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Question: 1325

A 38-year-old female patient with lumbar spinal stenosis undergoes a decompressive laminectomy at L3-L4 and L4-L5 with medial facetectomy and foraminotomy. The surgeon uses intraoperative neuromonitoring and documents no fusion was performed. The procedure is performed under general anesthesia. Which CPT code(s) should be reported?

A. 63047
B. 63047, 63048
C. 63056
D. 63056, 63057

Answer: B

Explanation: A decompressive laminectomy at L3-L4 and L4-L5 with facetectomy and foraminotomy is reported with CPT 63047 (Laminectomy, facetectomy and foraminotomy, single vertebral segment; lumbar) for the first segment (L3-L4) and CPT 63048 (each additional segment) for the second segment (L4-L5). Neuromonitoring is not separately reportable unless specified. CPT 63056 is for transpedicular decompression, which is not described, and 63047 alone does not account for the additional segment.

Question: 1326

A 48-year-old patient with controlled diabetes undergoes a diagnostic laparoscopy under general anesthesia. The anesthesia provider documents a start time of 10:30 and an end time of 11:15, with a 5-minute interruption for equipment adjustment. The patient's condition is stable. How should the anesthesia services be coded, including the physical status modifier and time?

A. 00840 with P2 modifier, 45 minutes
B. 00840 with P1 modifier, 40 minutes
C. 00844 with P1 modifier, 40 minutes
D. 00844 with P2 modifier, 45 minutes

Answer: B

Explanation: CPT code 00840 is appropriate for anesthesia for intraperitoneal procedures in the lower abdomen, such as diagnostic laparoscopy. The patient's controlled diabetes qualifies for the P1 modifier (normal healthy patient, as diabetes is well-controlled). The anesthesia time is calculated excluding the 5-minute interruption, so from 10:30 to 11:15 (45 minutes total) minus 5 minutes equals 40 minutes.

Question: 1327

A patient with a history of recurrent urinary tract infections has a urinalysis performed with microscopic examination and an additional test for urine osmolality to assess kidney concentrating ability. The laboratory uses automated equipment for the urinalysis and a separate method for osmolality. Which CPT codes should be reported?

A. 81001, 83935
B. 81000, 83935
C. 81002, 83935
D. 81003, 83935

Answer: A

Explanation: CPT code 81001 is appropriate for an automated urinalysis with microscopy, which includes both macroscopic and microscopic examination of the urine sample. Code 83935 is used for the measurement of urine osmolality, a separate test to evaluate kidney function. Code 81000 is for urinalysis without microscopy, 81002 is for non-automated urinalysis with microscopy, and 81003 is for automated urinalysis without microscopy, none of which fully match the described procedure.

Question: 1328

Which of the following is an example of a Category II code?

A. 99213
B. 99024
C. 36415
D. 58662

Answer: B

Explanation: 99024 is an example of a Category II code. Category II codes are used to track performance measures and provide additional information about the quality of healthcare services provided. These codes are optional and used for data collection purposes. Category II codes are typically used in conjunction with other primary procedure codes to provide supplemental information that is not captured by the primary code alone.

Which of the following is a key requirement for assigning E/M codes based on time?

A. The provider must spend more than 50% of the total face-to-face time counseling the patient.

B. The provider must spend more than 50% of the total face-to-face time performing a procedure.
C. The provider must spend a minimum of 30 minutes face-to-face with the patient.
D. The provider must spend a minimum of 60 minutes face-to-face with the patient.

Answer: B

Explanation: When assigning E/M codes based on time, a key requirement is that the provider must spend a minimum of 30 minutes face-to-face with the patient. This time includes both the counseling and/or coordination of care and the total face-to-face time spent with the patient. The documentation should clearly indicate the time spent, and it must meet or exceed the minimum time threshold specified in the coding guidelines for the specific E/M code being reported.

Question: 1329

A 60-year-old female patient with a cervical disc herniation undergoes an anterior cervical discectomy and fusion (ACDF) at C5-C6. The surgeon uses an allograft and places an anterior plate. Intraoperative neuromonitoring is documented. Which CPT code(s) should be reported?

