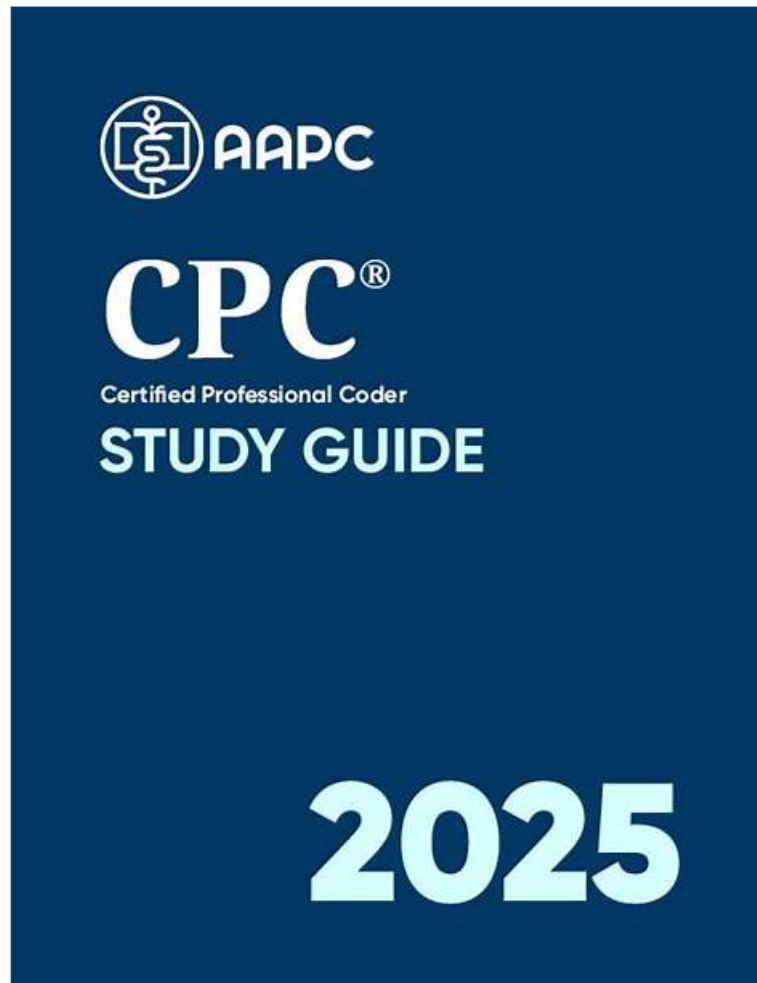


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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q94-Q99):

NEW QUESTION # 94

Assign the appropriate procedure and diagnosis codes for a biopsy of a posterior mediastinal mass that was obtained through an incision at the base of the neck.

- A. 39000, R22.2
- B. 39401, D49.89
- C. 39401, R22.1
- D. 39000, D38.3

Answer: A

Explanation:

The procedure performed was a mediastinotomy with a biopsy, represented by CPT 39000.

CPT code 39401 is reported for a mediastinoscopy, which is the insertion of a scope through an incision in the notch above the sternum. ICD-IO-CM crosswalk for a mass found on the chest wall is R22.-. Although the approach is cervical, the location of the mass is mediastinal, falling under the anatomical site of the trunk

NEW QUESTION # 95

What would NOT be included in a global obstetrical package?

- A. A patient complains of flu-like symptoms and is prescribed an antibiotic.
- B. Contraception following delivery is discussed at length.
- C. Sutures are removed from a first-degree perineal laceration during the delivery.
- D. A patient with anemia comes in to check hemoglobin levels.

Answer: A

Explanation:

The treatment of flu-like symptoms is considered a non-obstetric service, and a separate E/M can be billed for reimbursement. All other answer choices would be included in the global obstetrical package as routine care.

NEW QUESTION # 96

Based on the following documentation for an established patient, which CPT code should be reported?

Number and complexity of problems addressed: Moderate

Amount or complexity of data to be reviewed and analyzed: Straightforward Risk of complications, morbidity, or mortality of patient management: Low Total time: 35 minutes

- A. 0
- B. 1
- C. 2
- D. 3

Answer: B

Explanation:

When leveling a visit based on the documentation, the lower of the two highest components should be used to determine the level of complexity. In this case, because the number and complexity of problems addressed is moderate and level of risk of complications and/or morbidity or mortality of patient management is low, the MDM is low. On the other hand, because total time is documented and would constitute a higher level of service, total time should be used to select CPT 99214.

NEW QUESTION # 97

A physician documents a comprehensive electrophysiologic evaluation with an unsuccessful attempted induction of arrhythmia. Upon review, the bundle-of-His recording is missing. What code(s) should be reported?

- A. 93620-52
- B. 93619-52
- C. 0
- D. 93610, 93602, 93612, 93603, 93618

Answer: D

Explanation:

To bill a comprehensive electrophysiologic evaluation (93619-93622), the following five components must be documented: right atrial pacing (93610), right atrial recording (93602), right ventricular pacing (93612), right ventricular recording (93603), and bundle-of-His recording (93600). If the documentation does not support all five components, each study must be reported separately, as opposed to billing the procedure with a "reduced services" modifier. The exception to this rule would be if an add-on procedure were performed and required to be reported in addition to the comprehensive electrophysiologic evaluation. In this case, however, the attempted induction arrhythmia (93618) is not an add-on code and can be reported in addition to the primary procedures.

NEW QUESTION # 98

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

Answer: C

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 # 99

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