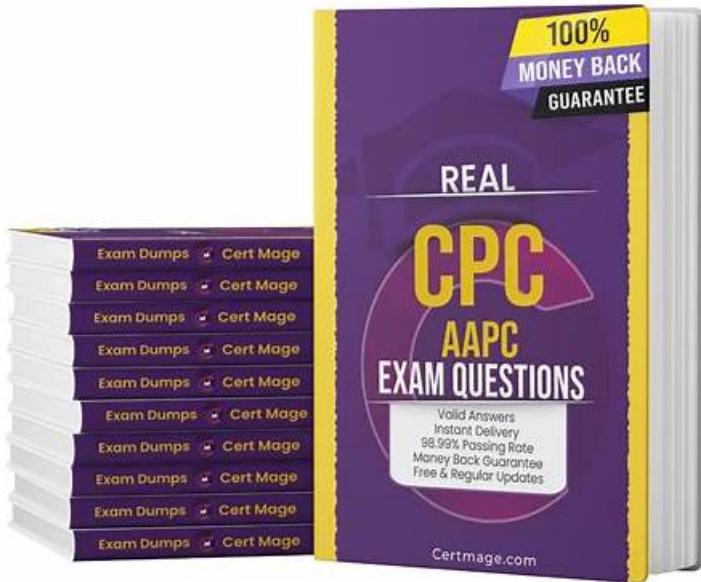


# CPC exam dumps and AAPC CPC exam Simulator



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## AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"><li>The Business of Medicine: This section of the exam measures the skills of medical coders and covers foundational knowledge regarding the healthcare system, reimbursement models, insurance payers, HIPAA compliance, and the ethical responsibilities coders hold within clinical and billing environments. It establishes the context in which coding decisions directly affect healthcare operations and financial outcomes.</li></ul>
Topic 2	<ul style="list-style-type: none"><li>Integumentary System: This section of the exam measures the skills of medical coders and covers procedures related to the skin and related structures. Topics include excisions, biopsies, repairs, and destruction services, focusing on accurate code selection and modifier usage for integumentary interventions.</li></ul>
Topic 3	<ul style="list-style-type: none"><li>Accurate ICD-10-CM Coding: This section of the exam measures the skills of medical coders and focuses on the precise assignment of diagnosis codes using the ICD-10-CM system. The goal is to ensure accurate representation of patient conditions, proper sequencing, and a clear linkage between diagnoses and services.</li></ul>

Topic 4	<ul style="list-style-type: none"> <li>• Anesthesia: This section of the exam measures the skills of medical coders and involves coding anesthesia services based on surgical site, complexity, and time. It tests the understanding of anesthesia modifiers and the importance of linking anesthesia codes with the correct primary procedures.</li> </ul>
Topic 5	<ul style="list-style-type: none"> <li>• Special Senses (Ocular and Auditory): This section of the exam measures the skills of coding specialists and covers the coding of procedures related to the eyes and ears. Topics include surgeries on the cornea, retina, and middle inner ear, as well as related diagnostic procedures.</li> </ul>
Topic 6	<ul style="list-style-type: none"> <li>• Pathology &amp; Laboratory: This section of the exam measures the skills of medical coders and includes lab tests, specimen analysis, and pathological examination procedures. It ensures that coders understand how to apply codes for chemistry panels, cultures, and histopathological diagnostics.</li> </ul>
Topic 7	<ul style="list-style-type: none"> <li>• Cardiovascular System: This section of the exam measures the skills of coding specialists and addresses services related to the heart, arteries, and veins. It involves the coding of diagnostic and therapeutic procedures, including catheterizations, bypasses, and repairs.:</li> </ul>
Topic 8	<ul style="list-style-type: none"> <li>• Digestive System: This section of the exam measures the skills of coding specialists and evaluates the coding of surgeries and procedures involving the oral cavity, pharynx, esophagus, stomach, intestines, liver, pancreas, and related organs. Understanding endoscopic procedures is particularly critical here.</li> </ul>
Topic 9	<ul style="list-style-type: none"> <li>• Endocrine System and Nervous System: This section of the exam measures the skills of medical coders and assesses the ability to assign codes for surgeries involving glands, the brain, spinal cord, and peripheral nerves. Procedures like resections and electrical stimulation are part of the evaluated content.</li> </ul>
Topic 10	<ul style="list-style-type: none"> <li>• Overview of ICD-10-CM: This section of the exam measures the skills of medical coders and introduces the structure, format, and usage of the ICD-10-CM coding system. It reviews the purpose of ICD-10-CM in diagnosis reporting and prepares candidates to interpret chapters, code ranges, and conventions embedded in the system.</li> </ul>
Topic 11	<ul style="list-style-type: none"> <li>• Review of Anatomy: This section of the exam measures the skills of coding specialists and covers a high-level understanding of human anatomy. It includes organs, systems, directional terminology, and anatomical locations, enabling coders to link procedures and diagnoses to the correct bodily structures with accuracy and consistency.</li> </ul>

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## AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q166-Q171):

### NEW QUESTION # 166

A 1-year-old is with his mom to have his scheduled vaccinations. The physician provides counseling for routine immunizations and carries out measles, mumps, rubella and varicella (MMRV) subcutaneously and dose 3 of Hepatitis B intramuscularly without difficulty.

What CPT codes are reported?

