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**AAPC CPC FINAL EXAM 2023-2024 REAL EXAM 3 LATEST
VERSIONS EACH VERSION CONTAINS 100 QUESTIONS
AND CORRECT ANSWERS(VERIFIED
ANSWERS)|AGRADE**

VERSION A

Question 1

Correct

1.00 points out of 1.00

What does CMS-HCC stand for?

Select one:

- ☐ a. Centers for Medicare & Medicaid Services &C* Hospital Correct Coding Initiative
- ☐ b. County Mandated Services &C* Heightened Control Center
- ☐ c. Country Mandated Services &C* Hospital Correct Coding Initiative
- ☐ d. Centers for Medicare & Medicaid Services &C* Hierarchal Condition Category

The correct answer is: Centers for Medicare & Medicaid Services &C* Hierarchal Condition Category

Question 2

Correct

1.00 points out of 1.00

Evaluation and management services are often provided in a standard format such as SOAP notes. What does the acronym SOAP stand for?

Select one:

- ☐ a. Subjective, Objective, Assessment, Plan
- ☐ b. Scope, Observation, Action, Plan
- ☐ c. Standard, Objective, Activity, Period
- ☐ d. Source, Opinion, Advice, Provider

The correct answer is: Subjective, Objective, Assessment, Plan

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q60-Q65):

NEW QUESTION # 60

A 34-year-old established male patient presents for treatment to his lower back. He reports exacerbated symptoms due to lifting heavy materials at work. The osteopath performs a problem-focused history and exam followed by manipulative treatment to the lumbar and sacral region of the spine. What procedure(s) should the osteopath report?

- A. 0
- B. 99212-25, 97140x2
- C. 99212-25, 98925
- D. 1

Answer: C

Explanation:

Osteopathic manipulation services do not include evaluation and management services.

Although the patient's treatment has already been established, the osteopathic physician has enough supporting documentation to report a separate evaluation and management code.

Manipulation services rendered by an osteopathic physician are reported with CPT codes 98925-

98929. A chiropractor would report manipulative treatment to the body regions with CPT 98940, and a physical therapist would report CPT 97140.

NEW QUESTION # 61

What must the documentation for a consultation include?

- A. Which family member prompted the consultation, a written report of the physical findings/recommendations, and the time spent discussing the recommended treatment plan
- B. Who requested the consultation, the consulting providers, professional opinion, and a written report that is provided to the referring physician
- C. Documentation of assumption of care, who requested the consultation, and the consulting providers, professional opinion
- D. The reason for the consultation, the time spent discussing the recommended treatment plan, and a medical decision-making of moderate complexity

Answer: B

Explanation:

Per CPT guidelines, the Office of Inspector General, and Medicare, a consultation must include who requested the consultation, the consulting provider's professional opinion, and a written report of the findings, which is provided to the referring physician. Time can be used to select the level of E/M; however, it is not required if all three components of the documentation are met (history, exam, and medical decision-making). Additionally, once the provider assumes care, a subsequent code appropriate for that place of service would be reported (e.g., 99211-99215) and not a consultation code.

NEW QUESTION # 62

Alzheimer's disease with early onset usually presents itself in which age group?

- A. 30-40 years old
- B. 40-50 years old
- C. 60-70 years old
- D. 50-60 years old

Answer: B

Explanation:

According to CPT, the rarest form of Alzheimer's disease occurs before 30 years of age.

Early onset Alzheimer's disease usually affects those between the age of 40 and 50 years old. The most common form of Alzheimer's disease occurs after the age of 65 and is largely contributed to a combination of environmental and genetic factors.

NEW QUESTION # 63

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

Answer: D

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 # 64

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

Answer: B

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 # 65

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