AAPC

CPC

Certified Professional Coder (CPC) Exam

Latest Version: 6.2

Question: 1

What is the correct CPT code assignment for the following scenario?
A 34-year-old female patient is seen in the operating room for partial distal gastrectomy with formation of an intestinal pouch. A vagotomy will also be performed in this session.

A. 43622, 43635
B. 43640, 43631-51
C. 43634, 43635
D. 43634, 43635-59

Answer: C

Explanation:
In the CPT index, look for Gastrectomy/Partial. Code 43634 is for the procedure with the specified intestinal pouch formation. Code 43635 is also needed for the vagotomy procedure, and since it is an add-on code, no modifier is needed. Code 43622 is for total gastrectomy, not partial; 43640 is for a separate vagotomy; and 43631 does not include the formation of the pouch.

Question: 2

What is the correct CPT code assignment for the following scenario?
A 68-year-old patient presents for a transurethral resection of the prostate (TURP) procedure due to recurrent bladder outlet obstruction, secondary to prostate enlargement. This patient underwent a prior TURP procedure 14 years ago, so regrowth of obstructive tissue is suspected.

A. 52500
B. 52601, 52630-51
C. 52630
D. 52601

Answer: C

Explanation:
In the CPT index, look for TURP. Only codes 52601 and 52630 are listed: code 52601 is for an initial procedure, so the correct single-code selection is 52630 for residual/regrowth of tissue. Code 52500 is for a transurethral resection, but of the bladder neck not the prostate.

Question: 3

Fractures can be specified as open or closed and as displaced or nondisplaced. In cases of fractures that lack these designations, the ICD- 10-CM codes should default to which of the following?

A. Open and displaced
B. Closed and displaced
C. Open and nondisplaced
D. Closed and nondisplaced

Answer: B

Explanation:
An undesignated fracture should be coded as closed and displaced in the absence of further documentation. ICD-10-CM Guideline I.C.19.c and Figure I.C.19.c give further instructions on proper coding and sequencing of traumatic fractures.

Question: 4

A new patient is seen at her residence for care. The encounter ran for I hour in total. A history was gathered, and an examination was performed. The patient has type 2 diabetes that she has managed long-term with diet and exercise. The patient is in good spirits today, and a low level of medical decision-making was required for this encounter. What CPT code should be used for this visit?

A. 99205
B. 99342
C. 99350
D. 99344

Answer: D

Explanation:
CPT guidelines on determining the level of evaluation and management services state that the greater of the two factors of time and medical decision-making (MDM) must be used for code selection. Code 99344 covers the 60 minutes for this encounter, which is the greater of the two factors in this case. Code 99205 represents the correct time level (60 minutes), but it is for a new patient seen in a clinic, not at home. Code 99342 is for the correct MDM level (low), but according to the CPT guidelines, we must code for 60 minutes in this case. Code 99350 is correct for MDM and for a patient seen at home, but it specifies an established patient.

Question: 5

A 46-year-old patient is seen at the chiropractic clinic after a fall from a motorcycle, complaining of sharp pain in his lower back. At the time of the accident, no fractures were observed on x-ray. Today, the chiropractor will manipulate the patient's lower spine in the lower lumbar region as well as S1 (i.e., the first vertebra of the sacral region). What is the correct CPT code assignment for this visit?

A. 98940×2

B. 98940
C. 98943
D. 98925

Answer: B

Explanation:
In the CPT Index, find Manipulation/Chiropractic. Of the code range given, 98940 describes the manipulation of one to two spinal regions, which is correct for lumbar and sacral manipulation. 98943 is for regions outside the spine, and 98925 is for an osteopathic treatment rather than a chiropractic one.

Question: 6

A patient visits urgent care with fractures to both thumbs after falling from a horse. According to the ICD-10-CM guidelines in Section I.B., how should the diagnoses of these injuries be reported?

A. S62.5XXX
B. S62.501A, S62.502A
C. S62.50XA-50
D. S62-LT, -RT

Answer: B

Explanation:
In the ICD-10-CM alphabetic index, look for Fracture, Traumatic/Thumb. Code S62.50 is given. Next, verify this code in the tabular list Since no further details are given, use codes S62.501A and S62.502A for the initial encounter, traumatic fracture of the right and left thumbs respectively. This follows the guidelines in section I.B.13 regarding laterality, and it codes the encounter to the highest specificity using seven characters.
Modifiers -50, -LT, and -RT are for use with CPT procedural codes, not ICD-IO-CM diagnosis codes.

Question: 7

A 22-year-old man will be receiving a right lung today after many months on the transplant list. The organ donor was pronounced dead on arrival at the hospital after a motorcycle accident and is confirmed as an organ donor. What is the correct CPT codeassignment and sequencing for the cadaver pneumonectomy, allograft backbench preparation, and insertion of the lung into the recipient under cardiopulmonary bypass? (Note that each of these procedures is to be performed by a different surgeon on the same surgical team.)

