

## CCS-P Sample Multiple-choice Questions and Answer Key

1. A patient, followed for a past myocardial infarction that occurred one year ago, has chronic cholecystitis (575.11) and is seen in the cardiology clinic for surgical clearance. The cardiologist indicates the patient is currently at no risk for surgery and no treatment is necessary. Upon review of the record, the coder notes that there is a right bundle branch block on the EKG. Which of the following is the correct coding and sequencing for this case?
- |        |  |
|--------|--|
| 411.0  | Postmyocardial infarction syndrome               |
| 412    | Old myocardial infarction                        |
| 414.8  | Chronic stage myocardial infarction              |
| 426.4  | Right bundle branch block                        |
| 794.31 | Abnormal findings on EKG                         |
| V12.50 | History of unspecified circulatory disease       |
| V65.8  | Other reasons for seeking consultation           |
| V70.0  | Routine general medical examination              |
| V71.7  | Observation for suspected cardiovascular disease |
| V72.81 | Preoperative cardiovascular examination          |
- A. 575.11; 426.4; V12.50; V71.7  
B. V65.8; 794.31; V71.7, consult with cardiologist on definitive diagnosis; 412  
C. V72.81; 575.11; 412, ask physician for clarification on bundle branch block  
D. V72.81; 426.4; 414.8; 575.11
2. A patient is seen in a physician's office and the nurse has recorded a blood-pressure reading of 140/90mm Hg. The physician evaluates the patient and records a blood pressure of 120/80mm Hg and schedules a follow-up visit in 2 weeks to rule out hypertension. The coder should code:
- A. 796.2, Elevated blood pressure  
B. 401.9, Hypertension  
C. V71.7, Observation for suspected cardiovascular disease  
D. V12.59, Personal history of other specified circulatory disorder
3. A patient presents to a physician's office with a previous lab test that indicates hyperglycemia. The physician records the final diagnosis as suspected diabetes mellitus. For this case, the coder would assign the code(s) for:
- A. Diabetes mellitus with specified complication  
B. Diabetes mellitus with unspecified complication  
C. Hyperglycemia  
D. Hyperglycemia, diabetes mellitus uncomplicated

4. A patient was seen in the clinic for wheezing and a productive cough. The physician documented "probable bronchitis--pending CXR results." Performance of the chest x-ray revealed bronchitis. A blood-sugar measurement was also taken to determine the status of the patient's diabetes. The patient indicated that previously reported arthritis and insomnia were not currently troublesome. Which of the following diagnoses should be reported?

- A. Bronchitis; diabetes mellitus
- B. Bronchitis; diabetes mellitus; arthritis; insomnia
- C. Productive cough
- D. Productive cough; arthritis; insomnia

5. A patient returns to the emergency department after a previous visit earlier in the day for severe epistaxis. The epistaxis arose spontaneously at 7:00 am and was controlled in the emergency department by Doctor A, using bilateral anterior nasal packing with satisfactory control of the epistaxis. The patient was discharged in satisfactory condition at 10:30 am. She returned again at 4:00 p.m. with moderate epistaxis. Doctor A was not available. Doctor B completed the following procedure: nasal packing, anteriorly, bilaterally. Hemorrhage was adequately controlled. There were no further complications and the patient was discharged at 7:00 p.m. Which of the following are the correct modifiers for Doctor B?

- 50 Bilateral procedure
- 51 Multiple procedures
- 76 Repeat procedure by same physician
- 77 Repeat procedure by another physician

- A. -50, -76
- B. Emergency department physicians do not use modifiers to report their services
- C. -50, -77
- D. -51, -77

6. A coding specialist was hired to conduct reviews to assess coding accuracy at a large primary care clinic. To ensure accurate coding, the following sample of claims was reviewed. What type of error may be revealed in this review?