A. 22551, 20930
B. 22551
C. 22554, 22845
D. 22554, 22845, 20930

Answer: B

Explanation: An anterior cervical discectomy and fusion (ACDF) at C5-C6, including allograft and anterior plate placement, is reported with CPT 22551 (Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2). This code includes the discectomy, fusion, and instrumentation. Allograft (20930) and neuromonitoring are bundled into 22551. CPT 22554 and 22845 are used for multilevel or separate procedures, which are not indicated.

Question: 1330

A hospital outpatient department administers 150 mg of rituximab (Rituxan) to a patient for non-Hodgkin's lymphoma. The drug is supplied in a 500 mg single-use vial, and the remaining 350 mg is discarded. Per Medicare guidelines, how should the coder report the administered and discarded amounts using HCPCS Level II codes and modifiers to comply with billing requirements?

A. J9312 x 35, J9312-JW x 15
B. J9312 x 15, J9312-JW x 35
C. J9312 x 150, J9312-JW x 350
D. J9312 x 350, J9312-JW x 150

Answer: B

Explanation: HCPCS code J9312 represents rituximab, 10 mg per unit. For 150 mg, 15 units are reported (150 ÷ 10 = 15). The discarded 350 mg equates to 35 units (350 ÷ 10 = 35), reported with the JW modifier to indicate drug wastage. Medicare requires separate lines for administered and discarded amounts. Thus, J9312 x 15 for the administered dose and J9312-JW x 35 for the discarded amount is correct.

Question: 1331

A patient presents to the physician's office for a follow-up visit after a recent surgery. The physician performs a comprehensive history, examination, and medical decision-making. Which Evaluation and Management (E/M) code should be assigned for this visit?

A. 99203
B. 99204
C. 99215
D. 99205

Answer: C

Explanation: The appropriate E/M code for a follow-up visit after surgery with a comprehensive history, examination, and medical decision-making is 99215. This code is used when a physician provides a high level of service.

Question: 1332

A 66-year-old patient with a history of severe COPD undergoes a 4-hour lung transplant under general anesthesia provided by an anesthesiologist supervising two concurrent procedures. The procedure is complicated by the patient’s extreme age. How should this service be coded?

A. 00561-QK-P4, +99100
B. 00560-AA-P3, +99116
C. 00561-QZ-P4, +99140
D. 00560-QK-P4, +99100

Answer: A

Explanation: The CPT code 00561 is used for anesthesia during lung transplant procedures. The anesthesiologist supervising two concurrent procedures requires the QK modifier. The patient’s severe COPD warrants a P4 physical status modifier. The patient’s age (66) is a qualifying circumstance, reported with +99100, though lung transplant codes often account for complexity, but the question specifies reporting it. The total time (240 minutes) equals 16 time units, but this is not part of the code selection.

Question: 1333

A 65-year-old female patient with type 2 diabetes mellitus with proliferative diabetic retinopathy

(E11.351) and macular edema (H35.81) undergoes a focal laser photocoagulation (CPT 67210). According to ICD-10-CM and CPT guidelines, how should the diagnoses and procedure be coded, considering sequencing and modifier usage?

A. E11.351, 67210
B. H35.81, E11.351, 67210
C. E11.351, H35.81, 67210
D. H35.81, 67210

Answer: C

Explanation: ICD-10-CM guidelines require the underlying condition (E11.351, type 2 diabetes with proliferative diabetic retinopathy) to be sequenced first, followed by the manifestation code H35.81 (macular edema), as per the “code first” note under H35.81. CPT 67210 (focal laser photocoagulation) is the correct procedure code. Both diagnosis codes are necessary to fully describe the condition, and no modifier is required for the procedure in this context.

Question: 1334

A 31-year-old female undergoes a cesarean delivery at 38 weeks gestation due to breech presentation. During the procedure, the obstetrician performs a tubal ligation using the Pomeroy technique. The operative note confirms a low transverse incision and no complications. Which CPT code(s) should be reported for this combined procedure?

