

Question Review & Study Tips

Question 21: A 42-year-old with renal pelvis cancer receives general anesthesia for a laparoscopic radical nephrectomy. The patient has controlled type 2 diabetes otherwise no other co-morbidities. What is the correct CPT and ICD-10 CM code for the anesthesia services?

- A. 00860-P1, C64.9, E11.9
- B. 00840-P3, C65.9, E11.9
- C. 00862-P2, C65.9, E11.9
- D. 00868-P2, C79.02, E11.9

Keywords:

renal pelvis cancer

controlled type 2 diabetes otherwise no other co-morbidities

general anesthesia

laparoscopic radical nephrectomy

Your choice:

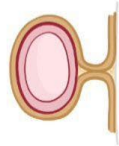
B. 00840-P3, C65.9, E11.9

Anesthesia for *intra*peritoneal procedures in lower abdomen including *laparoscopy*; not otherwise specified

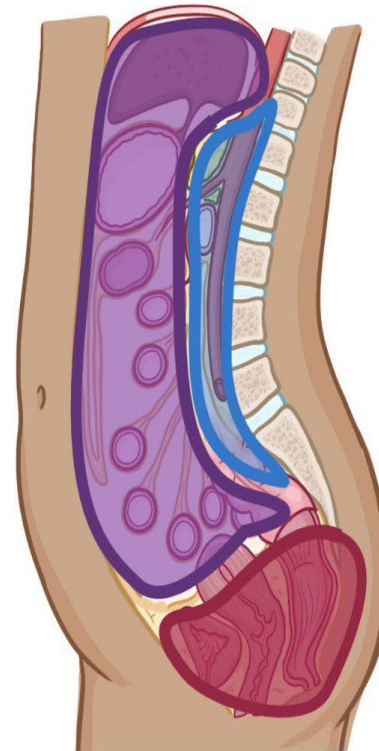
Tricky word: LAPAROSCOPY

P3: Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): **poorly controlled DM** or HTN, COPD, morbid obesity (BMI \geq 40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD, undergoing regularly scheduled dialysis, premature infant PCA<60 weeks, history (>3 months) of MI, CVA, TIA or CAD/stents

