Healthcare

AAPC-CPC-H

AAPC Certified Professional Coder-Hospital Outpatient (CPC)

Latest Version: 6.0

Question: 1

Which code exempt from diagnosis present on admission requirement is defined as “encounter for supervision of normal pregnancy”?

A. Z30.
B. Z31.
C. Z34.
D. Z36.

Answer: C

Explanation:
The code that is exempt from the diagnosis present on admission requirement, defined as "encounter for supervision of normal pregnancy," is Z34.
The ICD-10 code Z34 is specifically designated for the supervision of a normal pregnancy. This code is used by healthcare providers to document visits that are intended to monitor the health of the mother and the developing fetus when no complications or known issues are present. The use of this code indicates that the pregnancy is progressing without any significant health problems that require special medical attention beyond standard prenatal care.
The Present on Admission (POA) indicator is a coding convention used to identify diagnoses that are present at the time of hospital admission. Codes that are exempt from the POA requirement, such as Z34, are typically for conditions that are a normal part of a healthy pregnancy and do not represent complications or illnesses. Therefore, Z34 is used to signify routine prenatal visits that are expected and planned as part of normal obstetric care.
Other codes listed, such as Z30 (Encounter for contraceptive management), Z31 (Encounter for procreative management), and Z36 (Encounter for antenatal screening of mother), serve different purposes. Z30 involves management of contraception and is not specifically related to an ongoing pregnancy. Z31 deals with medical supervision related to procreative techniques, such as fertility treatments. Z36 is used for specific antenatal screenings that are typically done to identify potential congenital anomalies or other conditions in the fetus, not for routine prenatal care.
In summary, the correct code for an "encounter for supervision of normal pregnancy" is Z34, which is also exempt from the diagnosis present on admission requirement. This code ensures that healthcare providers accurately document visits that are meant to oversee the course of a normal pregnancy, distinguishing them from visits necessitated by complications or other health concerns.

Question: 2

Which cardiovascular suffix is defined as narrowing; stricture?

A. -ium.
B. -ole.

C. -sclerosis.
D. -stenosis.

Answer: D

Explanation:
The correct answer to the question regarding which cardiovascular suffix is defined as narrowing or stricture is "-stenosis."
-ium: The suffix "-stenosis" is derived from the Greek word "stenos," which means narrow. In medical terminology, "-stenosis" is used to describe an abnormal narrowing of a passage or opening in the body. This can occur in various parts of the cardiovascular system, such as arteries or valves. For instance, aortic stenosis refers to the narrowing of the aortic valve, which can impede the flow of blood from the heart to the aorta, affecting the efficient circulation of blood throughout the body.
-ole: This condition can lead to significant health issues, as the narrowing creates a bottleneck that can reduce or obstruct blood flow. The restricted blood flow requires the heart to work harder to pump blood through the narrowed areas, potentially leading to symptoms such as chest pain, dizziness, and shortness of breath. If left untreated, severe stenosis can lead to critical complications, including heart failure and stroke.
-sclerosis: Therefore, understanding and identifying stenosis within the cardiovascular system is crucial for timely and effective treatment. Treatments may include lifestyle changes, medication, or surgical procedures such as angioplasty or valve replacement, depending on the severity and location of the narrowing.
-stenosis: In summary, the suffix "-stenosis" specifically relates to the concept of narrowing or stricture within medical terminology, particularly in reference to the cardiovascular system. It helps in the diagnosis and categorization of conditions that involve the constriction of blood vessels or other anatomical passageways.

Question: 3

The patient is receiving anesthesia for radical intraoral surgery. Which of these is the correct CPT code?

A. 00174.
B. 00172.
C. 00170.
D. 00176.

Answer: D

Explanation:
The question asks for the correct Current Procedural Terminology (CPT) code for a patient undergoing radical intraoral surgery. The options given are 00174, 00176, 00172, and 00170. Each of these codes corresponds to different surgical procedures within the oral and maxillofacial region, thus it is crucial to select the accurate code that specifically describes the surgical procedure being performed.
The correct CPT code for radical intraoral surgery is 00176. This code is designated specifically for anesthesia services provided for extensive or radical procedures on the palate, nasopharynx,

oropharynx, or the mouth; including biopsy. This definition precisely covers the nature of a radical intraoral surgery, making it the appropriate choice among the options.
To further clarify why the other codes are incorrect: 00174 is used specifically for anesthesia during procedures on the pharynx, adenoids, or tonsils, which does not encompass the broader and more complex scope of radical intraoral surgery. 00172 is the code used for cleft palate repair, which is a specific type of reconstructive surgery and does not apply to all forms of intraoral surgeries. Lastly, 00170 is a general code for intraoral procedures excluding cleft palate repair or procedures involving the pharynx, adenoids, or tonsils, but it does not specifically cover the extensive or radical nature of the surgery described in the question.
In conclusion, the selection of CPT code 00176 is justified as it most accurately reflects the anesthesia service for a radical intraoral procedure, as described in the scenario. It is essential for medical coding professionals to choose the most specific code available to ensure accurate billing and appropriate medical records documentation.

