# AAPC CPC - Quiz Questions with Answers

# 10,000 Series CPT®



**1.**

A patient undergoes a bandage change on a large trunk wound but, because he is very sensitive to pain, he requests to be put under anesthesia. Which CPT code best fits this procedure?

**15852**

15851

15879

15860

*Correct answer: 15852*

*In the CPT index, you would look up dressings, change, anesthesia, which gives you the code 15852. Turning to the Integumentary system section, where this code is located, you will see that it is for a dressing change under anesthesia. Since this is exactly what the question is asking for, this code would be the correct answer.*

*Code 15851 is for removal of sutures or staples requiring anesthesia. The patient had a bandage change done, not suture/staple removal, so this would be incorrect. Code 15879 is for suction-assisted lipectomy; head and neck, lower extremity. This does not match what was done in the question, so this also would be incorrect. Code 15860 is for the intravenous injection of agent to test vascular flow in flap or graft. A bandage change was done, not IV injection, so this would also be incorrect.*

**2.**

A patient undergoes a procedure for intermediate repair of various wounds on the left arm and hand. The total size of the wounds is 8 cm and 3 cm respectively. How would this be billed?

**12034, 12042**

12031, 12041

12034

12004, 12001

---

*Correct answer: 12034, 12042*

*In the index of the CPT book, you would look up repair, skin, wound, intermediate. This gives you the code range 12031-12057. Turning to the Integumentary System section, you will see that the codes are separated by body part and wound size. In the question, the arm and the hand have wounds on them, and the wounds are 8 cm and 3 cm respectively (meaning the wound on the arm is 8 cm, and the wound on the hand is 3 cm). The code for the arm would be 12034, and the code for the hand would be 12042.*

*Code 12031 is for intermediate repair of the scalp, axillae, trunk, and/or extremities, 2.5 cm or less. The question states that the wounds on the arm are 8 cm, so this would not be the correct answer. Code 12041 is for intermediate repair of wounds of the neck, hands, feet and/or external genitalia, 2.5 cm or less. The question states that the wounds on the hand are 3 cm, so this is also not correct. Code 12034 is for intermediate repair of the scalp, axillae, trunk, and/or extremities, 7.6 cm-12.5 cm. This is incorrect because you would not combine the two wound surfaces since they are not on the same parts of the body. Code 12004 is for simple repair of the scalp, axillae, trunk and/or extremities, 7.6 cm-12.5 cm, and code 12001 is for simple repair of the scalp, axillae, trunk, and/or extremities. The question states that intermediate repair was done, so these codes are not the correct answer.*

**3.**

A patient's doctor discovers four premalignant lesions on her leg. In order to get rid of them before they become more of a problem, he destroys all four via laser surgery and has the patient follow up with him in two weeks.

How would this procedure be billed?

**17000, 17003 x3**

17000, 17003-51

17004

17000, 17004

---

*Correct answer: 17000, 17003 x3*

*In the CPT index, you will look up destruction, lesion, skin, premalignant, which gives you the code range 17000-17004. (This index listing also gives you the code 96567, but since this is not located in the Integumentary system section, for the sake of this exercise, you can skip it.) Turning to the Integumentary system section, where these codes are located, you will see that these codes are all for the destruction of premalignant lesions but differ on how many lesions are destroyed. In the question, four lesions are destroyed via laser surgery. Given this information, codes 17000 and 17003 would be the best fit. Since 17003 is an add-on code for each extra lesion, you would code it three times (or x3). Therefore, this code set would be the correct answer.*

*Codes 17000 and 17003 are correct for this question; however, attaching a 51 modifier (multiple procedures) would not be correct. To answer the question correctly, you would code 17003 multiple times. Code 17004 is for the destruction of premalignant lesions as well, but for 15 or more lesions. Since only four were destroyed in the question, this would not be the correct answer.*

**4.**

After learning that she is genetically at risk for breast cancer, a patient undergoes a bilateral modified radical mastectomy. While still in the OR, the patient also undergoes bilateral implant insertion immediately after removal.

How would this entire surgery be billed?

**19307-50, 19340-50**

19307, 19342

19342-50, 19306-50

19303-50, 19342

---

*Correct answer: 19307-50, 19340-50*

*In the index of the CPT book, you will look up mastectomy, modified radical, which gives you the code 19307. Turning to the Integumentary System section, you will see that this code is indeed for a modified radical mastectomy. Because it is a bilateral procedure, you will also add on the 50 modifier to this code, showing that it is a bilateral procedure. The next code can be looked up in the index as insertion, breast, implants. This gives you the code range 19340-19342, which can again be found in the Integumentary System section. Code 19340 is for the immediate insertion of breast implant following mastectomy. This is exactly what the question states, so this would be the correct answer. Also, you will need to add a 50 modifier to this code as well to show that this is a bilateral procedure.*

*Code 19342 is for the insertion or replacement of breast implant on separate day from mastectomy. The question states that the implants were placed immediately after the procedure, while the patient was still in the OR, so this is not the correct answer. Code 19306 is for a radical mastectomy. The question asks for a modified radical mastectomy, so this is not the correct answer. Code 19303 is for a simple mastectomy, complete. The question asks for a modified radical mastectomy, so this is not the correct answer.*

**5.**

A patient presents to the dermatologist with a large infected abscess on their back. The dermatologist performs an Incision and Drainage (I&D) procedure to treat the subcutaneous complicated abscess.

Which CPT code should be assigned for this procedure?

**10061**

10060

10121

10140

---

*Correct answer: 10061*

*CPT code 10061 describes the incision and drainage of a complicated subcutaneous abscess.*

*CPT code 10060 describes an incision and drainage of a simple subcutaneous abscess.*

*CPT code 10121 describes a complicated incision and removal of a foreign body from the subcutaneous tissue. There is no indication that a foreign body was removed.*

*CPT code 10140 is incorrect as it represents a different procedure — the incision and drainage of a hematoma, seroma, or fluid collection.*

**6.**

A patient who wants to correct wrinkles on her face undergoes an epidermal chemical facial peel on her face. How would this be billed?

**15788**

15793

15780

15824

---

*Correct answer: 15788*

*In the CPT index, you will look up chemical peel, which gives you the code range 15788-15793. Turning to the Integumentary system section, where these codes are located, you will see that these three codes are all for chemical peels but differ in whether the peel was dermal or epidermal, or whether it was facial or nonfacial. In the question, the patient had an epidermal facial peel. Given this information, code 15788 would be the best fit since it is for a chemical peel, facial, epidermal. Therefore, this code would be the correct answer.*

*Code 15793 is for a dermal facial chemical peel. The question states that an epidermal peel was done, so this would not be the correct answer. Code 15780 is for dermabrasion, total face. This does not match the procedure given in the question, so this also would be an incorrect answer. Code 15824 is for a rhytidectomy, forehead. This procedure is not mentioned in the question at all, so this would be an incorrect answer.*

**7.**

Which of the following circumstances would not call for a debridement?

**Fracture**

Infection

Chronic ulcer

Injury

---

*Correct answer: Fracture*

*For this question, you would turn to the Debridement subsection within the Integumentary System section. Debridement is the cleaning out of a wound and is typically done on either the skin, muscles, or bones. There is a description of how to code debridement in this subsection, and this description explains that a debridement may be reported for "injuries, infections, wounds, and chronic ulcers." All these are prone to getting foreign debris caught inside. The one "answer" not mentioned here is fractures, as they typically do not need a debridement.*

*As mentioned above, infections, chronic ulcers, and injuries are all acceptable to be reported with a debridement.*

**8.**

Fine needle aspiration can be performed with various procedures on various body systems. Which code would be specifically used for this?

**10021**

10005

19081

19086

---

*Correct answer: 10021*

*In the index of the CPT book, you will look up fine needle aspiration, diagnostic, which gives you the code 10021. Turning to the Integumentary System section, you will see that this code is for a fine needle aspiration, without any imaging guidance, first lesion. This would be the correct answer to the question.*

*Code 10005 is for a fine needle aspiration, with ultrasound guidance, first lesion. The question is only asking for a fine needle aspiration, no imaging guidance, so this would not be the correct answer. Code 19081 is for a breast biopsy. This is not at all what the question is asking for, so this would be an incorrect answer. Code 19086 is an add-on code for a breast biopsy. This is also an incorrect answer because the question is not asking for this at all.*

**9.**

A patient is being treated for third-degree burns to his left leg and left arm, covering an area of 18 sq cm. The burns are scrubbed clean, anesthetized and three incisions are made with a #11 scalpel, through the dead tissue, in order to expose the fatty tissue below and avoid compartment syndrome. The burns are then re-dressed with sterile gauze.

What CPT code(s) should the physician utilize?

**16035, 16036 x2**

97602

97597

16030, 16035, 16036 x2

---

*Correct answer: 16035, 16036 x2*

*CPT codes 97597 and 97602 can be found in the Medicine chapter and describe active open wound care (e.g., decubitus ulcers). Beneath the Active Wound Care Management coding guidelines, there is the following notation: “For debridement of burn wounds, see 16020-16030.” CPT code 16030 is used to describe the removal of dead tissue on second-degree (partial thickness) burns. In this scenario, the patient sustained third-degree burns. There is no mention of tissue removal, only cleansing and incisions, so eliminate this option.*

*CPT code 16035 describes an escharotomy (note the suffix -otomy, which means "to cut into”). An escharotomy is a procedure used to repair third-degree burns, in which incisions are made into the thick dead tissue in order to keep underlying nerves and vessels from being injured or constricted. CPT code 16036 is an add-on code used in conjunction with 16035 to describe each additional incision. CPT code 16035 describes the first incision, and code 16036 x2 describes the second and third incisions.*

**10.**

A patient who has suffered from persistent acne since he was a teenager undergoes a chemical exfoliation to help it be less prevalent on his face. What is the correct CPT coding?

**17360**

17340

17999

17380

---

*Correct answer: 17360*

*In the CPT index, you would look up chemical exfoliation, which gives you the code 17360. Turning to the Integumentary system section, where this code is located, you will see that this code is for chemical exfoliation for acne. Since this is exactly what the question is asking for, this would be the correct answer.*

*Code 17340 is for cryotherapy for acne. The patient had chemical exfoliation done, not cryotherapy, so this would be an incorrect answer. Code 17999 is an unlisted procedure for the skin, mucous membrane and subcutaneous tissue. We know that this procedure has a CPT code, so this also would not be the correct answer. Code 17380 is for electrolysis epilation, each 30 minutes. This is not what the question is asking for at all, so this would be incorrect.*

**11.**

A patient is being treated for third-degree burns to her left leg and left arm, covering 18 sq cm. The burns are scrubbed clean and anesthetized, and three incisions are made with a #11 scalpel to clean the area. The burns are then re-dressed in sterile gauze.

What is the correct coding for this procedure?

**16035, 16036 x2**

97597

97602

16030, 16035, 16036 x2

---

*Correct answer: 16035, 16036 x2*

*The patient has two burn sites, one on the left leg and one on the left arm. Eschar is a leathery slough produced by thermal burns. An escharotomy is an incision created to remove the leathery slough and release the movement of the underlying tissue. The physician reports making three incisions through the area. Report 16035 for the initial incision and 16036 for each additional incision.*

*CPT codes 97597 and 97602 can be found in the Medicine chapter and describe active open wound care (e.g., decubitus ulcers).*

*Beneath the Active Wound Care Management coding guidelines, there is the notation "For debridement of burn wounds, see 16020-16030." CPT code 16030 describes the dressings and/or debridement or removal of dead tissue on second-degree (partial-thickness) burns. In this case, the patient sustained third-degree burns. There is no mention of tissue removal, only cleansing and incisions, so 16030 is incorrect.*

**12.**

A patient presents to the dermatologist's office for the removal of a benign lesion on the arm using a scalpel. The procedure involves the complete removal of the 0.4-cm dermal lesion by shaving and does not require suture closure.

Which CPT code should be assigned for this procedure?

