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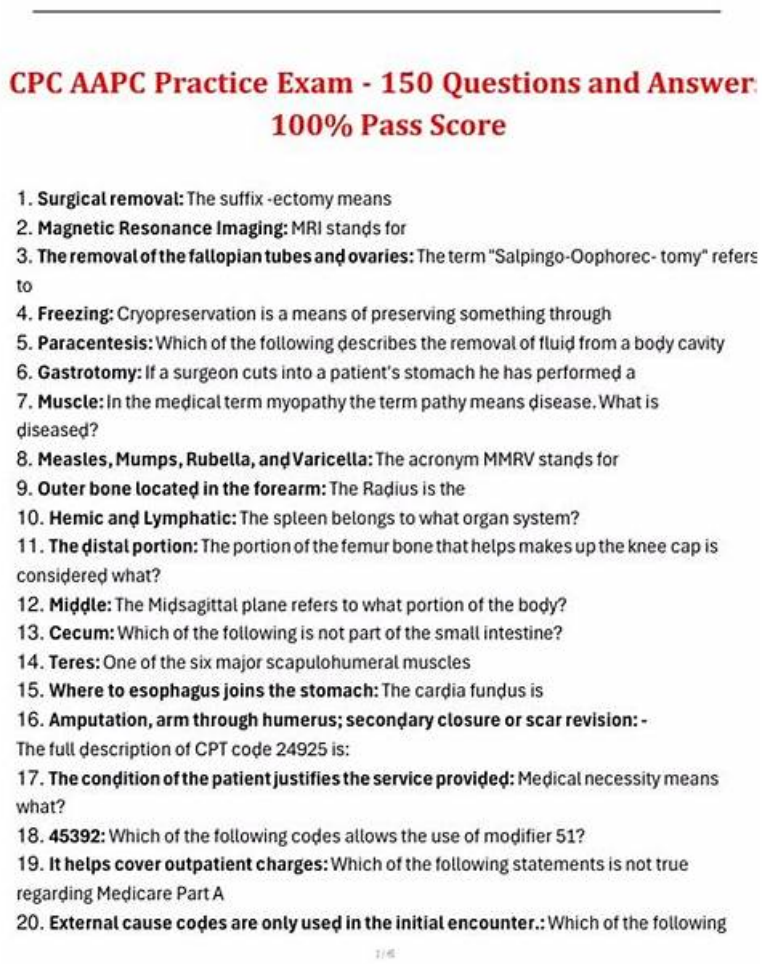

CPC AAPC Practice Exam - 150 Questions and Answer
100% Pass Score

1. **Surgical removal:** The suffix -ectomy means
2. **Magnetic Resonance Imaging:** MRI stands for
3. **The removal of the fallopian tubes and ovaries:** The term "Salpingo-Oophorec- tomy" refers to
4. **Freezing:** Cryopreservation is a means of preserving something through
5. **Paracentesis:** Which of the following describes the removal of fluid from a body cavity
6. **Gastrotomy:** If a surgeon cuts into a patient's stomach he has performed a
7. **Muscle:** In the medical term myopathy the term pathy means disease. What is diseased?
8. **Measles, Mumps, Rubella, and Varicella:** The acronym MMRV stands for
9. **Outer bone located in the forearm:** The Radius is the
10. **Hemic and Lymphatic:** The spleen belongs to what organ system?
11. **The distal portion:** The portion of the femur bone that helps makes up the knee cap is considered what?
12. **Middle:** The Midsagittal plane refers to what portion of the body?
13. **Cecum:** Which of the following is not part of the small intestine?
14. **Teres:** One of the six major scapulohumeral muscles
15. **Where to esophagus joins the stomach:** The cardia fundus is
16. **Amputation, arm through humerus; secondary closure or scar revision: -** The full description of CPT code 24925 is:
17. **The condition of the patient justifies the service provided:** Medical necessity means what?
18. **45392:** Which of the following codes allows the use of modifier 51?
19. **It helps cover outpatient charges:** Which of the following statements is not true regarding Medicare Part A
20. **External cause codes are only used in the initial encounter.:** Which of the following

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• Radiology: This section of the exam measures the skills of coding specialists and focuses on diagnostic imaging procedures including X-rays, CT scans, MRIs, ultrasounds, and nuclear medicine. It emphasizes proper selection of codes based on anatomical site and modality used.
Topic 2	• 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 3	• 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 4	• Evaluation & Management Services: This section of the exam measures the skills of coding specialists and covers office visits, hospital care, consultations, and other E • M services. It tests the understanding of time-based coding, medical decision-making, and history • exam components per current CMS guidelines.
Topic 5	• Cardiovascular System: This section of the exam measures the skills of coding specialists and addresses services related to the heart, arteries, and veins. It involves the coding of diagnostic and therapeutic procedures, including catheterizations, bypasses, and repairs.:
Topic 6	• 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 7	• 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 8	• 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 9	• 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 10	• Musculoskeletal System: This section of the exam measures the skills of coding specialists and focuses on coding procedures involving bones, joints, muscles, and tendons. It covers surgeries, reductions, arthroscopies, and fracture treatments, emphasizing accurate mapping of procedures to anatomical areas.
Topic 11	• Applying the ICD-10-CM Guidelines: This section of the exam measures the skills of coding specialists and covers how to apply official ICD-10-CM guidelines to real-world coding scenarios. It emphasizes the hierarchy of instructional notes, general and chapter-specific rules, and how to make judgment calls within compliant coding frameworks.
Topic 12	• 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.

