AAPC Certified Evaluation and Management Coder (CEMC) Practice Exam (Sample)

Study Guide

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Questions

1. What does the ICD-10-CM code book typically use to indicate specific coding situations?

A. Notes and colors

B. Brackets and italics

C. Different languages

D. Separation of conditions

2. What does Z codes classify?

A. Factors influencing health status and contact with health services

B. Chronic diseases that require ongoing treatment

C. Emergency medical conditions

D. Outcomes of surgical interventions

3. When should healthcare providers begin using the latest ICD-10-CM code revisions?

A. January 1st

B. March 1st

C. October 1st

D. December 1st

4. Which categories should be used as a secondary diagnosis with burn/corrosion codes?

A. T30 and T31

B. T31 and T32

C. T32 and T33

D. T33 and T34

5. In coding burns, what does code T31.21 indicate?

A. 10-19% of the body surface burned

B. 20-29% of the body surface with 10-19% third degree burns

C. 30-39% of the body surface with 20-29% third degree burns

D. 40-49% of the body surface burned

6. Which Z Codes categories pertain to follow-up care?

A. Z00 - Z07

B. Z08 - Z09 and Z39

C. Z30 - Z34

D. Z20 - Z29

7. When coding for asthma, what aspect of the asthma must be documented?

A. Severity

B. Type

C. Duration

D. Frequency

8. When scoring an E/M, what documentation guidelines should be used?

A. The guidelines that support the physician's credentialing

B. The guidelines that provide the highest level of documentation

C. The guidelines that are the most updated

D. The guidelines recommended by third-party payers

9. What is the type of supervision required for a service to be billed incident-to?

A. General supervision

B. Direct supervision

C. Personal supervision

D. No supervision is necessary

10. When the tendon sheath injections are to multiple different tendon sheaths, how should each injection be reported?

A. One time

B. Two times

C. Each separately

D. None of the above

Answers

1. B
2. A
3. C
4. B
5. B
6. B
7. A
8. B
9. B
10. C

Explanations

1. What does the ICD-10-CM code book typically use to indicate specific coding situations?

A. Notes and colors

B. Brackets and italics

C. Different languages

D. Separation of conditions

The ICD-10-CM code book employs brackets and italics as conventions to indicate specific coding situations. Brackets are typically used to enclose synonyms, alternative wording, or explanatory phrases within the code descriptions. This helps coders understand that the terms included within the brackets may not be required for the code but can provide additional context. Italics are used to highlight certain terms, such as the titles of specific conditions or diseases, emphasizing the primary focus for that coding section. These formatting choices are crucial for accurate coding, as they guide coders in selecting the appropriate codes based on the clinical scenario and documentation provided. Understanding how these elements function within the code structure enhances a coder's ability to ensure compliance and accuracy in healthcare billing and reporting practices.

2. What does Z codes classify?

A. Factors influencing health status and contact with health services

B. Chronic diseases that require ongoing treatment

C. Emergency medical conditions

D. Outcomes of surgical interventions

Z codes are used in medical coding to classify factors influencing health status and contact with health services. These codes, found in the ICD-10-CM coding system, provide additional information about a patient's health situation. They are particularly useful for capturing non-medical reasons for encounters, such as routine examinations, family history affecting health, or barriers to accessing health services. Z codes are important for a variety of reasons. First, they help in the identification of preventive services and screenings, thus facilitating better healthcare planning and resource allocation. Second, they reflect social determinants of health, which can play a crucial role in patient care and outcomes. By using Z codes, healthcare providers can ensure comprehensive documentation of a patient's health challenges beyond just their medical conditions or treatment history. The other options relate to more specific classifications that do not encompass the broader purpose of Z codes. Chronic diseases and emergency medical conditions focus strictly on the diagnosis and treatment of illness, while outcomes of surgical interventions are specifically related to the results of surgical procedures, which is a different aspect of patient care entirely. Therefore, the classification of Z codes as factors influencing health status and contact with health services accurately captures their role in the health coding system.

