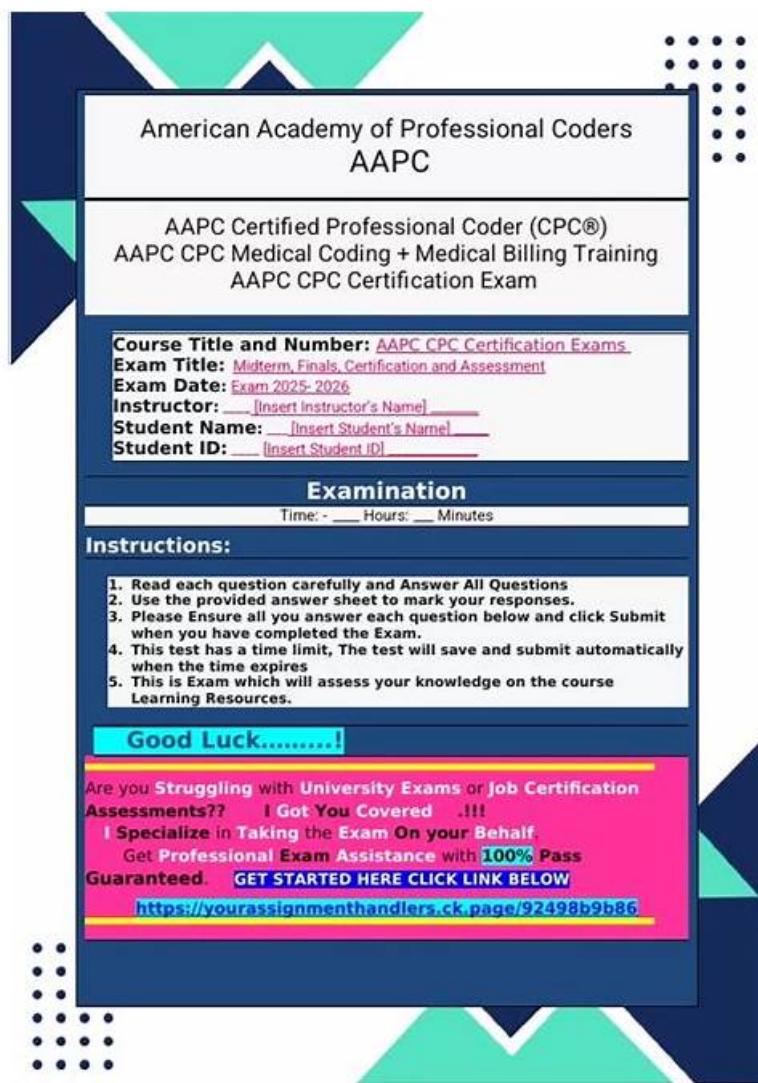


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## Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q30-Q35):

### NEW QUESTION # 30

Which service is NOT included in the central nervous system assessment?

- A. Clinical dementia rating
- B. Discussion of suicidal intentions
- C. Review of an advance care plan
- D. Prescription for an opioid

**Answer: D**

Explanation:

A central nervous system assessment is comprised of multiple screenings that are reported with CPT codes 96105-96146 and includes, but is not limited to, the following elements: use of standardized instruments for staging and rating clinical dementia; evaluation for behavioral symptoms using standardized screening instruments; and development, updating, revision, and/or review of an Advance Care Plan. A review of high-risk medications is also included in the central nervous system assessment; however, if in the same encounter a prescription is issued, the clinician should document and report the treatment with an appropriate E/M.

### NEW QUESTION # 31

A female patient with type II diabetes, asthma, and hypertension is admitted with complaints of chest pain. Testing rules out heart attack and other underlying conditions as the cause. Which diagnosis codes should be listed on the discharge note?

