

Final Examination

SECTION 1 QUESTIONS 1-43

Medical Terminology

1. This term means the surgical removal of the fallopian tube:
 - A. ligation
 - B. hysterectomy
 - C. salpingostomy
 - D. salpingectomy

2. This combining form means thirst:
 - A. dips/o
 - B. acr/o
 - C. cortic/o
 - D. somat/o

3. This term is also known as a homograft:
 - A. autograft
 - B. allograft
 - C. xenograft
 - D. zenograft

4. Which of the following terms does NOT describe a receptor of the body?
 - A. mechanoreceptor
 - B. proprioceptor
 - C. thermoreceptor
 - D. endoreceptor

5. Which of the following terms means taste?
 - A. Meissner
 - B. pacinian
 - C. gustatory
 - D. astrocytes

6. This suffix means removal:
- A. -penia
 - B. -ectomy
 - C. -itis
 - D. -pexy
7. This term means abnormal thickening of the skin:
- A. ductus
 - B. dermatofibroma
 - C. dermatitis
 - D. pachyderma
8. The term that defines the relaxation phase of the heartbeat is:
- A. systole
 - B. sinoatrial
 - C. diastole
 - D. septa

Anatomy

9. This is the first portion of the small intestine:
- A. jejunum
 - B. ileum
 - C. duodenum
 - D. cecum
10. This is a part of the inner ear:
- A. vestibule
 - B. malleus
 - C. incus
 - D. stapes

11. This is the area behind the cornea:
- A. anterior chamber
 - B. choroid layer
 - C. ciliary body
 - D. fundus
12. This is the collarbone:
- A. patella
 - B. tibia
 - C. scapula
 - D. clavicle
13. The act of turning upward, such as the hand turned palm upward:
- A. supination
 - B. adduction
 - C. pronation
 - D. circumduction
14. The middle layer of the skin, also known as the corium or true skin, is the:
- A. epidermis.
 - B. stratum corneum.
 - C. dermis.
 - D. subcutaneous.
15. The shaft of a long bone:
- A. diaphysis
 - B. epiphysis
 - C. metaphysis
 - D. periosteum
16. Which of the following is NOT a covering of the chamber walls of the heart?
- A. endocardium
 - B. myocardium
 - C. pericardium
 - D. epicardium

ICD-9-CM

17. Three-week-old female with obstructive apnea.
- A. 770.8
 - B. 770.82
 - C. 769
 - D. 770.83
18. Mild retardation due to congenital hypothyroidism.
- A. 243, 317
 - B. 244.8, 317
 - C. 243, 318.0
 - D. 317, 243
19. Glomerulonephritis due to infectious hepatitis.
- A. 580.9, 070
 - B. 070, 580.9
 - C. 580.81, 070.9
 - D. 070.9, 580.81
20. Bloody stool.
- A. 772.4
 - B. 792.1
 - C. 578.1
 - D. 578.0
21. A lethargic patient with vomiting and severe cramping ingested five tablets of Tylenol with codeine and half a bottle of whiskey.
- A. 965.01, 965.4, 980.0, 780.79, 787.03, 789.00, E980.0, E980
 - B. 965.09, 965.61, 980.0, 780.79, 787.03, 789.00, E980.0
 - C. 966.09, 965.4, 980.0, 780.71, 787.03, 789.00, E980.4, E980.9
 - D. 965.09, 965.4, 980.0, 780.79, 787.03, 789.00, E980.0, E980.9
22. Admission for hemodialysis because of acute renal failure.
- A. V56.31, 584.9
 - B. V56, 584
 - C. V56.0, 584.9
 - D. 584.9, V56.0

23. Sarcoidosis with cardiomyopathy.

- A. 135, 517.8
- B. 135, 425.8
- C. 425.8, 135
- D. 135, 425.8, V71.7

24. Laceration of left hand.

- A. 882.0
- B. 883.0
- C. 887.2
- D. 882.2

25. Fracture of the right patella with abrasion.

- A. 822.0, 916.0
- B. 822.0
- C. 916.0, 822.1
- D. 823.00

26. Mr. Hallberger is 62 and has multiple problems. I am examining him in the intensive critical care unit. I understand he has fluid overload with acute renal failure and was started on ultrafiltration by the nephrologist on duty. He has an abnormal chest x-ray. He has preexisting type II diabetes mellitus and sepsis. We are left with a patient now who is still sedated and on a ventilator because of respiratory failure. Code the diagnoses only.

- A. 782.3, 585.9, 792, 250.40, 039.9, 518.81
- B. 789.59, 584.7, 793.1, 250.4, 039.9, 518.81
- C. 276.50, 587, 793.1, 250.00, 038.9, 518.81, 99223
- D. 038.9, 995.91, 584.9, 518.81, 276.6, 250.00, 793.1

HCPCS

27. A patient is issued a 22-inch seat cushion for his wheelchair.

- A. E2601
- B. E0950
- C. E0190
- D. E2602

28. A patient with chronic lumbar pain previously purchased a TENS and now needs replacement batteries.
- A. E1592
 - B. A5082
 - C. A4772
 - D. A4630
29. Which HCPCS modifier indicates the great toe of the right foot?
- A. T1
 - B. T3
 - C. T4
 - D. T5
30. A patient with chronic obstructive pulmonary disease is issued a medically necessary nebulizer with a compressor and humidifier for extensive use with oxygen delivery.
- A. E0570, E0550
 - B. E0555, E0571
 - C. E0580, E0550
 - D. E0575, E0550
31. A patient presents for trimming of 10 dystrophic toenails.
- A. G0127 × 2, 703.8
 - B. G0127, G0127 × 9, 703.0
 - C. G0127, 703.8
 - D. G0127 × 5, G0127 × 5, 703.9

Practice Management

32. This entity develops and publishes an annual plan that outlines the Medicare monitoring program.
- A. MACs
 - B. FIs
 - C. OIG
 - D. CMS

33. This program was developed by CMS to promote national correct coding methods and to control inappropriate payment of Part B claims and hospital outpatient claims.
- A. NCCI
 - B. NFS
 - C. HIPAA
 - D. MA-PA
34. What is a NPI?
- A. National Payer Incentive
 - B. National Provider Identification
 - C. National Provider Index
 - D. National Payer Identification
35. The RBRVS is a
- A. payment reform implemented in 1992
 - B. listing of the customary charge for services
 - C. payment list that indicates the prevailing charge in a locality
 - D. listing of the physician's individual charges for a service
36. Which of the following is NOT considered fraud or abuse?
- A. Lack of documentation of medical necessity for services reported
 - B. Accepting a \$20 gift card from a shoe repair representative for each Medicare patient referred to his store
 - C. Referring patients to a radiology center in which your physician is a partner
 - D. Going to lunch with a pharmaceutical representative
37. This document is a notification in advance of services that Medicare probably will not pay for and the estimated cost to the patient.
- A. Wavier of Liability
 - B. Coordination of Benefits
 - C. Advanced Beneficiary Notice
 - D. UPIN

Coding Guidelines

38. Specific coding guidelines in the CPT manual are located in:
- A. the index.
 - B. the introduction.
 - C. the beginning of each section.
 - D. Appendix A.
39. Which punctuation mark between codes in the index of the CPT manual indicates a range of codes is available?
- A. period
 - B. comma
 - C. semicolon
 - D. hyphen
40. The term that indicates this is the type of code for which the full code description can be known only if the common part of the code (the description preceding the semicolon) of a preceding entry is referenced:
- A. stand-alone
 - B. indented
 - C. independent
 - D. add-on
41. The symbol that indicates an add-on code is:
- A. ▲
 - B. ●
 - C. +
 - D. ▶◀
42. When you see the symbol “Ⓢ” next to a code in the CPT manual, you know that:
- A. the code is a new code.
 - B. the code contains new or revised text
 - C. the code is a modifier -51 exempt code.
 - D. FDA approval is pending.

43. Which of the following is most accurately about the designation “(Separate procedure).” The procedure is:
- A. incidental to another procedure
 - B. reported if it is the only procedure performed
 - C. reported if the procedure is unrelated to a more major procedure performed at the same time on the same site
 - D. All of the above

SECTION 2
QUESTIONS 44–103

10000 Integumentary System

44. OPERATIVE REPORT

OPERATIVE PROCEDURE: Excision of back lesion.

INDICATIONS FOR SURGERY: The patient has an enlarging lesion on the upper midback.

FINDINGS AT SURGERY: There was a 5-cm, upper midback lesion.

OPERATIVE PROCEDURE: With the patient prone, the back was prepped and draped in the usual sterile fashion. The skin and underlying tissues were anesthetized with 30 mL of 1% lidocaine with epinephrine.

Through a 5-cm transverse skin incision, the lesion was excised. Hemostasis was ensured. The incision was closed using 3-0 Vicryl for the deep layers and running 3-0 Prolene subcuticular stitch with Steri-Strips for the skin.

The patient was returned to the same-day surgery center in stable postoperative condition. All sponge, needle, and instrument counts were correct. Estimated blood loss is 0 mL.

PATHOLOGY REPORT LATER INDICATED: Dermatofibroma, skin of back. Assign code(s) for the physician service only.

