10. c  
11. c  
12. d
CHAPTER 5 Legal and Regulatory Issues


ANSWERS TO REVIEW

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

CHAPTER 6 ICD-9-CM Coding

ANSWERS TO ICD-9-CM CODING EXERCISES

(The underlined word is the condition found in the Index to Diseases.)

EXERCISE 6-1 Finding the Condition in the Index to Diseases

1. Bronchiole spasm 519.11
2. Congenital candidiasis (age 3) 771.7

NOTE: Code 771.7 is assigned during the first 28 days of the patient's life, and code 112.9 is assigned if the patient is older than 28 days. (This exercise does not indicate the patient's age. Therefore, either code is acceptable. In practice, review the medical record to determine the patient's age to assign the correct code.)

3. Irritable bladder 596.8
4. Earthquake injury E909.0
(No site mentioned. See Injury in Index to External Causes)
5. Exposure to AIDS V01.79
6. Ground itch 126.9
7. Nun's knees 727.2
8. Mice in right knee joint 717.6
9. Contact dermatitis 692.9
10. Ascending neuritis 355.2

EXERCISE 6-2 Working with Coding Conventions (Index to Diseases)

1. Acute purulent sinusitis 461.9 - (purulent) is a nonessential modifier
2. Fracture, mandible 802.20 - (closed) is a nonessential modifier
3. Actinomycotic meningitis 039.8, 320.7 - sequence bracketed code second
4. Psychomotor akinetic epilepsy 345.40 - requires fifth digit

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5. 3 cm laceration, right forearm 881.00 - See also wound, open
6. Contusion, abdomen 868.00 - NEC
7. Pneumonia due to H. influenzae 482.2 - H. influenzae is an essential modifier
8. Delayed healing, open wound, abdomen 879.3 - Boxed Note describes “delayed healing” as “complicated”
9. Bile duct cicatrix 576.8 “Trust the Index.”
10. Uncontrolled type II diabetes mellitus with osteomyelitis 250.82, 731.8 - Bracketed code

EXERCISE 6-3 Confirming Codes in the Tabular List of Diseases

1. 515 Postinflammatory pulmonary fibrosis C
2. 250.0 Type II diabetes E (250.00)
3. 727.67 Nontraumatic rupture of Achilles tendon C
4. 422.0 Acute myocarditis due to Coxsackie virus E (074.23)
5. 813.22 Malunion, closed right radial fracture E (733.81)
6. 483.0 Mycoplasmic pneumonia C
7. 795.71 Positive HIV test, asymptomatic E (V08)
8. 796.2 Elevated blood pressure C
9. 718.06 Old tear of right knee meniscus E (717.5)
10. 383.1 Tuberculous mastoiditis E (015.60)

EXERCISE 6-4 Working with Tabular List of Diseases Coding Conventions

1. Pregnancy complicated by chronic gonorrhea; chronic gonococcal endometritis 647.10 - fifth digit required
   098.36 - Use additional code
2. Benign neoplasm, ear cartilage 215.0 - ear cartilage is not excluded
3. Cervicitis, tuberculous 016.70 - Includes
4. Uncontrolled type II diabetes with polyneuropathy 357.2 - Use additional code
5. Congenital hemangioma on face 228.01 - Site is skin. Includes
6. Hiss-Russell shigellosis 004.1 - “Trust the Index.”
7. Closed fracture, right leg 827.0 - NOS
8. Diabetic cataract 250.50, 366.41 - Use additional code
9. Muscular atrophy, left leg 728.2 - NEC
10. Chronic smoker’s bronchitis with acute bronchitis 491.0 - Includes (the underlying chronic condition)

EXERCISE 6-5 Hypertension/Hypertensive Coding

1. Essential hypertension 401.9
2. Transient hypertension due to pregnancy 642.30 (episode of care is not stated)
3. Malignant hypertensive crisis 401.0
4. Heart disease with hypertension 402.90
5. Orthostatic hypertension, benign 401.1

EXERCISE 6-6 Neoplasm Coding I

1. Kaposi’s sarcoma 176.9
2. Lipoma, skin, upper back 214.1
3. Carcinoma in situ, skin, left cheek 232.3
4. Scrotum mass 608.89
5. Neurofibroma  215.9
6. Cyst on left ovary  620.2
7. Ganglion right wrist  727.41
8. Yaws, frambesia  102.2
9. Breast, chronic cystic disease  610.1
10. Hürthle cell tumor  226

EXERCISE 6-7  Neoplasm Coding II

1. Ca (carcinoma) of the lung  162.9
2. Metastasis from the lung (Neoplasms table)  162.9 (lung is primary), 199.1 (unknown secondary site)
3. Abdominal mass  789.30
4. Carcinoma of the breast (female) with metastasis to the axillary lymph nodes  174.9, 196.3

NOTE: The breast does not contain neuroendocrine cells, which means code 209.71 is not assigned. Neuroendocrine tumors arise in organs that contain specialized nerve cells that produce hormones, such as the pancreas.

5. Carcinoma of axillary lymph nodes and lungs, metastatic from the breast (female)  174.9 (breast is primary) 196.3, 197.0 (secondary sites)

EXERCISE 6-8  Using the Table of Drugs and Chemicals

1. Adverse reaction to pertussis vaccine (Table of Drugs and Chemicals, Therapeutic)  995.29 (unspecified adverse effect)  E948.6 (therapeutic use)
2. Cardiac arrhythmia caused by interaction between prescribed ephedrine and unprescribed alcohol (Table of Drugs and Chemicals, Poisoning)  971.2 (poisoning, ephedrine), 980.0 (poisoning, alcohol), 427.9 (arrhythmia), E980.4, E980.9 (undetermined external cause)
3. Stupor, due to overdose on Nytol (suicide attempt) (Table of Drugs and Chemicals, Poisoning, Suicide)  963.0 (poisoning, Nytol), 780.09 (stupor), E950.4 (suicide attempt)
4. High blood pressure due to prescribed Albuterol  401.9 (hypertension)  E945.7 (therapeutic use)
5. Rash due to combining prescribed Amoxicillin with nonprescribed Benadryl  960.0 (poisoning, Amoxicillin)  963.0 (poisoning, Benadryl)  E980.4 (undetermined external cause)  693.0 (rash)

EXERCISE 6-9  Exploring V Codes

1. Family history of epilepsy with no evidence of seizures  V17.2
2. Six-week postpartum checkup  V24.2
3. Premarital physical (examination, marriage)  V70.3
4. Consult with dietitian for patient with diabetes mellitus  V65.3, 250.00
5. Rubella screening  V73.3
EXERCISE 6-10 Coding HIV/AIDS and Fracture Cases
1. Patient is HIV-positive with no symptoms V08
2. AIDS patient treated for candidiasis 042, 112.9
3. Open fracture, maxilla 802.5
4. Greenstick fracture, third digit, right foot 826.0
5. Multiple fractures, right femur, distal end 821.29

EXERCISE 6-11 Coding Late Effects and Burns
1. Malunion due to fracture, right ankle, 9 months ago 733.81, 905.4 (Late Effect)
2. Brain damage due to subdural hematoma, 18 months previously 348.9, 438.9 (nontraumatic) or 907.0 (traumatic) (depending on documentation)
3. Second-degree burn, anterior chest wall 942.22, 948.00 (extent of body surface burned is 9 percent)
4. Scalding with erythema, right forearm and hand 943.11, 944.10, 948.00
5. Third-degree burn, back, 18 percent body surface 942.34, 948.11

EXERCISE 6-12 Coding External Cause of Injury
1. Automobile accident, highway, passenger E819.1 (Accident, motor vehicle)
2. Worker injured by fall from ladder E881.0 (fall from ladder), E849.9 (unspecified place)
3. Accidental drowning, fell from power boat located on lake 994.1 (drowning), E832.1 (fall from boat), E849.8 (other specified place)
4. Soft tissue injury, right arm, due to snowmobile accident in patient’s yard 884.0, E820.9 (Accident, snow vehicle) and E849.0 (home)
5. Fall from playground equipment E884.0 (fall), E849.4 (playground)

ANSWERS TO REVIEW
Infectious and Parasitic Diseases (including HIV)
1. Aseptic meningitis due to AIDS 042, 047.8
2. Asymptomatic HIV infection V08
3. Septicemia due to streptococcus 038.0
4. Dermatophytosis of the foot 110.4
5. Measles; no complications noted 055.9
6. Nodular pulmonary tuberculosis; confirmed histologically 011.15
7. Acute cystitis due to E. coli (infection) 595.0, 041.4
8. Tuberculosis osteomyelitis of lower leg, confirmed by histology 015.55, 730.86
9. Gas gangrene 040.0

Neoplasms
10. Malignant melanoma of skin of scalp 172.4
11. Lipoma of face 214.0
12. Glioma of the parietal lobe of the brain (Neoplasm, brain, malignant, primary) 191.3

NOTE: Reference the ICD-9-CM Index to Diseases, and locate the condition documented in the diagnostic statement (e.g., melanoma). Then, follow the instructions to appropriately code each case (e.g., see also Neoplasm by site, malignant).
13. Adenocarcinoma of prostate (Neoplasm, prostate, malignant, primary) 185
14. Carcinoma in situ of vocal cord (Neoplasm, vocal cord, malignant, carcinoma in situ) 231.0
15. Hodgkin’s granuloma of intra-abdominal lymph nodes and spleen 201.18

NOTE: One code is reported when multiple sites are positive for Hodgkin’s.

