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AAPC CPC EXAM CHAPTER 1 STUDY GUIDE WITH COMPLETE SOLUTION!!

What does MAC stands for?

ANSWER : Medicare Administrative Contractor

Which coding manuals do outpatient coders focus on learning?

ANSWER : CPT®, HCPCS Level II and ICD-10-CM

In what year was the AAPC founded?

ANSWER : 1988

What type of provider goes through approximately 26 1/2 months of education and is licensed to practice medicine with the oversight of a physician?

ANSWER : Physician Assistant (PA)

In what year did HIPAA become law?

ANSWER : 1996

Which type of information is NOT maintained in a medical record?

ANSWER : Financial Records

The minimum necessary rule is based on sound current practice that protected health information should NOT be used or disclosed when it is not necessary to satisfy a particular purpose or carry out a function. What does this mean?

ANSWER : Providers should develop safeguards to prevent unauthorized access to protected health information.

If an NCD does not exist for a particular service/procedure performed on a Medicare patient, who determines coverage?

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is ideal for users who prefer offline AAPC-CPC exam practice. This format is supported by Windows computers and laptops. You can easily install this software in your system to use it anytime to prepare for the examination.

Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q43-Q48):

NEW QUESTION # 43

If a provider documents in an assessment that a patient is obese, but the BMI extracted from the chart is consistent with morbid obesity, what should be reported on the claim?

- A. Obesity and the appropriate BMI
- B. Morbid obesity
- C. Obesity
- D. Morbid obesity and the appropriate BMI

Answer: A

Explanation:

The diagnosis is always based on the provider's documentation, which in this case would be obesity. Coding guidelines also state that if there is a reportable diagnosis related to weight, "the BMI can be assigned from documentation of someone other than the patient's provider, such as nursing notes."

NEW QUESTION # 44

CPT code 11102 is a column 2 code that has an NCCI edit of 1 when paired with CPT code 11402. How would this be interpreted?

- A. The two codes can be billed together with an appropriate modifier.
- B. The two codes are inclusive of each other and can never be billed together.
- C. The two codes are exclusive of each other and can never be billed together.
- D. If being billed together, only report one unit of each.

Answer: A

Explanation:

NCCI stands for National Correct Coding Initiative and was created by CMS to prevent unbundling and prevent incorrect payments. Column one represents a correct code when listed next to column two. There are three edits listed with the combination of the two columns: 0, 1, and

9. Edit 0 means that the two codes should never, under any circumstance, be reported together. Edit

1 means that the procedures may be coded together with the use of a modifier. Edit 9 means that the edit does not apply.

NEW QUESTION # 45

A patient presents to physical therapy status post repair of a complete rotator cuff tear in the right shoulder due to a fall. After applying ice to the shoulder for 8 minutes, the physical therapist performs a soft-tissue massage to the infraspinatus muscle that lasts 23 minutes. Just prior to discharge, the therapist spends 20 minutes instructing the patient on isokinetic exercises to help improve range of motion. Which CPT and ICD-IO-CM code(s) should be used to accurately describe encounter?

- A. 97110, 97140, 97010, Z48.89, S46.091A, W19XXXA
- B. 97110, 97010, S46.011D, W19,XXXD
- C. 97010, 97140, 97530, S46.011A, W19XXXA
- D. 97010, 97140x2, 97530, M75.121

Answer: B

Explanation:

Although CPT code 97530 does describe therapeutic activities, the focus is directed at improving functional performance, whereas the correct CPT code 97110 works to develop range of motion. The CPT code for a soft tissue massage (or manual therapy 97140) is based on 15-minute increments, however, anything over 8 minutes prior to or after can be counted as a unit. Based on this, the 23 minutes spent can be counted as two units. Sequencing is based on highest RVU.

Coding crosswalk for a rotator cuff tear is classified as a muscle strain, so answer B, which specifies

"other injury," can be eliminated. Because the patient is in the recovery period of the injury, the seventh character would not be considered active but subsequent.

NEW QUESTION # 46

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

Answer: A

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 # 47

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

Answer: C

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 # 48

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