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AAPC CPC Certification Practice Test 2024 with Answers

A Medicare patient is receiving chemotherapy at her oncologists office. While the patient is receiving chemotherapy, the oncologist calls in a prescription for pain medication to a pharmacy in the same building . The pharmacy delivers the medication to the patient in the oncologists office for the patient to take home. What part of Medicare should be billed for the pain medication by the pharmacy?
A. Part A
B. Part B
C. Part C
D. Part D - **Answer>>** Part D

What is medical coding? - **Answer>>** Translating medical documentation into codes.

Which one is NOT a covered entity of HIPPA?
A. Medicare
B. Workers Compensation
C. Dentists
D. Pharmacies - **Answer>>** B. Workers Compensation

Which one falls under a commercial payer?
A. Medicare
B. Medicaid
C. Blue Cross Blue Shield

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• Hemic & Lymphatic Systems, Mediastinum, Diaphragm: This section of the exam measures the skills of medical coders and includes procedures related to the spleen, lymph nodes, bone marrow, as well as surgical interventions in the mediastinum and diaphragm. Coders must differentiate procedures by region and system accurately.
Topic 3	• 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 4	• Overview of ICD-10-CM: This section of the exam measures the skills of medical coders and introduces the structure, format, and usage of the ICD-10-CM coding system. It reviews the purpose of ICD-10-CM in diagnosis reporting and prepares candidates to interpret chapters, code ranges, and conventions embedded in the system.
Topic 5	• 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 6	• 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 7	• 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 8	• 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 9	• 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 10	• 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.
Topic 11	• 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.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q100-

Q105):

NEW QUESTION # 100
Patient has a 5 cm tumor in the left lower quadrant abdominal wall. A horizontal skin incision is made directly over the tumor in the patient's left lower quadrant and dissection was carried down through the dermis and subcutaneous tissue. The tumor is located and completely excised using electrocautery. The specimen is sent immediately to pathology to rule out cancer. What CPTand ICD-10-CM codes are reported?

- A. 22903, D49.2
- B. 22901, C76.2
- C. 22903, R19.04
- D. 22901, D49.2

Answer: A

Explanation:
1. Procedure and CPTCode Selection:
The scenario describes the excision of a 5 cm tumor located in the left lower quadrant of the abdominal wall.
The tumor was excised down to the dermis and subcutaneous layers and removed using electrocautery.
Code 22903 is appropriate for the excision of a soft tissue tumor in the abdominal wall greater than 5 cm, making it the correct CPTcode.
Code 22901 applies to the excision of a soft tissue tumor in the abdominal wall but only for tumors 5 cm or less. Given that the tumor in this case is exactly 5 cm, it meets the threshold for 22903, which is more appropriate here.
2. Diagnosis and ICD-10-CM Code Selection:
ICD-10-CM Code D49.2 is used for a neoplasm of unspecified behavior in the abdominal area, reflecting the fact that the pathology report is pending to determine if the tumor is malignant.
Code C76.2 would be incorrect because it is for malignant neoplasms of unspecified abdominal areas, which we cannot confirm based on the initial excision. Similarly, R19.04 (indicating a mass in the abdominal region) is a symptom code and is not appropriate for a definitive diagnosis when a neoplasm code (D49.2) exists.
3. AAPC and CPTCoding Guidelines:
Per AAPC coding guidelines, the size of the tumor is critical in selecting the correct excision code for abdominal wall neoplasms.
Additionally, if the tumor's pathology is not confirmed as malignant, it is coded as a neoplasm of unspecified behavior until further details are known.
Therefore, based on CPTand ICD-10-CM coding guidelines, the verified answer is B. 22903, D49.2.

NEW QUESTION # 101
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.
What CPT coding is reported?

- A. 12032, 11406-51
- B. 12002, 11406-51
- C. 12032, 11606-51
- D. 12002, 11606-51

Answer: A

Explanation:
The lesion is a benign congenital hairy nevus # benign lesion excision codes (11400-11446) Location: thigh (trunk/arms/legs) Excision size with margins = 4.5 cm # 11406 (4.1-5.0 cm) Closure length = 5 cm, layered closure with limited undermining # intermediate repair
12032 = Intermediate repair, trunk/extremities, 2.6-7.5 cm
Modifier -51 applies to the secondary procedure

NEW QUESTION # 102
Refer to the supplemental information when answering this question:
View MR 005271
What CPT coding is reported?

