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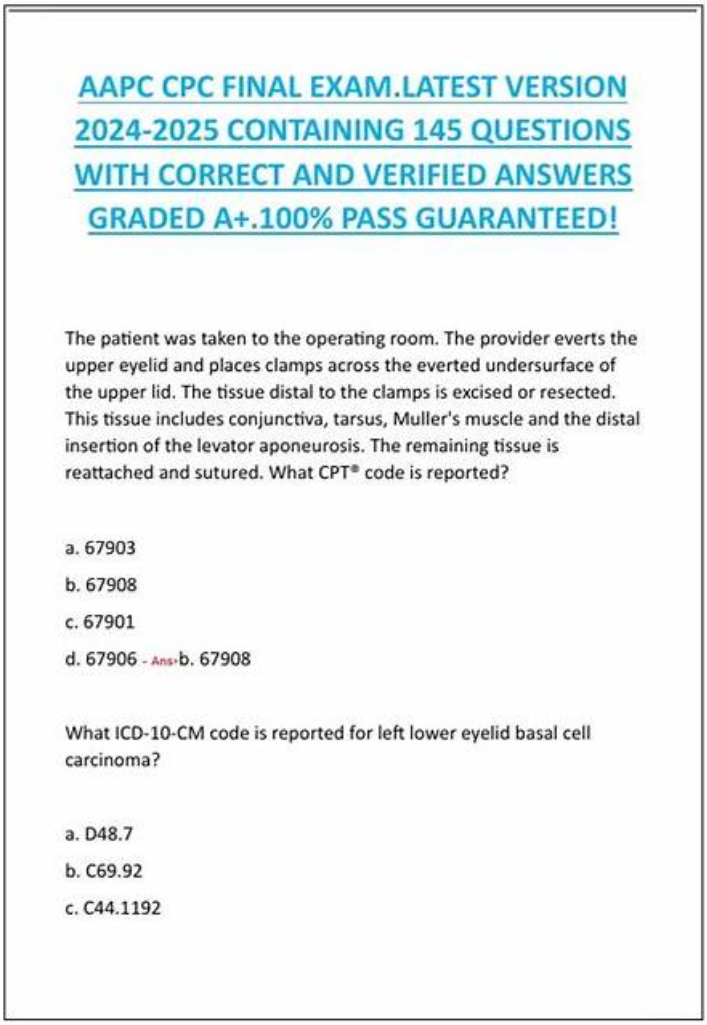

AAPC CPC FINAL EXAM.LATEST VERSION 2024-2025 CONTAINING 145 QUESTIONS WITH CORRECT AND VERIFIED ANSWERS GRADED A+.100% PASS GUARANTEED!

The patient was taken to the operating room. The provider everts the upper eyelid and places clamps across the everted undersurface of the upper lid. The tissue distal to the clamps is excised or resected. This tissue includes conjunctiva, tarsus, Muller's muscle and the distal insertion of the levator aponeurosis. The remaining tissue is reattached and sutured. What CPT® code is reported?

a. 67903

b. 67908

c. 67901

d. 67906 - Ans-b. 67908

What ICD-10-CM code is reported for left lower eyelid basal cell carcinoma?

a. D48.7

b. C69.92

c. C44.1192

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q336-Q341):

NEW QUESTION # 336
Provider performs staged procedures for gender reassignment surgery converting female anatomy to male anatomy.
What CPT code is reported?

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

Answer: D

Explanation:
55970 = Female-to-male sex transformation
55980 is for male-to-female transformation
Unlisted codes (58999, 55899) are not used when a specific CPT code exists

NEW QUESTION # 337
The evisceration of ocular contents was performed using a surgical microscope for enhanced visualization. The procedure was performed on the left eye and an implant was not placed in the ocular cavity.
What CPT coding is reported?

- A. 65091-LT, 69990-51
- B. 65093-LT, 69990
- C. 65091-LT
- D. 65093-LT

Answer: C

Explanation:
1. Procedure and CPT Code Selection:
The procedure performed was an evisceration of ocular contents without the placement of an implant. The surgical microscope was used for enhanced visualization, but this does not require a separate code if the primary procedure code includes it inherently.
CPT Code 65091 is used for an evisceration of the ocular contents without implant placement. This code correctly describes the procedure performed on the left eye.
2. Modifier:
Modifier LT is added to indicate that the procedure was performed on the left eye.
3. Exclusion of Code 69990:
Code 69990 is for the use of an operating microscope, but it should not be billed separately when it is used as part of a procedure where enhanced visualization is typical or expected, such as an evisceration procedure. According to CPT guidelines, 69990 is not separately reported when the microscope is used for visualization in procedures where its use is considered part of the standard of care.
4. Rationale for Excluding Other Options:
Code 65093 is for an evisceration with implant placement, which does not apply since no implant was used.
Options B and C incorrectly include 69990, which is not separately reportable in this scenario.
5. AAPC and CPT Coding Guidelines:
According to AAPC and CPT coding guidelines, 65091 is sufficient to capture the procedure without the need to add code 69990 for the microscope.
Therefore, the correct answer is D. 65091-LT.

NEW QUESTION # 338

What is the muscular ring around a lumen that contracts to control flow through that lumen called?

- A. Sinus
- B. Stricture
- C. Snare
- D. Sphincter

Answer: D

Explanation:
A sphincter is a muscular ring that encircles a lumen (or passage) and contracts to control the flow of substances through it. Sphincters are found throughout the body in areas such as the gastrointestinal tract (e.g., the lower esophageal sphincter, pyloric sphincter, anal sphincter) and the urinary system (e.g., urethral sphincter), where they regulate the passage of food, waste, and other materials.
A: Stricture refers to an abnormal narrowing of a passage or duct in the body, often due to scarring or disease, not a muscular ring.
B: Snare is a surgical instrument, not a structure within the body.
D: Sinus refers to a cavity or channel within bone or tissue, unrelated to muscle control of flow.
Therefore, the correct answer is C. Sphincter.

NEW QUESTION # 339
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 CPTcode is reported?

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

Answer: C

Explanation:
1. Procedure and CPTCode 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.
CPTCode 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 CPTCoding 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 # 340
An anesthesiologist medically directs two cases during EGD and colonoscopy in a PS III patient with severe bleeding risk.
What CPT codes are reported?

- A. 00813-QK-P3, 99100, 99140
- B. 00731-QX-P3, 99100
- C. 00731-QY-P3, 99140
- D. 00813-AA-P3, 99100, 99140

Answer: A

Explanation:
00813 = Anesthesia for colonoscopy
QK = Medical direction of 2-4 cases
99100 = Extreme age
99140 = Emergency anesthesia

NEW QUESTION # 341
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