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affecting right dominant side.Per ICD-10-CM guideline I.C.9.d.1 because the right side was affected and we do not know the dominant side, the default for dominance is right

Four years post hepatic transplant, the patient is diagnosed with combined hepatocellular carcinoma and cholangiocarcinoma of the liver. What ICD-10-CM codes are reported?
a. T86.49, C80.2, C22.0, C22.1, Z94.4
b. C80.2, C22.0
c. C80.2, C22.0, C22.1, Z94.4
d. T86.49, C80.2, C22.0 - Answer d. T86.49, C80.2, C22.0

What is NOT an example of active treatment for pathological fractures?
a. Surgical treatment
b. Emergency department encounter
c. Evaluation and treatment by a new provider
d. Cast change - Answer d. Cast change

A patient was admitted three weeks following a normal vaginal delivery with a postpartum breast abscess. What ICD-10-CM code is reported?
a. O91.12
b. O91.22
c. N61.1

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q148-Q153):

NEW QUESTION # 148
Code the following adverse effect:
Initial encounter of drug-induced tremors that was caused by Cyclosporin the patient takes for anemi a. The anemia is caused by a current diagnosis of colon cancer.

- A. T45.1X5A G25.1, C18.9, D63.O
- B. C18.9, D63.O, G25.1, T45.1X5A
- C. D63.O, C18.9, T45.1X5A, G25.1
- D. G25.1, T45.1X5A, C18.9, D63.O

Answer: D

Explanation:
The correct sequencing of the code would be as follows: side effect of the drug. medication that caused the adverse effect and the underlying condition for why the drug is being taken. In this scenario, because the anemia is caused by a malignancy, ICD-IO-CM guidelines state that the malignancy should be the principal diagnosis "followed by the appropriate code for the anemia (such as D63.0, Anemia in neoplastic disease)."

NEW QUESTION # 149
Modifier 50 is not an appropriate modifier to append on CPT code 52000.

- A. False
- B. True

Answer: B

Explanation:
The statement is true. In general, modifier 50 is not appended on cystourethroscopies because human anatomy has only one bladder. However, if the descriptor includes "with ureteral catherization," the procedure can be performed tvvice and billed once with modifier 50 because there are two ureters. CPT 52000 does not include this descriptor.

NEW QUESTION # 150
Which healthcare professional may NOT report medical nutrition therapy?

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

Answer: B

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 # 151
Which service is NOT bundled into pediatric critical care CPT 99475?

- A. A blood transfusion is given to a 2-year-old patient with sickle cell disease.

- B. The doctor suspects meningitis on a 4-year-old patient and performs a lumbar puncture totest the fluid around the spinal cord.
- C. A suprapubic aspiration is performed on a 3-year-old patient who has blood in her urine.
- D. A central line is inserted to stabilize a 5-year-old patient in respiratory arrest.

Answer: D

Explanation:
A blood transfusion (CPT 36430, 36440), lumbar puncture (CPT (62270), and suprapubic aspiration (CPT 51100) are all considered inclusive to pediatric critical care services rendered on patients betvv'een the age of 2 and 5 years old. A complete list of all additional services can be found in the CPT Section Guidelines for Newborn and Pediatric Services. A central line insertion (CPT 36556) is not bundled into critical care services and may be reported separately.

NEW QUESTION # 152
A 92-year old female with Medicare part A coverage receives ongoing hospice care due to dementi a. 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-GW, 99202-25, S73.003A W19XXYuA
- B. 27250, 99213-25, S73.003A
- C. 27250-GW, S73.003A, W19XXXA
- D. 27250, S73.003A, W19XXXA

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 # 153
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