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AAPC Certified Emergency Department Coder



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Question: 1

A claim is selected for audit. The ED physician's note states only, "Seen with student. Agree." The medical student note contains the history, examination, MDM, and procedure description. No additional physician documentation of personal performance, review, or decision-making is present. Which compliance conclusion is most appropriate?

- A. The student note alone fully supports the physician's professional claim in all cases
- B. The physician documentation may be insufficient to support professional billing without required physician participation and attestation elements
- C. The coder should copy the student's MDM into the physician note before coding
- D. The highest ED E/M level is supported because a student documented a detailed note

Answer: B

Question: 2

A patient comes to the ED two days after outpatient dental extraction with mild gum bleeding. The ED physician documents "postprocedural hemorrhage following dental extraction" and treats the bleeding with local measures. No anticoagulant toxicity is documented. Which diagnosis-coding principle is most appropriate?

- A. Code poisoning by anticoagulant because all postprocedural bleeding is medication-related
- B. Code only gum bleeding because complication codes are never used in ED encounters
- C. Code a postprocedural hemorrhage complication because the provider documented hemorrhage following the dental extraction
- D. Code routine aftercare only because the dental procedure occurred before the ED visit

Answer: C

Question: 3

A professional claim for an ED ECG lists only a screening diagnosis even though the physician note documents evaluation of palpitations and near-syncope. The payer denies the ECG for lack of medical necessity. Which coding correction is most appropriate if supported by the record?

- A. Change the ED E/M level to a higher code to make the ECG payable
- B. Remove all diagnosis codes because CPT® codes alone should prove medical necessity
- C. Add a myocardial infarction diagnosis because ECGs are commonly used to detect infarction

D. Use diagnosis codes supported by the physician documentation that reflect the symptoms or conditions prompting the ECG

Answer: D

Question: 4

An ED physician documents an embedded earring back in the left earlobe with localized swelling. After local anesthesia, the physician makes a small incision, removes the embedded earring back, irrigates the wound, and applies a dressing. No abscess drainage or laceration repair is documented. Which procedure-coding interpretation is most appropriate?

- A. Report laceration repair because an incision was made
- B. Report cerumen removal because the service involved the ear
- C. Report the foreign body removal service supported by the documented incision and removal of the embedded earring back
- D. Report incision and drainage because the earlobe was swollen

Answer: C

Question: 5

An ED physician evaluates a patient with a retained rectal foreign body. The physician documents digital rectal examination, visualization with anoscopy, removal of the object using forceps without incision, post-removal examination showing no bleeding or perforation signs, and discharge instructions. Which procedure-coding interpretation is most appropriate?

- A. Evaluate foreign body removal coding based on anatomic site, technique, anoscopy documentation, and payer rules
- B. Report laceration repair because post-removal examination was performed
- C. Report abdominal surgery because rectal foreign bodies always require operative removal
- D. Report incision and drainage because an object was removed from a body cavity

Answer: A

Question: 6

An ED physician performs abscess drainage and documents use of bedside ultrasound to identify the fluid collection before incision. The note does not include saved images, a separate ultrasound interpretation, or documentation meeting payer requirements for a separately reportable ultrasound service. Which coding interpretation is most appropriate?

- A. Do not separately report ultrasound guidance or diagnostic ultrasound unless documentation meets CPT® and payer requirements
- B. Replace the incision and drainage code with an ultrasound code because imaging guided the procedure
- C. Always report a separate ultrasound code whenever ultrasound is mentioned
- D. Report modifier 50 because ultrasound can scan both sides of the body

Answer: A

Question: 7

An internal audit reviews an ED professional claim with a high-level ED E/M, critical care, and two procedure codes. The physician note documents a stable patient with a superficial splinter, no abnormal vital signs, no high-risk diagnosis, no critical care time, and only simple removal of the splinter with forceps. The coder is asked to validate the billed claim. Which audit conclusion is most appropriate?

- A. Critical care is supported because any foreign body can become infected if untreated
- B. The billed claim is likely unsupported because the documented patient condition and services do not substantiate high-level E/M, critical care, or multiple procedures
- C. Multiple procedures are supported because forceps removal, dressing, and discharge instructions are separate services
- D. The claim is supported because ED encounters are presumed high acuity unless proven otherwise

Answer: B

Question: 8

A 3-year-old child is brought to the ED after a brief episode of unresponsiveness at home. The parent provides the entire history because the child cannot describe the event. The ED physician documents the parent's account, orders point-of-care glucose and electrolytes, reviews the child's medication list, and discusses follow-up with the pediatrician. Which MDM data element is most directly supported by the parent's history?

- A. Use of an independent historian when the patient cannot provide a reliable history
- B. A separately billable procedure because the physician spoke with the parent
- C. Prescription drug management because the parent gave the history
- D. Critical care because the patient is a young child

Answer: A

Question: 9

A coder reviews an ED claim for abdominal pain. The physician's final assessment states "acute cholecystitis." The ultrasound report says "gallbladder wall thickening and stones, suspicious for acute cholecystitis." The physician treated with IV antibiotics and admitted the patient to surgery. Which coding conclusion is most appropriate?

- A. Code abdominal pain only because surgery made the final diagnosis after admission
- B. Code only abnormal ultrasound findings because the radiology report used the word "suspicious"
- C. Code chronic cholecystitis because gallstones are usually chronic
- D. Code acute cholecystitis based on the provider's final documented diagnosis, with supporting imaging and treatment context

Answer: D

Question: 10

An ED physician treats a superficial abrasion contaminated with dirt after a fall. The note documents cleansing with saline, removal of surface debris with gauze, topical antibiotic, and dressing. No excisional debridement, laceration closure, or burn treatment is documented. Which coding interpretation is most appropriate?

- A. Report excisional debridement because gauze was used to remove debris
- B. Routine cleansing and dressing may be included in the ED E/M service unless separately reportable debridement criteria are documented
- C. Report complex laceration repair because dirt was removed from the wound
- D. Report burn treatment because the skin surface was damaged

Answer: B

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