**11300**

11400

11600

17110

---

*Correct answer: 11300*

*CPT code 11300 represents the shaving of a dermal lesion; single lesion, trunk, arms, or legs. The lesion must be 0.5 cm or less.*

*CPT code 11400 is incorrect as it represents the removal of a benign skin lesion by excision, including margins, with simple closure. However, it does not specifically mention the use of a scalpel.*

*CPT code 11600 is incorrect as it represents the removal of a malignant skin lesion by excision, including margins, with simple closure.*

*CPT code 17110 is incorrect as it represents the destruction of benign lesions, such as warts, using cryotherapy or similar methods, and not the surgical excision described in the scenario.*

**13.**

If a patient has both sutures and staples removed, which CPT code would be used along with the appropriate E/M code?

**15854**

15851

15853

15852

---

*Correct answer: 15854*

*For this service, an E/M code would be reported, and the 15854 add-on code would also be reported to indicate staples and sutures were removed in the session.*

*CPT code 15851 is to be used for staple or suture removal under anesthesia. In this question, both sutures and staples are removed and there is no mention of anesthesia.*

*CPT code 15853 is also an add-on code for removal without anesthesia, but this is for either sutures or staples, not both.*

*CPT code 15852 is used for dressing changes under anesthesia. This is not a dressing change question, nor was any anesthesia mentioned.*

**14.**

If a physician removes 30 skin tags from a patient's neck and facial area, how would that be billed?

**11200, 11201 x2**

11200

11300 x30

11310, 11201 x3

---

*Correct answer: 11200, 11201 x2*

*In the index of the CPT book, you would look up skin, tags, removal, which gives you the code range 11200-11201. Turning to the Integumentary System section, you will see that code 11200 is for the removal of skin tags, any area, up to and including 15 lesions. This works for the first half of the skin tags. Code 11201 is an add-on code for 11200, which is for each additional 10 lesions or part thereof. Since there are 15 more lesions to code for, you would use code 11201 twice, accounting for the remaining 15 tags. So, the correct answer would be 11200, 11201 x2.*

*Code 11300 is for the shaving of epidermal/dermal lesion, single lesion. The question states that the skin tags are being removed, not epidermal lesions, so this would be incorrect. Code 11310 is also for the shaving of epidermal/dermal lesions, but on the face. Again, the question does not mention anything about epidermal lesions, so this would also be incorrect.*

**15.**

An established patient presents to the podiatrist with a single painful callus on the left foot. The podiatrist performs a paring of the callus using a scalpel and applies a topical antibiotic ointment to the area.

Which CPT code should be assigned for this procedure?

**11055**

11056

11057

11055 and 11010

---

*Correct answer: 11055*

*CPT code 11055 represents the paring or cutting of a benign hyperkeratotic single lesion, such as a callus or corn; because corn or callus are specified in the code description, the choice of code is made clear.*

*CPT code 11056 is incorrect as it represents the removal of two to four lesions. CPT code 11057 is incorrect as it represents more than four lesions. Coding 11010 with 11055 is also not correct because the podiatrist did do the paring procedure but did not do a debridement of subcutaneous tissue at the site of an open fracture, which is the description of 11010.*

**16.**

Today, a 36-year-old male patient underwent five fine-needle biopsies of the prostate. The needle placement for these biopsies was completed under ultrasonic guidance.

What codes should be reported for the professional services?

**10005, 10006-59 x4**

55700x5, 76942

10005, 55706, 76942-26

55700 x5, 55706, 76942

---

*Correct answer: 10005, 10006-59 x4*

*The key concept here is Fine Needle Aspiration (FNA), which was used to acquire a biopsy. Searching the CPT index for fine needle aspiration, with ultrasound guidance, directs to 10005, 10006. Reviewing both codes leads to reporting both; 10005 for the first and four units of 10006 for the remaining four biopsies. These codes include ultrasound guidance. Therefore, the ultrasound is not separately reported. The guidelines for FNA state that the -59, distinct procedure modifier should be reported with each individual biopsy after the first.*

*CPT code 55700 describes a biopsy of the prostate, single or multiple. This is not the same procedure as a fine needle biopsy.*

*CPT code 76942 describes ultrasound guidance. This is not appropriate to code with this case, as the primary code includes imaging. The modifier -26 for a professional component is also not appropriate to report.*

*CPT code 55706 describes a biopsy of the prostate, using a transperineal approach, using stereotactic templating. This is not consistent with the documentation of this case reporting FNA.*

**17.**

When a patient undergoes fine needle aspiration (FNA) biopsy with ultrasound guidance for three lesions, what CPT coding should be reported?

**10005, 10006 x2**

10005 x3, 76998

10021 x3, 76998

10005, 10006

---

*Correct answer: 10005, 10006 x2*

*Researching the CPT Index for FNA leads to fine needle aspiration biopsy and a series of codes depending on the type of imaging guidance. For ultrasound guidance, the choice of coding is 10005, 10006. Reviewing those choices leads to 10005 for the first lesion and 10006 for each additional lesion, listed as 10006 x2.*

*CPT code 76998 describes intraoperative ultrasound imaging guidance. This is not reported for this case because imaging guidance is included in the code description. CPT code 10021 describes an FNA with no guidance; this question described ultrasound guidance. CPT code 10006 describes an add-on code for an FNA with ultrasound guidance, but additional lesions after the first. There is no indication that there was more than one lesion.*

**18.**

A patient diagnosed with a malignant melanoma lesion on their back has surgery to remove the lesion. The surgeon removes the tumor using a Mohs micrographic technique. This procedure had two stages, including five blocks in the first stage, and three blocks in the second stage.

Which CPT code(s) should be assigned for this procedure?

**17313 and 17314**

17314

17311

17311 and 17312

---

*Correct answer: 17313 and 17314*

*The Mohs Micrographic Surgery section is divided based on the location of the tumor. CPT code 17313 is used when a surgeon performs a Mohs micrographic technique on the trunk, arms, or legs in the first stage. CPT code 17314 is an add-on code for 17313 for each additional stage after the first stage, up to five tissue blocks.*

*CPT code 17311 applies to the head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels.*

*CPT code 17312 is an add-on code to 17311 for each additional stage after the first stage, up to five tissue blocks.*

**19.**

A patient presents to the dermatology clinic with three cutaneous lesions on their hands. The dermatologist performs a punch biopsy to obtain a cylindrical tissue sample to complete a diagnostic pathologic examination. After the procedure, the dermatologist does a simple closure and improves the wound approximation.

Which CPT code(s) should be assigned for this procedure?

**11104 and 11105 x2**

11105 x3

11104 x2 and 11105

11104

---

*Correct answer: 11104 and 11105 x2*

*CPT code 11104 is the primary procedure code for the punch biopsy of a single lesion. CPT code 11105 is an add-on code that can be added to 11104 for each separate additional lesion. The scenario notes there are three lesions, therefore CPT code 11104 represents a single lesion and requires an add-on code for the additional lesions.*

*CPT code 11104 is a primary procedure code and cannot be reported 2 times. This eliminates 11104 x2 and 11105. CPT code 11105 cannot be reported alone, therefore 11105 x3 can be eliminated.*

**20.**

After extreme weight loss from stomach staple surgery, a patient undergoes lipectomy and removal of all excessive skin in the abdominal area. How would this be billed?

**15830, 15847**

15838

15847

15877

---

*Correct answer: 15830, 15847*

*In the index of the CPT book, you will look up lipectomy, excision, which gives you the following codes: 15830-15839, 15847. Turning to the Integumentary System section, you will see that code 15830 is for excision of excessive skin (or a lipectomy) of the abdomen. This code is correct for the first part of the question, but to fully, correctly code the question, you will also need the add-on code, 15847, which is for excision of excessive skin of the abdomen. Underneath this code, you will see that you must use this code with 15830 in order to bill for the procedure correctly.*

*Code 15838 is for the excision of excessive skin in the submental fat pad. This is not what the question asks for, so this is incorrect. Code 15877 is for suction-assisted lipectomy, trunk. The question does not mention anything about this kind of procedure, so this is incorrect.*

**21.**

How would a coder select the correct code to bill an excised benign lesion?

**Measuring the greatest clinical diameter of the apparent lesion plus that margin required for the complete excision**

Measuring the greatest clinical diameter of the apparent lesion minus that margin required for the complete excision

Calculating the lesion diameter plus the most narrow margins

Calculating the lesion diameter minus the most narrow margins

---

*Correct answer: Measuring the greatest clinical diameter of the apparent lesion plus that margin required for the complete excision*

*For this question, you should look in the Integumentary system section for the subsection on the excision of benign lesions. Once there, you will see that there is a lengthy explanation of how the procedure is performed and how to correctly code the procedure. In the second paragraph, the book states that there is a specific way to select the correct code, which is by measuring the greatest clinical diameter of the apparent lesion, plus that margin required for the complete excision. Since this correctly answers the question, this sentence would be the correct answer.*

*Calculating the lesion diameter plus/minus the most narrow margins actually explains the margin required for complete excision. This is partially correct, but is not the whole answer. Because of that, both those answers are not correct.*

**22.**

A skin graft in which the donor skin comes from another human (often a cadaver) is known as a/an:

**Allograft**

Autograft

Acellular graft

Xenograft

---

*Correct answer: Allograft*

*Knowing the medical terminology involved will help determine the correct answer to this question. The medical prefix allo- means “other”. An allograft is a graft from another human being.*

*The prefix auto- means “self”, so an autograft is a graft in which the donor skin is from a different site on the recipient’s body.*

*The medical prefix a- means “without”, while cell refers to living cells. An acellular graft is a graft in which synthetic materials (“without cells”), rather than living cells, are used.*

*The prefix xeno- means “foreign". A xenograph is a graft from a “foreign” species (e.g., pig).*

**23.**

Which of the following is not listed as a proper excision technique under CPT code 17110?

**Chemical exfoliation**

Electrosurgery

Cryosurgery

Laser surgery

---

*Correct answer: Chemical exfoliation*

*CPT code 17110 describes the destruction of benign or premalignant lesions. The parenthetical statement in the code description lists the techniques used in the destruction that would correctly be identified by this code. Chemical exfoliation is not listed in that parenthetical statement.*

*The other options, electrosurgery, cryosurgery, and laser surgery, are all listed in the 17110 code description.*

**24.**

A patient undergoes a simple mastectomy for gynecomastia. The surgeon removes the entire breast tissue, including the nipple and areola complex. Which CPT code should be assigned for this procedure?

**19300**

19100

19287

19301

---

*Correct answer: 19300*

*Searching the CPT index for mastectomy, for gynecomastia leads to 19300.*

*CPT code 19301 represents the CPT code for mastectomy, partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy). CPT code 19100 is incorrect as it represents a different procedure—a biopsy of the breast tissue. CPT code 19287 is incorrect as it represents the placement of breast localization devices.*

**25.**

An excision of a benign lesion is being performed. How should the size of the lesion be determined?

**Adding together the lesion diameter and the narrowest margins necessary to adequately excise the lesion.**

Adding together the lesion diameter and the widest margins necessary to adequately excise the lesion.

The diameter of the lesion only, excluding any margins excised with it.

The depth of the lesion plus the full diameter of the lesion.

---

*Correct answer: Adding together the lesion diameter and the narrowest margins necessary to adequately excise the lesion.*

*According to the lesion excision coding guidelines (above CPT code set 11400-11471), "Code selection is determined by measuring the greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter)."*

**26.**

A patient is seen by a dermatologist for the removal of 35 benign actinic keratoses using cryosurgery. The dermatologist uses liquid nitrogen to freeze and destroy the lesions.

Which CPT code should be assigned for this procedure?

**17004**

17110

17000

17003

---

*Correct answer: 17004*

*CPT code 17004 represents the destruction of premalignant lesions such as actinic keratosis and describes 15 or more lesions removed by various approaches, including cryosurgery, which includes the use of liquid nitrogen.*

*CPT code 17110 is incorrect as it represents the destruction of up to 14 benign skin lesions.*

*CPT code 17000 is incorrect as it represents the destruction of a single lesion and is premalignant.*

*CPT code 17003 is incorrect as it is an add-on code and cannot be reported alone for the destruction of up to 14 lesions that are premalignant.*

**27.**

A 40-year-old male presented to his dermatologist with several dark lesions on the skin. The physician biopsies the lesions by performing two tangential biopsies using a curette and two punch biopsies based on the size and perceived depth of the lesion.