Question: 4

The patient has chronic instability of an unspecified knee. Which of the following is the proper diagnosis code?

A. M23.50.
B. M23.5.
C. M23.52.
D. M23.51.

Answer: A

Explanation:
When selecting the appropriate diagnosis code for a patient with chronic instability of an unspecified knee, it is crucial to choose a code that accurately reflects the condition as described in the patient's medical records. The diagnosis code M23.50 is specified for chronic instability of a knee when the affected knee is not specified as either left or right. This specificity is essential for accurate medical billing and appropriate medical treatment planning.
The coding within the M23 series pertains to disorders of the meniscus or other internal derangements of the knee. Within this series: - M23.5 category specifically addresses issues related to chronic instability of the knee. - M23.50 is used when the instability is in an unspecified knee, meaning the medical record does not clarify whether the left or right knee is affected. - M23.51 specifies the code for chronic instability of the right knee. - M23.52 specifies the code for chronic instability of the left knee.
The correct choice of M23.50 in the scenario provided is crucial because it directly corresponds to the description of the condition without specifying which knee is affected. Choosing either M23.51 or M23.52 would imply a specific knee is noted in the diagnosis, which does not align with the information given ("unspecified knee"). Using a specific code without clear documentation can lead to errors in patient care management and potential issues in the billing process.
Thus, M23.50 is the proper diagnosis code for a patient with chronic instability of an unspecified knee. This ensures that the medical coding accurately reflects the patient's medical record, which is essential for both clinical accuracy and administrative processes.

Question: 5

Chapter 17 of the Tabular List includes codes Q00 – Q99. Which diseases are included in this category?

A. Congenital Malformations, Deformations and Chromosomal Abnormalities.
B. Symptoms, Signs, and Abnormal Clinical Findings.
C. Injury, Poisoning and Certain Other Consequences of External Causes.
D. External Causes of Morbidity.

Answer: A

Explanation:
Chapter 17 of the Tabular List, which encompasses codes Q00 – Q99, is specifically designated for congenital malformations, deformations, and chromosomal abnormalities. These conditions are typically structural or genetic disorders that are present from birth, although they may not be diagnosed until later in life.
Congenital malformations are structural or anatomical abnormalities that occur during the development of an embryo. These can range from minor anomalies, such as a webbed toe, to more severe conditions like congenital heart defects or neural tube defects such as spina bifida. Deformations refer to abnormalities that develop due to mechanical forces on a normally developed body part, often occurring late in pregnancy or during delivery. Examples include clubfoot or congenital hip dislocation.
Chromosomal abnormalities involve the alteration in the number or structure of chromosomes, which can lead to various syndromes with physical and intellectual impairments; common examples include Down syndrome (trisomy 21), Turner syndrome (monosomy X), and Klinefelter syndrome (XXY).
These categories are crucial for medical coding and data collection, aiding in the tracking of prevalence of these conditions and in the research into their causes and treatments. Understanding the classification in Chapter 17 also helps in aligning with global health information standards, such as those set by the World Health Organization (WHO).
It is important to note that the subsequent chapters after Chapter 17 cover entirely different sets of conditions. Chapter 18 (codes R00-R99) deals with symptoms, signs, and abnormal clinical findings that are not classified elsewhere. Chapter 19 (codes S00-T88) addresses issues related to injury, poisoning, and certain other consequences of external causes. Lastly, Chapter 20 (codes V01-Y98) is concerned with external causes of morbidity, detailing the external context and circumstances of injuries and other health conditions. Each chapter serves a specific and distinct purpose in the categorization and management of health data.

Question: 6

Which of these is defined as calcification, stone?