3. When should healthcare providers begin using the latest ICD-10-CM code revisions?

A. January 1st

B. March 1st

C. October 1st

D. December 1st

Healthcare providers should begin using the latest ICD-10-CM code revisions on October 1st because this is the date that the updates are officially implemented by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics (NCHS). Each year, these organizations review and publish updates to the ICD-10-CM coding system, and the effective date for these revisions is consistently set for October 1st. Starting with the latest codes on this date ensures that providers comply with the most current coding practices, which is crucial for accurate billing and appropriate reimbursement. This date is important for all healthcare facilities, as any claims submitted using outdated codes after this effective date may be denied or delayed by payers. The other potential dates do not align with the established timeline for ICD-10-CM updates, as January 1st marks the start of a new calendar year but not the transition to updated codes, while March 1st and December 1st have no significance in relation to the ICD-10-CM revision schedule.

4. Which categories should be used as a secondary diagnosis with burn/corrosion codes?

A. T30 and T31

B. T31 and T32

C. T32 and T33

D. T33 and T34

The correct answer is associated with the categories T31 and T32, which relate to the severity of burns and the extent of body surface affected. When coding for burns or corrosions, it is important to also capture the impact of the injury comprehensively on the patient's health status. Category T31 includes codes for burn injuries covering a specific percentage of body surface area, which helps in determining the severity and management of the burn. Meanwhile, category T32 deals with complications and sequelae of burns, which can include issues like infection or other complications arising from the burn injury. Using T31 and T32 as secondary diagnoses provides a complete clinical picture; this combination not only captures the nature of the burn but also considers any complications that might arise, which is critical for correct coding and for ensuring appropriate treatment plans and resource allocation are made. In summary, T31 and T32 complement the diagnosis of a burn injury, ensuring that all aspects of the patient's condition are accurately represented in medical records and billing.

5. In coding burns, what does code T31.21 indicate?

A. 10-19% of the body surface burned

B. 20-29% of the body surface with 10-19% third degree burns

C. 30-39% of the body surface with 20-29% third degree burns

D. 40-49% of the body surface burned

The code T31.21 is used in medical coding to indicate the extent of burn injuries when assessing burn coverage on a patient's body. Specifically, this code refers to patients who have experienced burns that encompass 20-29% of their total body surface area, with at least 10-19% of those being classified as third-degree burns. Understanding this classification is crucial for accurate coding, as it informs treatment plans, insurance billing, and statistical reporting related to burn injuries. In this case, recognizing that T31.21 corresponds to the percentage of body surface burned and the specific severity classification allows coders and healthcare providers to appropriately document the severity of the injuries and provide necessary care. This coding reflects the importance of proper burn classification, where different percentages and degrees of burns guide clinical decisions and long-term management of care for patients.

6. Which Z Codes categories pertain to follow-up care?

A. Z00 - Z07

B. Z08 - Z09 and Z39

C. Z30 - Z34

D. Z20 - Z29

The choice that pertains to follow-up care is correctly identified as Z08 - Z09 and Z39. Z08 and Z09 are specifically designed for follow-up examinations of patients who have previously been treated for conditions such as cancer, where ongoing monitoring and assessments are crucial to assess the potential for recurrence. Z08 is utilized when a patient is being seen for follow-up after a previous malignancy, while Z09 is applicable for follow-up after other specific conditions, ensuring that patients receive the necessary ongoing care as dictated by their prior treatments. Z39 is included as it relates to postpartum care, which also involves follow-up visits after delivery to ensure both maternal and newborn health. This reflects the importance of monitoring health status after significant medical events. In contrast, the other code ranges do not focus primarily on follow-up care. Z00 - Z07 includes general health examinations and assessments rather than specific follow-up situations. Z30 - Z34 relates to encounters for contraceptive management and other reproductive health factors. Z20 - Z29 focuses more on factors influencing health status and contact with health services rather than direct follow-up care after treatment. Thus, B is clearly the appropriate designation for follow-up care in this context.