Claims	Code Interpretation
427.9	Cardiac dysrhythmia
425	Cardiomyopathy
414.0	Coronary artery disease
401	Hypertension
402	Hypertensive heart and renal disease
428.1	Left ventricular failure
424.0	Mitral valve stenosis
428.0	Right ventricular failure
424.90	Valvular heart disease

- A. The ICD-9-CM codes are too specific  
B. The CPT codes are incomplete  
C. The HCPCS codes lack specificity  
D. The ICD-9-CM codes are incomplete
7. The physician records the following office visit note:
- T. 99.3 P. 70 reg. R. 16 Pt c/o productive cough. Lungs clear. Throat red. To hospital Outpatient Radiology for chest x-ray. Removal of impacted cerumen. Dx: acute bronchitis. Which of the following CPT code(s) should be assigned?
- A. Evaluation and management office visit code  
B. Evaluation and management office visit code; removal impacted cerumen  
C. Removal of impacted cerumen  
D. Evaluation and management office visit code; chest x-ray
8. The following CPT codes appear:

93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
99201	Office or other outpatient visit with problem focused history and examination, straightforward medical decision making, new patient
99241	Office consultation with problem-focused history and examination, straightforward medical decision making, new or established patient
99271	Confirmatory consultation with problem-focused history and examination, straightforward medical decision making, new or established patient

A patient, without a history of cardiac problems, was referred to a cardiologist for surgical clearance at the request of a general surgeon. A problem-focused history and examination was performed and medical decision-making was straightforward. A routine EKG was performed and interpreted. Findings were

sent to the surgeon. Which of the following is the appropriate coding by the cardiologist?

- A. 99241; 93000
- B. 93000
- C. 99201; 93000
- D. 99271; 93000

9. The physician performed a diagnostic colonoscopy with hot biopsy forceps removal of one polyp and removal of a second polyp by snare technique. The following is an excerpt from CPT codes/modifiers:

45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)
45379	with removal of foreign body
45380	with biopsy, single or multiple
45382	with control of bleeding, any method
45383	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery, or the snare technique
45384	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery
45385	with removal of tumor(s), polyp(s), or other lesion(s) by the snare technique
Modifiers:	
-22	Unusual procedural service
-51	Multiple procedures

Which of the following is the correct coding assignment?

- A. 45384-22
  - B. 45384; 45385-51
  - C. 45380-51; 45384-51; 45385-51
  - D. 45378; 45384-22
10. Which of the following series of Evaluation and Management codes should be used to report an admission of a patient to a partial hospitalization program according to CPT guidelines?
- A. 90804-90809, Individual psychotherapy based on time
  - B. 99217-99220, Initial observation care
  - C. 99221-99223, Hospital inpatient services
  - D. 99321-99323, Domiciliary, rest home, or custodial care services

11. Which of the following statements describes a poisoning that should be coded in ICD-9-CM?
- A. Interaction between two prescribed medications
  - B. Side effect of a medication taken according to instructions
  - C. Medication taken by the wrong person
  - D. Drug intoxication from a medication taken as prescribed by the physician
12. A Medicare patient has a surgical procedure performed in the office. Which of the following services is most likely to result in additional reimbursement, depending on coverage policy?
- A. A4550, Surgical trays
  - B. A4554, Disposable underpads for the surgical table
  - C. D9215, Local anesthesia
  - D. D9241, Intravenous sedation/analgesia – first 30 minutes
13. Modifier -51 (multiple procedures) is assigned to a CPT code. What will happen to the payment for that code?
- A. Reimbursement will generally be reduced according to the terms of the health plan
  - B. Payment will be doubled because the insurance company will recognize that the procedure is bilateral
  - C. Payment will be increased due to an unusual procedure requiring more physician work
  - D. Reimbursement will not be affected
14. In which situation is it appropriate to use modifier –59?
- A. Distinct and different operative session or patient encounter.
  - B. Multiple procedures performed at the same session by same provider
  - C. A combination of medical and operative procedures performed at the same session
  - D. Any CPT procedure considered a “Separate Procedure”
15. The physician documents that a cannula was inserted into the subclavian vein and the tip was threaded through the vein. The tip rested within the right atrium of the heart. The above description explains which of the following insertions?
- A. Implantable venous access port
  - B. Balloon-tipped flotation catheter
  - C. Implantable infusion pump
  - D. Central venous catheter