- A. 11406, 12002, 216.5
- B. 11424, 215.7
- C. 11406, 12032, 216.5
- D. 11606, 232.5

45. EMERGENCY DEPARTMENT REPORT CHIEF COMPLAINT: Nasal bridge laceration.

SUBJECTIVE: The patient is a 74-year-old male who presents to the emergency department with a laceration to the bridge of his nose. He fell in the bathroom tonight. He recalls the incident. He just sort of lost his balance. He denies any vertigo. He denies any chest pain or shortness of breath. He denies any head pain or neck pain. There was no loss of consciousness. He slipped on a wet floor in the bathroom and lost his balance; that is how it happened. He has not had any blood from the nose or mouth.

PAST MEDICAL HISTORY:

1. Parkinson's.
2. Back pain.
3. Constipation.

MEDICATIONS: See the patient record for a complete list of medications.

ALLERGIES: NKDA.

REVIEW OF SYSTEMS: Per HPI. Otherwise, negative.

PHYSICAL EXAMINATION: The exam showed a 74-year-old male in no acute distress. Examination of the HEAD showed no obvious trauma other than the bridge of the nose, where there is approximately a 1.5- to 2-cm laceration. He had no bony tenderness under this. Pupils were equal, round, and reactive. EARS and NOSE: OROPHARYNX was unremarkable. NECK was soft and supple. HEART was regular. LUNGS were clear but slightly diminished in the bases.

PROCEDURE: The wound was draped in a sterile fashion and anesthetized with 1% Xylocaine with sodium bicarbonate. It was cleansed with sterile saline and then repaired using interrupted 6-0 Ethilon sutures (Dr. Barney Teller, first-year resident, assisted with the suturing).

ASSESSMENT: Nasal bridge laceration, status post fall.

PLAN: Keep clean. Sutures out in 5 to 7 days. Watch for signs of infection.

- A. 12051, 873.20, E885.9
- B. 12011, 873.20, E885.9
- C. 12011, 873.32, E888.8
- D. 12011, 11000, 873.32, E929.9

46. SAME-DAY SURGERY

DIAGNOSIS: Inverted nipple with mammary duct ectasia, left.

OPERATION: Excision of mass deep to left nipple.

With the patient under general anesthesia, a circumareolar incision was made with sharp dissection and carried down into the breast tissue. The nipple complex was raised up using a small retractor. We gently dissected underneath to free up the nipple entirely. Once this was done, we had the nipple fully unfolded, and there was some evident mammary duct ectasis. An area 3 x 4 cm was excised using electrocautery. Hemostasis was maintained with the electrocautery, and then the breast tissue deep to the nipple was reconstructed using sutures of 3-0 chromic. Subcutaneous tissue was closed using 3-0 chromic, and then the skin was closed using 4-0 Vicryl. Steri-Strips were applied. The patient tolerated the procedure well and was returned to the recovery area in stable condition. At the end of the procedure, all sponges and instruments were accounted for.

- A. 19120-RT, 610.4
- B. 11404-LT, 611.1
- C. 19112, 610.4
- D. 19120-LT, 610.4

47. This patient returns today for palliative care to her feet. Her toenails have become elongated and thickened, and she is unable to trim them on her own. She states that she has had no problems and no acute signs of any infection or otherwise to her feet. She returns today strictly for trimming of her toenails.

EXAMINATION: Her pedal pulses are palpable bilaterally. The nails are mycotic, 1 through 4 on the left, and 1 through 3 on the right.

ASSESSMENT: Onychomycosis, 1 through 4 on the left and 1 through 3 on the right.

PLAN: Mild debridement of mycotic nails x 7. This patient is to return to the clinic in 3 to 4 months for follow-up palliative care.

- A. 11721 x 7, 117.9
- B. 99212, 11721, 110.1
- C. 11719, 110.1
- D. 11721, 110.1

48. OPERATIVE REPORT

With the patient having had a wire localization performed by radiology, she was taken to the operating room and, under local anesthesia of the left breast, was prepped and draped in a sterile manner. A breast line incision was made through the entry point of the wire, and a core of tissue surrounding the wire (approximately 1 × 2 cm) was removed using electrocautery for hemostasis. The specimen, including the wire, was then submitted to radiology, and the presence of the lesion within the specimen was confirmed. The wound was checked for hemostasis, and this was maintained with electrocautery. The breast tissue was reapproximated using 2-0 and 3-0 chromic. The skin was closed using 4-0 Vicryl in a subcuticular manner. Steri-Strips were applied. The patient tolerated the procedure well and was discharged from the operating room in stable condition. At the end of the procedure, all sponges and instruments were accounted for.

Pathology report later indicated: Benign lesion.

- A. 11602-LT, 238.3
- B. 11400-LT, 174.9
- C. 19125-LT, 217
- D. 19125-LT, 239.3

49. What CPT and ICD-9-CM codes would be used to code a split-thickness skin graft, both thighs to the abdomen, measuring 45 × 21 cm performed on a patient who has third-degree burns of the abdomen. Documentation stated 20% of the body surface was burned, with 9% third degree. The patient also sustained second-degree burns of the back.

- A. 15100 × 2, 949.3, 949.2, 948.00
- B. 15100, 15101 × 9, 942.33, 942.24, 948.20
- C. 15100, 15101 × 9-51, 946.3, 949.2, 948.02
- D. 15100, 15101 × 8, 948.01, 942.29

50. What CPT and ICD-9-CM codes would be used to report a massive debridement of an open anterior abdominal wound, including subcutaneous tissue and muscle? The patient fell while speed walking and landed on a sharp rock.

- A. 11000, 879.2, E880.1, E920.8
- B. 11010, 879.6, E880.1
- C. 11042, 879.2
- D. 11043, 879.3, E888.0, E920.8

51. The patient is brought to surgery for repair of an accidentally inflicted open wound of the left thigh, the total extent measuring approximately 40 x 35 cm.

DESCRIPTION OF PROCEDURE: The legs were prepped with Betadine scrub and solution and then draped in a routine sterile fashion. Split-thickness skin grafts measuring about a 10,000th inch thick were taken from both thighs, meshed with a 3:1 ratio mesher, and stapled to the wounds. The donor sites were dressed with scarlet red, and the recipient sites were dressed with Xeroform, Kerlix fluffs, and Kerlix roll, and a few ABD pads were used for absorption. Estimated blood loss was negligible. The patient tolerated the procedure well and left surgery in good condition.

- A. 15120, 15121 x 12, 891.0, E929.9
B. 15100, 15101, 11010, 891.0, E928.9
C. 15220, 15221 x 13, 890.0, E928.9
D. 15100, 15101 x 13, 890.0, E928.9
52. What CPT and ICD-9-CM codes would be used to code the destruction of a malignant lesion on the female genitalia measuring 1.6 cm using cryosurgery?
- A. 17272, 184.4
B. 11602, 199.0
C. 11420, 198.82
D. 11622, 184.4
53. What code(s) is used by the radiologist when performing preoperative placement of a needle localization wire of a single lesion of the breast? The patient was diagnosed with adenocarcinoma of the upper outer quadrant of the right breast, primary site.
- A. 19290, 19125, 174.5
B. 19125, 174.4
C. 19290, 174.4
D. 19295, 174.5

20000 Musculoskeletal System

54. Carl Ostrick, a 21-year-old male, slipped on a patch of ice on his sidewalk while shoveling snow. When he fell, his left hand was wedged under his body and his carpometacarpal joint was dislocated. After manipulating the joint back into normal alignment, the surgeon fixed the dislocation by placing a wire through the skin at the tip of the finger and on through the carpometacarpal joint to maintain alignment.
- A. 26608-F1, 833.01, E886.0
 - B. 26650-FA, 833.14, E888.9
 - C. 26706-LT, 833.00, E885.9
 - D. 26676-LT, 833.04, E885.9
55. John, an 84-year-old male, tripped while on his morning walk. He stated he was thinking about something else when he inadvertently tripped over the sidewalk curb and fell to his knees. X-ray indicated a fracture of his right patella. With the patient under general anesthesia, the area was opened and extensively irrigated. The left aspect of the patella was severely fragmented, and a portion of the patella was subsequently removed. The remaining patella fractures were wired. The surrounding tissue was repaired, thoroughly irrigated, and closed in the usual manner.
- A. 27524-RT, 822.0, E880.1
 - B. 27520-RT, 822.0, E880.1
 - C. 27524-RT, 822.1, E888.9
 - D. 27524-RT, 822.0, E888.9
56. Maryann received a blow to her right tibial shaft while moving a large stuffed chair up a flight of stairs when the person in front of the chair slipped and released his hold on the chair. The full weight of the chair was pushed against her; when she was unable to hold the chair in place, both she and the chair fell to the landing a dozen steps below. The chair tipped on its side and landed on her tibia. On x-ray, the right tibia shaft was fractured in three places. Screws and pins were placed through the skin to secure the fracture sites.
- A. 27750-RT, 823.80, E880.9
 - B. 27756-RT, 823.80, E888.9
 - C. 27756-RT, 823.20, E880.9
 - D. 27750-RT, 823.20, E880.9

57. Darin was a passenger in an automobile rollover accident and was not wearing a seat belt at the time. He was thrown from the automobile and was pinned under the rear of the overturned vehicle. He sustained craniofacial separation, Le Forte III fracture, that required complicated internal and external fixation using an open approach to repair the extensive damage. A halo device was used to hold the head immobile.
- A. 21435, 20661
 - B. 21435
 - C. 21432
 - D. 21436, 20661
58. Libby was thrown from a horse while riding in the ditch; a truck that honked the horn as it passed her startled her horse. The horse reared up, and Libby was thrown to the ground. Her left tibia was fractured and required insertion of multiple pins to stabilize the defect area. A Monticelli multiplane external fixation system was then attached to the pins. Code the placement of the fixation device and diagnosis only.
- A. 20661-LT, 823.82, E828.9
 - B. 20692-LT, 823.80, E828.2
 - C. 20692-LT, 823.82, E828.2
 - D. 20690-LT, 823.80, E828.2
59. A small incision was made over the left proximal tibia, and a traction pin was inserted through the bone to the opposite side. Weights were then affixed to the pins to stabilize the closed tibial fracture temporarily until fracture repair could be performed. Assign codes for the physician service.
- A. 20650-LT, 823.80
 - B. 20663-LT, 823.90
 - C. 20690-LT, 823.40
 - D. 20692-LT, 823.90
60. Mary tells her physician that she has been having pain in her left wrist for several weeks. The physician examines the area and palpates a ganglion cyst of the tendon sheath. He marks the injection sites, sterilizes the area, and injects corticosteroid into two areas.
- A. 20550-LT × 2, 727.42
 - B. 20551-LT, 727.41
 - C. 20551-LT × 2, 727.43
 - D. 20612-LT, 20612-59-LT, 727.42

61. The physician applies a Minerva-type fiberglass body cast from the hips to the shoulders and to the head. Before application, a stockinette is stretched over the patient's torso, and further padding of the bony areas with felt padding was done. The patient was diagnosed with Morquio-Brailsford kyphosis. Assign codes for the physician service only.

