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Patient presents with no menses and positive pregnancy test but ultrasound finds no uterine contents. Embryo has implanted on left ovary and this is treated with laparoscopic oophorectomy. What are the CPT® and ICD-10-CM codes reported for this procedure? Do not code the ultrasound.

- a. 59150, 000.90
- b. 59151, 000.202
- c. 59121, 000.102
- d. 58661, 000.00 - ---Answers---b. 59151, 000.202

What ICD-10-CM codes are reported for an encounter for full-term uncomplicated delivery of a single live birth at 41 weeks of pregnancy?

- a. 080, Z37.0, Z3A.41
- b. 080, Z37.1, Z3A.41
- c. 082, Z37.1, Z3A.41
- d. 082, Z37.0, Z3A.41 - ---Answers-----a. 080, Z37.0, Z3A.41

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none">• 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 2	<ul style="list-style-type: none">• 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 3	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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 5	<ul style="list-style-type: none">• Digestive System: This section of the exam measures the skills of coding specialists and evaluates the coding of surgeries and procedures involving the oral cavity, pharynx, esophagus, stomach, intestines, liver, pancreas, and related organs. Understanding endoscopic procedures is particularly critical here.
Topic 6	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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 8	<ul style="list-style-type: none">• Pathology & Laboratory: This section of the exam measures the skills of medical coders and includes lab tests, specimen analysis, and pathological examination procedures. It ensures that coders understand how to apply codes for chemistry panels, cultures, and histopathological diagnostics.
Topic 9	<ul style="list-style-type: none">• Anesthesia: This section of the exam measures the skills of medical coders and involves coding anesthesia services based on surgical site, complexity, and time. It tests the understanding of anesthesia modifiers and the importance of linking anesthesia codes with the correct primary procedures.
Topic 10	<ul style="list-style-type: none">• 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.

Topic 11	<ul style="list-style-type: none"> • Endocrine System and Nervous System: This section of the exam measures the skills of medical coders and assesses the ability to assign codes for surgeries involving glands, the brain, spinal cord, and peripheral nerves. Procedures like resections and electrical stimulation are part of the evaluated content.
Topic 12	<ul style="list-style-type: none"> • 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.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q71-Q76):

NEW QUESTION # 71

A patient with multiple atypical lesions on the face and trunk is in the office to perform a biopsy. A punch tool was used to obtain a full-thickness tissue sample for two lesions on the trunk.

Partial-thickness tissue sample was taken from one lesion on the forehead using a curette.

What CPT coding is reported?

- A. 11104, 11103 x 2
- B. 11104 x 2, 11102
- C. 011104, 11102 x 2
- D. 11104, 11105, 11103

Answer: B

Explanation:

The CPT codes for skin biopsies depend on the method used and the location of each lesion. Here, the scenario includes:

1. Two punch biopsies on the trunk: CPT code 11104 is used for a full-thickness punch biopsy of the skin, and 11104 x 2 is appropriate since two lesions on the trunk were sampled.
2. One partial-thickness shave biopsy on the forehead: CPT code 11102 is used for a tangential (shave) biopsy, which captures a partial-thickness sample, appropriate for the forehead lesion.

Explanation of other options:

B: 11104, 11105, 11103: Incorrect, as 11105 is an add-on for additional punch biopsies at separate sites but not used here.

C: 11104, 11103 x 2: 11103 is an add-on code for additional shave biopsies, which does not apply to the punch biopsies on the trunk.

D: 11104, 11102 x 2: Incorrect, as 11102 is only used for the shave biopsy, not for the punch biopsies.

NEW QUESTION # 72

A 10-year-old had a cochlear implant in his left ear few weeks ago. Today he sees the audiologist to initialize and program the implant.

What CPT code is reported?

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

Answer: A

Explanation:

1. Procedure and CPT Code Selection:

The patient had a cochlear implant placed in the left ear and is now seeing the audiologist for initialization and programming of the implant.

CPT Code 92603 is specific for initial programming of a cochlear implant for patients younger than 12 years old. This includes the setup and initial adjustments required for the cochlear implant, making it the correct code.

2. Rationale for Excluding Other Options:

Code 92626 is used for evaluating auditory function with the cochlear implant, focusing on assessment rather than programming, and is therefore incorrect for this programming session.

Code 92630 is for aural rehabilitation following cochlear implant, which does not apply to the programming/initiation stage. Code 92604 is for subsequent programming sessions after the initial programming and is therefore not applicable for the first-time programming.

3. AAPC and CPT Coding Guidelines:

According to AAPC guidelines, 92603 is the appropriate code for initial programming of a cochlear implant in children under 12 years of age.

Therefore, the correct answer is D. 92603.

NEW QUESTION # 73

A patient complains of tarry, black stool, and epigastric tightness. An esophagogastroduodenoscopy is recommended to evaluate the source of the bleeding. The endoscope is inserted orally. The esophagus appears normal on scope insertion. No evidence of bleeding in the stomach. The scope is then passed into the duodenum, where a polyp is found and removed with hot biopsy forceps. No evidence of bleeding post procedure.

What CPT code is reported?

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

Answer: C

NEW QUESTION # 74

Where is a Warthin's tumor found?

- **A. Salivary gland**
- B. Bone
- C. Back of eye
- D. Ovary

Answer: A

Explanation:

Warthin's tumor, also known as papillary cystadenoma lymphomatosum, is a benign tumor of the salivary glands, most commonly affecting the parotid gland. It typically presents as a painless, slow-growing mass near the angle of the jaw.

ICD-10-CM, medical dictionaries, and oncology textbooks

NEW QUESTION # 75

911 is called by the physician for an ambulance with non-emergency basic life support to pick up a patient from his office that had fainted. The patient was taken to the hospital. What HCPCS Level II coding is reported for the ambulance's service?

- A. A0429-QM-HP
- B. A0429-QM-PH
- **C. A0428-QM-PH**
- D. A0428-QM-HP

Answer: C

Explanation:

To select the correct HCPCS Level II code for a non-emergency ambulance service, we focus on the following components: A0428 represents "Ambulance service, Basic Life Support (BLS), non-emergency transport," which is appropriate here as the patient was transported with non-emergency BLS following a fainting episode. This eliminates options B and D, which indicate "emergency" (A0429).

QM Modifier indicates "Ambulance service provided under arrangement by a provider of services," relevant when a physician arranges the ambulance transport.

PH Modifier specifies "Physician's office to hospital" transport, matching the scenario where the patient was taken from the physician's office to the hospital.

Thus, A0428-QM-PH accurately describes a non-emergency BLS transport arranged by a provider from a physician's office to the

hospital, aligning with choice A.

NEW QUESTION # 76

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