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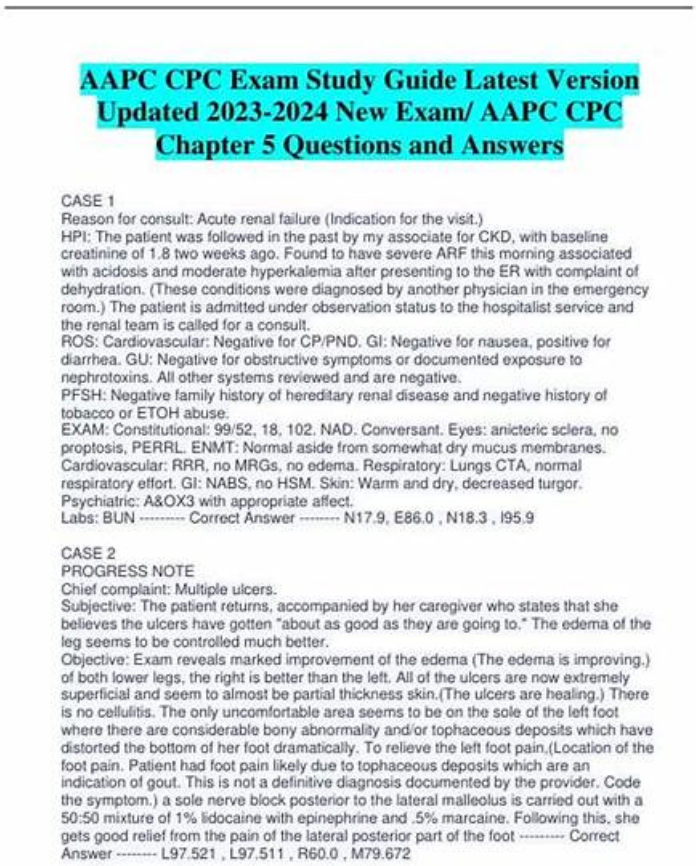

AAPC CPC Exam Study Guide Latest Version Updated 2023-2024 New Exam/ AAPC CPC Chapter 5 Questions and Answers

CASE 1
Reason for consult: Acute renal failure (Indication for the visit.)
HPI: The patient was followed in the past by my associate for CKD, with baseline creatinine of 1.8 two weeks ago. Found to have severe ARF this morning associated with acidosis and moderate hyperkalemia after presenting to the ER with complaint of dehydration. (These conditions were diagnosed by another physician in the emergency room.) The patient is admitted under observation status to the hospitalist service and the renal team is called for a consult.
ROS: Cardiovascular: Negative for CP/PND. GI: Negative for nausea, positive for diarrhea. GU: Negative for obstructive symptoms or documented exposure to nephrotoxins. All other systems reviewed and are negative.
PFSH: Negative family history of hereditary renal disease and negative history of tobacco or ETOH abuse.
EXAM: Constitutional: 99/52, 18, 102. NAD. Conversant. Eyes: anicteric sclera, no proptosis, PERRL. ENMT: Normal aside from somewhat dry mucus membranes. Cardiovascular: RRR, no MRGs, no edema. Respiratory: Lungs CTA, normal respiratory effort. GI: NABS, no HSM. Skin: Warm and dry, decreased turgor. Psychiatric: A&OX3 with appropriate affect.
Labs: BUN --------- Correct Answer -------- N17.9, E86.0 , N18.3 , I95.9

CASE 2
PROGRESS NOTE
Chief complaint: Multiple ulcers.
Subjective: The patient returns, accompanied by her caregiver who states that she believes the ulcers have gotten "about as good as they are going to." The edema of the leg seems to be controlled much better.
Objective: Exam reveals marked improvement of the edema (The edema is improving.) of both lower legs, the right is better than the left. All of the ulcers are now extremely superficial and seem to almost be partial thickness skin.(The ulcers are healing.) There is no cellulitis. The only uncomfortable area seems to be on the sole of the left foot where there are considerable bony abnormality and/or tophaceous deposits which have distorted the bottom of her foot dramatically. To relieve the left foot pain,(Location of the foot pain. Patient had foot pain likely due to tophaceous deposits which are an indication of gout. This is not a definitive diagnosis documented by the provider. Code the symptom.) a sole nerve block posterior to the lateral malleolus is carried out with a 50:50 mixture of 1% lidocaine with epinephrine and .5% marcaine. Following this, she gets good relief from the pain of the lateral posterior part of the foot --------- Correct Answer -------- L97.521 , L97.511 , R60.0 , M79.672

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q128-Q133):

NEW QUESTION # 128
A sternal closure using sutures is considered inclusive to CPT 33255 and should not be reported separately.

- A. True
- B. False

Answer: A

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 # 129
Code the excision of a large goiter extending into the chest cavity using a transthoracic approach.

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

Answer: D

Explanation:
A goiter is an abnormal enlargement of the thyroid gland. The removal of that gland is a thyroidectomy, represented by CPT codes 60240-60271. CPT 60270 is selected based on the approach used. CPT codes 21602 and 32900 are obtained by using the coding crosswalk for resection ofthe chest wall and describe the removal of a tumor and one or more ribs. CPT 32140 is a thoracotomy, which involves pulling apart the ribs to reach and remove a lung cyst.

NEW QUESTION # 130
The base unit for anesthesia CPT code 00600 is 10 units. If an anesthesiologist spends 105 minutes in the procedure room with a patient, how many units should be reported for reimbursement?

- A. 17 units
- B. 14 units
- C. 12 units
- D. 11 units

Answer: A

Explanation:
To calculate the total number of units, it is important to understand that anesthesia time is measured in 15-minute intervals (or in fractions thereof). In this scenario, take the total number of minutes spent on the procedure (105) and divide it by 15. The total number of time units is 7. The time units are then added to the base unit (10) for a total of 17 units.

NEW QUESTION # 131
The appendix is removed through an abdominal incision due to metastatic colon malignancy. How should this be reported?

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

Answer: C

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 # 132
Code the following physician's note:
A 14-year-old established patient is seen with mother to evaluate five 2 cm superficial lacerations to the left wrist. Patient admits to suicidal thoughts.
Lacerations were treated with Steri-Strips. Patient and mother counseled on suicide prevention and told to follow up with psych.

- A. 12004, S61.512A, R45.851
- B. 12004, S61.512A, T14.91XA
- C. 99214, S61.512A, T14.91XA
- D. 99213, S61.512A, R45.8S1

Answer: D

Explanation:
When the injury is treated with Steri-Strips or bandages, it should be reported with an E/M code and not a procedure code. Within the medical decision making, the number and complexity of problems addressed is low, the amount of data reviewed or analyzed is straightforward, and the risk of complications and/or morbidity or mortality of patient management from the injuries is low.
Therefore, the E/M is a 99213 because the medical decision-making is low. A suicide attempt would not be coded because the documentation is not specific as to whether the lacerations were an attempt at suicide.

NEW QUESTION # 133
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