A. -cele.
B. cyst/o.
C. -ia/sis.
D. lith/o.

Answer: D

Explanation:
lith/o is a prefix used in medical terminology to refer to stone formation or calcification. It is often used to form words that describe conditions involving stones in the body, such as in the kidneys or gallbladder. For example, "lithiasis" refers to the formation of stones (calculi), and "nephrolithiasis" specifically refers to kidney stones.
-cele, on the other hand, is a suffix used in medical terms to indicate a herniation or a prolapse of a part of the body. For instance, "cystocele" refers to a prolapse of the bladder into the vagina.
cyst/o is a root word in medical terminology that pertains to the bladder. It is used to describe conditions, structures, or concerns relating to the bladder, such as in "cystitis," which means inflammation of the bladder.
-ia/sis is a suffix used to describe a condition or state. It is commonly used in medical terms to indicate a pathological state. For example, "neuralgia" refers to a condition of nerve pain.
Therefore, in the context of the question asking for the term defined as calcification or stone, the correct choice is "lith/o." This prefix directly relates to conditions involving stone formations in the body.

Question: 7

Which of the following is NOT a term classified to stress fractures?

A. fatigue fracture
B. march fracture
C. stress reaction fracture
D. pathological fracture

Answer: D

Explanation:
Pathological fractures occur in bones that are weakened by disease. Stress fractures are due to repetitive force applied before the bone and its supporting tissues have had enough time to provide such force.

Question: 8

A patient has late-onset cerebellar ataxi
a. Which of the following is the correct diagnosis code?
A. G11.8.
B. G11.2.
C. G11.4.
D. G11.3.

Answer: B

Explanation:

In the context of medical coding, precise diagnosis codes are crucial for accurate patient records and billing. The question involves identifying the correct diagnosis code for a patient with late-onset cerebellar ataxia. The codes presented include G11.2, G11.8, G11.4, and G11.3, each pertaining to different neurological conditions.
The correct diagnosis code for late-onset cerebellar ataxia is G11.2. This specific code is used for late-onset cerebellar ataxia, which accurately matches the patient's condition as described. Cerebellar ataxia refers to a disorder that occurs when the cerebellum, the part of the brain that controls coordination and balance, is affected leading to uncoordinated movements and instability.
On the other hand, the other codes represent related but distinct conditions: - G11.8 is used for other hereditary ataxias, which does not specifically denote late-onset cerebellar ataxia. This code would be used for ataxias that do not fall into more specifically defined categories. - G11.4 is the code for hereditary spastic paraplegia, a different neurological condition characterized by stiffness and contraction in the lower limbs, differing significantly from cerebellar ataxia. - G11.3 corresponds to cerebellar ataxia with defective DNA repair, a specific subgroup where the ataxia is coupled with issues in DNA repair mechanisms. This is different from the typical late-onset cerebellar ataxia where DNA repair is not necessarily implicated.
Therefore, the choice of G11.2 as the diagnosis code is appropriate because it directly corresponds to the patient's condition as described. The other codes, while related to neurological disorders, describe conditions with specific characteristics or etiologies that do not match the description of simple late-onset cerebellar ataxia. This precision in coding ensures appropriate treatment can be administered and accurately billed.

Question: 9

Of the following, which means eyelid?

A. Acous/o.
B. Blephar/o.
C. Canth/o.
D. Dacry/o.

Answer: B

Explanation:
Of the prefixes provided, the one that specifically means "eyelid" is Blephar/o. Each prefix listed is related to different parts or functions of the body, primarily focused around the eye and ear. Understanding these prefixes can help in medical terminology, especially when identifying or discussing conditions related to these areas.
Acous/o is a prefix related to hearing. This term is often used in medical contexts to discuss elements pertaining to the ears or the sense of hearing. Therefore, it is not related to the eyelid.
Blephar/o specifically refers to the eyelid. In medical terms, this prefix is used to denote conditions, surgical procedures, or anatomical descriptions concerning the eyelids. This makes Blephar/o the correct answer to the question about which prefix means "eyelid."
Canth/o refers to the corner of the eyelid, more specifically the angle where the upper and lower eyelids meet. This prefix is sometimes used when discussing issues or features at these junctions of the eyelids.

Dacry/o relates to the lacrimal system of the eye, which includes the structures involved in the production and drainage of tears. This prefix is used when discussing conditions or procedures affecting the tear ducts and associated components.
Therefore, the correct answer to the question is Blephar/o, as it is the only prefix among those listed that directly means "eyelid."

