CODING KNOWLEDGE AND SKILLS ASSESSMENT

Physician Side Coding

Section A – Multiple Choice: Select the Best Answer

1. For a comprehensive review of systems, the physician may only document “All Systems Negative”.
   a. True
   b. False

2. A new patient requests a consult for a second opinion on lung cancer. A code from which category would be assigned?
   a. Office Visit, New Patient
   b. Office Visit, Established Patient
   c. Office Consult, New Patient
   d. Inpatient Consult, New Patient

3. According to the 1995 E/M guidelines, a comprehensive exam can be obtained with the following documentation?
   a. Head, neck, eyes, ears, CV, respiratory, abdomen, skin
   b. Chest, Breast, 4 extremities, CV, skin, neuro, GU
   c. Eyes, Ears, LN’s, CV, GI, GU, skin, neuro, psych
   d. Detailed skin exam, LN’s, Back, Musculoskeletal, CV

4. According to the 1997 E/M guidelines an extended HPI can be obtained with the following documentation?
   a. 4 elements of the HPI
   b. Status of 3 chronic conditions
   c. Status of 3 inactive conditions
   d. All of the above

5. A new patient is seen for a consultation during their hospital admission. The physician sees the patient in the office 1 week following discharge for follow up. A code from which category would be assigned for the follow up visit.
   a. Office Visit, New Patient
   b. Office Visit, Established Patient
   c. Office Consult, Established Patient
   d. Subsequent Hospital Care
6. The physician may bill separately for a gastric intubation, CPT code 43752, when done at the same time critical care services are provided, CPT code 99291?
   a. True
   b. False

7. A woman presents for her annual well women exam. During the exam, her hypertension and diabetes are addressed. Can the physician bill a separate office visit E/M in addition to the preventive medicine E/M if the key components are documented for the hypertension and diabetes assessment?
   a. Yes
   b. No

8. CPT procedure code 12031 has a global period of how many days?
   a. 0
   b. 10
   c. 30
   d. 90

9. A physician performs a TKA. 5 weeks later, the total knee arthroplasty becomes infected and the patient is taken to surgery to remove all of the components of the arthroplasty. Which modifier will be appended to the code for the removal of the TKA?
   a. No modifier required
   b. Modifier 22
   c. Modifier 78
   d. Modifier 79

10. According to CPT guidelines, what is the correct way to report a bilateral breast reduction?
    a. 19318 x 2 units
    b. 19318-RT and 19218-LT
    c. 19318 and 19318-50
    d. 19318-50

Section B– Line Coding: Assign CPT codes with appropriate modifier if applicable (include anatomical modifiers).

1. Twelve actinic keratoses removed from the back by cryosurgical destruction.

2. LHC for coronary angiogram only. Interpretations and Supervision by physician.

3. Closure of 2.5 cm foot wound with Dermabond (Non-Medicare patient).

5. Cautery of 1 cm open nose wound.
6. Interpretation with report of EKG tracing.
7. Office follow up 6 weeks after THA. PF hx, EXP exam, and SF MDM documented.
8. Replacement of dual chamber pacemaker generator.
9. Left heart catheterization, coronary angiograms, left ventriculography. Interpretation and supervision by physician.

Section C – Injections and Infusions: Assign CPT codes with appropriate modifier if applicable. Assume all injections and infusions are performed/supervised by the physician.

1. Intramuscular injection of human rabies immune globulin.
2. TD vaccination, preservative free 10 year old boy – given IM.
3. IVP of Toradol at 11:00 and Demerol at 12:00.
4. IV Infusion of Cipro from 10:00 – 11:30.
5. IV Infusion of Levaquin from 7:45 – 8:25 and IVP of Zofran.
6. IV Infusion of NS for dehydration from 12:32 – 1:15, IV Infusion of Rocephin from 1:45 – 2:30, IVP of Benadryl at 2:55.
7. IV Infusion of NS for hydration from 9:05 – 9:55 and IV Infusion of 5-Fluorouracil from 10:00 – 11:55.

