

2006

PMCC Midterm - with Answers and References

1. What is undercoding?
 - 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 provider's 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. Covered services refer to:
 - a. Services and procedures listed in the Medicare Physician Fee Schedule
 - b. **Services that are payable in accordance with terms of the payer's benefit plan/contract** (page 3.2)
 - c. Services that are considered elective and therefore not payer reimbursed, unless the provider fails to notify the beneficiary of noncoverage policies
 - d. Documented services and procedures regardless of medical necessity
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** (pages 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. In general, HIPAA was established for which of the following two purposes? (Choose two)
 - a. To establish information guidelines for patients only
 - b. **To establish health care privacy standards**
 - c. To establish health care accountability systems for electronic medical records
 - d. **To establish health care security standards** (page 3.3)

6. A retrospective audit refers to:
- Auditing according to earlier methods that – when looking back – appear to have been more efficient and reliable
 - Auditing patient records against proposed billing information
 - Checking levels of reimbursement for a given specialty against the fees charged by the specialist in a specific group practice
 - Auditing paid claims as a way to solve potential problems in documentation and billing** (*page 1.14*)
7. The “indication” portion listed on the operative report is used to describe:
- The surgical procedure being performed
 - The patient’s status intraoperatively
 - The medical necessity for the procedure** (*page 3.15*)
 - The severity of the procedure being performed
8. The Integumentary system refers to the following structures:
- Skin, hair, nails, and glands** (*page 9.1*)
 - Heart and blood vessels
 - Skin, sebaceous glands, and thyroid
 - Eyes, nose, and throat
9. What is the correct term used to report inflammation of the spinal cord?
- Spinocostalis
 - Medulla oblongata
 - Myelitis** (*page 2.20–2.21*)
 - Spinitis
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
 - Consistent with the diagnosis** (*page 3.2*)
 - Always chronic in nature
 - The most appropriate level of care provided in the most appropriate setting** (*page 3.2*)

12. Surgical connection of two hollow tubes is known as:
- Bisection
 - Resection
 - Adherence
 - Anastomosis** (*page 3.18*)
13. For correct ICD-9-CM code assignment in the physician setting, a coder must:
- Consult Volume 2 only
 - Consult Volume 1 only
 - Consult the V code section only
 - Consult Volume 2 and confirm code in Volume 1** (*ICD-9-CM book*)
14. Italicized codes listed in ICD-9-CM Volume 1 are listed as a coding convention that informs the coder to:
- Code the underlying disease first and the italicized code second** (*page 4.5*)
 - Look for one code that describes the underlying disease in relation to the presenting problem
 - Code the italicized code first and the underlying disease second
 - 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**
 - Carcinoma in situ** (*ICD-9-CM book*)
 - 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 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 not stated as uncontrolled
 - b. and c.** (*page 4.15 and ICD-9-CM book*)
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 and this is her first pregnancy. This high risk pregnancy must be closely supervised. What are the correct diagnosis codes for this pregnancy?
- 633.00, 628.9
 - V23.89, 628.9
 - V23.81, V23.0** (*ICD-9-CM book*)
 - V23.0, 646.90, V23.81
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. Which are the appropriate ICD-9-CM codes for this encounter?
- 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 Bunsen burner (blowlamp) while moving a crucible with a pair of tongs during an experiment in her junior high chemistry class. Which ICD-9-CM codes accurately report this scenario?
- 944.06, E924.0
 - 944.16, E898.1** (*ICD-9-CM book*)
 - 944.26, E891.3
 - 944.00, E898.1

