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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none">Identify the information in appendices of the CPT® code bookList the major features of HCPCS Level II codes
Topic 2	<ul style="list-style-type: none">Apply coding conventions when assigning diagnoses and procedure codesIdentify the purpose of the CPT®, ICD-10-CM, and HCPCS Level II code books
Topic 3	<ul style="list-style-type: none">Code a wide variety of patient services using CPT®, ICD-10-CM, and HCPCS Level II codesExplain the determination of the levels of EM services
Topic 4	<ul style="list-style-type: none">Provide practical application of coding operative reports and evaluation and management servicesUnderstand and apply the official ICD-10-CM coding guidelines

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q48-Q53):

NEW QUESTION # 48

Which patient is receiving critical care services?

- A. A 93 -year-old male is admitted to the intensive care unit for monitoring after a coronaryangioplasty procedure that was performed to relieve symptoms of atherosclerosis.
- **B. A 60-year-old male is admitted with an acute chronic heart failure exacerbation causinghypoxic respiratory failure. The patient is intubated, sedated, and started on 50 mg ofertapenem for a potential lung infection.**
- C. A 47 -year-old female with a history of unrepaired chronic heart disease and anemia has anoxxygen saturation level of 80. She is put on a nasal cannula and given a blood transfusion toimprove her oxygen-carrying capacity and oxygen saturation level.
- D. A 67 -year-old female receives chronic ventilator therapy after a cerebral infarction thatcaused hemorrhage in the brain.

Answer: B

Explanation:

CPT guidelines define critical care as an illness or injury that acutely impairs one or more vital organ systems, where there is a high probability of imminent or life-threatening deterioration in the patients condition. Additionally, to report a critical care service, the documentation should provide evidence of high-complexity medical decision-making (e.g.endotracheal tube insertion, defibrillation, fluid administration for shock, Narcan, etc.). Answer B is the only option listed that contains documentation to support critical care services.

This male patient has Vyvo life-threatening conditions, in which emergent intervention is provided to prevent further deterioration. In ansvver A the female patient may have a life-threatening condition; however, administering oxygen via a nasal cannula and/or transfusing blood does not qualify as critical care. Management of a patient who receives chronic ventilator therapy is also not considered critical care because the medical decision-making involved in the therapy is quite low.

The care a patient receives after having surgery would be considered routine and postoperative, regardless of where they are sent, unless a complication arises in which one or more of the vital organ systems begins to deteriorate in a fashion that poses a threat to life.

NEW QUESTION # 49

An established 27-year-old female patient is seen with complaints of fatigue and muscle aches that began 3 days ago. The physician draws two vials of blood, collects a urine sample, and performs a pregnancy test. The patient is instructed to drink 8 ounces of water daily, rest, and follow up in 3 days for her results. What CPT codes should be reported for this encounter?

- A. 99213, 81025, 36410, 81005
- **B. 99213, 81025, 36415, 81002**
- C. 99212, 81025, 36410x2, 99000, 81020
- D. 99212, 81025, 36416, 81007

Answer: B

Explanation:

The documentation demonstrates that the number and complexity of problems addressed is low (fatigue and muscle aches are self-limited problems), the amount or complexity of data to be reviewed and analyzed is moderate (three unique tests), and the risk of complications, morbidity, or mortality of patient management is minimal (the patient was advised to drink more water). (To determine the final level of medical decision making, choose the lowest of the highest two elements. In this scenario, the final level of medical decision making is low, and the CPT code is

99213. Vihen reporting a routine venipuncture, use CPT code 36415. CPT code 36410(a) is reported when it is medically necessary for the physician to draw a patient's blood, and 36416 describes capillary blood collected through a skin prick-certainly not enough to fill two vials. CPT code 99000 can be used to report a specimen being transported to an outside laboratory, but that is unknown in this scenario. A generic urinalysis is reported with CPT code 81002 unless specifically stated that an automated analyzer (81005), a commercial kit (81007), and/or an agar test (81020) was utilized.

NEW QUESTION # 50

Which option would best fall under a level II HCPC code?

- A. Diagnostic colonoscopy
- B. Radiation treatment management
- C. A malignant neoplasm
- **D. Advanced life support**

Answer: D

Explanation:

A level II HCPC code describes medical devices, supplies, medication, and/or other services that a provider and/or entity used during a service provided to a patient. Advanced life support (ALS) fits this description because it is a set of life-saving protocols administered in transit.

Radiation treatment management and a diagnostic colonoscopy describe a level I HCPC code, otherwise known as a CPT code. If the patient was asymptomatic and the colonoscopy was for screening purposes only, a level II HCPC code could be assigned. However, a diagnostic procedure implies a past medical/family history that puts the patient at risk and/or symptoms that warrant the procedure. A malignant neoplasm describes an ICD-IO-CM code because it is a diagnosis.

NEW QUESTION # 51

Which service is NOT included in the central nervous system assessment?

- **A. Prescription for an opioid**
- B. Clinical dementia rating
- C. Review of an advance care plan
- D. Discussion of suicidal intentions

Answer: A

Explanation:

A central nervous system assessment is comprised of multiple screenings that are reported with CPT codes 96105-96146 and includes, but is not limited to, the following elements: use of standardized instruments for staging and rating clinical dementia; evaluation for behavioral symptoms using standardized screening instruments; and development, updating, revision, and/or review of an Advance Care Plan. A review of high-risk medications is also included in the central nervous system assessment; however, if in the same encounter a prescription is issued, the clinician should document and report the treatment with an appropriate E/M.

NEW QUESTION # 52

A mammogram is done on a patient who has a lump on her right breast at 4 O'clock and a lump in her left breast at 6 O'clock. What CPT and ICD-IO-CM code(s) should be reported?

- A. 77067, D49.3
- B. 77065-50, N63.13, N63.20
- C. 77067, D48.61, D48.62
- **D. 77066, N63.14, N63.25**

Answer: D

Explanation:

CPT code 77067 is a screening mammogram. In this case, the mammogram would be diagnostic because the purpose is to rule out and/or make a diagnosis based on physical exam findings. Code 77065-50 is an inappropriate use of the modifier because there exists a bilateral procedure code. A breast lump should only be coded to "mass" and not as a neoplasm unless specifically stated in the diagnosis. When deciphering the location of the mass, 12 O'clock is at the top of each breast, and the point of movement is clockwise. Therefore, 4 O'clock in the right breast is equivalent to the lower-inner quadrant, and 6 O'clock in the left breast is in the middle of the lower quadrants.

NEW QUESTION # 53

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