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AAPC CRHC

AAPC Certified Rheumatology Coder



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Question: 1

A new patient is evaluated for positive rheumatoid factor found during an insurance physical. The patient has no joint pain, swelling, stiffness, rash, or systemic symptoms. The rheumatologist reviews the outside lab result, performs a medically appropriate history and exam, provides counseling, and recommends no medication or additional testing. MDM is straightforward, and total time is not documented.

Which E/M code is best supported?

- A. 99204
- B. 99202
- C. 99205
- D. 99203

Answer: B

Question: 2

A patient taking mycophenolate mofetil for connective tissue disease is seen for follow-up. The note documents stable symptoms, CBC and CMP monitoring, counseling about infection precautions, and continuation of therapy. The provider does not document infection, cytopenia, or organ toxicity.

Which coding interpretation is most appropriate?

- A. Code organ toxicity because CMP monitoring was ordered
- B. Code cytopenia because CBC monitoring was performed
- C. Code infection because infection precautions were discussed
- D. Support medication monitoring and long-term therapy status when documented, without coding complications not diagnosed

Answer: D

Question: 3

A provider documents: "Age-related osteoporosis with current pathological fracture of the right femur, subsequent encounter for fracture with routine healing. Patient is followed for osteoporosis management and fracture healing." The coder is selecting diagnosis codes for the follow-up encounter. Which coding principle is most appropriate?

- A. Code traumatic femur fracture because all femur fractures are traumatic by default

- B. Code only age-related osteoporosis without fracture because the fracture is healing
- C. Code age-related osteoporosis with current pathological fracture using the documented site and encounter status
- D. Code personal history of healed fracture because routine healing is documented

Answer: C

Question: 4

A rheumatologist injects corticosteroid into the right glenohumeral shoulder joint using ultrasound guidance. The note documents ultrasound visualization of needle placement, permanent image storage, written report, medication, and patient tolerance. Which CPT® code is most appropriate?

- A. 20611
- B. 20610
- C. 20605
- D. 76942 only

Answer: A

Question: 5

A rheumatology infusion suite administers a biologic infusion from 8:00 a.m. to 9:15 a.m. A nurse documents a separately ordered premedication given by subcutaneous injection at 7:45 a.m., including drug name, dose, route, site, and patient tolerance. The payer permits separately reportable premedication administration when supported. Which administration coding principle is most appropriate?

- A. Convert the premedication injection to an IV push code because it was related to an infusion visit
- B. Evaluate the biologic infusion and separately documented subcutaneous premedication injection under CPT® and payer rules
- C. Report only the premedication injection because it occurred before the infusion
- D. Report only the biologic infusion because premedications are always bundled

Answer: B

Question: 6

An established patient with osteoarthritis and calcium pyrophosphate deposition disease presents with an acute swollen wrist. The rheumatologist reviews prior imaging, orders synovial fluid crystal analysis,

performs prescription NSAID management, and documents concern for an inflammatory flare versus infection. No procedure is performed, and total time is not documented.

Which E/M code is best supported by the documented medical decision making?

- A. 99214
- B. 99213
- C. 99215
- D. 99212

Answer: A

Question: 7

During a scheduled follow-up for stable gout medication monitoring, the patient reports new severe left knee swelling after a fall. The physician performs and documents a separately identifiable evaluation of the acute knee injury, orders an X-ray, and also performs a left knee corticosteroid injection during the same visit.

Which modifier is most appropriate for the E/M service if documentation supports billing both the E/M and the injection?

- A. Modifier 51
- B. Modifier 57
- C. Modifier 25
- D. Modifier 78

Answer: C

Question: 8

Before initiating a tumor necrosis factor inhibitor, the rheumatologist documents active rheumatoid arthritis, prior inadequate response to conventional therapy, and plans for tuberculosis and hepatitis screening. The payer's policy requires evidence of infection screening before biologic approval.

Which documentation element most directly supports biologic therapy coverage?

- A. Documentation of required infection screening and prior therapy response criteria
- B. A note that the patient has transportation difficulty attending visits
- C. A general statement that biologic therapy is commonly used in rheumatology
- D. A statement that the patient prefers an injectable medication

Answer: A

Question: 9

A biologic infusion is ordered for 500 mg. The practice uses two single-dose vials of 300 mg each. The nurse documents 500 mg administered and 100 mg discarded, including vial sizes and reason for discard. The payer follows Medicare-style single-dose vial wastage rules.

Which drug-line reporting principle is most appropriate?

- A. Report no drug supply because part of the medication was discarded
- B. Report the administered amount and, when supported, separately identify the discarded amount using the payer-required wastage modifier
- C. Report 600 mg as administered because both vials were opened
- D. Report only 500 mg because discarded drug is never separately reportable

Answer: B

Question: 10

The rheumatologist documents: "Systemic lupus erythematosus with glomerular disease. Patient is followed by nephrology for lupus nephritis." The assessment also lists chronic fatigue, arthralgia, and long-term immunosuppressive therapy.

Which ICD-10-CM coding principle is most appropriate?

- A. Code unspecified lupus because nephrology manages the kidney manifestation
- B. Code only the fatigue and arthralgia because they are the symptoms treated today
- C. Code chronic kidney disease only because lupus nephritis is implied but not stated
- D. Code systemic lupus erythematosus with organ involvement as documented

Answer: D

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