A. 29040, 277.5, 737.41
B. 29590, 737.41
C. 29025, 737.41, 277.5
D. 29000, 737.10, 277.5

62. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Compound fracture, left humerus, with possible loss of left radial pulse.

PROCEDURE PERFORMED: Open reduction internal fixation, left compound humerus fracture.

PROCEDURE: While under a general anesthetic, the patient's left arm was prepped with Betadine and draped in sterile fashion. We then created a longitudinal incision over the anterolateral aspect of his left arm and carried the dissection through the subcutaneous tissue. We attempted to identify the lateral intermuscular septum and progressed to the fracture site, which was actually fairly easy to do because there was some significant tearing and rupturing of the biceps and brachialis muscles. These were partial ruptures, but the bone was relatively easy to expose through this. We then identified the fracture site and thoroughly irrigated it with several liters of saline. We also noted that the radial nerve was easily visible, crossing along the posterolateral aspect of the fracture site. It was intact. We carefully detected it throughout the remainder of the procedure. We then were able to strip the periosteum away from the lateral side of the shaft of the humerus both proximally and distally from the fracture site. We did this just enough to apply a 6-hole plate, which we eventually held in place with six cortical screws. We did attempt to compress the fracture site. Due to some comminution, the fracture was not quite anatomically aligned, but certainly it was felt to be very acceptable.

Once we had applied the plate, we then checked the radial pulse with a Doppler. We found that the radial pulse was present using the Doppler, but not with palpation. We then applied Xeroform dressings to the wounds and the incision. After padding the arm thoroughly, we applied a long-arm splint with the elbow flexed about 75 degrees. He tolerated the procedure well, and the radial pulse was again present on Doppler examination at the end of the procedure.

A. 24515-RT, 812.30, E887
B. 24500-LT, 812.20, E888.9
C. 24515-LT, 812.31, E887
D. 24505-LT, 812.20, E888.9

63. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Left thigh abscess.

PROCEDURE PERFORMED: Incision and drainage of left thigh abscess.

OPERATIVE NOTE: With the patient under general anesthesia, he was placed in the lithotomy position. The area around the anus was carefully inspected, and we saw no evidence of communication with the perirectal space. This appears to have risen in the crease at the top of the leg, extending from the posterior buttocks region up toward the side of the base of the penis. In any event, the area was prepped and draped in a sterile manner. Then we incised the area in fluctuation. We obtained a lot of very foul-smelling, almost stool-like material (it was not stool, but it was brown and very foul-smelling material). This was not the typical pus one sees with a *Staphylococcus aureus*-type infection. The incision was widened to allow us to probe the cavity fully. Again, I could see no evidence of communication to the rectum, but there was extension down the thigh and extension up into the groin crease. The fascia was darkened from the purulent material. I opened some of the fascia to make sure the underlying muscle was viable. This appeared viable. No gas was present. There was nothing to suggest a necrotizing fasciitis. The patient did have a very extensive inflammation within this abscess cavity. The abscess cavity was irrigated with peroxide and saline and packed with gauze vaginal packing. The patient tolerated the procedure well and was discharged from the operating room in stable condition.

- A. 26990-LT, 682.6
- B. 27301-LT, 682.6
- C. 27301-LT, 682.60
- D. 27025-LT, 682.6

30000 Respiratory System and Cardiovascular System

64. OPERATIVE REPORT

Code only the operative procedure and diagnosis(es).

PREOPERATIVE DIAGNOSIS:

1. Hypoxia.
2. Pneumothorax.

POSTOPERATIVE DIAGNOSIS:

1. Hypoxia.
2. Pneumothorax.

PROCEDURE: Chest tube placement.

DESCRIPTION OF PROCEDURE: The patient was previously sedated with Versed and paralyzed with Nimbex. Lidocaine was used to numb the incision area in the midlateral left chest at about nipple level. After the lidocaine, an incision was made, and we bluntly dissected to the area of the pleural space, making sure we were superior to the rib. On entrance to the pleural space, there was immediate release of air noted. An 18-gauge chest tube was subsequently placed and sutured to the skin. There were no complications for the procedure, and blood loss was minimal.

DISPOSITION: Follow-up, single-view, chest x-ray showed significant resolution of the pneumothorax except for a small apical pneumothorax that was noted.

- A. 32422, 799.02, 512.8
- B. 32551, 71010, 799.00, 512.8
- C. 32551, 512.8, 799.02
- D. 32422, 799.00, 512.0

65. OPERATIVE PROCEDURE

PREOPERATIVE DIAGNOSIS: 68-year-old male in a coma.

POSTOPERATIVE DIAGNOSIS: 68-year-old male in a coma.

PROCEDURE PERFORMED: Placement of a triple lumen central line in right subclavian vein.

With the usual Betadine scrub to the right subclavian vein area and with a second attempt, the subclavian vein was cannulated and the wire was threaded. The first time the wire did not thread right, and so the attempt was aborted to make sure we had good identification of structures. Once the wire was in place, the needle was removed and a tissue dilator was pushed into position over the wire. Once that was removed, then the central lumen catheter was pushed into position at 17 cm and the wire removed. All three ports were flushed. The catheter was sewn into position, and a dressing applied.

- A. 36011, 780.09
- B. 36011, 780.01
- C. 36556, 780.09
- D. 36556, 780.01

66. OPERATIVE REPORT: The patient is in for a bone marrow biopsy. The patient was sterilized by standard procedure. Bone marrow core biopsies were obtained from the left posterior iliac crest with minimal discomfort. At the end of the procedure, the patient denied discomfort, without evidence of complications. The patient has diffuse, malignant lymphoma. Assign codes for the physician service only.

- A. 20225, 229.0
- B. 38221, 202.80
- C. 38230, 200.10
- D. 38220, 202.80

67. What CPT and ICD-9-CM codes report a percutaneous insertion of a dual-chamber pacemaker by means of the subclavian vein? The diagnosis was sick sinus syndrome, tachy-brady.

- A. 33249, 427.0, 427.81
- B. 33217, 427.81
- C. 33208, 427.81
- D. 33240, 426.12, 427.0

68. Patient is a 40-year-old male who was involved in a motor vehicle crash. He is having some pulmonary insufficiency.

PROCEDURE: Bronchoscope was inserted through the accessory point on the end of the ET tube and was then advanced through the ET tube. The ET tube came pretty close down to the carina. We selectively intubated the right mainstem bronchus with the bronchoscope. There were some secretions here, and these were aspirated. We then advanced this selectively into first the lower and then the middle and upper lobes. Secretions were present, more so in the middle and lower lobes. No mucous plug was identified. We then went into the left mainstem and looked at the upper and lower lobes. There was really not much in the way of secretions present. We did inject some saline and aspirated this out. We then removed the bronchoscope and put the patient back on the supplemental O₂. We waited a few minutes. The oxygen level actually stayed pretty good during this time. We then reinserted the bronchoscope and went down to the right side again. We aspirated out all secretions and made sure everything was clear. We then removed the bronchoscope and pulled back on the ET tube about 1.5 cm. We then again placed the patient on supplemental oxygenation.

FINDINGS: No mucous plug was identified. Secretions were found mainly in the right lung and were aspirated. The left side looked pretty clear.

- A. 31646, 518.5, E819.9
B. 32654, 518.82, E812
C. 31645-50, 518.5, E819.9
D. 31645-RT, 31622-51-LT, 518.5, E988.5
69. This 52-year-old male has undergone several attempts at extubation, all of which failed. He also has morbid obesity and significant subcutaneous fat in his neck. The patient is now in for a flap tracheostomy and cervical lipectomy. The cervical lipectomy is necessary for adequate exposure and access to the trachea and also to secure tracheotomy tube placement. Assign code(s) for the physician service only.
- A. 31610, 15839-51
B. 31610
C. 31610, 15838
D. 31603, 15839-51
70. This patient returns to the operating room for placement of an additional chest tube for an anterior pneumothorax due to a contusion lung injury. The same physician had just placed a chest tube 4 days earlier.
- A. 32551, 860.0
B. 32420, 861.21
C. 32551-58, 861.21
D. 32551, 861.3

71. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Atelectasis of the left lower lobe.

