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AAPC Certified Professional Coder (CPC®)  
AAPC CPC Medical Coding + Medical Billing Training  
AAPC CPC Certification Exam

Course Title and Number: AAPC CPC Certification Exams  
Exam Title: Midterm, Finals, Certification and Assessment  
Exam Date: Exam 2025- 2026  
Instructor: [Insert Instructor's Name]  
Student Name: [Insert Student's Name]  
Student ID: [Insert Student ID]

**Examination**  
Time: - \_\_\_\_ Hours: \_\_\_\_ Minutes

**Instructions:**

1. Read each question carefully and Answer All Questions
2. Use the provided answer sheet to mark your responses.
3. Please Ensure all you answer each question below and click Submit when you have completed the Exam.
4. This test has a time limit, The test will save and submit automatically when the time expires
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### Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q70-Q75):

#### NEW QUESTION # 70

A sternal closure using sutures is considered inclusive to CPT 33255 and should not be reported separately.

- A. False
- **B. True**

**Answer: B**

Explanation:

The statement is true. Regardless of how a sternal closure is performed, it would be considered integral to this, and any other open cardiac procedure, when a sternal approach is used as the method of exposure. If a sternal closure were performed as the only procedure to repair an injury, the closure would then be reported.

#### NEW QUESTION # 71

Code the following physician's note:

A 14-year-old established patient is seen with mother to evaluate five 2 cm superficial lacerations to the left wrist. Patient admits to suicidal thoughts.

Lacerations were treated with Steri-Strips. Patient and mother counseled on suicide prevention and told to follow up with psych.

- A. 99214, S61.512A, T14.91XA
- B. 12004, S61.512A, R45.851
- **C. 99213, S61.512A, R45.8S1**
- D. 12004, S61.512A, T14.91XA

**Answer: C**

Explanation:

When the injury is treated with Steri-Strips or bandages, it should be reported with an E/M code and not a procedure code. Within the medical decision making, the number and complexity of problems addressed is low, the amount of data reviewed or analyzed is straightforward, and the risk of complications and/or morbidity or mortality of patient management from the injuries is low.

Therefore, the E/M is a 99213 because the medical decision-making is low. A suicide attempt would not be coded because the documentation is not specific as to whether the lacerations were an attempt at suicide.

#### NEW QUESTION # 72

During surgery to remove a malignant melanoma from the intestinal tract, one frozen section is sent for pathological consultation to confirm an adequate excision of the margins. A second specimen is also sent, which requires frozen sections on two tissue blocks. What CPT code(s) should the pathologist report?

- A. 88329, 88331, 88332, 88332
- B. 88331, 88332
- **C. 88331, 88331, 88332**
- D. 88331, 88332, 88332

**Answer: C**

Explanation:

CPT code 88331 is used to report only a single specimen. In this scenario, there are two separate specimens being sent to the pathologist. The first specimen, with one frozen section, is reported with CPT code 88331. The second specimen has two tissue

blocks with frozen sections, thus represented by coding 88331 for the first tissue block, followed by 88332 for the additional tissue block CPT code 88329 is inclusive to 88331 and should not be reported separately.

### NEW QUESTION # 73

Code the following adverse effect:

Initial encounter of drug-induced tremors that was caused by Cyclosporin the patient takes for anemia. The anemia is caused by a current diagnosis of colon cancer.

- A. G25.1, T45.1X5A, C18.9, D63.O
- B. C18.9, D63.O, G25.1, T45.1X5A
- C. D63.O, C18.9, T45.1X5A, G25.1
- D. T45.1X5A G25.1, C18.9, D63.O

**Answer: A**

Explanation:

The correct sequencing of the code would be as follows: side effect of the drug, medication that caused the adverse effect and the underlying condition for why the drug is being taken. In this scenario, because the anemia is caused by a malignancy, ICD-IO-CM guidelines state that the malignancy should be the principal diagnosis "followed by the appropriate code for the anemia (such as D63.0, Anemia in neoplastic disease)."

### NEW QUESTION # 74

Which is NOT considered inclusive to hydration services?

- A. Flush solution
- B. Subcutaneous catheter access
- C. Catheter flush
- D. Catheter declotting

**Answer: D**

Explanation:

Catheter access, standard supplies such as a flush solution, and the flush at the end of the infusion are all considered necessary to facilitate the infusion and are inclusive to CPT codes

96360-96361. Declotting a catheter involves the injection of a thrombolytic agent to dissolve the clot and is separately reportable with CPT 36593.

### NEW QUESTION # 75

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