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Medical

AHIMA-CCS

Certified Coding Specialist (CPC) (ICD-10-CM)

Question: 562

Which ICD-10-CM code is used to report a patient's personal history of breast cancer?

A. Z85.3
B. Z86.11
C. Z87.891
D. Z90.11

Answer: A

Explanation: The correct ICD-10-CM code to report a patient's personal history of breast cancer is Z85.3. This code is used to indicate a personal history of malignant neoplasm, and the additional characters can be used to specify the type and location of the cancer.

Question: 563

Admission Date: 4/24
Discharge Date: N/A
Admitting Diagnosis: Non-ST elevation myocardial infarction (NSTEMI)
Chief Complaint: A 62-year-old male presented to the emergency department with chest discomfort, diaphoresis, and shortness of breath.
Past Medical History: Hypertension, hyperlipidemia, diabetes mellitus
Physical Exam:
General: Diaphoretic, in distress
Cardiovascular: Irregular heart rhythm, elevated cardiac enzymes
Impression: The patient was diagnosed with non-ST elevation myocardial infarction based on the clinical presentation, electrocardiogram findings, and elevated cardiac enzyme levels.

Plan: The patient was admitted to the cardiac care unit for further management, including antiplatelet therapy and cardiac catheterization.

What should the principal ICD-10-CM code be for this encounter?

A. I21.4
B. I21.9
C. I21.0
D. I21.1
E. I21.2
F. I21.3
G. I21.9 and I50.9

Answer: A

Explanation: The principal ICD-10-CM code for this encounter should be I21.4. The patient presented with symptoms and was diagnosed with non-ST elevation myocardial infarction (NSTEMI). The I21.4 code represents non-ST elevation (NSTEMI) myocardial infarction, which accurately describes the condition in this scenario. The clinical presentation, electrocardiogram findings, and elevated cardiac enzyme levels support the selection of this code. Additional codes for hypertension (I10), hyperlipidemia (E78.5), and diabetes mellitus (E11.9) may also be assigned as secondary diagnoses if documented and supported by the medical record.

Question: 564

A patient with a history of diabetes mellitus type 2 presents for a routine follow-up visit. During the visit, the physician performs a comprehensive examination and adjusts the patient's medication. Which CPT code should be reported for this encounter?

A. 99212

B. 99213
C. 99214
D. 99215

Answer: C

Explanation: The correct CPT code to report for a routine follow-up visit with a comprehensive examination and medication adjustment is 99214. This code is appropriate when the physician performs a detailed history, detailed examination, and moderate complexity medical decision-making.

Question: 565

A patient undergoes a left total mastectomy with axillary lymph node dissection for breast cancer. Which CPT code should be assigned for this procedure?

A. 19303
B. 19304
C. 19305
D. 19307

Answer: C

Explanation: The correct CPT code for a left total mastectomy with axillary lymph node dissection is 19305. This code is used when the entire breast tissue is removed, along with lymph node dissection.

Question: 566

A patient undergoes a colonoscopy with removal of a small polyp in the sigmoid colon. The polyp is sent for biopsy, which confirms it to be a benign adenomatous polyp. Which CPT code(s) would be reported?

A. 45385
B. 45380
C. 45381
D. 45384, 88305

Answer: A

Explanation: The correct CPT code(s) for this scenario are:
45385 (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique)
88305 (Surgical pathology, gross and microscopic examination for tumor, polyp, or other lesion [except for Mohs surgery]; single specimen)
In this case, the patient undergoes a colonoscopy with removal of a small polyp in the sigmoid colon, and the polyp is sent for biopsy. The biopsy confirms the polyp to be benign. Therefore, option A is the correct answer, as it includes the appropriate CPT code for the colonoscopy with removal of the polyp.

Question: 567

Which of the following ICD-10-CM codes is used to report a deep vein thrombosis (DVT) of the right lower extremity?

A. I82.421
B. I82.422
C. I82.431
D. I82.432

Answer: B

Explanation: The ICD-10-CM code I82.422 is used to report a deep vein thrombosis (DVT) of the right lower extremity. The code I82.422 represents a DVT of the right femoral vein. The specific location and details of the DVT are important factors in selecting the correct code.

Question: 568

A patient presents to the dermatologist for the removal of multiple skin tags on the neck. The physician performs the removal using electrosurgery. Which CPT code should be reported for this procedure?

A. 11200
B. 11201
C. 11202
D. 11204

Answer: C

Explanation: The correct CPT code to report for the removal of multiple skin tags using electrosurgery is 11202. This code is appropriate when the physician removes 2 to 14 skin tags.

Question: 569

A patient is admitted to the hospital with a diagnosis of pneumonia due to Streptococcus pneumoniae. Which ICD-10-CM code represents the appropriate diagnosis for this patient?