A. 59514
B. 59515
C. 59514, 58611
D. 59515, 58611

Answer: C

Explanation: The cesarean delivery is reported with CPT code 59514, which covers cesarean delivery only. The tubal ligation performed during the same session is reported with CPT code 58611, an add-on code for ligation or transection of fallopian tubes when done at the time of cesarean delivery or intra-abdominal surgery. Code 59515 includes postpartum care, which is not mentioned. Reporting both 59514 and 58611 is appropriate per CPT guidelines, as the tubal ligation is a separately identifiable procedure. The Pomeroy technique and incision type do not alter the codes.

Question: 1335

A 65-year-old patient with alcoholic cirrhosis presents with ascites and a SAAG of 1.8 g/dL. Paracentesis yields 4 L of cloudy fluid with PMN 300/µL, glucose 40 mg/dL, and total protein 1 g/dL. Which antibiotic regimen is most appropriate for this patient?

A. Metronidazole 500 mg IV every 8 hours
B. Levofloxacin 500 mg orally daily for 7 days

C. Vancomycin 1 g IV every 12 hours
D. Ceftriaxone 1 g IV daily for 5 days

Answer: D

Explanation: The fluid analysis (PMN >250/µL, low glucose, low protein) indicates spontaneous bacterial peritonitis (SBP). Ceftriaxone is the first-line treatment for SBP in cirrhosis, covering common pathogens like E. coli. Levofloxacin is an alternative for penicillin-allergic patients. Vancomycin targets gram-positive organisms, not typical SBP pathogens. Metronidazole is ineffective for SBP.

Question: 1336

Which of the following is an example of a bundled service?

A. Evaluation and management (E/M) visit
B. Laboratory test
C. Surgical procedure
D. Durable medical equipment (DME) supply

Answer: C

Explanation: A bundled service refers to a group of related healthcare services that are considered to be part of a single unit of care. These services are often performed together and are not separately reported or reimbursed. A surgical procedure is an example of a bundled service because it typically includes multiple components, such as preoperative evaluation, the procedure itself, postoperative care, and any necessary follow-up visits.

Question: 1337

A patient undergoes a skin excision of a 2.5 cm malignant lesion on the back with intermediate closure. Which CPT codes should be reported?

A. 11604, 12032
B. 11603, 12032
C. 11603, 12031
D. 11604, 12031

Answer: B

Explanation: Excision of a 2.5 cm malignant lesion is coded with CPT 11603. Intermediate closure of a 2.5 cm defect is coded with 12032. CPT 11604 is for larger lesions, and 12031 is for smaller repairs.

Question: 1338

A 50-year-old patient with generalized anxiety disorder undergoes a 45-minute biofeedback session in a

psychiatric clinic to manage stress. The session involves heart rate variability (HRV) biofeedback training, with the provider monitoring physiological responses and providing real-time feedback. The provider also spends 10 minutes discussing coping strategies. How should this biofeedback session be coded?

A. 90875
B. 90876
C. 90901
D. 90880

Answer: C

Explanation: Biofeedback training, including HRV biofeedback for stress management, is coded with 90901. This code encompasses the entire session, including monitoring and feedback. The other options are incorrect: 90875 and 90876 are for psychophysiological therapy incorporating biofeedback, which is not applicable here, and 90880 is for hypnosis, which is unrelated to this scenario.

Question: 1339

A 68-year-old female with a history of osteoporosis undergoes kyphoplasty at L1 and L2 for compression fractures. Fluoroscopic guidance is used, and no biopsy is performed. The surgeon documents separate incisions for each level. Which CPT code(s) should be reported?

A. 22514
B. 22513, 22515
C. 22514, 22515
D. 22514, 22514-51

Answer: C

Explanation: Kyphoplasty at two lumbar levels (L1 and L2) is reported with CPT code 22514 (first lumbar vertebral body) and 22515 (each additional vertebral body, thoracic or lumbar). Fluoroscopic guidance is included in these codes. Modifier 51 is not needed, as 22515 is an add-on code. Code 22513 is for vertebroplasty, not kyphoplasty.

Question: 1340

A patient with a history of breast cancer presents for a routine screening mammogram. The radiologist performs a bilateral digital mammography with computer-aided detection (CAD) and notes no suspicious findings. The facility owns the equipment, and the radiologist provides the interpretation. Which CPT code and modifier combination should be reported by the radiologist?