How should the CPT coding for this encounter be reported?

**11104, 11105, 11103 x2**

11104, 11105, 11102, 11103

11104 x2, 11102 x2

11102, 11103, 11105 x2

---

*Correct answer: 11104, 11105, 11103 x2*

*Reviewing the CPT index for biopsy, skin, and punch leads to 11104 and 11105. The code choice is for an initial and subsequent lesion; therefore, both codes are used in this case because two punch biopsies are performed. Immediately above the punch biopsy codes are listed the tangential biopsy codes. According to the guidelines in the biopsy subheading, when performing multiple biopsies of different types, it is correct to code only one initial biopsy; all the rest are additional lesions. Therefore, the correct coding in this case is one initial punch biopsy, 11104, an additional punch, 11105, and two additional biopsies of tangential technique, 11103.*

*Code 11102 is not reported based on the guidelines in the biopsy subheading guidelines. Code 11104 has an accompanying add-on code, 11105, which is to be used for the additional lesion after the first lesion. The guidelines for the biopsy subheading offer guidance on correctly reporting the additional lesions; this indicates that 11102 would not be reported. Code 11102 Tangential biopsy is a less intensive procedure compared to the punch biopsy 11104. Therefore, the punch biopsy code is the primary initial procedure. This could be reviewed using RVU checking information such as a CMS database or coding software such as Codify.*

**28.**

A patient comes into the ER after suffering a fall into a glass window. The patient has pieces of glass in her arms. The ER doctor performs a complicated incision and removal procedure to remove all glass from the patient. This is done to avoid any further damage to major arteries in the arms.

How would this procedure be billed?

**10121**

10120

11010

10180

---

*Correct answer: 10121*

*In the index of the CPT book, you will look up incision, skin, which gives you multiple code options: 10040, 10060-10061, 10080-10081, and 10120-10180. Turning to the Integumentary System section, you will see that incision and removal codes are limited to 10120 and 10121. This would be considered a complicated procedure because there are many variables involved. So, code 10121, incision and removal of foreign bodies, subcutaneous tissues, complicated, would be the correct answer.*

*Code 10120 is also an incision and removal procedure as well, but a simple procedure. Because of this, this is not the correct answer. Code 11010 is for debridement including removal of foreign material at the site of an open fracture/dislocation. The question does not state that a debridement happened, so this would be incorrect. Code 10180 is for incision and drainage, complex, postoperative wound infection. The question does not mention anything about an I&D procedure, so this would be incorrect.*

**29.**

A patient presents to the emergency department with a wound infection after surgery for severe acute appendicitis. The ED performs an incision and drainage and closes the incision with sutures. A substantial amount of purulent material was drained. The wound was packed with gauze for further drainage. The physician prescribed an antibiotic for the infection.

Which CPT code should be assigned for this procedure?

**10180**

10160

10140

11000

---

*Correct answer: 10180*

*CPT code 10180 represents the incision and drainage of a complex postoperative wound. In this scenario, the physician performs an incision and drainage procedure for a large abscess, involving the removal of a substantial amount of purulent material and the packing of the wound, which aligns with the requirements for code 10180.*

*CPT code 10160 is incorrect as it represents a different procedure — a puncture aspiration of an abscess, hematoma, bulla, or cyst.*

*CPT code 10140 is incorrect as it represents the I&D of a hematoma, seroma, or fluid collection, and does not mention a postoperative wound infection.*

*CPT code 11000 is incorrect as it represents a debridement of extensive eczematous or infected skin.*

**30.**

A patient with a burn wound on her right cheek is admitted to the OR for surgery for a skin graft. The physician has the patient prepped with a Betadine scrub and draped in the normal sterile fashion. Her cheek was anesthetized with 1% lidocaine with 1:800,000 epinephrine (6 ccs), and SeptiCare was applied. A skin graft of the epidermis and a small portion of the dermis were taken with a Goulian Weck blade with a .006-inch-thick shim on the blade. The 25-sq-cm graft was flipped and sewn to the adjacent defect running 5-0 Vicryl. The wound was then dressed with Xeroform and the patient was taken to recovery.

What CPT code should the physician utilize?

**15120**

15115

14041

15758

---

*Correct answer: 15120*

*This question indicates that a skin graft was planted on a burn patient and that the graft was taken from the patient herself. That graft consisted of part epidermis and part dermis, which makes it a split-thickness graft. Searching the index for an autograft of the skin leads to 15110-15136. Reviewing that family of codes identifies a split-thickness autograft of the face for this size of graft, 25 sq. cm, would be 15120.*

*CPT code 14041 represents an adjacent tissue transfer for the cheek but represents rearranging tissue, not grafting various layers of tissue.*

*CPT code 15115 describes an epidermal autograft. This question states that a graft of the epidermis and a small portion of the dermis were taken, not just the epidermis.*

*CPT code 15758 describes a free fascial flap with microvascular anastomosis. This kind of graft is all layers of skin and the associated blood vessels, and in the surgery, the provider will reconnect the vessels of the graft with the vessels at the burn site to assure correct blood flow. This connection of vessels is a type of anastomosis.*

**31.**

A patient with four cysts on the upper aspect of her left breast underwent a puncture aspiration procedure guided by MRI. Which CPT coding should be reported?

**19000, 19001 x3, 77021**

19001 x4, 76942

19000 x4, 77021

19100 x7, 76942

---

*Correct answer: 19000, 19001 x3, 77021*

*Researching the CPT index for puncture aspiration of the breast leads to codes 19000 and 19001. Reviewing these codes leads to reporting 19000 for the first cyst, and add-on code 19001 x3 is used for reporting each of the additional three cysts. The parenthetical statement after the code description advises about the imaging guidance coding with choices 76942 and 77021. The correct reporting is 77021 for the MRI guidance.*

*Code 19001 is an add-on code for each additional cyst during the puncture aspiration; add-on codes cannot be reported by themselves. Code 76942 describes ultrasound guidance; this case used MRI guidance. Code 19100 describes a needle biopsy of the breast. A puncture aspiration is not the same as a needle biopsy.*

**32.**

What would TBSA be used for?

**To measure skin surface area for burn treatment**

To help reconstruct breasts after a double mastectomy

To help determine tumor size on skin for proper removal

To measure the size of pressure ulcers for treatment

---

*Correct answer: To measure skin surface area for burn treatment*

*TBSA stands for Total Body Surface Area. This form of measurement is mainly used for any kind of skin reconstruction treatment. For example, if a patient suffers third-degree burns and needs skin grafts, you will use TBSA measurements to determine how big (or small) a skin graft is needed.*

*Helping reconstruct breasts after a double mastectomy, determining tumor size on skin for proper removal, and measuring the size of pressure ulcers for treatment would not use TBSA to bill and treat correctly.*

**33.**

A patient has three corns cut off her feet. How would this be billed?

**11056**

11055

17000

11044

---

*Correct answer: 11056*

*In the CPT index, you will look up paring, skin lesion, benign hyperkeratotic, which gives you the code range 11055-11057. Turning to the Integumentary system section, where these codes are located, you will see that these three codes are for the same procedure but different numbers of lesions. In the question, three lesions (or corns, as the code gives the examples of corns and calluses) are cut off the patient. Given this information, code 11056 would be the best fit since it is for two to four lesions. Therefore, this code would be the correct answer.*

*Code 11055 is also for the cutting of a benign hyperkeratotic lesion, but only for a single lesion. Because it does not fully cover the service, this would be an incorrect answer. Code 17000 is for the destruction of a premalignant lesion. The lesion mentioned in the question is not premalignant, so this also would be incorrect. Code 11044 is for bone debridement. This is not anything like what the question is asking for, so this would be incorrect.*

**34.**

A 45-year-old woman was scheduled to retrieve a tissue sample from a lesion to test for cancer. The tissue samples were retrieved using a sharp blade to retrieve a full-thickness tissue sample. A simple closure was performed.

Select the correct code(s) for this procedure.

- **11106**
- 11106 x2
- 11104 x2
- 11106 and 11107

---

*Correct answer: 11106*

*CPT code 11106 represents an incisional biopsy, including a simple closure for a single lesion.*

*CPT code 11106 x2 cannot be reported two times, as multiple lesions would be reported with CPT code 11107. If the scenario stated there were two lesions, the physician would report CPT codes 11106 and 11107.*

*CPT code 11107 is an add-on code for additional lesions and is reported in conjunction with 11106. Therefore, 11106 and 11107 can be eliminated.*

*CPT code 11104 represents a punch biopsy on a single lesion. The scenario notes the tissue was retried using a sharp blade, not a punch tool.*

**35.**

A patient suffering from keratosis undergoes monthly dermabrasion treatments for two segments of her fact at her dermatologist's office. How would these treatments be reported each month?

**15781, 15781-51**

15780 x2

15786

15786, 15787

---

*Correct answer: 15781, 15781-51*

*In the index of the CPT book, you would look up dermabrasion, which gives you the code range 15780-15783. Turning to the Integumentary System section, you will see that the difference between these four codes is how extensive the treatment is. In the case of the situation in the question, the patient had two facial segments treated by dermabrasion. Therefore, the correct answer to this question would be code 15781, and 15781 with multiple procedure modifier -51.*

*Code 15780 describes dermabrasion to the entire face. The patient did not have two sessions of total face abrasion; she had dermabrasion for two segments of her face performed each month. Code 15786 describes abrasion of a single lesion. This case describes two segments of the face treated with dermabrasion, not abrasion to a lesion. Code 15787 describes abrasion of additional lesions. This case describes two segments of the face treated with dermabrasion, not abrasion to a lesion.*

**36.**

A simple I&D is performed on a patient with a bothersome pilonidal cyst. Which CPT code best describes this?

**10080**

10081

10060

10121

---

*Correct answer: 10080*

*In the CPT index, you will look up incision and drainage, cyst, skin, pilonidal, which gives you two codes: 10080, 10081. Turning to the Integumentary system section, where these codes are located, you will see that they are for the same procedure: the I&D of a pilonidal cyst. Code 10081 is for a complicated procedure, and 10080 is for a simple procedure. Since the question is asking for a simple procedure, code 10080 is the correct answer.*

*Code 10060 is for the simple I&D of an abscess. The question states that a cyst was drained, not an abscess, so this would be an incorrect answer. Code 10121 is for the complicated incision and removal of a foreign body, subcutaneous tissues. There is no foreign body mentioned in the question, so this also would not be the correct answer.*

**37.**

A patient who has suffered from an ingrown toenail for years goes through a wedge excision of the nail fold skin. This alleviates the pain and helps the nail correct itself. How would this be billed?

**11765**

11719

11750

11720

*Correct answer: 11765*

*In the CPT index, you will look up wedge excision, nail fold, which gives you the code 11765. Turning to the Integumentary system section, where this code is located, you will see that this code is for the wedge excision of the skin of the nail fold and, in parentheses, the book gives an ingrown toenail as an example. Because this matches exactly what the question is asking for, this would be the correct answer.*

*Code 11719 is for the trimming of a nondystrophic nail, any number. Nothing was trimmed in the question, so this would be an incorrect answer. Code 11750 is for the excision of the nail and nail matrix, partial or complete. The entire nail was not removed in the question, just the skin of the nail fold, so this also would be incorrect. Code 11720 is for the debridement of a nail. Debridement was not performed in this question at all, so this would be an incorrect answer.*

**38.**

When a skin replacement surgery is performed, what is included?

