

Quiz Medical Tests - AAPC-CPC Pass-Sure Test Pass4sure

AAPC CPC Certification Practice Test 2024 with Answers

A Medicare patient is receiving chemotherapy at her oncologists office. While the patient is receiving chemotherapy, the oncologist calls in a prescription for pain medication to a pharmacy in the same building . The pharmacy delivers the medication to the patient in the oncologists office for the patient to take home. What part of Medicare should be billed for the pain medication by the pharmacy?

- A. Part A
- B. Part B
- C. Part C
- D. Part D - **Answer>>** Part D

What is medical coding? - **Answer>>** Translating medical documentation into codes.

Which one is NOT a covered entity of HIPPA?

- A. Medicare
- B. Workers Compensation
- C. Dentists
- D. Pharmacies - **Answer>>** B. Workers Compensation

Which one falls under a commercial payer?

- A. Medicare
- B. Medicaid
- C. Blue Cross Blue Shield

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q13-Q18):

NEW QUESTION # 13

A patient relocates after receiving treatment for an arm fracture. The patient schedules an appointment with a new orthopedist to remove the cast. The orthopedic office should report the fracture diagnosis code with the seventh character A to indicate active treatment.

- A. False
- B. True

Answer: A

Explanation:

The statement is false. When a patient is in the healing and/or recovery phase of an injury, the seventh character would be D to indicate that the care is subsequent-whether the provider has treated the patient in the past or not.

NEW QUESTION # 14

A young man is triaged in the emergency room after sustaining multiple injuries in a car accident. The physician performs the following limited exams with image documentation: an abdominal and retroperitoneal ultrasound, a transthoracic echocardiography, and a chest ultrasound. He indicates in his report that all findings are normal. What charges should the provider submit to the insurance company?

- A. 93304-TC, 76700-TC, 76770-TC, 76604-TC
- B. 93308-26, 76705-26, 76775-26, 76604-26
- C. 93304-26, 76705-26, 76775-26, 76604-26
- D. 93308, 76705-59, 76770-59, 76604-59

Answer: B

Explanation:

CPT code 93304 describes an echocardiography used to evaluate a congenital defect. In this case, the provider is screening for any trauma-related injuries to the heart. Bearing in mind that the study is limited leads you to CPT 93308. Modifier 26 is used on all CPT codes because the procedures are being performed in a hospital setting. Therefore, only the professional component of the service should be billed. Modifier TC is reported by the entity providing the equipment, which in this case would be the hospital. Modifier 59 is not necessary because the procedures are routinely done in conjunction with each other.

NEW QUESTION # 15

A radiation oncologist reviews the port films, dose delivery, and treatment parameters of a 52-year-old female patient who has received external beam therapy three times in the current week. He also spends 15 minutes examining the patient and collecting an intake of her response to the treatment program. Which CPT code(s) should the physician report?

- A. 77435, 99213-25
- B. 0
- C. 1
- D. 99213-25, 77401x3units

Answer: B

Explanation:

Treatment management of a patient undergoing radiation therapy is reimbursed by reporting CPT codes 77427-77470. Treatment management includes a review of the port films, dosimetry, dose delivery, treatment parameters, a physical examination, and related counseling. It would therefore not be appropriate to bill for a separate evaluation and management. CPT 77435 describes treatment

management for a course of stereotactic body radiation therapy (SBRT), which the patient is not receiving. CPT 77401 describes the actual radiation and not the evaluation from the physician. CPT 77431 is reported when the entire course of therapy consists of one or two treatment sessions; however, a coder can infer from the documentation that the patient in this scenario has or will receive multiple sessions over the course of one or more weeks. Additionally, CPT guidelines advise that only three treatment sessions must occur to support the face-to-face encounter described in CPT 77427.

NEW QUESTION # 16

A patient opts to replace his semi-rigid penile prosthesis with a multicomponent, inflatable penile prosthesis. What CPT code(s) should the urologist report if this was completed in one encounter?

- A. 0
- B. 54405, 54415-51
- C. 1
- D. 54415, 54405-51

Answer: C

Explanation:

Penile prosthesis procedure codes are based on the type of prosthesis being used. In this scenario, a semi-rigid prosthesis is being replaced by a multicomponent inflatable one. Currently, there are no CPT codes that encompass the removal of one type of prosthesis and insertion of another type. The most common course of action might be to code the removal and insertion separately and amend a multi-procedural modifier on the secondary code. However, CPT 54415 indicates that the prosthesis removed was not replaced by another, which is an inaccurate description of services rendered. In this case, only the insertion (CPT 54405) should be reported because it has the highest RVU value.

NEW QUESTION # 17

Code the following procedure note:

A 45-year-old female was referred for a urodynamics study due to complaints of bladder pain and weak urination. The provider places a rectal catheter simultaneously with a urethral catheter and begins to fill the bladder with water.

Using calibrated equipment, cytometry was done with a medium fill rate of 40 cc/ minute. A strong desire to void occurred at 84 cc. and the patient is instructed to void. The provider determines that the maximum urinary flow rate is 12 cc per second with a voiding time of 45 seconds and a voided volume of 102 cc. She voided with a sustained detrusor pressure. An abdominal pressure measurement was also taken, indicating no urinary leaking with abdominal straining. EMG patches were placed on the anal sphincter and found to be elevated with increased intra-abdominal pressure. All catheters and EMG patches were removed, and the procedure was completed without complications. A report will be forwarded to the referring provider, who will provide the interpretation of the results to the patient.

- A. 51728-TC, 51784-TC, 51797-TC, 51741-TC
- B. 51726-TC, 51784-51-TC, 51797-51-TC
- C. 51726-TC, 51784-59-TC, 51797-59-TC, 51741-59-TC
- D. 51728-TC, 51784-TC, 51797-TC

Answer: A

Explanation:

A urodynamics study is a diagnostic test to evaluate the function of the bladder. When performed using calibrated equipment, it becomes known as a complex cystometrogram (51726-

51729). In CPT code 51728, a complex cystometrogram is performed in conjunction with voiding pressure studies. In the provider's documentation, the bladder is filled with water, and voiding times and volume are recorded, thus fulfilling the requirements for this code. CPT code 51726 in answers A and B only describe a complex cystometrogram without the voiding pressure studies. Electromyography (EMG) studies were performed without a needle to evaluate pelvic floor activity and are represented by 51784. An intraabdominal voiding pressure study (51797) can be inferred in that the provider had earlier inserted a rectal catheter and, after instructing the patient to cough, obtained an abdominal pressure measurement. A complex urinary flow study (51741) was performed in obtaining the maximum urinary flow rate through calibrated equipment. This procedure is missing in answers B and C. Modifier TC (indicating only a technical component) is amended on all the procedures because the provider is not interpreting the results to the patient.

Modifiers 51 and/or 59 is not amended on any procedure (A and B) because these are routinely billed together.

NEW QUESTION # 18

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