INTRAPERITONEAL
COMPLETELY COVERED with
VISCERAL PERITONEUM

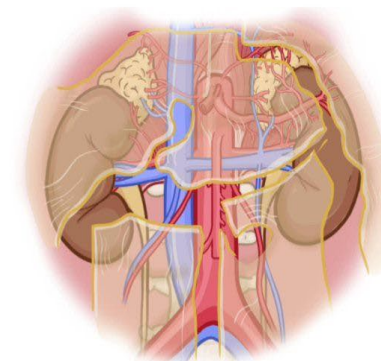


- * STOMACH
- * 1st PART DUODENUM
- * JEJUNUM
- * ILEUM
- * TRANSVERSE COLON
- * SIGMOID COLON
- * LIVER
- * SPLEEN



RETROPERITONEAL
PARTIALLY COVERED with
PERITONEUM

- * KIDNEYS
- * URETERS
- * SUPRARENAL GLANDS
- * RECTUM

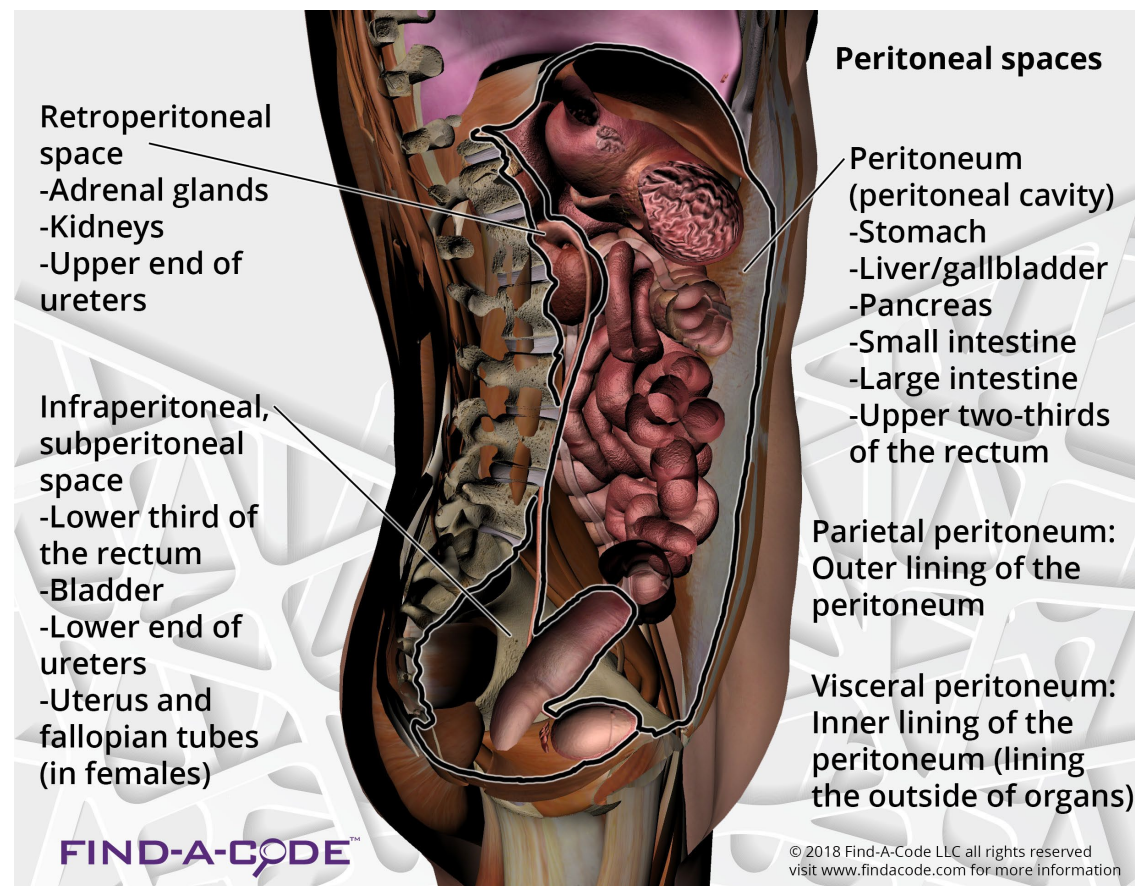


C: 00862-P2, C65.9, E11.9

Anesthesia – Renal Procedure – 00862

Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; renal procedures, including upper one-third of ureter, or donor nephrectomy

P2: Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease



A healthy 32-year-old with closed distal radius fracture received monitored anesthesia care for an ORIF of the distal radius. What is the code for the anesthesia service?

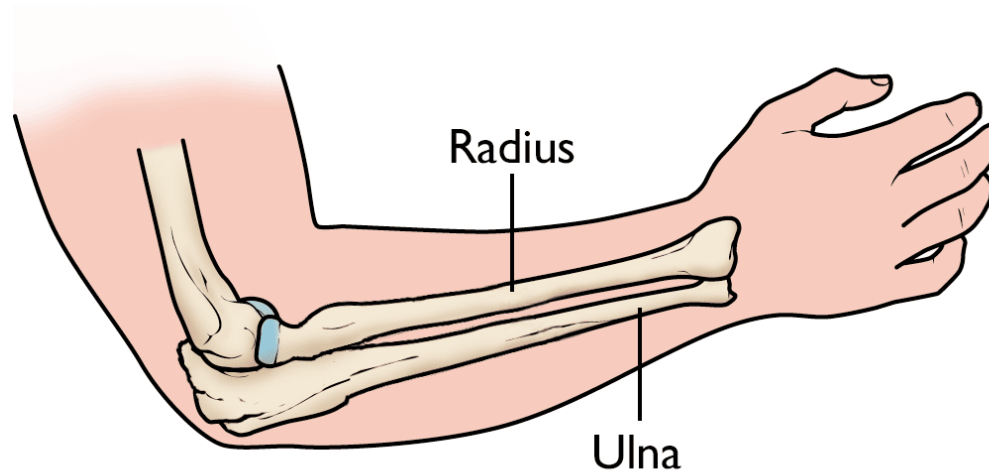
- A. 01830-P1
- B. 01860-QS-P1
- C. 01830-QS-P1
- D. 01860-QS-G9-P1

