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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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on their first attempts because of the challenging level of topics included in the Medical Tests AAPC-CPC test. Free4Torrent AAPC-CPC actual dumps help applicants in clearing the test very easily.

## Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q32-Q37):

### NEW QUESTION # 32

A female patient presents to her obstetrical office 32 -weeks pregnant for a bi-weekly ultrasound. Code the following technician's report:

Fetal views obtained via transabdominal ultrasound as follows:

BPD: 32 mm

Femur Length: 63 mm

Head Circumference: 288 mm

Abdominal Circumference: 270 mm

BPP 8/8

NST from 11:15 to 12:17, showing 160 BPM and positive movement activity Doppler shows adequate systolic and diastolic flow velocities of the fetal umbilical artery.

- A. 76816-TC, 76816-TC, 76820-TC
- B. **76816, 76818, 76820**
- C. 76815-TC, 76819-TC, 76820-TC
- D. 76815, 78819, 76820

### Answer: B

Explanation:

CPT 76815 is a limited ultrasound, in which only the fetal heartbeat, position, placental location, and/or volume of amniotic fluid are evaluated. In this scenario, much more was done than a limited study. The ultrasound technician documented age-appropriate fetal measurements, which are supported by CPT 76816. A biophysical profile (BPP) was also done, which monitors the fetus's movements, tone, and breathing as well as evaluates the volume of amniotic fluid. Each of these elements counts as 2 units of grading to evaluate the general well-being of the fetus. The desired score of a BPP is 8/8. Because a fetal nonstress test (NST) was completed in conjunction with a BPP, report CPT 76818 instead of CPT 76819. Modifier TC is used to reflect that only a technical component of the procedure was completed. However, because the patient received these services in an obstetrical office that employs the physicians providing prenatal care and owns the ultrasound equipment the code should be submitted without modifiers TC or 26 to receive 100% reimbursement.

### NEW QUESTION # 33

A laboratory receives a pap smear as a screening for a patient's annual gynecological exam. A thin-layer preparation screened by an automated system with manual rescreening is performed. A pathologist interprets the results and confirms a diagnosis of high-grade squamous intraepithelial lesion. What should the laboratory report?

- A. 88175, Z12.4
- B. G0148, G0141, Z12.4 R8.613
- C. G0148, R87.610
- D. **88175, 88141, ZOI.419,R87.613**

### Answer: D

Explanation:

The CPT codes for cytopathology smears are dependent on the payer and the method used to test the specimen. HCPC II G0148 does accurately describe the test method; however, this code is used for Medicare payers only. As the documentation does not specify that this is the case, it should be assumed that the carrier is non-Medicare. The appropriate non-Medicare CPT for this test method is 88175. CPT 88141 is always reported as a secondary code for the associated physician interpretation. Regarding the diagnosis, the primary ICD-10-CM code should be synonymous with the reason for the encounter, which in this scenario would be the Gynecological exam (ZOI.419).

Although Z12.4 does describe a screening of the cervix, it specifically is excluded from the diagnosis list "when the screening is part of general gynecological examination (ZOI.4-ZOI.42)." Any abnormal findings are reported as secondary and/or tertiary.

#### NEW QUESTION # 34

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

#### Answer: A

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 # 35

It is appropriate to use a HCPCS Level II G code, as opposed to a CPT code, to report a screening service performed on an asymptomatic patient.

- A. False
- B. True

#### Answer: B

Explanation:

The statement is true. G codes apply to various healthcare screenings. If a patient is experiencing any symptoms that initiate the encounter, it then becomes diagnostic, and an appropriate CPT code would be selected instead.

#### NEW QUESTION # 36

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-10-CM code(s) should be used to accurately describe encounter?

- A. 97110, 97140, 97010, Z48.89, S46.091A, W19XXA
- B. 97110, 97010, S46.011D, W19,XXXD
- C. 97010, 97140x2, 97530, M75.121
- D. 97010, 97140, 97530, S46.011A, W19XXA

#### 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 # 37

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