Digestive System (Multiple Choice)

CPC® Study Group with Legacy Education

1. What CPT® and ICD-10-CM codes are reported for a hemicolectomy performed on a patient with colon cancer?

   a. 44140, C18.9
   b. 44210, D49.0
   c. 44155, C19
   d. 44213, D49.0

2. A 7-year-old female presents to the same day surgery unit for a tonsillectomy. During the surgery the physician notices the adenoids are very inflamed and must be taken out as well. The adenoids, although not planned for removal, are removed following the tonsillectomy. What CPT® code(s) is/are reported for the procedure?

   a. 42820
   b. 42821
   c. 42825, 42830
   d. 42825, 42835

3. What CPT® and ICD-10-CM codes represent the creation of an opening into the stomach to insert a temporary feeding tube for nutritional support in an adult patient with proximal esophageal carcinoma due to alcohol dependence? A gastric tube was not created.

   a. 43831, D49.0, F10.10
   b. 43870, C15.8, F10.99
   c. 43653, C15.9, F10.20
   d. 43830, C15.3, F10.20

4. A patient presents with a 2 cm benign lip lesion. The provider decides to remove the lesion along with a portion of the lip by performing a wedge excision. Single-layer suture repair is performed. What CPT® code(s) is/are reported for this service?

   a. 11442, 12011-51
   b. 11442, 40510
   c. 40510
   d. 40510, 12011-51

5. What CPT® coding is reported when a physician makes two separate incisions to perform a laparoscopic appendectomy and laparoscopic cholecystectomy?

    a. 44960, 47562
    b. 47562
    c. 47562, 44970-51
    d. 47562, 44970-59

6. What CPT® and ICD-10-CM codes are reported for a gastric restriction by placing a gastric band via laparoscopic surgery for an adult patient diagnosed as morbidly obese having a BMI of 43, type 2 uncontrolled diabetes and elevated blood sugar readings daily?

    a. 43771, E66.01, Z68.41, E10.65
    b. 43842, E66.01, Z68.41, E11.9
    c. 43770, E66.01, Z68.41, E11.65
    d. 43644, E66.9, Z68.41, E10.9

7. A patient is seen in the gastroenterologist's clinic for a diagnostic colonoscopy. When performing the service, the physician notes suspicious looking polyps and removes three using a snare technique to send to pathology for further testing. What CPT® coding is reported?

    a. 45385
    b. 45380
    c. 45378, 45385-51
    d. 45378, 45380-51

8. A 20-year-old patient presented to the hospital for a sigmoidoscopy due to a history of bloody stools for three weeks duration. The patient was prepped and the sigmoidoscope was passed without difficulty to about 40 cm. The entire mucosal lining was erythematosus. There was no friability of the overlying mucosa and no bleeding noted. No pseudo polyps were identified. Biopsies were taken at about 30 cm; these were thought to be representative of the mucosa in general. The scope was retracted; no other abnormalities were seen. What CPT® and ICD-10-CM codes are reported?

    a. 45330, 45331, K62.5
    b. 45331, K92.1
    c. 45333, Z12.11, K62.5
    d. 45305, K92.1

9. A 4-year-old patient, who accidentally ingests valium found in his mother's purse, is found unconscious and rushed to the ED. The child is treated by the ED physician, who inserted a tube orally into the stomach and performed a gastric lavage, removing the stomach contents. What CPT® and ICD-10-CM codes are reported?

    a. 43754, R40.20, T42.71XA
    b. 43753, T42.4X1A, R40.20
    c. 43756, T42.71XA
    d. 43755, T43.501A

10. An 11-year-old patient is seen in the OR for a secondary palatoplasty for complete unilateral cleft palate. Shortly after general anesthesia is administered, the patient begins to seize. The surgeon quickly terminates the surgery in order to stabilize the patient. What CPT® and ICD-10-CM codes are reported for the surgeon?

    a. 42220-52, Q35.7, R56.9
    b. 42220-53, Q35.9, R56.9
    c. 42215-53, Q35.9, R56.9
    d. 42215-76, Q35.7, R56.9

Digestive System (Fill in the Blanks)

CPC® Study Group with Legacy Education

1. What CPT® and ICD-10-CM codes are reported for a hemicolectomy performed on a patient with colon cancer?

   CPT®: _____

   ICD-10-CM: _____

2. A 7-year-old female presents to the same day surgery unit for a tonsillectomy. During the surgery the physician notices the adenoids are very inflamed and must be taken out as well. The adenoids, although not planned for removal, are removed following the tonsillectomy. What CPT® code(s) is/are reported for the procedure?