Keywords:

closed distal radius fracture

monitored anesthesia care (MAC)

ORIF of the distal radius
(Open Reduction Internal Fixation)



Your choice:

B. 01860-QS-P1

Anesthesia for forearm, wrist, or hand *cast application, removal, or repair*

QS: Monitored anesthesia care services

P1: A normal healthy patient

As 01860 is for cast application it can be eliminated as a correct answer. Thereby making choice "D" also incorrect.

Choice D includes G9 - Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition



C. 01830-QS-P1

Anesthesia – Forearm

Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified

The procedure was OPEN and performed on the DISTAL RADIUS



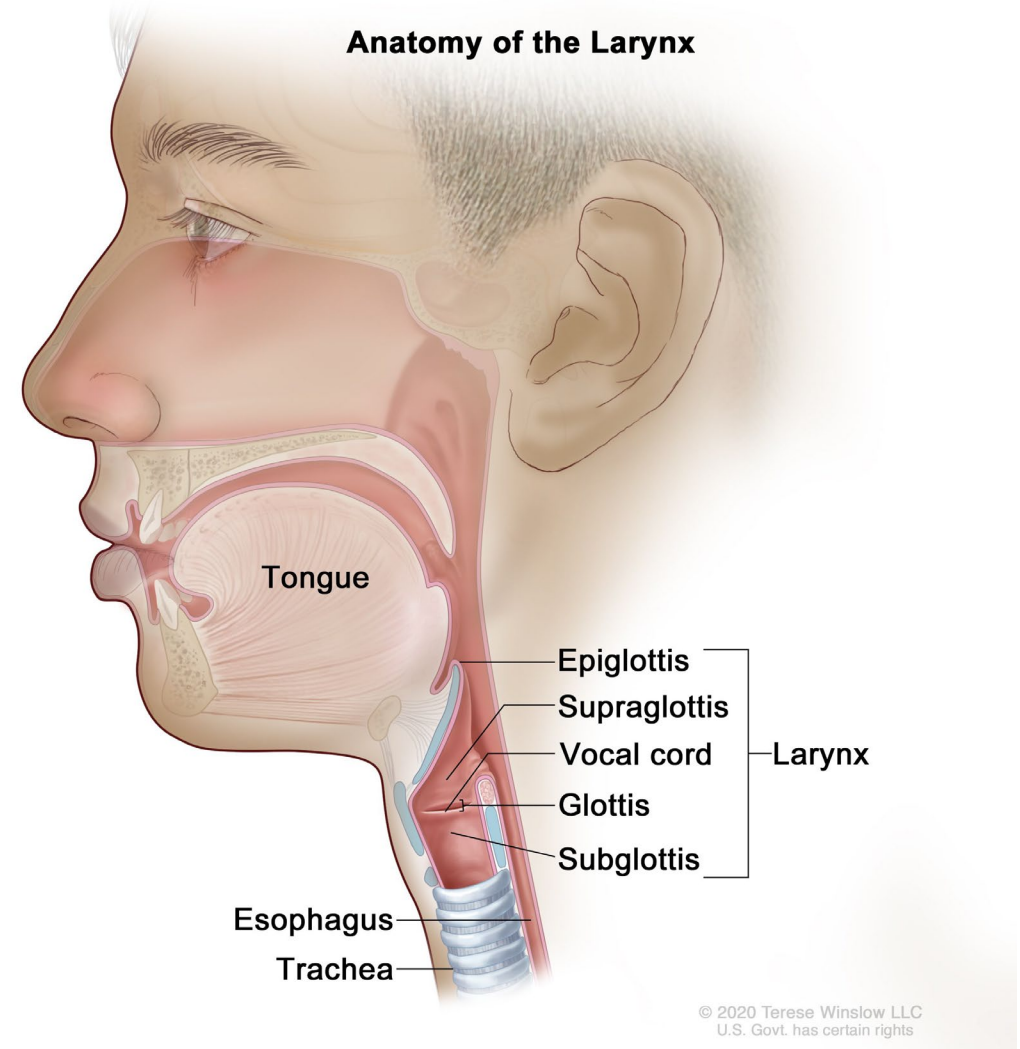
Question 23: A 10-month-old child is taken to the operating room for removal of a laryngeal mass. What is (are) the appropriate anesthesia code(s) to report?