16. Paget’s disease with infiltrating duct carcinoma of breast, nipple, and areola (Neoplasm, breast, malignant, primary) 174.8
17. Liver cancer (Neoplasm, liver, malignant) 155.2

NOTE: One code is reported when multiple regions of the same organ are positive for cancer.

18. Metastatic adenocarcinoma from breast to brain (right mastectomy performed five years ago) (Neoplasm, breast, malignant, primary, and Neoplasm, brain, malignant, secondary) 174.9, 198.3 (in this order)
19. Cancer of the pleura (primary site) (Neoplasm, pleura, malignant, primary) 163.9

Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders

20. Cushing’s Syndrome 255.0
21. Hypokalemia 276.8
22. Type II diabetes mellitus, uncontrolled, with malnutrition 250.02, 263.9
23. Hypogammaglobulinemia 279.00
24. Hypercholesterolemia 272.0
25. Nephrosis due to type II diabetes 250.40, 581.81
26. Toxic diffuse goiter with thyrotoxic crisis 242.01
27. Cystic fibrosis 277.00
28. Panhypopituitarism 253.2
29. Rickets 268.0

Diseases of the Blood and Blood-forming Organs

30. Sickle cell disease with crisis 282.62
31. Iron deficiency anemia secondary to blood loss 280.0
32. Von Willebrand’s disease 286.4
33. Chronic congestive splenomegaly 289.51
34. Congenital nonspherocytic hemolytic anemia 282.3
35. Essential thrombocytopenia 287.30
36. Malignant neutropenia 288.09
37. Fanconi’s anemia 284.09
38. Microangiopathic hemolytic anemia 283.19
39. Aplastic anemia secondary to antineoplastic medication for breast cancer 174.9, E933.1

Mental Disorders

40. Acute exacerbation of chronic undifferentiated schizophrenia 295.64
41. Reactive depressive psychosis due to the death of a child 298.0
42. Hysterical neurosis 300.10
43. Anxiety reaction manifested by fainting (do not code fainting because it is a symptom) 300.00
44. Alcoholic gastritis due to chronic alcoholism (episodic) 535.30, 303.92
45. Juvenile delinquency: patient was caught shoplifting 312.9
46. Depression 311
47. Hypochondria; patient also has continuous laxative habit 300.7, 305.91
48. Acute senile dementia with Alzheimer’s disease (in this order) 331.0, 294.10
49. Epileptic psychosis with generalized grand mal epilepsy 294.8, 345.10

Diseases of the Nervous System and Sense Organs

50. Neisseria meningitis 036.0
51. Intracranial abscess 324.0
52. Postvaricella encephalitis 052.0
53. Hemiplegia due to old CVA 438.20

**NOTE:** 342.9x is assigned to hemiplegia if not associated with old CVA.

54. Encephalitis 323.9
55. Retinal detachment with retinal defect 361.00
56. Congenital diplegic cerebral palsy 343.0
57. Tonic-clonic epilepsy 345.10
58. Infantile glaucoma 365.14
59. Mature cataract 366.9

Diseases of the Circulatory System

60. Congestive rheumatic heart failure 398.91
61. Mitral valve stenosis with aortic valve insufficiency 396.1
62. Acute rheumatic heart disease 391.9
63. Hypertensive cardiovascular disease, malignant 402.00
64. Congestive heart failure; benign hypertension 428.0, 401.1
65. Secondary benign hypertension; stenosis of renal artery 405.11, 440.1
66. Malignant hypertensive nephropathy with uremia (Uremia is renal failure, code 586, which is not assigned because it is included in 403.01) 403.01
67. Acute renal failure; essential hypertension (no cause-and-effect relationship between the renal failure and hypertension; therefore, two codes are reported) 584.9, 401.9
68. Acute myocardial infarction of inferolateral wall, initial episode of care 410.21
69. Arteriosclerotic heart disease (native coronary artery) with angina pectoris 414.01, 413.9

Diseases of the Respiratory System

70. Aspiration pneumonia due to regurgitated food 507.0
71. Streptococcal Group B pneumonia 482.32
72. Respiratory failure due to myasthenia gravis (in this order) 518.81, 358.00
73. Intrinsic asthma in status asthmaticus 493.11
74. COPD with emphysema (do not assign 496; see note at code 496 in ICD-9-CM Tabular List) 492.8

Diseases of the Digestive System

75. Supernumerary tooth 520.1
76. Unilateral femoral hernia with gangrene 551.00
77. Cholesterosis of gallbladder 575.6
78. Diarrhea 787.91
79. Acute perforated peptic ulcer 533.10
80. Acute hemorrhagic gastritis with acute blood loss anemia 535.01, 285.1
81. Acute appendicitis with perforation and peritoneal abscess 540.1
82. Acute cholecystitis with cholelithiasis 574.00
83. Aphthous stomatitis 528.2
84. Diverticulosis and diverticulitis of colon 562.11
85. Esophageal reflux with esophagitis 530.11

Diseases of the Genitourinary System

86. Vesicoureteral reflux with bilateral reflux nephropathy 593.72
87. Acute glomerulonephritis with necrotizing glomerulitis 580.4
88. Actinomycotic cystitis 039.8, 595.4 (in this order)
89. Subserosal uterine leiomyoma, cervical polyp, and endometriosis of uterus 218.2, 622.7, 617.0
90. Dysplasia of the cervix 622.10

Diseases of Pregnancy, Childbirth, and the Puerperium

91. Defibrination syndrome following termination of pregnancy (TOP) procedure two weeks ago (see Excludes note at 286.6 regarding TOP procedure) 639.1
92. Miscarriage at 19 weeks gestation 634.90
93. Incompetent cervix resulting in miscarriage and fetal death 634.91, 654.53
94. Postpartum varicose veins of legs 671.04
95. Spontaneous breech delivery 652.21, V27.9
96. Triplet pregnancy, delivered spontaneously 651.11, V27.9
97. Retained placenta without hemorrhage, delivery this admission 667.02
98. Pyrexia of unknown origin during the puerperium (postpartum), delivery during previous admission 672.04
99. Late vomiting of pregnancy, undelivered 643.23
100. Pre-eclampsia complicating pregnancy, delivered this admission 642.41, V27.9

Diseases of the Skin and Subcutaneous Tissue

101. Diaper rash 691.0
102. Acne vulgaris 706.1
103. Post-infectious skin cicatrix 709.2
104. Cellulitis of the foot; culture reveals staphylococcus 682.7, 041.10
105. Infected ingrowing nail 703.0

Diseases of the Musculoskeletal System and Connective Tissue

106. Displacement of thoracic intervertebral disc 722.11
107. Primary localized osteoarthritis of the hip 715.15
108. Acute juvenile rheumatoid arthritis 714.31
109. Chondromalacia of the patella 717.7
110. Pathologic fracture of the vertebra due to metastatic carcinoma of the bone from the lung 733.13, 198.5, 162.9

NOTE: The lung does not contain neuroendocrine cells, which means code 209.73 is not assigned. Neuroendocrine tumors arise in organs that contain specialized nerve cells that produce hormones, such as the pancreas.
Congenital Anomalies

111. Congenital diaphragmatic hernia 756.6
112. Single liveborn male (born in the hospital) with polydactyly of fingers (newborn) V30.00, 779.89, 755.01
113. Unilateral cleft lip and palate 749.22
114. Patent ductus arteriosus 747.0
115. Congenital talipes equinovarus 754.69

Certain Conditions Originating in the Perinatal Period

116. Erythroblastosis fetalis 773.2
117. Hyperbilirubinemia of prematurity, prematurity (birthweight 2,000 grams) 774.2, 765.18
118. Erb's palsy 767.6
119. Hypoglycemia in infant with diabetic mother 775.0
120. Premature “crack” baby born in hospital to cocaine-dependent mother (birthweight 1,247 grams) 765.14, 760.75, 779.5, 304.20

Symptoms, Signs, and Ill-defined Conditions

121. Abnormal cervical Pap smear 795.00
122. Sudden infant death syndrome 798.0
123. Sleep apnea with insomnia 780.51
124. Fluid retention and edema (edema is coded because of Excludes note associated with 276.6) 276.6, 782.3
125. Elevated blood pressure reading 796.2