   CPT®: _____

3. What CPT® and ICD-10-CM codes represent the creation of an opening into the stomach to insert a temporary feeding tube for nutritional support in an adult patient with proximal esophageal carcinoma due to alcohol dependence? A gastric tube was not created.

   CPT®: _____

   ICD-10-CM: _____, _____

4. A patient presents with a 2 cm benign lip lesion. The provider decides to remove the lesion along with a portion of the lip by performing a wedge excision. Single-layer suture repair is performed. What CPT® code(s) is/are reported for this service?

   CPT®: _____

5. What CPT® coding is reported when a physician makes two separate incisions to perform a laparoscopic appendectomy and laparoscopic cholecystectomy?

   CPT®: _____, _____

6. What CPT® and ICD-10-CM codes are reported for a gastric restriction by placing a gastric band via laparoscopic surgery for an adult patient diagnosed as morbidly obese having a BMI of 43, type 2 uncontrolled diabetes and elevated blood sugar readings daily?

   CPT®: _____

   ICD-10-CM: _____, _____, _____

7. A patient is seen in the gastroenterologist's clinic for a diagnostic colonoscopy. When performing the service, the physician notes suspicious looking polyps and removes three using a snare technique to send to pathology for further testing. What CPT® coding is reported?

   CPT®: _____

8. A 20-year-old patient presented to the hospital for a sigmoidoscopy due to a history of bloody stools for three weeks duration. The patient was prepped and the sigmoidoscope was passed without difficulty to about 40 cm. The entire mucosal lining was erythematosus. There was no friability of the overlying mucosa and no bleeding noted. No pseudo polyps were identified. Biopsies were taken at about 30 cm; these were thought to be representative of the mucosa in general. The scope was retracted; no other abnormalities were seen. What CPT® and ICD-10-CM codes are reported?

   CPT®: _____

   ICD-10-CM: _____

9. A 4-year-old patient, who accidentally ingests valium found in his mother's purse, is found unconscious and rushed to the ED. The child is treated by the ED physician, who inserted a tube orally into the stomach and performed a gastric lavage, removing the stomach contents. What CPT® and ICD-10-CM codes are reported?

   CPT®: _____

   ICD-10-CM: _____, _____

10. An 11-year-old patient is seen in the OR for a secondary palatoplasty for complete unilateral cleft palate. Shortly after general anesthesia is administered, the patient begins to seize. The surgeon quickly terminates the surgery in order to stabilize the patient. What CPT® and ICD-10-CM codes are reported for the surgeon?

    CPT®: _____

    ICD-10-CM: _____, _____

Answer Key

1. What CPT® and ICD-10-CM codes are reported for a hemicolectomy performed on a patient with colon cancer?

   a. 44140, C18.9
   b. 44210, D49.0
   c. 44155, C19
   d. 44213, D49.0

   Rationale: For the CPT® code, hemi- means half or partial and colectomy is the removal of the colon. Look in the CPT® Index for Colectomy/Partial directing you to code 44140.

   Next, look in the ICD-10-CM Alphabetic Index for Carcinoma, directing you to see also, Neoplasm, by site, malignant. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/colon directing you to see also Neoplasm/intestine/large and report code C18.9 under the Malignant Primary column. There is no documentation the cancer is secondary or had metastasized from another site, it is considered primary. Verify the code in the Tabular List.

2. A 7-year-old female presents to the same day surgery unit for a tonsillectomy. During the surgery the physician notices the adenoids are very inflamed and must be taken out as well. The adenoids, although not planned for removal, are removed following the tonsillectomy. What CPT® code(s) is/are reported for the procedure?

   a. 42820
   b. 42821
   c. 42825, 42830
   d. 42825, 42835

   Rationale: In the CPT® Index look for Tonsils/Excision/with Adenoids referring you to 42820-42821. Code 42820 represents the removal of both the tonsils and adenoids. These are age specific codes and 42820 represents anyone younger than age 12.

