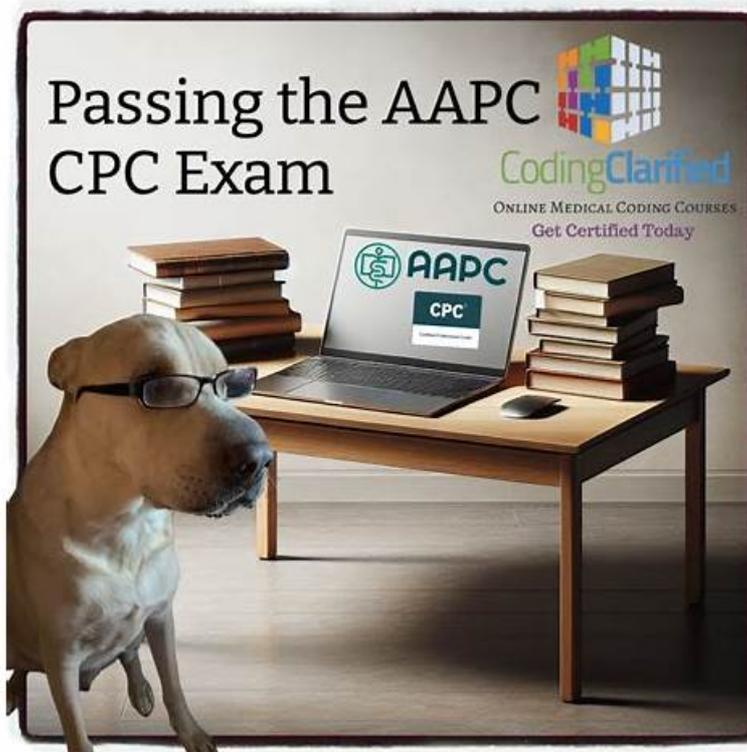


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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q56-Q61):

NEW QUESTION # 56

A diaphragm resection and repair are done using a biologic mesh to reduce the formation of adhesions. Which procedure code should be reported?

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

Answer: C

Explanation:

A diaphragm resection is reported with CPT codes 39560-39561. The use of a biologic mesh makes the repair complex, whereas a simple repair would implement only internal sutures.

NEW QUESTION # 57

A male patient is admitted with symptoms of a persistent cough and temperature of 101.2. A skin test reveals that the patient has tuberculosis. His medical history is positive for HIV. Assign the appropriate diagnosis codes for this patient.

- A. A18.4, R05.8, R50.9, B20
- B. B20, A15.9
- C. A18.4, Z21
- D. A15.9,

Answer: B

Explanation:

Tuberculosis (TB) can usually spread from the lungs to another site via the bloodstream.

Because the documentation does not specify whether the TB is primary or secondary, the coder would default to A15.9, as TB unspecified. A cough and fever are symptoms of an underlying illness and would not be coded because a definitive diagnosis of TB is present. Because TB is an HIV-related illness, B20 would be the first listed code.

NEW QUESTION # 58

The base unit for anesthesia CPT code 00600 is 10 units. If an anesthesiologist spends 105 minutes in the procedure room with a patient, how many units should be reported for reimbursement?

- A. 17 units
- B. 12 units
- C. 14 units
- D. 11 units

Answer: A

Explanation:

To calculate the total number of units, it is important to understand that anesthesia time is measured in 15-minute intervals (or in fractions thereof). In this scenario, take the total number of minutes spent on the procedure (105) and divide it by 15. The total number of time units is 7. The time units are then added to the base unit (10) for a total of 17 units.

NEW QUESTION # 59

A patient is seen in the emergency room with a thermal burn to the left thigh because of a fire. The patient denies feelings of hypothermia. Vitals are obtained, and a physical examination reveals that approximately 4% of the body is affected by second-degree burns, and nonviable tissue needs to be removed to avoid the risk of infection. After consent is obtained, the physician debrides the wound, cleanses the area, and applies a gauze. The patient is discharged and told to follow up with their primary care physician in 2 days. What CPT code(s) should be reported for this encounter?

- A. 99283-25, 16020
- B. 0
- C. 99282-25, 16020
- D. 16020, 99282

Answer: A

Explanation:

When billing for physician services in the emergency room, it is appropriate to report a standalone E/M when the documentation supports its necessity in determining the need for appropriate treatment. Modifier 25 is necessary to the E/M code when being billed alongside a procedure and/or surgery to indicate a separately billable service. In this case, the documentation supports decision-making of moderate complexity. CPT code 99283 meets these criteria, whereas CPT code 99282 reflects a medical decision-making of low complexity and does not accurately portray the services rendered. The emergency room visit is always the first listed code, followed by the procedure and/or surgery performed.

NEW QUESTION # 60

A 59-year-old male patient presents for a routine colonoscopy. During the procedure, a polyp is discovered. What is the proper ICD- 10-CM coding for this encounter?

- A. Z12.11
- B. K63.5, Z12.11
- C. Z12.11, K63.5
- D. K63.5

Answer: C

Explanation:

Because the reason for the visit was a routine colonoscopy, the "encounter for screening for malignant neoplasm of colon" (Z12.11) would be the first-listed code. ICD-IO-CM guidelines advise that if there is a finding during a screening, the finding may be used as an additional code. In this example, the colon polyp (K63.5) is a physical finding and would be listed as the secondary diagnosis.

NEW QUESTION # 61

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