**CCS-P Multiple-choice Answer Key**

1. C 2. A 3. C 4. A 5. C 6. D 7. B 8. A 9. B 10. C 11. C 12. A 13. A 14. A 15. D

## PROCEDURES FOR CODING PART II OF THE CCS-P EXAMINATION

1. Apply ICD-9-CM instructional notations and conventions and current approved "Basic Coding Guidelines for Outpatient Services" and "Diagnostic Coding and Reporting Requirements for Physician Billing" (*Coding Clinic* for ICD-9-CM, Fourth Quarter, 1995), to select diagnoses, conditions, problems, or other reasons for care that require ICD-9-CM coding in a physician-based encounter/visit either in a physician's office, clinic, outpatient area, emergency room, ambulatory surgery, or other ambulatory care setting. Code for professional services only.
2. Sequencing is not required for the diagnoses or procedures.
3. Modifiers are not required.
4. Apply the following directions to assign codes to secondary diagnoses:
  - A. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient is receiving treatment and care for the condition(s).
  - B. Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment, or management.
  - C. Conditions previously treated and no longer existing are not coded.
5. Code for the professional services only and only for the physician designated on the cover sheet for each individual case.
6. Assign CPT and/or HCPCS Level II codes for all appropriate procedures.
7. Assign CPT codes for anesthetic procedures listed in the anesthesia section only if indicated on the case cover sheet.
8. Assign CPT codes for medical procedures based on current CPT guidelines.
9. Confirm Evaluation and Management (E/M) codes based on the information provided in the box for each case.

*For the purposes of this examination do not challenge the level of key components chosen. You will not be expected to assign the level of history, examinations, and medical decision-making.*
10. Assign CPT codes for radiologic and laboratory procedures listed in the radiology and laboratory sections only when applicable.
11. Assign HCPCS Level II National (alphanumeric) codes, as appropriate.
12. Do not assign HCPCS Level III Local (alphanumeric) codes.
13. Do not assign ICD-9-CM E-codes.
14. Do not assign ICD-9-CM Morphology codes (M-codes).

15. Do not assign ICD-9-CM, Volume 3, procedure codes.

## CCS-P Sample Medical Record Coding Cases and Answer Sheets

### Case No. 1

Code the procedure(s) performed at the ambulatory surgery center for the gastroenterologist only.

### AMBULATORY SURGERY CENTER CHART

**Admit Date/Time:** 3/14 10:00 am **Discharge Date/Time:** 3/14 12:45 pm

**Sex:** M      **Age:** 59      **Disposition:** Home      **Height:** 5'6"      **Weight:** 160

#### **Admitting Diagnosis:**

1. Abdominal Pain
2. R/O Ulcer

#### **Discharge Diagnosis:**

1. Hiatal hernia
2. Moderate reflux esophagitis
3. Healing prepyloric gastric ulcer
4. Normal flexible sigmoidoscopy

#### **Procedures:**

1. EGD and sigmoidoscopy

## **GASTROENTEROLOGY NOTE**

**Date:** 3/14

**Height:** 5'6"

**Vital Signs:** T 99, P 80, R 20, BP 122/74, stable

**Mental Status:** Alert and oriented

**Allergies:** NKA

**NPO:** Yes, since midnight

**Current Meds:** Stomach pills, Tagamet

### **History and Physical**

**Date:** 3/10 (performed in office)

**History of Present Illness:** 59-year-old male with abdominal pain, unresponsive to H2 blockers

**Past Medical History:** Periodic high blood-pressure readings

**Medications:** Tagamet, Dicyclomine

**Allergies:** NKA

### **Examination:**

**General:** Well-developed, well-nourished male in minor distress.

### **HEENT:**

No gross lesions noted. Pupils round and equal. No icterus. Neck supple, trachea midline. Negative soft tissue swelling. Oropharynx negative. Soft tissues within normal limits.

**Heart:** Regular rate and rhythm. EKG showed normal sinus rhythm

**Lungs:** Clear to auscultation

**Abdomen:** Soft, tender to touch

**Extremities:** No clubbing, cyanosis, or edema

**Rectal:** Deferred

**Impression:** Abdominal pain, possible ulcer

**Pre-procedure Diagnosis:** Abdominal pain, rule out ulcer

**Orders:**

1. Set up EGD and possible flexible sigmoidoscopy at ambulatory surgery center
2. NPO after midnight day of procedure

**OPERATIVE REPORT****Date of Procedure:** 3/14**Procedure:** Esophagogastroduodenoscopy and flexible sigmoidoscopy

Preoperative Medication: Preop Demerol 50 mg, Vistaril 50 mg, Atropine .4 mg, Versed 4 mg given by the anesthesiologist

**Preoperative Diagnosis:**

Abdominal pain, possible peptic ulcer disease. Patient has upper abdominal pain, unresponsive to H2 blockers.

