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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q33-Q38):

NEW QUESTION # 33

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

Answer: D

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 # 34

Assign the CPT codes for the following surgical note:

A patient who is confirmed to have lymphoma is placed under general anesthesia. A flexible bronchoscope is first inserted through the oral cavity to determine if the primary carcinoma has spread to the lung tissue. No lesions are observed in the bronchus, and the bronchoscope is removed. An incision is then made in the parasternal second left intercostal space, thus exposing the anterior mediastinal lymph nodes. Tissue samples from the lymph nodes are removed without complication. The incision is closed with sutures, and the patient is discharged to recovery.

- A. 39010, 31623-51
- B. 39402, 31623-51
- **C. 39010, 31622-51**
- D. 39402, 31622-51

Answer: C

Explanation:

The first procedure documented is a bronchoscopy, reported with CPT codes 31622-31654.

Because the procedure was specifically aimed at confirming a diagnosis based off a previously confirmed malignancy, the bronchoscopy would be considered diagnostic (CPT 31622). The second procedure performed is a mediastinotomy with removal of cancerous tissue. An incision made into the parasternal intercostal space is considered transthoracic, making the correct procedure code

39010. Sequencing is based off the highest RVU value, and modifier 51 is appended to the bronchoscopy procedure code to indicate that multiple procedures were performed in the same session.

NEW QUESTION # 35

A patient is referred to a radiology clinic with a diagnosis of chest bruising. A radiologist who works for the clinic performs a 3-view x-ray on the patient's ribcage bilaterally. The radiologist interprets images and determines that there is a right-sided stress fracture to one rib. Which ICD-IO-CM and CPT codes should be reported for this encounter?

- A. 71110-26, M84.48XA
- B. 71110, S22.31Y.4
- **C. 71110, M84.48XA**
- D. 71110-26, S22.31Y.A

Answer: C

Explanation:

Modifier 26, indicating only a professional component of the study, would be inappropriate because the radiologist who obtained the images and interpreted the results works for the clinic that owns the x-ray machines. By reporting the procedure without a modifier, the clinic is requesting 100% reimbursement of the study, which includes the technical and professional components. When searching the index in the ICD-IO-CM book a stress fracture is related to fatigue and is coded as a bone disorder as opposed to an injury.

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 (ARF) 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 pneumonia. I will start him on 875 mg of amoxicillin every 12 hours and follow up tomorrow.

- A. 99232, 144.1, 196.00, 169.0, R00.0
- B. 99231, 169.0, 196.00, 144.1
- C. 99233, 169.0
- **D. 99232, 196.00, 144.1, 169.0**

Answer: D

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

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

- A. Discussion of suicidal intentions
- B. Review of an advance care plan
- C. Clinical dementia rating
- **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 # 38

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