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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q36-Q41):

NEW QUESTION # 36
Code the following note:
A male patient with a medical history of chronic obstructive pulmonary disease (COPD) presented to the emergency room 3 days ago with tachycardia and shortness of breath. He was intubated and admitted with acute respiratory failure (ARE) due to an acute exacerbation of COPD. Upon follow-up with the patient today, dark sputum was noted in the intubation tube, and testing confirmed aspiration pneumoni a. I will start him on 875 mg of amoxicillin every 12 hours and follow up tomorrow.

- A. 99231, 169.0, 196.00, 144.1
- B. 99232, 196.00, 144.1, 169.0
- C. 99232, 144.1, 196.00, 169.0, ROO.O

- D. 99233, 169.0

Answer: B

Explanation:
This documentation supports a decision-making of moderate complexity (number and complexity of problems addressed: high; amount and/or complexity of data to be reviewed and analyzed: minimal: diagnostic procedures and management examples: moderate), making CPT
99232 the most accurate description of services rendered. Regarding selection and sequencing of the diagnoses, always select the reason for the admission as the primary diagnosis code. In this case, the patient was admitted for ARF 096.00). The secondary code would be the underlying COPD
044.1), and conditions arising after admission would be tertiary and so forth. Tachycardia would not be reported because it is a symptom of ARF and symptoms are not reportable when the underlying disease has been confirmed.

NEW QUESTION # 37
The appendix is removed through an abdominal incision due to metastatic colon malignancy. How should this be reported?

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

Answer: A

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 # 38
Which option would best fall under a level II HCPC code?

- A. Advanced life support
- B. A malignant neoplasm
- C. Diagnostic colonoscopy
- D. Radiation treatment management

Answer: A

Explanation:
A level II HCPC code describes medical devices, supplies, medication, and/or other services that a provider and/or entity used during a service provided to a patient. Advanced life support (ALS) fits this description because it is a set of life-saving protocols administered in transit.
Radiation treatment management and a diagnostic colonoscopy describe a level I HCPC code, otherwise known as a CPT code. If the patient was asymptomatic and the colonoscopy was for screening purposes only, a level II HCPC code could be assigned. However, a diagnostic procedure implies a past medical/family history that puts the patient at risk and/or symptoms that warrant the procedure. A malignant neoplasm describes an ICD-IO-CM code because it is a diagnosis.

NEW QUESTION # 39
Which patient is receiving critical care services?

- A. A 93 -year-old male is admitted to the intensive care unit for monitoring after a coronaryangioplasty procedure that was performed to relieve symptoms of atherosclerosis.

- B. A 67 -year-old female receives chronic ventilator therapy after a cerebral infarction thatcaused hemorrhage in the brain.
- C. A 60-year-old male is admitted with an acute chronic heart failure exacerbation causinghypoxic respiratory failure. The patient is intubated, sedated, and started on 50 mg ofertapenem for a potential lung infection.
- D. A 47 -year-old female with a history of unrepaired chronic heart disease and anemia has anoxygen saturation level of 80. She is put on a nasal cannula and given a blood transfusion toimprove her oxygen-carrying capacity and oxygen saturation level.

Answer: C

Explanation:
CPT guidelines define critical care as an illness or injury that acutely impairs one or more vital organ systems, where there is a high probability of imminent or life-threatening deterioration in the patients condition. Additionally, to report a critical care service, the documentation should provide evidence of high-complexity medical decision-making (e.gendotracheal tube insertion, defibrillation, fluid administration for shock, Narcan, etc.). Answer B is the only option listed that contains documentation to support critical care services.
This male patient has Vyvo life-threatening conditions, in which emergent intervention is provided to prevent further deterioration. In ansvver A the female patient may have a life-threatening condition: however, administering oxygen via a nasal cannula and/or transfusing blood does not qualify as critical care. Management of a patient who receives chronic ventilator therapy is also not considered critical care because the medical decision-making involved in the therapy is quite low.
The care a patient receives after having surgery would be considered routine and postoperative, regardless of where they are sent, unless a complication arises in which one or more of the vital organ systems begins to deteriorate in a fashion that poses a threat to life.

NEW QUESTION # 40
A 72 -year-old patient is admitted due to atrial fibrillation. A comprehensive electrophysiology study is completed with fluoroscopic guidance, followed by a cardiac catheter ablation during the same procedure. The procedure took 22 minutes, and the patient was moderately sedated. Which CPT codes should the cardiologist report?

- A. 93656, 99152
- B. 93656, 77001, 99152, 99153
- C. 93650, 93619-26-59, 77001, 99152, 99153
- D. 93650, 93619-26-59, 99152

Answer: A

Explanation:
It is common practice to perform both an electrophysiology (EP) study and a cardiac ablation procedure in the same session. These procedures have been bundled in the CPC manual, and the coding of such is dependent on the type of arrhythmia being treated. The EP study and cardiac ablation are not to be reported separately. In this scenario, the patient has atrial fibrillation, which is reported with CPT 93656. When fluoroscopy is used for guidance rather than for diagnostic imaging, it is usually not reported separately from the primary procedure. Moderate sedation can be reported when used, and selection is based on time. CPT 99152 and 99153 are counted in 15-minute intervals. lvVhen the procedure does not fall on a 15-minute interval, it must at least meet the halfway point of the time stated to be reported.

NEW QUESTION # 41
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Coder.

Programmers coming from another background, such as Visual Basic, AAPC-CPC Reliable Exam Cost will find most of the concepts familiar and all of the syntax very different—you will want to read this chapter very carefully.

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