**Postoperative Diagnosis:**

1. Hiatal Hernia
2. Moderate reflux esophagitis
3. Healing prepyloric gastric ulcer
4. Normal sigmoidoscopy

**Findings:**

Endoscopy was performed with the Olympus video panendoscope, which was easily introduced into the esophagus. This was normal to the proximal midportion of the esophagus, but at the GE junction, there was evidence of a moderate degree of reflux esophagitis with several small superficial erosions at the location and also isolated erosions several centimeters above. The endoscope was advanced into the stomach and turned in a retrograde direction. The cardiac and fundic areas were examined and found to be otherwise normal. The antrum showed normal peristalsis and mucosa. In the immediate prepyloric area, there was a small defect that was thought to represent scarring from previous ulcer, which was still healing. Biopsies were obtained. The duodenum, including the second portion, was normal. Subsequently, the endoscope was withdrawn. The patient turned on his left side. Flexible sigmoidoscopy was then carried out to the lower descending colon. A biopsy of the sigmoid was obtained. Patient tolerated the procedure well.

## **ENDOSCOPY ORDERS**

**3/14:**

Admit to ambulatory surgery, endoscopy area

Obtain consent for procedure, sign, and witness

Start IV of 55 cc D5W or NS TO KVO or heparin lock.

Preoperative Medications: Vistaril 50 mg IM, Demerol 50 mg IM, atropine .4 mg IM

**3/14:**

To Recovery

Give soft diet

Discharge at 12:30 p.m.

# CCS-P EXAMINATION ANSWER SHEET

## DIAGNOSES

DX1 \_\_\_\_\_  
DX2 \_\_\_\_\_  
DX3 \_\_\_\_\_  
DX4 \_\_\_\_\_

## ICD-9-CM CODES

	5	3	1	•	9	0
	5	5	3	•	3	
	5	3	0	•	1	1
				•		

## PROCEDURES

PR1 \_\_\_\_\_  
PR2 \_\_\_\_\_  
PR3 \_\_\_\_\_  
PR4 \_\_\_\_\_  
PR5 \_\_\_\_\_  
PR6 \_\_\_\_\_

## CPT CODES

4	3	2	3	9
4	5	3	3	1

## Case No. 2

Code the professional service(s) and procedure(s) performed at the physician office visit only.

### **PHYSICIAN OFFICE RECORD**

- S:** This is a 17-year-old established patient, with a problem hearing out of his right ear. The problem began two weeks ago and hearing slowly deteriorated. Chief Complaint: He currently describes his hearing as “muffling sounds” in the right ear. There is some ear discomfort in both ears. Brief History: This has been an ongoing problem for this patient. He has been seen seven times in the past two years for cerumen impaction and otitis. No other complaints at this time.
- O:** Examined HEENT including external and internal inspection of ears and nose, and otoscopic examination of auditory canals and tympanic membranes. Found a wax plug in right ear and inflammation of both ear canals.
- A:**
1. Cerumen plug impaction, right
  2. Externa otitis, both ears
- P:** Removed impacted ear wax successfully. Due to history of cerumen impaction, I counseled the patient on daily ear maintenance and demonstrated the appropriate wax removal techniques. Placed patient on Cortisporin Otic suspension for the next three days as directed. Should use the drops if this problem recurs before next visit. Follow-up for ear check in two weeks if no additional problems.

#### **Evaluation and Management Data:**

**History:** Problem focused

**Examination:** Problem focused

**Medical Decision Making:** Straightforward

# CCS-P EXAMINATION ANSWER SHEET

## DIAGNOSES

DX1 \_\_\_\_\_

DX2 \_\_\_\_\_

DX3 \_\_\_\_\_

DX4 \_\_\_\_\_

## ICD-9-CM CODES

	<b>3</b>	<b>8</b>	<b>0</b>	<b>•</b>	<b>4</b>	
	<b>3</b>	<b>8</b>	<b>0</b>	<b>•</b>	<b>1</b>	<b>0</b>
				<b>•</b>		
				<b>•</b>		

## PROCEDURES

PR1 \_\_\_\_\_

PR2 \_\_\_\_\_

PR3 \_\_\_\_\_

PR4 \_\_\_\_\_

PR5 \_\_\_\_\_

PR6 \_\_\_\_\_

## CPT CODES

<b>9</b>	<b>9</b>	<b>2</b>	<b>1</b>	<b>2</b>
<b>6</b>	<b>9</b>	<b>2</b>	<b>1</b>	<b>0</b>