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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q34-Q39):

NEW QUESTION # 34

A patient is seen in the emergency room with a thermal burn to the left thigh because of a fire. The patient denies feelings of hypothermia. Vitals are obtained, and a physical examination reveals that approximately 4% of the body is affected by second-degree burns, and nonviable tissue needs to be removed to avoid the risk of infection. After consent is obtained, the physician debrides the wound, cleanses the area, and applies a gauze. The patient is discharged and told to follow up with their primary care physician in 2 days. What CPT code(s) should be reported for this encounter?

- A. 0
- B. 16020, 99282
- C. 99282-25, 16020
- D. **99283-25, 16020**

Answer: D

Explanation:

When billing for physician services in the emergency room, it is appropriate to report a standalone E/M when the documentation supports its necessity in determining the need for appropriate treatment. Modifier 25 is necessary to the E/M code when being billed alongside a procedure and/or surgery to indicate a separately billable service. In this case, the documentation supports decision-making of moderate complexity. CPT code 99283 meets these criteria, whereas CPT code 99282 reflects a medical decision-making of low complexity and does not accurately portray the services rendered. The emergency room visit is always the first listed code, followed by the procedure and/or surgery performed.

NEW QUESTION # 35

An 8-year year old female is seen by her pediatrician for an allergic reaction to a bee sting. The pediatrician administers 0.3 mg of epinephrine intramuscularly. Which code(s) should be reported?

- A. 99212, J0171
- B. **96372, 10171 (3 units)**
- C. 10171 (3 units)
- D. 99213-25, 96372, (3 units)

Answer: B

Explanation:

Epinephrine is listed in alphabetical order in the HCPC book under "Table of Common Drugs." The documentation reflects a dosage of 0.3 mg, so three units of 0.1 mg epinephrine (00171) should be reported. The injection of the medication is reported with CPT code 96372 and includes an inherent E/M component unless the provider goes beyond the normal assessment of the patient prior and/or after administration of a drug.

NEW QUESTION # 36

Which service is NOT bundled into pediatric critical care CPT 99475?

- A. **A central line is inserted to stabilize a 5-year-old patient in respiratory arrest.**
- B. A suprapubic aspiration is performed on a 3-year-old patient who has blood in her urine.
- C. The doctor suspects meningitis on a 4-year-old patient and performs a lumbar puncture to test the fluid around the spinal cord.
- D. A blood transfusion is given to a 2-year-old patient with sickle cell disease.

Answer: A

Explanation:

A blood transfusion (CPT 36430, 36440), lumbar puncture (CPT (62270), and suprapubic aspiration (CPT 51100) are all considered inclusive to pediatric critical care services rendered on patients between the age of 2 and 5 years old. A complete list of all additional services can be found in the CPT Section Guidelines for Newborn and Pediatric Services. A central line insertion (CPT 36556) is not bundled into critical care services and may be reported separately.

NEW QUESTION # 37

Code the following surgical note:

Patient is seen for an epidural injection into the following three levels: L3-L4, L4-L5 and L5-S1.

A 22 -gauge spinal needle is inserted into the zygapophyseal joint using fluoroscopic guidance. After confirming the needles placement at L3-L4 on the left side, 0.5 cc of a local anesthetic is injected into the joint. The whole process is repeated on the left side at the other two levels. The procedure was completed without any complications.

- A. 64493-LT, 64494-LT, 64495-LT
- B. 0216T-LT, 0217T-LT, 0218T-LT
- C. 64493-LT, 64494-59-LT, 64495-59u
- D. 0

Answer: A

Explanation:

64493 is used for the initial injection of an anesthetic, followed by 64494 and 64495 as add-on codes for the other two levels. Because there are two sides of a facet joint, modifier LT would be amended to show the carrier that the procedure occurred on the left side of the spine.

In answer B, CPT codes 0216T-0218T exclude fluoroscopic guidance and refer the biller to codes

64490-64495. In general, modifier 59 would not be used on add-on codes, so answer C can be eliminated. Answer D describes an injection in the interlaminar epidural or subarachnoid space and is not the correct procedure code for this circumstance.

NEW QUESTION # 38

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 # 39

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