Injury and Poisoning

Fractures, Dislocations, and Sprains

126. Open frontal fracture with subarachnoid hemorrhage with brief loss of consciousness 800.72
127. Supracondylar fracture of right humerus and fracture of olecranon process of the right ulna 812.41, 813.01
128. Anterior dislocation of the elbow 832.01
129. Dislocation of the first and second cervical vertebrae 839.08
130. Sprain of lateral collateral ligament of knee 844.0

Open Wounds and Other Trauma

131. Avulsion of eye 871.3
132. Traumatic below-the-knee amputation with delayed healing 897.1
133. Open wound of buttock 877.0
134. Open wound of wrist involving tendons 881.22
135. Laceration of external ear 872.00
136. Traumatic subdural hemorrhage with open intracranial wound; loss of consciousness, 30 minutes 852.32
137. Concussion without loss of consciousness 850.0
138. Traumatic laceration of the liver, moderate 864.03
139. Traumatic hemothorax with open wound into thorax and concussion with loss of consciousness 860.3, 850.5
140. Traumatic duodenal injury (internal) 863.21
Burns

141. Third-degree burn of lower leg and second-degree burn of thigh 945.34, 945.26, 946.11

142. Deep third-degree burn of forearm 943.41, 948.00

143. Third-degree burns of back involving 20 percent of body surface 942.34, 948.22

144. Thirty percent body burns with 10 percent third-degree 948.31

145. First- and second-degree burns of palm 944.25, 948.00

Foreign Bodies

146. Coin in the bronchus with bronchoscopy for removal of the coin (foreign body, entering through orifice) 934.1

147. Foreign body in the eye (entering through orifice) 930.9

148. Marble in colon (foreign body, entering through orifice) 936

149. Bean in nose (foreign body, entering through orifice) 932

150. Q-tip stuck in ear (foreign body, entering through orifice) 931

Complications

151. Infected ventriculoperitoneal shunt (Complication, infection, ventricular shunt) 996.63

152. Displaced breast prosthesis (Complication, mechanical, implant, prosthetic, in breast) 996.54

153. Leakage of mitral valve prosthesis (Complication, mechanical, heart valve prosthesis) 996.02

154. Postoperative superficial thrombophlebitis of the right leg 997.2, 451.0

155. Dislocated hip prosthesis (Complication, orthopedic device, internal, mechanical) 996.42

V Codes

156. Exposure to tuberculosis V01.1

157. Family history of colon carcinoma V16.0

158. Status (post) unilateral kidney transplant, human donor V59.4

159. Encounter for removal of cast (plaster cast) V54.89

160. Admitted to donate bone marrow (donor) V59.3

161. Encounter for chemotherapy for patient with Hodgkin’s lymphoma V58.11, 201.90

162. Reprogramming of cardiac pacemaker V53.31

163. Replacement of tracheostomy tube (Attention to) V55.0

164. Encounter for renal dialysis for patient in chronic renal failure V56.0, 585.9

165. Encounter for speech therapy for patient with dysphasia secondary to an old CVA (late effect) V57.3, 438.12

166. Encounter for fitting of artificial leg V52.1

167. Encounter for observation of suspected malignant neoplasm of the cervix V71.1

168. Visit to radiology department for barium swallow; abdominal pain; barium swallow performed and the findings are negative V71.0

169. Follow-up examination of colon adenocarcinoma resected one year ago, no recurrence found (history, personal, of) V67.09, V10.05

170. Routine general medical examination V70.0

171. Examination of eyes V72.0

172. Encounter for laboratory test; patient complains of fatigue 780.79

NOTE: Do not report code V72.6 because the symptom, fatigue, is documented as the reason for laboratory testing.
173. Encounter for physical therapy; status post below-the-knee amputation six months ago
174. Kidney donor
175. Encounter for chemotherapy; breast carcinoma (ICD-9-CM code V58.11 was added in 2006.)

Coding Late Effects

X 176. Hemiplegia due to previous cerebrovascular accident
X 177. Malunion of fracture, right femur
X 178. Scoliosis due to infantile paralysis
X 179. Keloid secondary to injury nine months ago
180. Gangrene, left foot, following third-degree burn of foot two weeks ago
181. Cerebral thrombosis with hemiplegia
X 182. Mental retardation due to previous viral encephalitis
183. Laceration of tendon of finger two weeks ago. Admitted now for tendon repair

NOTE: Refer first to the ICD-9-CM Index to Diseases main term, Late (effect), for each diagnosis below. When the sequela (residual or resulting problem) is documented, report that code first followed by the late effect code.

184. Residuals of poliomyelitis 138
185. Sequela of old crush injury to left foot 906.4
186. Cerebrovascular accident two years ago with late effects 438.9
187. Effects of old gunshot wound, left thigh 906.1
188. Disuse osteoporosis due to previous poliomyelitis 733.03, 138
189. Brain damage following cerebral abscess seven months ago 348.9, 326
190. Hemiplegia due to old cerebrovascular accident 438.20

NOTE: Adverse reactions occur when patients take a prescribed medication, and a reaction develops. The first code reported is the adverse reaction (e.g., rash), and subsequent code(s) report the drug(s) taken, located in the Therapeutic Use column of the Table of Drugs and Chemicals. Poisonings occur when patients take a nonprescribed medication or combine prescribed with nonprescribed medications or drugs/alcohol. The first code reported is the poisoning code located in the first column of the Table of Drugs and Chemicals, and subsequent code(s) report the drug(s) and/or substance(s) (e.g., alcohol) (E-codes from the remaining columns in the Table of Drugs and Chemicals).

191. Ataxia due to interaction between prescribed carbamazepine and erythromycin (Adverse Reaction) 781.3, E936.3, E930.3
192. Vertigo as a result of dye administered for a scheduled IVP (Adverse Reaction) 780.4, E947.8
193. Accidental ingestion of mother’s oral contraceptives (no signs or symptoms resulted) (Poisoning) 962.2, E858.0
194. Hemiplegia; patient had an adverse reaction to prescribed Enovid one year ago (Late Effect of Adverse Reaction) 342.90, 909.5, E932.2
195. Stricture of esophagus due to accidental lye ingestion three years ago (Late Effect of Adverse Reaction) 530.3, 909.1, E929.2
196. Listlessness resulting from reaction between prescribed Valium and ingestion of a six-pack of beer (Poisoning) 969.4, 980.0, 780.79, E980.9, E980.3
197. Lead poisoning (child had been discovered eating paint chips) (Poisoning) 984.0, E980.9
198. Allergic reaction to unspecified drug (Adverse Reaction) 995.20, E935.9
199. Theophylline toxicity (Adverse Reaction) 995.29, E944.1
200. Carbon monoxide poisoning from car exhaust (suicide attempt) (Poisoning) 986, E952.0
CHAPTER 7  CPT Coding

ANSWERS TO CPT CODING EXERCISES

EXERCISE 7-1  Working with CPT Symbols and Conventions

NOTE: The underlined words indicate key terms in the index. Words in parentheses are word substitutions to help you locate the procedure/service in the index, and they provide explanations of special coding situations.

1.  F  The major sections of CPT are evaluation and management, anesthesia, surgery, pathology and laboratory, radiology, and medicine.
2.  F  The triangle indicates a code description revision.
3.  F  CPT requires a two-digit modifier to be attached to the five-digit CPT code.
4.  T  “Notes” should be applied to all codes located under a heading.
5.  T  Semicolons save space in CPT where a series of related codes are found.
6.  F  Qualifiers may appear in the main and subordinate clauses.
7.  F  Parenthetical statements beginning with “eg” provide examples of terms that may be included in the healthcare provider’s documentation of services/procedures performed.
8.  T  Horizontal triangles (\(\textbullet\)) are found in revised guidelines, notes, and procedure descriptions.
9.  T  The bullet (*) located to the left of a CPT code indicates a code new to that edition of CPT.
10.  F  Code 50620 would be reported for a ureterolithotomy performed on the middle one-third of the ureter.

EXERCISE 7-2  Working with the CPT Index

1. Marsupialization means creating a pouch to exteriorize a cyst.
2. 47350 Management of liver hemorrhage; simple suture of liver wound or injury
    47360 complex suture of liver wound or injury, with or without hepatic artery ligation
    47361 exploration of hepatic wound, extensive debridement, coagulation and/or suture, without packing of liver
    47362 re-exploration of hepatic wound for removal of packing
3.  T
4.  F  Main terms appear in boldface in the CPT index.
5.  F  Inferred words do not appear in the CPT index.

