1. The patient fell and fractured his left femoral shaft in three places. The fracture is treated with an ORIF of the left femur with an intramedullary nail and interlocking screws (peritrochanterically). The orthopedist also places the leg in a plaster splint prior to leaving the OR. What CPT® code(s) is/are reported?
   a. 27245
   b. 27507, 29505
   c. 27513, 29505
   d. 27506

2. A patient is given Xylocaine, a local anesthetic, by injection in the thigh above the site to be biopsied. A small bore needle is then introduced into the muscle, about 3 inches deep, and a muscle biopsy is taken. What CPT® code is reported for this service?
   a. 20205
   b. 20206
   c. 20225
   d. 27324

3. A 63-year-old man presents with a neck mass to be excised. The neck mass was palpated and an incision was then made and carried down through the dermis with electrocautery. The subcutaneous tissue of the skin was opened encountering an organized mass with a benign appearance of a lipoma. Using careful blunt and sharp dissection, the mass measuring 5 cm was completely excised around its entire circumference leaving the capsule intact. The mass was removed from its posterior attachments using electrocautery. What CPT® code is reported for this procedure?
   a. 11426
   b. 21552
   c. 11626
   d. 21555

4. A 42-year-old with chronic right trochanteric bursitis is scheduled to receive an injection at the Pain Clinic. A 22-gauge spinal needle is introduced into the trochanteric bursa, and a total volume of 8 cc of normal saline and 40 mg of Kenalog (triamcinolone acetonide) is injected. What are the CPT® codes?
   a. 20610-RT, J3301 x 4
   b. 27093-RT, J3301 x 1
   c. 20550-RT, J3301 x 4
   d. 20611-RT, J3301 x 1

5. A patient presented with a closed, displaced supracondylar fracture of the left elbow. After conscious sedation, the left upper extremity was draped and closed reduction was performed, achieving anatomical reduction of the fracture. The elbow was then prepped and with the use of fluoroscopic guidance, two K-wires were directed crossing the fracture site and piercing the medial cortex of the left distal humerus. Stable reduction was obtained, with full flexion and extension. K-wires were bent and cut at a 90-degree angle. Telfa padding and splint were applied. What CPT® code(s) is/are reported?
   a. 24535-LT, 29105-LT
   b. 24538-LT
   c. 24582-LT
   d. 24566-LT, 29105-LT

6. This 45-year-old male presents to the operating room with a painful mass of the right upper arm. Upon deep dissection a large mass in the soft tissue of the patient's shoulder was noted. The mass appeared to be benign in nature. With deep blunt dissection and electrocautery, the mass was removed and sent to pathology. What CPT® code is reported?
   a. 23076-RT
   b. 23066-RT
   c. 23075-RT
   d. 23030-RT

7. The patient has a torn medial meniscus. An arthroscope was placed through the anterolateral portal for the diagnostic procedure. The patellofemoral joint showed grade 2 chondromalacia on the patellar side of the joint only, this was debrided with a 4.0-mm shaver. The medial compartment was also entered and a complex posterior horn tear of the medial meniscus was noted. It was probed to define its borders. A meniscectomy was carried out to a stable rim. What CPT® code(s) is/are reported?
   a. 29880
   b. 29870, 29877-59
   c. 29881, 29877-59
   d. 29881

8. A 50-year-old male had surgery on his upper leg one day ago to remove an intramuscular tumor and presents with heavy serous drainage from the wound. He was taken back to the operating room for evaluation of a possible bacterial infection. His wound was explored down to the rectus femoris muscle, and there was a hematoma discovered which was very carefully evacuated. The wound was irrigated with antibacterial solution, and the wound was closed in multiple layers. What CPT® and ICD-10-CM codes are reported?
   a. 10140-79, M96.810
   b. 27603-78, T81.40XA
   c. 10140-76, T81.9XXA
   d. 27301-78, M96.840

