
PMCC Instructor Midterm

1. What is under 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. **Billing for a service that is less than that actually rendered and/or documented (page 1.15)**
 - d. Using a Level 1 code rather than the appropriate Level II code.
2. A coder should never change a providers billing or coding information without:
 - a. Informing/consulting with the patient
 - b. Informing/consulting with the HIM office
 - c. Informing/consulting with the insurance carrier
 - d. **Informing/consulting with the provider (page 1.10)**
3. What are the three units that make up a RVU for physicians services? (Choose three)
 - a. **Physician work expense**
 - b. **Practice expense**
 - c. Supply cost
 - d. **Professional liability insurance (page 1.3)**
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 1.12 and 3.5).**
 - 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. Under HIPAA, which of the following two choices are examples of a “covered entity?” (Choose two)
 - a. Health fair participants
 - b. Health care providers**
 - c. Elementary school health programs
 - d. Health care clearing houses (page 1.6)**

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 1.14).**

7. In order for a service to qualify as “incident to” the physician must:
 - a. Be in the same room with the nonphysician provider performing the service
 - b. Be on his/her way to the office where the nonphysician provider is performing the service
 - c. Be in the office suite and available to the nonphysician provider (page 3.20)**
 - d. Physician does not have to be available to the nonphysician provider or patient

8. The Integumentary system refers to the following structures:
 - a. Skin, hair, nails, and glands (page 9.1)**
 - 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 2.14)**
 - d. Pituitary gland

10. Which of the following is part of the lymphatic system?
- a. **Bone marrow (CPT® book)**
 - b. Uvula
 - c. Appendix
 - d. Bladder
11. Which two statements are true? (Choose two) “Medically necessary services are”
- a. Reimbursed at a higher value than those that are not medically necessary
 - b. **Consistent with the diagnosis (page 3.2)**
 - c. Always chronic in nature
 - d. **The most appropriate level of care provided in the most appropriate setting (page 3.2)**
12. Surgical removal of a segment of an organ or body structure is known as:
- a. Bisection
 - b. **Resection (page 3.17)**
 - c. Adherence
 - d. Anastomosis
13. For correct ICD-9-CM code assignment, in the physician setting, a coder must:
- a. Consult Volume 2 only
 - b. Consult Volume 1 only
 - c. Consult the V code section only
 - d. **Consult Volume 2 and confirm code in Volume 1 (ICD-9-CM book)**
14. Italicized codes listed in ICD-9-CM Volume 1 is a coding convention that tells you:
- a. **The coder should code the underlying disease first and the italicized code second (page 4.5)**
 - b. The coder should look for one code that describes the underlying disease in relation to the presenting problem.
 - c. The coder should code the italicized code first the underlying disease second.
 - d. 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 4.34)**
 - To identify the known cause of a communicable disease
16. The Neoplasm Table lists neoplasms according to which of the following three categories? (Choose three)
- Primary**
 - Secondary**
 - Ca in situ (ICD-9-CM)**
 - Layer of skin affected
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 4.33)**
 - A reaction that occurs after the acute phase of an illness or injury has terminated
18. Scarring of the left leg due to third degree burn is an example of:
- A late effect (page 4.34)**
 - 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 I or Type II
 - Whether the condition is stated as controlled or uncontrolled
 - b and c (page 4.15 and ICD-9-CM)**

Choose the appropriate ICD-9-CM diagnostic code(s) for questions 20-24.

20. A 36-year-old woman has just been informed that she is pregnant. She is very excited because she has had a previous history of infertility. This high risk pregnancy must be closely supervised.

What is the correct code for this high risk pregnancy?

- a. 646.80
 - b. V23.5
 - c. **V23.0 (page 4.20 and ICD-9-CM book)**
 - d. 646.90
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.
- a. 616.10, 041.10
 - b. 780.6, 008.41, 729.1, 782.1, 996.32
 - c. **040.82, 041.11, 996.32 (ICD-9-CM book)**
 - d. 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 Bunsen 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. 944.26, E891.3
 - d. 944.00, E898.1
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. **V70.0, 401.9 (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 4.47)**
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 5.3)**
 - 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?
- a. Four digits followed by a single letter
 - b. A single letter followed by four digits (page 5.14)**
 - c. Two letters followed by three digits
 - d. Five digits and no letters
28. What is the correct Level II HCPCS modifier for describing the technical component of a procedure?
- a. -26
 - b. -GA
 - c. -50
 - d. -TC (HCPCS book)**

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 (HCPCS book)**
 - 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. Which of the following three items are considered significant components of basic documentation? (Choose three)
- X-ray reports
 - Date and time**
 - Signatures**
 - Patient identification (pages 3.8 - 3.9)**

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 6.3)**
 - History, time, and medical decision making
 - Time, examination, and medical decision making
34. A nurse gives an IM flu vaccination, split 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 nurse.
- 90471, 90658 (page 6.17)**
 - 99201, 90658
 - 99211, 90657
 - No code applies since injections require direct physician supervision of the nurse
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 6.16 - 6.17)**
 - 99212
36. Which of the following factors control the level of code selected when counseling takes greater than 50 percent of an encounter for a new or established patient?
- Time (page 7.34)**
 - Medical decision making
 - Level of consultation
 - Patient's age

37. The payer requires patient consult 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. What is the correct CPT® code for this service?
- a. 99241
 - b. 99271-32 (page 7.35-7.36)**
 - c. 99273
 - d. 99499-32
38. According to CPT® guidelines critical care is provided to which of the following?
- a. Patients with a heart rate below 58 bpm
 - b. Patients who have been in the hospital for more than a week
 - c. Patients who present to the ED with a gunshot wound
 - d. Patients that are critically ill or critically injured (page 6.24)**
39. The age of a neonate is considered to be:
- a. The first 24 hours after birth
 - b. Fourteen days old for an infant born prematurely and seven days for a full-term birth
 - c. Twenty-eight days of age or less (page 7.40)**
 - d. 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?
- a. -59
 - b. -79 (page 8.4)**
 - c. -78
 - d. -62
41. Which of the following modifiers would be appended to the office visit code when the provider determines the patient's problem warrants surgery?
- a. -25
 - b. -57 (page 8.4)**
 - c. -78
 - d. -62

42. An example of a procedure that is strictly bilateral by description in the CPT® manual is:
- a. **58565 (CPT® book)**
 - b. 58720
 - c. 58900)
 - d. 58750

Choose the correct 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. Eschar is:
- a. Outermost layer of skin
 - b. Tissue damage that involves the total loss of epidermis and dermis extending into the subcutaneous tissue
 - c. **Black or brown necrotic, devitalized tissue (page 9.4)**
 - d. Soft, moist avascular (devitalized) tissue, may be white, yellow, tan, or green
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 9.22)**
 - d. The number of specimens required when reporting code 17310

47. Of the following, which three are methods used to destroy lesions? (Choose three)
- a. Chemical peel
 - b. Electrosurgery**
 - c. Curettage**
 - d. Cryosurgery (page 9.23)**
48. What is the appropriate CPT® code(s) to report when replacing a cast on the forearm for the first cast applied after the initial application?
- a. 29085 (CPT® book)**
 - b. 99211
 - c. 29805 x 2
 - d. 99024
49. Which of the following two modifiers may not be reported with spinal instrumentation codes?
- a. -51, -62 (page 10.19)**
 - 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. 32520-RT, 32500-LT
 - c. 32440-RT, 32484-LT
 - d. 32500-LT, 32484-RT (CPT® book)**