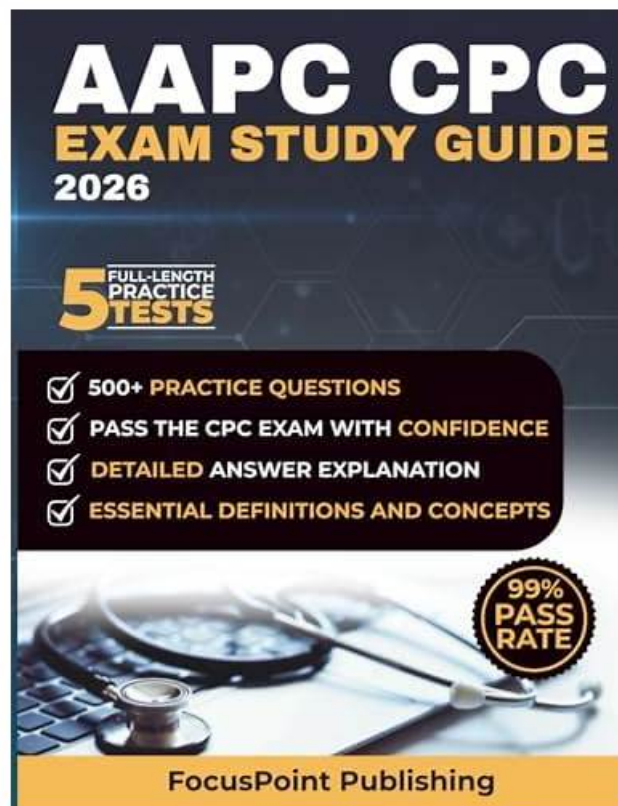


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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q69-

Q74):

NEW QUESTION # 69

Refer to the exhibit.

Refer to the supplemental information when answering this question:

View MR 065174

What E/M code is reported for this encounter?

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

Answer: A

Explanation:

To determine the correct E/M code, we need to consider the three key components: history, examination, and medical decision making (MDM).

History:

The documentation indicates an expanded problem-focused history. This is supported by the detailed history of present illness, including the patient's description of symptoms, family history, and review of systems with pertinent positives and negatives.

Examination:

The examination is also expanded problem-focused. The physician focused on the relevant systems (head, neck, throat) and documented specific findings related to the chief complaint (thyromegaly).

Medical Decision Making:

The MDM is straightforward. The physician is evaluating a new problem (bilateral thyroid nodules) with a low level of risk. Although further workup is planned, this alone doesn't automatically increase the MDM complexity.

Based on these components, 99213 is the most appropriate code.

Why other options are incorrect:

99212: Requires a problem-focused history and examination, which is less comprehensive than what was documented.

99214 and 99215: Require a higher level of MDM (low or moderate complexity) and/or a more detailed examination. The documentation doesn't support this level of service.

Reference:

CPT Codes 99211-99215: Office or other outpatient visit for the evaluation and management of an established patient

1995 and 1997 Documentation Guidelines for Evaluation and Management Services: These guidelines provide detailed criteria for selecting the appropriate E/M code based on history, examination, and MDM.

AAPC Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.

NEW QUESTION # 70

Eric is buying his first life insurance policy from XYZ Life Insurance Company. The company requires Eric have a physical exam prior to issuance of the policy. Eric sees his primary care provider who completes the required documentation and forms provided by the insurance company.

How does the primary care provider report his services?

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

Answer: D

NEW QUESTION # 71

Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1

Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.

Operation performed: Excision of right thigh benign congenital >1 nevus, excision size with margins 4.5 cm and closure size 5 cm.

Anesthesia: General.0

Intraoperative antibiotics: Ancef.0

Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks involved, which included but were not limited to risks of general anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.

Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient's right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.

This was passed to pathology for review. The wound required limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.

The patient was then cleaned and turned over to anesthesia for S extubation.

She was extubated successfully in the operating room and taken S to the recovery room in stable condition. There were no complications.

