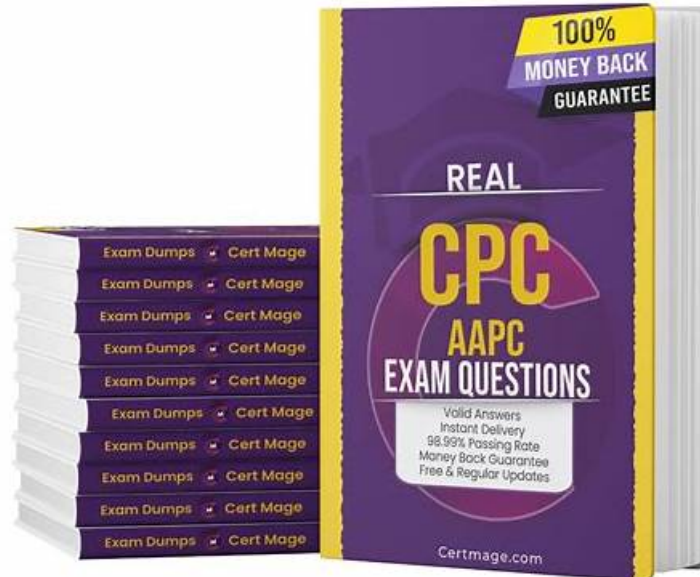


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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q353-Q358):

NEW QUESTION # 353

Ten-year-old boy has a painful felon abscess of the deep tissues of the palmar surface of his right thumb. The provider makes an

incision on one side of the nail and then across the fingertip parallel to the end of the nail. He identifies the area of abscess and drains it. A drainage tube is inserted.

What CPT and ICD-10-CM is reported?

- A. 26011-F5, L03.011
- **B. 26010-F5, L02.511**
- C. 10061-F5, L03.011
- D. 10140-F5, L02.511

Answer: B

Explanation:

1. Procedure and CPT Code Selection:

The procedure involves an incision and drainage (I&D) of a deep abscess (felon) on the palmar surface of the right thumb. A felon is an abscess in the pulp of the fingertip, often involving deep tissue.

Code 26010 is specific for incision and drainage of a finger abscess, which includes the thumb. This code applies to cases where the abscess is drained from a deep tissue level.

Code 26011 is similar but involves the use of extensive drainage or debridement, which is not indicated in this case. Therefore, 26011 is not appropriate here.

Code 10061 refers to incision and drainage of abscesses at different locations on the body but not for specific areas such as the thumb, making it inappropriate in this context.

Code 10140 pertains to the evacuation of hematoma, seroma, or fluid but does not apply to abscesses, so it is not suitable for this scenario.

2. Modifier:

Modifier F5 is added to specify that the procedure was performed on the right thumb.

3. Diagnosis and ICD-10-CM Code Selection:

ICD-10-CM Code L02.511 is appropriate for cutaneous abscess of the right finger, as it accurately describes the diagnosis of a felon on the thumb.

L03.011 would represent cellulitis but does not specify an abscess, making it less precise for this case.

4. AAPC and CPT Coding Guidelines:

The AAPC guidelines for coding finger abscess drainage emphasize the selection of specific codes for deep tissue drainage procedures in extremities. Additionally, correct laterality should be included with the use of modifiers and specific ICD-10-CM codes for an accurate representation of the site and nature of the condition.

Thus, based on the coding standards and guidelines, the verified answer is B. 26010-F5, L02.511.

NEW QUESTION # 354

A patient had surgery a year ago to repair two flexor tendons in his forearm. He is in surgery for a secondary repair for the same two tendons.

Which CPT coding is reported?

- A. 0
- B. 25263 x 2
- C. 25272 x 2
- **D. 1**

Answer: D

Explanation:

The scenario involves a secondary repair of two flexor tendons in the forearm. CPT code 25272 describes the repair of a secondary flexor tendon injury, including a graft, in the forearm and/or wrist, which fits the description provided. This code should be reported once, as the procedure encompasses the repair of multiple tendons.

Reference:

AMA's CPT Professional Edition (current year), Code 25272

NEW QUESTION # 355

Patient is diagnosed with dacryocystitis, which is the inflammation of?

- A. Fingernail
- B. Eardrum

- C. Lacrimal sac
- D. Cornea

Answer: C

Explanation:

Dacryocystitis is the inflammation of the lacrimal sac, which is part of the tear drainage system located in the inner corner of the eye. The lacrimal sac is connected to the nasolacrimal duct, which drains tears into the nasal cavity. Inflammation in this area can cause pain, redness, and swelling near the inner corner of the eye. References: ICD-10-CM, medical dictionaries

NEW QUESTION # 356

A patient undergoes a percutaneous liver biopsy with ultrasound guidance for primary biliary cirrhosis. What CPT and ICD-10-CM codes are reported?

- A. 47000, 76942, K74.3
- B. 47000, K74.5
- C. 47100, K74.5
- D. 47000, 10005, 76942, K74.3

Answer: A

Explanation:

47000 = Percutaneous liver biopsy

76942 = Ultrasound guidance

K74.3 = Primary biliary cirrhosis

NEW QUESTION # 357

A patient presents to the ER with a large sacral pressure ulcer measuring 7 cm. The provider excised the ulcer with 3 mm margins, removed muscle and segmental bone, and performed a layered skin flap closure. What CPT and ICD-10-CM coding is reported?

- A. 15933, L89.153
- B. 15931, L89.153
- C. 15935, L89.156
- D. 15937, L89.156

Answer: D

Explanation:

Pressure ulcer excision with bone involvement # CPT 15937 (sacral, with ostectomy) Stage 4 pressure ulcer # L89.156 (sacral region with necrosis of bone)

NEW QUESTION # 358

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