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AAPC CPC FINAL EXAM PRACTICE EXAM NEWEST 2024-2025 ACTUA EXAM 140 QUESTIONS AND CORRECT DETAILED ANSWERS (VERIFI ANSWERS)

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1.	**What form is used to submit a provider's charge to the insurance carrier?** **a. UB-04** **b. Provider reimbursement form** **c. CMS-1500** **d. ABN**	c. CMS-1500
2.	**Which coding manuals do outpatient coders focus on learning?** **a. CPT, HCPCS Level II and ICD-10-CM** **b. CPT and ICD-10-CM** **c. ICD-10-CM and ICD-10-PCS** **d. CPT, HCPCS Level II, ICD-10-CM, ICD-10-PCS**	a. CPT, HCPCS Level II and ICD-10-CM
3.	**In what year was HITECH enacted as part of the American Recovery and Reinvestment Act?** **a. 2010** **b. 2009** **c. 2000** **d. 2007**	b. 2009
4.	**Voluntary compliance programs also provide benefits by not only helping to prevent erroneous or ____, but also by showing that the**	c. Fraudulent claims

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• Urinary System and Male Genital System: This section of the exam measures the skills of medical coders and assesses understanding of procedures on kidneys, bladder, ureters, prostate, and male reproductive organs. Proper use of CPT codes for surgical and diagnostic interventions is tested.
Topic 2	• Evaluation & Management Services: This section of the exam measures the skills of coding specialists and covers office visits, hospital care, consultations, and other E • M services. It tests the understanding of time-based coding, medical decision-making, and history • exam components per current CMS guidelines.

Topic 3	• Special Senses (Ocular and Auditory): This section of the exam measures the skills of coding specialists and covers the coding of procedures related to the eyes and ears. Topics include surgeries on the cornea, retina, and middle • inner ear, as well as related diagnostic procedures.
Topic 4	• Integumentary System: This section of the exam measures the skills of medical coders and covers procedures related to the skin and related structures. Topics include excisions, biopsies, repairs, and destruction services, focusing on accurate code selection and modifier usage for integumentary interventions.
Topic 5	• Female Reproductive System and Maternity Care & Delivery: This section of the exam measures the skills of coding specialists and evaluates coding accuracy for gynecological and obstetric procedures. It includes deliveries, antepartum care, cesarean sections, and surgical procedures involving female reproductive anatomy.
Topic 6	• Radiology: This section of the exam measures the skills of coding specialists and focuses on diagnostic imaging procedures including X-rays, CT scans, MRIs, ultrasounds, and nuclear medicine. It emphasizes proper selection of codes based on anatomical site and modality used.
Topic 7	• Review of Anatomy: This section of the exam measures the skills of coding specialists and covers a high-level understanding of human anatomy. It includes organs, systems, directional terminology, and anatomical locations, enabling coders to link procedures and diagnoses to the correct bodily structures with accuracy and consistency.
Topic 8	• Introduction to CPT®, HCPCS Level II, and Modifiers: This section of the exam measures the skills of coding specialists and introduces candidates to CPT® coding for procedures, HCPCS Level II for supplies and services, and the correct use of modifiers. It helps learners distinguish between different code sets and understand their place in medical billing.
Topic 9	• Respiratory System: This section of the exam measures the skills of medical coders and evaluates the ability to code procedures involving the nose, sinuses, larynx, trachea, bronchi, and lungs. Attention is given to services like endoscopies, excisions, and resections within the respiratory tract.
Topic 10	• Musculoskeletal System: This section of the exam measures the skills of coding specialists and focuses on coding procedures involving bones, joints, muscles, and tendons. It covers surgeries, reductions, arthroscopies, and fracture treatments, emphasizing accurate mapping of procedures to anatomical areas.
Topic 11	• Cardiovascular System: This section of the exam measures the skills of coding specialists and addresses services related to the heart, arteries, and veins. It involves the coding of diagnostic and therapeutic procedures, including catheterizations, bypasses, and repairs.:
Topic 12	• Digestive System: This section of the exam measures the skills of coding specialists and evaluates the coding of surgeries and procedures involving the oral cavity, pharynx, esophagus, stomach, intestines, liver, pancreas, and related organs. Understanding endoscopic procedures is particularly critical here.
Topic 13	• Pathology & Laboratory: This section of the exam measures the skills of medical coders and includes lab tests, specimen analysis, and pathological examination procedures. It ensures that coders understand how to apply codes for chemistry panels, cultures, and histopathological diagnostics.
Topic 14	• Applying the ICD-10-CM Guidelines: This section of the exam measures the skills of coding specialists and covers how to apply official ICD-10-CM guidelines to real-world coding scenarios. It emphasizes the hierarchy of instructional notes, general and chapter-specific rules, and how to make judgment calls within compliant coding frameworks.
Topic 15	• Anesthesia: This section of the exam measures the skills of medical coders and involves coding anesthesia services based on surgical site, complexity, and time. It tests the understanding of anesthesia modifiers and the importance of linking anesthesia codes with the correct primary procedures.

Topic 16	• Accurate ICD-10-CM Coding: This section of the exam measures the skills of medical coders and focuses on the precise assignment of diagnosis codes using the ICD-10-CM system. The goal is to ensure accurate representation of patient conditions, proper sequencing, and a clear linkage between diagnoses and services.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q68-Q73):

NEW QUESTION # 68
56-year-old female is postmenopausal with abnormal vaginal bleeding. Ob-gyn provider performs a hysteroscopy to examine the uterine cavity.
What CPTcode is reported?

