Medical Technology

CCS

Certified Coding Specialist Examination

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Question: 1

Which one of the following is necessary to function as a clinical validation professional?

A. Certification in clinical documentation integrity
B. An ability to independently interpret basic studies such as EKGs and x-rays
C. Knowledge of evidence-based guidelines for diagnosing and treating various conditions
D. An active registered nursing license in the state of employment

Answer: C

Explanation:
The role of clinical validation professionals is to determine whether the documentation supports the given diagnoses; therefore, knowledge of the current evidence-based guidelines for diagnosing and treating various conditions is essential. This does not necessarily require a nursing or medical degree, or even clinical documentation improvement certification. With the appropriate training, coders can perform clinical validation. Independent interpretation of diagnostic tests is the responsibility of the provider, not the clinical validation professional.

Question: 2

Which ICD-10-CM code(s) should be reported? Select all that apply.

Outpatient Care: Primary care physician	**Date:** 7/23
Progress Note: 56-year-old established male here for annual physical. He is overall doing well at this point, really without issues or concerns. His blood test results were reviewed with him, and his levels are stable. Overall, he has been feeling very well	
Physical Exam: **BP:** 128/80 **Pulse:** 92 **Height:** 5′9″ **Weight:** 133.8 kg **BMI:** 43.56	
Constitutional: Patient is alert, pleasant, and in no acute distress. Well-developed, well-nourished, +obesity **HEENT:** Atraumatic, normocephalic, extraocular muscles intact, pupils equal and reactive to light, no signs of conjunctivitis, tympanic membranes are clear without lesions, neck without lymphadenopathy, trachea midline, no carotid bruits **Respiratory:** Clear to auscultation bilaterally without any wheezes, he is moving air very well, no accessory muscles of respiration	**Cardiovascular:** Normal rate, normal rhythm, no murmurs **Gastrointestinal:** Soft, nontender, and nondistended, normal active bowel sounds, no rebound or guarding **Musculoskeletal:** Patient without edema, 5+/5+ strength bilaterally in all upper and lower extremities, patient moving all extremities equally **Psychiatric:** Speech and behavior appropriate
Assessment: Physical exam with abnormal finding of obesity.	
Plan: Patient counseled for 20 minutes on exercise, nutrition, and weight loss. Advised to follow up in 3 months for a weight check. Recommended Cologuard and a CT scan of his chest for screening purposes; recommended flu, shingles, and tetanus booster. Administered 0.5 mL IIV3 P/F shot intramuscularly in the office.	

A. Z01.411
B. Z00.01
C. E66.09
D. E66.3
E. Z23
F. E66.9
G. Z68.41
H. E66.8

Answer: B,E,F,G

Explanation:
The correct codes that should be reported are Z00.01 (Encounter for general adult medical examination with abnormal findings), Z23 (Encounter for immunization), E66.9 (Obesity, unspecified), and Z68.41 (Body mass index 40.0—44.9, adult). Although the patients BMI is not documented in the assessment, it can be abstracted from the medical record when there is an associated and reportable diagnosis.

Question: 3

Which CPT code(s) should be reported for this encounter? Select all that apply.

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A. 90471
B. G0008
C. 99213
D. 96372
E. 99396
F. 99213-25
G. 99396-25
H. 90656

Answer: A,G,H

Explanation:
The correct codes that should be reported are 99396-25, 90471, and 90656. A preventative re-evaluation, otherwise known as an annual visit, is typically done to re-evaluate and manage the overall health condition of a patient This may include recommendations based on personal risk factors, orders for laboratory and diagnostic testing, and an applicable history intake and examination. Although a separately identifiable E/M service may be appended to these services, time should not be the determining factor. CPT code G0008 should only be reported for Medicare patients receiving the flu vaccine.

Question: 4

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

Admission Diagnosis: Acute respiratory failure with hypoxia	**Admission Date**: 5/27
Discharge Diagnosis: Acute respiratory failure with hypoxia secondary to acute on chronic diastolic congestive heart failure	**Discharge Date**: 6/02
Past Medical History: Hypertension, hyperlipidemia, coronary artery disease, cerebral vascular accident	
Hospital Course: The patient was admitted with complaint of significant increased swelling in her legs despite increased diuretic at home with addition of metolazone started by her cardiologist. The patient was treated with intravenous furosemide. She had greater than 9 L of fluid out during her hospitalization with her lower extremity edema being significantly improved. The patient had shortness of breath requiring oxygen but was on room air at the time of discharge. She was able to ambulate independently with a walker. She will be discharged with home nursing for close follow-up, and she will be started in the Helping Heart program.	
Physical Exam: **Pulse**: 80 **Respiration Rate**: 16 **Weight**: 104 kg **BP**: 136/69 **Temperature**: 99 °F **Height**: 5′ **SpO_2**: 95% **General**: Patient is alert, oriented, and in no acute distress **Neck**: Soft and supple, no carotid bruits, no thyromegaly **HEENT**: Normocephalic and atraumatic, pupils equally round and reactive to light, sclerae are anicteric, no conjunctivitis or subconjunctival lesions **Abdomen**: Soft, nontender and nondistended, bowel sounds are normoactive, no guarding or rebound tenderness, no palpable masses or hernias, no suprapubic tenderness	**Coronary**: Regular rate and rhythm without murmurs, rubs, or gallops **Pulmonary**: Normal respiratory effort, lungs are clear to auscultation bilaterally without wheezing **Extremities**: Warm without clubbing, edema in lower extremities greatly improved **Neurologic**: Alert and oriented to person, place, and time; cranial nerves II–XII are intact; strength and sensation are grossly intact; no focal deficits
More than 30 minutes was spent counseling and coordinating the care of this patient.	

