Dental codes (D0000–D9999) are copyrighted and published by the ________ HCPCS level II and CPT codes and multiple modifiers are reported on the same line of Block 24D on the ________ claim, such as 26010 FA F1.

**Coding Tip:** The National Correct Coding Policy Manual states that “HCPCS code M0064 is not reported with CPT codes 90801–90857 (psychiatric services)” because code M0064 “describes a brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.” If the patient is seen for the sole purpose of monitoring or changing drug prescriptions, report code M0064 only.

**Coding Tip:** The National Correct Coding Initiative (NCCI) Policy Manual states that HCPCS code Q0091 (screening Pap smears) includes “services necessary to procure and transport the specimen to the laboratory.” This means that if an evaluation and management (E/M) service is performed during the same visit solely for the purpose of performing a screening Pap smear, do not report a separate CPT E/M code. However, if a significant, separately identifiable E/M service is performed to evaluate other medical problems, report both Q0091 (screening Pap smear) and the appropriate CPT E/M code and add modifier -25 to the E/M code to indicate that the provider performed a significant, separately identifiable service.

Patient underwent diagnostic radiology procedure, which required injection of one 30-mcg 30-mCi dose of ammonia N-13 as the radiopharmaceutical diagnostic imaging agent.

Patient was fitted with a below-the-knee disarticulation prosthesis that contained a molded socket, external knee joint, shin, and solid ankle cushion heel (SACH) foot.

Patient purchased prescribed telephone amplifier assistive living listening device.

The Health Insurance, Portability, and Accountability Act of 1996 (HIPAA) named CPT and HCPCS level II as the procedure code sets for physician services, physical and occupational therapy services, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services including ambulance. (HIPAA also named ICD-9-CM as the code set for diagnosis codes and inpatient hospital services. Also included are ICD-10-CM as the code set for all diagnoses and ICD-10-PCS for inpatient procedures, replacing ICD-9-CM, CDT for dental services, and NDC for drugs. It eliminated HCPCS Level III local codes effective December 2003.)

**CPT Category II Codes**

CPT category II codes are supplemental tracking codes used for performance measurement in compliance with the Physician Quality Reporting System (PQRS). Category II codes (as well as certain HCPCS level II G codes defined by CMS) are assigned for certain services or tests results, which support nationally established performance measures that have proven to contribute to quality patient care. CPT category II codes are alphanumeric and consist of four digits followed by the alpha character F. (HCPCS level II G codes are alphanumeric and consist of the alpha character G followed by four digits.) The reporting of category II codes (and CMS-defined HCPCS level II G codes) is optional and is not a substitute for the assignment of CPT category I codes. When reported on the CMS-1500 claim, the submitted charge is zero ($0.00). CPT category II codes are arranged according to the following categories:

- **Modifiers (1P–8P),** reported with CPT category II codes only
- **Composite Measures (0001F–0015F)**
- **Patient Management (0500F–0575F)**
- **Patient History (1000F–1494F)**
The purpose of reporting category II codes is to facilitate the collection of information about the quality of services provided to patients. The use of category II is expected to decrease the time required for patient record abstracting and review, thus, minimizing the administrative burden on health care providers (e.g., physicians, hospitals).

**EXAMPLE:** Dr. Ryan is a dermatologist who is participating in a nationwide quality management study about malignant melanoma. CPT category II code 0015F is reported for each patient who receives melanoma follow up services, which include obtaining a history about new or changing moles (code 1050F), performing a complete physical skin examination (code 2029F), and providing patient counseling to perform a monthly skin self-examination (code 5005F). Thus, codes 0015F, 1050F, 2029F, and 5005F are reported on the CMS-1500 claim and the charge for each is zero ($0.00). In addition, ICD-10-CM reason for encounter code(s) and CPT category I service/procedure code(s) are reported on the same CMS-1500 claim with appropriate charges entered for each CPT category I code.

**CPT Category III Codes**

CPT category III codes are temporary codes that allow for utilization tracking of emerging technology, procedures and services. The codes facilitate data collection on and assessment of new services and procedures during the FDA approval process or to confirm that a procedure/service is generally provided. According to the CPT coding manual, “the inclusion of a service or procedure in this section neither implies nor endorses clinical efficacy, safety, or the applicability to clinical practice.” CPT category III codes are alphanumeric and consist of four digits followed by the alpha character T, and they range from 0019T–0318T. In 2002, CMS began designating certain CPT category III codes as covered by Medicare, which means charges are entered when reporting the codes on a CMS-1500 claim.

