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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 (Q139-Q144):

### NEW QUESTION # 139

Which is NOT considered inclusive to hydration services?

- A. Flush solution
- B. Subcutaneous catheter access
- C. Catheter flush
- D. Catheter declotting

**Answer: D**

Explanation:

Catheter access, standard supplies such as a flush solution, and the flush at the end of the infusion are all considered necessary to facilitate the infusion and are inclusive to CPT codes

96360-96361. Declotting a catheter involves the injection of a thrombolytic agent to dissolve the clot and is separately reportable with CPT 36593.

### NEW QUESTION # 140

A 59-year-old male patient presents for a routine colonoscopy. During the procedure, a polyp is discovered. What is the proper ICD- 10-CM coding for this encounter?

- A. Z12.11
- B. K63.5, Z12.11
- C. K63.5
- D. Z12.11, K63.5

**Answer: D**

Explanation:

Because the reason for the visit was a routine colonoscopy, the "encounter for screening for malignant neoplasm of colon" (Z12.11) would be the first-listed code. ICD-IO-CM guidelines advise that if there is a finding during a screening, the finding may be used as an additional code. In this example, the colon polyp (K63.5) is a physical finding and would be listed as the secondary diagnosis.

### NEW QUESTION # 141

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

**Answer: C**

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 # 142

An obstetrical patient carrying twins is seen. The physician performs a fetal non stress test on each fetus. How should the CPT code(s) be reported?

- A. 0
- B. 59025-76
- C. 59025, 59025-59
- D. 59025-22

**Answer: C**

Explanation:

Modifier 76 is used to identify a repeated procedure, but the test was performed on a separate fetus. Modifier 22 indicates increased procedural services; however, the services were not increased. Rather, a separate, identifiable test was rendered, and the modifier 59 would therefore apply to the second fetal nonstress test.

#### NEW QUESTION # 143

A complete pulmonary function test using a body plethysmograph is performed on a patient in conjunction with spirometry. After reviewing the results, a provider suspects the presence of an obstructive disease and administers a bronchodilating medicine just prior to repeating the test to reevaluate the expiratory flow rate. Which code(s) should be reported?

- A. 94726, 94060
- B. 99212-25, 94726, 94010-51, 94060-51
- C. 94726, 94060-51
- D. 99212-25, 94726, 94060-76

**Answer: A**

Explanation:

Answers A and B can be eliminated because the complete pulmonary function test includes interpretation of the test results; therefore, the review of this would not be considered separately identifiable. The CPT code 94060 includes spirometry before and after a bronchodilator has been administered, so a separate spirometry code (94010) would be inappropriate. Last, a modifier is not needed because the procedures are routinely done in conjunction with each other.

#### NEW QUESTION # 144

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