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## AAPC CPC PRACTICE EXAM A QUESTIONS WITH CORRECT ANSWERS 2025

A 46-year-old female had a previous biopsy that indicated positive malignant margins anteriorly on the right side of her neck. A 0.5 cm margin was drawn out and a 15 blade scalpel was used for full excision of an 8 cm lesion. Layered closure was performed after the removal. The specimen was sent for permanent histopathologic examination. What are the CPT® code(s) for this procedure?

- A. 11626
- B. 11626, 12004-51
- C. 11626, 12044-51
- D. 11626, 13132-51, 13133 - CORRECT ANSWER -C

According to CPT® guidelines "Repair of an excision of a malignant lesion requiring intermediate or complex closure should be reported separately". The intermediate repair code is reported because it was a layered closure.

A 30-year-old female is having 15 sq cm debridement performed on an infected ulcer with eschar on the right foot. Using sharp dissection, the ulcer was debrided all the way to down to the bone of the foot. The bone had to be minimally trimmed because of a sharp point at the end of the metatarsal. After debriding the area, there was minimal bleeding because of very poor circulation of the foot. It seems that the toes next to the ulcer may have some involvement and cultures were taken. The area was dressed with sterile saline and dressings and then wrapped. What CPT® code should be reported?

- A. 11043
- B. 11012
- C. 11044
- D. 11042 - CORRECT ANSWER -C

Debridement is not being performed on an open fracture/open dislocation eliminating multiple choice answer B. The ulcer was debrided all the way to the bone of the foot, making multiple choice answer C, the correct procedure.

### Question 3

A 64-year-old female who has multiple sclerosis fell from her walker and landed on a glass table. She lacerated her forehead, cheek and chin and the total length of these lacerations was 6 cm. Her right ar

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## Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q53-Q58):

### NEW QUESTION # 53

If past family and social history is not documented for the evaluation and management of a new patient, what is the highest level of service that can be coded?

- A. 0
- B. 1
- C. 2
- D. 3

**Answer: C**

Explanation:

Effective January 1, 2023, new evaluation and management (E/M) guidelines were implemented for inpatient, outpatient, home health, and preventative medicine services. These new guidelines remove the Patients' history and examination as elements in selecting the level of code.

Instead, E/M services are leveled based on the medical decision-making process. Therefore, in this scenario, the highest level of service that can be billed for a new patient with no documented past medical, family, and social history is 99205, CPT codes 99213 and 99214 are reported for established patients.

### NEW QUESTION # 54

What is NOT a condition related to the thyroid gland?

- A. Hashimoto's disease
- B. Toxic adenoma
- C. Acosta disease
- D. Graves' disease

**Answer: C**

Explanation:

Toxic adenoma E05.2- is a thyroid nodule that may secrete hormones into the body that results in an overactive thyroid. Graves' disease E05.0- is an autoimmune disorder that attacks the thyroid, resulting in overactivity. Hashimoto's disease E06.3 is also an autoimmune disorder:

however, it usually results in an underactive thyroid. Acosta disease T 70.29- is altitude sickness.

Even if a coder is unfamiliar with these terms, by locating the ICD-IO-CM code that correlates to the condition, a coder can infer which body system a diagnosis relates to.

### NEW QUESTION # 55

An established patient presents complaining of clumpy, white discharge for 3 days. A vaginal exam reveals an old tampon, which is removed. Diflucan is sent to the pharmacy, instructions given, and the patient is told to follow up in 1 week. How would the provider code the visit?

- A. 99213, N89.8, T19.2LXA
- B. 57415, 99212-25, T19.2kVA
- C. 99213, T19.2XXA, N89.8
- D. 57415, T19.2XXA, N89.8

**Answer: C**

Explanation:

Although a foreign body was removed, 57415 in answers A and B cannot be reported because anesthesia was not used. The documentation supports low-level medical decision making, so the appropriate E/M would be 99213. VVhen comparing answers C

and D, bear in mind that ICD-IO-CM requires sequencing "the underlying condition first, followed by the manifestation."

#### NEW QUESTION # 56

Code the following note:

A 43 -year-old new female patient with a history of type I diabetes was referred to my office by Dr. White, her primary care physician. Patient complains of blurred vision that began 2 weeks ago, however, reports compliance to a strict, healthy diet and to prescribed 10 mg of dexamethasone every day for 1 month. Given that the only change appears to be the dexamethasone, I suspect the blurred vision is an adverse reaction and will decrease the dosage to 5 mg per day. Patient will follow up with me in 1 week if symptoms persist.

Total time spent on today's encounter is 30 minutes.

- A. 99244, H53.8, T38.OX5A, E10.9
- B. 99203, H53.8, E10.69
- C. 99204, H53.8, E10.9
- D. 99243, H53.8 E10.39

**Answer: C**

Explanation:

When choosing between an outpatient evaluation and management code or a consultation service code, bear in mind the following four elements: request, reason, report, and intent. Although the first three elements are documented and support a consultation service, the endocrinologist is assuming immediate care of the patient's condition. In this case, the visit is not a consultation but a new transfer of care, which is encompassed by CPT codes 99202-99205. For this visit, coding based on medical decision-making as opposed to the total time spent on the encounter that day would be more advantageous. This is because coding based on time would lead a coder to report CPT code

99203 or a low level of medical decision making, whereas the medical decision-making is actually moderate, represented by CPT code 99204.

The documentation reflects that the blurry vision is most likely due to the dexamethasone:

therefore, a causal relationship is not assumed between the two conditions and should not be coded as such. Because an adverse reaction is suspected and not confirmed, it should not be coded. This general rule does not apply to inpatient encounters.

#### NEW QUESTION # 57

Code a polyp found in the transverse colon.

- A. D12.6
- B. K51.40
- C. K63.5
- D. D12.3

**Answer: C**

Explanation:

Coding crosswalk for a colon polyp would direct the coder to the benign neoplasm table.

However, careful examination of the guidelines reveals that if the documentation does not specifically state that a polyp was adenomatous and/or benign, or that a polyp was inflammatory, the most appropriate choice selection would be a code from K63.

#### NEW QUESTION # 58

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