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Question: 1

A CIRCC® coder reviews a follow-up interventional radiology report after prior abdominal endovascular aneurysm repair. The final diagnosis states: "Persistent type II endoleak from lumbar artery collateral supply with enlarging excluded aneurysm sac. No rupture is documented."

Which diagnosis coding approach is most appropriate?

- A. Assign only history of aneurysm repair because the original EVAR was already completed
- B. Assign a complication code for endoleak after endovascular aneurysm repair as documented
- C. Assign congenital lumbar artery malformation because collateral flow is described
- D. Assign ruptured abdominal aortic aneurysm because the aneurysm sac has enlarged

Answer: B

Question: 2

A CT-guided procedure report states: "A percutaneous catheter was placed into a right lower-quadrant abscess. Purulent fluid was aspirated, the cavity was irrigated, and the drainage catheter was left in place to gravity drainage. CT confirmed catheter position."

Which coding approach best reflects the documented service?

- A. Report diagnostic aspiration only because fluid was removed for evaluation
- B. Report open incision and drainage because a catheter remained after the procedure
- C. Report only CT guidance because the catheter position was confirmed by imaging
- D. Report percutaneous abscess drainage with catheter placement and CT guidance as supported

Answer: D

Question: 3

A patient undergoes an interventional radiology procedure in the morning. Later the same day, the patient develops procedure-related bleeding that requires an unplanned return to the angiography suite by the same physician for control of hemorrhage. The return procedure is related to the original service and is separately documented.

Which modifier logic is most appropriate when payer rules require a postoperative-period modifier?

- A. Append modifier 58 because all same-day returns are planned staged procedures
- B. Append modifier 76 because the hemorrhage control is automatically the same procedure
- C. Append modifier 78 for an unplanned related return to the procedure room

D. Append modifier 52 because a complication-related procedure is always reduced

Answer: C

Question: 4

A patient with prior coronary artery bypass grafting undergoes PCI. The report documents drug-eluting stent placement in a stenotic saphenous vein graft to the obtuse marginal artery. No intervention is performed in the native obtuse marginal artery.

Which coding principle is most appropriate?

- A. Report PCI to the native obtuse marginal artery because the graft supplies that territory
- B. Report PCI to the bypass graft according to coronary graft intervention rules
- C. Report peripheral venous stent placement because a saphenous vein graft is made from vein
- D. Report diagnostic bypass graft angiography only because the graft was surgically created

Answer: B

Question: 5

A procedure note documents right common femoral venous access, catheter advancement through the right heart into the main pulmonary artery, selective right and left pulmonary angiography, and interpretation of pulmonary arterial images for suspected pulmonary embolism. No thrombolysis, thrombectomy, or stent placement is performed.

Which coding approach best reflects the documented service?

- A. Report coronary angiography because the catheter passed through the right side of the heart
- B. Report pulmonary thrombectomy because the indication was suspected pulmonary embolism
- C. Report diagnostic pulmonary angiography with the documented catheter-based pulmonary arterial imaging
- D. Report venous duplex ultrasound because the access route began in the femoral vein

Answer: C

Question: 6

A same-session coronary intervention report documents balloon angioplasty of the left circumflex artery followed by drug-eluting stent placement in the same coronary artery. No atherectomy is performed. The physician documents successful reduction of stenosis after stent deployment.

Which coding approach is most appropriate?

- A. Report the coronary stent intervention as the primary PCI service for that artery/

- B. Report atherectomy because balloon angioplasty was performed before the stent
- C. Report only diagnostic coronary angiography because the intervention followed imaging
- D. Report both angioplasty and stent placement separately for the same coronary artery

Answer: A

Question: 7

An ultrasound-guided abdominal procedure report documents a large volume of ascites. The physician advances a catheter into the peritoneal fluid collection, drains 4.8 liters of straw-colored fluid, removes the catheter, and applies a dressing. No indwelling catheter is left in place.

Which coding approach is most appropriate?

- A. Report diagnostic ultrasound only because the catheter was removed after drainage
- B. Report tunneled peritoneal catheter placement because the fluid volume was large
- C. Report paracentesis with imaging guidance when supported by the documented approach
- D. Report peritoneal abscess drainage because fluid was removed through a catheter

Answer: C

Question: 8

During implanted chest port placement, fluoroscopy shows the catheter tip initially directed into the azygos vein. The physician withdraws and redirects the catheter, positions the final tip at the cavoatrial junction, confirms aspiration and flushing, and completes port pocket closure.

Which coding approach best reflects the documented service?

- A. Report azygos vein embolization because the catheter entered the azygos vein during placement
- B. Report diagnostic venography only because fluoroscopy identified malposition during the case
- C. Report port revision separately because the catheter was redirected before pocket closure
- D. Report implanted venous port placement with final tip position documented at the cavoatrial junction

Answer: D

Question: 9

A claim edit denies separate payment for a guidance service billed with a catheter-based interventional radiology procedure. The procedure code descriptor and parenthetical guidance indicate that the imaging guidance is included in the primary procedure. The operative report documents that the same imaging was used only to perform the intervention.

Which action is most compliant?

- A. Remove the separately billed guidance code when CPT® instructions include it in the primary service
- B. Replace the procedure code with the guidance code because imaging was the key technical step
- C. Append modifier 59 to the guidance code because imaging was necessary for the procedure
- D. Resubmit the guidance code with modifier 22 because guidance increased physician work

Answer: A

Question: 10

A cardiac catheterization report documents selective coronary angiography followed by physician-supervised intracoronary acetylcholine administration to evaluate suspected coronary vasospasm. The physician documents induced focal spasm, repeat angiography after nitroglycerin, and interpretation of the response. No PCI is performed.

Which coding principle is most appropriate?

- A. Report coronary stent placement because induced spasm confirms a flow-limiting lesion
- B. Evaluate separate reporting of provocative vasospasm testing only when supported by code rules and documentation
- C. Report electrophysiology study because a pharmacologic challenge was performed
- D. Report coronary angioplasty because nitroglycerin relieved the angiographic narrowing

Answer: B

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