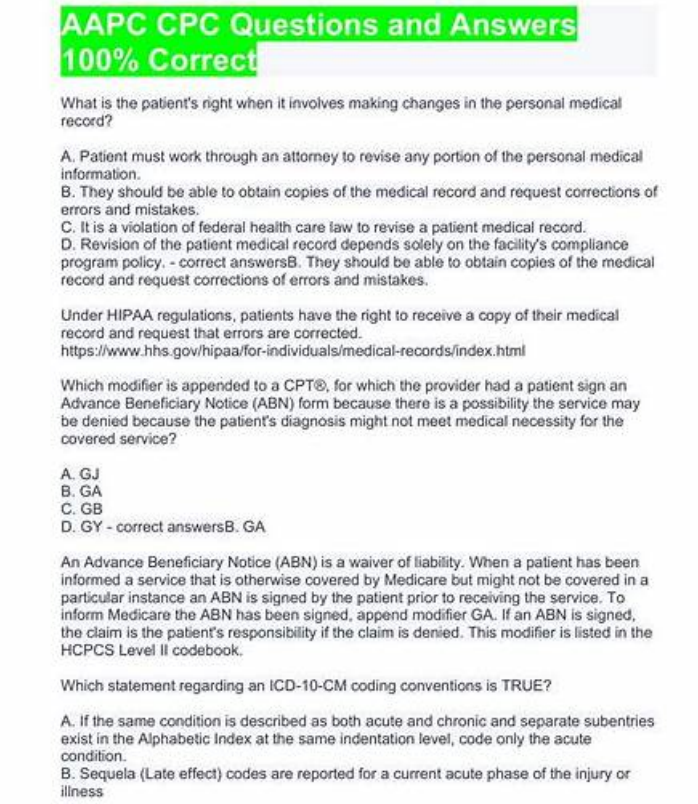
Three User-Friendly Formats With Real Medical Tests AAPC-CPC Questions



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 (Q83-Q88):

NEW QUESTION # 83
The base unit for anesthesia CPT code 00600 is 10 units. If an anesthesiologist spends 105 minutes in the procedure room with a patient, how many units should be reported for reimbursement?

- A. 12 units
- B. 11 units
- C. 14 units
- D. 17 units

Answer: D

Explanation:
To calculate the total number of units, it is important to understand that anesthesia time is measured in 15-minute intervals (or in fractions thereof). In this scenario, take the total number of minutes spent on the procedure (105) and divide it by 15. The total number of time units is 7. The time units are then added to the base unit (10) for a total of 17 units.

NEW QUESTION # 84
Consultation codes 99242-99245 have been deemed as not medically necessary and are no longer reimbursed by Medicare. This decision would fall under which term?

- A. Carrier Coding Determination
- B. Governed Coding Determination
- C. National Coding Determination
- D. Local Coding Determination

Answer: C

Explanation:
Decisions regarding coverage are made through evidence-based processes and public opinion. National Coding Determination (NCD) is specific to Medicare coverage nationwide, whereas Local Coding Determination (LDC) is contractor and commercial specific. Carrier and Governed Coding Determinations do not exist.

NEW QUESTION # 85
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. 93650, 93619-26-59, 99152
- B. 93656, 77001, 99152, 99153
- C. 93656, 99152
- D. 93650, 93619-26-59, 77001, 99152, 99153

Answer: C

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. lvVhen 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 # 86
Which is NOT part of the upper respiratory tract?

- A. Trachea
- B. Larynx
- C. Nasal cavity
- D. Pharynx

Answer: A

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 # 87
What is the main role of the tonsils?

- A. Secrete antibodies to destroy ingested microbes
- B. Remove bacteria that enter the body through the nose and/or mouth
- C. Trigger the formation of antibodies
- D. Filter lymph and form lymphocytes

Answer: B

Explanation:
The primary role of the tonsils is to remove bacteria that enter though the oral and nasal cavity. Antigens are molecules located on the surface of pathogens and trigger the formation of antibodies. Lymph nodes filter lymph and form lymphocytes. B cells secrete antibodies that assist in destroying bacterium causing disease.

NEW QUESTION # 88
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