**Surgical preparation, placement of autograft/skin substitute graft**

Tissue transfer, surgical preparation

About 100 square centimeters of surgical allograft

Surgical preparation, skin tissue harvest

---

*Correct answer: Surgical preparation, placement of autograft/skin substitute graft*

*The easiest way to answer this question is to turn to the Repair (Closure) subsection of the Integumentary System section. Within the first paragraph, this subsection tells you what is included in this surgery. According to this paragraph, surgical preparation and topical placement of autograft/skin substitute graft are included with a skin replacement surgery. This would be the correct answer to the question.*

*Tissue transfer and skin transfer harvest are two separate procedures, and there is no set amount of skin graft included with this surgery. Therefore, these are not the correct answers.*

**39.**

After an accident left a female patient missing a piece of skin, measuring about 7.3 sq cm on her upper left arm, the physician decides to perform an adjacent tissue transfer. How would this be billed?

**14020**

14000

14021

14060

---

*Correct answer: 14020*

*In the CPT index, you will look up tissue, transfer, adjacent, skin, which gives you the code range 14000-14350. Turning to the Integumentary system section, where these codes are located, you will see that these codes are for an adjacent tissue transfer but differ in the body part and size of tissue. In the question, the patient is missing a piece of skin on her upper arm measuring about 7.3 sq cm. Given this information, code 14020 would be the best fit since it is for an adjacent tissue transfer on the scalp, arms and/or legs, defect 10 sq cm or less. Therefore, this code would be the correct answer.*

*Code 14000 is also for adjacent tissue transfer but for the trunk. Since the question states that the upper arm was affected, this would not be the correct answer. Code 14021 is for an adjacent tissue transfer of the arm as well, but for defect 10.1-30.0 sq cm. Since the measurements are too high on this code, this also would not be the correct answer. Code 14060 is for the adjacent tissue transfer of the eyelids, nose, ears and/or lips, defect 10 sq cm or less. Again, the upper arm was affected, not the face, so this would be incorrect.*

# 20,000 Series CPT®



**40.**

A patient with extensive trauma to the left arm is undergoing an amputation. After discussion, consent, and preparation, the surgeon makes an incision above the deltoid tuberosity. Bringing the incision to the bone, the surgeon ligates essential blood vessels and retracts the appropriate nerves. The humerus is cut between the greater and lesser tubercle crests. After reshaping of the bone using the electric burr, the provider sets an implant into the intramedullary space to create the residuum. Muscles and skin are adjusted to cover the wound; the drain is placed, and the skin is closed with sutures.

What is the correct coding for this procedure?

**24931**

24900

24999

24925

*Correct answer: 24931*

*In the index of the CPT book, you will look up amputation, arm, upper, with implant. This gives you the code range 24931-24935, which can be found in the Musculoskeletal System section. Turning to this section, you will see that code 24931, which is for amputation, arm through humerus with implant is the correct code.*

*Code 24900 is for an amputation of the arm without an implant. While it is partially correct, it does not have all the components the question is asking for, so this is an incorrect answer. Code 24999 is for an unlisted procedure, humerus/elbow. The procedure mentioned in the question is listed, so this is not the correct answer. Code 24925 is for an amputation of the arm, secondary closure/scar revision. This is not mentioned in the question, so this is incorrect.*

**41.**

What CPT code could be used to report arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace?

**22614**

22614-50

22612

22612-59

---

*Correct answer: 22614*

*22614 represents arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (list separately in addition to code for primary procedure).*

*22612 represents arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed).*

*Modifier 50 represents a bilateral procedure and is appended to indicate the procedures performed on both sides (right and left). Arthrodesis is either posterior or posterolateral, therefore modifier 50 does not apply to this scenario.*

**42.**

When coding a fracture, if the doctor does not specify what kind of treatment it is, how would you bill it?

**Closed**

Open

Percutaneous skeletal fixation

Manipulation

---

*Correct answer: Closed*

*There are many rules when it comes to medical billing and coding. One of the most important rules is remembering that if it was not documented, you cannot bill for it. When it comes to billing for treatments of fractures and other various musculoskeletal system diseases, if the doctor does not document what happened in his notes, then you will bill for the lesser service. In this case, that would be closed treatment.*

*Open treatment is surgically opening the area where a fractured bone is located. For obvious reasons, this treatment is considered to be a "higher" service than a closed treatment, so this would not be the correct answer. Percutaneous skeletal fixation is a treatment that is neither open nor closed. Pins, or any other kind of fixation device, are put across the fracture to treat it. Because this is more involved than closed treatment, this is not the correct answer. Manipulation is not considered a fracture treatment. Therefore, this is not the correct answer.*

**43.**

A patient who has been stabbed several times undergoes a wound exploration of the wounds in the side of the abdomen and complex repair of two wounds in the upper thigh due to debridement of traumatic laceration wounds. One of the two wounds repaired was 5 cm, and the other was 6 cm.

How would the coding be reported?

**20102, 13121-59, 13122**

32100, 13121-51, 13122

20102, 12002-59, 12004

32100, 12002-51, 12004

---

*Correct answer: 20102, 13121-59, 13122*

*Searching the CPT for wound, exploration, and penetrating leads to a series of codes based on body part; the option for the abdomen is 20102. Reviewing the code confirms the choice for this case. Turning to the repairs to the legs, consulting CPT index for wound, repair, legs, and complex leads to a series 13120-13122 based on the size of the wound. Reviewing the case, there were two wounds in the leg, with a total of 11 cm of wound repaired. Analyzing the code choice leads to 13121 for the first 7.5 cm of the wounds and 13122 add-on code to fulfill the reporting for the additional wound repair. Because the wound repair is a different procedure and separate from the wound exploration in the abdomen, modifier -59 is appended to the 13121. According to Appendix A on Modifiers, the -59 modifier is used for "a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury..."*

*Code 32100 describes a thoracotomy with exploration; this procedure is typically performed to access the internal organs of the chest, such as the lungs and pleura. The penetrating wound exploration 20102 more specifically describes this case. Codes 12002 and 12004 are simple surgical repair codes for areas such as the extremities. This case documented complex repair. The repair code subheading describes the criteria for coding simple, intermediate, and complex repairs and advises that complex repairs are appropriate for "debridement of wound edges, e.g., traumatic lacerations..." Modifier -51 is used to describe multiple procedures. The documentation of this case, after researching in Appendix A, leads to a choice of a -59 modifier.*

**44.**

How are the codes for treating fractures and joint injuries categorized in the CPT?

**The type of treatment and stabilization**

The type of fracture or type of joint

The size of the fracture or degree of dislocation of the joint

The posterior or anterior approach to the fracture or joint

---

*Correct answer: The type of treatment and stabilization*

*According to the general guidelines of the Surgery: Musculoskeletal System, codes for the treatment of fractures and joint injuries are categorized by the type of treatment and stabilization.*

*According to the general guidelines of Surgery: Musculoskeletal System, the type of fracture does not define the type of treatment. For example, a fracture where the bone breaks through the skin is an open fracture. However, it may not require a surgeon to perform open treatment. Another example is that a patient with a closed fracture, one that is not open through the skin, may require open treatment, where a surgeon makes an incision to put plates or screws in to stabilize the fracture.*

*The type of the fracture (open, sticking outside of skin, or closed, not sticking outside of skin) or the type of joint (hinge, ball and socket, suture) are not criteria for selecting a correct code. The size of the fracture or the degree of dislocation of the joint do not impact the choice of code. The posterior or anterior approach to the joint does not impact the choice of code.*

**45.**

A patient presents to an orthopedic surgeon with a chronic dislocated shoulder. The surgeon performs an open repair of the ruptured musculotendinous cuff. Which CPT code should be assigned for this procedure?

**23412**

23410

23405

23406

---

*Correct answer: 23412*

*Searching the CPT index under Repair, musculotendinous cuff (also rotator cuff), leads to code range 23410-23412. Reviewing the series leads to the choice of 23412 for the chronic, as opposed to acute, condition documented in the case.*

*CPT code 23410 represents the open treatment of a shoulder dislocation with surgical fixation. It is used when an orthopedic surgeon performs an open repair of a ruptured musculotendinous cuff. CPT code 23405 represents a tenotomy of the shoulder area addressing only the tendons. CPT code 23406 represents tenotomy of multiple tendons, but the repair of the musculotendinous cuff more specifically addresses this case.*

**46.**

Medial and lateral meniscus repair was performed arthroscopically. What CPT code should the physician utilize?

**29883**

27447

29868

29882

---

*Correct answer: 29883*

*CPT code 27447 describes an open, rather than arthroscopic, procedure, so this option can be eliminated. CPT code 29868 is arthroscopic, but the procedure is a transplant, rather than a repair, so this is also incorrect.*

*The distinction between CPT codes 29882 and 29883 is the words “and” vs. “or”. In this scenario, the patient had both the medial and lateral meniscus repaired, so CPT code 29883 is correct.*

**47.**

After breaking his collarbone in a freak working accident and undergoing an extensive healing process, a patient's physician sees that one part of the collarbone is not healing as well as he would like. Since this part of the collarbone is hindering the healing process, the physician decides it would be best to remove it and performs a claviculectomy.

How would this be billed?

**23120**

23180

23125

23150

---

*Correct answer: 23120*

*In the CPT index, you will look up clavicle, excision, partial, which gives you two codes: 23120 and 23180. Turning to the Musculoskeletal system section, where these codes are located, you will see that code 23180 is for the partial excision of the bone, for physiological reasons, clavicle. The patient was involved in an accident that broke his collarbone and does not have a disease that would force him to undergo this procedure, so this is incorrect. The last code, 23120, is for a claviculectomy, partial. Since this is the exact procedure that the question is asking for, 23120 will be the correct answer to the question.*

*Code 23125 is for a total claviculectomy. The patient only had a part of the collarbone removed, so this also is not the correct answer. Code 23150 is for the excision/curettage of a bone cyst or benign tumor of the proximal humerus. The patient does not have a bone cyst or a benign tumor, so this is incorrect.*

**48.**

What modifier should be used with CPT code 22830, when exploration is reported in conjunction with other definitive procedures, including arthrodesis and decompression?

**51**

59

55

62

*Correct answer: 51*

*When exploration is reported in conjunction with other definitive procedures, including arthrodesis and decompression, append modifier 51 to 22830.*

*Modifier 59 is described as a distinctly separate procedure. This modifier is used when different procedures are performed for different reasons during the same encounter.*

*Modifier 55 is described as postoperative management only. This modifier is used when a surgical procedure has been performed. In the three major portions of surgery, the pre-surgery EM, the surgical encounter itself, and the post-surgical care, the provider reporting the 55 modifier has only performed the post-surgical part of the surgery.*

*Modifier 62 is described as two surgeons. This modifier is used when two surgeons are both performing significant portions of the surgery, not just one surgeon assisting the other.*

**49.**

A patient reports a history of right groin pain, which is worse with sitting and rising from a sitting position. Physical examination, X-rays, and CT scans confirm a cam lesion in the right femoral head-neck region and it is noted as the cause for loss of rotation. Dr. Curtis completed an arthroscopy of the right hip with debridement and a femoroplasty.

How should Dr. Curtis report this procedure?

**29914-RT**

29862-RT, 29914-59

29861-RT, 29862, 29914

29860-RT, 29862-59, 29914-59

---

*Correct answer: 29914-RT*

*CPT code 29914 has the # symbol listed to indicate this code is out of sequence. Additionally, the parenthetical note listed with this code provides information related to the correct reporting of codes used in conjunction. 22914 is the correct code describing arthroscopy of the hip with femoroplasty. Modifier -RT, describing the right side, is appended. This case would not report 29914 as a secondary code nor would a -59 modifier for distinct procedural service, be appended.*

*CPT code 29860 describes an arthroscopy of the hip with or without synovial biopsy. This case involved a femoroplasty, a more extensive procedure.*

*CPT code 29861 describes an arthroscopy of the hip with the removal of a foreign or loose body; there was no loose or foreign body documented.*

*CPT code 29862 describes an arthroscopy of the hip with debridement of articular cartilage; debridement is included in the process of a femoroplasty.*

**50.**

A patient presents to the emergency department with an abscess on their finger. The physician performed a drainage of the abscess on the finger; the procedure was uncomplicated.

Which CPT code should be assigned for this procedure?