PROCEDURE PERFORMED: Fiberoptic bronchoscopy with brushings and cell washings.

PROCEDURE: The patient was already sedated, on a ventilator, and intubated; so his bronchoscopy was done through the ET tube. It was passed easily down to the carina. About 2 to 2.5 cm above the carina, we could see the trachea, which appeared good, as was the carina. In the right lung, all segments were patent and entered, and no masses were seen. The left lung, however, had petechial ecchymotic areas scattered throughout the airways. The tissue was friable and swollen, but no mucous plugs were noted, and all the airways were open, just somewhat swollen. No abnormal secretions were noted at all. Brushings were taken as well as washings, including some with Mucomyst to see whether we could get some distal mucous plug, but nothing really significant was returned. The specimens were sent to appropriate cytological and bacteriological studies. The patient tolerated the procedure fairly well.

- A. 31622, 31623-51, 518.0
- B. 31623, 770.4
- C. 31622-RT, 31623-51-LT, 518.0
- D. 31624, 770.4

72. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Atherosclerotic heart disease.

POSTOPERATIVE DIAGNOSIS: Atherosclerotic heart disease.

OPERATIVE PROCEDURE: Coronary bypass grafts × 2 with a single graft from the aorta to the distal left anterior descending and from the aorta to the distal right coronary artery.

PROCEDURE: The patient was brought to the operating room and placed in a supine position. Under general intubation anesthesia, the anterior chest and legs were prepped and draped in the usual manner. A segment of greater saphenous vein was harvested from the left thigh, utilizing the endoscopic vein harvesting technique, and prepared for grafting. The sternum was opened in the usual fashion, and the left internal mammary artery was taken down and prepared for grafting. The flow through the internal mammary artery was very poor. The patient did have a 25-mm difference in arterial pressure between the right and left arms, the right arm being higher. The left internal mammary artery was therefore not used. The pericardium was incised sharply and a pericardial well created. The patient was systemically heparinized and placed on bicaval to aortic cardiopulmonary bypass with the stump in the main pulmonary artery for cardiac decompression. The patient was cooled to 26° C, and on fibrillation an aortic cross-clamp was applied and potassium-rich cold crystalline cardioplegic solution was administered through the aortic root with satisfactory cardiac arrest. Subsequent doses were given down the vein grafts as the anastomoses were completed and via the coronary sinus in a retrograde fashion. Attention was directed to the right coronary artery. The end of the greater saphenous vein was then anastomosed thereto with 7-0 continuous Prolene distally. The remaining graft material was then grafted to the left anterior descending at the junction of the middle and distal third. The aortic cross-clamp was removed after 149 minutes with spontaneous cardioversion. The usual maneuvers to remove air from the left heart were then carried out using transesophageal echocardiographic technique. After all the air was removed and the patient had returned to a satisfactory temperature, he was weaned from cardiopulmonary bypass after 213 minutes utilizing 5 g per kilogram per minute of dopamine. The chest was closed in the usual fashion. A sterile compression dressing was applied, and the patient returned to the surgical intensive care unit in satisfactory condition.

- A. 33511, 33517, 440.9
- B. 33511, 33508, 414.01
- C. 33534, 33508, 414.00
- D. 33511, 33517, 414.01

73. Connie was brought to the operating room for a sliding hiatal hernia, and transthoracic repair was performed.
- A. 39520, 553.3
 - B. 39503, 756.6
 - C. 39530, 553.3
 - D. 39540, 756.6

40000 Digestive System

74. What CPT code would you use if the physician performs a pyloroplasty and vagotomy in the same surgical session?
- A. 43865
 - B. 50400
 - C. 43635
 - D. 43640

75. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Leaking from intestinal anastomosis.

POSTOPERATIVE DIAGNOSIS: Leaking from intestinal anastomosis.

PROCEDURE PERFORMED: Proximal ileostomy for diversion of colon. Oversew of right colonic fistula.

OPERATIVE NOTE: This patient was taken back to the operating room from the intensive care unit. She was having acute signs of leakage from an anastomosis I performed 3 days previously. We took down some of the sutures holding the wound together. We basically exposed all of this patient's intestine. It was evident that she was leaking from the small bowel as well as from the right colon. I thought the only thing we could do would be to repair the right colon. This was done in two layers, and then we freed up enough bowel to try to make an ileostomy proximal to the area of leakage. We were able to do this with great difficulty, and there was only a small amount of bowel to be brought out. We brought this out as an ileostomy stoma, realizing that it was of questionable viability and that it should be watched closely. With that accomplished, we then packed the wound and returned the patient to the intensive care unit.

- A. 44310, 998.31
- B. 44310-78, 997.4, E878.2
- C. 45136, 996.5, E878.2
- D. 45136-78, 998.32, E879.1

76. This patient is taken to the operating room from the intensive care unit (ICU). The area of the stoma appears to be necrotic, and on this basis the surgeon indicates that the patient has been taken back to the operating room. The stoma was originally created 4 months ago by her previous surgeon.

PROCEDURE PERFORMED: Revision ileostomy stoma.

OPERATIVE NOTE: With the patient moved onto the operating table, the abdomen was prepped and draped. The segment of bowel that was serving as the ileostomy was freed up. Going in through this large open wound, we were able to identify which segment of bowel this was. We resected the end of the bowel that was necrotic and freed up enough of the distal small bowel so that we could bring it out through a new stoma that was placed lateral to the original stoma. The stoma was created, the bowel was brought out, and the mucosa was sewn onto the skin. With this accomplished, we appeared to have a viable stoma. The patient tolerated this procedure and was returned to the ICU in stable condition.

- A. 44310, 560.1, E878.1
B. 45136, 009.0, E878.0
C. 44312, 569.69, 557.0, E878.3
D. 44314, 557.0
77. This patient is brought back to the operating room during the postoperative period by the same physician to repair an esophagogastronomy leak, transthoracic approach, done 2 days ago. The patient is status post esophagectomy for cancer. Code the procedure and the diagnosis for the complication.
- A. 43320-78, 530.10
B. 43340-78, 578.9
C. 43341, 997.4, 239.0
D. 43415-78, 997.4, 150.9
78. The physician is using an abdominal approach to perform a proctopexy combined with a sigmoid resection; the patient was diagnosed with colon cancer, primary site sigmoid flexure of the colon.
- A. 45540, 153.3
B. 45541, 153.7
C. 45550, 153.3
D. 45345, 154.0

79. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Melena.

POSTOPERATIVE DIAGNOSIS: Normal endoscopy.

PROCEDURE: The video therapeutic endoscope was passed without difficulty into the oropharynx. The gastroesophageal junction was seen at 40 cm. Inspection of the esophagus revealed no erythema, ulceration, varices, or other mucosal abnormalities. The stomach was entered and the endoscope advanced to the second duodenum. Inspection of the second duodenum, first duodenum, duodenal bulb, and pylorus revealed no abnormalities. Retroflexion revealed no lesions along the curvature. Inspection of the antrum, body, and fundus of the stomach revealed no abnormalities. The patient tolerated the procedure well. The patient complained of abdominal pain and weight loss.

- A. 45378, 789.00, 783.21
- B. 43235, 789.00, 783.21
- C. 49320, 783.0, 789.00
- D. 43255, 278.01, 789.01

80. This 70-year-old male is brought to the operating room for a biopsy of the pancreas. A wedge biopsy is taken and sent to pathology. The report comes back immediately indicating that primary malignant cells were present in the specimen. The decision was made to perform a total pancreatectomy. Code the operative procedure(s) and diagnosis only.

- A. 48100, 197.8
- B. 48155, 157.8
- C. 48155, 48100-51, 157.9
- D. 48155, 48100-51, 88309, 157.9

81. The patient was taken to the operating room for a repair of a strangulated inguinal hernia. This hernia was previously repaired 4 months ago.

- A. 49521, 550.11
- B. 49520, 550.10
- C. 49492, 550.90
- D. 49521-78, 550.93

82. This 43-year-old female comes in with a peritonsillar abscess. The patient is brought to same-day surgery and given general anesthetic. On examination of the peritonsillar abscess, an incision was made and fluid was drained. The area was examined again, saline was applied, and then the area was packed with gauze. The patient tolerated the procedure well.

- A. 42825, 475
- B. 42700, 475
- C. 42825, 463
- D. 42700, 474.0

83. What code would you use to report a rigid proctosigmoidoscopy with removal of two nonadenomatous polyps of the rectum by snare technique?

- A. 45320, 569.0
- B. 45383, 211.3
- C. 45309 × 2, M8210/0
- D. 45315, 569.0

50000 Urinary System, Male Genital System, Female Genital System, and Maternity Care and Delivery

84. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Missed abortion with fetal demise, 11 weeks.

POSTOPERATIVE DIAGNOSIS: Missed abortion with fetal demise, 11 weeks.

PROCEDURE: Suction D&C.

The patient was prepped and draped in a lithotomy position under general mask anesthesia, and the bladder was straight catheterized; a weighted speculum was placed in the vagina. The anterior lip of the cervix was grasped with a single-tooth tenaculum. The uterus was then sounded to a depth of 8 cm. The cervical os was then serially dilated to allow passage of a size 10 curved suction curette. A size 10 curved suction curette was then used to evacuate the intrauterine contents. Sharp curette was used to gently palpate the uterine wall with negative return of tissue, and the suction curette was again used with negative return of tissue. The tenaculum was removed from the cervix. The speculum was removed from the vagina. All sponges and needles were accounted for at completion of the procedure. The patient left the operating room in apparent good condition having tolerated the procedure well.