23. A two-year-old female is scheduled to be seen for chicken pox. The physician examines the patient and determines the child has a viral xanthem type condition also known as pseudoscarlatina. What is the correct diagnosis code for this visit?
- a. 052.9
 - b. 057.9
 - c. 034.0
 - d. 057.8 (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. The patient's hypertensive medication was refilled. Which diagnosis code(s) would be reported for this encounter?
- 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. A home health agency provided occupational therapy services to a 52-year-old patient who is temporarily homebound. The therapist spent a total of 45 minutes with the patient. Which HCPCS Level II code describes this service?
- a. S9129 x 3
 - b. G0152
 - c. G0152 x 3**
 - d. G0156
26. A physician ordered an injection of 750 mg of ceftriaxone sodium to a patient with a severe respiratory infection. Which HCPCS Level II code should be used for the drug?
- a. J0697 x 1
 - b. J0694 x 1 -52
 - c. J0696 x 3**
 - d. J3590 x 750 mg
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?
- 26
 - GA
 - 50
 - TC** (*HCPCS Level II book*)
29. Level II HCPCS codes are used for Medicare, Medicaid, and many private payers. Which statement most accurately describes this wide range of services/supplies reported by HCPCS Level II codes?
- Supplies for partially ambulatory and nonambulatory beneficiaries, such as crutches, wheelchairs, and walkers, as well as removable and permanent prosthetics and OPPS supplies
 - Transportation services including ambulance, medical and surgical supplies, and administrative, OPPS services or supplies, miscellaneous and investigational supplies, procedures and services** (*HCPCS book–Introduction*)
 - Surgical supplies and drugs specific to procedures performed under the Outpatient Prospective Payment System and dental services
 - Laboratory services and travel allowance codes specific to specimen collection from homebound or nursing homebound patients
30. A patient's pap smear came back with a diagnosis of CIN III (severe cervical dysplasia). What diagnosis code should the provider use?
- 622.10
 - 233.1** (*ICD-9-CM book*)
 - 622.9
 - 180.9
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 findings by the provider?
- Subjective
 - Objective
 - Assessment** (*page 3.6*)
 - Plan
32. Which of the following three items are considered significant components of basic documentation? (Choose three)
- Date and time**
 - X-ray reports
 - 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 patient presents for a reading of a PPD that was administered three days prior. The physician is in the office but with another patient who had a scheduled physical examination. The nurse documented and noted a normal reading in the medical record that was signed off by the physician. Choose the most appropriate code(s) for the services provided by the nurse.
- 99211, 86580
 - 86580
 - 99211**
 - 99471, 86580
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 after performing a problem focused history, a problem focused examination, and straightforward medical decision making. Code the services the dermatologist provided.
- 99251; 706.3
 - 99201; 706.0
 - 99241; 706.1** (*pages 6.16–6.17*)
 - 99212; 706.9
36. Which of the following factors control the level of the code selected when physician counseling is greater than 50 percent of an encounter for a new or established patient?
- Consultation level
 - Medical decision making
 - Time** (*page 7.34*)
 - Nature of the presenting problem

37. The payer requires a 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 way to code for this service?
- a. 99242-SU
 - b. 99241-32** (pages 7.35–7.36)
 - c. 99253-SF
 - d. 99201-32
38. According to CPT® guidelines, critical care is provided to which of the following?
- a. Patients with a heart rate below 58 bpm and considered serious
 - b. Patients who are in the hospital intensive care unit
 - c. Patients who present to the ED with a gunshot wound
 - d. Patients who 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 a premature infant 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 code that is strictly bilateral by description in the CPT® manual is:
- a. 58720
 - c. 58900
 - c. 58565 (CPT® book)**
 - d. 58750
43. A female patient has cancer of the left breast, which was diagnosed by excisional biopsy over three months ago. Today she is undergoing an Urban type radical mastectomy and concurrently a single pedicle TRAM flap reconstruction with supercharging. Which CPT® codes describe the procedures performed?
- 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 CPT® codes would be reported for the procedure?
- a. 11404, 12002-51
 - b. 12032, 11404-51 (CPT® book)**
 - c. 11604, 12032-51
 - d. 11404, 12042-51
45. The term “eschar” is described as;
- a. Outermost layer of skin suffering first and second degree burns
 - 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 nine steps a coder is required to follow as outlined in the Academy Code of Ethics
 - 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 burned body surface (page 9.22)**
 - d. The number of specimens required when reporting code 17310

47. Of the following, which three methods are used to destroy lesions? (Choose three)
- a. Chemical peel
 - b. Electrosurgery**
 - c. Surgery**
 - d. Cryosurgery** (*page 9.23*)
48. What is the appropriate CPT® code to report replacement of a forearm cast on a date other than the initial application?
- a. 29085** (*CPT® book*)
 - b. None, as the cast application is part of the global fracture care code
 - 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 CPT® code(s) would be reported for a segmentectomy of the right lung and a wedge resection of the left lung due to a bacterial infection?
- a. 32484-50
 - b. 32503-RT, 32500-LT
 - c. 32440-RT, 32484-LT
 - d. 32500-LT, 32484-RT** (*CPT® book*)