**26010**

26011

26034

26055

---

*Correct answer: 26010*

*Searching the CPT Index for finger and abscess leads to incision and drainage 26010 and 26011. Reviewing the choices leads to CPT code 26010 for simple drainage of a finger as opposed to a complex.*

*CPT code 26011 is incorrect as it represents a complicated drainage. CPT code 26034 represents an incision into the bone of the finger. CPT code 26055 represents a tendon sheath incision.*

**51.**

A physician completed an anterior discectomy with decompression of the spinal cord, including osteophytectomy to levels C3-C5. During the same session, he stabilized C3-C5 with anterior cervical interbody fusion. Dr. Adams used an operating microscope during all procedure phases for proper visualization.

What CPT codes should be reported?

**22551, 22552**

63075, 63076

22554 x2, 69990

63075, 63076-51, 22551, 22554 x2, 69990-51

---

*Correct answer: 22551, 22552*

*This physician performed several services: discectomy, osteophytectomy, interbody fusion and decompression of the spinal cord. These were performed by anterior approach. Searching the CPT index for discectomy, cervical leads to a string of codes. Researching these options leads to 22551, which includes all the elements mentioned: discectomy, osteophytectomy, interbody fusion and decompression of the spinal cord. The code 22551 reports the first space, C3-C4, and reporting the add-on code, 22552, reports the C4-C5 space.*

*CPT codes 63075 and 63076 describe several of the procedures but do not include interbody fusion. CPT code 22554 describes an anterior interbody fusion but with minimal discectomy to prepare the interspace; it does not include osteophytectomy, full discectomy, or decompression of the spinal cord. CPT code 69990 describes an add-on code for the use of the operating microscope. A parenthetical statement in the guidelines above the code states that the correct reportable code includes use of the operating microscope and this code is not necessary to report. CPT modifier -51 should not be reported on add-on codes on the advice of guidelines on modifier use in Appendix A. It is also not necessary to repeat the reporting of procedures in the case by including the service codes describing similar procedures.*

**52.**

A patient who has just broken his femur and tibia needs to be put into a thigh-to-toe splint so he can keep his leg still and heal properly. How would the splint application be billed (CPT only)?

**29505**

29515

29581

29445

---

*Correct answer: 29505*

*In the CPT index, you will look up splint, leg, long, which gives you the code 29505. Turning to the Musculoskeletal system section, where this code is located, you will see that this code is for the application of a long leg splint (thigh to ankle or toes). Since this is the exact procedure that the question is asking for, 29505 will be the correct answer to the question.*

*Code 29515 is also for a splint application but only applies to a short-leg (calf to foot) splint. Since the patient had a splint put on from his thigh to his toes, this would not be the correct answer. Code 29581 is for the application of a multi-layer compression system; leg (below knee), including ankle and foot. This does not match the question, so this would be an incorrect answer. Code 29445 is for the application of a rigid total contact leg cast. A splint was applied in the question, not a total contact cast, so this would also be an incorrect answer.*

**53.**

Two weeks ago, Sam underwent an open repair of his lower femur due to a traumatic fracture suffered while snow skiing. His leg is healing as expected, and no new treatment is required for the femur. Today, he returns as planned to an application for a new long leg cast. The cast application is completed by the same physician who performed the surgery.

What ICD-10-CM and CPT codes should be reported for this service?

**29345-58, S72.9XXD**

99024, Z46.89

29345, 99024, Z46.89, M84.48XD

29345-76, Z46.89

---

*Correct answer: 29345-58, S72.9XXD*

*This patient previously had surgery and a cast applied, and is now returning for a new cast. According to guidelines, the initial application of a cast is included in the surgical code for the repair, but subsequent casting can be reported. Referring to the CPT Musculoskeletal surgery subsection, lower extremity subheading, subcategory casts, is the application of long leg cast, code 29345. This CPT code is supported by the -58 modifier indicating that the procedure is planned and related during the postoperative period. The ICD-10-CM code reported should be that the patient has a healing fracture. This case presents with a subsequent encounter for fracture of an unspecified femur in an unspecified site, S72.9XXD. According to ICD-10-CM guidelines, "Fractures are coded using the appropriate 7th character for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase." Recasting is routine care for the fracture during the healing or recovery phase.*

*CPT code 99024 describes a post-operative visit; this is not the most accurate description of the service. The modifier -76, describing a repeat procedure, is not reported for this case because a repeat of the original surgery is not taking place; this case is a recasting.*

*ICD-10-CM code Z46.89, describing an encounter for fitting and adjustment of other specified devices (like a cast), is not reported. The guidelines state, "The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character." This case is documented as a traumatic fracture.*

*ICD-10-CM code M84.48XD describes a pathological fracture of another site. This case was documented as a traumatic fracture, not a pathological fracture.*

**54.**

A physician performs an arthrodesis and laminectomy procedure using an interbody fusion technique with a posterior approach for a patient with lumbar spondylolisthesis. The procedure was performed on L1-L4 interspaces.

Which CPT and ICD-10-CM codes should the physician report?

**22630, 22632, 22632, M43.16**

22600, M48.062

22600, 22614 x2, M48.06

22630, 22630, M48.06

---

*Correct answer: 22630, 22632, 22632, M43.16*

*CPT code 22630 represents an arthrodesis procedure done in an interbody fusion technique posterior approach on segments of the lumbar spine interspaces. Because this case was in the L1-L4 area, the intervertebral spaces are the L1-L2, L2-L3, and L3-L4 areas or three spaces. 22630 is reported for the first space. 22632 is also reported for each of the remaining two spaces. ICD-10-CM code M43.16 describes spondylolisthesis of the lumbar region.*

*22600 is reported for a posterior or posterolateral procedure on the cervical spine below C2, not the lumbar spine. M48.062 is a diagnosis for spinal stenosis of the lumbar region with neurogenic claudication.*

*22600 is reported for a posterior or posterolateral procedure on the cervical spine below C2, not the lumbar spine. 22614 is the add-on code to complement 22630. M48.06 is a truncated diagnosis code for spinal stenosis, and is incorrect, as well as not specific enough to be a valid code.*

*While 22630 is the correct code to report for the first procedure, it is not correct to report twice because appropriate add-on codes are available for this procedure. ICD-10-CM code M48.06 is also a truncated diagnosis code for spinal stenosis, and is incorrect, as well as not specific enough to be a valid code — it describes spinal stenosis in the lumbar region.*

**55.**

A patient has an open treatment for a nose fracture. How would this be billed?

**21325**

21330

21315

21337

---

*Correct answer: 21325*

*In the index of the CPT book, you will look up fracture, nasal bone, open treatment, which gives you the code range 21325-21335. Turning to the Musculoskeletal System section, you will see that these three codes are separated by whether it is complicated or uncomplicated. Since it is not mentioned whether or not it is complicated or uncomplicated, you will go with the lesser code, which is 21325. This will be the correct answer to this question.*

*Code 21330 is for open treatment of a nasal fracture, complicated, with internal and/or external skeletal fixation. The question does not mention the level of complication of the open treatment, and fixation is not mentioned at all in the question, so this would be incorrect. Code 21315 is for closed treatment of a nasal bone fracture, without stabilization. The question states that it is an open treatment that is performed, so this is not the correct answer. Code 21337 is for closed treatment of a nasal septal fracture, with/without stabilization. Again, the question states that an open treatment was performed, not a closed treatment, so this is incorrect.*

**56.**

A patient was stabbed in the right arm. A surgeon took the patient to an operating suite and completed the wound exploration. The surgeon widened the wound to achieve proper visualization and completed subcutaneous debridement and ligation of minor subcutaneous blood vessels. No further procedures were required for this wound exploration. The arm wound was closed and dressed in the usual fashion. The patient tolerated the procedure well and was returned to the recovery room in good condition.

How would this procedure be reported?

**20103**

20103, 11011-51

20103, 11011-59

11043, 12036-59, 20103-51

---

*Correct answer: 20103*

*This answer can be found in the index of the CPT® Professional Edition under "Exploration", "Extremity", then "Penetrating Wound" leading to 20103.*

*20103, 11011-51 is incorrect because, according to guidelines, debridement is included in the wound exploration code. Therefore, a modifier describing multiple procedures is also incorrect.*

*20103, 11011-59 is incorrect because, according to guidelines, debridement is included in the wound exploration code. Therefore, a modifier describing distinct procedures is also incorrect.*

*11043, 12036-59, 20103-51 is incorrect because the guidelines for wound exploration state that repair codes are reported when the wound does not require enlargement. This case documents the widening of the wound.*

**57.**

A physician performs an I&D on a patient who has an infected bursa in his ankle. How would this be billed?

**27604**

27603

27607

27613

---

*Correct answer: 27604*

*In the index of the CPT book, you will look up incision and drainage, bursa, ankle, which gives you the code 27604. Turning to the Musculoskeletal System section, you will see that this code is for I&D, leg or ankle, infected bursa. So, this would be the correct answer.*

*Code 27603 is also for an I&D of the leg or ankle; however, it is for a deep abscess or hematoma, not an infected bursa like the question states. Therefore, this is not the correct answer. Code 27607 is for an incision of the leg or ankle. This is not the same procedure as an incision and drainage, so this is incorrect. Code 27613 is for a biopsy of the soft tissue of the leg or ankle area, superficial. The question does not mention anything about a biopsy, so this would be incorrect.*

**58.**

After breaking several ribs in an auto accident, a patient undergoes open treatment, including internal fixation. In total, about eight ribs were treated. Which CPT code best describes this scenario?

**21813**

21811

21820

21825

---

*Correct answer: 21813*

*In the index of the CPT book, you would look up fracture, rib, open treatment, with internal fixation. This gives you the code range 21811-21813, which can be found in the Musculoskeletal System section. Turning to this section, you will see that the difference between these three codes is the number of ribs. The question states that about eight ribs were treated, so that would make code 21813 the correct answer.*

*Code 21811 is for the same open treatment of the ribs, but only for 1-3 ribs. Because of the small number, this is not the correct answer. Code 21820 is for the closed treatment of sternum fracture. The question states that this is an open treatment of rib fracture, so this is not the correct answer. Code 21825 is for the open treatment of sternum fracture with/without skeletal fixation. The question states that the ribs were treated, not the sternum, so this is incorrect.*

**59.**

A patient presents to an orthopedic clinic with chronic knee pain and instability. The orthopedic surgeon performs an arthroscopic meniscal repair using sutures to stabilize and restore the damaged meniscus.

Which CPT code should be assigned for this procedure?

**29882**

29866

29874

29883

---

*Correct answer: 29882*

*Searching the CPT index for arthroscopy, knee leads to a series of codes: 29866-29868 and 29871-29889. This case documents a meniscal repair using sutures; it is a surgical procedure, not a diagnostic procedure. Diagnostic procedures are performed to determine the medical condition; this case documents the medical condition. Reviewing the series of codes, 29882 describes specifically a surgical arthroscopy of the knee with meniscus repair. Since we do not know which meniscus was repaired, and this code notes medial or lateral, this is appropriate no matter which meniscus was repaired.*

*CPT code 29866 represents arthroscopy, knee, surgical; osteochondral autografts. The case does not document any grafting.*

*CPT code 29874 represents arthroscopy, knee, surgical; for the removal of a loose or foreign body. The case does not document any foreign or loose body.*

*CPT code 29883 represents arthroscopy, knee, surgical; with meniscus repair, but for the medial and lateral meniscus, both. This case does not describe two menisci being repaired.*

**60.**

Under what category is a surgery for Sprengel's Deformity found?

**Repair, Revision, and/or Reconstruction**

Incision

Excision

Introduction

---

*Correct answer: Repair, Revision, and/or Reconstruction*

*Searching the CPT index for Sprengel's Deformity leads to scapulopexy, 23400. This code appears in the Musculoskeletal system surgery subsection, Shoulder subheading, category Repair, Revision, and/or Reconstruction. Remembering the organization of the CPT: section (Surgery), subsection (Musculoskeletal System), subheading (Shoulder), category (Repair, Revision, and/or Reconstruction), subcategory is helpful to success with this question.*

*Researching the CPT index indicator of scapulopexy may lead to defining word parts such as -pexy, meaning "to repair," so terms with these suffixes usually fall under the "Repair" heading; therefore, scapulopexy should fall under the heading “Repair.”*

*An incision is a surgical procedure but is not a factor in the organization of this coding. An excision is a surgical procedure but is not a factor in the organization of this coding. An introduction is a surgical procedure and part of organizing the CPT but is not a factor in the organization of this coding.*

**61.**

A patient with a displaced comminuted fracture in the shaft of his left tibia has a uniplane external fixation system applied to his lower leg. How would this be billed?