In the past, researchers were hindered by the length and requirements of the CPT approval process. Thus, CPT category III (temporary) codes facilitate the reporting of emerging technology, procedures, and services. They are generally retired if the emerging technology, procedure or service is not assigned a CPT category I code within five years. When a category III code is available, it must be reported instead of an unlisted CPT category I code (because reporting an unlisted code does not offer the opportunity for collection of specific data). Category III codes were initially released in July 2001 and are included as a separate section in CPT (following the category II codes). (HCPCS Level II codes also describe emerging technology, procedures and services; when a HCPCS Level II code exists, it must be reported for Medicare claims.)

**EXAMPLE:** The patient’s physician administered low energy extracorporeal shock wave therapy of the musculoskeletal system. Report category III code 0019T and its charge on the CMS-1500 claim.

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375 5. Refer to CPT code 47560 and review all code descriptions through code 47570. How does code 47560 differ from code 47562? The description for code 47560 is “Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy.” The code description for 47560 includes a semicolon, which means the description for code 47562 is ________________________________

377 • **Appendix H** (Alphabetic Clinical Topics Listing) was removed from the CPT coding manual in 2010 and relocated to the AMA website. (Go to http://www.ama-assn.org, click on the Physicians link, and click on the **CPT – Current Procedural Terminology** link that is located below Feature Resources. Then, click on the Category II Codes link where you will find a link to the CPT Category II Codes Alphabetic Clinical Topics Listing PDF file.) The document is a source of information that links CPT Category II codes, clinical conditions, and performance measures.

378 • **Appendix I** (Genetic Testing Code Modifiers) contains genetic testing code modifiers. (removed from the CPT coding manual)

• **Appendix J** (Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves) contains an electrodiagnostic medicine listing of sensory, motor, and mixed nerves that are reported for motor and nerve studies codes 95900, 95903, and 95904, respectively …
Appendix O (Multianalyte Assays with Algorithmic Analyses, MAAA) includes administrative codes for procedures that by their nature are typically unique to a single clinical laboratory or manufacturer.

Exercise 8.5 …

7. **Contains annual CPT coding changes**
   Contains codes for multianalyte assays with algorithmic analyses (MAAA) procedures

13. **Contains genetic testing modifiers**
   Contained genetic testing modifiers in an appendix that has been deleted from CPT

n. Appendix N
o. Appendix O

3. The numeric format for a reported procedure should be expressed with a five-digit main number and a two-digit modifier. When an unlisted procedure or service code is reported, a special report (e.g., copy of the procedure report) must accompany the claim.

28. A patient undergoes repeat evaluation of radiculopathy, which includes two nerve conduction studies: an amplitude study and an F-wave study. Code 95903 95907 is reported …

30. A 55-year-old patient undergoes an esophagoscopy at an ambulatory surgical center. The patient is administered a mixture of midazolam and fentanyl for moderate (conscious) sedation. Code 43228 43229 is assigned. Refer to CPT Appendix G to locate code 43228 43229. Does code 43228 43229 include moderate (conscious) sedation, or should a code from range 99143–99145 99150 be assigned as a secondary code.

Chapter 12
Page 535

**Coding Tip:**
- Do not report code 19100 (needle core breast biopsy) for fine-needle aspiration (FNA) of breast tissue. FNA procedures are reported with codes 10021–10022, which includes single and multiple lesions.
- Code 77031 is assigned as an additional code (for each lesion) if FNA (10022) is performed using imaging guidance and stereotactic localization.

536

**Coding Tip:**
- In addition to code 19100 for needle core biopsy, report code 77031 for stereotactic localization or code 77032 for mammographic guidance.
- A biopsy code (19100–19103 19101) is assigned for each biopsied site …
- Differentiating a puncture aspiration of a breast cyst, a needle core biopsy …
  - Codes 19100–19103 19101 are assigned for needle core breast biopsies …

**Coding Tip:**
- For an excisional biopsy, report code 19120. (However, if the lesion was identified with preoperative placement of a radiological marker, report codes 19081–19086, 19125–19126, and 19290–19294, depending on the number of localized lesions. Also report codes 77031–77032 for radiological supervision and interpretation.)