- A. 59812, 634.92
- B. 59812, 638.90
- C. 59820, 632
- D. 59856, 632

85. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Right ureteral stricture.

POSTOPERATIVE DIAGNOSIS: Right ureteral stricture.

PROCEDURE PERFORMED: Cystoscopy, right ureteral stent change.

PROCEDURE NOTE: The patient was placed in the lithotomy position after receiving IV sedation. He was prepped and draped in the lithotomy position. The 21-French cystoscope was passed into the bladder, and urine was collected for culture. Inspection of the bladder demonstrated findings consistent with radiation cystitis, which has been previously diagnosed. There is no frank neoplasia. The right ureteral stent was grasped and removed through the urethral meatus; under fluoroscopic control, a guidewire was advanced up the stent, and the stent was exchanged for a 7-French 26-cm stent under fluoroscopic control in the usual fashion. The patient tolerated the procedure well.

- A. 51702-LT, 593.3
- B. 52005-RT, 595.9
- C. 52332-RT, 595.9
- D. 52332-RT, 593.3

86. This patient is a 42-year-old female who has been having prolonged and heavy bleeding during menstruation.

SURGICAL FINDINGS: On pelvic exam under anesthesia, the uterus was normal size and firm. The examination revealed no masses. She had a few small endometrial polyps in the lower uterine segment.

DESCRIPTION OF PROCEDURE: After induction of general anesthesia, the patient was placed in the dorsolithotomy position, after which the perineum and vagina were prepped, the bladder straight catheterized, and the patient draped. After bimanual exam was performed, a weighted speculum was placed in the vagina and the anterior lip of the cervix was grasped with a single toothed tenaculum. An endocervical curettage was then done with a Kevorkian curet. The uterus was then sounded to 8.5 cm. The endocervical canal was dilated to 7 mm with Hegar dilators. A 5.5-mm Olympus hysteroscope was introduced using a distention medium. The cavity was systematically inspected, and the preceding findings noted. The hysteroscope was withdrawn and the cervix further dilated to 10 mm. Polyp forceps was introduced, and a few small polyps were removed. These were sent separately. Sharp endometrial curettage was then done. The hysteroscope was then reinserted, and the polyps had essentially been removed. The patient tolerated the procedure well and returned to the recovery room in stable condition. Pathology confirmed benign endometrial polyps.

- A. 58558, 57460-51, 626.2, 621.0
- B. 58558, 626.2, 621.0
- C. 58558, 57558-51, 626.2, 621.0
- D. 58558, 626.6, 239.5

87. This patient is 35 years old at 36 weeks' gestation. She presented in spontaneous labor. Because of her prior cesarean section, she is taken to the operating room to have a repeat lower-segment transverse cesarean section performed. The patient also desires sterilization, and so a bilateral tubal ligation will also be performed. A single, liveborn infant was the outcome of the delivery.

- A. 59510, 58600-51, V25.2
- B. 59620, 58615-51, 644.21, V27.0
- C. 59514, 58605-51, V27.0, 644.21
- D. 59514, 58611, 654.21, 644.21, V27.0, V25.2

88. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Possible recurrent transitional cell carcinoma of the bladder.

POSTOPERATIVE DIAGNOSIS: No evidence of recurrence.

PROCEDURE PERFORMED: Cystoscopy with multiple bladder biopsies.

PROCEDURE NOTE: The patient was given a general mask anesthetic, prepped, and draped in the lithotomy position. The 21-French cystoscope was passed into the bladder. There was a hyperemic area on the posterior wall of the bladder, and a biopsy was taken. Random biopsies of the bladder were also performed. This area was fulgurated. A total of 7 sq cm of bladder was fulgurated. A catheter was left at the end of the procedure. The patient tolerated the procedure well and was transferred to the recovery room in good condition. The pathology report indicated no evidence of recurrence.

- A. 52224, 595.9, V10.51
- B. 51020, 52204, V16.52
- C. 52234, V10.51
- D. 52224 x 4, 236.7

89. This 41-year-old female presented with a right labial lesion. A biopsy was taken, and the results were reported as VIN III, cannot rule out invasion. The decision was therefore made to proceed with wide local excision of the right vulva.

PROCEDURE: The patient was taken to the operating room, and general anesthesia was administered. The patient was then prepped and draped in the usual manner in lithotomy position, and the bladder was emptied with a straight catheter. The vulva was then inspected. On the right labium minora at approximately the 11 o'clock position, there was a multifocal lesion. A marking pen was then used to mark out an elliptical incision, leaving a 1-cm border on all sides. The skin ellipse was then excised using a knife. Bleeders were cauterized with electrocautery. A running locked suture of 2-0 Vicryl was then placed in the deeper tissue. The skin was finally reapproximated with 4-0 Vicryl in an interrupted fashion. Good hemostasis was thereby achieved. The patient tolerated this procedure well. There were no complications.

- A. 56605, 184.4
- B. 56625, 233.32
- C. 56620, 233.32
- D. 11620, 184.4

90. This 1-year-old boy has a midshaft hypospadias with a very mild degree of chordee. He also has a persistent right hydrocele. The surgeon brought the boy to surgery to perform a right hydrocele repair and one-stage repair of hypospadias with preputial onlay flap.
- A. 54322, 55040, 752.61, 752.63
 - B. 54322, 55041-51, 752.61, 752.63, 603.9
 - C. 54324, 55060-51, 752.61, 752.63, 603.9
 - D. 54324, 55060, 752.63, 603.9
91. The pediatric physician takes this newborn male to the nursery to perform a clamp circumcision.
- A. 54160, V50.2
 - B. 54150, V50.21
 - C. 54160, V50.21
 - D. 54150, V50.2
92. This gentleman has worsening bilateral hydronephrosis. He did not have much of a post void residual on bladder scan. He is taken to the operating room to have a bilateral cystoscopy and retrograde pyelogram. The results come back as gross prostatic hyperplasia.
- A. 52005, 600.3
 - B. 52000, 591, 600.9
 - C. 52005-50, 600.91, 591
 - D. 52000-50, 591, 600.9
93. This 32-year-old female presents with an ectopic pregnancy. The physician elects to remove the entire fallopian tube with the products of conception laparoscopically.
- A. 59120, 633.90
 - B. 59151, 633.90
 - C. 58943, 633.10
 - D. 59120, 633.80

60000 Endocrine System, Hemic and Lymphatic Systems, Nervous System, Eye and Ocular Adnexa, Auditory System

94. Left frontal ventricular puncture for implanting catheter, layered repair of 8-cm scalp laceration, and repair of multiple facial and eyelid lacerations with an approximate total length of 12 cm. Assign code(s) for the physician service only.
- A. 61020, 12015-51
 - B. 61107, 12034-51, 12015-51
 - C. 61215, 12015-51
 - D. 61107, 12034-51

95. Marginal laceration involving the left lower eyelid and laceration of the left upper eyelid involving the tarsus. Both required full-thickness repair. Also, there were multiple stellate lacerations above the left eye, totaling 24.2 cm and requiring full-thickness layered repair. Assign code(s) for the physician service only.

A. 67935-E2, 12017
B. 67930-E2, 13152-51, 13153
C. 67935-E2, 67935-E1-51, 12056-51
D. 67935-E2, 12017-51

96. OPERATIVE REPORT PREOPERATIVE DIAGNOSIS: FUO.

PROCEDURE PERFORMED: Lumbar puncture.

DESCRIPTION OF PROCEDURE: The patient was placed in the lateral decubitus position with the left side up. The legs and hips were flexed into the fetal position. The lumbosacral area was sterilely prepped. It was then numbed with 1% Xylocaine. I then placed a 22-gauge spinal needle on the first pass into the intrathecal space between the L4 and L5 spinous processes. The fluid was minimally xanthochromic. I sent the fluid for cell count for differential, protein, glucose, Gram stain, and culture. The patient tolerated the procedure well without apparent complication. The needle was removed at the end of the procedure. The area was cleansed, and a Band-Aid was placed.

A. 62272, 780.91
B. 62268, 780.60
C. 62272, 782.3, 780.60
D. 62270, 780.60

97. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Herniated disc L4-5 on the left.

PROCEDURE PERFORMED: Laminotomy, foraminotomy, removal of herniated disc L4-5 on the left.

PROCEDURE: Under general anesthesia, the patient was placed in the prone position and the back was prepped and draped in the usual manner. An incision was made in the skin extending through subcutaneous tissue. Lumbodorsal fascia was divided. The erector spinae muscles were bluntly dissected from the lamina of L4-5 on the left. The interspace was localized. I then performed a generous laminotomy and foraminotomy here, and retracted on the nerve root. It was obvious there was a herniated disc. I removed it, entered the space, and removed degenerating material, satisfied that I had decompressed the root well. There were free fragments lying around beneath the nerve root. We removed all of these. I was able to pass a hockey stick down the foramen across the midline, satisfied I had taken out the large fragments from the interspace at L4-5, and decompressed it well. I irrigated the wound well, put a Hemovac drain in the wound, and then closed the wound in layers using double-knotted 0 chromic on the lumbodorsal fascia with Vicryl, 2-0 plain in the subcutaneous tissue, and surgical staples on the skin. A dressing was applied. The patient was discharged to the recovery room.

- A. 63030-LT, 722.10
- B. 63012-LT, 722.32
- C. 63047-LT, 722.92
- D. 63047-LT, 63048-LT, 722.10

98. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Brain tumor versus abscess.