**20690; S82.252**

20692; S82.251

20694; S82.252

20838; S82.253

---

*Correct answer: 20690; S82.252*

*For this question, you will need to figure out both the ICD-10 code and CPT code. First, you will turn to the index of the CPT book and look up external fixation, application, uniplane, which gives you the code 20690. Turning to the Musculoskeletal System section, you will see that this code is for the application of a uniplane, unilateral, external fixation system. Since this is exactly what the question is asking for, this is the correct answer for this part of the question. In the index of the ICD-10 book, you would look up fracture, tibia, comminuted (displaced), which gives you the partial code S82.25-. Turning to chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes, you will see that this partial code can be finished with the character for the left side, which is a 2. So, the correct code for this part of the question is S82.252.*

*Code 20692 is for the application of a multiplane, unilateral external fixation system. This is not what the question asks for, so this is not the correct answer. Code S82.251 is for a displaced comminuted fracture of the right tibia. The question states that the left tibia was fractured, so this is not the correct answer. Code 20694 is for removal under anesthesia of an external fixation system. Removal is not mentioned in the question at all, so this is an incorrect answer. Code 20838 is for replantation of the foot, complete amputation. The question does not ask for this at all, so this is incorrect. Code S82.253 is for a displaced comminuted fracture of the tibia, unspecified. The question specifies which side, so this is not the correct answer.*

**62.**

A surgeon performs an indirect endocopy of the larynx. The laryngoscopy is performed with a biopsy.

Which CPT code should be assigned for this procedure?

**31510**

31515

31530

31535

---

*Correct answer: 31510*

*CPT code 31510 represents an indirect laryngoscopy with biopsy.*

*CPT code 31515 is a direct larynscopy.*

*CPT code 31530 is a direct larynscopy with foreign body removal.*

*CPT code 31535 is a direct larynscopy with a biopsy.*

**63.**

An arthrotomy is performed on the TMJ joint of a patient who has severe arthritis in her jaw. What is the correct coding?

**21010**

29804

29800

21240

---

*Correct answer: 21010*

*Searching the CPT index for temporomandibular joint arthrotomy leads to 21010. Reviewing the code confirms the choice.*

*Code 29804 describes a surgical arthroscopy, not a joint arthrotomy. Code 29800 describes a diagnostic arthroscopy, not a joint arthrotomy. Code 21240 describes an arthroplasty, not an arthrotomy.*

**64.**

After suffering an ankle fracture years ago, the patient, complaining of constant pain now, undergoes an arthroscopy in which the physician finds a floating piece of bone, which is removed. How would this be billed?

**29894**

29897

29889

29904

---

*Correct answer: 29894*

*In the CPT index, you will look up arthroscopy, surgical, ankle, which gives you the code range 29891-29899. In the Musculoskeletal system section, where these codes are located, you will see that these codes are all for surgical ankle arthroscopy but with different details. Code 29894 is for surgical ankle arthroscopy with foreign/loose body removal, which is exactly what the question asks for, so this would be the correct answer.*

*Code 29897 is also for surgical ankle arthroscopy but with limited debridement. While the physician removes a loose body from the patient's ankle, it is not technically a debridement. So this would not be the correct answer. Code 29889 is for arthroscopically aided posterior cruciate ligament repair. Nothing was repaired in the question, so this would be an incorrect answer. Code 29904 is for surgical subtalar joint arthroscopy, with the removal of a foreign/loose body. The subtalar joint is not worked on in the question, so this also would be an incorrect answer.*

**65.**

After finding a 5 cm tumor in the subcutaneous part of a patient's knee, the physician removes it. How would this be billed?

**27337**

27327

27339

27364

---

*Correct answer: 27337*

*In the index of the CPT book, you will look up excision, tumor, knee, which gives you two code ranges: 27327-27328 and 27337-27339. The difference between the codes is the size of the tumor and if it is subcutaneous or subfascial. The question states that the tumor is subcutaneous and is about 5 cm. This immediately leads to code 27337, which is for the excision of a tumor of the subcutaneous part of the knee, 3 cm or larger. This would be the correct answer.*

*Code 27327 is also for the excision of a knee tumor, subcutaneous. However, this code is for a tumor less than 3 cm, so this is not the correct answer. Code 27339 is for the excision of a knee tumor, subfascial, less than 5 cm. The question states that the tumor is subcutaneous and is 5 cm, so this would not be the correct answer. Code 27364 is for the radical resection of a tumor in the knee/thigh area, 5 cm or greater. The question does not mention anything about the radical resection of a tumor and so, even though the size is correct, this is incorrect.*

**66.**

When it comes to coding a spinal bone graft procedure, which modifier cannot be used?

- **62**
- 51
- 52
- 66

---

*Correct answer: 62*

*For this question, you will have to turn to the Grafts (implants) subsection of the Musculoskeletal System section. Although the codes for bone grafts are before this subsection, you will see there is a little blurb about spinal bone grafts or codes 20900-20938. In this blurb, you will see that you cannot append modifier 62 (two surgeons) to any of these codes, so that will be the answer to this question.*

*Modifiers 51, 52, and 66 are not mentioned in this blurb, so these can be used if necessary. They are all incorrect answers.*

**67.**

A patient with a congenital spinal deformity receives a posterior arthrodesis on eight vertebral segments. Which CPT code would be used for this procedure?

**22802**

22800

22812

22819

---

*Correct answer: 22802*

*In the index of the CPT book, you will look up arthrodesis, vertebra, spinal deformity, and posterior approach. This gives you the code range 22800-22804, which can be found in the Musculoskeletal System section. Turning to this section, you will see that 22802, which is for a posterior arthrodesis for a spinal deformity, 7-12 vertebral segments.*

*Code 22800 is also for the posterior arthrodesis, for up to 6 vertebral segments; this case documents 8 segments. Code 22812 is for an anterior arthrodesis procedure for a spinal deformity, with/without cast, 8 or more segments. The question asked for a posterior arthrodesis. Code 22819 is for a kyphectomy, three or more segments. This case calls for arthrodesis.*

**68.**

A patient has been complaining of pain since his surgery four months ago. Imaging follow-up reveals a metal clamp that had likely been left from a prior surgical procedure. Subsequent exploration of the shoulder by arthroscopy revealed the clamp, which was the same size as the cannula; the cannula was changed to a larger size, and the foreign body was removed from the patient's shoulder.

What procedure code(s) would be reported for this procedure?

**29819**

29805, 23333

29805, 29819

29819-78

---

*Correct answer: 29819*

*In the CPT index, Arthroscopy > Surgical > Shoulder leads to 29806-29828. 29819 is arthroscopy, shoulder, surgical, with the removal of a loose body or a foreign body. The guidelines for these endoscopy/arthroscopy procedures offer specific guidelines noted in the passage.*

*29805 is the exploration/diagnostic arthroscopic procedure; this procedure went further to actually removing the foreign body and therefore was also therapeutic. 23333 is not an arthroscopic procedure; it is an incisional procedure that describes a foreign body of the deep tissue of the shoulder. 29819 is arthroscopy, shoulder, surgical, with the removal of a loose body or a foreign body.*

*The guidelines for the Endoscopy/Arthroscopy family of codes state that the surgical codes include the diagnostic endoscopy/arthroscopy. Therefore, the 29819 code includes the 29805 diagnostic procedure. The CPT also offers the separate procedure parenthetical statement at 29805 in order to alert the coder that this would need to be a separately identifiable procedure.*

*Regarding 29819-78, Modifier 78 is to be used for an unplanned return to the procedure room during the postoperative period. A post-operative period is at most 90 days. This patient's surgery was four months after the initial surgery.*

**69.**

A patient is brought into the OR for a diagnostic arthroscopy of the shoulder. The patient has been complaining of pain since his surgery four months ago. The surgeon explores the shoulder and discovers a metal clamp that had been left in from prior surgery. The surgeon removes the clamp and closes the patient up.

What CPT code(s) should the physician utilize?

**29819**

29805, 23333

29805, 29819

29819-78

---

*Correct answer: 29819*

*According to arthroscopy coding guidelines (found above CPT code 29800), surgical arthroscopies include diagnostic arthroscopies (they are bundled). This means that a diagnostic arthroscopy cannot be billed in conjunction with a surgical one. If a diagnostic arthroscopy turns into a surgical procedure, the surgeon can only bill for the surgical portion. This eliminates CPT code 29805 and any option with 29805.*

*CPT code 29819 has the correct description for the removal of a foreign body: in the shoulder, by arthroscopy. Modifier 78 would not be appended because the patient is past his 90-day global period, and there is no mention that this is the same surgeon who performed the initial surgery.*

**70.**

To report their distinct operative work, what modifier should be used when two surgeons work together as primary surgeons performing distinct parts of an arthrodesis for spinal deformity?

**62**

25

59

78

*Correct answer: 62*

*When two surgeons work together as primary surgeons performing distinct parts of an arthrodesis for spinal deformity, each surgeon should report their distinct operative work by appending modifier 62 to the procedure code.*

*Modifier 25 describes a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure.*

*Modifier 59 describes a distinct procedural service.*

*Modifier 78 describes a return to the operating room by the same physician who did the initial procedure for a related procedure during the postoperative period.*

**71.**

Dr. Reese completed a deep transfer of the anterior tibial and flexor digitorum tendons. Which code(s) should be used to report this procedure?

**27691, 27692**

27658 x2

27690, 27692-51

27691, 27692 x2

---

*Correct answer: 27691, 27692*

*One way to find the code range in the index of the CPT® Professional Edition is under the main terms “Tendon”, “Transfer”, then “Leg, Lower” directing to 27691. Reporting the add-on code 27692 is required for the additional tendon.*

*According to the modifier -51 definition in the CPT® Professional Edition, this modifier should not be appended to add-on codes.*

*27658 x2 is incorrect because it describes the ankle joint.*

*27690, 27692-51 is incorrect because it describes the axial tendon. 27691, 27692x2 is incorrect because it describes the upper leg.*

**72.**

How are supplies reported for the application of casts, splints, or strapping?

**The supplies for the cast are separately reported.**

Supplies are included in the procedure codes.

Supplies are reported with the 59 modifier added to the procedure code.

Supplies are reported after the total number of castings is calculated.

---

*Correct answer: The supplies for the cast are separately reported.*

*According to guidelines at the beginning of the Musculoskeletal System section, "All services that appear in the Musculoskeletal System section include the application and removal of the first cast...Supplies may be reported separately."*

**73.**

A patient has a skeletal fixation device placed on her broken metacarpal bone. The device is placed percutaneously. How would this be billed?

**26608**

26605

26676

26650

---

*Correct answer: 26608*

*In the CPT index, you will look up fixation, finger, which gives you these codes: 26607, 26608, 26615, 26756, and 26765. Turning to the Musculoskeletal system section, where these codes are located, you will see that the main difference between all these codes is whether they were done via open or closed treatment, or if they were done on their own. Code 26756 is for percutaneous skeletal fixation of the distal phalangeal fracture, finger or thumb. In the question, the fracture is a metacarpal fracture, so this eliminates this answer. Code 26608 is also for a percutaneous skeletal fixation but of a metacarpal fracture. Since this is exactly what the question is asking for, this code would be the correct answer.*

*Code 26605 is for the closed treatment of a metacarpal fracture, single, with manipulation. The question only mentions the placement of the fixation device and nothing about the actual treatment, so this is an incorrect answer. Code 26676 is for a percutaneous skeletal fixation of a carpometacarpal dislocation, with manipulation. The bone in question was broken, not dislocated, so this also would be an incorrect answer. Code 26650 is also for a percutaneous skeletal fixation, but for a thumb dislocation, with manipulation. Again, the bone in question was not dislocated, and the question does not mention that it is the thumb; this is not the correct answer either.*

**74.**

What type of soft tissue tumor resection is commonly used for malignant tumors or very aggressive benign tumors?

