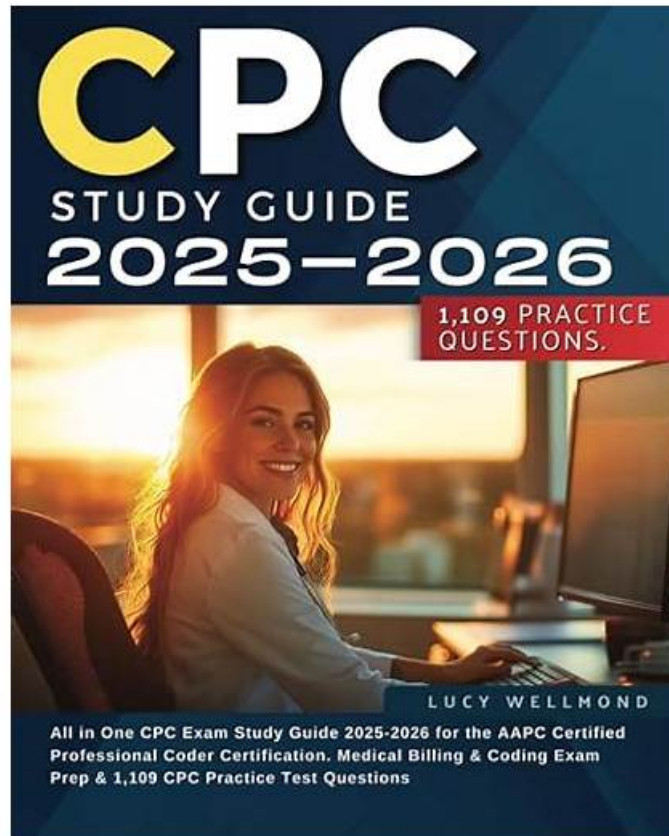


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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q74-Q79):

NEW QUESTION # 74

A patient is in labor with plans to deliver vaginally. An epidural is administered at 17:30. After several hours of pushing, the obstetrician determines that the cervix is swollen, and the baby must be delivered via a c-section. The patient consents, the baby is delivered, and both are discharged to the recovery room at 22:15. What CPT code(s) should the anesthesiologist report?

- A. 01967, 01968
- B. 01967, 01968, 99140
- C. 01967-23, 01968
- D. 01967-23, 01968, 99140

Answer: C

Explanation:

For a planned vaginal delivery with the use of an epidural, followed by a Cesarean delivery, the correct CPT codes are 10967 followed by add-on code 01968. CPT code 99140 is an add-on code portraying that the procedure was an emergency and that the patient and/or baby has a significant increase in the threat to life. The documentation gives no indication that these services were emergent. Modifier 23 is reported for unusual anesthesia services. This would include-but is not limited to-the use of general anesthesia for a procedure that usually requires only a local anesthetic or none and/or a procedure extending more than 4 hours. In this case, the total procedure time was 4.75 hours, and modifier 23 is appended on the primary procedure code only.

NEW QUESTION # 75

A patient is seen in the emergency room with a thermal burn to the left thigh because of a fire. The patient denies feelings of hypothermia. Vitals are obtained, and a physical examination reveals that approximately 4% of the body is affected by second-degree burns, and nonviable tissue needs to be removed to avoid the risk of infection. After consent is obtained, the physician debrides the wound, cleanses the area, and applies a gauze. The patient is discharged and told to follow up with their primary care physician in 2 days. What CPT code(s) should be reported for this encounter?

- A. 16020, 99282
- B. 0
- C. 99283-25, 16020
- D. 99282-25, 16020

Answer: C

Explanation:

When billing for physician services in the emergency room, it is appropriate to report a standalone E/M when the documentation supports its necessity in determining the need for appropriate treatment. Modifier 25 is necessary to the E/M code when being billed alongside a procedure and/or surgery to indicate a separately billable service. In this case, the documentation supports decision-making of moderate complexity. CPT code 99283 meets these criteria, whereas CPT code 99282 reflects a medical decision-making of low complexity and does not accurately portray the services rendered. The emergency room visit is always the first listed code, followed by the procedure and/or surgery performed.

NEW QUESTION # 76

A mammogram is done on a patient who has a lump on her right breast at 4 o'clock and a lump in her left breast at 6 o'clock. What CPT and ICD-IO-CM code(s) should be reported?

- A. 77067, D49.3
- B. 77067, D48.61, D48.62
- C. 77065-50, N63.13, N63.20
- D. 77066, N63.14, N63.25

Answer: D

Explanation:

CPT code 77067 is a screening mammogram. In this case, the mammogram would be diagnostic because the purpose is to rule out and/or make a diagnosis based on physical exam findings. Code 77065-50 is an inappropriate use of the modifier because there

exists a bilateral procedure code. A breast lump should only be coded to "mass" and not as a neoplasm unless specifically stated in the diagnosis. When deciphering the location of the mass, 12 O'clock is at the top of each breast, and the point of movement is clockwise. Therefore, 4 O'clock in the right breast is equivalent to the lower-inner quadrant, and 6 O'clock in the left breast is in the middle of the two lower quadrants.

NEW QUESTION # 77

A laboratory receives a pap smear as a screening for a patient's annual gynecological exam. A thin-layer preparation screened by an automated system with manual rescreening is performed. A pathologist interprets the results and confirms a diagnosis of high-grade squamous intraepithelial lesion. What should the laboratory report?

- A. 88175, 88141, Z01.419, R87.613
- B. G0148, R87.610
- C. G0148, G0141, Z12.4 R8.613
- D. 88175, Z12.4

Answer: A

Explanation:

The CPT codes for cytopathology smears are dependent on the payer and the method used to test the specimen. HCPC II G0148 does accurately describe the test method; however, this code is used for Medicare payers only. As the documentation does not specify that this is the case, it should be assumed that the carrier is non-Medicare. The appropriate non-Medicare CPT for this test method is 88175. CPT 88141 is always reported as a secondary code for the associated physician interpretation. Regarding the diagnosis, the primary ICD-IO-CM code should be synonymous with the reason for the encounter, which in this scenario would be the Gynecological exam (Z01.419).

Although Z12.4 does describe a screening of the cervix, it specifically is excluded from the diagnosis list "when the screening is part of general gynecological examination (Z01.4-Z01.42)." Any abnormal findings are reported as secondary and/or tertiary.

NEW QUESTION # 78

When it comes to documentation, which of the following is NOT an example of a moderate level of service?

- A. A physician changes the frequency of chemotherapy
- B. A physician reviews the most recent X-Ray
- C. A nurse practitioner reviews CBC, CMP, and tumor markers
- D. A new patient presents with lymphoma while undergoing treatment for melanoma

Answer: B

Explanation:

If a physician were to only review the most recent X-ray, the physician is only meeting one of the two categories in the amount and/or complexity of data reviewed and analyzed. Meeting only one of the categories contributes to a low level of medical decision-making. On the other hand, altering a drug management program, reviewing several unique tests, and/or addressing an exacerbation of a chronic illness, all contribute to a moderate level of medical decision-making.

NEW QUESTION # 79

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