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# PMCC Instructor Mid-Term

1. What is down coding?
  - a. Choosing a CPT® code to report a medicine service (90000 codes of CPT®)
  - b. Assigning a high-level visit or complex surgical CPT® code to a service that is not supported by documentation or was not performed at the level coded
  - c. **The under-reporting of levels of E/M services or other services (page 1.4)**
  - d. Using a Level 1 code rather than the appropriate Level II code
2. The surgical fee charged by the surgeon represents:
  - a. The amount Medicare reimburses for a given service nationally
  - b. The primary insurance holder in the family, as related to the birthday rule, and the subsequent fees the family pays according to the specific health care policy
  - c. **The single fee that covers all procedures and services associated with a specific procedure (page 1.5)**
  - d. The annual amount the primary insurance holder pays to renew the family or individual health care insurance policy
3. A coder may change the provider's billing information due to an error in billing without consulting the provider.
  - a. True
  - b. **False (page 1.13)**
4. The golden rule of procedural coding for compliance is:
  - a. It's not what you document that matters, but how much you get paid
  - b. **If it is not documented, it is not done; therefore, it is not billable (page 1.14)**
  - c. A penny billed is always a penny you will receive in reimbursement
  - d. Never question the provider about his or her documentation, despite the number of red flags the documentation may raise

5. The Health Insurance Portability and Accountability Act accomplishes the following:
  - a. Provides penalties for submitting fraudulent health care claims
  - b. Eliminates penalties for preexisting conditions for people with continuous health coverage
  - c. Makes it unacceptable to deny health care coverage for people with serious chronic illnesses
  - d. All of the above (page 1.18)**
  
6. A retrospective audit refers to:
  - a. Auditing according to earlier methods that – when looking back – appear to have been more efficient and reliable
  - b. Auditing patient records against proposed billing information
  - c. Checking levels of reimbursement for a given specialty against the fees charged by the specialist in a specific group practice
  - d. Auditing paid claims as a way to solve potential problems in documentation and billing (page 1.19)**
  
7. Of the following choices, which three are considered “alternative code sets?” (choose three)
  - a. SNOMED**
  - b. Modifiers Made Easy
  - c. ICD-10 PCS**
  - d. LOINC (page 1.20)**
  
8. The Integumentary system refers to the following structures:
  - a. Skin, hair and nails (page 2.3)**
  - b. Heart and blood vessels
  - c. Kidneys, ureters, urinary bladder and urethra
  - d. Eyes, nose and throat
  
9. This gland regulates metabolism and serum calcium levels:
  - a. Thymus gland
  - b. Adrenal gland
  - c. Thyroid gland (page 2.12)**
  - d. Pituitary gland

10. Which of the following is part of the lymphatic system?
- Bone marrow (CPT® book)**
  - Uvula
  - Appendix
  - Bladder
11. Which two statements are true? (choose two) “Medically necessary services....”
- Are reimbursed at a higher value than those that are not medically necessary
  - Are consistent with the diagnosis (page 3.2)**
  - Are always chronic in nature
  - Are the most appropriate level of care provided in the most appropriate setting (page 3.2)**
12. According to CMS guidelines for correct diagnostic coding, it is not necessary to report a chronic diagnosis more than once whether or not the diagnosis is applicable to the patient’s treatment during subsequent encounters.
- True
  - False (page 4.4)**
13. A coder can depend upon Volume 2 of ICD-9-CM (the Alphabetic Index) for correct code assignment without ever consulting Volume 1 (the Tabular Index).
- True
  - False (page 4.5)**
14. Italicized codes listed in ICD-9-CM Volume 1 is a coding convention that tells you:
- The coder should code the underlying disease first and the italicized code second (page 4.6)**
  - The coder should look for one code that describes the underlying disease in relation to the presenting problem
  - The coder should code the italicized code first, the underlying disease second
  - The coder should go back to the provider’s documentation, since the italics indicate the diagnosis is easily miscoded
15. The V codes are one of the two supplementary classifications found in ICD-9-CM Volume 1. When would you report a V code?
- To describe the cause of poisonings and other adverse effects
  - To describe a patient encounter for a specific illness
  - To describe a patient encounter for other than a disease or an injury (page 4.32)**
  - To identify the known cause of a communicable disease

