

Verified Exam AAPC-CPC Answers - Well-Prepared & Realistic AAPC-CPC Materials Free Download for Medical Tests AAPC-CPC Exam



AAPC CPC Exam with Verified Questions and Answers 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 layer closure, 6-0 Prolene sutures. The arm and leg were repaired by layered closure, 6-0 Vicryl subcutaneous sutures and Prolene sutures on the skin. The hand and foot were closed with adhesive strips. Select the appropriate procedure codes for this visit.

- A. 99283-25, 12014, 12034-59, 12002-59, 11042-51
- B. 99283-25, 12053, 12034-59, 12002-59
- C. 99283-25, 12014, 12034-59, 11042-51
- D. 99283-25, 12053, 12034-59 Correct Answer: D. 99283-25, 12053, 12034-59

A 52-year-old female has a mass growing on her right flank for several years. It has finally gotten significantly larger and is beginning to bother her. She is brought to the Operating Room for definitive excision. An incision was made directly overlying the mass. The mass was down into the subcutaneous tissue and the surgeon encountered a well encapsulated lipoma approximately 4 centimeters. This was excised primarily bluntly with a few attachments divided with electrocautery. What CPT® and ICD-10-CM codes are reported?

- A. 21932, D17.39

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q151-Q156):

NEW QUESTION # 151

A 15-year-old male patient is seen in the emergency department due to a dislocated left elbow, caused by a fall from his skateboard. The physician performs a comprehensive physical evaluation to check for other injuries before manually realigning the dislocation and placing a splint from the shoulder to wrist. The patient is informed to follow up in 4 weeks. Which CPT and ICD-IO-CM codes should the emergency department report?

- A. 24600-LT, 29105, S53.195AVOO.131A
- **B. 99282-57, 24600-LT, S53.105A VOO.131A**
- C. 24600-LT, S53.105A. VOO.131A
- D. 99283, 24600-LT, VOO.131A

Answer: B

Explanation:

An E/M is always billed when a patient is seen in the emergency department because it is unscheduled and urgent. In this case, the documentation encompasses a straightforward level of decision-making (one acute, uncomplicated injury, minimal or no data reviewed, superficial dressings that result in minimal risk or morbidity of the patient), which lead the coder to 99282.

Modifier 57 is appended to indicate that the decision for surgery was made just prior to the procedure and is not bundled. CPT coding crosswalk confirms that a closed treatment of a dislocated elbow is CPT code 24600. Application of a splint is represented by CPT code 29105 but is not applicable when performed with a surgery to correct the dislocation. ICD-IO-CM crosswalk for dislocation of left elbow is S53.105A.

NEW QUESTION # 152

The appendix is removed through an abdominal incision due to metastatic colon malignancy. How should this be reported?

- A. 44950, C78.5
- **B. 44950, C78.5, C18.9**
- C. 44970, C78.5
- D. 44970, C18.9, C78.5

Answer: B

Explanation:

An open appendectomy procedure is reported with CPT 44950. A metastatic colon malignancy is a cancer that began in the colon but has spread to other areas. In this scenario, that means that the primary malignancy is the colon, and the secondary malignancy is the appendix.

Additionally, ICD-IO-CM guidelines state that when "treatment is directed toward the metastatic site only, the metastatic site is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code." The malignancy codes do not specifically state

"appendix," but the ICD-IO-CM coding crosswalk in the neoplasm table assigns this diagnosis as C78.5 secondary malignant neoplasm of large intestine and rectum.

NEW QUESTION # 153

A 72-year-old patient is admitted due to atrial fibrillation. A comprehensive electrophysiology study is completed with fluoroscopic guidance, followed by a cardiac catheter ablation during the same procedure. The procedure took 22 minutes, and the patient was moderately sedated. Which CPT codes should the cardiologist report?

- A. 93650, 93619-26-59, 99152
- **B. 93656, 99152**
- C. 93656, 77001, 99152, 99153

- D. 93650, 93619-26-59, 77001, 99152, 99153

Answer: B

Explanation:

It is common practice to perform both an electrophysiology (EP) study and a cardiac ablation procedure in the same session. These procedures have been bundled in the CPC manual, and the coding of such is dependent on the type of arrhythmia being treated. The EP study and cardiac ablation are not to be reported separately. In this scenario, the patient has atrial fibrillation, which is reported with CPT 93656. When fluoroscopy is used for guidance rather than for diagnostic imaging, it is usually not reported separately from the primary procedure. Moderate sedation can be reported when used, and selection is based on time. CPT 99152 and 99153 are counted in 15-minute intervals. When the procedure does not fall on a 15-minute interval, it must at least meet the halfway point of the time stated to be reported.

NEW QUESTION # 154

A new, 29-year-old female patient is seen for a preventative visit and receives counseling that totals 30 minutes about contraceptive management. How would the provider code the CPT code(s) for this visit?

- A. 99385, 99203-25
- B. 99385, 99417, 99417
- **C. 0**
- D. 99385, 99402-25

Answer: C

Explanation:

If 99402 is part of a more complex service, it would not be separately identifiable, thus eliminating answer A. Because 99385 includes counseling/anticipatory guidance/risk factor reduction interventions, the additional 30 minutes that the provider spent discussing contraceptives would not be considered a significant, separately identifiable E/M service, eliminating answer B. Last, because time is not a factor when selecting a preventative service, 99417 reflected in answer C, indicating a prolonged outpatient E/M service totaling 30 minutes would not apply.

NEW QUESTION # 155

A gastroenterologist performs a gastric bypass surgery on an obese patient with a body mass index of 52. During the procedure, the size of the stomach is reduced by 77%; the intestine is bypassed from the duodenum and then attached to the ileum. The pylorus is preserved and left intact. Which CPT code best describes the surgery performed?

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

Answer: D

Explanation:

In this scenario, the gastroenterologist performed a procedure known as a biliopancreatic diversion with duodenal switch (BPD/DS). A BPD/DS removes a portion of the stomach and transfers parts of the duodenum and small intestine to the lower end of the large intestine in an effort to limit intestinal absorption for weight loss. CPT codes 43842-43843 describe gastric restrictive procedures without gastric bypass. However, gastric bypass was done in rearranging the small intestine to connect to the ileum.

NEW QUESTION # 156

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