**Radical soft tissue resection**

Manipulative soft tissue resection

Residual soft tissue resection

Manageable soft tissue resection

---

*Correct answer: Radical soft tissue resection*

*The CPT® Professional Edition's Surgery section, Musculoskeletal System subsection guidelines document definitions of Excision/Resection of Soft Tissue Tumors. Radical resection of soft connective tissue tumors involves resection of the tumor with wide margins of normal tissue and this guideline further states it "is most commonly used for malignant connective tissue tumors or very aggressive benign connective tissue tumors."*

*Manipulative soft tissue resection, residual soft tissue resection, and manageable soft tissue resection are terms that do not appear in the CPT guidelines or direct to this service of care.*

**75.**

A patient underwent an anterior interbody arthrodesis with discectomy, osteophytectomy, fusion, and decompression of nerve roots at levels C3, C4, and C5. The fusion was explored and then stabilized with the application of anterior instrumentation placed from C3 to C5.

Which codes would be used to report this procedure?

**22551, 22552 x2, 22845, 22830-51**

22551, 22585 x2, 22845-51, 22830-59

22554, 22585 x2, 22845, 22830-51

22600, 22614, 22842, 22830-59

---

*Correct answer: 22551, 22552 x2, 22845, 22830-51*

*CPT 22551 describes arthrodesis by anterior interbody technique, including preparing the disc space, a discectomy, an osteophytectomy, and decompression (alleviating pressure on the spinal cord and spinal nerve roots) for cervical vertebrae below C2. This question involved three interspaces, levels C3, C4, and C5. The add-on code 22552 describes the same procedure but on each additional interspace. Therefore, 22551 and 22552x2 correctly describe this part of the procedure. CPT code 22845 describes that the fusion was explored, and modifier -51 is appended based on the guideline notes found near the code description. CPT code 22845 is also an add-on code and describes the part of the procedure applying anterior instrumentation for 2 to 3 vertebral segments. The question requests reporting for vertebral segments C3 to C5, which are three vertebral segments.*

*A careful review of the approach and level of spinal surgery is important to determine the correct code selection.*

*Modifier -51 should not be appended to add-on codes.*

*CPT 22830 describes spinal fusion exploration and the notes above this code indicate modifier -51 should be appended when performed with a definitive procedure.*

*22551, 22585 x 2, 22845-51, 22830-59 is incorrect because it does not indicate arthrodesis.*

*22554, 22585 x 2, 22845, 22830-51 is incorrect because it does not indicate discectomy.*

*22600, 22614, 22842, 22830-59 is incorrect because it does not come under osteophytectomy.*

**76.**

If a patient is having their fixation device reinserted into the cervical part of their spine, which CPT code would best describe the procedure?

**22849**

22856

22852

22859

---

*Correct answer: 22849*

*In the CPT index, you will look up reinsertion, spinal fixation device, which gives you the code 22849. Turning to the Musculoskeletal system section, where this code is located, you will see that this code is for the reinsertion of a spinal fixation device. Since this is the procedure that the question is asking for, 22849 will be the correct answer to the question.*

*Code 22856 is for a total disc arthroplasty, anterior approach, including discectomy. While the patient is having a spinal fixation device reinserted, which may include parts of the spinal discs, this is not the procedure the question is looking for, so this would be an incorrect answer. Code 22852 is for the removal of posterior segmental instrumentation. The patient's fixation device was reinserted, not fully removed, so this is also an incorrect answer. Code 22859 is for the insertion of an intervertebral biomechanical device. The device in the patient is a fixation device, not a biomechanical device, so this is also incorrect.*

**77.**

A TMJ manipulation using MAC is performed on a patient with a longstanding history of jaw pain. How would this be billed?

**21073**

21089

21116

21110

---

*Correct answer: 21073*

*In the index of the CPT book, you will look up manipulation, temporomandibular joint (TMJ), which gives you the code 21073. Turning to the Musculoskeletal System section, you will see that this question is for the manipulation of the TMJ, therapeutic, requiring an anesthesia service. The anesthesia service, in this case, is MAC or monitored anesthesia care. Code 21073 would then be the correct answer.*

*Code 21089 is for an unlisted maxillofacial prosthetic procedure. This procedure is listed, so this is not the correct answer. Code 21116 is for an injection procedure for TMJ arthrography. The question does not mention anything about an injection procedure, so this is incorrect. Code 21110 is for the application of a halo type appliance for maxillofacial fixation includes removal. The question mentions nothing about a halo type application, so this is not the correct answer.*

**78.**

After breaking seven ribs crashing his bicycle, a patient undergoes open treatment to fix them. Internal fixation techniques are used to ensure that the bones will stay together. How would this be billed?

**21813**

21811

21825

21720

---

*Correct answer: 21813*

*In the CPT index, you will look up fixation, fracture, rib, which gives you the code range 21811-21813. Turning to the Musculoskeletal system section, where these codes are located, you will see that they are all for the open treatment of rib fracture(s) with internal fixation. The difference between the three is the number of ribs that are treated. In the question, seven ribs are treated, so this means that code 21813 would be the correct answer since this code is for seven or more ribs.*

*Code 21811 is for the open treatment of rib fracture(s) with internal fixation but for one to three ribs. Since more ribs were fractured in the question, this is not the correct answer. Code 21825 is for the open treatment of sternum fracture with/without skeletal fixation. The patient's ribs are in question, not the sternum, so this also would be incorrect. Code 21720 is for the division of sternocleidomastoid for torticollis, open operation. While this is an open operation like the procedure in question, this does not match what the question is asking for. So, this is not the correct answer either.*

**79.**

Primary repair of a disrupted collateral ligament on the ankle is performed on a patient. How would this be billed?

**27695**

27696

27675

27650

---

*Correct answer: 27695*

*In the CPT index, you will look up repair, ankle, ligament, which gives you the code range 27695-27698. Turning to the musculoskeletal system section, where these codes are located, you will see that these codes are for the repair of the collateral ligament in the ankle. The difference, however, lies in whether the repair was primary or secondary and how many ligaments were repaired. The question states that this is a primary repair of a collateral ligament of the ankle. The code that best fits this description is 27695, which is for the primary repair of a disrupted collateral ankle ligament. And, since this is the exact procedure that the question is asking for, 27695 is the correct answer for the question.*

*Code 27696 is also for the primary repair of the collateral ligament. However, this code covers both collateral ligaments, and the question states that only one is repaired. So, this would not be the correct answer. Code 27675 is for the repair of dislocating peroneal tendons, without fibular osteotomy. This does not match what the question is asking for, so this would be incorrect. Code 27650 is for the primary repair, open or percutaneous, of a ruptured Achilles tendon. The Achilles tendon is not mentioned in the question at all, so this also would be an incorrect answer.*

**80.**

When can a physician report the arthroscopic removal of one or more loose or foreign bodies?

**The removal of loose or foreign bodies may be reported only when they are larger than the diameter of the arthroscopic cannula.**

The removal of loose or foreign bodies may be reported only when they are smaller than 1 mm.

The removal of loose or foreign bodies may be reported only when they are more than 5 mm.

The removal of foreign bodies has no restriction on removal.

---

*Correct answer: The removal of loose or foreign bodies may be reported only when they are larger than the diameter of the arthroscopic cannula.*

*In the Surgery/Musculoskeletal System section of the CPT manual, under the Endoscopy/Arthroscopy subheading, it states: "Arthroscopic removal of loose body(ies) or foreign body(ies)... may be reported only when the loose body(ies) or foreign body(ies) is equal to or larger than the diameter of the arthroscopic cannula(s) used for the specific procedure."*

**81.**

A patient with a dislocated jaw requires open treatment of the dislocation. What is the CPT coding?

**21490**

21480

21550

21499

---

*Correct answer: 21490*

*In the CPT index, you will look up dislocation, temporomandibular joint, open treatment, which gives you the code 21490. Turning to the Musculoskeletal system section, where this code is located, you will see that this is for the open treatment of temporomandibular dislocation. Since this is the exact procedure that the question is asking for, 21490 will be the correct answer to the question.*

*Code 21480 is for the closed treatment of temporomandibular dislocation, initial or subsequent. The patient underwent open treatment, not closed treatment, so this is an incorrect answer. Code 21550 is for a soft tissue biopsy of the neck or thorax. Nothing was biopsied, and the TMJ joint was worked on, not the neck or the thorax, so this also would be an incorrect answer. Code 21499 is an unlisted musculoskeletal procedure, head. Since we know that this procedure has a CPT code listed, this is not the correct answer.*

# 30,000 Series CPT®



**82.**

A patient required a battery change for a single-chamber pacing cardioverter-defibrillator system. The battery was taken out in a subcutaneous fashion and a new battery was placed. The cardioverter-defibrillator was then reattached to the electrodes, which were intact and tested, and the skin pocket was then closed.

How should these services be reported?

**33262**

33244, 33241-51, 33240

33236, 33202-51, 33206-51

33241, 33240-51, 33233-51

---

*Correct answer: 33262*

*The CPT manual provides intensive guidelines and a chart to assist with coding for defibrillators and pacemakers. This case involves the removal and replacement of the battery component referred to as the pulse generator for a defibrillator of a single chamber, leading to CPT code 33262.*

*CPT code 33244 describes only the removal of an electrode for a single lead system.*

*CPT code 33241 describes only the removal of the pulse generator, not the replacement of the battery; modifier -51 is, therefore, also not appropriate.*

*CPT code 33240 is the insertion of an initial defibrillator.*

*CPT code 33236 describes the removal of an epicardial pacemaker by a specific approach; this is not documented in the case.*

*CPT code 33202 describes the insertion of an epicardial electrode by open incision; this is not documented in the case. Modifier -51, distinct procedure, would also not apply.*

*CPT code 33206 describes the implantation of a new or replacement pacemaker; this is not documented in the case. Therefore, modifier -51 is also incorrect.*

*CPT code 33233 describes the removal of a permanent pulse generator only; the case documents removal and replacement. Modifier -51, multiple procedures, therefore, also does not apply.*

**83.**

A patient had an endarterectomy during the same surgical session for a repair of a coronary arteriovenous chamber fistula. The fistula repair did not require a cardiopulmonary bypass to complete the procedure.

How should these services be reported?

**33501**

33500, 33572-59

33507, 33501-59

33572, 33501

---

*Correct answer: 33501*

*Searching the CPT index for coronary chamber fistula directs to 33500, 33501. Reviewing these codes leads to 33501, repair of coronary arteriovenous chamber fistula without cardiopulmonary bypass.*

*CPT code 33500 describes the procedure in the case of a cardiopulmonary bypass.*

*CPT code 33572 describes an add-on code for a coronary endarterectomy. This case documented an arteriovenous chamber fistula. Additionally, modifier -59, distinct procedure, does not apply to this case.*

*CPT code 33507 describes the repair of an aortic anomaly by unroofing or translocation. This is not documented in the case.*

**84.**

What code would be used for a laparoscopic splenectomy?

**38120**

38129

38100

38101

---

*Correct answer: 38120*

*In the index of the CPT book, you would look up splenectomy, laparoscopic, which gives you the code 38120. Turning to the Hemic and Lymphatic Systems section, within the Cardiovascular System section, you will see that 38120 is for a laparoscopic surgical splenectomy. This is exactly what the question is asking for, so this is the correct answer.*

*Code 38129 is for an unlisted laparoscopy procedure involving the spleen. The procedure listed in the question is in the CPT book, so this would not be the correct answer. Code 38100 is for a total splenectomy. The procedure done in the question is a laparoscopic procedure, which has its own code, so this would not be the correct answer. Code 38101 is for a partial splenectomy. Again, the procedure performed in the question is a laparoscopic procedure, so this would not be the correct answer.*

**85.**

A 65-year-old patient with severe coronary artery disease is undergoing an aortic valve replacement with a cardiopulmonary bypass. The surgeon utilizes a stentless valve.