A. 111.0
B. 196.01
C. E78.5
D. 150.31
E. 111.1
F. 150.33
G. 110
H. 125.10

Answer: A

Explanation:

Although the underlying disease responsible for the admission is acute on chronic diastolic congestive heart failure (ICD-10-CM code 150.33), there is a "Code first" note for any causal conditions that may be associated with it. Because the patient has hypertension, and the documentation does not explicitly state that the two conditions are unrelated, hypertensive heart failure (ICD-10-CM code 111.0) should be the principal code.

Question: 5

Which other ICD-IO-CM code(s) should be reported? Select all that apply.

Admission Diagnosis: Acute respiratory failure with hypoxia	**Admission Date:** 5/27
Discharge Diagnosis: Acute respiratory failure with hypoxia secondary to acute on chronic diastolic congestive heart failure	**Discharge Date**: 6/02
Past Medical History: Hypertension, hyperlipidemia, coronary artery disease, cerebral vascular accident	
Hospital Course: The patient was admitted with complaint of significant increased swelling in her legs despite increased diuretic at home with addition of metolazone started by her cardiologist. The patient was treated with intravenous furosemide. She had greater than 9 L of fluid out during her hospitalization with her lower extremity edema being significantly improved. The patient had shortness of breath requiring oxygen but was on room air at the time of discharge. She was able to ambulate independently with a walker. She will be discharged with home nursing for close follow-up, and she will be started in the Helping Heart program.	
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More than 30 minutes was spent counseling and coordinating the care of this patient.	

A. 125.10
B. Z86.73
C. 111.0
D. 150.33
E. 110
F. E78.5

G. 196.01

Answer: A,B,D,G,H

Explanation:
The correct additional codes that should be reported are 125.10 (Coronary artery disease), Z86.73 (Personal history of stroke NOS without residual deficits), 150.33 (Acute on chronic diastolic congestive heart failure), E78.5 (Hyperlipidemia), and 196.01 (Acute respiratory failure with hypoxia). ICD-10-CM code 110 should not be coded alone because it has a causal relationship assumed with the heart failure.

Question: 6

Which CPT code should be reported for this encounter?

Admission Diagnosis: Acute respiratory failure with hypoxia	**Admission Date:** 5/27
Discharge Diagnosis: Acute respiratory failure with hypoxia secondary to acute on chronic diastolic congestive heart failure	**Discharge Date**: 6/02
Past Medical History: Hypertension, hyperlipidemia, coronary artery disease, cerebral vascular accident	
Hospital Course: The patient was admitted with complaint of significant increased swelling in her legs despite increased diuretic at home with addition of metolazone started by her cardiologist. The patient was treated with intravenous furosemide. She had greater than 9 L of fluid out during her hospitalization with her lower extremity edema being significantly improved. The patient had shortness of breath requiring oxygen but was on room air at the time of discharge. She was able to ambulate independently with a walker. She will be discharged with home nursing for close follow-up, and she will be started in the Helping Heart program.	
Physical Exam: **Pulse**: 80 **Respiration Rate**: 16 **Weight**: 104 kg **BP**: 136/69 **Temperature**: 99 °F **Height**: 5′ **SpO_2**: 95% **General**: Patient is alert, oriented, and in no acute distress **Neck**: Soft and supple, no carotid bruits, no thyromegaly **HEENT**: Normocephalic and atraumatic, pupils equally round and reactive to light, sclerae are anicteric, no conjunctivitis or subconjunctival lesions **Abdomen**: Soft, nontender and nondistended, bowel sounds are normoactive, no guarding or rebound tenderness, no palpable masses or hernias, no suprapubic tenderness	**Coronary**: Regular rate and rhythm without murmurs, rubs, or gallops **Pulmonary**: Normal respiratory effort, lungs are clear to auscultation bilaterally without wheezing **Extremities**: Warm without clubbing, edema in lower extremities greatly improved **Neurologic**: Alert and oriented to person, place, and time; cranial nerves II–XII are intact; strength and sensation are grossly intact; no focal deficits
More than 30 minutes was spent counseling and coordinating the care of this patient.	

A. 99231
B. 99238

C. 99315
D. 99232
E. 99316
F. 99239
G. 99233
H. 99217

Answer: F

Explanation:
The note describes hospital discharge management which includes discharge instructions, a final patient evaluation, review of inpatient admission, final preparation of the patient's medical records, and provisional prescriptions/referrals. Hospital discharge management is reported with time spent with the patient, which, in this scenario, is greater than 30 minutes.