CPC Actual Lab Questions: Certified Professional Coder (CPC) Exam & CPC Study Guide

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q32-Q37):

NEW QUESTION # 32
A patient is sent to the hospital by his family care provider for admission due to a high fever and neck pain The patient is admitted to the hospital to rule out bacterial meningitis. The hospitalist admits the patient and orders a CBC. CMR Blood culture, CT of the head and chest, and a lumbar puncture (spinal tap). After review of the results, he determines the patient has bacterial meningitis and starts the patient on IV antibiotics.
What CPT and ICD-10-CM codes are reported for the admission?

- A. 99284, G00.9
- B. 99222, G00.9
- C. 99264, R50.81.M54.2
- D. 99222, R50.81.M54.2

Answer: B

Explanation:
99222 = Initial hospital inpatient care, moderate MDM
Extensive diagnostic workup → moderate complexity
Final diagnosis established during admission
Diagnosis Coding:
G00.9 - Bacterial meningitis, unspecified
Do not code symptoms (fever, neck pain) once definitive diagnosis is confirmed Why others are incorrect:
99284 - ED visit
99264 - Inpatient consultation (deleted code)
Symptom-only diagnosis codes inappropriate

NEW QUESTION # 33
A 65-year-old man had a right axillary block by the anesthesiologist. When the arm was totally numb, the arm was prepped and draped, and the surgeon performed tendon repairs of the right first, second, and third fingers.
The anesthesiologist monitored the patient throughout the case.
What anesthesia code is reported?

- A. 01830
- B. 01840
- C. 01820
- D. 01810

Answer: A

Explanation:
The anesthesia code for an axillary block for procedures on the upper arm and elbow, which includes the monitoring by the anesthesiologist throughout the procedure, is 01830. This code is appropriate for anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of the shoulder and axilla.
CPT Professional Edition, AMA
Anesthesia Coding Guidelines

NEW QUESTION # 34
Mr. Woolridge has had a suspicious lesion on his left shoulder for approximately eight weeks that is not healing. On the dermatologist's exam of left shoulder blade, there is excoriation and scabbing and the lesion not healing. Patient agrees and wishes to proceed with a punch biopsy of the lesion. A punch biopsy is taken of the lesion and sent to pathology. A simple repair is performed at the biopsy site.
What CPT and ICD-10-CM codes are reported?

- A. 11104, D49.2
- B. 11102, 12001-51, D49.2
- C. 11104,12001-51, L98.9
- D. 11102, L98.9

Answer: B

Explanation:
CPT code 11102 is for punch biopsy of skin, including simple closure. CPT code 12001-51 is for simple repair of superficial wounds, with modifier 51 indicating multiple procedures. ICD-10-CM code D49.2 is used for a neoplasm of unspecified behavior of the bone, soft tissue, and skin. This coding accurately reflects the punch biopsy and simple repair performed on the lesion.
AMA's CPT Professional Edition (current year), ICD-10-CM (current year)

NEW QUESTION # 35
Which one of the following is an example of a case in which a diabetes-related problem exists and the code for diabetes is never sequenced first?

- A. If the patient has hyperglycemia that Is not responding to medication
- B. If the patient is being treated for secondary diabetes
- C. If the patient has an underdose of insulin due to an insulin pump malfunction
- D. If the patient is being treated for type 2 diabetes

Answer: C

Explanation:
When a patient experiences an underdose of insulin due to an insulin pump malfunction, the primary reason for the encounter would be the malfunction itself, which is coded first. The resulting hyperglycemia or hypoglycemia due to the pump failure is a secondary condition. According to ICD-10-CM guidelines, the code for the mechanical complication of the pump (T85.633-) is sequenced first, followed by a code for the diabetes with complication (E11.65 for type 2 diabetes with hyperglycemia).
ICD-10-CM (current year), Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88), ICD-10-CM Official Guidelines for Coding and Reporting, Section I.C.4.

NEW QUESTION # 36
(Chief Complaint: Palpable lump in the left breast. Adiagnostic mammogram (unilateral)was performed on theleft breastusingdigital imaging with CAD, with standard and additional views. What CPT codes are reported for the radiological services?)

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

Answer: B

Explanation:
This is adiagnosticmammogram (not screening) performed onone breast (left). CPT distinguishes screening from diagnostic:77067is screening mammography and is not appropriate because there is a symptom (palpable lump) and the service is diagnostic. CPT also distinguishes unilateral vs bilateral diagnostic:
77065isdiagnostic mammography, unilateral, and77066is diagnostic mammography, bilateral-so the correct selection is77065. The vignette mentions CAD, but current mammography CPT coding incorporates digital and CAD elements into the diagnostic mammography code structure in typical CPC-style testing, and the question asks which code(s) are reported, offering only single-code answers.77061is not the primary diagnostic mammography code; it relates to breast tomosynthesis add-on concepts in many coding frameworks, but the stem describes diagnostic mammography with additional views, not explicit tomosynthesis reporting. Therefore, for unilateral diagnostic mammography of the left breast, the correct code is77065.

NEW QUESTION # 37
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