Certified Cardiovascular and Thoracic Surgery Coder (CCVTC) Practice Exam (Sample)

Study Guide

BY EXAMZIFY

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Questions

1. **What is the highest level that can be billed by a resident without the presence of a teaching physician?**
   - **A. I**
   - **B. II**
   - **C. III**
   - **D. IV**

2. **How many history items are required for a complete Past Family Social History (PFSH) in established outpatient settings?**
   - **A. 1 item from each of the 3**
   - **B. 1 item from 2 of the 3**
   - **C. 1 item from 1 of the 3**
   - **D. 2 items from 2 of the 3**

3. **What is the correct definition of a Comprehensive single system exam?**
   - **A. An overview of multiple body systems**
   - **B. A detailed evaluation of a specific organ system**
   - **C. A brief assessment of general health**
   - **D. A checklist of common symptoms**

4. **What does the term 'Context' refer to in HPI elements?**
   - **A. Patient's past medical history**
   - **B. Patient's statements regarding activities and circumstances surrounding the complaint**
   - **C. Current medication list**
   - **D. Family medical history**

5. **Which of the following best describes the quality aspect of HPI?**
   - **A. The intensity of the pain experienced**
   - **B. The duration of symptoms**
   - **C. The timeline of the condition**
   - **D. The symptoms associated with the condition**

6. How many body areas or organ systems are included in a Problem focused exam according to the 1995 DGs?

A. 1

B. 2

C. 3

D. 4

7. Which review of systems addresses visual disturbances and eye pain?

A. Ears, Nose, Throat (ENT)

B. Musculoskeletal

C. Eyes

D. Gastrointestinal

8. Which of the following is NOT included in the ROS systems?

A. Constitutional

B. Psychiatric

C. Immunogenic

D. Neurological

9. Which of the following is an example of a modifying factor?

A. Age of the patient

B. Time of day symptoms occur

C. Action that improves symptoms

D. Previous medical history

10. What type of HPI element describes an event that occurred in childhood, two weeks ago, or for several years?

A. Location

B. Severity

C. Duration

D. Timing

Answers

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

Explanations

1. What is the highest level that can be billed by a resident without the presence of a teaching physician?

A. I

B. II

C. III

D. IV

The highest level that can be billed by a resident without the presence of a teaching physician is Level III. This level indicates that the resident has evaluated the patient independently and that the complexity of the visit requires a moderately detailed history and examination. In the setting of residency, billing guidelines established by Medicare and other third-party payers allow residents to bill for services rendered independently, up to certain levels based on their training and the complexity of the patient's condition. Level III typically involves cases that are more intricate, but they do not require direct supervision by the attending physician. Levels I and II represent less complex evaluations and may not require as much clinical judgment as is displayed in Level III assessments. Level IV would indicate a higher complexity that, under normal circumstances, necessitates the teaching physician's presence for billing purposes, as these encounters often involve decision making at a higher level. Thus, Level III stands as the threshold where independent billing is permissible for residents without the supervising physician's presence.

2. How many history items are required for a complete Past Family Social History (PFSH) in established outpatient settings?

A. 1 item from each of the 3

B. 1 item from 2 of the 3

C. 1 item from 1 of the 3

D. 2 items from 2 of the 3

In established outpatient settings, the requirements for a complete Past Family Social History (PFSH) stipulate that you must gather at least one item from two of the three categories: Past Medical History, Family History, and Social History. The rationale behind this requirement is to ensure that the healthcare provider has sufficient information to understand the patient's context, which can significantly affect their health and care management. By collecting details from at least two categories, a clearer picture of the patient's background is established, which is essential for rendering high-quality medical care. For instance, knowing family history may reveal genetic predispositions, while social history could provide insights into lifestyle factors that impact health. Therefore, the chosen answer reflects the standard approach toward comprehensive patient evaluation in outpatient settings.

3. What is the correct definition of a Comprehensive single system exam?

A. An overview of multiple body systems

B. A detailed evaluation of a specific organ system

C. A brief assessment of general health

D. A checklist of common symptoms

The definition of a Comprehensive single system exam refers to a detailed evaluation of a specific organ system. This type of examination focuses on thoroughly assessing a particular system, such as the cardiovascular, respiratory, or digestive system, to ensure all aspects and functions are evaluated comprehensively. It allows healthcare providers to identify any abnormalities, diagnose conditions accurately, and develop appropriate treatment plans based on the specific findings from that particular organ system. Other options describe broader or less detailed approaches. An overview of multiple body systems would not fit the description of a single system exam, as it implies assessing several systems rather than focusing on one. A brief assessment of general health also does not encapsulate the thoroughness required for a comprehensive single system exam, as it lacks the specific detail and depth concerning a targeted organ system. Lastly, a checklist of common symptoms is more about symptom identification than a systematic evaluation of an organ system, thus not capturing the essence of a comprehensive assessment.

4. What does the term 'Context' refer to in HPI elements?

A. Patient's past medical history

B. Patient's statements regarding activities and circumstances surrounding the complaint

C. Current medication list

D. Family medical history

The term 'Context' in the elements of History of Present Illness (HPI) specifically refers to the patient's statements concerning the activities and circumstances surrounding their complaint. It encompasses pertinent details that describe not only the symptoms but also the situation in which those symptoms occur, such as what the patient was doing when they first noticed the problem, any relevant background information, or specific circumstances that may have contributed to their current health status. This contextual information is essential for healthcare providers to understand the full picture of the patient's condition, as it helps in identifying potential triggers for the symptoms and may influence treatment decisions. For instance, if a patient mentions that their symptoms began after a specific activity or event, this can guide the provider in making a more informed diagnosis and treatment plan. In contrast, the other options focus on aspects of a patient's history that, while important, do not directly define the context of the current complaint. The past medical history records diseases or medical conditions the patient has had, the current medication list refers to the medications the patient is presently taking, and the family medical history captures potential hereditary health issues faced by family members—all of which are crucial but do not provide the specific situational context related to the patient's present complaint.