9. A 47-year-old patient was previously treated with external fixation for a Type IIIA left lateral condyle tibial fracture. There is now nonunion of the left proximal tibia, and he is admitted for open reduction of tibia with bone grafting. Approximately 30 grams of cancellous bone was harvested from the iliac crest. The fracture site was exposed and the area of nonunion was osteotomized, cleaned and repositioned. Intrafragmentary compression was applied with three screws. The harvested bone graft was packed into the fracture site. What CPT® and ICD-10-CM codes are reported?
   a. 27724-LT, S82.122N
   b. 27722-LT, S82.122S
   c. 27722-LT, S82.102N
   d. 27724-LT, S82.102C

10. An elderly female presented with increasing pain in her left dorsal foot. The patient was brought to the operating room and placed under general anesthesia. A curvilinear incision was centered over the lesion itself. Soft tissue dissection was carried through to the ganglion. The ganglion was clearly identified as a gelatinous material. It was excised directly off the bone and sent to pathology. There was noted to be a large bony spur at the level of the head of the 1st metatarsal. Using a double action rongeur, the spur itself was removed and sequestrectomy was performed. A rasp was utilized to smooth the bone surface. The eburnated bony surface was then covered utilizing bone wax. The wound was irrigated and closed in layers. What CPT® codes are reported?
   a. 28122-LT, 28090-51-LT
   b. 28111-LT, 28092-51-LT
   c. 28045-LT, 28090-51-LT
   d. 28100-LT, 28092-51-LT

ANSWER KEY

1. The patient fell and fractured his left femoral shaft in three places. The fracture is treated with an ORIF of the left femur with an intramedullary nail and interlocking screws (peritrochanterically). The orthopedist also places the leg in a plaster splint prior to leaving the OR. What CPT® code(s) is/are reported?
   a. 27245
   b. 27507, 29505
   c. 27513, 29505
   d. 27506

   ANS: D
   Rationale: Documentation shows the patient had a fracture of his left femoral shaft. The fracture was repaired with open reduction and internal fixation (ORIF) using an intramedullary nail and interlocking screws. Selection of codes depends on the fracture site and the method of treatment (closed, open, or percutaneous). The range of codes can be found in the CPT® Index by looking for Fracture/Femur/Peritrochanteric/Intramedullary Implant Shaft. Check the numeric section to select the correct code. Code 27245 is not correct, because this was not a peritrochanteric fracture; it is a femoral shaft fracture. The approach is from the peritrochanteric region. The application of the first cast or splint is included in 27506. See the guidelines for Application of Casts and Strapping in the CPT® codebook.

2. A patient is given Xylocaine, a local anesthetic, by injection in the thigh above the site to be biopsied. A small bore needle is then introduced into the muscle, about 3 inches deep, and a muscle biopsy is taken. What CPT® code is reported for this service?
   a. 20205
   b. 20206
   c. 20225
   d. 27324

   ANS: B
   Rationale: In the CPT® Index, look for Biopsy/Muscle. You are referred to 20200-20206. The biopsy is taken through the skin, or percutaneously, with a needle. Although the biopsy is deep, it is performed by percutaneous technique, which is reported with 20206

3. A 63-year-old man presents with a neck mass to be excised. The neck mass was palpated and an incision was then made and carried down through the dermis with electrocautery. The subcutaneous tissue of the skin was opened encountering an organized mass with a benign appearance of a lipoma. Using careful blunt and sharp dissection, the mass measuring 5 cm was completely excised around its entire circumference leaving the capsule intact. The mass was removed from its posterior attachments using electrocautery. What CPT® code is reported for this procedure?
   a. 11426
   b. 21552
   c. 11626
   d. 21555

   ANS: B
   Rationale: In the CPT® Index, look for Neck/Tumor/Excision. You are referred to 21552-21558. Review the codes to choose the appropriate service. 21552 is the correct code to report the excision of a 5 cm mass where the surgeon incised the subcutaneous tissue to remove the mass. Codes 11426 and 11626 are reported for removal of a benign or malignant lesion, not an internal mass.