- A. Z03.89
- B. Z03.89
- C. R07.9, E11.9, J45.909, 110
- D. R07.9

**Answer: C**

Explanation:

The primary diagnosis on an inpatient record would be the primary reason the patient was admitted. In this case, because a definitive diagnosis could not be confirmed, the symptom of chest pain would be selected instead. The previously confirmed chronic conditions would also be coded because they affect the management of inpatient care. Diabetes would be coded to an unspecified code because the term "with" implies a causal relationship between the conditions that is not implicitly documented. Per ICD-IO-CM guidelines, a rule-out code is not assigned when "any signs or symptoms related to the suspected condition are present."

### NEW QUESTION # 32

Assign the appropriate CPT codes for the following surgical note: A 15-year-old patient is being treated for obstructive sleep apnea and adenoid tissue hypertrophy. After being placed under general anesthesia, a dental mirror is placed in the oropharynx to allow visualization of the nasopharynx. Suction electrocautery is used to remove the adenoid tissue that regrew after the initial adenoidectomy. Attention is then turned to the tonsils. The plane of tissue between the tonsillar capsule and the underlying muscles are cauterized, and the tonsils are removed. Bleeding is controlled by silver nitrate and gauze packing. Procedure is completed without complications, and patient is discharged to recovery.

- A. 42821, G47.33, 135.2
- B. 42826, 42831-59, 135.2, G47.33
- C. 42826, 42836-51, 135.2, G47.33
- D. 42999, 647.33, 135.2

**Answer: A****Explanation:**

An adenoidectomy and a tonsillectomy were performed in this surgical encounter (the root word -ectomy literally means the surgical removal of an anatomical structure). The adenoidectomy was done first and, if coded alone, would fall under one of E/M categories: primary (CPT 42830-42831) or secondary (CPT 42835-42836). A primary adenoidectomy refers to the initial removal of the adenoid, whereas a secondary adenoidectomy occurs when adenoid tissue that was once removed has grown back. Because the documentation states that "the adenoid tissue ... regrew after the initial adenoidectomy," a coder can infer that this procedure is secondary. However, distinguishing between the two procedures is not necessary when done in conjunction with a tonsillectomy because the procedures are bundled into two nonspecific CPT codes (42820 and 42821).

Billing for an adenoidectomy and a tonsillectomy separately, as shown in answers A and C, is considered unbundling and is not allowed under the Correct Coding Initiative (CCI) edits.

Regarding the sequencing of the diagnoses, ICD-IO-CM guidelines state that when two conditions meet the definition for principal diagnosis, either can be sequenced first. In this scenario, J35.2 or G47.33 could have been first listed because the procedures were to resolve both conditions in the same encounter.

**NEW QUESTION # 33**

A patient is having difficulties breast-feeding and receives a lactation consultation by a certified lactation consultant under the general supervision of a mid-level practitioner. How should this service be reported?

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

**Answer: B****Explanation:**

CPT 98960 is used by nonphysician healthcare professionals who provide education to patients that enable them to self-manage established conditions. CPT 99078 could also be used to report lactation services, but these are specifically rendered in a group setting. CPT 98966 is used for healthcare management via the telephone, and CPT 99211 is not considered the most appropriate descriptor for services rendered in this instance.

**NEW QUESTION # 34**

The appendix is removed through an abdominal incision due to metastatic colon malignancy. How should this be reported?

- A. 44970, C18.9, C78.5
- B. 44970, C78.5
- C. 44950, C78.5
- **D. 44950, C78.5, C18.9**

**Answer: D****Explanation:**

An open appendectomy procedure is reported with CPT 44950. A metastatic colon malignancy is a cancer that began in the colon but has spread to other areas. In this scenario, that means that the primary malignancy is the colon, and the secondary malignancy is the appendix.

Additionally, ICD-IO-CM guidelines state that when "treatment is directed toward the metastatic site only, the metastatic site is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code." The malignancy codes do not specifically state

"appendix," but the ICD-IO-CM coding crosswalk in the neoplasm table assigns this diagnosis as C78.5 secondary malignant neoplasm of large intestine and rectum.

**NEW QUESTION # 35**

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