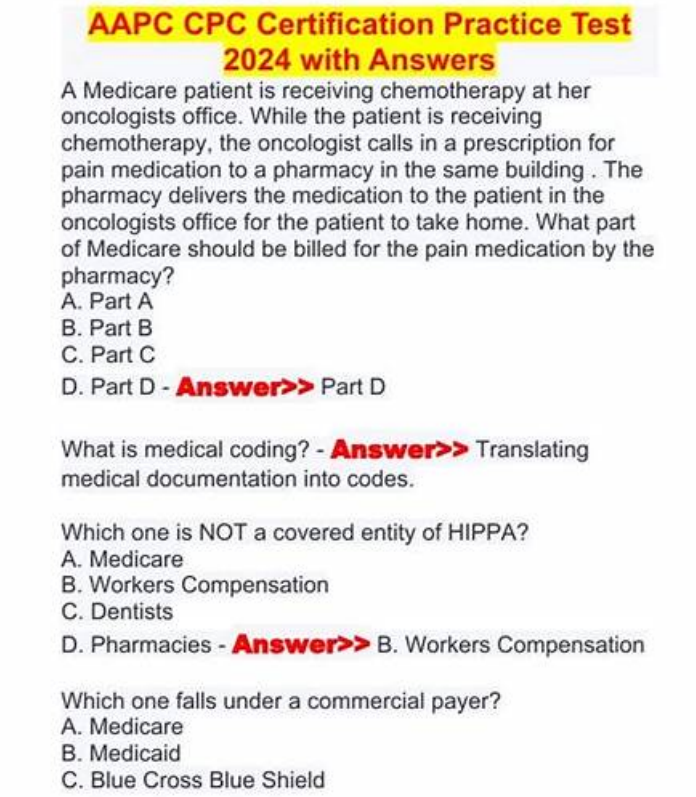
Exam AAPC-CPC Preview & AAPC-CPC Training Courses


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 (Q25-Q30):

NEW QUESTION # 25
To rule out malignancy, a provider collects two biopsies from the right thyroid nodule using a large bore needle that is inserted through the skin. Which CPT code(s) should be reported?

- A. 10021, 10004-59
- B. 10021, 10004
- C. 0
- D. 60100, 60100-59

Answer: C

Explanation:
Although CPT codes 10021, 10004, and 60100 all represent percutaneous procedures, only CPT 60100 describes the use of a large bore needle to obtain a specimen. When multiple biopsies are taken from the same nodule, only report CPT 60100 once. Ifa separate nodule is biopsied, report 60100 a second time with modifier 59, indicating a procedure on a sperate anatomical site.

NEW QUESTION # 26
Medical necessity has been established if a laboratory runs additional testing on a urine sample to determine the presence of a drug class that was not in question during confirmation testing.

- A. True
- B. False

Answer: B

Explanation:
The statement is false. To establish medical necessity, the provider/laboratory must indicate the drug class they are screening for prior to the test.

NEW QUESTION # 27
Assign the appropriate CPT codes for the following surgical note: A 15-year-old patient is being treated for obstructive sleep apnea and adenoid tissue hypertrophy. After being placed under general anesthesia, a dental mirror is placed in the oropharynx to allow visualization of the nasopharynx. Suction electrocautery is used to remove the adenoid tissue that regrew after the initial adenoidectomy. Attention is then turned to the tonsils. The plane of tissue between the tonsillar capsule and the underlying muscles are cauterized, and the tonsils are removed. Bleeding is controlled by silver nitrate and gauze packing. Procedure is completed without complications, and patient is discharged to recovery.

- A. 42826, 42831-59, 135.2, G47.33
- B. 42821, G47.33, 135.2
- C. 42999, 647.33, 135.2
- D. 42826, 42836-51, 135.2, G47.33

Answer: B

Explanation:
An adenoidectomy and a tonsillectomy were performed in this surgical encounter (the root word -ectomy literally means the surgical removal of an anatomical structure). The adenoidectomy was done first and, if coded alone, would fall under one of Evo categories: primary (CPT 42830-
42831) or secondary (CPT 42835-42836). A primary adenoidectomy refers to the initial removal of the adenoid, whereas a secondary adenoidectomy occurs when adenoid tissue that was once removed has grown back. Because the documentation states that "the adenoid tissue ... regrew after the initial adenoidectomy," a coder can infer that this procedure is secondary. However, distinguishing betvveen the two procedures is not necessary when done in conjunction with a tonsillectomy because the procedures

are bundled into two nonspecific CPT codes (42820 and
42821). Billing for an adenoidectomy and a tonsillectomy separately, as shown in answers A and C, is considered unbundling and is not allowed under the Correct Coding Initiative (CCI) edits.
Regarding the sequencing of the diagnoses, ICD-IO-CM guidelines state that when V,vo conditions meet the definition for principal diagnosis, either can be sequenced first In this scenario, J 35.2 or G47.33 could have been first listed because the procedures were to resolve both conditions in the same encounter.

NEW QUESTION # 28
When it comes to documentation, which of the following is NOT an example of a moderate level of service?

- A. A physician reviews the most recent X-Ray
- B. Anew patient presents with lymphoma while undergoing treatment for melanoma
- C. A nurse practitioner reviews CBC, CMP, and tumor markers
- D. A physician changes the frequency of chemotherapy

Answer: A

Explanation:
If a physician were to only review the most recent X-ray, the physician is only meeting one of the nvo categories in the amount and/or complexity of data reviewed and analyzed. Meeting only one ofthe categories contributes to a low level of medical decision-making. On the other hand, altering a drug management program, reviewing several unique tests, and/or addressing an exacerbation of a chronic illness, all contribute to a moderate level of medical decision-making.

NEW QUESTION # 29
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 # 30
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