Free Questions for CPC by certsinside

Shared by Matthews on 28-04-2023

For More Free Questions and Preparation Resources

Check the Links on Last Page

Question 1

Question Type: MultipleChoice

View MR 099407

MR 099407

Emergency Department Visit

Chief Complaint: VOMITING.

This started just prior to arrival and is still present. He has had nausea and vomiting. No diarrhea, black stools, bloody stools or abdominal pain. Pt is diabetic and has been having elevated blood sugars (320 mg/dL).

REVIEW OF SYSTEMS: Unobtainable due to patient's altered mental status.

PAST HISTORY: Poorly controlled diabetes mellitus, with history of poor compliance.

Medications: See Nurses Notes.

Allergies: PCN.

SOCIAL HISTORY: Nonsmoker. No alcohol use or drug use.

ADDITIONAL NOTES: The nursing notes have been reviewed.

PHYSICAL EXAM

Appearance: Lethargic. Patient in mild distress.

Vital Signs: Have been reviewed-tachycardic.

Eyes: Pupils equal, round and reactive to light.

ENT: Dry mucous membranes present.

Neck: Normal inspection. Neck supple.

CVS: Tachycardia. Heart sounds normal. Pulses normal.

E D. Course: Insulin IV drip per protocol, at 10 units/hr.

Zofran 8 mg 01:33 Jul 13 2008 IVP.

Phenergan 25 mg IVP. 07:52. Discussed case with physician. Dr. X. Reviewed test results. Agreed upon treatment plan. Physician will see patient in hospital.

Total critical care time: 45 min.

Disposition: Admitted to Intensive Care Unit. Condition: stable.

Admit decision based on need for monitoring and IV hydration and medications.

CLINICAL IMPRESSION: Vomiting, diabetic ketoacidosis, probable diabetes insipidus.

What E/M code is reported for this encounter?

Options:

A- 99291

B- 99291, 99292

C- 99222

D- 99285

Answer:

A

Question 2

Question Type: **MultipleChoice**

View MR 099405

MR 099405

CC: Shortness of breath

HPI: 16-year-old female comes into the ED for shortness of breath for the last two days. She is an asthmatic.

Current medications being used to treat symptoms is Advair, which is not working and breathing is getting worse. Does not feel that Advair has been helping. Patient tried Albuterol for persistent coughing, is not helping. Coughing 10-15 minutes at a time. Patient has used the Albuterol 3x in the last 16 hrs. ED physician admits her to observation status.

ROS: No fever, no headache. No purulent discharge from the eyes. No earache. No nasal discharge or sore throat. No swollen glands in the neck. No palpitations. Dyspnea and cough. Some chest pain. No nausea or vomiting. No abdominal pain, diarrhea, or constipation.

PMH: Asthma

SH: Lives with both parents.

FH: Family hx of asthma, paternal side

ALLERGIES: PCN-200 CAPS. Allergies have been reviewed with child's family and no changes reported.

PE: General appearance: normal, alert. Talks in sentences. Pink lips and cheeks. Oriented. Well developed. Well nourished. Well hydrated.

Eyes: normal. External eye: no hyperemia of the conjunctiva. No discharge from the conjunctiva

Ears: general/bilateral. TM: normal. Nose: rhinorrhea. Pharynx/Oropharynx: normal. Neck: normal.

Lymph nodes: normal.

Lungs: before Albuterol neb, mode air entry b/l. No rales, rhonchi or wheezes. After Albuterol neb. improvement of air entry b/l. Respiratory movements were normal. No intercostals inspiratory retraction was observed.

Cardiovascular system: normal. Heart rate and rhythm normal. Heart sounds normal. No murmurs were heard.

GI: abdomen normal with no tenderness or masses. Normal bowel sounds. No hepatosplenomegaly

Skin: normal warm and dry. Pink well perfused

Musculoskeletal system patient indicates lower to mid back pain when she lies down on her back and when she rolls over. No CVA tenderness.

Assessment: Asthma, acute exacerbation

Plan: Will keep her in observation overnight. Will administer oral steroids and breathing treatment. CXR ordered and to be taken in the morning.

What E/M code is reported?

Options:

A- 99221

B- 99284

C- 99285

D- 99222

Answer:

B

Question 3

Question Type: MultipleChoice

View MR 099401

MR 099401

Established Patient Office Visit

Chief Complaint: Patient presents with bilateral thyroid nodules.