4. A 42-year-old with chronic right trochanteric bursitis is scheduled to receive an injection at the Pain Clinic. A 22-gauge spinal needle is introduced into the trochanteric bursa, and a total volume of 8 cc of normal saline and 40 mg of Kenalog (triamcinolone acetonide) is injected. What are the CPT® codes?
   a. 20610-RT, J3301 x 4
   b. 27093-RT, J3301 x 1
   c. 20550-RT, J3301 x 4
   d. 20611-RT, J3301 x 1

   ANS: A
   Rationale: In the CPT® Index look for Injection/Bursa. You are referred to 20600-20611. Review the codes to choose appropriate service. 20610 is the correct code because the injection was given in the trochanteric bursa (hip, a major joint) without ultrasound guidance for drug therapy. The generic name for Kenalog is Triamcinolone Acetonide. In the HCPCS Level II codebook look for Triamcinolone Acetonide. Code J3301 is used for 10 mg of Kenalog. Report 4 units for 40 mg of Kenalog.

5. A patient presented with a closed, displaced supracondylar fracture of the left elbow. After conscious sedation, the left upper extremity was draped and closed reduction was performed, achieving anatomical reduction of the fracture. The elbow was then prepped and with the use of fluoroscopic guidance, two K-wires were directed crossing the fracture site and piercing the medial cortex of the left distal humerus. Stable reduction was obtained, with full flexion and extension. K-wires were bent and cut at a 90-degree angle. Telfa padding and splint were applied. What CPT® code(s) is/are reported?
   a. 24535-LT, 29105-LT
   b. 24538-LT
   c. 24582-LT
   d. 24566-LT, 29105-LT

   ANS: B
   Rationale: This is a supracondylar fracture of the elbow repaired by percutaneous fixation. In the CPT® Index look for Fracture/Humerus/Supracondylar/Percutaneous Fixation and you are referred to 24538. Modifier LT is appended to indicate the procedure is performed on the left side. The application of the first cast or splint is included in the fracture codes. See the guidelines before Application of Casts and Strapping in your CPT® codebook. Fluoroscopy guidance 76000, is listed as a separate procedure; therefore, is included in the procedure.

6. This 45-year-old male presents to the operating room with a painful mass of the right upper arm. Upon deep dissection a large mass in the soft tissue of the patient's shoulder was noted. The mass appeared to be benign in nature. With deep blunt dissection and electrocautery, the mass was removed and sent to pathology. What CPT® code is reported?
   a. 23076-RT
   b. 23066-RT
   c. 23075-RT
   d. 23030-RT

   ANS: C
   Rationale: Look in the CPT® Index for Excision/Tumor/Shoulder and you are referred to 23071-23078. Code 23075 reports the excision of a soft tissue mass (tumor), subcutaneous. The mass was removed with deep, blunt dissection; however, there is no mention of the depth and you cannot assume that the mass was subfascial because of the word deep. The measurement of the mass is not documented resulting in the default to the smallest measurement of less than 3 cm for code 23075. It is a rule of thumb that if a coder cannot ask the physician to document the size of a mass, lesion or repair in order to give the physician credit, the smallest measurement is reported. Modifier RT is appended to indicate the procedure is performed on the right side.

7. The patient has a torn medial meniscus. An arthroscope was placed through the anterolateral portal for the diagnostic procedure. The patellofemoral joint showed grade 2 chondromalacia on the patellar side of the joint only, this was debrided with a 4.0-mm shaver. The medial compartment was also entered and a complex posterior horn tear of the medial meniscus was noted. It was probed to define its borders. A meniscectomy was carried out to a stable rim. What CPT® code(s) is/are reported?
   a. 29880
   b. 29870, 29877-59
   c. 29881, 29877-59
   d. 29881

   ANS: D
   Rationale: In the CPT® Index look for Arthroscopy/Surgical/Knee. You are referred to 29866-29868, 29871-29889. Review the codes to choose appropriate service. 29881 is the correct code because the tear was in the medial meniscus. A meniscectomy as well as debridement with a shaver (or chondroplasty) were performed. 29877 is not reported as this is included in 29881. 29880 is not appropriate because a meniscectomy was not performed in both the medial and lateral compartments. The surgery started out as a diagnostic procedure but changed when the physician decided to perform surgical procedures on the knee.