EXERCISE 7-3  Assigning CPT Modifiers

1. Assistant surgeon reporting patient’s cesarean section, delivery only. –80
2. Cholecystectomy reported during postoperative period for treatment of leg fracture. –79
3. Treatment for chronic conditions at same time preventive medicine is provided. –25
4. Inpatient visit performed by surgeon, with decision to perform surgery tomorrow. –57
5. Office consultation as preoperative clearance for surgery. –56
6. Postoperative management of vaginal hysterectomy. –55
7. Repeat gallbladder x-ray series, same physician. –76
8. Arthroscopy of right elbow and closed fracture reduction of left wrist. –51
9. Needle core biopsy of right and left breast. –50
10. Consultation required by payer. –32
EXERCISE 7-4 Finding Procedures in the Index

1. Closed treatment of wrist dislocation 25660, 25675, 25680
2. Dilation of cervix (See Dilation and Curettage) 57558, 57800
3. Placement of upper GI feeding tube (Placement, Nasogastric Tube) 43752
4. Radiograph and fluoroscopy of chest, four views (See Radiology, Diagnostic; x-ray) x-ray, Chest, Complete (Four Views), with Fluoroscopy 71034
5. Magnetic resonance imaging (MRI), lower spine 72148-72158
6. Darrach procedure (See Excision, Ulna, Partial) 25150-25151, 25240
7. Manual CBC (See Blood Cell Count, Complete Blood Count [CBC]) 85027
8. Electrosurgical removal, skin tags 11200-11201
9. Molar pregnancy excision (See Hydatidiform Mole) 59100
10. Muscle denervation, hip joint 27035

EXERCISE 7-5 Evaluation and Management Section

1. Home visit, problem focused, established patient 99347
2. ED service, new patient, low complexity (Emergency Department Services) 99282
3. Hospital care, new patient, initial, high complexity 99223
4. Hospital care, subsequent, detailed 99233
5. ED care, problem focused, counseling 15 minutes. (Emergency Department Services) 99281
6. Patient requested consultation, new patient, moderate complexity 99244
7. Office consultation, high complexity, established patient, surgery scheduled tomorrow 99245
8. Follow-up consultation, office, problem focused, counseling 15 minutes, encounter was 25 minutes. (There is no follow-up outpatient consult; use Est. Office Visit. Counseling becomes the key factor, selection is based on time.) 99214
9. Follow-up consultation, inpatient, detailed, 35 minutes 99253
10. Blood pressure check by nurse (established patient). (Office and/or Other Outpatient Services) 99211
11. New patient, routine preventive medicine, age 11. Risk factor discussion, 20 minutes 99383
12. Critical care, 1.5 hours (Critical Care Services) 99291, 99292
13. Nursing facility visit, subsequent visit, expanded problem focused H&PE 99308
14. Medical team conference, 50 minutes, nurse practitioner and discharge planner 99368
15. Follow-up visit, ICU patient, stable, expanded problem focused H&PE (Patient is stable, use subsequent inpatient category.) 99232
16. Resuscitation of newborn in delivery room 99465
17. Telephone E/M service by physician to established patient, 10 minutes 99441
18. Custodial care, established patient, detailed H&PE, high complexity (CPT code 99336 was added in 2006.) 99336
19. Pediatrician on standby, high-risk birth, 65 minutes 99360, 99360
20. Heart risk factor education, group counseling, asymptomatic attendees, 65 minutes (Preventive Medicine) 99412

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EXERCISE 7-6 Anesthesia Section

1. Anesthesiologist provided anesthesia services to a 77-year-old female patient who received a corneal transplant. The patient has a history of prior stroke.

2. Anesthesiologist provided anesthesia services to a 50-year-old diabetic patient who underwent direct coronary artery bypass grafting.

3. Anesthesiologist provided anesthesia services for hernia repair in the lower abdomen of an otherwise healthy 9-month-old infant.

4. CRNA provided anesthesia services under physician direction during an extensive procedure on the cervical spine of an otherwise healthy patient.

5. CRNA provided anesthesia services to a morbidly obese female patient who underwent repair of malunion, humerus.

EXERCISE 7-7 Working with the Surgical Package

1. Incision and drainage (I&D), finger abscess
2. Percutaneous I&D, abscess, appendix
3. Therapeutic agent injection, L-5 paravertebral nerve, with image guidance
4. Laparoscopic cholecystectomy with cholangiography
5. Flexible esophagoscopy with removal of foreign body and radiologic supervision and interpretation (S&I) (Esophagus, Endoscopy, Removal, Foreign Body or Endoscopy, Esophagus, Removal, Foreign Body. See parenthetical note below 43215 for second code.)

EXERCISE 7-8 Coding Separate and Multiple Procedures

1. Diagnostic arthroscopy, right wrist, with synovial biopsy
2. Simple vaginal mucosal biopsy
3. Diagnostic nasal endoscopy, bilateral, and facial chemical peel
4. Diagnostic thoracoscopy, lungs and pleural space, with right lung biopsy
5. Needle biopsy of testis
6. Total abdominal hysterectomy with removal of ovaries and anterior colporrhaphy
7. Laparoscopic appendectomy and lumbar hernia repair
8. Biopsy of larynx (indirect) via laryngoscopy and laryngoplasty
9. Excision of chest wall lesion with removal of ribs and plastic reconstruction
10. Partial-thickness facial skin debridement and full-thickness leg skin debridement

EXERCISE 7-9 Radiology Coding

1. GI series (x-ray), with small bowel and air studies, without KUB
2. Chest x-ray, PA & left lateral
3. Cervical spine x-ray, complete, with flexion and extension (spine)
4. X-ray pelvis, AP
5. Abdomen, flat plate, AP (x-ray)
6. BE, colon, with air (x-ray colon)
7. Postoperative radiologic supervision and interpretation of cholangiography by radiologist
8. Bilateral screening mammography
9. Retrograde pyelography with KUB (Urography) via cystourethroscopy
10. SPECT liver imaging
EXERCISE 7-10 Pathology and Laboratory Coding

1. Hepatic function panel 80076
2. Hepatitis panel 80074
3. TB skin test, PPD 86580
4. UA (Urinalysis) by dip stick with micro, automated 81001
5. WBC count with Diff, automated 85004
6. Stool for occult blood 82272
7. Wet mount, vaginal smear 87210
8. Glucose/blood sugar, quantitative 82947
9. Sedimentation rate, automated 85652
10. Throat culture, bacterial 87070
11. Urine sensitivity, disk 87184
12. Microhematocrit blood count, spun (Blood Cell Count) 85013
13. Monospot test 86308
14. Strep test, group A, rapid (Streptococcus, Group A, Direct Optical Observation) 87880

NOTE: Identifying the correct CPT code for “strep” testing performed in an office setting often causes confusion. CPT code 87880 is reported for all immunologically based commercial Streptococcus Group A testing kits where the interpretation relies on a visual reaction that is observed by the naked eye.

15. One-year storage of sperm 89343

EXERCISE 7-11 Medicine Section

1. Cardiac catheterization, right side only, with conscious sedation, IV (Catheter, Cardiac, Right Heart) 93501
2. Routine EKG, tracing only 93005
3. Spirometry 94010
4. CPR, in office 92950
5. Diagnostic psychiatric examination 90801
6. Influenza vaccine, age 18 months 90471, 90657
7. Whirlpool and paraffin bath therapy 97022, 97018-51
8. WAIS-R and MMPI psychological tests and report, 1 hour (Psychiatric Diagnosis, Psychological Testing) 96101
9. Office services on emergency basis (Office Medical Service) 99058
10. Physical therapy evaluation (and management) 97001

ANSWERS TO REVIEW

NOTE: Observation services are coded from either the (1) Hospital Observation Services subsection/category of E/M or (2) Observation or Inpatient Care Services (Including Admission and Discharge Services) subsection/category in the Hospital Inpatient Services subsection/category. Designating a patient as receiving observation services has caused a great deal of confusion among providers and coders.

Observation services are furnished by a hospital on its premises and include the use of a bed and periodic monitoring by the hospital’s nursing or other staff as reasonable and necessary to evaluate an outpatient’s condition or to determine the need for possible admission to the hospital as an inpatient. Observation services are classified as acute care services, and usually do not exceed one day (24 hours). Coverage for observation services is limited to no more than 48 hours, unless the third-party payer approves an exception. An inpatient admission ordered only because the patient is expected to remain in observation overnight is not considered medically necessary (and would not be reimbursed).