Part IV – Case Studies: Code the following cases with ICD-9-CM diagnosis codes, CPT procedure codes, and applicable modifiers for physician reimbursement. For E/M, use 1997 guidelines. Follow CPT guidelines (not payor specific guidelines), appropriate NCCI edits, and add anatomical modifiers. Assign Medicare G-codes instead of CPT code if appropriate. Assume only interpretation and supervision for all radiology procedures.

**Case #1:**
Preoperative Diagnosis: Basal Cell Carcinoma and Pigmented Nose Lesion.
Postoperative Diagnosis: Same
Procedure Performed: Excision of Lesions x 2 and Advancement Flap.
Findings: 2 cm left cheek lesion and 1 cm nose lesion.
Pathology: Specimen A: 1.9 x 1.8 x 0.8 cm lesion, basal cell carcinoma. Specimen B: 0.9 x 0.7 x 0.4 cm lesion, seborrheic keratosis.
The patient was prepped and draped in sterile fashion in the supine position and administration of anesthesia was done. Lidocaine with epinephrine was infiltrated into the skin surrounding the lesions. An elliptical transverse incision was made to fully excise the nose lesion with 1 mm margins. Interrupted 6-0 Nylon sutures were then placed to close the skin defect. Next, the cheek lesion was addressed and an elliptical transverse incision was made to fully excise the cheek lesion. This was taken to the deep subcutaneous tissue to ensure removal of the carcinoma. The lesion was removed with 2mm margins. Frozen section came back basal cell carcinoma and the margins were clear. A defect was left and this was unable to be closed. Flaps were created and undermining performed. The flaps were advanced into the defect and closed with 6-0 Nylon sutures. This gave a nice closure. The patient tolerated the procedure well.

**Case #2:**
Preoperative Diagnosis: Screening Colonoscopy
Postoperative Diagnosis: Colon Polyp, Rectal Polyp, and Diverticulosis
Procedure Performed: Colonoscopy
Pathology: Adenomateous Colon Polyps and Hyperplastic Rectal Polyp.
The colonoscope was inserted into the rectum and advanced to the cecum. The cecum, ascending and transverse colon were normal. The descending colon was noted to have a 6 mm sessile polyp which was snared and retrieved. The sigmoid colon was noted to have a 2 mm polyp which was removed with biopsy forceps. On the exam of the rectum, a 3 mm polyp was noted. It was very flat and saline was injected to lift the polyp. The polyp was then removed with the snare and retrieved. The descending and sigmoid colon had diverticulosis. No hemorrhoids were noted. The patient tolerated the procedure well.

**Case #3:**
Chief Complaint/History of Present Illness: 19:15
A 28-year-old female that presented to the Emergency Department at 18:34 by AMB-POV. The patient was triaged at 18:45 with the following vital signs: T: 97.9 PO, P:73 regular, R: 18 unlabored, BP: 105/054, SP02: 100 Amt: RA, Pain: 10ear. The patient’s primary care physician is NONSTAFF.

**Chief Complaint – Ear Ache**
Exam Time: 19:01.
History obtained from: patient.
Onset of symptoms was 1 day(s) ago. Symptoms came on gradually and became progressively worse.
Symptoms are present now.
Symptoms located in the left and right ears.
Patient states symptoms are of mild severity.
Associated signs and symptoms are of mild severity.
Associated signs and symptoms: negative cough, negative drainage, positive excessive cerumen, negative fever, negative headache, positive hearing loss, negative nausea, negative runny nose, negative sore throat, negative tinnitus, negative vertigo. Patient reports that she has a one-day history of pain to both ears. Patient reports that she was sticking a Q-tip in right ear and believes that some cotton may still be in the ear canal.