8. A 50-year-old male had surgery on his upper leg one day ago to remove an intramuscular tumor and presents with heavy serous drainage from the wound. He was taken back to the operating room for evaluation of a possible bacterial infection. His wound was explored down to the rectus femoris muscle, and there was a hematoma discovered which was very carefully evacuated. The wound was irrigated with antibacterial solution, and the wound was closed in multiple layers. What CPT® and ICD-10-CM codes are reported?
   a. 10140-79, M96.810
   b. 27603-78, T81.40XA
   c. 10140-76, T81.9XXA
   d. 27301-78, M96.840

   ANS: D
   Rationale: In the CPT® Index look for Hematoma/Leg, Upper. You are referred to 27301. Verify the code for accuracy. Modifier 78 is appended to 27301 to indicate that an unplanned procedure related to the initial procedure was performed during the postoperative period. Use modifier 78 for a return to the OR for a complication in the global period of another procedure.

In the ICD-10-CM Alphabetic Index look for Complication/surgical procedure (on)/hematoma/post procedural – see Complication, postprocedural, hematoma. Look for Complication/post procedural/hematoma (of)/musculoskeletal structure/following musculoskeletal surgery M96.840. His wound was explored down to the level of the rectus femoris muscle; the excision of the mass was intramuscular. The code selection is specific to the location of the hematoma as well as the body system for which the procedure was performed. Review the code in the Tabular List for accuracy.

9. A 47-year-old patient was previously treated with external fixation for a Type IIIA left lateral condyle tibial fracture. There is now nonunion of the left proximal tibia, and he is admitted for open reduction of tibia with bone grafting. Approximately 30 grams of cancellous bone was harvested from the iliac crest. The fracture site was exposed and the area of nonunion was osteotomized, cleaned and repositioned. Intrafragmentary compression was applied with three screws. The harvested bone graft was packed into the fracture site. What CPT® and ICD-10-CM codes are reported?
   a. 27724-LT, S82.122N
   b. 27722-LT, S82.122S
   c. 27722-LT, S82.102N
   d. 27724-LT, S82.102C

   ANS: A
   Rationale: This is the repair of a nonunion of a tibial fracture. In the CPT® Index look for Nonunion Repair/Tibia, 27720, 27722, 27724, 27725. The correct code is 27724 for the repair of nonunion or malunion of the tibia; with iliac or other autograft (includes obtaining graft). Modifier LT is appended to indicate the procedure was performed on the left side.

   This was nonunion of a fracture of the tibia. In the ICD-10-CM Alphabetic Index, look for Fracture, traumatic/tibia/upper end/lateral condyle (displaced) referring you to S82.12-. The notes do not indicate displacement; however, the parentheses mean that displacement may or may not be noted in the documentation. In this case a type IIIA fracture is an open fracture. In the Tabular List the code is completed with seven characters. The 6th character 2 indicates laterality (left). The 7th character for fractures is used to identify the episode of care and the healing process. Documentation indicates a nonunion of Type IIIA fracture, and the appropriate 7th character is N subsequent encounter for open fracture Type IIIA, IIIB, IIIC with nonunion. The complete code is S82.122N.

10. An elderly female presented with increasing pain in her left dorsal foot. The patient was brought to the operating room and placed under general anesthesia. A curvilinear incision was centered over the lesion itself. Soft tissue dissection was carried through to the ganglion. The ganglion was clearly identified as a gelatinous material. It was excised directly off the bone and sent to pathology. There was noted to be a large bony spur at the level of the head of the 1st metatarsal. Using a double action rongeur, the spur itself was removed and sequestrectomy was performed. A rasp was utilized to smooth the bone surface. The eburnated bony surface was then covered utilizing bone wax. The wound was irrigated and closed in layers. What CPT® codes are reported?
   a. 28122-LT, 28090-51-LT
   b. 28111-LT, 28092-51-LT
   c. 28045-LT, 28090-51-LT
   d. 28100-LT, 28092-51-LT

   ANS: A
   Rationale: Look in the CPT® Index for Excision/Metatarsal/Head, and you are referred to 28110-28114, 28122, 28140, 28288. Code 28122 reports a partial excision or sequestrectomy of metatarsal bone. Next in the CPT® Index look for Lesion/Foot/Excision referring you to 28080, 28090. Code 28090 reports the excision of the ganglion of the foot. Modifier 51 is appended to indicate multiple procedures performed during the same session. Modifier LT is appended to indicate the procedure is performed on the left side.