16. The Neoplasm Table lists neoplasms according to:
- Alphabetical order
  - Anatomical location
  - Behavior, eg, malignant, secondary, Ca in situ
  - All of the above (page 4.12)**
17. The term adverse reaction means:
- A reaction when the wrong drug or an incorrect dosage of a correct drug is ingested
  - A morbid phenomenon or departure from the normal structure, function or sensation experienced by the patient and indicative of the disease
  - A reaction when a prescription medicine or drug is taken according to instructions and the patient develops a reaction (page 4.28)**
  - A reaction that occurs after the acute phase of an illness or injury has terminated
18. Scarring of the left leg due to a third degree burn is an example of:
- A late effect (page 4.30)**
  - An adverse reaction
  - A complication code reported as a primary diagnosis
  - A chronic condition
19. A fifth digit in reporting diabetes mellitus indicates:
- Manifestations that may appear with diabetes
  - Whether the patient is Type 1 (insulin-dependent) or Type II (noninsulin-dependent)
  - Whether the condition is not stated as uncontrolled or in an uncontrolled state
  - b and c (page 4.15-4.16 and ICD-9-CM)**
20. Writing “high risk” on a medical record is sufficient wording when an obstetrical patient presents with edema during the last trimester
- True
  - False (page 4.19)**

Choose the appropriate ICD-9-CM diagnostic code(s) for questions 21-24.

21. A 26-year-old female is seen at the ER for sudden onset of fever, chills, vomiting, diarrhea, muscle pains and rash. She is diagnosed as having toxic shock syndrome due to Staphylococcus aureus, is admitted and taken to the OR for immediate surgery to remove an intravaginal contraceptive device associated with the condition.
- 616.10, 041.10
  - 780.6, 008.41, 729.1, 782.1, 996.32
  - 040.82, 041.11, 996.32 (ICD-9-CM book)**
  - 780.6, 008.41, 729.1, 782.1, 616.10

22. A 14-year-old female suffers a superficial burn to the back of her hand from a Bunson Burner while moving a crucible using a pair of tongs during an experiment in her junior high chemistry class.
- a. 944.06, E924.0
  - b. 944.16, E898.1 (ICD-9-CM book)**
  - c. 944.15, V15.89
  - d. 944.00, E891.3
23. A two-year-old female is seen for chicken pox.
- a. 031.1
  - b. 055.9
  - c. 052.8
  - d. 052.9 (ICD-9-CM book)**
24. A 48-year-old male has an appointment with his family practitioner. The appointment includes a general medical exam with minimal assessment of his hypertension.
- a. 401.9, V70.0, V68.1
  - b. V71.7
  - c. V70.0, V68.1
  - d. 401.9, V70.0 (ICD-9-CM book)**
25. For ICD-10-CM, which of the following three statements are true? (choose three)
- a. Contains fewer injury codes
  - b. Has greater specificity in code assignment**
  - c. Incorporation of common fourth and fifth sub classifications**
  - d. Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition (page 4.45)**
26. There are two levels of HCPCS codes. Level I codes are described as:
- a. Five digit codes and two character modifiers developed and updated annually by the American Medical Association (page 5.2)**
  - b. Beginning with letters A-T and V followed by four digits and two character modifiers having either two letters or a letter and a digit, updated annually by the CMS
  - c. Five character codes beginning with the letters W, X, Y or Z and two character modifiers, developed by local carriers to report services and procedures, and equipment and supplies
  - d. Three to five digit codes developed and updated annually by the National Center for Health Statistics

27. Which of the following describes Level II HCPCS codes?
- Four digits followed by a single letter
  - A single letter followed by four digits (page 5.14)**
  - Two letters followed by three digits
  - Five digits and no letters
28. What is the correct Level II HCPCS modifier for describing the technical component of a procedure?
- 26
  - GA
  - 50
  - TC (page 5.22)**
29. Level II HCPCS codes report only the following:
- Supplies for partially ambulatory and nonambulatory beneficiaries, such as crutches, wheelchairs and walkers, as well as removable and permanent prosthetics
  - Transportation services including ambulance, medical and surgical supplies, and administrative, miscellaneous and investigational supplies, procedures and services (page 5.2)**
  - Surgical supplies and drugs specific to procedures performed under the Outpatient Prospective Payment System
  - Laboratory services and travel allowance codes specific to specimen collection from homebound or nursing homebound patients
30. Covered services refer to:
- Services that are payable in accordance with terms of the payer's benefit plan contract (page 3.2)**
  - Services and procedures payable under the Medicare Physician Fee Schedule
  - Services that are considered elective and therefore not payer reimbursed, unless the provider fails to notify the beneficiary of noncoverage policies
  - Documented services and procedures regardless of medical necessity
31. In the "SOAP" format of medical record documentation, the key components of the E/M service should be documented. What term describes the section of the medical record that contains the diagnostic process based on patient complaints and factors the provider noticed?
- Subjective
  - Objective
  - Assessment (page 3.6)**
  - Plan