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

Answer: C

Explanation:
1. Procedure and CPTCode Selection:
The procedure performed was a hysteroscopy to examine the uterine cavity due to abnormal vaginal bleeding.
This is a diagnostic hysteroscopy.
CPTCode 58555 is specifically for a diagnostic hysteroscopy to examine the uterine cavity, which aligns with the procedure performed in this case.
2. Rationale for Excluding Other Options:
Code 58558 is for a hysteroscopy with a surgical procedure, such as biopsy or removal of a lesion or polyp, which was not performed in this case.
Code 58579 is an unlisted procedure code for the female genital system and is unnecessary here because there is a specific code (58555) for diagnostic hysteroscopy.
Code 58578 is also an unlisted hysteroscopic procedure code and is not appropriate when a specific diagnostic code exists.
3. AAPC and CPTCoding Guidelines:
AAPC guidelines indicate that 58555 should be used for diagnostic hysteroscopy procedures without any surgical intervention.
Therefore, the correct answer, following CPTguidelines, is C. 58555.

NEW QUESTION # 69
The documentation states:
He was then sterilely prepped and draped along the flank and abdomen in the usual sterile fashion. I first made a skin incision off the tip of the twelfth rib, extending medially along the banger's lines of the skin. This was approximately 3.5 cm in length. Once this incision was carried sharply, electrocautery was used to gain access through the external oblique, internal oblique, and transverse abdominis musculature and fascia.
What surgical approach was used for this procedure?

- A. Cannot determine based on the documentation
- B. Open

- C. Percutaneous
- D. Laparoscopic

Answer: B

Explanation:
The documentation describes making a skin incision off the tip of the twelfth rib and extending medially along the banger's lines of the skin. The use of electrocautery to gain access through multiple layers of musculature and fascia indicates an open surgical approach. Open surgery involves making a large incision to expose and directly view the surgical site. This is distinct from percutaneous (which involves needles or catheters), laparoscopic (which uses small incisions and a camera), and other minimally invasive techniques.
References: AMA's CPTProfessional Edition, ICD-10-CM, and HCPCS Level II (current year)

NEW QUESTION # 70
(A patient is seen for nausea, vomiting, and sharp right lower abdominal pain. CT and labs support a diagnosis ofchronic appendicitis. The physician schedules anopen appendectomyand removes the appendix.
What CPT and diagnosis codes are reported?)

- A. 44950, K36, R11.2, R10.31
- B. 44950, K35.80
- C. 44970, K35.80
- D. 44950, K36

Answer: D

Explanation:
The operative approach is explicitlyopen surgery, so the correct CPT procedure code is44950(appendectomy; open).
Code44970is thelaparoscopicappendectomy code and is not supported because the scenario states
"open surgery." For diagnosis, the physician's final diagnosis ischronic appendicitis, which is reported withK36(other appendicitis) in the context of this question's choices;K35.80represents acute appendicitis (unspecified acute) and does not match "chronic." You also do not report symptom codes (nausea/vomiting
/abdominal pain) once a definitive diagnosis is established and documented as the reason for the surgery, unless a guideline or scenario specifically requires them as additional reporting (this question does not).
Therefore, the correct pairing is44950withK36only. CPC exam tip: always matchapproach(open vs laparoscopic) and code thefinal confirmed diagnosisrather than presenting symptoms when the definitive diagnosis is known.

NEW QUESTION # 71
Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1
Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.
Operation performed: Excision of right thigh benign congenital>1
nevus, excision size with margins 4.5 cm and closure size 5 cm.
Anesthesia: General.0
Intraoperative antibiotics: Ancef.0
Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks involved, which included but were not limited to risks of general anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.
Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient's right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.
This was passed to pathology for review. The wound required # limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.
The patient was then cleaned and turned over to anesthesia for S extubation.
She was extubated successfully in the operating room and taken S to the recovery room in stable condition.
There were no complications.
Which CPT and ICD-10-CM codes are reported for this procedure?

- A. 65426-LT, H11.062
- B. 65426-LT, H11.002
- C. 65420-LT, H11.002
- D. 65400-LT, H11.062

Answer: C

Explanation:
65420 = Excision or transposition of pterygium without graft
LT = Left eye
H11.002 = Pterygium of left eye

NEW QUESTION # 72
A patient presents with recurrent spontaneous episodes of dizziness of unclear etiology. Caloric vestibular testing is performed irrigating both ears with warm and cold water while evaluating the patient's eye movements. There is a total of three irrigations. What CPT coding is reported?

- A. 92537-50-52
- B. 92537-52
- C. 92537-50
- D. 92538-50

Answer: C

Explanation:
* Procedure: Caloric vestibular testing performed on both ears with three irrigations.
* CPT Code:
* 92537: Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear).
* Modifier -50: Bilateral procedure.
* Code Selection Justification: The procedure performed was bilateral caloric vestibular testing with bithermal irrigation, appropriately coded with 92537 and modifier -50 for bilateral procedures.
References:
* AMA CPT Professional Edition (current year)

NEW QUESTION # 73
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