Test Your Knowledge! Answer Key

# Chapter 1

1. *c.* An *Excludes2* note means “not included here” in International Classification of Diseases, 10th Revision, Clinical Modification.

2. *b.* The seventh character D indicates subsequent care during the healing phase.

3. *d.* When provided, category- or code-specific instructions are followed in lieu of the midpoint rule.

4. *b.* National Drug Codes must be submitted on a claim with 11 digits in 5-4-2 format.

5. *a.* The diagnosis code may be the same for each service performed.

# Chapter 2

1. *c.* A National Correct Coding Initiative modifier indicator of 0 indicates that the edit for this code pair cannot be overridden with a modifier.

2. *c.* Modifier 26 indicates that the reporting physician provided only the professional component.

3. *c.* Often, modifier 51 is not required by payers.

4. *c.* Modifier 80 indicates a second physician provided assistance throughout a procedure.

5. *c.* Modifier 95 indicates that real-time audiovisual technology was used to provide a service.

# Chapter 3

1. *c.* Hierarchal condition categories are used to calculate a patient’s risk of increased health care use or risk adjustment.

2. *d.* Many health plans provide specific information on documentation and codes that do or do not support Healthcare Effectiveness Data and Information Set measurement.

3. *b.* False. Medicaid and Children’s Health Insurance Program plans do participate in performance measurement programs.

4. *d.* Allergy to a vaccine or its components excludes a patient from performance measurement for immunization.

# Chapter 4

1. *b.* Fully read and ask questions, as necessary, about the terms of the contract.

2. *d.* All of the above; accurate listing of diagnoses, selection of complete codes, and procedure code selection based on work performed and documented are basic parts of charge capture in an electronic health record.

3. *a.* A clean claim contains sufficient and correct information for processing without further investigation or development by the payer.

4. *c.* Requesting payer guidance on codes that are more likely to be paid is seldom beneficial and would be more appropriate for preparing to submit a corrected claim (although payers seldom directly offer coding guidance).

5. *c.* Assignment refers to the patients that a payer lists on your panel roster.

# Chapter 5

1. *c.* Physician self-referral (Stark) law affects how a practice distributes income from designated health services.

2. *d.* All of the above; an auditor may be alerted to possible fraud or abuse by analysis of claims data across payers and care settings, inconsistency in billing by the physician and facility, and number of hours reported exceeding the hours in a day.

3. *b.* An overpayment must be refunded to Medicaid within 60 days of the date when the overpayment was identified.

4. *a.* Request identification of each claim included in the extrapolation in response to a payer’s request for refunds based on extrapolation.

5. *b.* False; physicians in all practices should be concerned about auditors.

# Chapter 6

1. *d.* All of the above; past, family, and social history is not required for a problem-focused, an expanded problem-focused, or an interval history.

2. *c.* Eight systems must be examined to support a general multisystem examination.

3. *c.* Differential diagnoses may be in the assessment or clinical impression of a presenting problem without an established diagnosis.

4. *b.* Documentation of “old records reviewed” without further description of relevant findings or lack thereof is not sufficient per the evaluation and management (E/M) guidelines.

5. *a.* Presence via real-time audiovisual technology is sufficient to support presence for the key portion of an E/M service provided by a resident in a rural area.

Chapter 7

1. *a.* Code 99211 is appropriately reported when clinical staff provide dietary education to an established patient on a date when no physician service is provided.

2. *b.* Discussion between a treating qualified health care professional (QHP) and a physician working in the same group and same specialty is not an example of discussion with an external physician as defined for office E/M.

3. *d.* Two acute, uncomplicated illnesses or injuries do not support a moderate number and complexity of problems addressed.

4. *c.* Ordering 3 unique tests and discussing management with an external physician or external source supports an extensive amount and/or complexity of data to be reviewed and analyzed.

5. *b.* Prolonged office E/M service (99417) is reported when a physician’s total time on the date of the encounter exceeds the minimum time of the range of total time assigned to 99205 or 99215 by at least 15 minutes.