Question: 10

Mock Medical Case 101
Inpatient Face Sheet
Admit Date:
08/15/2013
Discharge Date: 08/18/2013
Sex: Male
Age: 67
Disposition: Home
ADMITTING DIAGNOSES
1. Bronchitis, acute
2. Hypertension, uncontrolled
DISCHARGE DIAGNOSES:
1. Bronchitis acute
2. Hypertension, primary
3. Osteoarthritis
PROCEDURES:
1. Chest x-ray
2. CT scan of the chest with contrast
Mock Medical Case 101
History and Physical
CHIEF COMPLAINT: Shortness of breath
HISTORY OF PRESENT ILLNESS:
Patient admitted to the medical surgical floor with complaints of severe shortness of breath and his chest hurting. He states that this started 7 days ago and keeps progressively getting worse.
He is a retired police officer who lives at home with his wife.
PAST MEDICAL HISTORY:
The patient states that he has had high blood pressure for about two years that has been controlled, but that it has been running higher since he has been sick. States that he has not been able to eat or drink for over 48 hours and that his throat is very sore. He now feels extremely weak and shaky on his feet. He also states that he has “just plain old arthritis.” from too many years being a “cop.” He states he feels like he may have pneumonia, “just feels terrible”.
ALLERGIES: No known allergies.
MEDICATIONS: Lisinopril 10 mg once a day
Lipitor 40 mg at bedtime
Aleve 2 pills a day (over-the-counter)
SOCIAL HISTORY: Married for 15 years, smoked in the past about a pack a day but quiet 10 years ago. Only occasional social drink.
PHYSICAL EXAMINATION: The patient appears to be a well nourished 67 year old male. Blood pressure on admission 198/76.

REVIEW OF SYSTEMS:
HEENT: Head and ears are normal. Patient coughing yellow-greenish sputum.
Neck: No bruits noted.
Chest: Bilateral wheezing with scattered rhonchi. Pulse oximetry 88% on room air.
Abdomen: Negative
Extremities:
Negative
LABORATORY DATA:
WBC's elevated at 10.4 Creatinine 1.4 otherwise unremarkable
RADIOLOGY DATA:
Chest x-ray shows acute bronchitis
IMPRESSION:
1.Acute Bronchitis
2.Uncontrolled hypertension
PLAN:
1.Admit
2.IV fluids
3.IV antibiotics.
4.Supplemental oxygen.
Mock Medical Case 101
Discharge Summary
ADMITED:
08/15/2013
DISCHARGED: 08/18/2013
DISCHARGE DIAGNOSIS:
Acute bronchitis
Hypertension, primary
Osteoarthritis
HOSPITAL COURSE:
The patient was placed on 4 liters nasal cannula and monitored for oxygen saturation and treatment by respiratory therapy. D5W 1000 ml IV fluids was started at 100 ml per hour for dehydration. The patient was started on Levaquin 500 mg IV every 24 hours and received respiratory treatments.
Lisinopril was increased to 20mg per day and blood pressure on discharge was 124/72. The patient improved and upon discharge, the patient oxygen saturation was 94 % on room air and coarse lung sounds, but no wheezing or rhonci was heard. Patient will be sent home on oral antibiotics and will be seen in my office in 5 to 7 days for follow-up.
Mock Medical Case 101
PHYSICIAN ORDERS
08/15/2013
Admit to medical floor
Diagnosis: Acute bronchitis
Uncontrolled hypertension
Diet: Low sodium, low cholesterol
Bedrest with bathroom privileges
IV fluids D5W 1000ml to infuse at 100ml per hour
Levaquin 500mg IV every 24 hours (start after labs are drawn)
Labs: CBC, CMP, UA
Chest x-ray now and every AM

4l oxygen per NC, respiratory therapy to check pulse oximetry and treat.
Lisinopril 20mg by mouth daily for blood pressure
Lipitor 40mg by mouth daily for elevated cholesterol
Tylenol 500mg x2 by mouth every 6 hours PRN for gene
ralized pain.
8/16/2013
Restoril 15mg by mouth at bedtime for sleep
8/17/2013
CBC, CMP this AM
CT scan of the chest
Change IV fluids to D5W 1000ml to infuse at 24ml per hour.
Respiratory therapy to check pulse oximetry on room air
8/18/2013
Discharge patient home
Meds: Lisinopril 20mg by mouth every day
Lipitor 40mg by mouth nightly
See me in my office in 5 to 7 days.
In Medical Case 101, which of the following would be the correct bill code for Discharge Diagnosis 3, osteoarthritis?

A. M15.9
B. M15.3
C. M19.90
D. M19.92

Answer: C

Explanation:
M15.9 is polyosteoarthritis, unspecified
M15.3 is secondary multiple arthritis
M19.90 is unspecified osteoarthritis
M19.92 is post-traumatic osteoarthritis, unspecified site

Thank You for Trying Our Product

For More Information – Visit link below:

https://www.examsboost.com/

15 USD Discount Coupon Code:

G74JA8UF

FEATURES

- ✓ 90 Days Free Updates
- ✓ Money Back Pass Guarantee
- ✓ Instant Download or Email Attachment
- ✓ 24/7 Live Chat Support
- ✓ PDF file could be used at any Platform
- ✓ 50,000 Happy Customer