What is the radiology coding for this encounter?

- A. 73562-26
- B. 73560-26-LT
- C. 0
- D. 73560-LT

Answer: A

Explanation:

73562 = Knee X-ray, 3 views

-26 = Professional component only

NEW QUESTION # 72

(Full Case:Preoperative diagnosis:Low back pain; possible spinal stenosis L3-4.Postoperative diagnosis:No evidence of discogenic pathology or spinal stenosis at L3-4; normal discography L3-4.Procedure:Awake discography and injection, L3-4.Anesthesia:IV narcotic with reversal and local; propofol given transiently, then patient alert/responsive for pain response during injection.Technique:Patient to OR; right decubitus; sterile prep/drape; C-arm used to mark entry; local ethyl chloride + 1% Xylocaine; docking needle placed posterolateral at L3-4 under AP/lateral; inner needle advanced to disc nucleus center; contrast injected while monitoring patient response; normal bilocular pattern; 1.5 cc volume; no pain with pressurization.

Documentation:No videotape; plain films available; post-discography CT planned/reviewed for other causes.

Question:What CPT and ICD-10-CM coding is reported?)

- A. 62292, M48.07, M54.50
- B. 62290, M48.061, M54.50
- C. 62292, M54.50
- D. 62290, M54.50

Answer: D

Explanation:

This service is lumbar discography at a single level (L3-L4) with injection of contrast into the intervertebral disc under fluoroscopic (C-arm) guidance while the patient is awake/able to report symptoms, which is exactly what CPT 62290 describes for diagnostic discography at a lumbar level. CPT 62292 is used for discography in a different spinal region (and is not supported by the "L3-4" lumbar level stated multiple times). The post-discography CT scan is referenced as planned/reviewed but is not clearly documented as performed

/interpreted as part of this same physician service in the stem, and it is not part of the answer choices. For ICD-

10-CM, the confirmed postoperative finding is "normal discography," but the reason for the study remains the patient's low back pain and suspected stenosis; in outpatient/procedural settings you code the reason for the test when the definitive suspected condition is not confirmed. Here, the stenosis was ruled out ("no evidence"), so do not code spinal stenosis; report M54.50 for low back pain.

Therefore, 62290 with M54.50 is correct.

NEW QUESTION # 73

A patient who has colon adenocarcinoma undergoes an open partial colectomy. The surgeon removes the proximal colon and terminal ileum and reconnects the cut ends of the distal ileum and remaining colon. What procedure and diagnosis codes are reported?

- A. 44160, C18.2
- B. 44204, C18.2
- C. 44140, C18.9
- D. 44205, C18.9

Answer: A

Explanation:

1. Procedure and CPTCode Selection:

The patient underwent an open partial colectomy involving the removal of the proximal colon and terminal ileum with reconnection of the distal ileum to the remaining colon.

CPTCode 44160 is specific for an open partial colectomy with removal of a portion of the colon and the terminal ileum with an ileocolostomy (reconnection of the ileum to the colon). This accurately describes the procedure performed.

Code 44140 is for a partial colectomy without removal of the terminal ileum, making it inappropriate in this case.

Codes 44205 and 44204 involve laparoscopic approaches for colectomy procedures, but since this procedure was open, these codes are not suitable.

2. Diagnosis and ICD-10-CM Code Selection:

ICD-10-CM Code C18.2 is for a malignant neoplasm of the ascending colon, which is specified in this case as colon adenocarcinoma.

Code C18.9 represents an unspecified malignant neoplasm of the colon, which is less specific than C18.2.

Therefore, C18.2 is the most accurate choice based on the location of the adenocarcinoma.

3. AAPC and CPTCoding Guidelines:

Per AAPC guidelines, selecting the correct colectomy code involves identifying the specific approach (open vs. laparoscopic) and anatomical structures resected, both of which align with 44160 for this open ileocolic resection.

Thus, the correct answer, based on CPTand ICD-10-CM guidelines, is D. 44160, C18.2.

NEW QUESTION # 74

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