PROCEDURE: Craniotomy.

DESCRIPTION OF PROCEDURE: Under general anesthesia, the patient's head was prepped and draped in the usual manner. It was placed in Mayfield pins. We then proceeded with a craniotomy. An inverted U-shaped incision was made over the posterior right occipital area. The flap was turned down. Three burr holes were made. Having done this, I then localized the tumor through the burr holes and dura. We then made an incision in the dura in an inverted U-shaped fashion. The cortex looked a little swollen but normal. We then used the localizer to locate the cavity. I separated the gyrus and got right into the cavity and saw pus, which was removed. Cultures were taken and sent for pathology report, which came back later describing the presence of clusters of gram-positive cocci, confirming that this was an abscess. We cleaned out the abscessed cavity using irrigation and suction. The bed of the abscessed cavity was cauterized. Then a small piece of Gelfoam was used for hemostasis. Satisfied that it was dry, I closed the dura. I approximated the scalp. A dressing was applied. The patient was discharged to the recovery room.

- A. 61154, 324.0
- B. 61154, 239.6
- C. 61320, 324.0
- D. 61150, 239.6

99. This patient came in with an obstructed ventriculoperitoneal shunt. The procedure performed was to be a revision of shunt. After inspecting the shunt system, the entire cerebrospinal fluid shunt system was removed and a similar replacement shunt system was placed. Patient has normal pressure hydrocephalus (NPH).

- A. 62180, 996.1, 331.3
- B. 62258, 996.2, 331.5
- C. 62256, 996.2, 331.4
- D. 62190, 996.2, 331.5

100. This patient is in for a recurrent herniated disc at L5-S1 on the left. The procedure performed is a repeat laminotomy and foraminotomy at the L5-S1 interspace.

- A. 63030-LT, 722.10
- B. 63030-LT, 722.11
- C. 63042-LT, 722.11
- D. 63042-LT, 722.10

101. What CPT and ICD-9-CM codes would you assign to report the removal of 30% of the left thyroid lobe, with isthmusectomy? The diagnosis was benign growth of the thyroid.

- A. 60210, 226
- B. 60220, 237.4
- C. 60212, 239.7
- D. 60225, 226, 239.7

102. OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS: Paralytic ectropion, left eye.

PROCEDURE PERFORMED: Medial tarsorrhaphy, left eye.

In the operating room, after intravenous sedation, the patient was given a total of about 0.5 mL of local infiltrative anesthetic. The skin surfaces on the medial area of the lid, medial to the punctum, were denuded. A bolster had been prepared and double 5-0 silk suture was passed through the bolster, which was passed through the inferior skin and raw lid margin, then through the superior margin, and out through the skin. A superior bolster was then applied. The puncta were probed with wire instrument and found not to be obstructed. The suture was then fully tied and trimmed. Bacitracin ointment was placed on the surface of the skin. The patient left the operating room in stable condition, without complications, having tolerated the procedure well.

- A. 67875-LT, 374.12
- B. 67710-LT, 374.11
- C. 67882-LT, 374.10
- D. 67880-LT, 374.12

103. This 66-year-old male has been diagnosed with a senile cataract of the posterior subcapsular and is scheduled for a cataract extraction by phacoemulsification of the right eye. The physician has taken the patient to the operating room to perform a posterior subcapsular cataract extraction with IOL placement, diffuse of the right eye.

- A. 66982-RT, 366.09
- B. 66984-RT, 366.14
- C. 66983-RT, 366.12
- D. 66830-RT, 366.14

SECTION 3
QUESTIONS 104–150

Evaluation and Management (E/M)

104. Bill, a retired U.S. Air Force pilot, was on observation status 12 hours to assess the outcome of a fall from the back of a parked pickup truck into a gravel pit.

History of Present Illness: The patient is a 42-year-old gentleman who works at the local garden shop. He explained that yesterday he fell from his pickup truck as he was loading gravel for a landscaping project. He lost his footing when attempting to climb from the pickup bed and fell approximately 4 feet and landed on a rock that was protruding from the ground 4 inches, striking his head on the rock. He did not lose consciousness, but was dizzy. He subsequently developed a throbbing headache (8/10) and swelling at the point of impact. The duration of the dizziness was approximately 10 minutes. The headache persisted for 26 hours after the fall. He did take ibuprofen without significant improvement in the pain level.

Review of Systems: Constitutional, eyes, ears, nose, throat, lungs, cardiovascular, gastrointestinal, skin, neurologic, lymphatic, and immunologic negative except for HPI statements. PFSH: He is married and has 2 children. He has been working at the garden shop for 4 years. He currently smokes one pack of cigarettes a day and has smoked for 10 years. His father died of heart disease when he was 52. He has one brother with ankylosing spondylitis and one sister who is healthy as far as he knows. His mother died when he was 14 years old. He is currently on no prescribed medications. A comprehensive exam is documented and rendered. The medical decision making is of low complexity.

The physician discharged Bill from observation that same day after 10 hours, after determining that no further monitoring of his condition was necessary. The physician provided a detailed examination and indicated that the medical decision making was of a low complexity.

- A. 99218, 784.0, E888.8
- B. 99234, V71.4, E884.9
- C. 99217, V71.4, E888.8
- D. 99234, 99217, 784.0, E884.9

105. Dr. Martin admits a 65-year-old female patient to the hospital to rule out acute pericarditis following a severe viral infection. The patient has complained of retrosternal, sharp, intermittent pain of 2 days' duration that is reduced by sitting up and leaning forward, accompanied by tachypnea. ROS: She does not currently have chest pain but is complaining of shortness of breath. She states that her legs and feet have been swollen of late. She reports no change in her vision or her hearing, and she has not had a rash. No dyspnea stated. PFSH: She states that she has had an echocardiogram in the past when she complained of chest tightness and her family physician gave her some medication, but she is not certain what it was. She has three adult children, all healthy. Her husband is deceased. She does not smoke or consume alcohol. Her father died at age 69 from congestive heart failure and her mother died of influenza at 70. Refer to the admission form for a list of current medications. The examination was detailed. The medical decision making was of high complexity.

- A. 99236, 786.51, 786.06
- B. 99223, 420.91, 411.1, 442.9, 415.19, 530.9
- C. 99245, 420.91, 411.1, 442.9, 415.19, 530.9
- D. 99221, 786.51, 786.06

106. A gynecologist admits an established patient, a 35-year-old female with dysfunctional uterine bleeding, after seeing her in the clinic that day. During the course of the history, the physician notes that the patient has a history of infrequent periods of heavy flow. She has had irregular heavy periods and intermittent spotting for 4 years. The patient has been on a 3-month course of oral contraceptives for symptoms with no relief. The patient states that she has occasional headaches. A complete ROS was performed, consisting of constitutional factors, ophthalmologic, otolaryngologic, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic which were all negative, except for the symptoms described above. The family history is positive for endometrial cancer, with mother, two aunts, and two sisters who had endometrial cancer. The patient has a personal history of cervical and endometrial polyp removal 3 years prior to admission. The patient states that she does not smoke and only drinks socially. As a part of the comprehensive examination, the physician notes the patient has a large amount of blood in the vault and an enlarged uterus. The prolonged hemorrhaging has resulted in a very thin and friable endometrial lining. The physician orders the patient to be started on intravenous Premarin and orders a full laboratory workup. The medical decision making is of moderate complexity.

- A. 99215, 99222, V13.29, V16.49
- B. 99222, 626.8, V13.29, V16.49
- C. 99215, 99222, 623.8, V13.29, V16.4
- D. 99222, 626.1, V16.49

107. Dr. Black admits a patient with an 8-day history of a low-grade fever, tachycardia, tachypnea, and radiologic evidence of basal consolidation of the lung and limited pleural effusion on the left side, per patient as seen at outside clinic several days prior. The patient has also been experiencing swelling of the extremities. The pulse is rapid and thready, as checked by patient on her own during the past couple days. A complete ROS of constitutional factors, ophthalmologic, otolaryngologic, cardiovascular, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic was performed and negative except for the symptoms described above. Past history includes tachycardia and pneumonia. Family history includes heart disease, hypertension and high cholesterol in both parents. The patient drinks only occasionally and quit smoking four years ago. The comprehensive examination was performed and diminished bowel sounds were noted. The physician orders laboratory tests and radiographic studies, including a follow-up chest x-ray as he considers the extensive diagnostic options and the medical decision making complexity is high for this patient.

- A. 99233, 780.60, 785.0, 786.06, 511.9, 787.5, V15.82
- B. 99233, 780.60, 427.0, 786.06, 486, 511.9
- C. 99223, 780.60, 785.0, 786.06
- D. 99223, 780.60, 785.0, 786.06, 511.9, 787.5, V15.85, V17.49

108. Dr. Stephanopolis makes subsequent hospital visits to Salanda Ortez, who has been in the hospital for primary viral pneumonia. She was experiencing severe dyspnea, rales, fever, and chest pain for over a week. The patient states that this morning she had nausea and her heart was racing while she was experiencing some dyspnea and SOB. The chest radiography showed patchy bilateral infiltrates and basilar streaking. Sputum microbiology was positive for a secondary bacterial pneumonia. An expanded problem-focused physical examination was performed. The medical decision making was moderate. The patient was given intravenous antibiotic as treatment for the bacterial pneumonia.

