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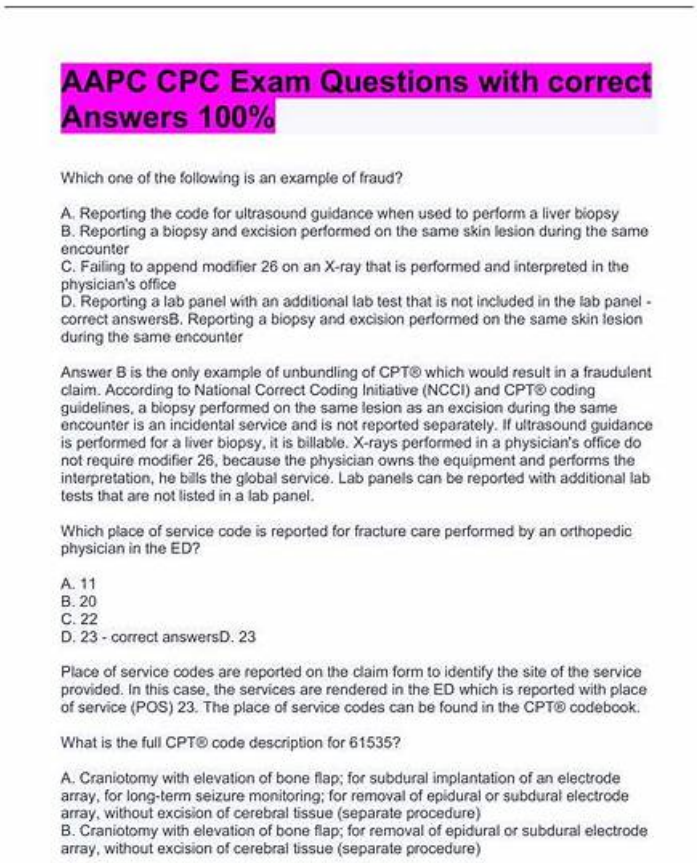

AAPC CPC Exam Questions with correct Answers 100%

Which one of the following is an example of fraud?

A. Reporting the code for ultrasound guidance when used to perform a liver biopsy
B. Reporting a biopsy and excision performed on the same skin lesion during the same encounter
C. Failing to append modifier 26 on an X-ray that is performed and interpreted in the physician's office
D. Reporting a lab panel with an additional lab test that is not included in the lab panel - correct answersB. Reporting a biopsy and excision performed on the same skin lesion during the same encounter

Answer B is the only example of unbundling of CPT® which would result in a fraudulent claim. According to National Correct Coding Initiative (NCCI) and CPT® coding guidelines, a biopsy performed on the same lesion as an excision during the same encounter is an incidental service and is not reported separately. If ultrasound guidance is performed for a liver biopsy, it is billable. X-rays performed in a physician's office do not require modifier 26, because the physician owns the equipment and performs the interpretation, he bills the global service. Lab panels can be reported with additional lab tests that are not listed in a lab panel.

Which place of service code is reported for fracture care performed by an orthopedic physician in the ED?

A. 11
B. 20
C. 22
D. 23 - correct answersD. 23

Place of service codes are reported on the claim form to identify the site of the service provided. In this case, the services are rendered in the ED which is reported with place of service (POS) 23. The place of service codes can be found in the CPT® codebook.

What is the full CPT® code description for 61535?

A. Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long-term seizure monitoring; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)
B. Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue (separate procedure)

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• Endocrine System and Nervous System: This section of the exam measures the skills of medical coders and assesses the ability to assign codes for surgeries involving glands, the brain, spinal cord, and peripheral nerves. Procedures like resections and electrical stimulation are part of the evaluated content.

Topic 2	• The Business of Medicine: This section of the exam measures the skills of medical coders and covers foundational knowledge regarding the healthcare system, reimbursement models, insurance payers, HIPAA compliance, and the ethical responsibilities coders hold within clinical and billing environments. It establishes the context in which coding decisions directly affect healthcare operations and financial outcomes.
Topic 3	• 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 4	• 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 5	• 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 6	• 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 7	• 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 8	• 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 9	• 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 10	• 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 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.
Topic 12	• 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 13	• 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q352-Q357):

NEW QUESTION # 352
A 60-year-old male has three-vessel disease and supraventricular tachycardia which has been refractory to other management. He previously had pacemaker placement and stenting of LAD coronary artery stenosis, which has failed to solve the problem. He will undergo CABG with autologous saphenous vein and an extensive modified MAZE procedure to treat the tachycardia.
He is brought to the cardiac OR and placed in the supine position on the OR table. He is prepped and draped, and adequate endotracheal anesthesia is assured. A median sternotomy incision is made and cardiopulmonary bypass is initiated. The endoscope is used to harvest an adequate length of saphenous vein from his left leg.
This is uneventful and bleeding is easily controlled. The vein graft is prepared and cut to the appropriate lengths for anastomosis. Two bypasses are performed: one to the circumflex and another to the obtuse marginal. The left internal mammary is then freed up and it is anastomosed to the ramus, the first diagonal, and the LAD. An extensive maze procedure is then performed and the patient is weaned from bypass. At this point, the sternum is closed with wires and the skin is reapproximated with staples. The patient tolerated the procedure without difficulty and was taken to the PACU.
Choose the procedure codes for this surgery.