History of present illness: A 54-year-old patient is here for evaluation of bilateral thyroid nodules. Thyroid ultrasound was done last week which showed multiple thyroid masses likely due to multinodular goiter. Patient stated that she can "feel" the nodules on the left side of her thyroid. Patient denies difficulty swallowing and she denies unexplained weight loss or gain. Patient does have a family history of thyroid cancer in her maternal grandmother. She gives no other problems at this time other than a palpable right-sided thyroid mass.

Review of Systems:

Constitutional: Negative for chills, fever, and unexpected weight change.

HENT: Negative for hearing loss, trouble swallowing and voice change.

Gastrointestinal: Negative for abdominal distention, abdominal pain, anal bleeding, blood in stool, constipation, diarrhea, nausea, rectal pain, and vomiting

Endocrine: Negative for cold Intolerance and heat intolerance.

Physical Exam:

Vitals: BP: 140/72, Pulse: 96, Resp: 16, Temp: 97.6 F (36.4 C), Temporal SpO2: 97%

Weight: 89.8 kg (198 lbs), Height: 165.1 cm (65")

General Appearance: Alert, cooperative, in no acute distress

Head: Normocephalic, without obvious abnormality, atraumatic

Throat: No oral lesions, no thrush, oral mucosa moist

Neck: No adenopathy, supple, trachea midline, thyromegaly is present, no carotid bruit, no JVD

Lungs: Clear to auscultation, respirations regular, even, and unlabored

Heart: Regular rhythm and normal rate, normal S1 and S2, no murmur, no gallop, no rub, no click

Lymph nodes: No palpable adenopathy

ASSESSMENT/PLAN:

1) Multinodular goiter - the patient will have a percutaneous biopsy performed (minor procedure).

What E/M code is reported for this encounter?

Options:

A- 99212

B- 99214

C- 99213

D- 99215

Answer:

A

Question 4

Question Type: **MultipleChoice**

View MR 007400

MR 007400

Radiology Report

Patient: J. Lowe Date of Service: 06/10/XX

Age: 45

MR#: 4589799

Account #: 3216770

Location: ABC Imaging Center

Study: Mammogram bilateral screening, all views, producing direct digital image

Reason: Screen

Bilateral digital mammography with computer-aided detection (CAD)

No previous mammograms are available for comparison.

Clinical history: The patient has a positive family history (mother and sister) of breast cancer.

Mammogram was read with the assistance of GE iCAD (computerized diagnostic) system.

Findings: No dominant speculated mass or suspicious area of clustered pleomorphic microcalcifications is apparent Skin and nipples are seen to be normal. The axilla are unremarkable.

What CPT coding is reported for this case?

Options:

A- 77067-50, Z80.3, Z12.31

B- 77066, Z80.3, Z12.31

C- 77067, Z12.31, Z80.3

D- 77066-50, Z12.31, Z80.3

Answer:

C

Question 5

Question Type: **MultipleChoice**

View MR 006399

MR 006399

Operative Report

Preoperative Diagnosis: Chronic otitis media in the right ear

Postoperative Diagnosis: Chronic otitis media in the right ear

Procedure: Eustachian tube inflation

Anesthesia: General

Blood Loss: Minimal

Findings: Serous mucoid fluid

Complications: None

Indications: The patient is a 2-year-old who presented to the office with chronic otitis media refractory to medical management. The treatment will be eustachian tube inflation to remove the fluid. Risks, benefits, and alternatives were reviewed with the family, which include general anesthetic, bleeding, infection, tympanic membrane perforation, routine tubes, and need for additional surgery. The family understood these risks and signed the appropriate consent form.

Procedure in Detail: After the patient was properly identified, he was brought into the operating room and placed supine. The patient was prepped and draped in the usual fashion. General anesthesia was administered via inhalation mask, and after adequate sedation was achieved, a medium-sized speculum was placed in the right ear and cerumen was removed atraumatically using instrument with operative microscope. The tube is dilated, an incision is made to the tympanum and thick mucoid fluid was suctioned. The patient was awakened after having tolerated the procedure well and taken to the recovery room in stable condition.

What CPT coding is reported for this case?

Options:

A- 69420-RT

B- 69436-RT

C- 69433-RT

D- 69421-RT

Answer:

D

Question 6

Question Type: **MultipleChoice**

View MR 099401

MR 099401

Established Patient Office Visit

Chief Complaint: Patient presents with bilateral thyroid nodules.

History of present illness: A 54-year-old patient is here for evaluation of bilateral thyroid nodules. Thyroid ultrasound was done last week which showed multiple thyroid masses likely due to multinodular goiter. Patient stated that she can "feel" the nodules on the left side of her thyroid. Patient denies difficulty swallowing and she denies unexplained weight loss or gain. Patient does have a family history of thyroid cancer in her maternal grandmother. She gives no other problems at this time other than a palpable right-sided thyroid mass.