- A. 00320
- B. 00326
- C. 00320, 99100
- D. 00326, 99100

Keywords:

10-month-old

removal of a laryngeal mass



Your choice:

D. 00326, 99100

00326 - Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age

CPT CodeBook Guidelines:(Do not report 00326 in conjunction with 99100)

99100 - Anesthesia for patient of extreme age, younger than 1 year and older than 70

(List separately in addition to code for primary anesthesia procedure)

*CPT CodeBook Guidelines:(For procedure performed on infants younger than 1 year of age at time of surgery,
See 00326, 00561, 00834, 00836)*

00326 is the CORRECT code. The code description indicates the age of the patient. (The answer was B.)

99100 is omitted as the age of the patient is already included in the previous code description

Parenthetical notes are instructions that verify the intent of the code(s).

The notes are enclosed in parentheses within the CPT® content and may be found preceding or following a code listing and within a code descriptor.

Question 25: A 56-year-old female is having a bilateral mammogram with computer aid detection conducted as a screening because the patient has a family history of breast cancer. She does not presently have signs or symptoms of breast disease. What radiological services are reported?

- A. 77065 x2
- B. 77065, 77066
- C. 77067
- D. 77066

Keywords:

a bilateral mammogram

computer aid detection

screening

family history of breast cancer

No signs or symptoms

MAMMOGRAMS: SCREENING VS. DIAGNOSTIC

Screening mammogram	Diagnostic mammogram
<ul style="list-style-type: none">Annual exam for women 40+ with no symptoms of breast cancer	<ul style="list-style-type: none">For women experiencing symptoms or to follow up on an abnormal screening
<ul style="list-style-type: none">Covered by insurance under the Affordable Care Act	<ul style="list-style-type: none">Check with your insurance company regarding coverage
<ul style="list-style-type: none">Reviewed by a radiologist after the exam and a report is provided to your doctor	<ul style="list-style-type: none">Reviewed by a radiologist at the time of the exam; additional imaging done immediately if needed

Visit beaumont.org/mammogram for more information. **Beaumont**

Your choice:

D. 77066

77066 - **Diagnostic** mammography, including computer-aided detection (CAD) when performed; bilateral

Diagnostic vs. Screening

Screening mammograms are annual preventive exams, while a doctor may order a diagnostic mammogram based on any signs of breast cancer symptoms. A diagnostic mammogram is more detailed than a screening mammogram.

MAMMOGRAMS

Diagnostic	Screening
Diagnose abnormalities or follow up with treatment	Early cancer detection
Ordered by a doctor	Annually
Women with abnormal mammograms or special circumstances	Women 40+ with No Symptoms

Correct Answer:

C. 77067

Mammogram – with Computer-Aided Detection (CAD)
Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

Question 26: A 63-year-old patient with bilateral ureteral obstruction presents to an outpatient facility for placement of a right and left ureteral stent along with an interpretation of a retrograde pyelogram. What codes should be reported?