Question: 7

The following codes are entered on the patient's claim: Ell.628, L03.115, M79.671, R53.83, M79.10, R50.81, and Z79.84. Which code(s) should be removed? Select as many as is appropriate.

Urgent Care Clinic	**Date:** 8/05
Progress Note: A 43-year-old male patient with a history of type II diabetes presents to an urgent care clinic with right foot pain, fatigue, muscle aches, and a fever of 101.4 °F that began 5 days ago.	
Physical Exam: **Constitutional:** Oriented to person, place, and time, +fever **Abdominal:** Soft, bowel sounds are normal, no masses or tenderness **Skin:** Warm and dry, no rash or ulceration noted, + cellulitis on right heel	**Pulmonary/Chest:** Effort is normal and breath sounds are normal, no respiratory distress **Musculoskeletal:** + Decreased range of motion due to generalized muscle pain, no edema, absent left big toe **Eyes:** Pupils are equal, round, and reactive to light; extraocular movement is normal
Assessment: Cellulitis of the right foot.	
Plan: The patient was prescribed amoxicillin and Augmentin and instructed to take 350 mg every 12 hours and follow up in 3 days.	

A. E11628
B. L03.115
C. M79.671
D. R53.83
E. M79.10
F. R50.81
G. Z79.84
H. None

Answer: C,D,E,F,G

Explanation:
Foot pain, fatigue, muscle aches, and fevers are all symptoms of cellulitis, a skin infection. Neither of these codes should be reported because ICD-10-CM guidelines stipulate that when a definitive diagnosis is present, signs and/or symptoms should not be listed on the claim. Additionally, because skin infections, ulcers, and abscesses are common in patients who suffer from diabetes, E11.628 should be reported as a comorbidity. However, long-term/current use of oral hypoglycemic drugs should not listed because the documentation does not specify how the diabetes is being managed.

Question: 8

If the patient has been treated at this urgent care clinic within the last three years, what CPT code should be reported for this encounter?

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Physical Exam: **Constitutional:** Oriented to person, place, and time, +fever **Abdominal:** Soft, bowel sounds are normal, no masses or tenderness **Skin:** Warm and dry, no rash or ulceration noted, + cellulitis on right heel	**Pulmonary/Chest:** Effort is normal and breath sounds are normal, no respiratory distress **Musculoskeletal:** + Decreased range of motion due to generalized muscle pain, no edema, absent left big toe **Eyes:** Pupils are equal, round, and reactive to light; extraocular movement is normal
Assessment: Cellulitis of the right foot.	
Plan: The patient was prescribed amoxicillin and Augmentin and instructed to take 350 mg every 12 hours and follow up in 3 days.	

A. 99215
B. 99214
C. 99213
D. 99212
E. 99202
F. 99203
G. 99204
H. 99205

Answer: B

Explanation:
Urgent care clinics follow the same rules regarding new versus established E/M procedure codes, even though the conditions are usually new. Outpatient E/M codes are leveled by time and/or the complexity

of MDM, which includes the problems addressed, the data to be reviewed, and the risk of complications, morbidity, and/or mortality of patient management. In this scenario, the patient is suffering from an acute illness with systemic symptoms that include fatigue, muscle aches, and fevers. Additional treatment involves prescription drug management. Although the complexity of data reviewed is minimal, the other two elements suggest moderate MDM, making the most appropriate E/M code 99214.

Question: 9

Which of the following is NOT a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?

A. The Centers for Disease Control and Prevention
B. Employer-sponsored health plan
C. Third-party billing agency
D. Healthcare provider

Answer: A

Explanation:
A covered entity is any person or organization that provides treatment or payment in the healthcare field. These include healthcare providers, healthcare clearinghouses, business associates such as third-party billing companies or consulting agencies, and any individual or group health plan. Public health authorities, which include state and local health departments and the Centers for Disease Control and Prevention, are not considered covered entities.

Question: 10

Which of the following is a risk adjustment model used by Medicare to predict health care costs and resource consumption of specific patient populations over time?

A. Risk adjustment factor (RAF)
B. Diagnosis-related groups
C. Outcome and Assessment Information Set
D. Hierarchical condition category (HCC) coding

Answer: D

Explanation:
Hierarchical condition category (HCC) coding is a risk adjustment model established in 2004 to predict health care costs and resource consumption of a specific patient population over time. Costs and consumption are calculated using a risk adjustment factor (RAF) score assigned to more than 9,500 ICD-10-CM codes associated to one of the 79 HCCs. The Outcome and Assessment Information Set is a quality measurement tool used to report and improve the quality of care delivered to Medicare and Medicaid patients in the home health setting. Diagnosis-related groups (DRGs) refer to a classification

system that factors in the age, gender, diagnosis, and procedures performed during a patient's inpatient hospital stay to determine how much the hospital should be paid.

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