563

**EXAMPLE:** Physician performed removal of a “total shoulder” implant with replacement of a new implant. Report codes 23332 23335 for removal of the …

576 Codes 31622–31656 31661 describe procedures that involve use of a bronchoscope …

583

19. Catheterization with bronchial brush biopsy. Which CPT code is assigned?
   a. 31715 31623  b. 31717  c. 31720  d. 31725

Chapter 13
Page 596

**Note:** When the physician performs an “operative” cardiac ablation (also called a Maze procedure), a code is assigned from the CPT Surgery section of CPT (e.g., 33254). Cardiac ablation is sometimes called cardiac catheter ablation;” however, that procedure is assigned a code from the CPT Medicine section (93650–93652 93657).

610

**Note:** Percutaneous transluminal coronary angioplasty (PTCA) (Figure 13-12) is performed on the coronary arteries, and codes are located in the Medicine section (92882–92884 92920-92944) …
**EXAMPLE 1:** Patient underwent open transcatheter placement of an intravascular stent under fluoroscopic guidance. Patient underwent open transluminal stent placement of the right femoral artery for revascularization with atherectomy and angioplasty of the same vessel. The catheter was introduced into the right femoral artery (second-order artery), and contrast medium was injected. Femoral angiogram was performed and revealed blockage of the femoral artery. Under fluoroscopic guidance, an intravascular stent was placed in the femoral artery. Repeat magnetic resonance femoral angiogram (Figure 13-14), after stent placement, revealed good arterial circulation in the femoral artery. Report codes 37207-RT, 36246-RT, and 75960-RT 73725-RT.

628
19. Percutaneous transcatheter retrieval of intravascular foreign body. Which CPT code is assigned?
   a. 37201 37184  
   b. 37202 37187  
   c. 37203 37195  
   d. 37204 37197

**Chapter 14**

643 Codes 43260–43272 43273 are reported for ERCP ...

644 **Manipulation**

When endoscopic esophageal procedures are performed, the advancement of the endoscope through the esophagus expands any stricture. The dilation is considered an integral part of the esophagoscopy procedure. This means that a code from 43450–43458 43453 ...

654 A **hepatotomy** (open drainage of abscess or cyst) is performed in one or two stages, but when it is performed as a two-stage procedure, the code is not reported a second time. **The percutaneous drainage of a liver abscess** (47011) may also be performed in stages, and this procedure includes the initial insertion and final removal of the catheter, using radiologic guidance.

669 8. Which gastrointestinal (GI) endoscopy procedure involves injecting dye through a tube in the endoscope to allow for visualization of the ducts on X-rays?
   a. Endoscopic retrograde cholangiopancreatography (ERCP) (43260–43272 43273)
   b. Esophagogastroduodenoscopy (EGD) (43235–43259)
   c. Esophagoscopy (43200–43232)
   d. Upper GI endoscopy (esophagogastroscopy) (43234 43235)

670 17. Open drainage of retroperitoneal abscess. Which CPT code is assigned?
   a. 49020  
   b. 49041 49060  
   c. 49060 49405  
   d. 49061 49406

**Chapter 16**

740 • Nuclear Medicine (78000 78012–79999)

746 • **Selective vascular catheterization** is the … therapeutic (e.g., endarterectomy) procedures (e.g., 75650) ...

**EXAMPLE:** Patient underwent outpatient bilateral carotid arteriograms. Catheter was inserted into right common femoral artery, advanced to aortic arch, inserted into left carotid artery, and contrast material was injected. Catheter was withdrawn from left carotid artery, advanced to brachiocephalic artery, inserted into right carotid artery, and contrast material was injected. Bilateral carotid arteriograms were performed. Report codes 36215-LT, 36218-RT, 75680. Do not add modifier -51 to code 36218 because it is an add-on code. Patient underwent selective catheter placement into the left common carotid artery with angiography of ipsilateral (same side) intracranial carotid circulation, extracranial carotid, and cervicocerebral arch. Procedure included associated radiological supervision and interpretation. Report code 36222.

**EXAMPLE:** Patient underwent thyroid imaging with vascular flow for which a and radioactive tracer was administered. Report code 78041 78013.

**Chapter 17**

782 described in a Tier 2 code, report an appropriate methodology code (codes 83890–83914 and 88384–88386).
Coding Tip:

- Many therapeutic and diagnostic cardiovascular procedure codes (93451–93461, 93451–93461, 93600–93624, 93640–93650, 93657) include intravenous

Coding Tip:

- The first procedure is reported with a primary code (92980, 92982, or 92995 e.g., 92920) that describes the most complex procedure performed.
- Procedures performed in other coronary arteries are reported with the add-on codes (92981, 92984, 92996 e.g., 92921).