# Chapter 8

1. *a.* A newborn who was cared for by a physician of a different group practice or different specialty during the birth admission is a new patient when a preventive medicine service is the first service to the newborn.

2. *b.* Immunization administration on a date different from the date physician counseling was provided is reported with 90471.

3. *c.* A preventive medicine E/M code and 99188 are reported when a preventive medicine service and counseling for oral health with application of fluoride varnish are provided at the same encounter.

4. *d.* Code 96161 is appropriate for reporting maternal depression screening.

5. *c.* The midpoint rule applies to codes 99401–99404.

# Chapter 9

1. *b.* Codes 99241–99245 may be selected on typical time when more than 50% of the physician’s face-to-face time is spent in counseling and/or coordination of care.

2. *b.* False; 99324–99337 are reported for E/M services in a group home setting.

3. *c.* A physician spends at least 5 minutes speaking to an established patient who requested a telephone service for a new problem unrelated to and not resulting in any face-to-face visit.

4. *d.* Time of online digital E/M services begins with a physician’s personal review of the patient’s initial inquiry.

5. *b.* Code 99291 includes the first 30 to 74 minutes, and code 99292 is reported for each additional period of up to 30 minutes.

# Chapter 10

1. *a.* Modifier 24 (unrelated E/M service by the same physician during a postoperative period) would be appended to the E/M code to signify an unrelated E/M service provided during the global surgical period.

2. *a.* A zero (0)-day global period applies to simple skin wound repair.

3. *c.* Layered closure of 1 or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia is an intermediate repair.

4. *c.* Codes 96360 and 96361 describe the initial infusion of hydration (prepackaged fluid and electrolytes) for the initial 31 minutes to 1 hour and each additional hour.

5. *b.* One unit of service is reported per injection (96372). Multiple units of service would be reported in conjunction with a Healthcare Common Procedure Coding System code describing the medication.

# Chapter 11

1. *d.* No modifier is required to indicate a physician provided both professional and technical components of a service.

2. *c.* Direct optical observation describes a laboratory testing platform that provides a result (ie, positive or negative) by producing a signal on the reaction chamber.

3. *b.* Modifier QW is appended to most Clinical Laboratory Improvement Amendments–waived tests.

4. *c.* Modifier 52 is appended to the code for the audiometry service to indicate it was performed unilaterally.

5. *b.* Code 95117 is reported for 3 injections of previously prepared allergy extracts.

# Chapter 12

1 *c.* A care plan must be established, implemented, revised, or monitored for principal care management.

2. *a.* Clinical staff time is not included in the time of service of code 99491.

3. *a.* A face-to-face visit must occur prior to provision of the care plan oversight (CPO) service.

4. *c.* Principal care management and CPO are never reported by the same individual in the same calendar month.

5. *d.* Transitional care management includes a face-to-face service that is not separately reported.

# Chapter 13

1. *b.* National Provider Identifier describes a unique identification number for covered health care professionals.

2. *c.* Only 99211 may be reported for a nurse’s assessment of a patient when Medicare incident-to billing requirements are met.

3. *a.* Use of a standardized curriculum is a required component of education and training for patient self-management.

4. *c.* Code Z39.1 is appropriately reported in the absence of feeding problems of an infant or health problems of the mother.

5. *d.* Medication therapy management services (99605–99607) are reported by a pharmacist.

# Chapter 14

1. *b.* Code 96110 and the preventive medicine service (eg, 99391) are used to report developmental screening using a standardized instrument during a well-child visit.

2. *c.* Codes 96132, 96133 × 2 are reported for 2 hours and 40 minutes of neuropsychological testing data interpretation, interactive feedback, and report creation.

3. *b.* False; family members may act as informants during individual psychotherapy.

4. *c.* A code for dependence is reported for abusive alcohol use with dependence.

5. *d.* Brief emotional/behavioral assessment using a standardized instrument in conjunction with general behavioral health integration services (99484).

