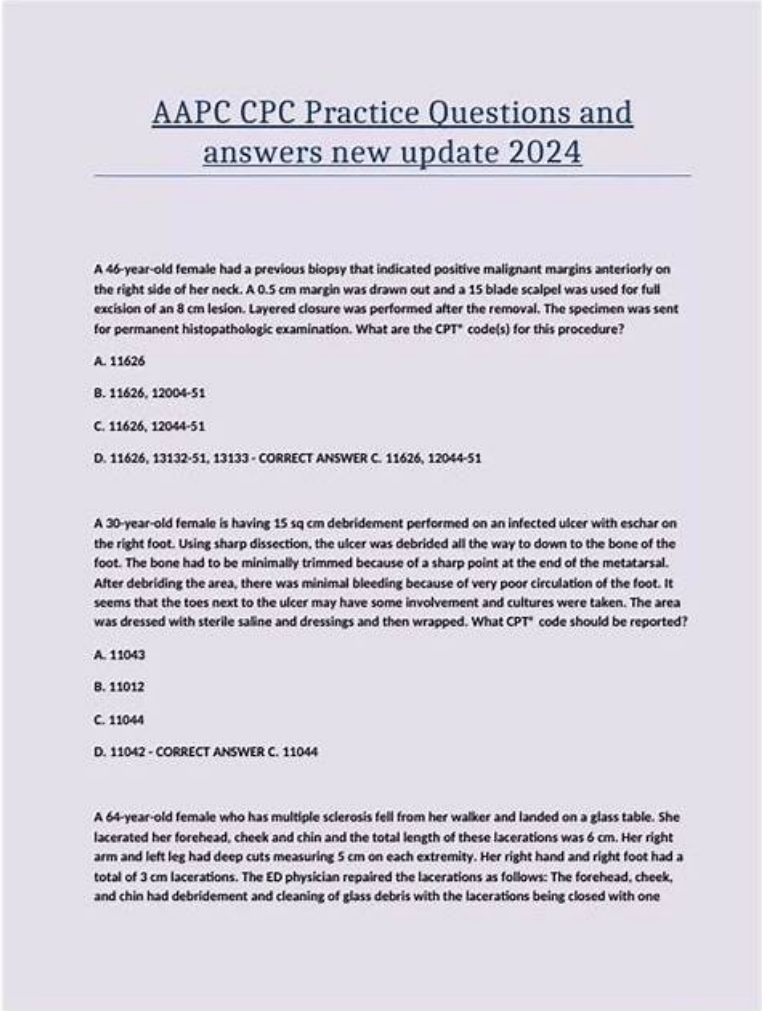
New AAPC-CPC Test Syllabus - New AAPC-CPC Practice Materials



AAPC CPC Practice Questions and answers new update 2024

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. 11626, 12044-51

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. 11044

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 arm and left leg had deep cuts measuring 5 cm on each extremity. Her right hand and right foot had a total of 3 cm lacerations. The ED physician repaired the lacerations as follows: The forehead, cheek, and chin had debridement and cleaning of glass debris with the lacerations being closed with one

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q82-Q87):

NEW QUESTION # 82
A patient develops an infection within the global period of a knee replacement. It is determined that the infection originated from the incision site and needs to be surgically removed. Which modifier should be appended to the secondary surgery?

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

Answer: D

Explanation:
Modifier 78 represents an additional, unplanned surgery during the global period for a complication arising for the initial procedure. In this case, the complication would be the infection.
Modifier 58 is generally used when a secondary procedure is planned prior to or during the time of the initial procedure. Modifier 79 is used to indicate two unrelated procedures. Modifier 25 is for use on E/M codes only.

NEW QUESTION # 83
A patient is in labor with plans to deliver vaginally. An epidural is administered at 17:30. After several hours of pushing, the obstetrician determines that the cervix is swollen, and the baby must be delivered via a c-section. The patient consents, the baby is delivered, and both are discharged to the recovery room at 22:15. What CPT code(s) should the anesthesiologist report?

