

New Medical Tests AAPC-CPC Dumps Questions - AAPC-CPC Reliable Braindumps Questions

AAPC CPC Exam Questions with correct Answers 100%

Which one of the following is an example of fraud?

- A. Reporting the code for ultrasound guidance when used to perform a liver biopsy
 - B. Reporting a biopsy and excision performed on the same skin lesion during the same encounter
 - C. Failing to append modifier 26 on an X-ray that is performed and interpreted in the physician's office
 - D. Reporting a lab panel with an additional lab test that is not included in the lab panel - correct answers
- B. Reporting a biopsy and excision performed on the same skin lesion during the same encounter

Answer B is the only example of unbundling of CPT® which would result in a fraudulent claim. According to National Correct Coding Initiative (NCCI) and CPT® coding guidelines, a biopsy performed on the same lesion as an excision during the same encounter is an incidental service and is not reported separately. If ultrasound guidance is performed for a liver biopsy, it is billable. X-rays performed in a physician's office do not require modifier 26, because the physician owns the equipment and performs the interpretation, he bills the global service. Lab panels can be reported with additional lab tests that are not listed in a lab panel.

Which place of service code is reported for fracture care performed by an orthopedic physician in the ED?

- A. 11
 - B. 20
 - C. 22
 - D. 23 - correct answers
- D. 23

Place of service codes are reported on the claim form to identify the site of the service provided. In this case, the services are rendered in the ED which is reported with place of service (POS) 23. The place of service codes can be found in the CPT® codebook.

What is the full CPT® code description for 61535?

- A. Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long-term seizure monitoring; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)
- B. Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q11-Q16):

NEW QUESTION # 11

What is the difference between presumptive and definitive testing?

- A. Presumptive testing assumes a diagnosis; definitive testing confirms a diagnosis.
- B. Presumptive testing is based on exhibited signs and/or symptoms; definitive testing is based on lab results.
- C. Presumptive testing requires additional observation time; definitive testing requires a blood draw.
- **D. Presumptive testing confirms the presence of a drug class; definitive testing identifies the quantity or presence of a drug.**

Answer: D

Explanation:

A presumptive test reports whether the patient is positive or negative for a specific drug. A definitive test would analyze which specific agent and/or how much of that agent is in the patient's system.

NEW QUESTION # 12

The physician suspects malignancy and decides to remove two lesions from the patient's back to confirm. The size of the first lesion has a diameter of 0.5 cm, and the excised diameter is 1.0 cm. The size of the second lesion has a diameter of 0.3 cm, and the excised diameter is 1.5 cm. Which CPT code(s) should be reported?

- A. 11600, 11600-51
- **B. 11402, 11401-59**
- C. 11401, 11402-59
- D. 11401, 11402-51

Answer: B

Explanation:

Without a pathology report to confirm malignancy, the excision code assumes that the lesion is benign. Code selection is based on the excision size, not the size of the lesion, and the more complex code takes priority in sequence, eliminating answer C. Answers A and B can be incorrect choices due to CPT guidelines outlining that when coding more than one excision, the appropriate modifier would be 59 on each additional procedure.

NEW QUESTION # 13

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

Answer: B

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 # 14

A patient relocates after receiving treatment for an arm fracture. The patient schedules an appointment with a new orthopedist to remove the cast. The orthopedic office should report the fracture diagnosis code with the seventh character A to indicate active treatment.

- A. True
- B. False

Answer: B

Explanation:

The statement is false. When a patient is in the healing and/or recovery phase of an injury, the seventh character would be D to indicate that the care is subsequent-whether the provider has treated the patient in the past or not.

NEW QUESTION # 15

Which type of anesthesia is NOT separately reportable?

- A. Metacarpal blocks
- B. Spinal anesthesia
- C. Regional anesthesia
- D. Monitored anesthesia care

Answer: A

Explanation:

CPT surgery guidelines uphold that local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia is always included in the surgical package. Under monitored anesthesia care (MAC), a patient is sedated but typically still aware, and the presence of qualified anesthesia personnel is required. Spinal and regional anesthesia is used for a variety of different procedures and is also separately reportable.

NEW QUESTION # 16

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