A. J13.0
B. J13.1
C. J13.2
D. J13.3

Answer: A

Explanation: The correct answer is A (J13.0). The appropriate ICD-10-CM

code for pneumonia due to Streptococcus pneumoniae is determined by the specific type of pneumonia. In this case, "J13.0" represents the correct code, which specifically indicates "Pneumonia due to Streptococcus pneumoniae."

Question: 570

Which of the following is true regarding the coding of external cause of morbidity in ICD-10-CM?

A. External cause codes are required for all healthcare encounters
B. External cause codes are used to indicate the intent of an injury or poisoning
C. External cause codes are only used for inpatient encounters
D. External cause codes are found in Chapter 20 of ICD-10-CM

Answer: B

Explanation: External cause codes in ICD-10-CM are used to provide additional information about the cause, intent, and circumstances of an injury, poisoning, or other external events. They are not required for all healthcare encounters, but they may be used when documenting the cause of an injury or the intent behind a poisoning. External cause codes can be used for both inpatient and outpatient encounters and can be found in Chapter 20 of ICD-10-CM.

Question: 571

Which of the following ICD-10-CM codes is used to report a migraine without aura?

A. G43.001
B. G43.009
C. G43.101
D. G43.109

Answer: BExplanation: The ICD-10-CM code G43.009 is used to report a migraine without aura. The code G43.009 represents a migraine without aura, not intractable, without status migrainosus.

Which of the following ICD-10-CM codes is used to report a nontraumatic subarachnoid hemorrhage?

A. I60.01
B. I60.02
C. I60.11
D. I60.12

Answer: A

Explanation: The ICD-10-CM code I60.01 is used to report a nontraumatic subarachnoid hemorrhage. The code I60.01 represents a nontraumatic subarachnoid hemorrhage from carotid siphon and bifurcation.

Question: 572

A patient undergoes a diagnostic bronchoscopy with bronchoalveolar lavage for the evaluation of a lung infection. Which CPT code should be assigned for this procedure?

A. 31622
B. 31623
C. 31625
D. 31628

Answer: B

Explanation: The CPT code for a diagnostic bronchoscopy with bronchoalveolar lavage is 31623. This code specifically identifies the performance of a lavage during the bronchoscopy procedure.

Question: 573

Admission Date: 2/24
Discharge Date: N/A
Admitting Diagnosis: Major depressive disorder, single episode, moderate
Chief Complaint: A 40-year-old female presented to the psychiatrist's office with a depressed mood, loss of interest, and feelings of worthlessness.
Past Medical History: None documented
Physical Exam:
General: Poor eye contact, psychomotor retardation
Psychiatric: Depressed affect, anhedonia
Impression: The patient was diagnosed with major depressive disorder, single episode, moderate based on the clinical presentation and psychiatric evaluation.
Plan: The patient was prescribed an antidepressant medication and referred for psychotherapy.

What should the principal ICD-10-CM code be for this encounter?

A. F32.1
B. F32.9
C. F32.0
D. F32.2
E. F32.1 and F41.9
F. F32.1 and Z63.0
G. F32.1 and Z87.891
H. F32.1 and Z73.89

Answer: A

Explanation: The principal ICD-10-CM code for this encounter should be F32.1. The patient presented with symptoms and was diagnosed with major depressive disorder, single episode, moderate. The F32.1 code represents major depressive disorder, single episode, moderate, which accurately describes the condition in this scenario. The clinical presentation and psychiatric evaluation support the selection of this code. Additional codes for generalized anxiety disorder (F41.9) or other relevant diagnoses may also be assigned as secondary diagnoses if documented and supported by the medical record.

Question: 574

Which ICD-10-CM code is used to report a patient's personal history of breast cancer in the left breast?

A. Z85.3
B. Z86.11
C. Z87.891
D. Z90.11

Answer: A

Explanation: The correct ICD-10-CM code to report a patient's personal history of breast cancer in the left breast is Z85.3. This code is used to indicate a personal history of malignant neoplasm, and the additional characters can be used to specify the type, location, and laterality of the cancer.

Question: 575

A patient is admitted to the hospital with a diagnosis of acute myocardial infarction (AMI). The physician documents a STEMI (ST-elevation myocardial infarction) of the anterior wall. Which of the following ICD-10-CM codes

should be assigned for this condition?

A. I21.09
B. I21.01
C. I21.11
D. I21.31

Answer: B

Explanation: The correct code for a STEMI of the anterior wall is I21.01 (ST elevation (STEMI) myocardial infarction involving left main coronary artery). Option A (I21.09) represents other ST elevation (STEMI) myocardial infarction, option C (I21.11) represents ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery, and option D (I21.31) represents ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall.

Question: 576

A patient presents to the clinic for a routine mammogram. The mammogram shows a suspicious mass, and a subsequent biopsy confirms a diagnosis of invasive ductal carcinoma of the breast. Which ICD-10-CM code should be assigned for the biopsy procedure?

A. 85.11
B. 85.12
C. 85.21
D. 85.22

Answer: B

Explanation: The correct ICD-10-PCS code for a breast biopsy is 85.12. This code specifically identifies the performance of a biopsy procedure on the

breast.