20. A psychiatrist used dolls to communicate with a 5-year-old patient during a psychiatric interview. Which CPT code is assigned?
   a. 90791    b. 90792   c. 90845   d. 90857 90853

--International Classification of Diseases, 9th 10th Revision, Clinical Modification (ICD-9-CM ICD-10-CM):
All diagnoses and inpatient hospital procedures and services

ICD-10 Alert!
ICD-9-CM will be replaced by ICD-10-CM and ICD-10-PCS when adopted for implementation.

Appendix J of CPT (8) contains an electrodiagnostic medicine listing of sensory, motor, and mixed nerves that are reported for motor and nerve studies codes 95900, 95903, and 95904, respectively.

Appendix O (8) (Multianalyte Assays with Algorithmic Analyses) (MAAA) includes administrative codes for procedures that by their nature are typically unique to a single clinical laboratory or manufacturer.
Workbook to Accompany 3-2-1 Code It!

Chapter 3
Page 31
15. Which code is assigned to menstrual migraine?
   a. G43.d G43.829  
   b. G43.d09 G43.831  
   c. G43.d19 G43.829  
   d. N94.3 G43.909

Chapter 7
Page 115
Overview
HCPCS level II code sections are identified by an alphabetic first character (e.g., B for enteral and parenteral therapy, C for outpatient PPS, and so on). Some code sections are logical, such as D for dental or R for radiology, whereas others, such as J for drugs, appear to be arbitrarily assigned.

120 5. Injection of Depo-Provera, 50 mg.
   a. J1051  
   b. J1055  
   c. J1056  
   d. J1060

   Injection, amphotericin B lipid complex, 10 mg.
   a. J0287  
   b. J0288  
   c. J0289  
   d. J0290

121 10. Michael Lincoln presents to the dental clinic for a fluoride treatment. Michael has several cavities, and he is only 7 years of age.
   a. D1110  
   b. D1120  
   c. D1203  
   d. D1206

   A brachytherapy needle was used during the patient's cancer treatment.
   a. C1715  
   b. C1716  
   c. C1717  
   d. C1719

Chapter 8
Page 130
34. Which code is located in the Radiology section of CPT and includes moderate (conscious) sedation?
   a. 33218  
   b. 43274 43277  
   c. 77600  
   d. 92987
Appendix I

36. Refer to CPT Appendix 11 and identify the required denominator for category II code 49151:
   a. all patients aged 10 years of age with asthma
   b. all patients aged 10 years with mild, moderate, or severe persistent asthma
   c. all patients with coronary artery disease (CAD)
   d. all patients

37. Under the clinical condition, prenatal postpartum care code 6501E is reported for:
   a. first prenatal visit to the physician
   b. normal number of prenatal visits to the physician
   c. subsequent prenatal care visit
   d. postpartum care visit

38. For “clinical condition, prenatal postpartum care,” to which website is the coder or physician directed for code 6502E:
   d. http://www.hedis.org

39. Which disease does code 4005E and 4006E share?
   a. diabetes
   b. coronary artery disease
   c. myoccardial infarction
   d. These codes do not share any disease.

40. A physician's office saw 500 patients during the past 12 months who identified themselves as smokers during the review of systems. To collect data for code 4004E, which is the correct denominator?
   a. all smokers who agreed to use 1-800 QUIT for counseling
   b. all patients identified as smokers and diagnosed with COPD
   c. smokers who agreed to pharmacologic therapy to quit smoking
   d. patients identified as smokers upon interview and evaluation

Appendix II

41. Referring to CPT Appendix 1, the I in modifier -17 identifies:
   a. congenital structure
   b. disease category
   c. gene type
   d. molecular structure

42. Modifiers 1A, 3K, and 4Z are all:
   a. biopsy compatibility modifiers  
   b. neoplasia modifiers  
   c. non-neoplastic modifiers  
   d. solid tumor neoplasia modifiers

43. Which modifier is reported to identify Duchenne muscular dystrophy genetic testing?
   a. 5K
   b. 6A
   c. 6Z
   d. 8Z

44. Modifier -OM is reported to identify:
   a. leukemia
   b. relapse or remission
   c. thalassemia
   d. Von Hippel-Lindau disease