- A. 01967, 01968, 99140
- B. 01967-23, 01968, 99140
- C. 01967, 01968
- D. 01967-23, 01968

Answer: D

Explanation:
For a planned vaginal delivery with the use of an epidural, followed by a Cesarean delivery, the correct CPT codes are 10967 followed by add-on code 01968. CPT code 99140 is an add-on code portraying that the procedure was an emergency and that the patient and/or baby has a significant increase in the threat to life. The documentation gives no indication that these services were emergent Modifier 23 is reported for unusual anesthesia services. This would include-but is not limited to-the use of general anesthesia for a procedure that usually requires only a local anesthetic or none and/or a procedure extending more than 4 hours. In this case, the total procedure time was 4.75 hours, and modifier 23 is appended on the primary procedure code only.

NEW QUESTION # 84
A female patient with type II diabetes, asthma, and hypertension is admitted with complaints of chest pain. Testing rules out heart attack and other underlying conditions as the cause. Which diagnosis codes should be listed on the discharge note?

- A. R07.9
- B. Z03.89
- C. Z03.89
- D. R07.9, E11.9, J45.909, I10

Answer: D

Explanation:
The primary diagnosis on an inpatient record would be the primary reason the patient was admitted. In this case, because a definitive

diagnosis could not be confirmed, the symptom of chest pain would be selected instead. The previously confirmed chronic conditions would also be coded because they affect the management of inpatient care. Diabetes would be coded to an unspecified code because the term "with" implies a causal relationship between the conditions that is not implicitly documented. Per ICD-IO-CM guidelines, a rule-out code is not assigned when "any signs or symptoms related to the suspected condition are present."

NEW QUESTION # 85
Which service is NOT bundled into pediatric critical care CPT 99475?

- A. A blood transfusion is given to a 2-year-old patient with sickle cell disease.
- B. A central line is inserted to stabilize a 5-year-old patient in respiratory arrest.
- C. The doctor suspects meningitis on a 4-year-old patient and performs a lumbar puncture totest the fluid around the spinal cord.
- D. A suprapubic aspiration is performed on a 3-year-old patient who has blood in her urine.

Answer: B

Explanation:
A blood transfusion (CPT 36430, 36440), lumbar puncture (CPT (62270), and suprapubic aspiration (CPT 51100) are all considered inclusive to pediatric critical care services rendered on patients betvv'een the age of 2 and 5 years old. A complete list of all additional services can be found in the CPT Section Guidelines for Newborn and Pediatric Services. A central line insertion (CPT 36556) is not bundled into critical care services and may be reported separately.

NEW QUESTION # 86
A 69-year-old patient with a medical history of diabetes is evaluated in the emergency room for a urinary tract infection. After performing a medically appropriate history and exam, the physician prescribes 100 mg of Macrobid every 12 hours and admits the patient to observation status to monitor for sepsis. After seeing an improvement in symptoms, the physician discharges the patient the following day. What CPT and ICD-IO-CM code(s) should be reported for the entirety of the patient's stay?

- A. 99284, 99238, Ell.69, N39.O
- B. 99222, 99238, N39.O
- C. 99234, N39.O, 397.89
- D. 99221, 99238, N39.O, Ell.9

Answer: D

Explanation:
When a patient is admitted into observation status from the emergency room, only the observation code is reported for that day. When observation extends past the initial date of service, the initial treatment would be reported with CPT codes 99221-99223. In this scenario, the appropriate level of service would be 99221, based on the moderate level of decision-making.
which can be ascertained by the number and complexity of problems addressed and the risk of complications and/or morbidity or mortality of patient management. Discharge from observation on a separate date is reported with CPT codes 99238-99239.
Because the diabetes is documented and is a coexisting chronic condition during the time of the encounter, it should follow the reason for admission. Due to a lack of specificity in the diabetes diagnosis, a causal relationship with a UTI is not presumed, and Ell.69 should not be coded.

NEW QUESTION # 87
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