Inpatient services are furnished when a hospital inpatient is formally admitted, as with the expectation of an overnight stay, and the severity of illness or intensity of services to be provided warrants hospital inpatient level of care.
Evaluation and Management Section

1. Office or Other Outpatient Services (refer to notes below the Office or Other Outpatient Services category).
2. FALSE.
3. Hospital Inpatient Services (refer to notes below the Hospital Inpatient Services category).
4. Consultation (refer to notes below the Consultations category).
5. FALSE (refer to the note below the Consultations category).
6. FALSE (refer to notes below the Office or Other Outpatient Consultations subcategory).
7. TRUE (refer to notes below the Initial Inpatient Consultations subcategory).
8. Subsequent Hospital Care (located within the Hospital Inpatient Services category/subsection).
9. The confirmatory consultations heading was deleted from CPT 2006. Modifier -32 is added to mandatory consultation codes.
10. FALSE (refer to notes below the Emergency Department Services category).
11. 99288 (refer to the Other Emergency Services subcategory).
12. According to CPT, “the physician is located in a hospital emergency or critical care department, and is in two-way voice communication with ambulance or rescue personnel outside the hospital. The physician directs the performance of necessary medical procedures. . . .”

NOTE: For example, if you watch the television show ER, you’ve seen a nurse on a two-way radio with ambulance personnel. I realize she is not a physician on the show, but you get the idea. For those of you who have long memories, back in the 1970s there was a television show called Emergency that depicted a physician in two-way communication with paramedic rescue personnel.

NOTE: SNF means skilled nursing facility, ICF means intermediate care facility, and LTCF means long-term care facility.

13. FALSE (refer to notes below the Critical Care Services category).
14. 99291, 99292 × 3 (refer to the chart below the Critical Care Services category).
15. Nursing facilities (refer to notes below the Nursing Facility Services category).

NOTE: Assign codes 99218–99220 from the Hospital Observation Services category only when patients are admitted to and discharged from observation on different dates.

21. 99396 (refer to Preventive Medicine Services category).
22. 99234 or 99235 or 99236 (depending on level of service provided) (refer to notes below Observation or Inpatient Care Services category).

NOTE: If well-baby care was not provided in addition to the administration of vaccines, do not code 99381/99291.

Note the sequencing of the Medicine Section codes above. Refer to the note below the Immunization Administration for Vaccines/Toxoids category that states, “Codes 90471–90472 must be reported in addition to the vaccine and toxoid code(s) 90476–90749.” You might think this means to sequence codes 90471–90472 below codes 90476–90749. However, when reviewing codes 90476–90749, note that the symbol for modifier -51 Exempt ( ) is printed in front of each code. The symbol means that you do not attach modifier -51 to these codes; this means that codes 90476–90749 are sequenced below codes 90471–90472.
23. 99291, 99292 × 5 (refer to the chart in the Critical Care Services category), 99223.

**NOTE:** Although the last 99292 code reflects just 16 minutes of critical care, it is reportable because it is ≥ 15 minutes.

24. 99455 (refer to Special Evaluation and Management Services category).

**NOTE:** “Treating physician” is the patient’s primary care physician.

25. Identify the CPT category and subcategory. *Hospital Inpatient Services, Initial Hospital Care*

Identify the appropriate CPT code. 99221 *(code selection requires 3/3 key components)*

26. Identify the CPT category and subcategory. *Consultations, Office or Other Outpatient Consultations*

Identify the appropriate CPT code. 99242 *(requirement of all three key components was met)*

27. Identify the CPT category. *Newborn Care Services*

Identify the appropriate CPT code. 99462

**NOTE:** “Healthy newborn” was cared for by Dr. Choi.

28. Identify the CPT category and subcategory. *Office or Other Outpatient Services, Established Patient*

Identify the appropriate CPT code. 99215

29. Identify the CPT category and subcategory. *Hospital Inpatient Services, Subsequent Hospital Care*

Identify the appropriate CPT code. 99232

**Surgery Section**

30. Pneumocentesis; assistant surgeon reporting 32420-80

31. Electrodesiccation, basal cell carcinoma (1 cm), face 17281

32. Complicated bilateral repair of recurrent inguinal hernia 49520-50-22

33. Biopsy of anorectal wall via proctosigmoidoscopy 45305

34. Mastectomy for gynecomastia, bilateral 19300-50

35. Open reduction, right tibia/fibula shaft fracture, with insertion of screws 27758-RT

36. Excision, condylomata, penis 54060

37. Replacement of breast tissue expander with breast prosthesis (permanent) 11970

38. Closed reduction of closed fracture, clavicle 23505

39. Incision and drainage of infected bursa, wrist 25031

40. Cystourethroscopy with biopsy of urinary bladder 52204

41. Endoscopic (nose) right maxillary sinusotomy with partial polypectomy 31237-RT

42. Insertion of non-tunnelled Hickman catheter (short-term) (age 70) *(Catheterization, Venous, Central Line)* 36556

43. Avulsion of four nail plates 11730, 11732 × 3

**Radiology, Pathology and Laboratory, and Medicine Sections**

44. Arthrography of the shoulder, supervision and interpretation 73040

45. Chest x-ray, frontal, single view (professional component only) 71010-26

46. Transabdominal ultrasound of pregnant uterus, first pregnancy (real time with image documentation), fetal and maternal evaluation, second trimester 76805

47. Application of radioactive needles (radioelement), intracavitary of uterus, intermediate 77762

48. Lipid panel blood test 80061
49. Drug screen for opiates (outside laboratory performed drug screen) 80101-90
50. Hemogram (manual) (complete CBC) 85014, 85018, 85032
51. Cervical cytology slides, manual screening under physician supervision 88150
52. Gross and microscopic examination of gallbladder (Pathology, Surgical) 88304
53. Complete echocardiography, transthoracic (real-time with image documentation [2D] with M-mode recording) 93307
54. Mumps vaccine immunization 90704, 90471
55. Intermittent positive pressure breathing of a newborn 94640
56. Gait training, first 30 minutes 97116 × 2
57. Medical psychoanalysis 90845
58. Ultraviolet light is used to treat a skin disorder 96900
59. Chemotherapy, IV infusion technique, 10 hours, requiring use of portable pump (including refill) 96416, 96521
60. Combined right cardiac catheterization and retrograde left heart catheterization 93526

Category II Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Index Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.</td>
<td>Initial prenatal care visit               0500F</td>
</tr>
<tr>
<td>62.</td>
<td>Assessment of tobacco use                 1000F</td>
</tr>
<tr>
<td>63.</td>
<td>Recording of vital signs                  2010F</td>
</tr>
<tr>
<td>64.</td>
<td>Documentation and review of spirometry results 3023F</td>
</tr>
<tr>
<td>65.</td>
<td>Inhaled bronchodilator prescribed for COPD patient 4025F</td>
</tr>
</tbody>
</table>

Category III Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Index Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>66.</td>
<td>Destruction of macular drusen via photocoagulation 0017T</td>
</tr>
<tr>
<td>67.</td>
<td>Expired gas analysis spectroscopy 0064T</td>
</tr>
<tr>
<td>68.</td>
<td>Remote real-time interactive video-conferenced critical care services provided for evaluation and management of critically ill patient, 45 minutes 0188T</td>
</tr>
<tr>
<td>69.</td>
<td>Pancreatic islet cell transplantation through portal vein, open approach 0142T</td>
</tr>
<tr>
<td>70.</td>
<td>Surgical laparoscopy with implantation of gastric stimulation electrodes, lesser curvature of the stomach, for patient diagnosed with morbid obesity 0155T</td>
</tr>
</tbody>
</table>

CHAPTER 8 HCPCS Level II Coding

ANSWERS TO HCPCS CODING EXERCISES

EXERCISE 8-1 HCPCS Index

<table>
<thead>
<tr>
<th>Code</th>
<th>Index Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>J3490 Key word(s): unclassified drug</td>
</tr>
<tr>
<td>2.</td>
<td>Q0114 Key word(s): fern test</td>
</tr>
<tr>
<td>3.</td>
<td>L3214 Key word(s): Benesch boot</td>
</tr>
<tr>
<td>4.</td>
<td>E0978 Key word(s): belt, wheelchair</td>
</tr>
<tr>
<td>5.</td>
<td>A4913 Key word(s): dialysis, supplies</td>
</tr>
</tbody>
</table>
EXERCISE 8-2 Recognizing Payer Responsibility

local MAC: none
regional MAC: L3214, E0978
local MAC or regional MAC: A4913, J3490, Q0114

ANSWERS TO REVIEW

1. a. Code: J3420  Modifier(s): -GA  Quantity: 1
   b. Code: E1031  Modifier(s): -NU -BP  Quantity: 1
   c. Code: A4253  Modifier(s): -KS  Quantity: 2
   d. Code: G0101  Modifier(s): none  Quantity: 1
   e. Code: E1392  Modifier(s): -RR  Quantity: 1

2. a. Code: 28072  Modifier(s): -T2  Quantity: 1
   b. Code: 82951  Modifier(s): -QW  Quantity: 1
   c. Code: 27810  Modifier(s): -LT -GJ  Quantity: 1
   d. Code: 00162  Modifier(s): none  Quantity: 1
   e. Code: 96118  Modifier(s): -AH  Quantity: 2