3. What CPT® and ICD-10-CM codes represent the creation of an opening into the stomach to insert a temporary feeding tube for nutritional support in an adult patient with proximal esophageal carcinoma due to alcohol dependence? A gastric tube was not created.

   a. 43831, D49.0, F10.10
   b. 43870, C15.8, F10.99
   c. 43653, C15.9, F10.20
   d. 43830, C15.3, F10.20

   Rationale: A gastrostomy is the creation of an opening into the stomach. Look in the CPT® Index for Gastrostomy/Temporary referring you to 43830. You could also look for Stomach/Creation/Stoma Temporary referring you to 43830, 43831. Code 43830 represents an open placement (accessing the stomach through the abdominal wall) for a feeding device, such as a tube.

   In the ICD-10-CM Alphabetic Index look for Carcinoma, which directs us to see also, Neoplasm, by site, malignant. Go to the Table of Neoplasms and look for Neoplasm, neoplastic/ esophagus/proximal (third)/Malignant Primary column referring you to code C15.3. The Tabular List confirms that code C15.3 represents the primary cancer of the upper or proximal third of the esophagus. There is an instructional note to report an additional code to identify alcohol abuse or dependence (F10.-). Alcohol dependence is reported with code F10.20. Verify code selection in the Tabular List.

4. A patient presents with a 2 cm benign lip lesion. The provider decides to remove the lesion along with a portion of the lip by performing a wedge excision. Single-layer suture repair is performed. What CPT® code(s) is/are reported for this service?

   a. 11442, 12011-51
   b. 11442, 40510
   c. 40510
   d. 40510, 12011-51

   Rationale: Because the physician is not only removing the lesion, but also removing part of lip, code 11422 is not reported. The lesion and a portion of the lip are removed by a transverse wedge technique. Look in the CPT® Index for Wedge Excision/Lip referring you to code 40510. The code description for code 40510 includes primary closure (suture repair) indicating an integumentary system repair code (12011) is not reported separately.

5. What CPT® coding is reported when a physician makes two separate incisions to perform a laparoscopic appendectomy and laparoscopic cholecystectomy?

   a. 44960, 47562
   b. 47562
   c. 47562, 44970-51
   d. 47562, 44970-59

   Rationale: Code 47562 represents the laparoscopic cholecystectomy. In the CPT® Index look for Laparoscopy/Biliary Tract/Cholecystectomy or Cholecystectomy/Laparoscopic. Referring you to 47562-47564. Next, look in the CPT® Index for Laparoscopy/Appendix/Appendectomy. Referring you to 44970. Both codes can be reported because the physician made two separate laparoscopic site incisions to remove the gallbladder and appendix. We indicate this by appending modifier 59 to the 2nd code.

6. What CPT® and ICD-10-CM codes are reported for a gastric restriction by placing a gastric band via laparoscopic surgery for an adult patient diagnosed as morbidly obese having a BMI of 43, type 2 uncontrolled diabetes and elevated blood sugar readings daily?

   a. 43771, E66.01, Z68.41, E10.65
   b. 43842, E66.01, Z68.41, E11.9
   c. 43770, E66.01, Z68.41, E11.65
   d. 43644, E66.9, Z68.41, E10.9

   Rationale: In the CPT® Index, look for Laparoscopy/Stomach/Gastric Restrictive Procedures which referring you to 43770-43775, 43842-43848, 43886-43888 or Laparoscopy/Gastric Restrictive Procedures referring you to 43644, 43645, 43770-43775. In reviewing the code descriptions, 43770 is correct code for placement of adjustable gastric bands laparoscopically.

   Look in the ICD-10-CM Alphabetic Index for Obesity/morbid, referring you to code E66.01. In the Tabular List, an instructional note beneath E66 states, "Use additional code to identify body mass index (BMI), if known (Z68.-)". Turning to Z68 in the Tabular List, you find a list of subcategories specific to adult and pediatric BMI ranges. The patient has a BMI of 43 falling into the range of ICD-10-CM code Z68.41. Next, look for Diabetes/type 2/uncontrolled, directing you to select between hyperglycemia (too much blood sugar) or hypoglycemia (too little blood sugar). This patient has daily elevated blood sugar sending you to see Diabetes, by type, with, hyperglycemia. Looking back at Diabetes/type 2/with/hyperglycemia directs to code E11.65. Verification of the codes in the Tabular List confirms code selections.

