# Free Questions for CPC by dumpssheet

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# Question 1

**Question Type:** MultipleChoice

View MR 005398

MR 005398

Operative Report

Preoperative Diagnosis: Nonfunctioning right kidney with ureteral stricture.

Postoperative Diagnosis: Nonfunctioning right kidney with ureteral stricture.

Procedure: Right nephrectomy with partial ureterectomy.

Findings and Procedure: Under satisfactory general anesthesia, the patient was placed in the right flank position. Right flank and abdomen were prepared and draped out of the sterile field. Skin incision was made between the 11th and 12th ribs laterally. The incision was carried down through the underlying subcutaneous tissues, muscles, and fascia. The right retroperitoneal space was entered. Using blunt and sharp dissection, the right kidney was freed circumferentially. The right artery, vein, and ureter were identified. The ureter was dissected downward where it is completely obstructed in its distal extent. The ureter was clipped and divided distally. The right renal artery was then isolated and divided between 0 silk suture ligatures. The right renal vein was also ligated with suture ligatures and 0 silk ties. The right kidney and ureter were then submitted for pathologic evaluation. The operative field was inspected, and there was no residual bleeding noted, and then it was carefully irrigated with sterile water. Wound closure was then undertaken using 0 Vicryl for the fascial layers, 0 Vicryl for the muscular layers, 2-0 chromic for subcutaneous tissue, and clips for the skin. A Penrose drain was brought out through the dependent aspect of the incision. The patient lost minimal blood and tolerated the procedure well.

What CPT coding is reported for this case?

### Options:

**A-** 50234

**B-** 50220

**C-** 50230

**D-** 50240

### Answer:

B

# Question 2

**Question Type:** **MultipleChoice**

View MR 004397

MR 004397

Operative Report

Preoperative Diagnosis: Calculi of the gallbladder

Postoperative Diagnosis: Calculi of the gallbladder, chronic cholecystitis

Procedure: Cholecystectomy

Indications: The patient is a 50-year-old woman who has a history of RUQ pain, which ultrasound revealed to be multiple gallstones. She presents for removal of her gallbladder.

Procedure: The patient was brought to the OR and prepped and draped in a normal sterile fashion. After adequate general endotracheal anesthesia was obtained, a trocar was placed and C02 was insufflated into the abdomen until an adequate pneumoperitoneum was achieved. A laparoscope was placed at the umbilicus and the gallbladder and liver bed were visualized. The gallbladder was enlarged and thickened, and there was evidence of chronic inflammatory changes. Two additional ports were placed and graspers were used to free the gallbladder from the liver bed with a combination of sharp dissection and electrocautery. Cystic artery and duct are clipped. Dye is injected in the gallbladder. Cholangiography revealed no intraluminal defect or obstruction. Gallbladder is dissected from the liver bed. The scope and trocars are removed.

What CPT coding is reported for this case?

## Options:

**A-** 47562, 74300-26

**B-** 47563, 74300-26

**C-** 47605, 74300-26

**D-** 47600, 74300-26

### Answer:

B

# Question 3

**Question Type:** **MultipleChoice**

View MR 003396

MR 003396

Operative Report

Preoperative Diagnosis: Acute MI, severe left main arteriosclerotic coronary artery disease

Postoperative Diagnosis: Acute MI, severe left main arteriosclerotic coronary artery disease

Procedure Performed: Placement of an intra-aortic balloon pump (IABP) right common femoral artery

Description of Procedure: Patient's right groin was prepped and draped in the usual sterile fashion. Right common femoral artery is found, and an incision is made over the artery exposing it. The artery is opened transversely, and the tip of the balloon catheter was placed in the right common femoral artery. The balloon pump had good waveform. The balloon pump catheter is secured to his skin after

local anesthesia of 2 cc of 1% Xylocaine is used to numb the area. The balloon pump is secured with a 0-silk suture. The patient has sterile dressing placed. The patient tolerated the procedure. There were no complications.

What CPT coding is reported for this case?

### Options:

**A-** 33975

**B-** 33967

**C-** 33970

**D-** 33973

### Answer:

C

## Question 4

**Question Type:** **MultipleChoice**

View MR 002395

MR 002395

Operative Report

Pre-operative Diagnosis: Acute rotator cuff tear

Post-operative Diagnosis: Acute rotator cuff tear, synovitis

Procedures:

1) Rotator cuff repair

2) Biceps Tenodesis

3) Claviculectomy

4) Coracoacromial ligament release

Indication: Rotator cuff injury of a 32-year-old male, sustained while playing soccer.

Findings: Complete tear of the right rotator cuff, synovitis, impingement.