Question: 577

Radiology
Imaging Report: A 55-year-old female patient with a history of breast cancer underwent a follow-up mammogram. The mammogram was performed bilaterally, consisting of two views of each breast. The images were reviewed by a radiologist, who noted stable findings without any signs of recurrence or new abnormalities. The radiologist provided a final impression of negative mammogram.

What CPT code should be reported for the follow-up mammogram?

A. 77065
B. 77066
C. 77067
D. 77068

Answer: C

Explanation: The correct CPT code for the follow-up mammogram is 77067. This code represents screening mammography, bilateral (two views of each breast), and is used for routine surveillance or follow-up mammograms. Codes 77065 and 77066 represent diagnostic mammography for unilateral and bilateral examinations, respectively, and code 77068 represents a diagnostic mammogram performed on a patient with a known breast abnormality. In this case, the mammogram is a routine follow-up, so code 77067 is the appropriate choice.

Question: 578

A patient undergoes a cesarean section delivery for a breech presentation.

Which CPT code should be assigned for this procedure?

A. 59510
B. 59514
C. 59515
D. 59525

Answer: C

Explanation: The correct CPT code for a cesarean section delivery for a breech presentation is 59515. This code is used when a cesarean section is performed for a nontransverse or oblique lie presentation, such as a breech presentation.

Question: 579

Admission Date: 1/24
Discharge Date: N/A
Admitting Diagnosis: Acute exacerbation of chronic obstructive pulmonary disease (COPD)
Chief Complaint: A 60-year-old male presented to the emergency department with increased shortness of breath, wheezing, and coughing up yellowish sputum.
Past Medical History: Chronic obstructive pulmonary disease (COPD), smoking history
Physical Exam:
General: Increased respiratory effort
Respiratory: Diffuse expiratory wheezes, decreased breath sounds in the bases
Impression: The patient was diagnosed with an acute exacerbation of chronic obstructive pulmonary disease (COPD) based on the clinical presentation, physical examination findings, and medical history.
Plan: The patient was admitted to the medical floor for further management, including bronchodilator therapy and oxygen supplementation.

What should the principal ICD-10-CM code be for this encounter?

A. J44.0
B. J44.1
C. J44.9
D. J44.0 and F17.210
E. J44.0 and Z87.891
F. J44.0 and Z87.01
G. J44.0 and J44.9
H. J44.0 and J44.1

Answer: A

Explanation: The principal ICD-10-CM code for this encounter should be J44.0. The patient presented with symptoms and was diagnosed with an acute exacerbation of chronic obstructive pulmonary disease (COPD). The J44.0 code represents chronic obstructive pulmonary disease with acute lower respiratory infection, which accurately describes the condition in this scenario. The clinical presentation, physical examination findings, and medical history support the selection of this code. Additional codes for tobacco use disorder (F17.210) or other relevant diagnoses may also be assigned as secondary diagnoses if documented and supported by the medical record.

Question: 580

Which ICD-10-CM code is used to report a patient's personal history of non-Hodgkin lymphoma?

A. Z85.79
B. Z86.010
C. Z87.891
D. Z90.11

Answer: A

Explanation: The correct ICD-10-CM code toreport a patient's personal history of non-Hodgkin lymphoma is Z85.79. This code is used to indicate a personal history of other malignant neoplasms of lymphoid, hematopoietic, and related tissues.

Question: 581

Which of the following is an example of unbundling in coding?

A. Reporting multiple services provided during a single patient encounter
B. Combining two or more codes into a single code
C. Coding a symptom instead of a confirmed diagnosis
D. Separating a procedure into its component parts and coding each part separately

Answer: D

Explanation: Separating a procedure into its component parts and coding each part separately. Unbundling occurs when a procedure is broken down into its individual components, and each component is coded and billed separately, instead of reporting the procedure as a whole. This practice is considered inappropriate coding and can result in overpayment. Reporting multiple services provided during a single patient encounter (A) is not unbundling if the services are distinct and separately identifiable. Combining two or more codes into a single code (B) is known as code bundling or code consolidation. Coding a symptom instead of a confirmed diagnosis (C) may be appropriate if a definitive diagnosis has not been established.

Question: 582

A patient is diagnosed with major depressive disorder and is started on pharmacotherapy with an SSRI antidepressant. Which ICD-10-CM code(s) would be reported?

A. F32.9, Z79.891
B. F33.9, Z79.891
C. F32.0, Z79.891
D. F33.0, Z79.891

Answer: A

Explanation: The correct ICD-10-CM codes for this scenario are:
F32.9 (Major depressive disorder, single episode, unspecified)
Z79.891 (Long-term (current) use of selective serotonin reuptake inhibitors [SSRIs])
In this case, the patient is diagnosed with major depressive disorder and started on pharmacotherapy with an SSRI antidepressant. Therefore, option A is the correct answer, as it includes the appropriate ICD-10-CM codes for the diagnosis and medication.

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