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Question: 1

A gastroenterologist receives a written request from a primary care physician to evaluate a patient with persistent dyspepsia and provide recommendations. The gastroenterologist evaluates the patient, documents the findings and recommendations, and sends a written report back to the requesting physician. The payer accepts consultation codes when documentation requirements are met. Which documentation element is most important to support reporting a consultation service rather than a routine transfer-of-care visit?

- A. A documented request for opinion or advice and a written report back to the requesting provider
- B. The patient's statement that another physician suggested the appointment
- C. The gastroenterologist's decision to order an upper endoscopy at a future date
- D. The fact that the visit occurred in a specialty practice rather than a primary care office

Answer: A

Question: 2

A patient is scheduled for a minor toenail procedure. On the same date, the physician also evaluates newly diagnosed uncontrolled hypertension, reviews home blood pressure readings, starts prescription therapy, and documents a separate treatment plan. The toenail procedure is performed as scheduled. Which modifier is most appropriate for the E/M service if the documentation supports separate reporting?

- A. Modifier 24
- B. Modifier 79
- C. Modifier 25
- D. Modifier 57

Answer: C

Question: 3

A pediatrician evaluates a school-age child for recurrent abdominal pain. The physician reviews a food and symptom diary, orders celiac serology, discusses alarm symptoms, and schedules follow-up after test results. No prescription medication is started, and no total time is documented. Which statement best describes the MDM analysis?

- A. The E/M level should be based on the number of abdominal examination findings

- B. Data review and ordered testing may support MDM even without prescription drug management
- C. The encounter must be low level because no prescription medication was started
- D. The child's school-age status determines the code family and level

Answer: B

Question: 4

A pregnant patient is seen for routine prenatal care but also reports new severe headache and elevated home blood pressure readings. The OB/Gyn documents a separate assessment for possible gestational hypertension, orders laboratory testing, reviews warning signs, and directs the patient to labor and delivery triage for further evaluation. Which coding consideration is most appropriate?

- A. A separately identifiable problem-oriented E/M service may be supported if the documentation and payer rules support reporting outside routine prenatal care
- B. The visit should be reported only with a preventive medicine code because pregnancy care is preventive
- C. The work must be included in routine prenatal care because the patient is pregnant
- D. The E/M service should be coded based on a comprehensive physical examination count

Answer: A

Question: 5

During the postoperative period after a major procedure, a surgeon evaluates the patient for routine medication questions related to the surgical recovery plan. The surgeon reviews expected postoperative pain control, confirms no complications, and gives routine recovery instructions. No unrelated problem is evaluated. Which modifier decision is most appropriate?

- A. Append modifier 25 because counseling was provided during the postoperative visit
- B. Append modifier 57 because pain control decisions may affect future procedures
- C. Do not append modifier 24 because the service is related to routine postoperative care
- D. Append modifier 24 because medication questions are always unrelated to surgery

Answer: C

Question: 6

An established cardiology patient with known atrial fibrillation presents with new palpitations. The cardiologist reviews a wearable-device rhythm strip brought by the patient, orders a Holter monitor, adjusts rate-control medication, and documents stroke-risk counseling. No total time is documented. Which factor most directly supports MDM risk analysis?

- A. The patient bringing a wearable-device rhythm strip
- B. The patient's established status with the cardiology practice
- C. The order for Holter monitoring alone
- D. Adjustment of rate-control medication with documented stroke-risk counseling/

Answer: D

Question: 7

A physician documents an office visit for an established patient with worsening depression. The note includes a clinically appropriate interval history, mental status examination, assessment, and medication plan. The coder notices that the examination is brief but relevant to the presenting problem. No total time is documented. Which interpretation is most appropriate under current office/outpatient E/M guidelines?

- A. The examination may be medically appropriate even if it is not extensive, and the E/M level should be selected by MDM
- B. The encounter cannot be reported because psychiatric symptoms require a comprehensive physical examination
- C. The E/M level should be selected by counting the number of examination elements documented
- D. The encounter must be downcoded because a complete multisystem examination is not documented

Answer: A

Question: 8

A patient is seen for shortness of breath. The physician documents "acute exacerbation of chronic systolic heart failure" after examination, chest x-ray review, and medication adjustment. The note does not indicate that shortness of breath is unrelated to heart failure. Which diagnosis-coding approach is most appropriate?

- A. Report a screening code because chest x-ray findings were reviewed
- B. Report shortness of breath as the only diagnosis because it prompted the visit
- C. Report unspecified heart disease because the patient's symptoms could have multiple causes
- D. Report the documented acute exacerbation of chronic systolic heart failure rather than separately coding shortness of breath

Answer: D

Question: 9

A new patient is evaluated for intermittent dizziness. The physician orders a complete blood count and metabolic panel, reviews an external urgent care note, and documents that symptoms are most consistent with benign positional vertigo. The patient is given home repositioning instructions and advised to return if symptoms worsen. No prescription medication is started, and no total time is documented. Which statement best describes the MDM analysis?

- A. The encounter automatically supports high risk because dizziness can indicate stroke
- B. The encounter must be selected by time because vertigo cannot be coded using MDM
- C. The ordered tests and external note review contribute to data, while conservative management limits the risk element
- D. The level is determined by the number of physical examination maneuvers performed

Answer: C

Question: 10

A 68-year-old established patient is seen for chronic kidney disease stage 3, hypertension, and type 2 diabetes with hyperglycemia. The physician reviews a recent nephrology note, orders a urine albumin-creatinine ratio, adjusts an ACE inhibitor, and documents discussion of kidney-protective diabetes management. No total time is documented. Which documentation feature most directly supports moderate or higher MDM consideration?

- A. Management of multiple chronic conditions with prescription drug adjustment and ordered testing
- B. The patient's age being greater than 65 years
- C. The absence of a complete physical examination
- D. The use of a specialist note as background information only

Answer: A

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