7. A patient is seen in the gastroenterologist's clinic for a diagnostic colonoscopy. When performing the service, the physician notes suspicious looking polyps and removes three using a snare technique to send to pathology for further testing. What CPT® coding is reported?

   a. 45385
   b. 45380
   c. 45378, 45385-51
   d. 45378, 45380-51

   Rationale: A surgical endoscopy always includes a diagnostic endoscopy so only the surgical is reported. Reporting 45385 is the correct code for the colonoscopy with removal of polyps by snare technique. In the CPT® Index, look for Colonoscopy/Flexible/Removal/Polyp referring you to 45384, 45385. Reviewing the descriptions of both codes directs you to 45385 which includes use of snare technique.

8. A 20-year-old patient presented to the hospital for a sigmoidoscopy due to a history of bloody stools for three weeks duration. The patient was prepped and the sigmoidoscope was passed without difficulty to about 40 cm. The entire mucosal lining was erythematosus. There was no friability of the overlying mucosa and no bleeding noted. No pseudo polyps were identified. Biopsies were taken at about 30 cm; these were thought to be representative of the mucosa in general. The scope was retracted; no other abnormalities were seen. What CPT® and ICD-10-CM codes are reported?

   a. 45330, 45331, K62.5
   b. 45331, K92.1
   c. 45333, Z12.11, K62.5
   d. 45305, K92.1

   Rationale: CPT® code for a sigmoidoscopy with single or multiple biopsies is reported 45331. This is indexed in CPT® under Sigmoidoscopy/Biopsy. Diagnostic sigmoidoscopy is always bundled with a surgical sigmoidoscopy when both are performed in the same operative session.

   The ICD-10-CM code for bloody stools is found looking in the ICD-10-CM Alphabetic Index for Blood/in/feces or Hematochezia (see also Melena) refers you to K92.1. When a patient comes in with a GI symptom (bloody stool, abdominal pain, etc.) and no definitive diagnosis is documented, the symptom(s) should be reported. Verify code selection in the Tabular List.

9. A 4-year-old patient, who accidentally ingests valium found in his mother's purse, is found unconscious and rushed to the ED. The child is treated by the ED physician, who inserted a tube orally into the stomach and performed a gastric lavage, removing the stomach contents. What CPT® and ICD-10-CM codes are reported?

    a. 43754, R40.20, T42.71XA
    b. 43753, T42.4X1A, R40.20
    c. 43756, T42.71XA
    d. 43755, T43.501A

    Rationale: Code 43753 is the correct CPT® code for gastric lavage performed for the treatment of ingested poison. Look in the CPT® Index for Gastric Lavage, Therapeutic/Intubation.

    The ICD-10-CM code for the poisoning is found in the Table of Drugs and Chemicals by looking for Valium/Poisoning, Accidental (unintentional) column. Referring you to code T42.4X1-. In the Tabular List a 7th character is needed to complete the code. A is reported as the 7th character because this was the patient's initial encounter.
    The next code is the manifestation of ingesting the Valium, unconsciousness. Unconsciousness is found in the ICD-10-CM Alphabetic Index referring you to see Coma R40.20. The Tabular List confirms this code is reported for unconsciousness.

10. An 11-year-old patient is seen in the OR for a secondary palatoplasty for complete unilateral cleft palate. Shortly after general anesthesia is administered, the patient begins to seize. The surgeon quickly terminates the surgery in order to stabilize the patient. What CPT® and ICD-10-CM codes are reported for the surgeon?

    a. 42220-52, Q35.7, R56.9
    b. 42220-53, Q35.9, R56.9
    c. 42215-53, Q35.9, R56.9
    d. 42215-76, Q35.7, R56.9

    Rationale: In the CPT® Index, look for Palatoplasty 42145, 42200-42225. An alternate path is Cleft Palate/Repair referring you to 42200-42225. Review of the code descriptions in the main section confirms code 42220 represents a secondary repair to a cleft palate. Modifier 53 is appended because the procedure was terminated after anesthesia due to extenuating circumstances.

    The diagnosis of a complete unilateral cleft palate is indexed in the ICD-10-CM Alphabetic Index under Cleft/palate referring you to code Q35.9. The unspecified code is the appropriate code because the surgeon did not provide specific information for the location of the cleft. Next, look for Seizure(s) (see also Convulsions) R56.9. Both listings direct the coder to R56.9 Unspecified convulsions. Code R56.9 is reported because the patient began to seize after administering the general anesthesia. Verify all code selections in the Tabular List.