

AAPC-CPC Answers Real Questions - Exam AAPC-CPC Study Guide

AAPC CPC FINAL EXAM PRACTICE QUESTIONS |231 REAL QUESTIONS WITH 100% CORRECT ANSWERS | LATEST UPDATED 2025 |

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 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

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q139-Q144):

NEW QUESTION # 139

A young man is triaged in the emergency room after sustaining multiple injuries in a car accident. The physician performs the following limited exams with image documentation: an abdominal and retroperitoneal ultrasound, a transthoracic echocardiography, and a chest ultrasound. He indicates in his report that all findings are normal. What charges should the provider submit to the insurance company?

- A. 93304-26, 76705-26, 76775-26, 76604-26
- B. 93308, 76705-59, 76770-59, 76604-59
- C. 93304-TC, 76700-TC, 76770-TC, 76604-TC
- D. **93308-26, 76705-26, 76775-26, 76604-26**

Answer: D

Explanation:

CPT code 93304 describes an echocardiography used to evaluate a congenital defect. In this case, the provider is screening for any trauma-related injuries to the heart. Bearing in mind that the study is limited leads you to CPT 93308. Modifier 26 is used on all CPT codes because the procedures are being performed in a hospital setting. Therefore, only the professional component of the service should be billed. Modifier TC is reported by the entity providing the equipment, which in this case would be the hospital. Modifier 59 is not necessary because the procedures are routinely done in conjunction with each other.

NEW QUESTION # 140

A 92-year old female with Medicare part A coverage receives ongoing hospice care due to dementia. She goes to a physician's office to receive closed treatment of a hip dislocation following a fall. No anesthesia was used. How should the provider submit this claim?

- A. 27250-GW, 99202-25, S73.003A W19XXYuA
- B. 27250, S73.003A, W19XXXA
- C. 27250, 99213-25, S73.003A
- D. **27250-GW, S73.003A, W19XXXA**

Answer: D

Explanation:

When a patient is receiving hospice care, Medicare will not reimburse the physician for services rendered that are unrelated to the terminal illness unless submitted with modifier GW. In Answers C and D, a separate, identifiable E/M is not to be billed because the procedure is considered minor (1- to 10-day global period) and includes an inherent E/M component.

NEW QUESTION # 141

A diaphragm resection and repair are done using a biologic mesh to reduce the formation of adhesions. Which procedure code should be reported?

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

Answer: D

Explanation:

A diaphragm resection is reported with CPT codes 39560-39561. The use of a biologic mesh makes the repair complex, whereas a simple repair would implement only internal sutures.

NEW QUESTION # 142

A sternal closure using sutures is considered inclusive to CPT 33255 and should not be reported separately.

- A. False
- B. True

Answer: B

Explanation:

The statement is true. Regardless of how a sternal closure is performed, it would be considered integral to this, and any other open cardiac procedure, when a sternal approach is used as the method of exposure. If a sternal closure were performed as the only procedure to repair an injury, the closure would then be reported.

NEW QUESTION # 143

An orthopedic surgeon performs a meniscectomy for a right radial tear using an arthroscope. During the procedure, the surgeon removes a piece of the damaged meniscus from the lateral compartment of the knee and shaves the articular cartilage of the same compartment. A separate incision was made to remove a 6 mm loose body in the medial compartment. The surgery was completed without any complications. What procedure and diagnosis code(s) should be reported?

- A. 29881, 29874-59, S83.281A
- B. 29887, 29874-59, S83.281A
- C. 29881, 29874-51, S83.203A
- D. 29882, 29877-51, 29874-51, S83.203A

Answer: A

Explanation:

The procedures performed on this encounter were the meniscectomy (removal of damaged meniscus from the lateral compartment) with a chondroplasty (shaving of articular cartilage, 29881) and loose body removal by means of an arthroscopy (29874). Because the removal of loose bodies is considered inclusive to the primary procedure, modifier 59 is appended as opposed to modifier 51 to indicate that it was a distinct procedural service due to the separate incision.

Answers A and D can be eliminated based on the diagnosis chosen. S83.203A indicates the location of meniscus is unspecified; however, the surgeon removed the damaged meniscus from the lateral compartment, leading the biller to S83.281A.

NEW QUESTION # 144

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