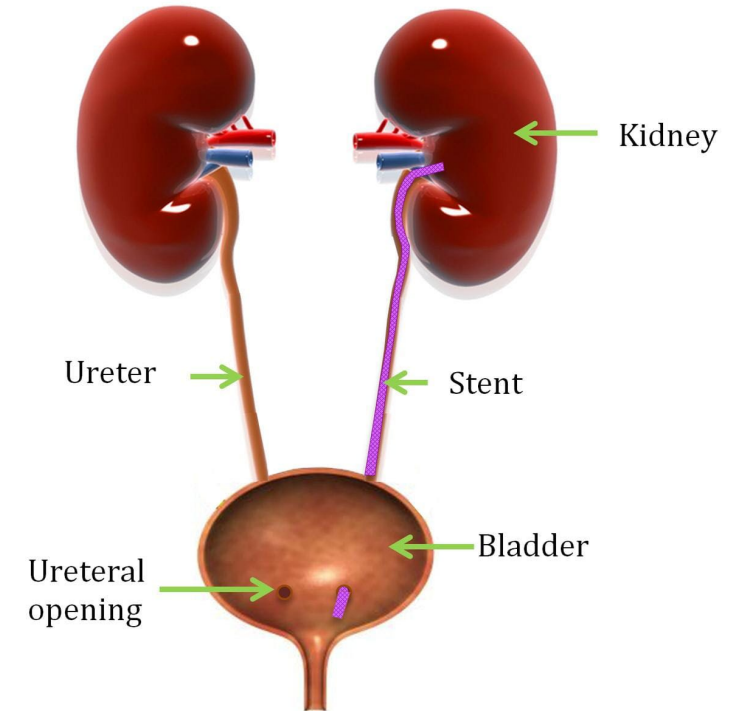
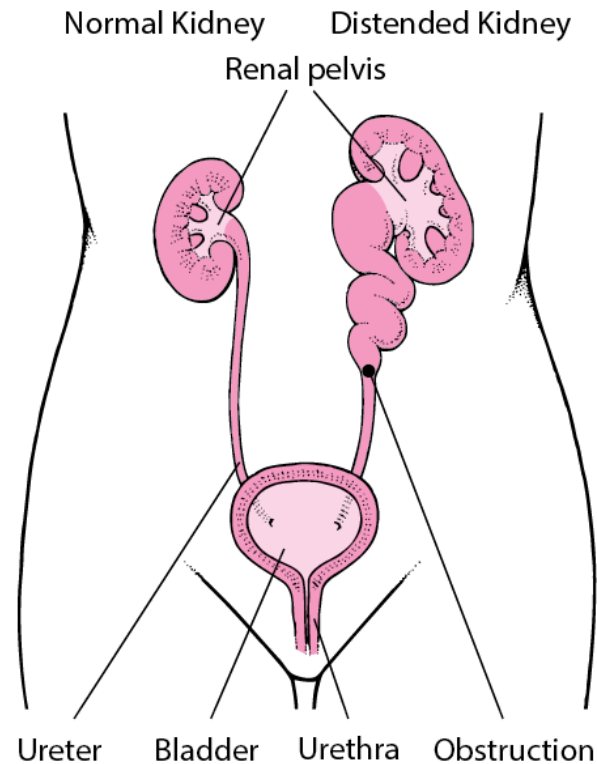
- A. 52332, 74425
- B. 52332-50, 74420-26
- C. 52005, 74420
- D. 52005-50, 74425-26

Keywords:

bilateral ureteral obstruction

right and left ureteral stent
(bilateral)

interpretation of a retrograde pyelogram



Your choice:

