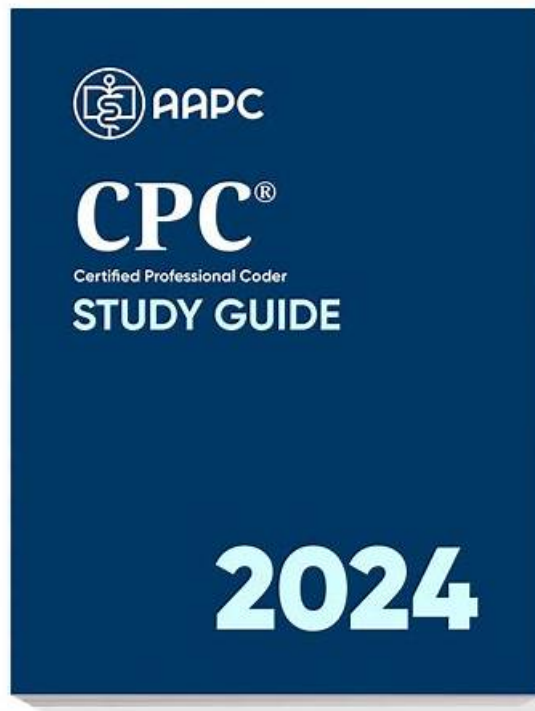


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## Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q29-Q34):

### NEW QUESTION # 29

A 92-year old female with Medicare part A coverage receives ongoing hospice care due to dementia. She goes to a physician's office to receive closed treatment of a hip dislocation following a fall. No anesthesia was used. How should the provider submit this claim?

- A. 27250, 99213-25, S73.003A
- B. 27250, S73.003A, W19XXXXA
- **C. 27250-GW, S73.003A, W19XXXXA**
- D. 27250-GW, 99202-25, S73.003A W19XXYUa

**Answer: C**

Explanation:

When a patient is receiving hospice care, Medicare will not reimburse the physician for services rendered that are unrelated to the terminal illness unless submitted with modifier GW. In Answers C and D, a separate, identifiable E/M is not to be billed because the procedure is considered minor (1- to 10-day global period) and includes an inherent E/M component.

#### **NEW QUESTION # 30**

A provider places a catheter on the right side of the heart chamber via an incision made on the lower left side of the patient's chest while performing a transcatheter mitral valve replacement. How should this encounter be coded?

- A. 0
- **B. 0484T**
- C. 0483T, 93451
- D. 0484T, 93451-59

**Answer: B**

Explanation:

0484T describes a transcatheter mitral valve replacement via a thoracic approach. CPT code

33430 describes a mitral valve replacement in which cardiopulmonary bypass is initiated. CPT code

0483T describes a transcatheter mitral valve replacement with a percutaneous approach; however, the documentation identifies a transthoracic incision. Catheterization is bundled into the procedure and is not separately identifiable unless the provider documents extenuating circumstances (i.e. no prior study available, inadequate visualization, etc.).

#### **NEW QUESTION # 31**

A surgeon performs a posterior fusion on the L2-L5 of the spine due to degenerative disc disease. CPT and ICD-IOOI code(s) should be reported?

- A. 22800, M51.37
- B. 22533, M51.37
- C. 22612, 22614x 3, M51.36
- **D. 22612, 22614x2, MSI.36**

**Answer: D**

Explanation:

The code for a joint fusion using a posterior approach is 22612. In this scenario, there are three fusion levels: L2-L3, L3-L4, and L4-L5. Following the primary code, 22614 would be billed twice and with no modifier because it is an add-on code. ICD-IO-CM code M51.37 is for degenerative discs in the lumbosacral region; however, L2-L5 is considered the lumbar region.

#### **NEW QUESTION # 32**

A 69-year-old patient with a medical history of diabetes is evaluated in the emergency room for a urinary tract infection. After performing a medically appropriate history and exam, the physician prescribes 100 mg of Macrobid every 12 hours and admits the patient to observation status to monitor for sepsis. After seeing an improvement in symptoms, the physician discharges the patient the following day. What CPT and ICD-IO-CM code(s) should be reported for the entirety of the patient's stay?

- A. 99284, 99238, E11.69, N39.O
- **B. 99221, 99238, N39.O, E11.9**
- C. 99234, N39.O, 397.89
- D. 99222, 99238, N39.O

**Answer: B**

**Explanation:**

When a patient is admitted into observation status from the emergency room, only the observation code is reported for that day. When observation extends past the initial date of service, the initial treatment would be reported with CPT codes 99221-99223. In this scenario, the appropriate level of service would be 99221, based on the moderate level of decision-making, which can be ascertained by the number and complexity of problems addressed and the risk of complications and/or morbidity or mortality of patient management. Discharge from observation on a separate date is reported with CPT codes 99238-99239. Because the diabetes is documented and is a coexisting chronic condition during the time of the encounter, it should follow the reason for admission. Due to a lack of specificity in the diabetes diagnosis, a causal relationship with a UTI is not presumed, and E11.69 should not be coded.

**NEW QUESTION # 33**

Which healthcare professional may NOT report medical nutrition therapy?

- A. Dietician
- B. Registered nurse
- C. Endocrinologist
- D. Nutritionist

**Answer: C**

**Explanation:**

Medical nutrition therapy describes nutritional assessments and interventions in a face-to-face or group patient setting and is reported with CPT codes 97802-97804. These codes are used by nonphysician healthcare professionals only. When a physician provides nutritional advice, a preventative service or evaluation and management code should be reported.

**NEW QUESTION # 34**

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