A. 32852-RT
B. 32850, 32851-51
C. 32852, 32850-RT, 32855
D. 32850, 32855, 32852

Answer: D

Explanation:
In the CPT index, first look up Donor Procedures/Lung Excision, followed by Transplantation/Lung. The correct codes and sequencing are 32850 for cadaver lung removal, 32855 for unilateral backbench preparation, and 32852 for single lung transplant under bypass. A modifier for multiple procedures (-51) is not needed since each surgeon performed a procedure in series with the others and will each bill their service separately.

Question: 8

Which of the following is true about billing for diagnostic thoracoscopy with a surgical thoracoscopy (i.e., video-assisted thoracoscopic surgery [VATS])?

A. Unbundling the diagnostic procedure from the VATS procedure may only be done if no anesthesia is used in either procedure.
B. Surgical thoracoscopy may be performed on a different day than the diagnostic thoracoscopy so that they can be billed as separate procedures.
C. VATS always includes diagnostic thoracoscopy.
D. Diagnostic thoracoscopy is a separate procedure and must be billed in addition to the VATS procedure.

Answer: C

Explanation:
Diagnostic thoracoscopy is bundled into the surgical VATS procedure. Per CPT guidelines, diagnostic thoracoscopy cannot be billed separately during the same surgical session. Purposefully separating the procedures into different days in order to bill them separately constitutes billing fraud and could potentially be investigated.

Question: 9

When an acute condition and a chronic condition are documented with separate codes, which of the following is correct based on ICD-IO-CM guidelines?

A. Report both codes in alphabetical order.
B. Report both codes in the sequence of oldest condition to newest condition.
C. Report both codes, with the acute code first.
D. Only code chronic conditions once, whether or not both acute and chronic codes are reported.

Answer: C

Explanation:
Both acute and chronic codes should be reported, with the acute condition being sequenced first. Alphabetical order and sequencing codes from oldest to newest are not part of the ICD-IO-CM

guidelines. Chronic conditions that are treated on an ongoing basis may be coded as many times as required for proper care of the patient within the care plan.

Question: 10

Diagnosis: mitral valve prolapse
A 33-year-old female patient is seen in the OR for insertion of a mitral valve ring due to prolapse of the mitral valve. The patient undergoes cardiopulmonary bypass for this procedure.
What is the correct CPT code assignment?

A. 33430
B. 33425, 33422
C. 33426
D. 33422, 33426-51

Answer: C

Explanation:
In the CPT index find Repair/Heart/Mitral Valve. Code 33426 for valvuloplasty is correct because it includes both the prosthetic ring and the bypass. Code 33430 is for a full mitral valve replacement, and this note specifies a repair with the prosthetic ring: 33425 is the correct procedure, but it does not include insertion of the prosthetic ring; and 33422 is for valvotomy, not valvuloplasty. Separate coding for the bypass is not needed here, since it is included in the stand- alone code 33426.

Question: 11

What is the correct code assignment for the excision of a 275 g uterus via a laparoscopic- assisted vaginal hysterectomy, bilateral salpingectomy, and oophorectomy?

A. 58554
B. 58553, 58661-50
C. 58544
D. 58544, 58661-50

Answer: A

Explanation:
Code 58554 is assigned from the Corpus Uteri, Laparoscopy/Hysteroscopy category in the Female Genital System chapter. Using the CPT index, this can be found in a few different ways:
Laparoscopy
Uterus
Hysterectomy
Vaginal: 58550, 58552-58554
or
Hysterectomy

Vaginal: 58260-58270, 58290-58294, 58550-58544
or
Hysterectomy
Vaginal
Removal of Tubes
Ovaries: 58562, 58263, 58291, 58292, 58552, 58554
The tabular section descriptions are then reviewed to assign the correct code.

Question: 12

Code assignment for medical conditions is usually based on documentation by the patient's provider. Which of the following conditions may be documented by a clinician other than the patient's provider?

A. Elevated blood pressure
B. Obesity
C. Laterality
D. Nonpressure ulcer

Answer: C

Explanation:
General Coding Guideline I.B.14 indicates that code assignment is based on the documentation by the patient's provider (i.e., the physician or other qualified health-care practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions when code assignment may be based on medical record documentation from clinicians who are not the patient's provider. In this context, the phrase "clinicians other than the patient's provider" refers to healthcare professionals permitted, based on regulatory or accreditation requirements or internal hospital policies, to document in a patient's official medical record. These exceptions include codes for the following:
• Body mass index
• Depth of non-pressure chronic ulcers
• Pressure ulcer stage
• Coma scale
• National Institutes of Health Stroke Scale
• Social determinants of health
• Laterality
• Blood alcohol level
• Under immunization status

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