# Chapter 15

1. *c.* 28 days old

2. *a.* 99460

3. *b.* A category Z38 code (liveborn infant)

4. *d.* 99462 25 and the appropriate code for the circumcision (eg, 54150)

5. *a.* 99231–99233 (subsequent hospital care)

# Chapter 16

1. *c.* Hospital services may be selected based on time when more than 50% of the total unit/floor time was spent in counseling and/or coordinating care.

2. *b.* *Split/shared* describes an E/M service in which a physician and a QHP from the same group practice/same specialty each personally perform and document a substantive portion of 1 or more face-to-face E/M encounters on the same date.

3. *d.* All of the above; observation care is not reported on the same date as inpatient care by the same physician and requires at least detailed history and examination.

4. *a.* Code 99217 represents all E/M services provided by an attending physician to a patient on discharge from observation status if the discharge is on other than the initial date of observation status.

5. *b.* A second consultation during one admission is reported with codes 99231–99233.

Chapter 17

1. *a.* Codes for reporting abuse or neglect describe suspected, ruled out, or confirmed abuse.

2. *d.* Codes 99281–99285 are only reported for care in an emergency department as defined by *Current Procedural Terminology®* or state regulation.

3. *d.* Both codes 99283 and 99284 include moderate medical decision-making.

4. *b.* Initial fracture care is reported with modifier 54 if another physician will provide follow-up care.

5. *c.* Thirty to 74 minutes is included in the service reported with code 99291.

Chapter 18.

1. *a.* Cardiopulmonary resuscitation is separately reported when provided in conjunction with critical care services.

2. *b.* Thirty to ­74 minutes of service time are included in 99291.

3. *b.* Subsequent inpatient neonatal critical care code 99469 is reported.

4. *d.* Codes 99291 and 99292 are reported because the child is outside the age range for codes 99466 and 99467 and codes 99485 and 99486. Code 99468 is reported only for services after the patient is admitted.

5. *c.* Car seat/bed testing services reported with codes 94780 and 94781 provided to patients 12 months and younger

Chapter 19

1. *c.* Modifier 22 is not indicated solely on a patient weighing less than 4 kg (reportable with modifier 63, when appropriate).

2. *d.* Report code 99024 for a related E/M service during the postoperative global period.

3. *b.* Echocardiography by another cardiologist during the same session as cardiac catheterization is separately reported.

4. *d.* Report a code for replacement when a central venous access device is removed and a new one is placed at the same access site.

5. *d.* Code 49491 is reported for initial hernia repair on a patient who was younger than 37 weeks’ gestation at birth when the procedure is performed from birth up to 50 weeks’ postconception age.

# Chapter 20

1. *b.* A consultation provided to patient via secure audiovisual technology is an example of a telemedicine service.

2. *c.* *Originating site* describes the location of the patient receiving a telemedicine service.

3. *a.* Medicaid plans typically align with state regulations for telemedicine services.

4. *c.* Modifier 95 should be appended to codes found in Appendix P when provided via telemedicine.

5. *b.* The same requirements required by the code descriptor and guidelines that apply when provided in person are required when provided via telemedicine.

# Chapter 21

1. *b.* Self-measured blood pressure (99474) is a report of average systolic and diastolic pressures that may be developed by clinical staff for review by a physician or QHP.

2. *c.* Code 99091 includes collection and interpretation of physiologic data collected over a 30-day period not occurring on the date of an E/M visit

3. *d.* Physician-provided equipment sensor placement, hookup, calibration of monitor, patient training, removal of sensor, and printout of recording and analysis, interpretation and report of ambulatory continuous glucose monitoring are reported once per month.

4. *d.* Physician review, interpretation, and preparation of a report is included in pediatric home apnea monitoring services described by code 94777.

5. *a.* The services described by codes 99457 and 99458 and codes 989X4 and 989X5 are differentiated by the type of data monitored and whether or not provision by clinical staff is included in the service.