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AAPC CPC Chapter 1 Questions and Answers 100% Pass

Medical coding ✓✓process of translating a healthcare provider's documentation of a patient encounter into a series of numeric or alphanumeric codes

Health information coders, medical record coders, coder/abstractors, coding specialists
✓✓coders who specialize in coding inpatient hospital services

MS-DRG ✓✓Medical Severity-Diagnosis Related Groups

MS-DRG are used to: ✓✓determine the amount the hospital will be reimbursed if the patient is covered by Medicare or other insurance programs using the MS-DRG system

Cancer (or tumor) registrars ✓✓maintain facility, regional, and national databases of cancer patients

EHR ✓✓electronic health record

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q39-Q44):

NEW QUESTION # 39

If a physician administers cyclophosphamide over 154 minutes, irinotecan over 72 minutes, and panitumumab over 15 minutes intravenously to a patient with pancreatic cancer, how should this be reported?

- A. 96413, 96413-59x2, 96415, 96417
- B. 96413, 96413-59, 9641512, 96417
- C. 96413, 96415x3, 96417x2
- D. 94613, 96415x2, 96417x2

Answer: C

Explanation:

Unless a separate IV site is established for a secondary or tertiary administration, CPT

96413 should be reported only once to represent the initial drug infusion. In this case, it is the cyclophosphamide. The remaining 94 minutes are reported with Ovu units of add-on CPT 96415, which may be reported if the time spent beyond the first hour is between 31 and 60 minutes. CPT

96417 is reported only once per subsequent infusion of a different drug up to the first hour.

Consequently, the 72 minutes of irinotecan is reported with a single unit of CPT 96417, and the 15 minutes of panitumumab is also reported with one unit of that same CPT code.

NEW QUESTION # 40

Code the following surgical note:

54-year-old male is experiencing left-sided weakness and visual disturbance. An MRI revealed a lesion in the brain. He presents today for a biopsy. General anesthesia is given, and the area is shaved and cleaned. The brain lab system is synced with prior MRI images to confirm the accurate placement of burr hole drilling. A cutting needle is inserted into the frontal lobe, and lesion location is confirmed with the brain lab system. A portion of the lesion is obtained without complication. All instruments removed, and the incision is sutured.

- A. 0
- B. 1
- C. 2
- D. 3

Answer: B

Explanation:

The coding crosswalk for a brain biopsy leads to three CPT codes. CPT code 61140 is a burr hole through which a lesion in the brain can be located and biopsied. CPT code 61750 is a biopsy using a CT or MRI scanning technique to locate the lesion in the brain. CPT code 61751 is the same as 61750, with the addition of the use of CT or MRI scanning during the procedure to confirm the location of lesion and/or accurate placement of surgical instruments. In this case, that occurred with the brain lab system. CPT code 61575 is a biopsy done on a different anatomic location and does not describe this procedure.

NEW QUESTION # 41

Which is NOT part of the upper respiratory tract?

- A. Larynx
- B. Pharynx
- C. Trachea

- D. Nasal cavity

Answer: C

Explanation:

The upper respiratory tract consists of the nose, nasal cavity, pharynx, and larynx. The lower respiratory tract includes the trachea, primary bronchi, lungs, and the bronchioles and alveoli within the lungs.

NEW QUESTION # 42

A 15-year-old male patient is seen in the emergency department due to a dislocated left elbow, caused by a fall from his skateboard. The physician performs a comprehensive physical evaluation to check for other injuries before manually realigning the dislocation and placing a splint from the shoulder to wrist. The patient is informed to follow up in 4 weeks. Which CPT and ICD-IO-CM codes should the emergency department report?

- A. 24600-LT, 29105, S53.195AVOO.131A
- **B. 99282-57, 24600-LT, S53.105A VOO.131A**
- C. 24600-LT, S53.105A. VOO.131A
- D. 99283, 24600-LT, VOO.131A

Answer: B

Explanation:

An E/M is always billed when a patient is seen in the emergency department because it is unscheduled and urgent. In this case, the documentation encompasses a straightforward level of decision-making (one acute, uncomplicated injury, minimal or no data reviewed, superficial dressings that result in minimal risk or morbidity of the patient), which lead the coder to 99282.

Modifier 57 is appended to indicate that the decision for surgery was made just prior to the procedure and is not bundled. CPT coding crosswalk confirms that a closed treatment of a dislocated elbow is CPT code 24600. Application of a splint is represented by CPT code 29105 but is not applicable when performed with a surgery to correct the dislocation. ICD-IO-CM crosswalk for dislocation of left elbow is S53.105A.

NEW QUESTION # 43

Code the following note:

A 43-year-old new female patient with a history of type I diabetes was referred to my office by Dr. White, her primary care physician. Patient complains of blurred vision that began 2 weeks ago, however, reports compliance to a strict, healthy diet and to prescribed 10 mg of dexamethasone every day for 1 month. Given that the only change appears to be the dexamethasone, I suspect the blurred vision is an adverse reaction and will decrease the dosage to 5 mg per day. Patient will follow up with me in 1 week if symptoms persist.

Total time spent on today's encounter is 30 minutes.

- A. 99203, H53.8, E10.69
- B. 99244, H53.8, T38.OX5A, E10.9
- **C. 99204, H53.8, E10.9**
- D. 99243, H53.8 E10.39

Answer: C

Explanation:

When choosing between an outpatient evaluation and management code or a consultation service code, bear in mind the following four elements: request, reason, report, and intent. Although the first three elements are documented and support a consultation service, the endocrinologist is assuming immediate care of the patient's condition. In this case, the visit is not a consultation but a new transfer of care, which is encompassed by CPT codes 99202-99205. For this visit, coding based on medical decision-making as opposed to the total time spent on the encounter that day would be more advantageous. This is because coding based on time would lead a coder to report CPT code

99203 or a low level of medical decision making, whereas the medical decision-making is actually moderate, represented by CPT code 99204.

The documentation reflects that the blurry vision is most likely due to the dexamethasone:

therefore, a causal relationship is not assumed between the two conditions and should not be coded as such. Because an adverse reaction is suspected and not confirmed, it should not be coded. This general rule does not apply to inpatient encounters.

NEW QUESTION # 44

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