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AAPC Certified Family Practice Coder



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Question: 1

During a family practice visit, a 15-year-old patient receives Tdap and meningococcal vaccines. The physician documents counseling for both vaccine components with the patient and parent present. The vaccine products, route, lot numbers, and administration are documented. Which coding issue is most important?

- A. Only one administration code may be reported because both vaccines were given at the same visit
- B. Vaccine product codes and appropriate administration codes should both be considered
- C. Vaccine administration should be reported with a therapeutic injection code
- D. Counseling means the visit must be coded only as preventive medicine

Answer: B

Question: 2

A physician performs a trigger point injection in the office and separately evaluates a new complaint of dizziness during the same encounter. The dizziness evaluation includes orthostatic vital signs, medication review, assessment, and a documented plan. The procedure note for the injection is also complete. Which modifier issue should the coder evaluate?

- A. Whether modifier 51 is required on the diagnosis code for dizziness
- B. Whether modifier 59 is required on the E/M service because dizziness is unrelated to the injection
- C. Whether the E/M service must be omitted because any procedure was performed
- D. Whether modifier 25 is supported on the E/M service because the dizziness evaluation is separately identifiable from the injection

Answer: D

Question: 3

A patient is seen after removing a tick from the thigh. The physician documents "tick bite of right thigh, initial encounter; no rash or signs of infection." The skin is cleaned, and prevention counseling is provided. No Lyme disease is diagnosed. Which diagnosis coding approach is most appropriate?

- A. Report Lyme disease because the patient had a tick bite
- B. Report only counseling because there is no rash or infection
- C. Report the superficial bite of the right thigh with appropriate encounter character and external cause details when required

D. Report cellulitis because all insect bites are infected wounds

Answer: C

Question: 4

A new patient presents with progressive shortness of breath on exertion and bilateral ankle swelling. The physician documents concern for new congestive heart failure, orders chest X-ray, BNP, metabolic panel, and ECG, starts a diuretic, and arranges cardiology follow-up. No total time is documented. Which E/M concept is most relevant?

- A. Preventive medicine coding is appropriate because cardiovascular risk was assessed
- B. The visit cannot be coded until cardiology confirms heart failure
- C. The lowest new patient level is required because the diagnosis is not confirmed yet
- D. MDM should reflect a potentially serious undiagnosed problem, multiple diagnostic tests, prescription management, and referral coordination

Answer: D

Question: 5

A family practice coder reviews a claim for a preventive medicine visit and a same-day problem-oriented E/M service with modifier 25. The preventive documentation is complete. The separate problem note documents new exertional shortness of breath, abnormal lung examination, chest X-ray order, prescription inhaler trial, and follow-up plan. Which audit conclusion is most appropriate?

- A. The separate E/M service may be supported because the respiratory evaluation is significant and separately identifiable from the preventive service
- B. The separate E/M must be denied because symptoms discovered during preventive visits are always included
- C. The preventive medicine service should be removed because a diagnostic problem was addressed
- D. Modifier 59 should replace modifier 25 because a chest X-ray was ordered

Answer: A

Question: 6

A coder audits a family practice note for an established patient visit. The physician selected a high-level E/M code, but the note includes only "meds refilled, stable, follow up in six months" with no diagnoses assessed, no medication risk discussion, no data reviewed, no time, and no treatment details. Which audit finding is most appropriate?

- A. The code should be increased because follow-up in six months shows long-term risk
- B. The high-level E/M code is supported because prescription refills always create high complexity
- C. The code is acceptable if the patient has many chronic conditions listed elsewhere in the chart
- D. The documented service does not support the high-level E/M code, and the record should be queried or corrected according to compliance policy

Answer: D

Question: 7

A 5-year-old established patient is seen for a kindergarten physical. The physician documents a comprehensive age-appropriate preventive history and examination, vision and hearing screening review, developmental assessment, anticipatory guidance, and completion of a school form. No abnormal findings or separate illness are documented. Which coding approach is best supported?

- A. Report a problem-oriented E/M service because vision and hearing screening were reviewed
- B. Report no service because school physicals are not medical encounters
- C. Report the age-appropriate preventive medicine service; form completion is part of the documented preventive encounter unless separately reportable by payer policy
- D. Report only an administrative form-completion service because the purpose was a school form

Answer: C

Question: 8

A 15-month-old child receives MMR and varicella vaccines during a well-child visit. The physician documents counseling with the parent, vaccine products, subcutaneous routes, lot numbers, consent, and administration sites. No separate illness is addressed. Which reporting concept is most important?

- A. Report one therapeutic injection code because both vaccines were given by injection
- B. Evaluate vaccine product and immunization administration coding for each documented vaccine service
- C. Report only the well-child preventive medicine service because vaccines are bundled into pediatric prevention
- D. Report a separate problem-oriented E/M service because vaccine counseling was documented

Answer: B

Question: 9

A family physician removes a 0.8 cm benign-appearing skin lesion from the patient's forearm using shave technique. The documentation states that the lesion was removed by sharp tangential shaving without full-thickness excision and without sutured closure. Which coding distinction is most important?

- A. Shave removal should be distinguished from excision based on technique and depth
- B. Excision should be coded because any lesion removal creates a surgical wound
- C. Destruction should be coded because the lesion was benign-appearing
- D. Simple repair should be coded separately because the lesion was removed from skin

Answer: A

Question: 10

A payer requests records for a claim reporting both a preventive medicine service and smoking cessation counseling. The preventive note includes routine anticipatory counseling, but the smoking cessation section separately documents the patient's tobacco use, readiness to quit, counseling strategies, pharmacotherapy options discussed, and 11 minutes of counseling. Which audit conclusion is most appropriate?

- A. Smoking cessation counseling is never separately reportable with a preventive visit
- B. Separate smoking cessation counseling may be supported when the required counseling content and time are documented
- C. The preventive medicine code should be deleted whenever smoking counseling is reported
- D. A separate problem-oriented E/M code is automatically supported by tobacco use

Answer: B

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