32. Transcripts of dictated notes do not require the provider's signature.
- True
  - False (page 3.10)**
33. The descriptions of the levels of E/M services recognize seven components for defining the levels of E/M services. Which components are considered the three key components among the seven in selecting the E/M level of service?
- Counseling, time and examination
  - History, examination and medical decision making (page 6.9)**
  - History, time and medical decision making
  - Time, examination and medical decision making
34. A nurse practitioner, who has the required state injection certification, gives an IM flu vaccination, whole virus, to an established patient as ordered by the physician after taking and recording vital signs. The physician is in the office but with a patient who had a scheduled physical exam for life insurance purposes. Choose the most appropriate code(s) for the NP.
- 99211, 90471, 90658 (page 6.17)**
  - 99201, 90658
  - 99506
  - No code applies since injections require direct physician supervision of the NP
35. A dermatologist sees a 15-year-old male in the office at the request of the family physician to give an opinion on the management of the teen's acne. The dermatologist sends a response back to the family physician. The dermatologist performed a problem focused history, a problem focused examination and straightforward medical decision making for the specific type of outpatient visit. Code the services the dermatologist provided.
- 99232
  - 99201
  - 99241 (page 6.19-6.20)**
  - 99212
36. Which of the following factors control the level of code selected when counseling takes greater than 50 percent of a home visit encounter for a new patient?
- Time (page 7.36)**
  - Medical decision making
  - Level of consultation
  - All of the above

37. The payer requires patient referral to an allergist to provide an opinion about the medication the primary physician prescribes. A problem focused history, expanded problem focused examination and low level of medical decision making are documented. The allergist forwards a copy of his report to the payer.
- 99241
  - 99271-32 (page 7.39-7.40)**
  - 99211
  - 99499-77
38. The appropriate E/M code is reported in lieu of a critical care code when less than a half-hour of service is provided in a critical care situation.
- True (page 7.42-7.43)**
  - False
39. The age of a neonate is considered to be:
- The first 24 hours after birth
  - Fourteen days old for an infant born prematurely and seven days for a full-term birth
  - Thirty days of age or less (page 7.44)**
  - Ninety days of age or less
40. When a patient is in a postoperative period and returns to the operating room for an unrelated procedure by the same physician, which of the following modifiers would you attach to the procedure being performed?
- 59
  - 79 (page 8.4)**
  - 78
  - 62
41. The following modifier would be appended to the office visit code when the provider decides the patient's problem warrants surgery within the next 24 hours.
- 25
  - 57 (page 8.4)**
  - 78
  - 62
42. A procedure that is bilateral by description requires a modifier -50, eg, adenoids and tonsils).
- True
  - False (page 8.13)**

Choose the CPT® code(s) for the scenarios in questions 43-44.

43. A female patient has cancer of the left breast, which was diagnosed by excisional biopsy. Today she is undergoing an Urban type radical mastectomy and concurrently a single pedicle TRAM flap reconstruction with supercharging.
- a. 19367, 19240-51
  - b. 19368, 19367-51, 19220-51
  - c. 19368, 19220-51 (CPT® book)**
  - d. 19367, 19200-51
44. A male patient came to the office with a 2.6 cm benign lesion on his left calf that was excised by his physician. The physician took an additional margin of .25 cm on both sides of the lesion, which was determined acceptable to remove the lesion in its entirety. Layered closure was used. What would the CPT® code(s) be for the procedure?
- a. 11404, 12002-51
  - b. 12032, 11404-51 (CPT® book)**
  - c. 11604, 12032-51
  - d. 11604, 12042-51
45. These glands are commonly referred to as oil glands.
- a. Apocrine sweat glands
  - b. Subderiferous glands
  - c. Sebaceous glands (page 9.6)**
  - d. Hypersecretion glands
46. The Rule of Nines refers to:
- a. The optimum number of diagnostic codes that can be reported on a CMS-1500 form
  - b. The maximum number of lesions that can be destroyed during the same operative session
  - c. The most commonly used method to evaluate the percentage of body surface burned (page 9.24)**
  - d. The number of specimens required when reporting code 17310
47. A replacement cast for the first cast applied within the follow-up period of fracture care is reported as an E/M visit.
- a. True
  - b. False (page 10.18)**

48. The surgical term for spinal fusion is:
- a. Laminectomy
  - b. Arthrodesis (page 10.25)**
  - c. Manipulation
  - d. Chondroplasty
49. Which of the following two modifiers may not be reported with spinal instrumentation codes?
- a. -51, -62 (page 10.25)**
  - b. -51, -50
  - c. -50, -62
  - d. -25, -50
50. What is the CPT® code(s) for a segmentectomy of the right lung and a wedge resection of the left lung due to bacterial infection?
- a. 32484-50
  - b. 32500-LT, 32484-RT (CPT® book)**
  - c. 32440-RT, 32484-LT
  - d. 32520-RT, 32500-LT