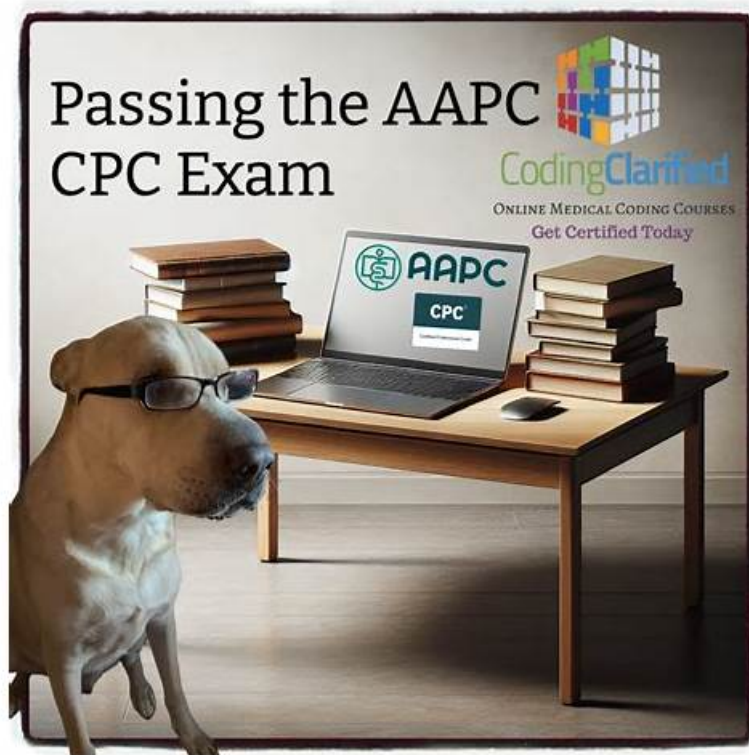


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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q49-Q54):

NEW QUESTION # 49

A gastroenterologist performs a gastric bypass surgery on an obese patient with a body mass index of 52. During the procedure, the size of the stomach is reduced by 77%; the intestine is bypassed from the duodenum and then attached to the ileum. The pylorus is

preserved and left intact. Which CPT code best describes the surgery performed?

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

Answer: A

Explanation:

In this scenario, the gastroenterologist performed a procedure known as a biliopancreatic diversion with duodenal switch (BPD/DS). A BPD/DS removes a portion of the stomach and transfers parts of the duodenum and small intestine to the lower end of the large intestine in an effort to limit intestinal absorption for weight loss. CPT codes 43842-43843 describe gastric restrictive procedures without gastric bypass. However, gastric bypass was done in rearranging the small intestine to connect to the ileum.

NEW QUESTION # 50

A physician provides a GIPO 39-weeks twin gestational patient with antepartum care, delivery, and postpartum care. Baby A was delivered vaginally without complications, and Baby B was delivered by Cesarean due to fetal tachycardia. Assign the correct ICD-10-CM and CPT codes.

- A. 59400, Z37.0 and 59510-51, 036.8332, Z37.0
- B. 59510, 076, Z3A39, Z37.0 and 59409-51, Z3A39, Z37.0
- C. 59410, Z37.2 and 59510-51, 076, Z37.2
- D. 59409, Z3A.39, Z37.0 and 59510-51, 076, Z3A39, Z37.0

Answer: B

Explanation:

The Cesarean delivery (59510) would be sequenced first because this code has the highest RVU and would include the antepartum and postpartum care. The vaginal delivery by itself (59409), without antepartum and postpartum care, would be reported secondary because the charges for the antepartum and postpartum care of the mother have already been included in the Cesarean delivery code.

NEW QUESTION # 51

Age, gender, height, and race are the four key factors in calculating a person's forced vital lung capacity (FVC). If FVC is calculated to be 3.00 L and anything under 80% is abnormal, what would be the cutoff value to a normal FVC?

- A. 3.2 L
- B. 2.8 L
- C. 2.0 L
- D. 2.4 L

Answer: D

Explanation:

A forced vital capacity test is the maximum amount of air that can be exhaled from the lungs and is used to determine whether there is an obstruction in the lungs. To calculate the abnormality, take 0.8 (80%), and multiply it by 3.00 (liters). Anything less than 2.4 L would be considered an abnormal result in this scenario.

NEW QUESTION # 52

Code the following physician's note:

A 14-year-old established patient is seen with mother to evaluate five 2 cm superficial lacerations to the left wrist. Patient admits to suicidal thoughts.

Lacerations were treated with Steri-Strips. Patient and mother counseled on suicide prevention and told to follow up with psych.

- A. 12004, S61.512A, T14.91XA
- B. 99213, S61.512A, R45.8S1
- C. 99214, S61.512A, T14.91XA

- D. 12004, S61.512A, R45.851

Answer: B

Explanation:

When the injury is treated with Steri-Strips or bandages, it should be reported with an E/M code and not a procedure code. Within the medical decision making, the number and complexity of problems addressed is low, the amount of data reviewed or analyzed is straightforward, and the risk of complications and/or morbidity or mortality of patient management from the injuries is low.

Therefore, the E/M is a 99213 because the medical decision-making is low. A suicide attempt would not be coded because the documentation is not specific as to whether the lacerations were an attempt at suicide.

NEW QUESTION # 53

A 69-year-old patient with a medical history of diabetes is evaluated in the emergency room for a urinary tract infection. After performing a medically appropriate history and exam, the physician prescribes 100 mg of Macrobid every 12 hours and admits the patient to observation status to monitor for sepsis. After seeing an improvement in symptoms, the physician discharges the patient the following day. What CPT and ICD-IO-CM code(s) should be reported for the entirety of the patient's stay?

- A. 99234, N39.O, 397.89
- **B. 99221, 99238, N39.O, ELL9**
- C. 99222, 99238, N39.O
- D. 99284, 99238, ELL69, N39.O

Answer: B

Explanation:

When a patient is admitted into observation status from the emergency room, only the observation code is reported for that day.

When observation extends past the initial date of service, the initial treatment would be reported with CPT codes 99221-99223. In this scenario, the appropriate level of service would be 99221, based on the moderate level of decision-making.

which can be ascertained by the number and complexity of problems addressed and the risk of complications and/or morbidity or mortality of patient management. Discharge from observation on a separate date is reported with CPT codes 99238-99239.

Because the diabetes is documented and is a coexisting chronic condition during the time of the encounter, it should follow the reason for admission. Due to a lack of specificity in the diabetes diagnosis, a causal relationship with a UTI is not presumed, and ELL69 should not be coded.

NEW QUESTION # 54

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