- A. 33533, 33257-51, 33519-51, 33508-51
- B. 33535, 33259, 33519, 33508
- C. 33535, 33259 51, 33519-51, 33508-51
- D. 33533, 33257, 33519, 33508

Answer: C

Explanation:
The CABG procedure involved multiple bypasses, with the use of autologous saphenous vein grafts and the left internal mammary artery, along with an extensive modified MAZE procedure. CPT code 33535 describes a coronary artery bypass using arterial grafts, including at least three coronary artery bypasses.
CPT code 33259-51 is for the MAZE procedure for supraventricular tachycardia, with the -51 modifier indicating multiple procedures. CPT code 33519-51 is for an additional vein graft, and CPT code 33508-51 describes the endoscopic harvesting of the vein.
References:
* AMA's CPT Professional Edition (current year), Codes 33535, 33259-51, 33519-51, 33508-51

NEW QUESTION # 353
A cardiologist performs remote monitoring for a 30-day period via a previously implanted hemodynamic pulmonary artery pressure monitor for a patient with congestive heart failure with resulting pulmonary edema. The first month of monitoring includes weekly downloads, interpretations, trend analysis, and subsequent reports.
What CPT code is reported?

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

Answer: C

Explanation:

1. Procedure and CPT Code Selection:
The cardiologist provided remote monitoring over a 30-day period for a hemodynamic pulmonary artery pressure monitor implanted in a patient with congestive heart failure.
CPT Code 93264 is appropriate for remote monitoring of a hemodynamic system for up to 30 days. This code includes services such as weekly data transmissions, interpretation, trend analysis, and reporting-exactly as described in this case.
2. Rationale for Excluding Other Options:
Code 93286 is for in-person interrogation and programming of pacemakers or defibrillators, not for remote monitoring of a hemodynamic monitor, making it incorrect.
Code 93288 is for interrogation device evaluation (remote), specifically for pacemakers or defibrillators, and does not apply to a pulmonary artery pressure monitor.
Code 93279 is for in-person programming of certain cardiac devices, which does not match the remote monitoring described in this scenario.
3. AAPC and CPT Coding Guidelines:
AAPC and CPT guidelines specify that 93264 is the correct code when reporting remote hemodynamic monitoring for a pulmonary artery pressure device over a period of up to 30 days, including data review and interpretation.
Therefore, the correct answer is B. 93264.

NEW QUESTION # 354
A 55-year-old patient with suspected liver cancer was seen by the physician to obtain a biopsy. The special biopsy needle was placed using ultrasonic guidance. The physician obtained a small tissue sample from the liver, which was then sent to pathology. What CPT codes are reported?

- A. 47000, 10005
- B. 47100, 77012-26
- C. 47000, 76942-26
- D. 47000, 77002-26

Answer: C

Explanation:
* Procedure: The physician performed a liver biopsy using ultrasonic guidance.
* CPT Codes:
* 47000: This code is for the liver biopsy.
* 76942-26: This code is for ultrasonic guidance for needle placement, with modifier -26 indicating the professional component.
* Code Selection Justification: The CPT code 47000 specifically captures the liver biopsy, and
76942-26 accurately represents the ultrasonic guidance utilized during the procedure.
References:
* AMA CPT Professional Edition (current year)
* ICD-10-CM (current year)
* HCPCS Level II (current year)

NEW QUESTION # 355
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 and ICD-10-CM codes are reported?

- A. 45540, 52332, K62.2
- B. 45540, 52332, K62.3
- C. 45400, 52332, K62.3
- D. 45400, 52332, K62.2

Answer: B

Explanation:
45540 = Repair of rectal prolapse, abdominal approach
52332 = Cystourethroscopy with ureteral stent
K62.3 = Rectal prolapse

NEW QUESTION # 356
A patient presents to the surgical suite for a planned sterilization procedure via a bilateral excisional vasectomy.
What is the correct CPTcode and diagnosis code for the service?

- A. 55250, Z30.2
- B. 55250-50, Z30.2
- C. 55250, Z30.012
- D. 55250-50, Z30.012

Answer: A

Explanation:
1. Procedure and CPTCode Selection:
The patient underwent a bilateral excisional vasectomy for sterilization.
CPTCode 55250 represents a bilateral vasectomy with excision, which includes postoperative care. The code already implies a bilateral procedure, so it is not necessary to add the -50 modifier for bilateral designation.
2. Diagnosis and ICD-10-CM Code Selection:
ICD-10-CM Code Z30.2 is used for encounter for sterilization and is the correct code to report for a planned sterilization procedure such as a vasectomy.
Code Z30.012 is specific to encounter for sterilization of a female patient, which does not apply in this male patient scenario.
3. Rationale for Excluding Other Options:
55250-50 (in options C and D) is unnecessary because the CPTcode 55250 inherently covers a bilateral vasectomy, and applying the -50 modifier is redundant.
Z30.012 (options B and D) is incorrect as it pertains to female sterilization procedures, not male.
4. AAPC and CPTCoding Guidelines:
According to AAPC guidelines, 55250 is reported without a bilateral modifier, as the procedure inherently covers both sides.
Additionally, Z30.2 is the correct ICD-10-CM code for male sterilization procedures.
Thus, the correct answer based on CPTand ICD-10-CM guidelines is A. 55250, Z30.2.

NEW QUESTION # 357
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