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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q138-Q143):

NEW QUESTION # 138

Which type of anesthesia is NOT separately reportable?

- A. Spinal anesthesia
- B. Monitored anesthesia care
- C. Metacarpal blocks
- D. Regional anesthesia

Answer: C

Explanation:

CPT surgery guidelines uphold that local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia is always included in the surgical package. Under monitored anesthesia care (MAC), a patient is sedated but typically still aware, and the presence of qualified anesthesia personnel is required. Spinal and regional anesthesia is used for a variety of different procedures and is also separately reportable.

NEW QUESTION # 139

Code the following note:

A 43 -year-old new female patient with a history of type I diabetes was referred to my office by Dr. White, her primary care physician. Patient complains of blurred vision that began 2 weeks ago, however, reports compliance to a strict, healthy diet and to prescribed 10 mg of dexamethasone every day for 1 month. Given that the only change appears to be the dexamethasone, I suspect the blurred vision is an adverse reaction and will decrease the dosage to 5 mg per day. Patient will follow up with me in 1 week if symptoms persist.

Total time spent on todays encounter is 30 minutes.

- A. 99204, HS3.8, E10.9
- B. 99203, H53.8, E10.69
- C. 99244, H53.8, T38.OX5A, E10.9
- D. 99243, H53.8 E10.39

Answer: A

Explanation:

When choosing between an outpatient evaluation and management code or a consultation service code, bear in mind the following four elements: request, reason, report, and intent. Although the first three elements are documented and support a consultation service, the endocrinologist is assuming immediate care of the patient's condition. In this case, the visit is not a consultation but a new transfer of care, which is encompassed by CPT codes 99202-99205. For this visit, coding based on medical decision-making as opposed to the total time spent on the encounter that day would be more advantageous. This is because coding based on time would lead a coder to report CPT code

99203 or a low level of medical decision making, whereas the medical decision-making is actually moderate, represented by CPT code 99204.

The documentation reflects that the blurry vision is most likely due to the dexamethasone:

therefore, a causal relationship is not assumed between the two conditions and should not be coded as such. Because an adverse reaction is suspected and not confirmed, it should not be coded. This general rule does not apply to inpatient encounters.

NEW QUESTION # 140

A physician performs an esophagogastroduodenoscopy on a patient who has GERD. A single tissue sample is obtained from the upper gastrointestinal tract using biopsy forceps. A reflux test was also done and a Bravo capsule temporarily attached to the esophageal wall to monitor pH levels. What procedures should the physician report?

- A. 43235, 91035
- **B. 43239, 91035**
- C. 43239, 91034
- D. 43235, 91034

Answer: B

Explanation:

To report an esophagogastroduodenoscopy, see CPT code range 43233-43259. In this scenario, the procedure is not considered diagnostic (43235) because the physician is stating the patient has GERD. Additionally, the tissue sample was obtained by means of biopsy forceps and not by brushing or washing. The secondary procedure is a reflux test and an esophageal pH test by means of a bravo capsule, which evaluates the level of acid refluxing into the esophagus. Although CPT 91035 doesn't specifically state a capsule in the description of the code, it would fall under a "mucosal attached" placement. A nasal catheter was not used, so reporting CPT 91034 would be incorrect.

NEW QUESTION # 141

An orthopedic surgeon performs a meniscectomy for a right radial tear using an arthroscope. During the procedure, the surgeon removes a piece of the damaged meniscus from the lateral compartment of the knee and shaves the articular cartilage of the same compartment. A separate incision was made to remove a 6 mm loose body in the medial compartment. The surgery was completed without any complications. What procedure and diagnosis code(s) should be reported?

- A. 29881, 29874-51, S83.203A
- B. 29882, 29877-51, 29874-51, S83.203A
- C. 29887, 29874-59, S83.281A
- **D. 29881, 29874-59, S83.281A**

Answer: D

Explanation:

The procedures performed on this encounter were the meniscectomy (removal of damaged meniscus from the lateral compartment) with a chondroplasty (shaving of articular cartilage, 29881) and loose body removal by means of an arthroscopy (29874). Because the removal of loose bodies is considered inclusive to the primary procedure, modifier 59 is appended as opposed to modifier 51 to indicate that it was a distinct procedural service due to the separate incision.

Answers A and D can be eliminated based on the diagnosis chosen. S83.203A indicates the location of meniscus is unspecified; however, the surgeon removed the damaged meniscus from the lateral compartment, leading the biller to S83.281A.

NEW QUESTION # 142

If a cardiologist bills an electrocardiogram (93010) in the emergency department and then follows up with the patient a week later for arteriosclerosis, he should bill an established patient E/M.

- **A. False**
- B. True

Answer: A

Explanation:

The statement is false. According to CPT, a new patient is one who has "not received professional services from the physician." In lieu of this, because the cardiologist only interpreted an electrocardiogram and did not actually provide care to the patient, a new patient E/M service should be billed.

NEW QUESTION # 143

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