CHAPTER 9 CMS Reimbursement Methodologies

ANSWERS TO REVIEW

1. Submitted charge (based on provider’s regular fee for office visit) $75
    Medicare physician fee schedule (PFS) $60
    Coinsurance amount (paid by patient or supplemental insurance) $12
    Medicare payment (80 percent of the allowed amount) $48
    Medicare write-off (not to be paid by Medicare or the beneficiary) $15

2. Submitted charge (based on provider’s regular fee) $650
    NonPAR Medicare physician fee schedule allowed amount $450
    Limiting charge (115 percent of MPFS allowed amount) $517.50
    Medicare payment (80 percent of the MPFS allowed amount) $360
    Beneficiary is billed 20 percent plus the balance of the limiting charge $157.50
    Medicare write-off (not to be paid by Medicare or the beneficiary) ($650 – $517.50) $132.50

3. Submitted charge (based on provider’s regular fee for office visit) $75
    Medicare allowed amount (according to the Medicare physician fee schedule) $60
    Nurse practitioner allowed amount (100 percent of MPFS) $60
    Medicare payment (80 percent of the allowed amount) $48

4. a
5. a
6. b
7. a
8. a
9. b
10. c
11. a
12. b
13. b
14. c
15. b
16. b
17. c
18. c
19. b
20. c
CHAPTER 10 Coding for Medical Necessity

ANSWERS TO EXERCISES

EXERCISE 10-1 Choosing the First-Listed Diagnosis

Review the list of symptoms, complaints, and disorders in each case and underline the first-listed diagnosis, which is reported as reference number in Block 21 of the CMS-1500 claim.

1. Acute pharyngitis
2. Musculoligamentous sprain, left ankle
3. Benign prostatic hypertrophy (BPH) with urinary retention
4. Bacterial endocarditis
5. Partial drop foot gait, right

EXERCISE 10-2 Linking Diagnoses with Procedures/Services

CASE 1

<table>
<thead>
<tr>
<th>DIAGNOSIS POINTER</th>
<th>PROCEDURE/SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Hemoccult lab test</td>
</tr>
<tr>
<td>2</td>
<td>Proctoscopy with biopsy</td>
</tr>
<tr>
<td>3</td>
<td>Proctectomy</td>
</tr>
</tbody>
</table>

NOTE: The hemoccult lab test and proctoscopy with biopsy are done because the patient presents with the symptom, blood in the stool. Occult blood is present in such minute amounts in stool that it is not visible to the naked eye. Patients who present with blood in their stools undergo the hemoccult lab test to determine the cause of the bleeding (e.g., colorectal cancer vs. hemorrhaging hemorrhoids). A positive hemoccult test would indicate a need for proctoscopy with biopsy, which (in this case) was done to determine the cause of the bleeding. While pathological diagnosis upon biopsy indicates Duke’s C carcinoma of the colon, at the time the CMS-1500 claim was submitted, this diagnosis was unknown; therefore, link the proctoscopy with biopsy to the blood in the stool.

CASE 2

<table>
<thead>
<tr>
<th>DIAGNOSIS POINTER</th>
<th>PROCEDURE/SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Office visit</td>
</tr>
<tr>
<td>1</td>
<td>Urinalysis</td>
</tr>
<tr>
<td>4</td>
<td>Rapid strep test</td>
</tr>
</tbody>
</table>

NOTE: Urinary frequency with dysuria, sore throat with cough, and headaches are signs and symptoms; therefore, link all with the office visit. The urinalysis was specifically done because of the urinary frequency with dysuria. The rapid strep test was performed because of the sore throat with cough, but it came back positive; therefore, link “strep throat” with the test.

CASE 3

<table>
<thead>
<tr>
<th>DIAGNOSIS POINTER</th>
<th>PROCEDURE/SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Office visit</td>
</tr>
<tr>
<td>1</td>
<td>Chest x-ray</td>
</tr>
</tbody>
</table>

NOTE: Unlike pathological diagnoses, which can require several days prior to the establishment of a definitive diagnosis, a chest x-ray can be evaluated immediately upon completion and a diagnosis rendered. Because wheezing, congestion, and labored respirations are signs detected on physical examination, and pneumonia is a definitive diagnosis, report only the pneumonia on the CMS-1500 claim.
CASE 4

<table>
<thead>
<tr>
<th>DIAGNOSIS POINTER</th>
<th>PROCEDURE/SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nursing facility visit</td>
</tr>
</tbody>
</table>

**NOTE:** Diagnosis 2, 3, or 4 could also be entered as the diagnosis pointer, and for payers that allow more than one diagnosis pointer to be reported, the answer would be 1, 2, 3, 4.

CASE 5

<table>
<thead>
<tr>
<th>DIAGNOSIS POINTER</th>
<th>PROCEDURE/SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Emergency department visit</td>
</tr>
</tbody>
</table>

**NOTE:** Do not report signs or symptoms (e.g., chills and fever) on the CMS-1500 when a definitive diagnosis (e.g., acute diverticulitis) is documented.

**EXERCISE 10-3 National Coverage Determinations**

1. 93511 (left heart cardiac catheterization, cut-down); 414.00 (coronary artery disease); 413.9 (angina pectoris); 412 (status post myocardial infarction, four weeks ago). Review of the national coverage determination (NCD) about Cardiac Catheterization Performed in Other than a Hospital Setting indicates that this NCD is undergoing review. However, the original consideration stated that a “cardiac catheterization performed in a hospital setting for either inpatients or outpatients is a covered service. The procedure may also be covered when performed in a freestanding clinic when the carrier, in consultation with the appropriate quality improvement organization (QIO), determines that the procedure can be performed safely in all respects in the particular facility. Prior to approving Medicare payment for cardiac catheterizations performed in freestanding clinics, the carrier must request QIO review of the clinic.”

2. 93798 (cardiac rehabilitation program); V57.89 (cardiac rehab); V45.82 (status post coronary angioplasty); V45.81 (status post coronary bypass); 411.1 (unstable angina). Review of the NCD about Cardiac Rehabilitation Programs indicates “Medicare coverage of cardiac rehabilitation programs are considered reasonable and necessary only for patients who (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or (2) have had coronary bypass surgery; or (3) have stable angina pectoris; or (4) have had heart valve repair/replacement; or (5) have had percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; or (6) have had a heart or heart-lung transplant.”

**NOTE:** This patient has unstable angina; therefore, Medicare will not cover a cardiac rehabilitation program.

3. 44388 (colonoscopy); V10.05 (history of colon cancer, treatment complete); 555.9 (Crohn’s disease); 578.1 (blood in stool); 789.00 (abdominal pain). Review of the NCD about Endoscopy indicates that “endoscopic procedures are covered when reasonable and necessary for the individual patient.”

**NOTE:** A colonoscopy is an endoscopy.

4. 70450 (CT scan of head); 959.01 (closed head trauma); 920 (contusion of scalp); 873.0 (laceration of scalp). Review of the NCD about Computed Tomography indicates that “computed tomography is covered if you find that the medical and scientific literature and opinion support the effective use of a scan for the condition, and the scan is: (1) reasonable and necessary for the individual patient; and (2) performed on a model of CT equipment that meets the criteria for approved models of CT equipment.”
### EXERCISE 10-4 Coding Case Scenarios

**NOTE:** The underlined term in the Diagnoses column is the first-listed diagnosis or condition.

1. **Procedures**
   - Preventive medicine, established patient, age 66
     - Procedure Codes: 99397
     - Diagnoses: Annual exam Codes: V70.0
   - Outpatient, established patient, level 4
     - Procedure Codes: 99214-25
     - Diagnoses: Hypertension Codes: 401.9

   **NOTE:** Do not code dizziness or tiredness, which are symptoms of hypertension.

2. **Procedures**
   - Arthroscopy, shoulder
     - Procedure Codes: 29805
     - Diagnoses: Pain, shoulder NOS Codes: 719.41
   - Outpatient, established patient, expanded problem focused
     - Procedure Codes: 99214-25
     - Diagnoses: Weak and Tired Codes: 780.79
     - Diagnoses: Depression Codes: 311

3. **Procedure**
   - The emergency department physician reports the following codes:
     - Procedure Code: 99282
     - Diagnosis: Ruptured appendix with abscess Codes: 540.1
   - The surgeon reports the following codes:
     - Procedure Code: 99203-57
     - Diagnosis: Ruptured appendix with abscess Codes: 540.1
     - Laparoscopic appendectomy
     - Procedure Code: 44970
     - Diagnosis: Ruptured appendix with abscess Codes: 540.1

   **NOTE:** The diagnosis code is the same for both the emergency department physician and the surgeon.

4. **Procedure**
   - The emergency department physician reports the following codes:
     - Procedure Code: 99283
     - Diagnosis: Acute Cholecystitis Codes: 575.0
   - The surgeon reports the following codes:
     - Gallbladder ultrasound
     - Procedure Code: 76705
     - Diagnosis: Acute Cholecystitis Codes: 575.0
     - E/M service, new patient (decision for surgery)
     - Procedure Code: 99203-57
     - Diagnosis: Acute Cholecystitis Codes: 575.0
     - Laparoscopic cholecystectomy
     - Procedure Code: 47562
     - Diagnosis: Acute Cholecystitis Codes: 575.0

   **NOTE:** The diagnosis code is the same for both the emergency department physician and the surgeon.
5. Procedure  
   Postop care, appendectomy, open  
   Code  44950-55  
   Diagnosis  Aftercare, surgery  
   Codes  V58.32  

NOTE: Do not report an E/M office visit code. Modifier -55 is reported with the surgery code to obtain reimbursement for postoperative care. Do not code appendicitis; the appendix is no longer present.

