CRIP Study Module

Section 3

Surgical Services and Procedures

The standard charge for a kidney transplant should represent the acquisition cost of a specific kidney.

a. True
b. False

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a. True
b. False

Transplant hospitals must develop two basic standard charges from the costs expected to be incurred in the acquisition of a kidney: the standard charge for acquiring a live donor kidney and the standard charge for acquiring a cadaver kidney.

When a transplant hospital bills the program for the transplant, it shows the standard kidney acquisition charge with a revenue code of _____.

a. 036X
b. 092X
c. 081X
d. 051X

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a. 036X
b. 092X
c. 081X
d. 051X

The donor physicians’ services must be billed to the account of the recipient.

a. True
b. False

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a. **True**
b. False

For live donor - the donor physicians' services must be billed to the account of the recipient. What is the modifier that should be appended to the claim?

a. Q3
b. Q1
c. Q2
d. QX

For live donor - the donor physicians' services must be billed to the account of the recipient. What is the modifier that should be appended to the claim?

a. **Q3**
b. Q1
c. Q2
d. QX

Standard kidney acquisition charges are billed on the UB-04 and are identified in Form Locator 42 by the appropriate revenue code:

a. 811 – Living donor kidney acquisition / 812 – Cadaver donor kidney acquisition
b. 360 – Living donor kidney acquisition / 361 – Cadaver donor kidney acquisition
c. 921 – Living donor kidney acquisition / 922 – Cadaver donor kidney acquisition
d. 801 – Living donor kidney acquisition / 802 – Cadaver donor kidney acquisition

Standard kidney acquisition charges are billed on the UB-04 and are identified in Form Locator 42 by the appropriate revenue code:

a. **811 – Living donor kidney acquisition / 812 – Cadaver donor kidney acquisition**
b. 360 – Living donor kidney acquisition / 361 – Cadaver donor kidney acquisition
c. 921 – Living donor kidney acquisition / 922 – Cadaver donor kidney acquisition
d. 801 – Living donor kidney acquisition / 802 – Cadaver donor kidney acquisition

If an interim bill is submitted, the standard acquisition charge should appear on the billing form for the period during which the transplant took place.

a. True
b. False

If an interim bill is submitted, the standard acquisition charge should appear on the billing form for the period during which the transplant took place.

a. **True**
b. False

See pages 4-2 through 4-5 for additional information on kidney transplants.

Heart and liver acquisitions are billed with the revenue code of 081X, which is the same as a kidney transplant.

a. True
b. False

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a. **True**
b. False

Autologous stem cell transplants uses:

a. Stem cells from a healthy donor
b. The patient’s own cells
c. A family member’s stem cells
d. None of the above

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a. Stem cells from a healthy donor
b. The patient's own cells
c. A family member's stem cells
d. None of the above

Allogeneic stem cell transplants uses:

a. Stem cells from a healthy donor
b. The patient’s own cells
c. A family member’s stem cells
d. None of the above

Allogeneic stem cell transplants uses:

a. **Stem cells from a healthy donor**
b. The patient's own cells
c. A family member's stem cells
d. None of the above

The stem cell transplant charges for the actual transplant will be placed on the UB-04 under revenue code _____.

a. 0362
b. 0360
c. 0812
d. 0811

The stem cell transplant charges for the actual transplant will be placed on the UB-04 under revenue code _____.

a. **0362 – Transplant other than kidney**
b. 0360
c. 0812
d. 0811

CMS developed an NCD for bariatric surgery – under the NCD which of the following surgeries are covered?

a. An open and laparoscopic Roux-en-Y Gastric Bypass
b. An open and laparoscopic Biliopancreatic Diversion with Duodenal Switch
c. A laparoscopic Adjustable Gastric Banding
d. An open Adjustable Gastric Banding
e. All of the above
f. A, B, & C

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b. An open and laparoscopic Biliopancreatic Diversion with Duodenal Switch
c. A laparoscopic Adjustable Gastric Banding
d. An open Adjustable Gastric Banding
e. All of the above
f. A, B, & C

All bariatric surgery procedures are considered inpatient only.

a. True
b. False

All bariatric surgery procedures are considered inpatient only.

a. **True**
b. False

A status indicator of _____ indicates inpatient only procedures.

a. N
b. C
c. J
d. K

A status indicator of ____ indicates inpatient only procedures.

a. N
b. C
c. J
d. K

Any inpatient-only procedure performed and billed as outpatient will not be paid by CMS. The inpatient only procedure should not be removed from the claim but billed for a denial.

Modifier ___ can be added when a patient has an inpatient only procedure as an outpatient in an emergent situation.

a. BA
b. DD
c. CA
d. KL

Modifier ____ can be added when a patient has an inpatient only procedure as an outpatient in an emergent situation.

a. BA
b. DD
c. **CA**
d. KL

In order for the facility to receive payment for a service billed with a CA modifier, which of the following conditions must be met?

a. The patient is an outpatient
b. The patient had an emergent, life-threatening condition
c. The procedure on the inpatient-only list is performed on an emergency basis to stabilize the patient
d. The patient expires without being admitted
e. All of the above

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b. The patient had an emergent, life-threatening condition
c. The procedure on the inpatient-only list is performed on an emergency basis to stabilize the patient
d. The patient expires without being admitted
e. **All of the above**

The FDA defines an implant as “A device intended to be implanted into a surgically or naturally formed cavity of the human body to continuously assist, restore, or replace the function of an organ system or structure of the human body for 60 days or more.”

a. True
b. False

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a. True
b. **False**

Supplies or drugs that are not actually administered to the patient are considered billable services provided the record has documentation to support the intention.

a. True
b. False

Supplies or drugs that are not actually administered to the patient are considered billable services provided the record has documentation to support the intention.

a. True
b. False

Supplies or drugs that are **not** actually administered to the patient are not considered billable services. This would include situations like accidentally dropping an item on the floor or opening an item and not using it.

