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Question: 1

A CRNA claim line includes QX. The corresponding physician anesthesia claim is missing, and the documentation does not show physician medical direction, immediate availability, or physician participation in the case. The CRNA record supports independent CRNA performance. Which correction is most appropriate?

- A. Replace QX with AA because the CRNA personally performed the anesthesia service
- B. Keep QX because all CRNA services require QX whether or not a physician participated
- C. Add QK to the CRNA line because the physician claim is missing
- D. Replace QX with QZ if the service was furnished by the CRNA without physician medical direction and payer rules support QZ

Answer: D

Question: 2

A pain clinic documents chronic low back pain for several years after a prior lumbar fusion. The provider also documents psychosocial dysfunction, disability behavior, and explicitly states "chronic pain syndrome." The encounter is for ongoing medication management. Which diagnosis-coding principle is most important?

- A. Chronic pain syndrome may be coded because the provider explicitly documented that condition
- B. The prior fusion procedure code should be reported as the diagnosis because it explains the pain history
- C. Chronic pain syndrome may not be coded because pain has to be acute to report a G89 code
- D. Only a nonspecific low back pain code may be reported because chronic pain syndrome is never coded in pain management

Answer: A

Question: 3

A pain practice reports a diagnostic nerve block and a therapeutic injection during the same session. The documentation states only, "Multiple injections performed for pain," without identifying separate

anatomical targets, distinct indications, or medical necessity for each service. The payer applies NCCI-style bundling and distinct-procedure rules. Which action best supports compliant billing?

- A. Append modifier 59 to both lines because multiple injections were performed
- B. Bill only the higher-paying code and ignore the documentation deficiency
- C. Add separate targets based on the scheduler's procedure list
- D. Hold or query because separate services require documentation of distinct targets, indications, and reportable procedural work

Answer: D

Question: 4

A patient receives anesthesia for an open femoral-popliteal bypass. The operative report documents vascular reconstruction of the lower extremity. No separate postoperative nerve block, invasive monitoring service, or unusual circumstance is separately documented as billable. Which factor should guide the anesthesia crosswalk?

- A. The number of vascular clamps listed in the operative supply record
- B. The discharge diagnosis from a prior unrelated hospitalization
- C. The documented lower-extremity vascular bypass procedure
- D. The patient's postoperative ambulation plan

Answer: C

Question: 5

A physician documents a 42-minute established patient pain-management visit. The note states that the time includes reviewing records, counseling the patient, adjusting medications, documenting the encounter, and calling the patient's pharmacy on the same date. The payer follows current office/outpatient E/M time rules. Which time-related coding principle is most appropriate?

- A. Count the entire clinic session because the provider was available to all patients
- B. Count supported total physician time on the date of the encounter when using time-based office/outpatient E/M selection
- C. Count time spent by the patient completing intake forms in the waiting room
- D. Count only face-to-face counseling time and exclude same-day documentation time in all cases

Answer: B

Question: 6

A provider documents chronic chest wall pain due to post-thoracotomy pain syndrome after prior lung surgery. The encounter is for intercostal nerve block planning. No acute surgical complication, infection, or recurrent malignancy is documented. Which coding approach is most appropriate?

- A. Report acute postoperative complication because the pain is related to a prior surgery
- B. Report only unspecified chest pain because the thoracotomy occurred in the past
- C. Report the documented post-thoracotomy pain condition with chest wall pain context as supported
- D. Report recurrent lung malignancy because thoracotomy is commonly performed for cancer

Answer: C

Question: 7

An anesthesia record documents anesthesia start at 11:18 and anesthesia end at 12:43. The anesthesia code has 5 base units. The payer uses exact 15-minute time-unit conversion. No physical status or qualifying circumstance units are separately allowed for this claim. Which total unit value is supported before applying the conversion factor?

- A. 85.00 total units
- B. 10.67 total units
- C. 10.50 total units
- D. 5.00 total units

Answer: B

Question: 8

A claim edit denies a fluoroscopy-guided spine injection because the practice reported a separate imaging guidance code. The CPT® descriptor for the injection code already includes imaging guidance. The procedure note documents only the injection and the guidance required to perform it. Which corrective action best reduces future denial risk?

- A. Remove the separately reported guidance code when the primary procedure code already includes imaging guidance
- B. Report the imaging guidance code twice to show that fluoroscopy was used throughout the procedure
- C. Add modifier 59 to the imaging guidance code for every spine injection claim
- D. Replace the injection code with the imaging guidance code because imaging was documented

Answer: A

Question: 9

A labor epidural is placed for planned vaginal delivery. After several hours, the patient requires an urgent cesarean delivery, and the anesthesia record documents that the existing epidural was dosed and used for surgical anesthesia during the cesarean section. No general anesthesia is documented. Which coding approach best reflects the anesthesia documentation?

- A. Report only a routine vaginal-delivery labor analgesia service because the epidural was originally placed for labor
- B. Report only an E/M service because the same epidural catheter was used for both phases of care
- C. Report a general anesthesia service because all cesarean deliveries require general anesthesia coding
- D. Select the obstetric anesthesia pathway that accounts for labor epidural service converted for cesarean delivery when supported by documentation

Answer: D

Question: 10

An operative report documents an open intraperitoneal lower abdominal procedure. The anesthesia record identifies general anesthesia for the abdominal surgery, and no special anesthesia code is documented outside the standard surgical crosswalk pathway. Which crosswalk approach is most appropriate?

- A. Select a pain-management injection code because the anesthesia practitioner managed perioperative pain
- B. Select the highest-base-unit anesthesia code available because the procedure was open
- C. Select the anesthesia code family based on the surgical procedure and anatomical region documented in the operative report
- D. Select an anesthesia code based only on the patient's postoperative diagnosis

Answer: C

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