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AAPC CPC Study Guide Exam Questions with Correct Answers

A 46-year-old female had a previous biopsy that indicated positive malignant margins anteriorly on the right side of her neck. A 0.5 cm margin was drawn out and a 15 blade scalpel was used for full excision of an 8 cm lesion. Layered closure was performed after the removal. The specimen was sent for permanent histopathologic examination. What are the CPT® code(s) for this procedure?

- A. 11626
- B. 11626, 12004-51
- C. 11626, 12044-51
- D. 11626, 13132-51, 13133 - Answer-C: 11626, 12044-51

A 30-year-old female is having 15 sq cm debridement performed on an infected ulcer with eschar on the right foot. Using sharp dissection, the ulcer was debrided all the way to down to the bone of the foot. The bone had to be minimally trimmed because of a sharp point at the end of the metatarsal. After debriding the area, there was minimal bleeding because of very poor circulation of the foot. It seems that the toes next to the ulcer may have some involvement and cultures were taken. The area was dressed with sterile saline and dressings and then wrapped. What CPT® code should be reported?

- A. 11043
- B. 11012
- C. 11044
- D. 11042 - Answer-C: 11044

A 64-year-old female who has multiple sclerosis fell from her walker and landed on a glass table. She lacerated her forehead, cheek and chin and the total length of these lacerations was 6 cm. Her right arm and left leg had deep cuts measuring 5 cm on each extremity. Her right hand and right foot had a total of 3 cm lacerations. The ED physician repaired the lacerations as follows: The forehead, cheek, and chin had debridement and cleaning of glass debris with the lacerations being closed with one layer closure, 6-0 Prolene sutures. The arm and leg were repaired by layered closure, 6-0 Vicryl subcutaneous sutures and Prolene sutures on the skin. The hand and foot were closed with adhesive strips. Select the appropriate procedure codes for this visit.

- A. 99283-25, 12014, 12034-59, 12002-59, 11042-51
- B. 99283-25, 12053, 12034-59, 12002-59
- C. 99283-25, 12014, 12034-59, 11042-51
- D. 99283-25, 12053, 12034-59 - Answer-D: 99283-25, 12053, 12034-59

A 52-year-old female has a mass growing on her right flank for several years. It has finally gotten significantly larger and is beginning to bother her. She is brought to the Operating Room for definitive excision. An incision was made directly overlying the mass. The mass was down into the subcutaneous tissue and the surgeon encountered a well encapsulated lipoma approximately 4 centimeters. This was excised primarily

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q75-Q80):

NEW QUESTION # 75

CPT code 11102 is a column 2 code that has an NCCI edit of 1 when paired with CPT code 11402. How would this be interpreted?

- A. The two codes are exclusive of each other and can never be billed together.
- B. If being billed together, only report one unit of each.
- C. The two codes are inclusive of each other and can never be billed together.
- **D. The two codes can be billed together with an appropriate modifier.**

Answer: D

Explanation:

NCCI stands for National Correct Coding Initiative and was created by CMS to prevent unbundling and prevent incorrect payments. Column one represents a correct code when listed next to column two. There are three edits listed with the combination of the two columns: 0, 1, and

9. Edit 0 means that the two codes should never, under any circumstance, be reported together. Edit

1 means that the procedures may be coded together with the use of a modifier. Edit 9 means that the edit does not apply.

NEW QUESTION # 76

In which scenario would the modifier 53 be appended?

- A. An IUD removal is not completed because the patient reports severe pain when the speculum is inserted.
- B. A patient receives an x-ray of one femur when the doctor ordered bilateral views.
- **C. A surgeon decides to stop a gallbladder removal procedure in the hospital operating room after the patient has extensive bleeding at the incision site.**
- D. The surgeon decides to terminate a routine colonoscopy when the patient becomes hypertensive before receiving anesthesia in the outpatient procedure room.

Answer: C

Explanation:

Modifier 53 is used to indicate that a procedure was terminated by the provider after anesthesia was given due to extenuating circumstances that affected the health of the patient.

Although option B is similar, the procedure that was discontinued was done so prior to anesthesia in the outpatient setting, in which case modifier 73 would be appended.

NEW QUESTION # 77

Anesthesiologist A begins providing services at 7:02 but is relieved at 8:47 by Anesthesiologist Z. If the recorded end time for anesthesia services is 11:32, which statement is true?

- A. Anesthesiologist A would report 1.75 hours, and Anesthesiologist Z would report 2.75 hours of anesthesia time.
- B. Both anesthesiologists would separately report 4.5 hours of anesthesia time.
- **C. Anesthesiologist Z would report 4.5 hours of anesthesia time.**
- D. Anesthesiologist A would report 4.5 hours of anesthesia time.

Answer: C

Explanation:

When splitting/providing relief in the middle of a procedure, the anesthesiologist who provides services for the longest amount of time bills for the anesthesia services in their entirety. In this scenario, Anesthesiologist Z provided 60 minutes more than Anesthesiologist A and so would bill for the entire 4.5 hours. Even though Anesthesiologist A provided 1.75 hours, they would not submit any coding to the insurance carrier.

NEW QUESTION # 78

V codes are related to which procedures/products?

- A. Orthotic procedures
- B. Enteral therapy
- C. Durable medical equipment
- **D. Hearing services**

Answer: D

Explanation:

Durable medical equipment is represented by E codes, orthotic procedures are L codes, and enteral therapy is inclusive to B codes in the HCPC manual.

NEW QUESTION # 79

Which is NOT considered inclusive to hydration services?

- A. Catheter flush
- **B. Catheter declotting**
- C. Flush solution
- D. Subcutaneous catheter access

Answer: B

Explanation:

Catheter access, standard supplies such as a flush solution, and the flush at the end of the infusion are all considered necessary to facilitate the infusion and are inclusive to CPT codes

96360-96361. Declotting a catheter involves the injection of a thrombolytic agent to dissolve the clot and is separately reportable with CPT 36593.

NEW QUESTION # 80

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