45. For modifier -5M, the M symbolizes:
   a. geno typo
   b. neurological disease
   c. non-neoplastic neurological disease
   d. spinocerebellar ataxia

46. Code SS900 is reported for a nerve conduction study without wave of the ____________ nerve.
   a. median sensory nerve
   b. saphenous nerve
   c. sciatric nerve
   d. tibial sensory nerve

47. A patient presents with bilateral numbness, tingling, and pain of fingers on hands. The physician orders a needle EMG to rule out carpal tunnel syndrome. Based on information in CPT Appendix J, what is the maximum number of needle EMGs the patient should undergo for the physician to arrive at a diagnosis?
   a. 1
   b. 2
   c. 3
   d. 4

48. A patient reports the following signs and symptoms: dysphagia, muscle weakness of the upper arms, and impaired speech. After examining the patient and getting a comprehensive history, the physician orders a sensory nerve conduction study (NSCS) to rule out amyotrophic lateral sclerosis (ALS) based on information in CPT Appendix J. What is the maximum number of sensory NSCS the patient should undergo for the physician to arrive at a diagnosis?
   a. 1
   b. 2
   c. 3
   d. 4

49. A patient reports the following signs and symptoms: muscle cramps and muscle twitching of the upper left arm. The physician orders a motor NSCS with i wave. Based on information in CPT Appendix J, what is the maximum number of motor NSCS the patient should undergo for the physician to arrive at a diagnosis?
   a. 1
   b. 2
   c. 4
   d. 6

50. Patient Rachel Gibbons presents to her primary care physician with the complaint of burning and tingling in the soles of both feet. Rachel is an avid weekend runner and, at first, she thought she had shin splints. However, the pain and tingling have been present now for three months. The symptoms are relieved by resting or massaging the feet. The physician recommends that the patient have sensory nerve conduction study. The physician's differential diagnosis is tarsal tunnel syndrome. Based on information in CPT Appendix J, what is the maximum number of sensory NSCS the patient should undergo for the physician to arrive at a diagnosis?
   a. 1
   b. 2
   c. 4
   d. 6
20. Which CPT appendix contains genetic testing modifiers?
   a. J               c. L
   b. I               d. M

Which CPT appendix contains annual coding changes (added, deleted, revised codes)?
   a. A
   b. B
   c. C
   d. D

Chapter 12
   a. 32424 32554       c. 32402
   b. 32400             d. 32405

Chapter 13
   a. 37195                c. 37202
   b. 37204 37197           d. 37204 37216

Chapter 14
   drainage via catheter. Which CPT code is assigned?
   a. 48000         c. 48510
   b. 48120         d. 48511 49405

13. Open drainage of liver abscess via incision. Which CPT code is assigned?
   a. 47010         c. 47045 47100
   b. 47011         d. 47120

Chapter 16
Page 226  6. Angiography of right cerebral carotid artery, including supervision and reporting. Which code is
   assigned?
   a. 75662              c. 75671
   b. 75665              d. 75676

   Cardiac magnetic resonance imaging for morphology and function, with stress imaging. Which code is
   assigned?
   a. 75557
   b. 75559
   c. 75561
   d. 75563

9. Angiography of renal arteries with flush aortogram. Which code is assigned?
   a. 75722              c. 75734
   b. 75724              d. 75733

   Computed tomography of the heart, with contrast material, for evaluation of cardiac structure and
   morphology. Which code is assigned?
   a. 75571
   b. 75572
   c. 75573
   d. 75574

Chapter 18
Page 243  1. IM injection of varicella-zoster immune human globulin. Which code(s) are assigned?
   a. 90716              c. 90396, 90772 93672
   b. 90396, 90471        d. 90716, 90772 93672

244 18. Balloon valvuloplasty of the pulmonary heart valve done percutaneously. Which code is assigned?
   a. 92982 92943        c. 92987
   b. 92986              d. 92990
19. Ablation procedure for treatment of ventricular tachycardia. Which code(s) are assigned?
   a. 93651 93650  
   b. 93652 93653  
   c. 93652 93654, 93609  
   d. 93622, 93652 93655, 93609

Appendix E

Page 644 146. Established patient received individual insight-oriented psychotherapy for 25 minutes. The physician also provided a problem-focused history and examination and straightforward level of medical decision making. Which CPT code(s) are assigned?
   a. 90804 90832, 99212  
   b. 90805 90836  
   c. 90810 90836, 99212  
   d. 90814 90837