- A. 99233, 786.09, 786.7, 780.60, 729.1, 786.50, 793.1, 795.39
- B. 99232, 482.9, 480.9
- C. 99221, 786.09, 786.7, 780.60, 729.1, 786.50, 793.1, 795.39
- D. 99234, 482.89

109. A 57-year-old male was sent by his family physician to a urologist for an office consultation due to hematuria. The patient has had bright red blood in his urine sporadically for the past 3 weeks. His family physician gave him a dose of antibiotic therapy for urinary tract infection; however, the symptom still persists. The patient states that he does experience some lower back discomfort when urinating, with no fever, chills or nausea. The patient is currently taking Lotrel 10/20 for his hypertension which is stable at this time and has allergies to Sulfa. The urologist performs a detailed history and physical examination. The urologist recommends a cystoscopy to be scheduled for the following day and discusses the procedure and risks with the patient. The urologist also contacted the family physician with the recommendations and is requested to proceed with the cystoscopy and any further follow-up required. The medical decision making is of moderate complexity. A report was sent to attending physician. Report only the office service.

- A. 99243, 599.70, 724.2
- B. 99244-57, 52000, 599.0, 724.2
- C. 99253, 599.9, 724.2
- D. 99221, 599.70, 724.2

110. A neurological consultation in the emergency department of the local hospital is requested by the ED physician for a 25-year-old male with suspected closed head trauma. The neurologist saw the patient in the ED. The patient had a loss of consciousness this morning after receiving a blow to the head in a basketball game. He presents to the emergency department with a headache, dizziness, and confusion. During the course of the history, the patient relates that he has been very irritable, confused, and has had a bit of nausea since the incident. All other systems reviewed and are negative: Constitutional, ophthalmologic, otolaryngologic, cardiovascular, respiratory, genitourinary, musculoskeletal, integumentary, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic. The patients states that he does have a history of headaches and that both parents have hypertension, also a grandfather with heart disease. He also states that he does drink beer on the weekends and does not smoke. Physical examination reveals the patient to be unsteady and exhibiting difficulty in concentration when stating months in reverse. The pupils dilate unequally. The physician continues with a complete comprehensive examination involving an extensive review of neurological function. The neurologist orders a stat CT and MRI. The physician suspects a subdural hematoma or an epidural hematoma and the medical decision-making complexity is high. The neurologist admits the patient to the hospital. Assign codes for the neurologist's services only.

- A. 99285, 780.09, 780.4, 784.0
- B. 99253, 784.0, 780.09, 780.4
- C. 99255, 784.0, 298.9, 780.4
- D. 99245, 784.0, 780.09, 780.4

111. An obstetrician is requested to provide an office consultation to a 23-year-old female with first-trimester bleeding from Dr A. The patient presents with a history of brownish discharge and occasional pinkish discharge. During the history, the patient relates that she has had suprapubic pain in the past week and cramping. She states her pain is 8/10. She has felt nausea and has vomited on three occasions. On one occasion, the nausea was accompanied by dizziness and vertigo, all other systems are negative at this time and included: Constitutional factors, ophthalmologic, otolaryngologic, cardiovascular, respiratory, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic, lymphatic, allergic, and immunologic. The PFSH included patient history of tonsillectomy with family history of breast cancer on her mother's side. The patient does not smoke or drink. The physician conducts a comprehensive examination focused on the chief complaint and related systems. The uterus is found to be soft and involuted. There is cervical motion tenderness and significant abdominal tenderness on palpation. A left pelvic mass is palpated in the left quadrant. The physician orders a pelvic ultrasound, a complete CBC, and differential. Considering the range of possible diagnoses, the medical decision-making complexity is high.

- A. 99255, 634.91, 719.65
- B. 99242, 634.90, 719.65
- C. 99245, 640.93, 789.34
- D. 99245, 649.53, 789.34

112. A 56-year-old established male patient presents to his family physician for a preventive checkup at the local outpatient clinic. The physician conducts a multi- system history and physical examination, and the checkup takes 45 minutes.

- A. 99214, V70.4
- B. 99403, V70.7
- C. 99386, V70.0
- D. 99396, V70.0

113. Karra Hendricks, a 37-year-old female, is an established patient who presents to the office with right lower quadrant abdominal pain with fever. The patient states she has had the pain for 3 days. She has taken Tylenol for her fever with some relief. The patient does have occasional diarrhea and headaches. She smokes approximately 5-10 cigarettes a day and drinks socially. The physician performs a problem focused examination. The medical decision making is noted to be of a moderate complexity.
- A. 99203, 789.03
 - B. 99213, 789.04, 780.60
 - C. 99214, 789.03, 780.60
 - D. 99221, 789.05, 780.60

Anesthesia

114. If the anesthesia service were provided to a patient who had severe systemic disease, what would the physical status modifier be?
- A. P1
 - B. P2
 - C. P3
 - D. P4
115. What qualifying circumstances code would be used to identify the administration of anesthesia that is complicated by an emergency condition?
- A. 99100
 - B. 99116
 - C. 99135
 - D. 99140
116. Anesthesia service includes the following care:
- A. Preoperative, intraoperative
 - B. Preoperative, intraoperative, postoperative
 - C. Intraoperative, postoperative
 - D. Preoperative, postoperative
117. The following is the anesthesia formula:
- A. BTC
 - B. TBC
 - C. BTQ
 - D. BTM

118. Which HCPCS modifier indicates an anesthesia service in which the anesthesiologist medically directs one CRNA?

- A. QX
- B. QY
- C. QZ
- D. QK

119. Anesthesia service for a pneumocentesis for lung aspiration, 32420.

- A. 00522
- B. 00500
- C. 00520
- D. 00524

120. This type of anesthesia is also known as a nerve block.

- A. Local
- B. Epidural
- C. Regional
- D. MAC

121. This is the anesthesia formula:

- A. B + M + P
- B. B + P + M
- C. B + T + M
- D. B + T + N

70000 Radiology

Direction: Report only the professional component unless specifically directed to do otherwise within the question.

122. This 69-year-old female is in for a magnetic resonance examination of the brain because of new seizure activity. After imaging without contrast, contrast was administered and further sequences were performed. Examination results indicated no apparent neoplasm or vascular malformation.

- A. 70543-26, 780.31
- B. 70543-26, 780.39
- C. 70553-26, 780.39
- D. 70553, 345.90

123. This patient undergoes a gallbladder sonogram due to epigastric pain. The report indicates that the visualized portions of the liver are normal. No free fluid noted within Morison's pouch. The gallbladder is identified and is empty. No evidence of wall thickening or surrounding fluid is seen. There is no ductal dilatation. The common hepatic duct and common bile duct measure 0.4 and 0.8 cm, respectively. The common bile duct measurement is at the upper limits of normal.

- A. 76700-26, 789.07
- B. 76705-26, 789.06
- C. 76775-26, 789.05
- D. 76705, 789.07

124. EXAMINATION OF: Chest.

CLINICAL SYMPTOMS: Pneumonia.

PA AND LATERAL CHEST X-RAY WITH FLUOROSCOPY.

CONCLUSION: Ventilation within the lung fields has improved compared with previous study.

- A. 71020-26, 482.89
- B. 71034, 482.83
- C. 71023-26, 486
- D. 71023, 486

125. EXAMINATION OF: Abdomen and pelvis.

CLINICAL SYMPTOMS: Ascites.

CT OF ABDOMEN AND PELVIS: Technique: CT of the abdomen and pelvis was performed without oral or IV contrast material per physician request. No previous CT scans for comparison.

FINDINGS: No ascites. Moderate-sized pleural effusion on the right.

- A. 74160-26, 789.59
- B. 74150-26, 511.9
- C. 74150, 511.9
- D. 74160, 789.59

126. EXAMINATION OF: Brain.

CLINICAL FINDING: Headache.

COMPUTED TOMOGRAPHY OF THE BRAIN was performed without contrast material.

FINDINGS: There is blood within the third ventricle. The lateral ventricles show mild dilatation with small amounts of blood.

IMPRESSION: Acute subarachnoid hemorrhage.

- A. 70460-26, 784.0
- B. 70250, 784.0
- C. 70450-26, 430
- D. 70450-26, 784.0

127. Report both the technical and professional components of the following service:
This 68-year-old male is seen in Radiation Oncology Department for prostate cancer. The oncologist performs a complex clinical treatment planning, dosimetry calculation, complex isodose plan; treatment devices include blocks, special shields, wedges, and treatment management. The patient had 5 days of radiation treatments for 2 weeks, a total of 10 days of treatment.

- A. 77263, 77300, 77315, 77334, 185
- B. 77300, 77315, 77334, 77427 × 2, 185
- C. 77263, 77300, 77315, 77334, 77427 × 2, 185
- D. 77263, 77427 × 2, 185

128. EXAMINATION OF: Right hip.

DIAGNOSIS: Osteoarthritis right hip.

ONE-VIEW RIGHT HIP: A single frontal view is obtained of the right hip. No previous studies are available for comparison. Right hip arthroplasty is seen. Alignment appears grossly unremarkable on this single view. There are skin staples present. Air is seen in the soft tissues, likely due to recent surgery. There appear to be two drains present. The tip of one overlies the soft tissues superolateral to the greater trochanter. The second one is more inferior. The tip overlies the right proximal femoral prosthesis.

IMPRESSION: Single view of the right hip with findings consistent with recent right total hip arthroplasty.

- A. 72100, 719
- B. 73500-RT, 715.95
- C. 72100-26, 715.9
- D. 73500-26-RT, 715.95, V43.64

129. EXAMINATION OF: Cervical spine.

CLINICAL SYMPTOMS: Herniated disc.