5. Which of the following best describes the quality aspect of HPI?

A. The intensity of the pain experienced

B. The duration of symptoms

C. The timeline of the condition

D. The symptoms associated with the condition

The quality aspect of the history of present illness (HPI) primarily relates to the nature and characteristics of the symptoms experienced by the patient. The intensity of the pain is an essential part of this quality because it provides valuable information about the severity and impact of the condition on the patient's life. For example, a patient might describe their pain as sharp, dull, throbbing, or aching, which helps healthcare providers understand the nature of the symptom and guide diagnostic and therapeutic efforts accordingly. While other aspects such as duration, timeline, and associated symptoms are important in evaluating a patient's overall condition, they do not specifically address the quality of the symptoms themselves. Proficient documentation of the quality of symptoms is crucial in the assessment and management of many cardiovascular and thoracic conditions, allowing for a more targeted approach to treatment. This is why identifying the intensity of the pain directly relates to the quality aspect of HPI.

6. How many body areas or organ systems are included in a Problem focused exam according to the 1995 DGs?

A. 1

B. 2

C. 3

D. 4

In the context of the 1995 Documentation Guidelines (DGs), a Problem Focused examination is defined as one that involves the examination of a single body area or organ system. This means that during a Problem Focused exam, the healthcare provider is primarily concerned with a specific complaint or issue, which typically requires an assessment of just one area. This assessment may include a limited number of key components, such as the patient's history of present illness and a focused examination relevant to that single area. The goal is to address a specific health concern efficiently and effectively without requiring a broader systemic review. Therefore, recognizing that a Problem Focused exam only involves one body area or organ system aligns perfectly with the guidelines established in 1995.

7. Which review of systems addresses visual disturbances and eye pain?

A. Ears, Nose, Throat (ENT)

B. Musculoskeletal

C. Eyes

D. Gastrointestinal

The correct choice focuses on the specific body system that pertains to the eyes, which includes various conditions related to vision and ocular health. This review of systems is critical for assessing a patient's overall eye health, as it directly addresses issues like visual disturbances and eye pain—symptoms that can indicate a range of eye-related conditions such as glaucoma, cataracts, or retinal issues. The other options, while pertinent to their respective areas, do not cover the concerns of ocular health. For example, the choice related to Ears, Nose, and Throat deals with auditory and respiratory issues, while the Musculoskeletal review focuses on the bones, joints, and muscles. The Gastrointestinal review pertains to the digestive system and is unrelated to visual symptoms. Therefore, the eyes are the correct system to evaluate when considering issues like visual disturbances and eye pain.

8. Which of the following is NOT included in the ROS systems?

A. Constitutional

B. Psychiatric

C. Immunogenic

D. Neurological

The Review of Systems (ROS) is a systematic approach used in patient evaluations that focuses on various bodily systems to identify symptoms that the patient may be experiencing. Each system is designed to capture specific aspects of a patient's health and history. The constitutional system addresses general health characteristics such as weight loss or fever. The psychiatric system evaluates mental health conditions including mood disorders or anxiety. The neurological system explores issues related to the nervous system, such as headaches or seizures. In contrast, the immunogenic system is not typically recognized as a standalone system in the ROS. While components related to immunology, such as allergies or infections, might be encompassed within other systems (like constitutional or review of specific organ systems), there isn't a designated "immunogenic" section within the standard ROS. Therefore, the correct answer highlights that this option does not fit within the conventional categories of Review of Systems, making it distinct from the others listed.

9. Which of the following is an example of a modifying factor?

A. Age of the patient

B. Time of day symptoms occur

C. Action that improves symptoms

D. Previous medical history

The correct choice highlights a modifying factor as it addresses an action that can influence the severity or presence of symptoms. In the context of patient assessments or diagnostic evaluations, recognizing actions that improve symptoms is crucial for developing appropriate treatment plans. This can indicate how the patient's condition responds to therapy or other interventions, which may help guide future care decisions or further investigations. The other options are indeed relevant aspects of a patient's medical profile but do not serve as modifying factors in the same context. The age of the patient provides demographic information but does not specifically alter the symptoms themselves. Similarly, the time of day when symptoms occur may provide insight into patterns of symptomatology but lacks the direct implication of improving or worsening symptoms. Previous medical history is essential for understanding risk factors and context but does not modify symptoms directly during an evaluation like an action taken might. Therefore, the focus on an action that leads to symptom improvement makes this choice align with what qualifies as a modifying factor in clinical settings.

10. What type of HPI element describes an event that occurred in childhood, two weeks ago, or for several years?

A. Location

B. Severity

C. Duration

D. Timing

The correct answer is related to how the duration of an event is defined in the context of a patient's history of present illness (HPI). Duration refers specifically to the length of time that a condition, symptom, or event has been present. This could encompass a variety of timeframes including events that occurred in childhood, recently (such as two weeks ago), or conditions that have been persistent for several years. By identifying the duration, healthcare providers can better understand the pattern of the illness and its potential implications for treatment and diagnosis. In contrast, the other options refer to different aspects of the HPI. Location describes where the symptoms are occurring in the body; severity indicates how intense or severe the symptoms are; and timing addresses when the symptoms occur, such as their frequency or the specific times they present. While these elements are all important in forming a comprehensive picture of a patient's condition, it is the concept of duration that encapsulates the timeline and overall length of the illness or event, making it the correct choice in this context.