- A. 90471, 90472 x 4, 90707, 90746
- B. 90460, 90461, 90710, 90744
- **C. 90460 x 2, 90461 x 3, 90710, 90744**
- D. 90471, 90472, 90707, 90746

**Answer: C**

Explanation:

1. Procedure and CPT Code Selection:

The physician administered the MMRV (measles, mumps, rubella, and varicella) vaccine subcutaneously and dose 3 of Hepatitis B vaccine intramuscularly. The physician also provided counseling on routine immunizations.

CPT Code 90460 is used for immunization administration with counseling by the physician for patients 18 years or younger for the first or only component of each vaccine.

CPT Code 90461 is used for each additional component in a vaccine with counseling.

90710 is the code for the MMRV vaccine.

90744 is the code for the Hepatitis B vaccine (pediatric).

2. Application of 90460 and 90461:

For the MMRV vaccine (which has four components: measles, mumps, rubella, and varicella), 90460 is reported once for the first component, and 90461 is reported three times (once for each additional component).

For the Hepatitis B vaccine, 90460 is reported again since it is a separate vaccine with one component.

3. Rationale for Excluding Other Options:

Option A (90471, 90472 x 4, 90707, 90746) uses codes for vaccine administration without counseling and incorrect vaccine codes (90707 for MMR instead of MMRV and 90746 for adult Hepatitis B instead of pediatric).

Option B and Option D also contain incorrect vaccine codes and do not correctly apply the counseling administration codes.

4. AAPC and CPT Coding Guidelines:

According to AAPC guidelines, 90460 and 90461 are the appropriate administration codes for vaccines with counseling provided to pediatric patients, with each component of a multi-component vaccine coded separately.

Therefore, the correct answer is C. 90460 x 2, 90461 x 3, 90710, 90744.

**NEW QUESTION # 167**

A 55-year-old patient with suspected liver cancer was seen by the physician to obtain a biopsy. The special biopsy needle was placed using ultrasonic guidance. The physician obtained a small tissue sample from the liver, which was then sent to pathology. What CPT codes are reported?

- A. 47000, 77002-26
- B. 47000, 10005
- C. 47100, 77012-26
- D. 47000, 76942-26

**Answer: D**

Explanation:

\* Procedure: The physician performed a liver biopsy using ultrasonic guidance.

\* CPT Codes:

\* 47000: This code is for the liver biopsy.

\* 76942-26: This code is for ultrasonic guidance for needle placement, with modifier -26 indicating the professional component.

\* Code Selection Justification: The CPT code 47000 specifically captures the liver biopsy, and

76942-26 accurately represents the ultrasonic guidance utilized during the procedure.

References:

\* AMA CPT Professional Edition (current year)

\* ICD-10-CM (current year)

\* HCPCS Level II (current year)

**NEW QUESTION # 168**

A 4-year-old, critically ill child is admitted to the PICU from the ED with respiratory failure due to an exacerbation of asthma not manageable in the ER. The PICU provider takes over the care of the patient and starts continuous bronchodilator therapy and pharmacologic support with cardiovascular monitoring and possible mechanical ventilation support.

What is the E/M code for this encounter?

- A. 0
- B. 1
- C. 2
- D. 3

**Answer: A**

Explanation:

The code 99471 is used for initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill infant or young child. Given the scenario where a 4-year-old critically ill child is admitted to the PICU and requires intensive care management, this code is appropriate as it reflects the critical care provided beyond the emergency department services. References: CPT Professional Edition (current year), AMA.

**NEW QUESTION # 169**

A 42-year-old male is diagnosed with a left renal mass. An abdominal incision along with rib resection is made to expose and access the kidney. The left kidney is removed, along with surrounding fat, adrenal gland, lymph nodes in the area, and the incision site is sutured. What CPT code is reported for this procedure?

- A. 0
- **B. 1**
- C. 2
- D. 3

**Answer: B**

Explanation:

50230 - Radical nephrectomy, including removal of kidney, perirenal fat, adrenal gland, and regional lymph nodes Open approach with rib resection Correct for extensive removal beyond simple nephrectomy Why Other Options Are Incorrect:

50545 / 50543 - Laparoscopic/robotic approaches

50220 - Simple nephrectomy only

**NEW QUESTION # 170**

The evisceration of ocular contents was performed using a surgical microscope for enhanced visualization.

The procedure was performed on the left eye and an implant was not placed in the ocular cavity.

What CPT coding is reported?

- A. 65093-LT
- **B. 65091-LT**
- C. 65091-LT, 69990-51
- D. 65093-LT, 69990

**Answer: B**

Explanation:

1. Procedure and CPT Code Selection:

The procedure performed was an evisceration of ocular contents without the placement of an implant. The surgical microscope was used for enhanced visualization, but this does not require a separate code if the primary procedure code includes it inherently.

CPT Code 65091 is used for an evisceration of the ocular contents without implant placement. This code correctly describes the procedure performed on the left eye.

2. Modifier:

Modifier LT is added to indicate that the procedure was performed on the left eye.

3. Exclusion of Code 69990:

Code 69990 is for the use of an operating microscope, but it should not be billed separately when it is used as part of a procedure where enhanced visualization is typical or expected, such as an evisceration procedure.

According to CPT guidelines, 69990 is not separately reported when the microscope is used for visualization in procedures where its use is considered part of the standard of care.

4. Rationale for Excluding Other Options:

Code 65093 is for an evisceration with implant placement, which does not apply since no implant was used.

Options B and C incorrectly include 69990, which is not separately reportable in this scenario.

5. AAPC and CPT Coding Guidelines:

According to AAPC and CPT coding guidelines, 65091 is sufficient to capture the procedure without the need to add code 69990 for the microscope.

Therefore, the correct answer is D. 65091-LT.

## NEW QUESTION # 171

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