

AAPC-CPC Exam Dumps.zip - AAPC-CPC Practice Exam Fee

AAPC CPC Practice Exam C Answers

If a ST elevation myocardial infarction (STEMI) converts to a non ST elevation myocardial infarction (NSTEMI) due to thrombolytic therapy, how is it reported, according to ICD-10-CM guidelines?

- A. As unspecified AMI
- B. As a subendocardial AMI
- C. As STEMI**
- D. As a NSTEMI - ✓ C. As STEMI

ICD-10-CM guidelines (Section I.C.9.e.1) indicate: If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

Which place of service code is reported on the physician's claim for a surgical procedure performed in an ASC?

- A. 21
- B. 22
- C. 24**
- D. 11 - ✓ C. 24

Place of service codes are two digit numerical codes that define the location where services are performed and reported on the CMS-1500 form. A complete chart of Place-Of-Service codes is found on the first page in CPT® codebook. A service provided in an ASC is reported with POS code 24.

Local Coverage Determinations (LCD) are published to give providers information on which of the following?

- A. Information on modifier use with procedure codes
 - B. CPT® codes that are bundled
 - C. Fee schedule information listed by CPT® code
 - D. Reasonable and necessary conditions of coverage for an item or service - ✓ D.**
- Reasonable and necessary conditions of coverage for an item or service

Local Coverage Determinations (LCD) are Medicare Administrative Contractor rules indicating whether or not a particular item or service is covered. Most LCDs also provide a list of diagnosis codes for which a procedure may be covered; however, because other issues factor into payment, coverage is not guaranteed. Modifier guidelines and fee schedule information is included in the annual Medicare Physician Fee Schedule. National Correct Coding Initiative (NCCI) is used to know what CPT® codes are bundled.

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q108-Q113):

NEW QUESTION # 108

Health behavior assessment and intervention codes capture services related to mental health.

- A. False
- B. True

Answer: A

Explanation:

The statement is false. Health behavior assessment and intervention codes capture services related to a patient's physical health and can be used only when the patient has a physical health diagnosis as the primary reason for treatment-not a mental disorder. Although assessing factors related to the patient's mental state, it is done to promote functional improvement and lessen any obstacles to a patient's recovery.

NEW QUESTION # 109

A 92-year old female with Medicare part A coverage receives ongoing hospice care due to dementia. She goes to a physician's office to receive closed treatment of a hip dislocation following a fall. No anesthesia was used. How should the provider submit this claim?

- A. 27250, S73.003A, W19XXXA
- B. 27250, 99213-25, S73.003A
- C. 27250-GW, S73.003A, W19XXXA
- D. 27250-GW, 99202-25, S73.003A W19XXYuA

Answer: C

Explanation:

When a patient is receiving hospice care, Medicare will not reimburse the physician for services rendered that are unrelated to the terminal illness unless submitted with modifier GW. In Answers C and D, a separate, identifiable E/M is not to be billed because the procedure is considered minor (1- to 10-day global period) and includes an inherent E/M component.

NEW QUESTION # 110

A patient who is experiencing rectal bleeding has a colonoscopy. Prior to the procedure, the provider administers general anesthesia. What CPT code(s) should be reported?

- A. 45378, 0081147
- B. 45382, 00811
- C. 45378-47
- D. 0

Answer: C

Explanation:

The patient is having the colonoscopy done because they have been experiencing symptoms. Therefore, the colonoscopy would be considered diagnostic versus screening. CPT crosswalk for a diagnostic colonoscopy is 45378. The documentation gives no indication that any bleeding was identified and controlled. When the surgeon performing the primary procedure is simultaneously administering anesthesia services, modifier 47 is appended rather than billing an additional anesthesia delivery code.

NEW QUESTION # 111

A female patient experiencing swollen lymph nodes is seen for a follow-up to discuss the results of her open axillary biopsy that occurred last week. The results are positive for diffuse large cell lymphoma. The patient is given multiple treatment options, including

success rates, risks, and side effects. She opts to begin radiation treatment next week. What CPT and ICD-IO-CM codes should the provider report for this visit?

- A. 99213-24, C83.84
- B. 99214, (285.94
- **C. 99214-24, 25, 99024, C83.34**
- D. 99024, C85.84

Answer: C

Explanation:

To determine which services to report for this encounter, it is important to understand which services were rendered on the last. The patient had an open biopsy of the axillary lymph nodes (CPT 38525) last week. This procedure has a postoperative 90-day global period. This means that any related services provided to the patient within that time are reported with zero-charge CPT 99024. Services such as biopsy results, follow-up incisional care, and any postoperative complications are all inclusive to this code. As the patient was given biopsy results, CPT 99024 should be reported for this encounter. However, CPT guidelines also state that when it comes to diagnostic procedures, "care of the condition for which the diagnostic procedure was performed... is not included and may be listed separately." In this case, that care begins with the discussion of treatment options with their identified risks, and the decision to begin radiation. This level of moderate medical decision-making is reported by means of E/M CPT 99214. Modifier 24 is appended to indicate that it is unrelated to postoperative care, and modifier 25 is appended to indicate it is separately identifiable to CPT 99024. ICD-IO-CM crosswalk for lymphoma, diffuse large cell, is C83.34.

NEW QUESTION # 112

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 recurrence 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. Z08, Z85.038**
- C. C18.9
- D. Z48.3, C18.9

Answer: B

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 # 113

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