The revenue code on the UB-04 used to report anesthesia services is _____.

a. 037X
b. 047X
c. 058X
d. 055X

The revenue code on the UB-04 used to report anesthesia services is _____.

a. **037X**
b. 047X
c. 058X
d. 055X

Revenue code 037X does not require a HCPCS code from CMS.

a. True
b. False

Revenue code 037X does not require a HCPCS code from CMS.

a. **True**
b. False

True – although, some payers such as Tricare, do request a code on the claim.

Appendix _____ of the CPT manual provides a list of procedure codes in which conscious sedation is considered inherent to the procedure.

a. Appendix F
b. Appendix C
c. Appendix G
d. Appendix H

Appendix _____ of the CPT manual provides a list of procedure codes in which conscious sedation is considered inherent to the procedure.

a. Appendix F
b. Appendix C
c. **Appendix G**
d. Appendix H

The UB-04 revenue used to report recovery room services is _____.

a. 077X
b. 071X
c. 070X
d. 072X

The UB-04 revenue used to report recovery room services is _____.

a. 077X
b. 071X
c. 070X
d. 072X

No cost devices are usually the result of which of the following:

a. There is a new device for the physician to sample
b. There is an indigent patient needing the device
c. The device failed while under warranty
d. There is a device recall
e. All of the above

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a. There is a new device for the physician to sample
b. There is an indigent patient needing the device
c. The device failed while under warranty
d. There is a device recall
e. **All of the above**

When billing for no cost devices, usually there is a token charge of $1 or less in the covered charge field.

a. True
b. False

When billing for no cost devices, usually there is a token charge of $1 or less in the covered charge field.

a. **True**
b. False

When billing for a replacement device (with full or partial credit) the condition code indicates why the replacement was needed. Which of the following condition codes represents that the device was not working properly and was replaced earlier than anticipated?

a. Condition code 49
b. Condition code 50
c. Condition code 53
d. None of the above

When billing for a replacement device (with full or partial credit) the condition code indicates why the replacement was needed. Which of the following condition codes represents that the device was not working properly and was replaced earlier than anticipated?

a. **Condition code 49**
b. Condition code 50
c. Condition code 53
d. None of the above

When billing for a replacement device (with full or partial credit) the condition code indicates why the replacement was needed. Which of the following condition codes represents the initial placement of a medical device was provided as part of a clinical trial or free sample?

a. Condition code 49
b. Condition code 50
c. Condition code 53
d. None of the above

When billing for a replacement device (with full or partial credit) the condition code indicates why the replacement was needed. Which of the following condition codes represents the initial placement of a medical device that was provided as part of a clinical trial or free sample?

a. Condition code 49
b. Condition code 50
c. **Condition code 53**
d. None of the above

When billing for a replacement device (with full or partial credit) the condition code indicates why the replacement was needed. Which of the following condition codes represents that the device was recalled by the FDA or the manufacturer and new device replacements are necessary (applied when credit is 50% or more)?

a. Condition code 49
b. Condition code 50
c. Condition code 53
d. None of the above

When billing for a replacement device (with full or partial credit) the condition code indicates why the replacement was needed. Which of the following condition codes represents that the device was recalled by the FDA or the manufacturer and new device replacements are necessary (applied when credit is 50% or more)?

a. Condition code 49
b. **Condition code 50**
c. Condition code 53
d. None of the above

See pages 4-25 through 4-27 for examples of reporting no cost devices.

Cardiac catheterization CPT codes are separated into how many code families?

a. One code family with distinct code guidelines
b. Two code families each with distinct coding guidelines – (CHD and non-CHD)
c. Three code families with the same guidelines (CHD, non-CHD and juvenile onset)
d. None of the above

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c. Three code families with the same guidelines (CHD, non-CHD and juvenile onset)
d. None of the above

Per CMA, most cardiac catheterization procedures are now coded with a CPT code that includes:

a. Most injection procedures
b. Imaging supervision, interpretation, and report
c. Contrast injection to image access site(s)
d. Closure device placement at the vascular access site
e. All of the above
f. A, B and C

Per CMA, most cardiac catheterization procedures are now coded with a CPT code that includes:

See pages 4-28 through 4-29 for more coding guidelines for cardiac catheterization.

a. Most injection procedures
b. Imaging supervision, interpretation, and report
c. Contrast injection to image access site(s)
d. Closure device placement at the vascular access site
e. **All of the above**
f. A, B and C

CMS guidelines state that, in order for an implantable automatic defibrillator to be covered, which of the following conditions must exist?

a. There has to be a documented episode of a cardiac arrest due to ventricular fibrillation
b. There has to be a documented, sustained ventricular tachyarrhythmia, which can be either spontaneous or induced by an electrophysiology study, that is not associated with an acute MI
c. The patient has a documented prior MI and a measured left ventricular ejection fraction >= 30%
d. All of the above

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c. The patient has a documented prior MI and a measured left ventricular ejection fraction >= 30%
d. All of the above

CMS guidelines state that, in order for an implantable automatic defibrillator to be covered, which of following must a patient *not* have an enzyme positive MI within:

a. The past month
b. The past 60 days
c. The past year
d. The past week

CMS guidelines state that, in order for an implantable automatic defibrillator to be covered, which of following must a patient *not* have an enzyme positive MI within:

a. **The past month**
b. The past 60 days
c. The past year
d. The past week