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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q114-Q119):

NEW QUESTION # 114

A patient has a colonoscopy in which the provider removes three polyps from the transverse colon. The first polyp is removed by means of a hot snare technique, and the following two polyps are removed using hot biopsy forceps. What CPT code(s) should be reported for this encounter?

- A. 45385, 45384-59, 45384-59
- **B. 45385, 45384-59**
- C. 0
- D. 1

Answer: B

Explanation:

When coding colonoscopies, remember that the number of removal techniques is what has a bearing on code selection and not the number of lesions and/or polyps that are being removed. In this case, two techniques are being used: 1) the snare technique (CPT 45385) and 2) the hot biopsy forceps technique (CPT 45384). Modifier 59 is appended onto the secondary code to indicate that separate polyps were removed by two different techniques. CPT 45388 is reported when a provider uses any methods other than snare and hot biopsy forceps to remove a lesion and/or polyp.

NEW QUESTION # 115

A radiation oncologist reviews the port films, dose delivery, and treatment parameters of a 52-year-old female patient who has received external beam therapy three times in the current week. He also spends 15 minutes examining the patient and collecting an intake of her response to the treatment program. Which CPT code(s) should the physician report?

- A. 77435, 99213-25
- B. 99213-25, 77401x3units
- **C. 0**
- D. 1

Answer: C

Explanation:

Treatment management of a patient undergoing radiation therapy is reimbursed by reporting CPT codes 77427-77470. Treatment management includes a review of the port films, dosimetry, dose delivery, treatment parameters, a physical examination, and related counseling. It would therefore not be appropriate to bill for a separate evaluation and management. CPT 77435 describes treatment management for a course of stereotactic body radiation therapy (SBRT), which the patient is not receiving. CPT 77401 describes the actual radiation and not the evaluation from the physician. CPT 77431 is reported when the entire course of therapy consists of one or two treatment sessions; however, a coder can infer from the documentation that the patient in this scenario has or will receive multiple sessions over the course of one or more weeks. Additionally, CPT guidelines advise that only three treatment sessions must occur to support the face-to-face encounter described in CPT 77427.

NEW QUESTION # 116

A low-risk obstetrical patient is told to come in for weekly ultrasounds in her first trimester. This is an example of what?

- A. Abuse
- **B. Waste**
- C. Fraud
- D. Misuse

Answer: B

Explanation:

In this case, the patient is not at risk, and most organs either are not developed and/or cannot be visualized in the first trimester. Thus, this would constitute as waste due to the provider overutilizing services that result in unnecessary cost. AAPC defines fraud as purposely billing "for services that were never given or to bill for a service that has a higher reimbursement than the service provided." Abuse is payment for services "that are billed by mistake by providers."

NEW QUESTION # 117

CPT code 11102 is a column 2 code that has an NCCI edit of 1 when paired with CPT code 11402. How would this be interpreted?

- A. If being billed together, only report one unit of each.
- B. The two codes are exclusive of each other and can never be billed together.
- C. The two codes are inclusive of each other and can never be billed together.
- D. The two codes can be billed together with an appropriate modifier.

Answer: D

Explanation:

NCCI stands for National Correct Coding Initiative and was created by CMS to prevent unbundling and prevent incorrect payments. Column one represents a correct code when listed next to column two. There are three edits listed with the combination of the two columns: 0, 1, and

9. Edit 0 means that the two codes should never, under any circumstance, be reported together. Edit 1 means that the procedures may be coded together with the use of a modifier. Edit 9 means that the edit does not apply.

NEW QUESTION # 118

Code the excision of a large goiter extending into the chest cavity using a transthoracic approach.

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

Answer: B

Explanation:

A goiter is an abnormal enlargement of the thyroid gland. The removal of that gland is a thyroidectomy, represented by CPT codes 60240-60271. CPT 60270 is selected based on the approach used. CPT codes 21602 and 32900 are obtained by using the coding crosswalk for resection of the chest wall and describe the removal of a tumor and one or more ribs. CPT 32140 is a thoracotomy, which involves pulling apart the ribs to reach and remove a lung cyst.

NEW QUESTION # 119

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