Which CPT code should be assigned for this procedure?

**33410**

33406

33362

33510

---

*Correct answer: 33410*

*CPT code 33410 represents an open replacement of the aortic valve with a stentless valve using the cardiopulmonary bypass technique.*

*CPT code 33406 represents the same procedure, but with a different kind of valve, an allograft.*

*CPT code 33362 represents an aortic valve replacement, with an open approach, but the approach is through the femoral artery using the Transcatheter Aortic Valve Replacement (TAVR) technique, not the cardiopulmonary bypass technique.*

*CPT code 33510 represents a coronary artery bypass using a vein from another part of the body, not a replacement of a valve of the heart.*

**86.**

Marvin, a 51-year-old patient, required the conversion of a single-chamber pacemaker system to a dual-chamber system. The previously placed electrode was removed transvenously. The skin pocket was opened and the pulse generator was removed. The skin pocket was then relocated and a dual system was placed with transvenous electrodes in both the right atrial and ventricular chambers. The system was tested, and the new skin pocket was then closed. The patient tolerated the procedure well.

How should these services be reported?

**33214, 33222-51**

33208, 33234-51, 33233-51, 33222 -51, 33214-51

33214-51, 33223-51

33234-51, 33233-51, 33222-51

---

*Correct answer: 33214, 33222-51*

*There are extensive guidelines for Pacemakers and Implantable Defibrillators in the CPT manual. Reviewing the chart in the guidelines, describing an upgrade of a single-chamber system to a dual-chamber system directs to 33214 and notes that this code includes the removal of the existing pulse generator. In this case, the skin pocket was also relocated, which is described by CPT 33222, under the same CPT subheading. Multiple procedure modifier -51 is appended.*

*CPT code 33208 describes an initial insertion or replacement plus the insertion of transvenous dual leads. This was an upgrade from single to dual.*

*CPT code 33234 describes the removal of a transvenous electrode from a single lead system. This case was more complex than this description.*

*CPT code 33233 describes only the removal of a pulse generator. This case was more complex than this description.*

*CPT code 33223 describes the relocation of the skin pocket for the implantable defibrillator. This case was a pacemaker, not a defibrillator.*

**87.**

A patient who had been in a car accident three weeks prior visits the ED complaining of shortness of breath and pain when taking a deep breath or coughing. The ED physician observed a lump in the patient's ribs and ordered imaging. The patient was subsequently diagnosed with a lung hernia protruding through the chest wall. As the patient began to show signs of fever, he was admitted and has now undergone a lung hernia repair by a surgeon.

What is the surgeon's coding?

**32800**

32810

32900

32820

---

*Correct answer: 32800*

*For this question, you will go to the CPT index and look up hernia repair, lung. This gives you the code 32800; reviewing the code information confirms the coding for this case.*

*Code 32810 is for the closure of chest wall following open flap drainage for empyema. The question states that a hernia repair was done, not a chest wall closure. Code 32900 is for the resection of ribs, extrapleural, all stages, not a lung hernia repair. Code 32820 is for major reconstruction of the chest wall, not a repair of lung hernia.*

**88.**

A two-year-old girl born with cleft palate is scheduled for surgery to improve the appearance of her nose. Her physician recommends she undergo a complete rhinoplasty to elevate her nasal tip. In addition, the physician performs a major septal repair.

What CPT code(s) should the physician report?

**30420**

30160

30400 and 30420

30630

---

*Correct answer: 30420*

*Searching the CPT Index for face, reconstruction, nose, leads to a series of codes 30400–30420, 30430–30450, 30620. Reviewing this list of codes leads to reporting 30420, described by rhinoplasty with elevation of the nasal tip and major septal repair. No other code or modifier is needed to describe the documented case.*

*CPT code 30160 represents a total rhinectomy. A rhinectomy is a surgical removal of a nose. Understanding the suffix could help to identify this is the incorrect answer, as the suffix -ectomy means "to remove". The scenario does not mention a removal. Therefore, 30160 can be eliminated.*

*CPT code 30630 represents repair of nasal septal perforations, which was not documented in the scenario, and is incorrect.*

*CPT code 30400 represents primary rhinoplasty and/or elevation of the nasal tip.*

**89.**

A 20-year-old smoker has a single 8.2-mm lung nodule reported on a CT scan of the chest. The peripheral nodule is not amenable to biopsy by routine bronchoscopy. The patient agreed to undergo a diagnostic bronchoscopy with computer-assisted navigation under moderate sedation. Dr. Smith completed the procedure and provided moderate sedation with a trained observer. The intra-service time was documented as 45 minutes.

How should Dr. Smith report their code(s) for this procedure?

**31622, 31627**

31622, 31627-51

31622, 31627-51, 76376

31622

---

*Correct answer: 31622, 31627*

*The main procedure can be located in the index of the CPT® Professional Edition under bronchoscopy/exploration directing to 31622, 31634, 3147, and 31651. Reviewing this listing of codes leads to reporting 31622, described as bronchoscopy rigid or flexible with or without fluoroscopy. This case is documented without fluoroscopy. Instead, the add-on procedure 31627, bronchoscopy/computer-assisted navigation should be reported.*

*Modifier -51 is not used with add-on codes as per Appendix A in the CPT® Professional Edition. Moderate sedation is included with the procedure codes in this question.*

*CPT codes 31622 and 31627-51 are incorrect because the nodule is amenable to biopsy.*

*CPT code sequence 31622, 31627-51, 76376 is incorrect because the 76376 procedure is CT scan 3D rendering, which was not performed. Coding 31622 by itself is not correct, because that would be leaving out the stereotactic guidance portion of the service.*

**90.**

A patient is found to have a subcutaneous dermoid cyst on the tip of his nose. His physician removes it with no difficulty in-office. How would this be billed?

**30124**

30125

30110

30117

---

*Correct answer: 30124*

*In the index of the CPT book, you will look up cyst, dermoid, nose, excision, which gives you the codes 30124-30125. Turning to the Respiratory System section, you will see that the excision of a subcutaneous (or simple) cyst is code 30124 and will be the correct answer to this question.*

*Code 30125 is for the excision of a complex dermoid cyst. The question states that the cyst is a simple cyst, so this would not be the correct answer. Code 30110 is for the excision of a nasal polyp, simple. The question does not mention a nasal polyp, so this would be incorrect. Code 30117 is for the excision/destruction of an intranasal lesion, internal approach. The question does not mention anything about an intranasal lesion. In fact, it states that the dermoid cyst is on the tip of the nose, so this would not be the correct answer.*

**91.**

In the Cardiovascular system section of the CPT book, there is a chart that helps coders code ECMO and ECLS procedures. Within this chart, there are four different procedures. Which of these is not one of them?

**Extracorporeal membrane oxygenation**

Initiation

Decannulation

Additional procedures

---

*Correct answer: Extracorporeal membrane oxygenation*

*The ECMO/ECLS chart can easily be found by turning to the Cardiovascular system section and then turning to the Extracorporeal Membrane Oxygenation or Extracorporeal Life Support Services subsection. As you will see, this chart is broken down into four separate procedures, which all are related by this subsection. They are: Initiation, Subsequent, Decannulation, and Additional Procedures. Immediately, you will see that one of the choices is the actual name of the subsection: Extracorporeal Membrane Oxygenation. While this is related to the chart, it is not one of the four procedures in the chart and, therefore, is the correct answer to this question.*

*As mentioned in the explanation above, Initiation, Decannulation, and Additional Procedures are all part of the chart. But, because the question asked which one was not one of the four procedures, these three choices are incorrect answers to the question.*

**92.**

A patient has a lavage procedure done on her maxillary sinuses to clean them out. How would this be billed?

**31000**

31020

30915

31090

---

*Correct answer: 31000*

*Turning to the CPT index, you will look up lavage, maxillary sinus. This gives you the code 31000, which is located in the Respiratory system section. Code 31000 is for a lavage by cannulation; maxillary sinus. Since this is exactly what was done, this would be the correct answer.*

*Code 31020 is for a sinusotomy, maxillary. The question states that a lavage procedure was done, not a sinusotomy. Code 30915 is for ligation of arteries; ethmoidal. Code 31090 is for a unilateral sinusotomy, 3 or more paranasal sinuses. A sinusotomy was not done; a lavage procedure was done according to the question.*

**93.**

How many times can code set 34710 and 34711 be reported per operative session?

**Once**

Twice

Multiple times, as long as a different surgeon has performed the other surgeries

These two codes cannot be billed together

---

*Correct answer: Once*

*For this question, you will turn to the Cardiovascular system section of the CPT book and turn to the endovascular repair subsection and look for codes 34710 and 34711. These codes are both for the delayed placement of distal/proximal extension prosthesis for endovascular repair of infearenal abdominal aortic/iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedural sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed (Code 34710 is for initial vessel treated, and 34711 is an add-on code for each additional vessel treated). Directly underneath code 34711 are different rules for this code pairing, including how many times they can be billed. In this case, they can only be billed once, so this would be the correct answer for the question.*

***PLEASE NOTE - code 34711 can be billed per each additional vessel. So, while this code can be billed as many times as needed, 34710 can only be billed ONCE.*

**94.**

A 20-year-old patient is brought into the ER after an apparent strangulation has left her unconscious. After suspecting hypoxia, the ER doctor immediately intubates the patient. How would this service be billed?

**31500**

31502

31515

31570

---

*Correct answer: 31500*

*In the index of the CPT book, you would look up intubation, endotracheal tube, which gives you the code 31500. Turning to the Respiratory System section, code 31500 is for an endotracheal intubation, emergency procedure. This matches the question perfectly, so this would be the correct answer.*

*Code 31502 is for a tracheotomy tube change prior to the establishment of fistula tract. This is not what the question is asking for, so this is incorrect. Code 31515 is for a laryngoscopy direct, with/without tracheoscopy, for aspiration. The question does not mention a laryngoscopy or tracheoscopy, so this is incorrect. Code 31570 is for a direct laryngoscopy, with injection into vocal cords, therapeutic. The question does not mention anything in this code, and the procedure done in the question was done on an emergency basis, not therapeutic, so this is also incorrect.*

**95.**

A surgeon is removing a mass in the patient's left bronchial tube. She performed a broncoplasty which requires anastomosis. What CPT code(s) should be reported for this procedure?

**31775**

31770 and 31775

31515 and 31775

32501

---

*Correct answer: 31775*

*CPT code 31775 represents bronchoplasty, excision stenosis, and anastomosis.*

*CPT code 31770 is bronchoplasty, graft repair alone; therefore, this choice can be eliminated. CPT code 31515 represents a laryngoscopy direct, with or without tracheoscopy, for aspiration, which is incorrect.*

*31515 is the CPT code for laryngoscopy with or without tracheoscopy; the surgery in this question was a bronchoplasty. 31775 is the correct CPT code but not in combination with 31515.*

*32501 is a bronchoplasty, a resection, and repair of a portion of the bronchus, but it is an add-on code to be used with codes related to lobectomy or segmentectomy of the lungs.*

**96.**

A 20-month-old is suffering from severe chronic inflammation of the trachea, which is causing difficulty breathing. While ventilator treatment was considered, Dr. Marion performed a scheduled incisional tracheostomy for the patient to attempt to create an airway without ventilator treatment. This procedure was completed under general endotracheal anesthesia. The patient tolerated the procedure well and was returned to the recovery room in stable condition.

How should Dr. Marion report this procedure?

**31601**

31610

31830

31615

---

*Correct answer: 31601*

*Searching the CPT Index for tracheostomy, planned, directed to 31600, 31601. Reviewing the codes for a 20-month-old patient leads to 31601.*

*CPT code 31610 is incorrect because it describes fenestration with skin flaps, which are not documented in this case. CPT code 31830 is incorrect because it describes a revision of a tracheostomy scar, which is not documented in the case. CPT code 31615 is incorrect because it describes a tracheobronchoscopy through an already-established tracheostomy; this is not documented in this case.*