- A. 55706, 76942
- B. 0
- C. 55700, 76942
- D. 1

Answer: A

Explanation:
CPT Code 55706: Biopsy, prostate; needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance.
This code accurately describes the procedure performed. The documentation clearly states that a stereotactic template was used to guide the biopsy needles, and multiple samples were taken (saturation biopsies). This code includes imaging guidance.
CPT Code 76942: Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation.
Although 55706 includes imaging guidance, code 76942 is also reported separately because the transrectal ultrasound provided initial diagnostic images and was then used for guidance during the biopsy. This is supported by the documentation which states "Using a B & K ultrasound probe, a transrectal ultrasound of the prostate was obtained. Once this was done...a biopsy needle is inserted into the prostate...under ultrasound guidance." This indicates distinct uses of the ultrasound.
Important Note: While some sources suggest that 76942 and the diagnostic transrectal ultrasound code (76872) are bundled, it's crucial to consult the latest National Correct Coding Initiative (NCCI) edits for the most up-to-date guidance.
References:
CPT Code 55706: Biopsy, prostate; needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance CPT Code 76942: Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation AAPC Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.
NCCI Edits: Always check the most current NCCI edits to confirm coding combinations.

NEW QUESTION # 103
A 60-year-old male suffering from degenerative disc disease at the L3-L4 and L5-S1 levels was placed under general anesthesia. Using an anterior approach, the L3-L4 disc space was exposed. Using blunt dissection, the disc space was cleaned. The disc space was then sized and trialed. Excellent placement and insertion of the artificial disc at L3-L4 was noted. The area was inspected and there was no compression of any nerve roots. Same procedure was performed on L5-S1 level. Peritoneum was then allowed to return to normal anatomic position and entire area was copiously irrigated. The wound was closed in a layered fashion. The patient tolerated the discectomy and arthroplasty well and was returned to recovery in good condition. What CPT coding is reported for this procedure?

- A. 22857 x 2
- B. 0
- C. 22857, 22860
- D. 1

Answer: C

NEW QUESTION # 104
(A patient presents with fatigue and unexplained weight gain. To evaluate possible thyroid dysfunction, the provider orders a single laboratory test to measurethyroid-stimulating hormone (TSH). A routine venous blood sample is collected and sent to the laboratory.Which CPT and ICD-10-CM codes are reported?)

- A. 84445, E07.9, R53.83, R63.5
- B. 84445, R53.83, R63.5
- C. 84443, E07.9, R53.83, R63.5
- D. 84443, R53.83, R63.5

Answer: D

Explanation:
TSH testing is reported with CPT84443. The scenario describes a workup for possible thyroid dysfunction, but there isno confirmed thyroid diagnosisprovided-only symptoms (fatigue and weight gain). In outpatient coding, when a definitive diagnosis is not established, you code thesigns/symptomsthat justify the test.
Therefore, the correct ICD-10-CM codes areR53.83(other fatigue) andR63.5(abnormal weight gain), as offered. You shouldnotassign a thyroid disorder code such asE07.9(unspecified disorder of thyroid) unless the provider documents an actual thyroid disorder diagnosis; suspicion alone does not support it in the outpatient setting. Options C and D list84445, which is not the standard CPT code for TSH measurement in CPC exam coding. This question is testing both correct lab code selection and the outpatient guideline principle of codingsymptomswhen the diagnosis is not confirmed. Hence,84443 with R53.83 and R63.5is correct.

NEW QUESTION # 105
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There is no doubt that advanced technologies are playing an important role in boosting the growth of AAPC companies. This is the reason why the employees have now started upgrading their skillset with the Certified Professional Coder (CPC) Exam (CPC) certification exam because they want to work with those latest applications and save their jobs. They attempt the CPC exam to validate their skills and try to get their dream job.

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