**Review of Systems:** 19:17
Respiratory: negative cough
Constitutional: negative fever.
Neurological: negative headache, negative vertigo.
Gastrointestinal: negative nausea.
ENT: negative rhinorrhea, negative sore throat, negative tinnitus.
All (other) systems have been reviewed and are negative.

**Past Medical And Surgical History:** 19:18
Past Medical History: positive ASTHMA.
Reproductive History: LMP: 2 WEEKS.

**Family and Social Histories, Allergies and Meds:** 19:18
Allergies: *NO KNOWN ALLERGIES
Medications: ALBUTEROL, INHALER, NEBULIZER
Family History has been reviewed and is non-contributory.

**Physical Examination:** 19:18
**General:** WD, well nourished and in NAD.
**HEENT:** Ears: Left otic canal normal, hard, black cerumen, not able to see TM. No foreign object visualized. Right otic canal normal, Black, hard cerumen in canal, TM not visualized, no foreign body visualized. **Head/Face:** NC/AT. **Eyes:** Pupils equal, round and reactive to light. Extraocular motion intact. **Nose:** Normal external appearance. Septum midline and intact. **Pharynx:** Posterior pharynx is unremarkable.
**Neck:** Supple with no palpable adenopathy.
**Respiratory:** No respiratory distress. Lungs clear with equal breath sounds bilaterally.
**Cardiovascular:** PMI normal. RRR. S1, S2 normal with no murmurs, clicks, gallops or rubs. All distal pulses 2+ and symmetric.
**Abdomen:** Bowel sounds are normal. Abdomen is soft, flat, non-tender, without organomegaly or palpable mass.
**Neurologic:** Mental Status: awake and alert. Oriented X 3.
After irrigation of ear canals and removal of cerumen, both TM’s are erythematous.
Ed Course and Treatment: 19:16

Procedures: Treatments Performed: Both ears irrigated with soln H20/H202

Clinical Impression: 19:16
1. Cerumen Impaction, Bilateral
2. Acute Otitis Media

Disposition: 19:23
Disposition: Patient discharged to home.
Condition: Stable, Improved.
Disposition date/time: 04/06/2007 19:23.
Discussed care with patient and family. Explained findings, diagnosis, and need for follow-up care.

Instructions: 19:23
Patient has received printed discharge instructions. Discharge plans discussed with patient who verbalizes understanding and willingness to comply. Prescription(s) written for: Amoxil 875 mg: by mouth twice a day; quantity: 20 (twenty).
Patient agrees to obtain follow up care in three days.
Patient agrees to return to Emergency Department immediately if symptoms worsen or fail to improve.

Case #4:
ESTABLISHED PHYSICAL EXAMINATION

Subjective: Patient presents to clinic today for an evaluation of ear pain. She reports symptoms started 2 days ago and that she has had some cough and congestion. She reports no fever and no medications.

Objective: Vitals: Weight is 100.04 pounds. Blood pressure 110/70, pulse is 84, temperature is 98.6. GCS is 15. Pain level is 0. General: White female in no acute distress. Alert and oriented. HEENT: AC, AT. Right TM with erythema, bulging, decrease in bony landmarks. Left TM with thick effusions. PERRL. EOMs are intact. Nasal mucosa with small amount of yellow mucoid drainage. Oropharynx with post nasal drip. NECK: Supple without LAD. LUNGSL Clear to auscultation bilaterally. CARDIOVASCULAR: Regular rate and rhythm without MRG. ABDOMEN: Soft, nondistended, nontender and normal bowel sounds. No hepatosplenomegaly and no masses. EXT: No clubbing, cyanosis or edema. SKIN: No rashes noted. NEURO: No focal deficits.

Assessment: 1. Right otitis media. 2. Left serous otitis. 3. Upper respiratory infection

Plan: Our plan today is to start Augmentin 875 mg, 1 p.o.bid.x 7 days. Atuss – DS 1.5 teaspoon b.i.d. p.r.n. with 4 ounces given. Motrin and Tylenol p.r.n. Patient to return to clinic without improvement in symptoms.