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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 (Q87-Q92):

NEW QUESTION # 87

An established 27-year-old female patient is seen with complaints of fatigue and muscle aches that began 3 days ago. The physician draws two vials of blood, collects a urine sample, and performs a pregnancy test. The patient is instructed to drink 8 ounces of water daily, rest, and follow up in 3 days for her results. What CPT codes should be reported for this encounter?

- A. 99212, 81025, 36410x2, 99000, 81020
- B. 99213, 81025, 36410, 81005
- C. 99212, 81025, 36416, 81007
- D. **99213, 81025, 36415, 81002**

Answer: D

Explanation:

The documentation demonstrates that the number and complexity of problems addressed is low (fatigue and muscle aches are self-limited problems), the amount or complexity of data to be reviewed and analyzed is moderate (three unique tests), and the risk of complications, morbidity, or mortality of patient management is minimal (the patient was advised to drink more water). (To determine the final level of medical decision making, choose the lowest of the highest two elements. In this scenario, the final level of medical decision making is low, and the CPT code is

99213. When reporting a routine venipuncture, use CPT code 36415. CPT code 36410(a) is reported when it is medically necessary for the physician to draw a patient's blood, and 36416 describes capillary blood collected through a skin prick-certainly not enough to fill two vials. CPT code 99000 can be used to report a specimen being transported to an outside laboratory, but that is unknown in this scenario. A generic urinalysis is reported with CPT code 81002 unless specifically stated that an automated analyzer (81005), a commercial kit (81007), and/or an agar test (81020) was utilized.

NEW QUESTION # 88

If a provider documents in an assessment that a patient is obese, but the BMI extracted from the chart is consistent with morbid obesity, what should be reported on the claim?

- A. **Obesity and the appropriate BMI**
- B. Morbid obesity and the appropriate BMI
- C. Morbid obesity
- D. Obesity

Answer: A

Explanation:

The diagnosis is always based on the provider's documentation, which in this case would be obesity. Coding guidelines also state that if there is a reportable diagnosis related to weight, "the BMI can be assigned from documentation of someone other than the patient's provider, such as nursing notes."

NEW QUESTION # 89

The CPT code 76805 requires that multiple elements of the exam be documented, such as the evaluation of the amniotic fluid, umbilical cord insertion site, and placental location. If the provider documents most elements, he/she can bill the CPT code 76805.

- A. False
- B. True

Answer: A

Explanation:

The statement is false. Per ICD-IO-CM, "Results must be documented in the report for each of the elements described in the code description." If the provider does not document a given element, they must include a reason for non-visualization for the CPT to be

reported.

NEW QUESTION # 90

A patient with a stab wound to the chest was taken to the operating room and put under general anesthesia for a thoracotomy. The anesthesiologist should report CPT 00520 with the total number of time units spent providing face-to-face care with the patient.

- A. False
- B. True

Answer: A

Explanation:

The statement is false. CPT 00520 is anesthesia services for closed-chest procedures.

However, a thoracotomy is an open procedure involving a surgical incision to the chest wall. The correct CPT code that should be reported is 00540 (anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum).

NEW QUESTION # 91

Code the following procedure note:

A 45-year-old female was referred for a urodynamics study due to complaints of bladder pain and weak urination. The provider places a rectal catheter simultaneously with a urethral catheter and begins to fill the bladder with water.

Using calibrated equipment, cytometry was done with a medium fill rate of 40 cc/ minute. A strong desire to void occurred at 84 cc. and the patient is instructed to void. The provider determines that the maximum urinary flow rate is 12 cc per second with a voiding time of 45 seconds and a voided volume of 102 cc. She voided with a sustained detrusor pressure. An abdominal pressure measurement was also taken, indicating no urinary leaking with abdominal straining. EMG patches were placed on the anal sphincter and found to be elevated with increased intra- abdominal pressure. All catheters and EMG patches were removed, and the procedure was completed without complications. A report will be forwarded to the referring provider, who will provide the interpretation of the results to the patient.

- A. 51726-TC, 51784-59-TC, 51797-59-TC, 51741-59-TC
- B. 51728-TC, 51784-TC, 51797-TC
- C. **51728-TC, 51784-TC, 51797-TC, 51741-TC**
- D. 51726-TC, 51784-51-TC, 51797-51-TC

Answer: C

Explanation:

A urodynamics study is a diagnostic test to evaluate the function of the bladder. When performed using calibrated equipment, it becomes known as a complex cystometrogram (51726-51729). In CPT code 51728, a complex cystometrogram is performed in conjunction with voiding pressure studies. In the provider's documentation, the bladder is filled with water, and voiding times and volume are recorded, thus fulfilling the requirements for this code. CPT code 51726 in answers A and B only describe a complex cystometrogram without the voiding pressure studies.

Electromyography (EMG) studies were performed without a needle to evaluate pelvic floor activity and are represented by 51784. An intraabdominal voiding pressure study (51797) can be inferred in that the provider had earlier inserted a rectal catheter and, after instructing the patient to cough, obtained an abdominal pressure measurement. A complex urinary flow study (51741) was performed in obtaining the maximum urinary flow rate through calibrated equipment. This procedure is missing in answers B and C. Modifier TC (indicating only a technical component) is amended on all the procedures because the provider is not interpreting the results to the patient.

Modifiers 51 and/or 59 is not amended on any procedure (A and B) because these are routinely billed together.

NEW QUESTION # 92

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