EXERCISE 10-5 Coding SOAP Notes

Diagnoses  ICD-9-CM Codes
1. Atrophic gastritis  535.10  
   Leg pain  729.5  
2. Aftercare, surgery  V58.49

NOTE: Do not assign 574.10 (cholecystitis with cholelithiasis) because the gallbladder has been removed, and this code was reported on the outpatient surgery claim. This is a postoperative office visit (V58.49).

Diagnoses  ICD-9-CM Codes
3. Rheumatoid arthritis  714.0  
   Synovitis, knee  727.09  
4. Unstable angina  411.1  
5. Exudative tonsillitis  463  
6. Seizure disorder  780.39

NOTE: Lymphoma and COPD were not treated or medically managed.

EXERCISE 10-6 Coding Operative Reports

CASE 1
Diagnoses:  Granulation, tissue, skin  701.5  
   History, personal, malignant, skin  V10.83  
Procedure:  Excision, lesion, scalp, benign (0.3 cm)  11420

CASE 2
Diagnosis:  Atypical neoplasm, skin (uncertain behavior)  238.2  
   (Pathology ordered the re-excision because of atypical cells)  
Procedures:  Excision, lesion, benign (return to O.R.)  11406-58,  
   (5.0 cm, skin of back). Layered closure, intermediate.  12032

CASE 3
Diagnoses:  Neoplasm, benign, intestine, sigmoid  211.3  
   Melanosis coli  569.87  
Procedure:  Colonoscopy, with biopsy of polyp and fulguration  45380,  
   of polyp  45384-51

NOTE: Do not assign sigmoidoscopy codes (instead of colonoscopy codes) because the scope was advanced to the ascending colon, transverse colon, and proximal descending colon. The sigmoid colon is located just above the rectum—if the scope was advanced to just the sigmoid colon, only then would sigmoidoscopy codes be reported instead of colonoscopy codes.
CASE 4
Diagnosis: Serous otitis media 381.4
Procedure: Myringotomy (Tympanostomy) with insertion of ventilating tubes (procedure performed bilaterally) 69436-50

CASE 5
Diagnosis: Lesion, buccal mucosa
Procedure: Biopsy, buccal mucosa 40812

NOTE: Report code 528.9 as the (outpatient or inpatient) admitting diagnosis. The pathology report will indicate whether the lesion is benign or malignant, for which an appropriate neoplasm code is reported (e.g., 145.0 if primary malignancy, 210.4 if benign, and so on).

Do not report code 528.5 because buccal mucosa is the mucous membrane located on the inside of the cheek. The physician included “left upper lip” to indicate the region where the lesion of the buccal mucosa is located.

CASE 6
Diagnosis: Pilonidal cyst (no mention of abscess) 685.1
Procedure: Excision, pilonidal cyst (no mention of extensive or complicated excision) 11770

CASE 7
Diagnosis: Femoral hernia, incarcerated (incarcerated equals strangulated) 552.00
Procedure: Herniorrhaphy, femoral (not stated as recurrent) 49553

ANSWERS TO REVIEW

Comprehensive Coding Practice

<table>
<thead>
<tr>
<th>Diagnosis Code(s)</th>
<th>Procedure Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>569.3 (rectal bleeding)</td>
<td>99204 (level 4 office or outpatient E/M service, new patient)</td>
</tr>
<tr>
<td>569.3 (rectal bleeding)</td>
<td>45378-53 (or 45378-73, depending on setting) (colonoscopy)</td>
</tr>
<tr>
<td>562.10 (diverticulitis)</td>
<td>562.10 (diverticulitis)</td>
</tr>
<tr>
<td>211.3 (polyp)</td>
<td>45385 (colonoscopy/snare removal of polyp)</td>
</tr>
<tr>
<td>530.85 (Barrett esophagus)</td>
<td>74241 (Upper GI with KUB)</td>
</tr>
<tr>
<td>427.9 (cardiac arrhythmia)</td>
<td>93312 (echocardiography) (conscious sedation is not coded)</td>
</tr>
<tr>
<td>473.9 (sinusitis)</td>
<td>99212 (level II office or outpatient E/M service, established patient)</td>
</tr>
<tr>
<td>436 (CVA)</td>
<td>99223 (level III initial hospital care E/M service)</td>
</tr>
<tr>
<td>436 (CVA)</td>
<td>99291, 99292 (critical care E/M services)</td>
</tr>
</tbody>
</table>

Determining Medical Necessity (Case Studies: Set One) (5–8)
Answers to Case Studies: Set One are located in Section IV of this manual.

Coding and Determining Medical Necessity (Case Studies: Set Two) (9–14)
Answers to Case Studies: Set Two are located in Section IV of this manual.
Evaluation and Management Coding Practice

15. Identify the E/M category/subcategory: Hospital Inpatient Services, Initial Hospital Care
   Determine the extent of history obtained: Expanded problem focused
   RATIONALE FOR EXTENT OF HISTORY SELECTION: Upon review of the case study compared
   with the HCFA Documentation Guidelines (in your textbook appendix),
   three elements were documented for the HPI = Brief HPI; seven elements were documented for
   the ROS = Extended ROS; and three elements were documented for the PFSH = Complete PFSH.
   Therefore, select expanded problem focused history because brief HPI (with only three elements
   documented) “drives” selection of lower level of extent of history.
   Determine the extent of examination performed: Expanded problem focused
   RATIONALE FOR EXTENT OF PE SELECTION: Upon review of the case study compared
   with the HCFA Documentation Guidelines (in your textbook appendix), seven elements were
   documented on PE. Therefore, expanded problem focused PE was documented.
   Medical decision making: Straightforward
   RATIONALE FOR MEDICAL DECISION MAKING SELECTION: This is a judgment call on
   my part; if you wanted to go with “low complexity,” I would not have a problem with that. Code
   Number: 99221

16. Identify the E/M category/subcategory: Office or Other Outpatient Services, Established Patient
   Determine the extent of history obtained: Detailed
   RATIONALE FOR EXTENT OF HISTORY SELECTION: Upon review of the case study com-
   pared with the HCFA Documentation Guidelines (in your textbook appendix), four elements
   were documented for the HPI = Extended HPI; eight elements were documented for the ROS =
   Extended ROS; and three elements were documented for the PFSH = complete PFSH. Therefore,
   select detailed history because extended HPI and extended ROS “drive” selection of extent of
   history. Determine the extent of examination performed: Detailed
   RATIONALE FOR EXTENT OF PE SELECTION: Upon review of the case study compared
   with the HCFA Documentation Guidelines (in your textbook appendix), 19 elements were
   documented in the General Multisystem Exam.
   Medical decision making: Low complexity
   RATIONALE FOR MEDICAL DECISION MAKING SELECTION: This is a judgment call on
   my part; if you wanted to go with “straightforward,” I would not have a problem with that. Code
   Number: 99214

17. Identify the E/M category/subcategory: Office or Other Outpatient Services, Established Patient
   Determine the extent of history obtained: Expanded problem focused
   RATIONALE FOR EXTENT OF HISTORY SELECTION: Upon review of the case study com-
   pared with the HCFA Documentation Guidelines (in your textbook appendix), one element
   was documented for the HPI = Brief HPI; one element was documented for the ROS = problem
   pertinent; and no elements were documented for the PFSH = none. Therefore, select expanded
   problem focused history because no PFSH is required.
   Determine the extent of examination performed: Problem focused
   RATIONALE FOR EXTENT OF PE SELECTION: Upon review of the case study compared
   with the HCFA Documentation Guidelines (in your textbook appendix), just one element was
   documented in the General Multisystem Exam.
   Medical decision making: Low complexity
   Code Number: 99213
   RATIONALE: Only two of three key components are required to select the code.

