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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q65-Q70):

NEW QUESTION # 65

A young man is triaged in the emergency room after sustaining multiple injuries in a car accident. The physician performs the following limited exams with image documentation: an abdominal and retroperitoneal ultrasound, a transthoracic echocardiography, and a chest ultrasound. He indicates in his report that all findings are normal. What charges should the provider submit to the insurance company?

- A. 93304-TC, 76700-TC, 76770-TC, 76604-TC
- **B. 93308-26, 76705-26, 76775-26, 76604-26**
- C. 93308, 76705-59, 76770-59, 76604-59
- D. 93304-26, 76705-26, 76775-26, 76604-26

Answer: B

Explanation:

CPT code 93304 describes an echocardiography used to evaluate a congenital defect. In this case, the provider is screening for any trauma-related injuries to the heart. Bearing in mind that the study is limited leads you to CPT 93308. Modifier 26 is used on all CPT codes because the procedures are being performed in a hospital setting. Therefore, only the professional component of the service should be billed. Modifier TC is reported by the entity providing the equipment, which in this case would be the hospital. Modifier 59 is not necessary because the procedures are routinely done in conjunction with each other.

NEW QUESTION # 66

A sternal closure using sutures is considered inclusive to CPT 33255 and should not be reported separately.

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

Answer: A

Explanation:

The statement is true. Regardless of how a sternal closure is performed, it would be considered integral to this, and any other open cardiac procedure, when a sternal approach is used as the method of exposure. If a sternal closure were performed as the only procedure to repair an injury, the closure would then be reported.

NEW QUESTION # 67

A 59-year-old male patient presents for a routine colonoscopy. During the procedure, a polyp is discovered. What is the proper ICD- 10-CM coding for this encounter?

- **A. Z12.11, K63.5**
- B. Z12.11
- C. K63.5, Z12.11
- D. K63.5

Answer: A

Explanation:

Because the reason for the visit was a routine colonoscopy, the "encounter for screening for malignant neoplasm of colon" (Z12.11) would be the first-listed code. ICD-10-CM guidelines advise that if there is a finding during a screening, the finding may be used as an additional code. In this example, the colon polyp (K63.5) is a physical finding and would be listed as the secondary diagnosis.

NEW QUESTION # 68

A patient with a history of colon cancer was treated with radiation therapy. CT scans and blood tests show the malignancy has been eradicated. The patient is directed to take 81 mg of aspirin daily over the course of the next year to help prevent reoccurrence of the malignancy. What ICD-IO-CM code(s) should be reported by the provider on subsequent visits related to this patient's condition?

- A. Z85.038
- **B. Z08, Z85.038**
- C. Z48.3, C18.9
- D. C18.9

Answer: B

Explanation:

Regarding Z08, ICD-IO-CM guidelines state: "The follow-up codes are used to explain continuing surveillance following completed treatment of a disease. They imply that the condition has been fully treated and no longer exists." When using a follow-up code as the primary reason for an encounter, a history code indicating what condition the patient originally had should be assigned as secondary. Aftercare codes are used to describe the continued treatment of a disease. In this case, the malignancy has been eradicated, the disease no longer exists, and aspirin is being used merely as a preventative measure. History codes can never be reported as first listed; rather, a follow-up code or other current disease and/or condition should precede it.

NEW QUESTION # 69

If past family and social history is not documented for the evaluation and management of a new patient, what is the highest level of service that can be coded?

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

Answer: D

Explanation:

Effective January 1, 2023, new evaluation and management (E/M) guidelines were implemented for inpatient, outpatient, home health, and preventative medicine services. These new guidelines remove the Patients' history and examination as elements in selecting the level of code.

Instead, E/M services are leveled based on the medical decision-making process. Therefore, in this scenario, the highest level of service that can be billed for a new patient with no documented past medical, family, and social history is 99205, CPT codes 99213 and 99214 are reported for established patients.

NEW QUESTION # 70

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