Procedure: The patient was prepared for surgery and placed in left lateral decubitus position. Standard posterior arthroscopy portals were made followed by an anterior-superior portal. Diagnostic arthroscopy was performed. Significant synovitis was carefully debrided. There was a full-thickness upper 3rd subscapularis tear, which was repaired. The lesser tuberosity was debrided back to bleeding healthy bone and a Mitek 4.5 mm helix anchor was placed in the lesser tuberosity. Sutures were passed through the subcapulans in a combination of horizontal mattress and simple interrupted fashion and then tied. There was a partial-thickness tearing of the long head of the biceps. The biceps were released and then anchored in the intertubercular groove with a screw. There was a large anterior acromial spur with subacromial impingement. A CA ligament was released and acromioplasty was performed. Attention was then directed to the

supraspinatus tendon tear. The tear was V-shaped and measured approximately 2.5 cm from anterior to posterior. Two Smith & Nephew PEEK anchors were used for the medial row utilizing Healicoil anchors. Side-to-side stitches were placed. One set of suture tape from each of the medial anchors was then placed through a laterally placed Mitek helix PEEK knotless anchor which was fully inserted after tensioning the tapes. A solid repair was obtained. Next there were severe degenerative changes at the AC joint of approximately 8 to 10 mm. The distal clavicle was resected taking care to preserve the superior AC joint capsule. The shoulder was thoroughly lavaged. The instruments were removed and the incisions were closed in routine fashion. Sterile dressing was applied. The patient was transferred to recovery in stable condition.

What CPT coding is reported for this case?

### Options:

**A-** 29827, 29828-51, 29824-51, 29826

**B-** 29827, 29824-51, 29826-51

**C-** 29827, 29828-51, 29824-51, 29826, 29805-59

**D-** 29827, 29824-51, 29826-51, 29805-59

### Answer:

A

## Question 5

**Question Type:** **MultipleChoice**

View MR 001394

MR 001394

Operative Report

Procedure: Excision of 11 cm back lesion with rotation flap repair.

Preoperative Diagnosis: Basal cell carcinoma

Postoperative Diagnosis: Same

Anesthesia: 1% Xylocaine solution with epinephrine warmed and buffered and injected slowly through a 30-gauge needle for the patient's comfort.

Location: Back

Size of Excision: 11 cm

Estimated Blood Loss: Minimal

Complications: None

Specimen: Sent to the lab in saline for frozen section margin control.

Procedure: The patient was taken to our surgical suite, placed in a comfortable position, prepped and draped, and locally anesthetized in the usual sterile fashion. A #15 scalpel blade was used to excise the basal cell carcinoma plus a margin of normal skin in a circular

fashion in the natural relaxed skin tension lines as much as possible The lesion was removed full thickness including epidermis, dermis, and partial thickness subcutaneous tissues. The wound was then spot electro desiccated for hemorrhage control. The specimen was sent to the lab on saline for frozen section.

Rotation flap repair of defect created by foil thickness frozen section excision of basal cell carcinoma of the back. We were able to devise a 12 sq cm flap and advance it using rotation flap closure technique. This will prevent infection, dehiscence, and help reconstruct the area to approximate the situation as it was prior to surgical excision diminishing the risk of significant pain and distortion of the anatomy in the area. This was advanced medially to close the defect with 5 0 Vicryl and 6-0 Prolene stitches.

What CPT coding is reported for this case?

## Options:

**A-** 14001

**B-** 15271

**C-** 14001, 11606-51, 12034-51

**D-** 14001, 11606-51

## Answer:

A

# Question 6

**Question Type:** MultipleChoice

Patient has undergone open surgery for a left total knee arthroplasty. While in the recovery room, he continued to have severe postoperative pain. The surgeon ordered a femoral block for postoperative pain. The anesthesiologist evaluated the patient and performed a left femoral block, which provided significant post-operative pain relief.

What CPT coding is reported?

## Options:

**A-** 01404, 64450, 01996

**B-** 01380, 64447-59-LT

**C-** 01402, 64447-59-LT

**D-** 01402, 64448-59-LT, 01996

## Answer:

D

# Question 7

**Question Type:** MultipleChoice

A patient is taken to the radiology department for a radiological cardiac catheterization. An acute MI of the left anterior descending coronary artery is found. The cardiologist performs a suction thrombectomy, followed by atherectomy and a stent to the artery. A CRNA provides MAC for this patient, who is status P5.

What code/modifier combination would you report for the services of the CRNA?

### Options:

**A-** 01925-QZ-QS-P5

**B-** 00520-QZ-P5

**C-** 00520-QX-QS-P5

**D-** 01925-QZ-P5

### Answer:

A

# Question 8

**Question Type:** MultipleChoice

A patient presents to the labor and delivery department for a planned cesarean section for triplets. She is at 37 weeks gestation. She is given a continuous epidural for the delivery.

What anesthesia coding is reported?

### Options:

**A-** 01967, 01968

**B-** 01958

**C-** 01967

**D-** 01961

### Answer:

D

## Question 9

**Question Type:** MultipleChoice

A 65-year-old man had a right axillary block by the anesthesiologist. When the arm was totally numb, the arm was prepped and draped, and the surgeon performed tendon repairs of the right first, second, and third fingers. The anesthesiologist monitored the patient throughout the case.

What anesthesia code is reported?

### Options:

**A-** 01830

**B-** 01820

**C-** 01810

**D-** 01840

### Answer:

C

## Question 10

**Question Type:** **MultipleChoice**

A patient with malignant lymphoma is administered the antineoplastic drug Rituximab 800 mg and then 100 mg of Benadryl.

Which HCPCS Level II codes are reported for both drugs administered intravenously?

## Options:

**A-** J9312 x 80, J1200 x 2

**B-** J9312, J1200

**C-** J9312, Q0163

**D-** J9312 x 80, 00163 x 2

## Answer:

D