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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q23-Q28):

NEW QUESTION # 23
A patient is scheduled for a total knee replacement. The assigned anesthesiologist performs a femoral nerve block using an ultrasound machine just prior to entering the operating room to aid in postoperative pain control. Once in the operating room, general anesthesia is administered to the patient. What CPT code(s) should the anesthesiologist report?

- A. 01402,64447_59, 76942
- B. 01400, 01991, 76942
- C. 01400, 01991-59
- D. 01402

Answer: A

Explanation:
CPT crosswalk for anesthesia administered during a total knee replacement is 01402.
Although CPT 01991 does describe a nerve block, it is considered monitored anesthesia care because the patient is awake. However, in this scenario, general anesthesia is being used for the primary procedure, and the femoral nerve block is administered for postoperative pain management. Therefore, the nerve block would be billed as CPT 64447 with modifier 59 to indicate that it is separately reportable from the primary procedure. If, on the other hand, the nerve block was being used as a component of the general anesthesia, CPT 64447 would be considered inclusive to the general anesthesia and not reported separately. Ultrasound guidance is not currently bundled with the administration of a nerve block and, when used, should be reported separately with CPT 76942.

NEW QUESTION # 24
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 (ARE) 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 pneumoni a. I will start him on 875 mg of amoxicillin every 12 hours and follow up tomorrow.

- A. 99232, 144.1, 196.00, 169.0, ROO.O
- B. 99232, 196.00, 144.1, 169.0
- C. 99231, 169.0, 196.00, 144.1
- D. 99233, 169.0

Answer: B

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 # 25
A 22-year-old patient presents with a 5.5 cm gaping laceration on the right forearm and a
2 cm superficial laceration on the right wrist caused by a table saw. A local anesthetic is injected around both laceration sites. The

physician irrigates the laceration on the wrist before closing the wound with a tissue adhesive and then performs an extensive cleaning and single-layer closure with sutures on the forearm. What should be coded for this encounter?

- A. 12032, S41.111A, S61.411A,W31.2kX.A
- B. 12032, 12001-59, S41.111A S61.411A W31.2XXA
- C. 12001, 12032-59, S61.411AS41.111A W31.2XXA
- D. 12032, 97597, G0168, S41.111A, S61.411A W31.2XXA

Answer: B

Explanation:
A "gaping" injury and/or "single-layer closure" is indicative of an intermediate repair and a "superficial" injury and/or use of a "tissue adhesive" is indicative of a simple repair. Because the repairs are not in the same classification, each repair is reported in a single code, sequenced from the most to the least severe (eliminating answers B and D), with modifier 59 appended to the less complicated procedure(s). Local anesthesia is included in these procedures, as is debridement unless the provider specifically indicates that it is extensive. In answer A, an HCPC's code for tissue adhesive would be reported only if the patient had Medicare.

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

Answer: B

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 # 27
A patient with a stab wound to the chest was taken to the operating room and put under general anesthesia for a thoracotomy. The anesthesiologist should report CPT 00520 with the total number of time units spent providing face-to-face care with the patient.

- A. True
- B. False

Answer: B

Explanation:
The statement is false. CPT 00520 is anesthesia services for closed-chest procedures.
However, a thoracotomy is an open procedure involving a surgical incision to the chest wall. The correct CPT code that should be reported is 00540 (anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum).

NEW QUESTION # 28
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