FINDINGS: A single spot fluoroscopic film from the operating room is submitted for interpretation. The cervical spine is not well demonstrated above the level of the inferior aspect of C6. There is a metallic surgical plate seen anterior to the cervical spine. The cephalic portion of the plate is at the level of C6 at its superior endplate. That extends in an inferior direction, presumably anterior to C7; however, there is not adequate visualization of C7 to confirm location. Density overlies the C6-7 intervertebral disc space, suggesting the presence of a bone plug in this area; however, again visualization is not adequate in this area. Further evaluation with plain radiographs is recommended.

- A. 72100-26, 722.10
- B. 72020-26, 722.0
- C. 72100-52-26, 722.0
- D. 72020-52-26, 722.11

130. This patient is suffering from primary lung cancer and is in for a follow-up CT scan of the thorax with contrast material. Code the physician component only.

- A. 71250-26, 197.0
- B. 71260, 162.9
- C. 71260-26, 162.9
- D. 71270-26, 239.1

80000 Pathology and Laboratory

Direction: Report only the professional component of the service unless directed to do so otherwise.

131. CLINICAL HISTORY: Boil, left groin.

SPECIMEN RECEIVED: Necrotic fascia left groin and leg (anterior and posterior).

GROSS DESCRIPTION: The specimen is labeled with the patient's name and "fascia left groin and leg" and consists of multiple segments of skin and soft tissue measuring up to 30 cm in greatest dimension. The skin is unremarkable, with the soft tissue being hemorrhagic and friable and foul smelling.

MICROSCOPIC DESCRIPTION: Sections of skin and soft tissue show coagulative necrosis with neutrophilic exudates.

DIAGNOSIS: Skin and soft tissue, left groin and leg, anterior and posterior showing coagulative necrosis and acute inflammation.

- A. 88304, 680.9
- B. 88305-26, 709.8
- C. 88304-26, 709.8, 686.9
- D. 88305, 680.2

132. Report the global service.

CLINICAL HISTORY: Mass, left atrium.

SPECIMEN RECEIVED: Left atrium.

GROSS DESCRIPTION: The specimen is labeled with patient's name and "left atrial myxoma" and consists of a 4 × 4 × 2-cm ovoid mass with a partially calcified hemorrhagic white-tan tissue.

INTRAOPERATIVE FROZEN SECTION DIAGNOSIS: Myxoma.

MICROSCOPIC DESCRIPTION: Sections show a well-circumscribed mass consisting of fibromyxoid tissue showing numerous vascular channels. Areas of superficial ulceration and chronic inflammatory infiltrate are noted. Areas of calcification are also present.

DIAGNOSIS: Myxoma, benign, left atrium.

- A. 88305, 239.89
- B. 88307, 88331, 212.7
- C. 88307, 88331-26, 212.7
- D. 88305, 212.7

133. This patient is in for a kidney biopsy (50200) because a mass was identified by ultrasound. The specimen is sent to pathology for gross and microscopic examination. Report the technical and professional components for this service. The results were inconclusive.

- A. 88305-26, 593.9
- B. 88307-26, 593.89
- C. 88307, 593.9
- D. 88305, 593.9

134. This 69-year-old female presents to the laboratory after her physician ordered quantitative and qualitative assays for troponin to assist in the diagnosis of her chief complaint of acute onset of chest pain.

- A. 84484, 80299, 786.51
- B. 84512, 84484, 80299, 786.59
- C. 84484, 84512, 786.50
- D. 84484, 84512, 786.59

135. CLINICAL HISTORY: Necrotic soleus muscle, right leg.

SPECIMEN RECEIVED: Soleus muscle, right leg.

GROSS DESCRIPTION: Submitted in formalin, labeled with the patient's name and "soleus muscle right leg," are multiple irregular fragments of tan, gray, brown soft tissue measuring 8 × 8 × 2.5 cm in aggregate. Multiple representative fragments are submitted in four cassettes.

MICROSCOPIC DESCRIPTION: The slides show multiple sections of skeletal muscle showing severe coagulative and liquefactive necrosis. Patchy neutrophilic infiltrates are present within the necrotic tissue.

DIAGNOSIS: Soft tissue, soleus muscle, right leg debridement; necrosis and patchy acute inflammation, skeletal muscle—infective myositis.

- A. 88305-26, 728.2
- B. 88304-26, 728.0
- C. 88307-26, 785.4
- D. 88304-26, 728.2

136. This 34-year-old established female patient is in for her yearly physical and lab. The physician orders a comprehensive metabolic panel, hemogram automated and manual differential WBC count (CBC), and a thyroid-stimulating hormone. Code the lab only.

- A. 99395, 80050
- B. 80050-52
- C. 80069, 80050
- D. 80050

137. This is a patient with atrial fibrillation who comes to the clinic laboratory routinely for a quantitative digoxin level.

- A. 80101, 80102, 428.0
- B. 81001, V58.83, V58.69, 427.41
- C. 80162, V58.83, V58.69, 427.31
- D. 80162, 785.0

138. This patient presented to the laboratory yesterday for a creatine measurement. The results came back at higher than normal levels; therefore, the patient was asked to return to the laboratory today for a repeat creatine test before the nephrologist is consulted. Report the second day of test only.

- A. 82540 × 2, 790.6
- B. 82550, 790.6
- C. 82550, 790.91
- D. 82540, 790.6

139. Code a pregnancy test, urine.

- A. 84702
- B. 84703
- C. 81025
- D. 84702 × 2

140. What CPT code would you use to code a bilirubin, total (transcutaneous)?

- A. 82252
- B. 82247
- C. 82248
- D. 88720

90000 Medicine

141. DIALYSIS INPATIENT NOTE: This 24-year-old male patient is on continuous ambulatory peritoneal dialysis (CAPD) using 1.5%. He drains more than 600 mL. He is tolerating dialysis well. He continues to have some abdominal pain, but his abdomen is not distended. He has some diarrhea. His abdomen does not look like acute abdomen. His vitals, other than blood pressure in the 190s over 100s, are fine. He is afebrile.

At this time, I will continue with 1.5% dialysate. I gave him labetalol IV for blood pressure. Because of diarrhea, I am going to check stool for white cells, culture. Next we will see what the primary physician says today. His HIDA scan was normal. The patient suffers from ESRD and has had 6 encounters this month. Code the month of service.

- A. 90947, 90960, 585.6, 787.91, V45.11
- B. 90945, 585.6, 787.91, V45.11
- C. 90960, 585.6, V45.11
- D. 90945, 585.6

142. INDICATION: Pulmonary hypertension with newly diagnosed acute myocardial infarction.

PROCEDURE PERFORMED: Insertion of Swan-Ganz catheter.

DESCRIPTION OF PROCEDURE: The right internal jugular and subclavian area was prepped with antiseptic solution. Sterile drapes were applied. Under usual sterile precautions, the right internal jugular vein was cannulated. A 9-French introducer was inserted, and a 7-French Swan-Ganz catheter was inserted without difficulty. Right atrial pressures were 2 to 3, right ventricular pressures 24/0, and pulmonary artery 26/9 with a wedge pressure of 5. This is a Trendelenburg position. The patient tolerated the procedure well.

- A. 93501, 93503-51, 410.91
- B. 93508, 416.8
- C. 93503, 93539, 401.9, 410.91
- D. 93503, 410.91, 416.8

143. DIAGNOSIS: Atrial flutter.

PROCEDURE PERFORMED: Electrical cardioversion.

DESCRIPTION OF PROCEDURE: The patient was sedated with Versed and morphine. She was given a total of 5 mg of Versed. She was cardioverted with 50 joules into sinus tachycardia.

The patient was given a 20-mg Cardizem IV push. Her heart rate went down to the 110s, and she was definitely in sinus tachycardia.

CONCLUSION: Successful electrical cardioversion of atrial flutter into sinus tachycardia.

- A. 92961, 427.61
- B. 92960, 427.32
- C. 92960, 92973, 427.32
- D. 92960, 427.89

144. A patient presents for a pleural cavity chemotherapy session with 10 mg doxorubicin HCl that requires a thoracentesis to be performed.

- A. 96445, J9000
- B. 96440, 32421, J9000
- C. 96440, J9000
- D. 96445, 32421, J9000

145. What CPT code would be used to report a home visit for a respiratory patient to care for the mechanical ventilation?
- A. 99503
 - B. 99504
 - C. 99505
 - D. 99509
146. What CPT code would be used to code the technical aspect of an evaluation of swallowing by video recording using a flexible fiberoptic endoscope?
- A. 92611
 - B. 92612
 - C. 92610
 - D. 92613
147. Which code would be used to report an EEG (electroencephalogram) provided during carotid surgery?
- A. 95816
 - B. 95819
 - C. 95822
 - D. 95955
148. This 40-year-old patient who is a type II diabetic is seen in an inpatient setting for psychotherapy. The doctor spends 50 minutes face to face with the patient. The patient is seen for depression.
- A. 90818, 311, 250.90
 - B. 90817, 311, 250.90
 - C. 90818, 311
 - D. 90817, 311
149. How would you report a screening hearing test?
- A. 92551, V80.3
 - B. 92555, V72.19
 - C. 92553, V72.19
 - D. 92620, V80.3

150. The patient presented for a spontaneous nystagmus test that included gaze, fixation, and recording and used vertical electrodes. Assign code(s) for the physician service only.

- A. 92541
- B. 92547
- C. 92541, 92544, 92547
- D. 92541, 92547