18. Identify the E/M category/subcategory: Office or Other Outpatient Services, Established Patient
   Determine the extent of history obtained: Expanded problem focused
   RATIONALE FOR EXTENT OF HISTORY SELECTION: Upon review of the case study com-
   pared with the HCFA Documentation Guidelines (in your textbook appendix), two elements
   were documented for the HPI = Brief HPI; one element was documented for the ROS = problem
   pertinent; and no elements were documented for the PFSH = none. Therefore, select expanded
   problem focused history because no PFSH is required.
Determine the extent of examination performed: Problem focused
RATIONALE FOR EXTENT OF PE SELECTION: Upon review of the case study compared
with the HCFA Documentation Guidelines (in your textbook appendix), three elements were
documented in the General Multisystem Exam.
Medical decision making: Straightforward
Code Number: 99212 (just 2/3 key components “drives” code selection)

19. Identify the E/M category/subcategory: Non-Face-to-Face Physician services, Telephone services
Code Number: 99443

Correcting Claims Submission Errors

20. CODING ERROR PROCEDURE CODE DIAGNOSIS CODE

<table>
<thead>
<tr>
<th>(c)</th>
<th>81003</th>
<th>599.0</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>041.4</td>
</tr>
</tbody>
</table>

Select (c) because the coder should have reported code 788.1 for dysuria. There is no mention in
the case of urinary tract infection (599.0) or E. coli (041.4) as a final diagnosis.

21. CODING ERROR PROCEDURE CODE DIAGNOSIS CODE

<table>
<thead>
<tr>
<th>(c)</th>
<th>71010</th>
<th>553.3</th>
</tr>
</thead>
</table>

Code 786.05 (shortness of breath) should have been reported as the first-listed diagnosis because
there were no acute findings suggesting a cause of the shortness of breath.

22. CODING ERROR PROCEDURE CODE DIAGNOSIS CODE

| (a) | 99394 | V70.3 |

Code 99395 should have been reported instead of 99394.

23. CODING ERROR PROCEDURE CODE DIAGNOSIS CODE

<table>
<thead>
<tr>
<th>(e)</th>
<th>66984</th>
<th>366.12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>66985-51</td>
<td></td>
</tr>
</tbody>
</table>

Do not report code 66985-51 as a secondary procedure code. Code 66984 is a combination code
reported for extracapsular cataract removal, phacoemulsification and insertion of intraocular
lens prosthesis.

24. CODING ERROR PROCEDURE CODE DIAGNOSIS CODE

| (b) | 97001 | 438.2 |

Code 438.2 requires addition of a fifth digit to indicate which side was affected by hemiplegia. If
this information is unknown, report 438.20 to indicate “unspecified side.”

CHAPTER 11 Essential CMS-1500 Claim Instructions

ANSWERS TO EXERCISES

EXERCISE 11-1 Applying Optical Scanning Guidelines

1. GREEN JEFFERY L
2. 300 00
3. 12345 22 51
4. 123456789
6. 03 08 2000
7. Blank space in the upper left corner of the claim
8. Be sure all pin-fed borders are neatly removed and the individual claims are separated.
9. No handwritten information except signatures in Blocks 12, 13, and 31
10. Pica font and 10 characters per inch

EXERCISE 11-2 Entering Procedures in Block 24

<table>
<thead>
<tr>
<th>D.C.</th>
<th>D.C.</th>
<th>C.P.</th>
<th>O.C.</th>
<th>E.</th>
<th>$</th>
<th>A.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1012</td>
<td>YYYY</td>
<td>: : :</td>
<td>: : :</td>
<td>:</td>
<td>35</td>
<td>1</td>
</tr>
<tr>
<td>1109</td>
<td>YYYY</td>
<td>: : :</td>
<td>: : :</td>
<td>:</td>
<td>900</td>
<td>1</td>
</tr>
<tr>
<td>1109</td>
<td>YYYY</td>
<td>: : :</td>
<td>: : :</td>
<td>:</td>
<td>500</td>
<td>1</td>
</tr>
</tbody>
</table>

EXERCISE 11-3 Completing Block 33

1. Goodmedicine Clinic
2. Dr. Blank
3. Dr. Jones PA

ANSWERS TO REVIEW

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

CHAPTER 12 Commercial Insurance

ANSWERS TO EXERCISES

EXERCISES 12-1 and 12-2

Students should manually complete the commercial case studies in the order provided in the text. The commercial insurance case studies can also be entered using the Self Study mode of the CD-ROM program, which provides immediate feedback every time the enter key is struck.

Additional hints for using the CD-ROM can be found in the Preface of the text, as well as in the Resources section of the CD.

The completed claims can be found in Figures 12-4 and 12-5 of the textbook.
ANSWERS TO REVIEW
1. a 9. d
2. c 10. d
3. b 11. d
4. a 12. c
5. d 13. d
6. b 14. a
7. d 15. b
8. a

CHAPTER 13  Blue Cross Blue Shield

ANSWERS TO EXERCISES

EXERCISES 13-1 and 13-2  Completing the Mary S. Patient BCBS CMS-1500 Claim; Filing a Claim When a Patient Is Covered by the Same BCBS Payer for Primary and Secondary Policies
The completed Mary S. Patient CMS-1500 claims can be found in Figures 13-7 and 13-8 of the textbook.

EXERCISE 13-3  Filing BCBS Secondary Claims
The completed Janet B. Cross CMS-1500 secondary claim can be found in Figure 13-10 of the textbook.

ANSWERS TO REVIEW
1. b 6. d
2. c 7. a
3. b 8. b
4. a 9. b
5. d 10. d

CHAPTER 14  Medicare

ANSWERS TO EXERCISES

EXERCISE 14-1  Medicare as Secondary Payer
1. Billing order is: The hospital plan can be billed at any time. The large group plan is primary, Medicare is secondary. Medigap is billed on the same CMS-1500 claim form as Medicare, if the provider participates in Medicare.

2. Billing order is: The liability plan is billed first. The other plans will not be billed unless the claim is refused by the liability company. If refused, the large group plan is primary, Medicare secondary, and the retirement plan billing will be electronically transferred by Medicare or billed last by the provider.

3. Billing order is: Cancer policy is billed at any time. Medicare is primary; retirement plan is supplemental.
4. Billing order is: Patient's large group plan is primary, Medicare is secondary. Medigap is billed on the Medicare claim if the provider is a PAR. Spouse's plan is not billed because there is no mention that the patient is covered by this plan. Small groups are also never primary to Medicare.

5. Billing order is: Medicare is primary. The employer plan has fewer than 100 employees.

EXERCISE 14-2  Completing the Mary S. Patient Medicare Primary CMS-1500 Claim
The completed Mary S. Patient primary Medicare CMS-1500 claim can be found in Figure 14-9 of the textbook.

EXERCISE 14-3  Medicare and Medigap Claims Processing
The completed John Q. Public Medicare/Medigap CMS-1500 claim can be found in Figure 14-10 of the textbook.

EXERCISE 14-4  Medicare–Medicaid Crossover Claims Processing
The completed Mary S. Patient Medicare/Medicaid crossover CMS-1500 claim can be found in Figure 14-11 of the textbook.

EXERCISE 14-5  Medicare as Secondary Payer Claims Processing
The completed Jack L. Neely MSP CMS-1500 claim can be found in Figure 14-13 of the textbook.

ANSWERS TO REVIEW
1. b       6. b
2. a       7. b
3. a       8. a
4. a       9. b
5. b       10. a

CHAPTER 15  Medicaid

ANSWERS TO EXERCISES

EXERCISE 15-1  Medicaid CMS-1500 Claims Processing
The completed Mary S. Patient primary Medicaid CMS-1500 claim form can be found in Figure 15-6 of the textbook.

ANSWERS TO REVIEW
1. a       6. a
2. b       7. a
3. d       8. c
4. a       9. c
5. b       10. a
CHAPTER 16  TRICARE

ANSWERS TO EXERCISES

EXERCISE 16-1  TRICARE CMS-1500 Claim
The completed Mary S. Patient primary TRICARE CMS-1500 claim can be found in Figure 16-7 of the textbook.

EXERCISE 16-2  Completion of TRICARE Secondary CMS-1500 Claim
The completed John R. Neely CMS-1500 secondary TRICARE claim can be found in Figure 16-9 of the textbook.

ANSWERS TO REVIEW
1. d   6. b
2. b   7. c
3. d   8. c
4. a   9. a
5. d   10. a

CHAPTER 17  Workers’ Compensation

ANSWERS TO EXERCISES

EXERCISE 17-1  CMS-1500 Claims Completion
The completed Mary S. Patient CMS-1500 claim can be found in Figure 17-6 of the textbook.

ANSWERS TO REVIEW
1. d   6. b
2. c   7. d
3. a   8. a
4. d   9. a
5. b   10. b