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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q77-Q82):

NEW QUESTION # 77
A patient who is experiencing rectal bleeding has a colonoscopy. Prior to the procedure, the provider administers general anesthesi a. What CPT code(s) should be reported?

- A. 45378-47
- B. 45378, 0081147
- C. 45382, 00811
- D. 0

Answer: A

Explanation:

The patient is having the colonoscopy done because they have been experiencing symptoms.
Therefore, the colonoscopy would be considered diagnostic versus screening. CPT crosswalk for a diagnostic colonoscopy is 45378. The documentation gives no indication that any bleeding was identified and controlled. When the surgeon performing the primary procedure is simultaneously administering anesthesia services, modifier 47 is appended rather than billing an additional anesthesia delivery code.

NEW QUESTION # 78
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: D

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 # 79
A sternal closure using sutures is considered inclusive to CPT 33255 and should not be reported separately.

- A. False
- B. True

Answer: B

Explanation:
The statement is true. Regardless of how a sternal closure is performed, it would be considered integral to this, and any other open cardiac procedure, when a sternal approach is used as the method of exposure. If a sternal closure were performed as the only procedure to repair an injury, the closure would then be reported.

NEW QUESTION # 80
A physician documents a comprehensive electrophysiologic evaluation with an unsuccessful attempted induction of arrhythmi a. Upon review, the bundle-of-His recording is missing. What code(s) should be reported?

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

Answer: B

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 # 81
A physician performs a simple repair on a Medicare patient who comes in with a 2.7 cm cut, an open wound, on the neck. The repair is made with Dermabond. Which CPT code(s) should be reported?

- A. G0168
- B. 99213-25, G0168
- C. 12002, G0168
- D. 0

Answer: A

Explanation:
When a wound is repaired with a tissue adhesive, Medicare accepts only the HCPC code G0168. Answers B and C accurately reflect the repair code for a commercial carrier. An E/M would not be added as an additional charge because the patient's encounter was only for the repair, thus eliminating answer D.

NEW QUESTION # 82
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