7. When coding for asthma, what aspect of the asthma must be documented?

A. Severity

B. Type

C. Duration

D. Frequency

To accurately code for asthma, the severity of the condition must be documented. This aspect is crucial because asthma can present in varying degrees, such as intermittent, mild persistent, moderate persistent, and severe persistent. The severity classification affects the management and treatment protocols a patient may receive. Understanding the severity helps healthcare providers determine the necessary interventions and medication adjustments required to optimize patient care. Additionally, severity levels are linked to specific coding guidelines in the ICD-10 system, ensuring precise billing and compliance with healthcare regulations. While the type, duration, and frequency of asthma symptoms are relevant to the overall understanding of the patient's condition, they do not directly influence the coding as significantly as severity does. This specific focus on severity ensures that the coded information accurately reflects the patient's health status and treatment needs.

8. When scoring an E/M, what documentation guidelines should be used?

A. The guidelines that support the physician's credentialing

B. The guidelines that provide the highest level of documentation

C. The guidelines that are the most updated

D. The guidelines recommended by third-party payers

The correct choice is focused on the importance of adhering to documentation guidelines that allow for the highest level of documentation. This means that when scoring an Evaluation and Management (E/M) service, it is crucial to follow guidelines that ensure comprehensive and accurate documentation of the patient's condition, treatment, and interaction. High-level documentation reflects a thorough understanding of the patient's medical history, the complexity of the medical decision-making process, and the overall scope of the encounter. When documentation accurately represents the service provided, it not only supports the claim for reimbursement but also showcases the quality of care delivered, which is essential for effective communication within the healthcare team and for continuity of care. High-level documentation can also be beneficial in audits and appeals, reflecting the provider's intent to deliver a detailed and complete evaluation. While updates to guidelines and recommendations from third-party payers play important roles in the broader context of healthcare billing and regulatory compliance, they do not specifically address the nuance of maximizing the documentation's quality in every individual patient's case, which is central to the correct answer. Thus, focusing on the guidelines that promote the highest level of documentation will help ensure that E/M services are not only compliant but also reflective of best practices in patient care.

9. What is the type of supervision required for a service to be billed incident-to?

A. General supervision

B. Direct supervision

C. Personal supervision

D. No supervision is necessary

For a service to be billed as incident-to, it is crucial that the supervision provided is direct supervision. This means that the physician must be present in the office suite and immediately available to provide assistance and direction as needed when the clinical service is being performed by the non-physician provider, such as a nurse practitioner or physician assistant. Direct supervision is essential because it ensures that the billing physician can oversee the service being rendered and can step in if necessary, which is a fundamental requirement for incident-to billing. The service must be an integral part of the physician's ongoing care for the patient, and the presence of the physician is what allows for the appropriate billing under this stipulation. While general supervision allows the non-physician provider to work independently, it does not meet the criteria for incident-to billing since the physician's immediate involvement is absent. Personal supervision, typically a more stringent standard requiring the physician to be in the same room during the service, is not a requirement for incident-to. Lastly, stating that no supervision is necessary contradicts the very principle of incident-to billing, where the relationship between the physician and the non-physician provider is central to the billing process.

10. When the tendon sheath injections are to multiple different tendon sheaths, how should each injection be reported?

A. One time

B. Two times

C. Each separately

D. None of the above

When reporting tendon sheath injections that are performed at multiple different tendon sheaths, it is essential to report each injection separately. This approach reflects the distinct nature of each procedure and the specific anatomical locations involved. Each injection involves independent clinical decision-making, preparation, and medication use, which justifies the separate reporting. By reporting each injection separately, it ensures accurate documentation of the services rendered and appropriate reimbursement based on the complexity of the procedures performed. This method aligns with coding guidelines that advocate for capturing the full scope of services provided to the patient. Each tendon sheath injection can address different pathologies or conditions, warranting its individual representation in medical billing.