

Medical Tests AAPC-CPC ExamQuestions - 100% Success

AAPC CPC Questions and Answers 100% Correct

What is the patient's right when it involves making changes in the personal medical record?

- A. Patient must work through an attorney to revise any portion of the personal medical information.
- B. They should be able to obtain copies of the medical record and request corrections of errors and mistakes.
- C. It is a violation of federal health care law to revise a patient medical record.
- D. Revision of the patient medical record depends solely on the facility's compliance program policy. - correct answersB. They should be able to obtain copies of the medical record and request corrections of errors and mistakes.

Under HIPAA regulations, patients have the right to receive a copy of their medical record and request that errors are corrected.
<https://www.hhs.gov/hipaa/for-individuals/medical-records/index.html>

Which modifier is appended to a CPT®, for which the provider had a patient sign an Advance Beneficiary Notice (ABN) form because there is a possibility the service may be denied because the patient's diagnosis might not meet medical necessity for the covered service?

- A. GJ
- B. GA
- C. GB
- D. GY - correct answersB. GA

An Advance Beneficiary Notice (ABN) is a waiver of liability. When a patient has been informed a service that is otherwise covered by Medicare but might not be covered in a particular instance an ABN is signed by the patient prior to receiving the service. To inform Medicare the ABN has been signed, append modifier GA. If an ABN is signed, the claim is the patient's responsibility if the claim is denied. This modifier is listed in the HCPCS Level II codebook.

Which statement regarding an ICD-10-CM coding conventions is TRUE?

- A. If the same condition is described as both acute and chronic and separate subentries exist in the Alphabetic Index at the same indentation level, code only the acute condition.
- B. Sequela (Late effect) codes are reported for a current acute phase of the injury or illness

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q86-Q91):

NEW QUESTION # 86

An 88-year-old patient with Medicare comes in for her yearly flu shot. After receiving a 0.5 mL single shot dose of preservative-free Alfuria intramuscularly, the provider observes the patient for 15 minutes to monitor any adverse reactions. How should the provider code for this encounter?

- A. G0008, 90656, Z23
- B. 99211-25, 90471, 90656, Z23, Z03.89
- C. 96372, 90686 Z23
- D. 90471, 90656, Z23

Answer: A

Explanation:

The patient has Medicare insurance and therefore requires the use of an HCPC code (G0008) in place of a CPT intramuscular injection code. The use of an E/M code in answer B is not warranted because the provider only administered services related to the vaccination. The appropriate diagnosis code for any vaccination would be Z23.

NEW QUESTION # 87

A 72 -year-old patient is admitted due to atrial fibrillation. A comprehensive electrophysiology study is completed with fluoroscopic guidance, followed by a cardiac catheter ablation during the same procedure. The procedure took 22 minutes, and the patient was moderately sedated. Which CPT codes should the cardiologist report?

- A. 93656, 99152
- B. 93650, 93619-26-59, 77001, 99152, 99153
- C. 93650, 93619-26-59, 99152
- D. 93656, 77001, 99152, 99153

Answer: A

Explanation:

It is common practice to perform both an electrophysiology (EP) study and a cardiac ablation procedure in the same session. These procedures have been bundled in the CPC manual, and the coding of such is dependent on the type of arrhythmia being treated. The EP study and cardiac ablation are not to be reported separately. In this scenario, the patient has atrial fibrillation, which is reported with CPT 93656. When fluoroscopy is used for guidance rather than for diagnostic imaging, it is usually not reported separately from the primary procedure. Moderate sedation can be reported when used, and selection is based on time. CPT 99152 and 99153 are counted in 15-minute intervals. When the procedure does not fall on a 15-minute interval, it must at least meet the halfway point of the time stated to be reported.

NEW QUESTION # 88

A patient with a history of colon cancer was treated with radiation therapy. CT scans and blood tests show the malignancy has been eradicated. The patient is directed to take 81 mg of aspirin daily over the course of the next year to help prevent reoccurrence of the malignancy. What ICD-IO-CM code(s) should be reported by the provider on subsequent visits related to this patient's condition?

- A. Z85.038
- B. Z48.3, C18.9
- C. C18.9
- D. Z08, Z85.038

Answer: D

Explanation:

Regarding Z08, ICD-IO-CM guidelines state: "The follow-up codes are used to explain continuing surveillance following completed treatment of a disease. They imply that the condition has been fully treated and no longer exists." When using a follow-up code as the

primary reason for an encounter, a history code indicating what condition the patient originally had should be assigned as secondary. Aftercare codes are used to describe the continued treatment of a disease. In this case, the malignancy has been eradicated, the disease no longer exists, and aspirin is being used merely as a preventative measure. History codes can never be reported as first listed; rather, a follow-up code or other current disease and/or condition should precede it.

NEW QUESTION # 89

V codes are related to which procedures/products?

- A. Durable medical equipment
- B. Hearing services
- C. Orthotic procedures
- D. Enteral therapy

Answer: B

Explanation:

Durable medical equipment is represented by E codes, orthotic procedures are L codes, and enteral therapy is inclusive to B codes in the HCPC manual.

NEW QUESTION # 90

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

Answer: C

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 # 91

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