A. 77065-TC
B. 77066-26
C. 77067
D. 77066-TC

Answer: B

Explanation: A bilateral screening mammogram with CAD is reported with CPT code 77067 when both the technical and professional components are performed. However, since the radiologist provides only the interpretation and the facility owns the equipment, the professional component is reported with modifier -26. Code 77066 is for diagnostic mammography, not screening, and modifier -TC is for the technical component, which is not applicable for the radiologist's service. Code 77065 is for unilateral mammography.

Question: 1341

A patient undergoes a fine needle aspiration of a thyroid nodule, and the cytopathology evaluation includes preparation, staining, and interpretation with a report. The procedure requires immediate evaluation for adequacy. Which CPT codes should be reported?

A. 88172, 88173
B. 88173, 88177
C. 88172, 88177
D. 88173, 88305

Answer: A

Explanation: CPT code 88172 is used for the immediate cytologic study to assess specimen adequacy, and 88173 is for the cytopathology evaluation of a fine needle aspirate with interpretation and report. Code 88177 is for additional evaluations, and 88305 is for surgical pathology, not cytopathology.

Question: 1342

A patient presents for a routine physical examination. During the examination, the physician discovers an abnormal mole and performs a biopsy. How should this encounter be coded?

A. Code for the routine physical examination only
B. Code for the biopsy only
C. Code for the biopsy and report the physical examination as incidental
D. Code for both the physical examination and the biopsy

Answer: D

Explanation: In this scenario, both the physical examination and the biopsy were performed, and they serve distinct purposes. The physical examination was part of the routine preventive care, while the biopsy was performed to investigate and diagnose the abnormal mole. Therefore, both services should be coded separately.

Question: 1343

A 40-year-old female patient with a history of ectopic pregnancy undergoes a laparoscopic salpingectomy. The surgeon removes the left fallopian tube due to a 2 cm tubal pregnancy confirmed by preoperative ultrasound. The procedure is uncomplicated, and pathology confirms ectopic pregnancy. What is the appropriate CPT code for this procedure?

A. 59151
B. 58700
C. 59120
D. 58661

Answer: D

Explanation: A laparoscopic salpingectomy for ectopic pregnancy is coded with 58661 (Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)). CPT 58700 is for open salpingectomy, not applicable. CPT 59120 is for surgical treatment of ectopic pregnancy requiring laparotomy, and 59151 is for laparoscopic treatment with salpingo-oophorectomy, both incorrect.

Question: 1344

A patient undergoes a bone marrow aspiration and biopsy from the iliac crest for evaluation of anemia. The pathology report confirms iron deficiency anemia. Which CPT and ICD-10-CM codes should be reported?

A. 38221, D50.9
B. 38220, 38221, D50.9
C. 38220, D50.0
D. 38221, D50.0

Answer: B

Explanation: Bone marrow aspiration (38220) and biopsy (38221) are separately reportable when both are performed at the same session, as in this case. ICD-10-CM code D50.9 is used for iron deficiency anemia, unspecified, as the pathology report does not specify chronic blood loss (D50.0).

Question: 1345

Which of the following is an example of a modifier used in medical coding?

A. 81002
B. 36415
C. 25
D. 99213

Answer: C

Explanation: Modifiers are two-digit codes used to provide additional information or clarification about a service or procedure. Modifier 25, for example, indicates that a significant, separately identifiable evaluation and management service was provided on the same day as another procedure.

Question: 1346

A 70-year-old female patient undergoes a dual-energy X-ray absorptiometry (DXA) bone density study of the hips, pelvis, and spine at a hospital outpatient department. The procedure is ordered to evaluate osteoporosis risk, and the radiologist provides the professional interpretation only. How should the professional services for this bone density study be reported?

A. 77080-26
B. 77081-26
C. 77085-26
D. 77086-26

Answer: A

Explanation: A DXA bone density study of the hips, pelvis, and spine is reported with CPT code 77080. Since the radiologist provides only the professional component in a hospital setting, modifier -26 is appended. This code accurately captures the axial skeleton DXA study, which is commonly used to assess osteoporosis risk.

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