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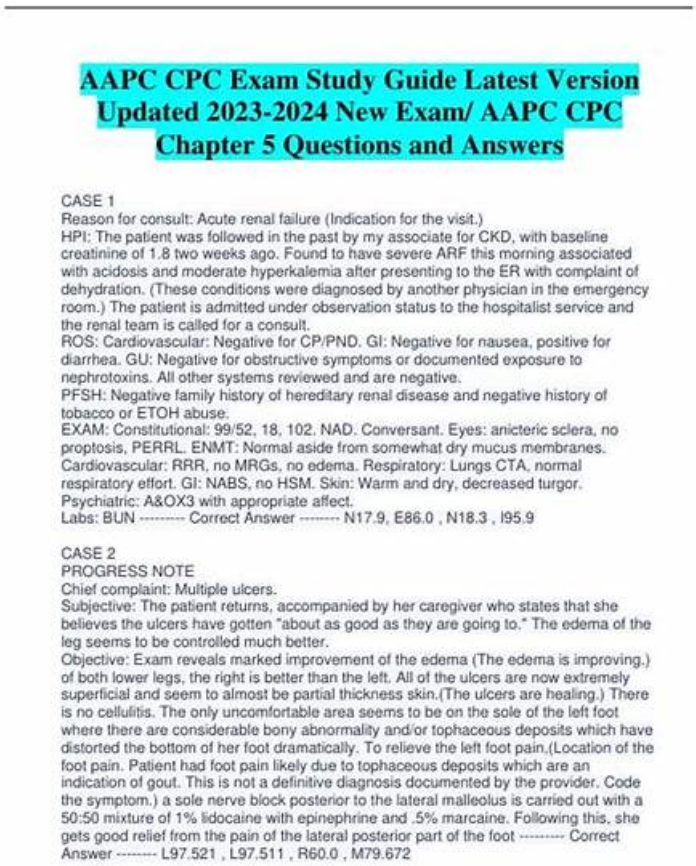

AAPC CPC Exam Study Guide Latest Version Updated 2023-2024 New Exam/ AAPC CPC Chapter 5 Questions and Answers

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 (Q52-Q57):

NEW QUESTION # 52
Which service would NOT be covered under Medicare part A?

- A. Observation hospital care
- B. Home health care
- C. Hospice care
- D. Inpatient hospital care

Answer: A

Explanation:
Observation hospital care is provided to patients who are not sick enough to be admitted.
Therefore, it is considered an outpatient service and is covered under Medicare part B.

NEW QUESTION # 53
A physician performs an esophagogastroduodenoscopy on a patient who has GERD. A single tissue sample is obtained from the upper gastrointestinal tract using biopsy forceps. A reflux test was also done and a bravo capsule temporarily attached to the esophageal wall to monitor pH levels. What procedures should the physician report?

- A. 43239, 91034
- B. 43235, 91034
- C. 43235, 91035
- D. 43239, 91035

Answer: D

Explanation:
To report an esophagogastroduodenoscopy, see CPT code range 43233-43259. In this scenario, the procedure is not considered diagnostic (43235) because the physician is stating the patient has GERD. Additionally, the tissue sample was obtained by means of biopsy forceps and not by brushing or washing. The secondary procedure is a reflux test and an esophageal pH test by means of a bravo capsule, which evaluates the level of acid refluxing into the esophagus. Although CPT 91035 doesn't specifically state a capsule in the description of the code, it would fall under a
"mucosal attached" placement. A nasal catheter was not used, so reporting CPT 91034 would be incorrect.

NEW QUESTION # 54
A patient is seen with complaints of recurring infections in the foreskin. The physician recommends circumcision to help improve penile hygiene. The patient agrees, a local anesthetic is injected into the penis, and the procedure is completed by clamping the foreskin and trimming the excess skin. How should the physician report the encounter?

- A. 54150, 64450, Z41.2, Z87.2
- B. 54150-52, Z41.2, Z87.2
- C. 54150, N48.29
- D. 54150-52, 64450, N48.89

Answer: C

Explanation:
A circumcision procedure includes a local anesthetic, also known as a ring block. Therefore, an additional anesthesia code (CPT 64450) should not be reported as a secondary code, nor should modifier 52 be appended on the primary procedure. The code

notes for ICD-IO-CM code Z41.2 specifically state that this diagnosis should be used only when the procedure is elective and not related to a specific diagnosis. In this case, because the procedure is related to a recurring condition the patient is experiencing. the infection should be the primary diagnosis. The diagnosis crosswalk would be "infection" followed by "penis," which directs the coder to N48.29.

NEW QUESTION # 55
A 69-year-old patient with a medical history of diabetes is evaluated in the emergency room for a urinary tract infection. After performing a medically appropriate history and exam, the physician prescribes 100 mg of Macrobid every 12 hours and admits the patient to observation status to monitor for sepsis. After seeing an improvement in symptoms, the physician discharges the patient the following day. What CPT and ICD-IO-CM code(s) should be reported for the entirety of the patient's stay?

- A. 99234, N39.O, 397.89
- B. 99221, 99238, N39.O, Ell.9
- C. 99284, 99238, Ell.69, N39.O
- D. 99222, 99238, N39.O

Answer: B

Explanation:
When a patient is admitted into observation status from the emergency room, only the observation code is reported for that day. When observation extends past the initial date of service, the initial treatment would be reported with CPT codes 99221-99223. In this scenario, the appropriate level of service would be 99221, based on the moderate level of decision-making.
which can be ascertained by the number and complexity of problems addressed and the risk of complications and/or morbidity or mortality of patient management. Discharge from observation on a separate date is reported with CPT codes 99238-99239. Because the diabetes is documented and is a coexisting chronic condition during the time of the encounter, it should follow the reason for admission. Due to a lack of specificity in the diabetes diagnosis, a causal relationship with a UTI is not presumed, and Ell.69 should not be coded.

NEW QUESTION # 56
A female patient experiencing swollen lymph nodes is seen for a follow-up to discuss the results of her open axillary biopsy that occurred last week The results are positive for diffuse large cell lymphom a. The patient is given multiple treatment options, including success rates, risks, and side effects. She opts to begin radiation treatment next week. What CPT and ICD-IO-CM codes should the provider report for this visit?

- A. 99024, C85.84
- B. 99213-24, C83.84
- C. 99214, (285.94
- D. 99214-24, 25, 99024, C83.34

Answer: D

Explanation:
To determine which services to report for this encounter, it is important to understand which services were rendered on the last. The patient had an open biopsy of the axillary lymph nodes (CPT 38525) last week This procedure has a postoperative 90-day global period. This means that any related services provided to the patient within that time are reported with zero-charge CPT 99024. Services such as biopsy results, follow-up incisional care, and any postoperative complications are all inclusive to this code. As the patient was given biopsy results, CPT 99024 should be reported for this encounter. However, CPT guidelines also state that when it comes to diagnostic procedures, "care of the condition for which the diagnostic procedure was performed...
is not included and may be listed separately." In this case, that care begins with the discussion of treatment options with their identified risks, and the decision to begin radiation. This level of moderate medical decision-making is reported by means of E/M CPT 99214. Modifier 24 is appended to indicate that is it unrelated to postoperative care, and modifier 25 is appended to indicate it is separately identifiable to CPT 99024. ICD-IO-CM crosswalk for lymphoma, diffuse large cell, is C83.34.

NEW QUESTION # 57
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