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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 (Q149-Q154):

NEW QUESTION # 149

A patient develops an infection within the global period of a knee replacement. It is determined that the infection originated from the incision site and needs to be surgically removed. Which modifier should be appended to the secondary surgery?

- A. 0
- B. 1
- C. 2
- D. 3

Answer: C

Explanation:

Modifier 78 represents an additional, unplanned surgery during the global period for a complication arising for the initial procedure. In this case, the complication would be the infection.

Modifier 58 is generally used when a secondary procedure is planned prior to or during the time of the initial procedure. Modifier 79 is used to indicate two unrelated procedures. Modifier 25 is for use on E/M codes only.

NEW QUESTION # 150

A provider documents that he spent 20 minutes with a patient. Based on this, an E/M can be chosen solely based on time.

- A. False
- B. True

Answer: B

Explanation:

The statement is true. According to AMA time documented is considered the minimum time the physician or other qualified health care professional spent on face-to-face and non-face-to-face services. This includes time spent reviewing the patient's medical record, consulting other healthcare professionals, or ordering prescriptions, tests, and/or other services.

NEW QUESTION # 151

A physician inserts a chest tube through the right chest wall and into the pleural cavity to release trapped air in a 19-year-old patient with recurring pneumothorax. A second physician assists in providing moderate sedation. In total, the procedure took 8 minutes. What ICD-IO-CM and CPT codes should the provider report?

- A. 32551, 193.83
- B. 32551, 99156-59, 193.9
- C. 32550-62, 99156, 193.83
- D. 32550, 193.9

Answer: A

Explanation:

The code description "tube thoracostomy" is not clearly stated in the documentation, but CPT crosswalk for a 'tube placement' followed by "chest" leads the coder to CPT 32551. CPT 32550 describes the insertion of a catheter that allows the patient to drain pleural fluid in an outpatient setting. Moderate sedation can be separately billed but only by the provider administering the medication. The 193 series is circumstantial (e.g., spontaneous, acute). Even though the term "recurrent" is not used, it does describe the background of the patient's condition and so would fall into the other specified diagnosis rather than unspecified.

NEW QUESTION # 152

What would NOT be included in a global obstetrical package?

- A. Sutures are removed from a first-degree perineal laceration during the delivery.
- B. Contraception following delivery is discussed at length.
- C. A patient with anemia comes in to check hemoglobin levels.
- D. A patient complains of flu-like symptoms and is prescribed an antibiotic.

Answer: D

Explanation:

The treatment of flu-like symptoms is considered a non-obstetric service, and a separate E/M can be billed for reimbursement. All other answer choices would be included in the global obstetrical package as routine care.

NEW QUESTION # 153

A physician documents a comprehensive electrophysiologic evaluation with an unsuccessful attempted induction of arrhythmia. Upon review, the bundle-of-His recording is missing. What code(s) should be reported?

- A. 93610, 93602, 93612, 93603, 93618
- B. 93619-52
- C. 93620-52
- D. 0

Answer: A

Explanation:

To bill a comprehensive electrophysiologic evaluation (93619-93622), the following five components must be documented: right atrial pacing (93610), right atrial recording (93602), right ventricular pacing (93612), right ventricular recording (93603), and bundle-of-His recording (93600). If the documentation does not support all five components, each study must be reported separately, as opposed to billing the procedure with a "reduced services" modifier. The exception to this rule would be if an add-on procedure were performed and required to be reported in addition to the comprehensive electrophysiologic evaluation. In this case, however, the attempted induction arrhythmia (93618) is not an add-on code and can be reported in addition to the primary procedures.

NEW QUESTION # 154

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