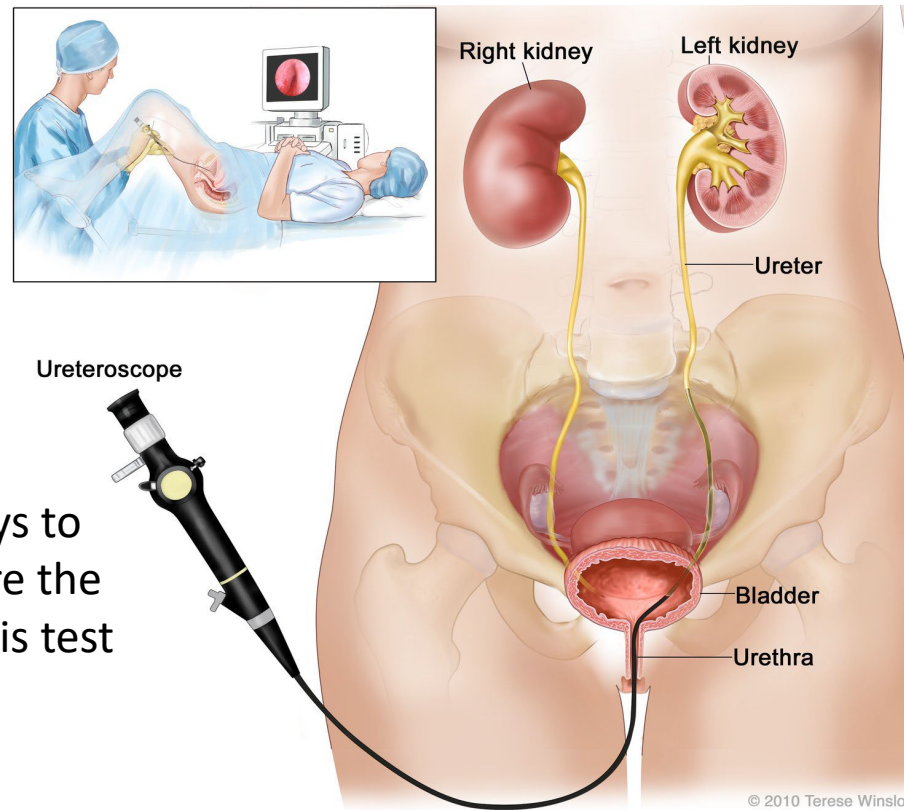
C: 52005, 74420

52005 - Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;

Cystourethroscopy is a procedure that allows your provider to visually examine the inside of your bladder and urethra. This is done using either a rigid or flexible tube (cystoscope), which is inserted through the urethra and into the bladder.

74420 - Urography, retrograde, with or without KUB

A retrograde pyelogram is an imaging test that uses X-rays to look at your bladder, ureters, and kidneys. The ureters are the long tubes that connect your kidneys to your bladder. This test is usually done during a test called cystoscopy. It uses an endoscope, which is a long, flexible, lighted tube.



Correct Answer:

B. 52332-50, 74420-26
Ureter – Stent – Insertion
Pyelogram

52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5-digit code.
Note: This modifier should not be appended to designated "add-on" codes

26 - Professional Component
Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC - Technical component; under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier 'tc' to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier tc; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles

Question 29: Per CPT guidelines for Organ or Disease-Oriented Panels how is a basic (88047) and comprehensive Metabolic (80053) panels reported?

- A. 80053, 80047
- B. 80053
- C. 80047, 82040, 82247, 82310, 84075, 84115, 84460, 84450
- D. 80053, 82330

Your Choice: C

Correct Answer: D

80047 - Basic metabolic panel (Calcium, ionized)

This panel must include the following:

Calcium, ionized (82330)

- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Potassium (84132)
- Sodium (84295)
- Urea Nitrogen (BUN) (84520)

80053 - Comprehensive metabolic panel

This panel must include the following:

- Albumin (82040)
- Bilirubin, total (82247)
- Calcium, total (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphatase, alkaline (84075)
- Potassium (84132)
- Protein, total (84155)
- Sodium (84295)
- Transferase, alanine amino (ALT) (SGPT) (84460)
- Transferase, aspartate amino (AST) (SGOT) (84450)
- Urea nitrogen (BUN) (84520)

If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using Individual test codes (eg, do not report 80047 in conjunction with 80053)

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