Review of Systems:

Constitutional: Negative for chills, fever, and unexpected weight change.

HENT: Negative for hearing loss, trouble swallowing and voice change.

Gastrointestinal: Negative for abdominal distention, abdominal pain, anal bleeding, blood in stool, constipation, diarrhea, nausea, rectal pain, and vomiting

Endocrine: Negative for cold Intolerance and heat intolerance.

Physical Exam:

Vitals: BP: 140/72, Pulse: 96, Resp: 16, Temp: 97.6 F (36.4 C), Temporal SpO2: 97%

Weight: 89.8 kg (198 lbs), Height: 165.1 cm (65")

General Appearance: Alert, cooperative, in no acute distress

Head: Normocephalic, without obvious abnormality, atraumatic

Throat: No oral lesions, no thrush, oral mucosa moist

Neck: No adenopathy, supple, trachea midline, thyromegaly is present, no carotid bruit, no JVD

Lungs: Clear to auscultation, respirations regular, even, and unlabored

Heart: Regular rhythm and normal rate, normal S1 and S2, no murmur, no gallop, no rub, no click

Lymph nodes: No palpable adenopathy

ASSESSMENT/PLAN:

1) Multinodular goiter - the patient will have a percutaneous biopsy performed (minor procedure).

What E/M code is reported for this encounter?

Options:

A- 99212

B- 99214

C- 99213

D- 99215

Answer:

A

Question 7

Question Type: **MultipleChoice**

View MR 099407

MR 099407

Emergency Department Visit

Chief Complaint: VOMITING.

This started just prior to arrival and is still present. He has had nausea and vomiting. No diarrhea, black stools, bloody stools or abdominal pain. Pt is diabetic and has been having elevated blood sugars (320 mg/dL).

REVIEW OF SYSTEMS: Unobtainable due to patient's altered mental status.

PAST HISTORY: Poorly controlled diabetes mellitus, with history of poor compliance.

Medications: See Nurses Notes.

Allergies: PCN.

SOCIAL HISTORY: Nonsmoker. No alcohol use or drug use.

ADDITIONAL NOTES: The nursing notes have been reviewed.

PHYSICAL EXAM

Appearance: Lethargic. Patient in mild distress.

Vital Signs: Have been reviewed-tachycardic.

Eyes: Pupils equal, round and reactive to light.

ENT: Dry mucous membranes present.

Neck: Normal inspection. Neck supple.

CVS: Tachycardia. Heart sounds normal. Pulses normal.

E D. Course: Insulin IV drip per protocol, at 10 units/hr.

Zofran 8 mg 01:33 Jul 13 2008 IVP.

Phenergan 25 mg IVP. 07:52. Discussed case with physician. Dr. X. Reviewed test results. Agreed upon treatment plan. Physician will see patient in hospital.

Total critical care time: 45 min.

Disposition: Admitted to Intensive Care Unit. Condition: stable.

Admit decision based on need for monitoring and IV hydration and medications.

CLINICAL IMPRESSION: Vomiting, diabetic ketoacidosis, probable diabetes insipidus.

What E/M code is reported for this encounter?

Options:

A- 99291

B- 99291, 99292

C- 99222

D- 99285

Answer:

A

Question 8

Question Type: MultipleChoice

View MR 006399

MR 006399

Operative Report

Preoperative Diagnosis: Chronic otitis media in the right ear

Postoperative Diagnosis: Chronic otitis media in the right ear

Procedure: Eustachian tube inflation

Anesthesia: General

Blood Loss: Minimal

Findings: Serous mucoid fluid

Complications: None

Indications: The patient is a 2-year-old who presented to the office with chronic otitis media refractory to medical management. The treatment will be eustachian tube inflation to remove the fluid. Risks, benefits, and alternatives were reviewed with the family, which include general anesthetic, bleeding, infection, tympanic membrane perforation, routine tubes, and need for additional surgery. The family understood these risks and signed the appropriate consent form.

Procedure in Detail: After the patient was properly identified, he was brought into the operating room and placed supine. The patient was prepped and draped in the usual fashion. General anesthesia was administered via inhalation mask, and after adequate sedation was achieved, a medium-sized speculum was placed in the right ear and cerumen was removed atraumatically using instrument with operative microscope. The tube is dilated, an incision is made to the tympanum and thick mucoid fluid was suctioned. The patient was awakened after having tolerated the procedure well and taken to the recovery room in stable condition.

What CPT coding is reported for this case?

Options:

A- 69420-RT

B- 69436-RT

C- 69433-RT

D- 69421-RT

Answer:

D