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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q212-

Q217):

NEW QUESTION # 212

A patient is seen at the doctor's office for nausea, vomiting, and sharp right lower abdominal pain. CT scan of the abdomen is ordered. Labs come back indicating an increased WBC count with review of the abdominal CT scan. The physician determines the patient has a ruptured appendicitis. The physician schedules an appendectomy and takes the patient to the operating room. The appendix is severed from the intestines and removed via scope inserted through an umbilical incision. What CPT and diagnosis codes are reported?

- A. 44960. K35.80. R11.2.R10.31
- B. 44970, K35.32.R11.2.R10.31
- C. 44950. K35.890
- D. 44970, K35.32

Answer: D

Explanation:
Procedure Coding:
44970 - Laparoscopic appendectomy
Appendix removed via scope through umbilical incision, confirming laparoscopic approach Diagnosis Coding:
K35.32 - Acute appendicitis with perforation and localized peritonitis, without abscess Documentation supports ruptured (perforated) appendicitis No abscess documented Why Other Options Are Incorrect:
B - Signs/symptoms (R11.2, R10.31) not coded once definitive diagnosis is established C - 44960 = open appendectomy (not performed) D - 44950 = open appendectomy, diagnosis code incorrect ICD-10-CM Guideline Reference:
Do not code symptoms when a definitive diagnosis is confirmed.

NEW QUESTION # 213

A patient with a history of chronic venous embolism in the inferior vena cava has a radiographic study to visualize any abnormalities. In outpatient surgery the physician accesses the subclavian vein and the catheter is advanced to the inferior vena cava for injection and imaging. The supervision and interpretation of the images is performed by the physician.
What codes are reported for this procedure?

- A. 36000, 75827-26
- B. 36010, 75825-26
- C. 36010, 75827-26
- D. 36000, 75825-26

Answer: B

Explanation:
For the procedure involving access to the subclavian vein and advancing a catheter to the inferior vena cava for injection and imaging, the following codes are used:
* 36010 for the catheter placement.
* 75825-26 for the supervision and interpretation of the imaging.
Modifier -26 indicates the professional component of the radiological supervision and interpretation.
References:
* AMA's CPT Professional Edition (current year)
* ICD-10-CM (current year)

NEW QUESTION # 214

Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1
Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.
Operation performed: Excision of right thigh benign congenital>1
nevus, excision size with margins 4.5 cm and closure size 5 cm.
Anesthesia: General.0
Intraoperative antibiotics: Ancef.0
Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks

involved, which included but were not limited to risks of general anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.

Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient's right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.

This was passed to pathology for review. The wound required limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.

The patient was then cleaned and turned over to anesthesia for S extubation.

She was extubated successfully in the operating room and taken S to the recovery room in stable condition. There were no complications.

What is the radiology coding for this encounter?

- A. 73562-26
- B. 73560-LT
- C. 73560-26-LT
- D. 0

Answer: A

Explanation:
73562 = Knee X-ray, 3 views
-26 = Professional component only

NEW QUESTION # 215

A retinal specialist diagnoses type 2 diabetic mild nonproliferative retinopathy with macular edema, bilateral. Diabetes is secondary to Cushing's syndrome and controlled with oral hypoglycemics. What ICD-10-CM codes are reported?

- A. E08.3213, E24.9, Z79.84
- B. E11.3213, E24.9, Z79.4
- C. E24.9, E11.3213, Z79.84
- D. E24.9, E08.3213, Z79.84

Answer: D

Explanation:
E08.3213 = Diabetes due to underlying condition with mild NPDR with macular edema, bilateral E24.9 = Cushing's syndrome (underlying condition) Z79.84 = Long-term use of oral hypoglycemic drugs Sequencing follows ICD-10-CM guidelines for secondary diabetes.

NEW QUESTION # 216

A patient is diagnosed with sepsis and associated acute respiratory failure.
What ICD-10-CM code selection is reported?

- A. A41.9, R65.20, J96.00
- B. A41.9, R65.21, J96.00
- C. A41.9, J96.00
- D. A41.9

Answer: C

NEW QUESTION # 217

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