

Boost up Your Certification Score

AAPC CCC

AAPC Certified Cardiology Coder



For More Information – Visit link below:

<https://www.examsboost.com/>

Product Version

- ✓ Up to Date products, reliable and verified.
- ✓ Questions and Answers in PDF Format.

Latest Version: 6.0

Question: 1

A cardiology note documents: "Congenital bicuspid aortic valve with mild aortic stenosis. No rheumatic valve disease. Continue surveillance echocardiography." The provider identifies the valve abnormality as congenital. Which ICD-10-CM coding approach best reflects the documentation?

- A. Code rheumatic aortic stenosis because all aortic stenosis is coded as rheumatic unless stated otherwise
- B. Code the congenital bicuspid aortic valve condition and any separately documented valve disease when supported
- C. Code only unspecified cardiac murmur because surveillance echocardiography is planned
- D. Code acquired mitral valve disease because bicuspid valves involve two valve leaflets

Answer: B

Question: 2

A congenital/interventional cardiology report documents balloon angioplasty of left upper pulmonary vein stenosis after prior atrial fibrillation ablation. The physician catheterizes the pulmonary vein, inflates a balloon across the stenosis, documents improved gradient, and performs no coronary intervention. Which coding distinction is most important?

- A. Code according to pulmonary vein intervention rules rather than coronary or peripheral arterial PCI rules
- B. Code lower-extremity venous angioplasty because the vessel is a vein
- C. Code coronary angioplasty because pulmonary veins enter the left atrium
- D. Code atrial fibrillation ablation because the patient previously had ablation

Answer: A

Question: 3

A hospitalized patient in the intensive care unit requires hemodynamic monitoring. The cardiologist places a flow-directed pulmonary artery catheter at the bedside for ongoing pressure monitoring. The documentation does not describe a formal diagnostic right heart catheterization study with full hemodynamic interpretation. Which coding distinction is most important?

- A. The service should be coded as coronary angiography because a catheter entered the heart
- B. The service should be coded as left heart catheterization because pressures were measured

- C. Flow-directed catheter placement for monitoring is distinct from diagnostic right heart catheterization
- D. The service should be coded as PCI because the patient was in an intensive care unit

Answer: C

Question: 4

A patient with an existing single-chamber ICD undergoes upgrade to a CRT-D system. The operative report documents removal of the old ICD generator, insertion of a new right atrial lead and a new coronary sinus left ventricular lead, retention of the existing right ventricular defibrillator lead, connection to a new CRT-D generator, and testing of all leads. Which coding concept is most important?

- A. Code initial CRT-D implantation with all new leads because the final system is CRT-D
- B. Code only remote monitoring because the old ICD was already present
- C. Code loop recorder insertion because additional rhythm monitoring will occur after surgery
- D. Capture the generator replacement and new lead additions required for upgrade to CRT-D when supported

Answer: D

Question: 5

A structural heart report documents percutaneous transcatheter left atrial appendage closure for a patient with nonvalvular atrial fibrillation who is not a long-term anticoagulation candidate. The physician performs transseptal access, deploys an occlusion device in the left atrial appendage, confirms seal by imaging, and releases the device. Which coding concept best matches the procedure?

- A. External electrical cardioversion is supported because the patient has atrial fibrillation
- B. Pacemaker insertion is supported because an intracardiac device was implanted
- C. Transcatheter left atrial appendage occlusion is supported by device deployment and seal confirmation
- D. Atrial fibrillation ablation is supported because transseptal access was obtained

Answer: C

Question: 6

An established cardiology patient is seen for stable coronary artery disease and medication-related dizziness. The cardiologist reviews home blood pressure logs, decreases the beta-blocker dose, orders a basic metabolic panel, and documents low medical decision making. Total time is not documented. Which E/M level-selection principle is most appropriate?

- A. Select the level based only on the number of diagnoses listed in the assessment
- B. Select a new patient code because the medication plan changed
- C. Select the level based on a scored comprehensive history because medication was changed
- D. Select the established patient office visit level based on the documented medical decision making

Answer: D

Question: 7

An operative report documents removal of an existing dual-lead implantable cardioverter-defibrillator pulse generator due to battery depletion. The existing right atrial and right ventricular defibrillator leads are tested and retained. A new ICD generator is connected and placed in the existing pocket. No new leads are inserted. Which CPT® coding concept best represents this service?

- A. Remote ICD interrogation with physician analysis and report
- B. Repositioning of previously implanted pacemaker electrodes only
- C. ICD generator removal and replacement for an existing dual-lead system
- D. Initial insertion of a new dual-chamber ICD system with new leads

Answer: C

Question: 8

During high-risk PCI, the cardiologist documents percutaneous insertion of a ventricular assist device for hemodynamic support, performance of PCI with stent placement, and removal of the support device at the end of the case. The report includes device insertion site, support duration, and reason for use. Which coding issue should be reviewed?

- A. Whether the case should be coded as TAVR because large-bore arterial access was required
- B. Whether temporary mechanical circulatory support insertion and removal are separately reportable or bundled with PCI under current rules
- C. Whether PCI should be omitted because a support device was used
- D. Whether the support device should be coded as a permanent pacemaker because it assisted the heart

Answer: B

Question: 9

An echocardiography follow-up note documents: "Severe nonrheumatic tricuspid regurgitation with right atrial enlargement. No rheumatic valve disease. No mitral valve stenosis." The cardiologist is

monitoring the patient for possible transcatheter valve therapy. Which ICD-10-CM coding concept best applies?

- A. Code unspecified heart failure because right-sided chamber enlargement is present
- B. Code mitral stenosis because right atrial enlargement is documented
- C. Code rheumatic tricuspid valve disease because severe regurgitation is usually rheumatic
- D. Code nonrheumatic tricuspid valve insufficiency when supported by the documentation

Answer: D

Question: 10

A cath report documents selective coronary angiography only. The cardiologist evaluates the native coronary arteries, provides interpretation, and does not cross the aortic valve, measure left ventricular pressures, or perform left ventriculography. No intervention is performed. Which coding concept is most important?

- A. Select a coronary angiography code that matches coronary imaging without left heart catheterization when supported
- B. Report echocardiography because left ventricular pressure was not measured
- C. Report PCI because selective coronary arteries were imaged
- D. Report left heart catheterization because all coronary angiography includes crossing the aortic valve

Answer: A

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**



Visit us at: <https://www.examsboost.com/test/ccc>