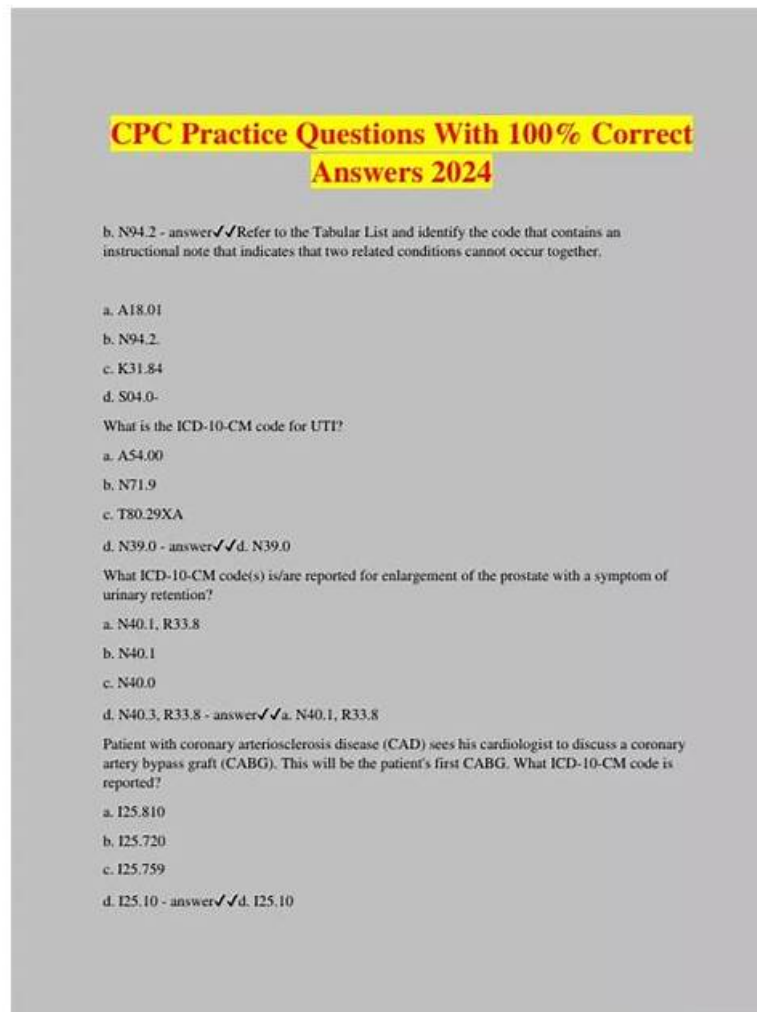


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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> • 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.
Topic 2	<ul style="list-style-type: none"> • 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.
Topic 3	<ul style="list-style-type: none"> • 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.
Topic 4	<ul style="list-style-type: none"> • 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.
Topic 5	<ul style="list-style-type: none"> • 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.
Topic 6	<ul style="list-style-type: none"> • Evaluation & Management Services: This section of the exam measures the skills of coding specialists and covers office visits, hospital care, consultations, and other E • M services. It tests the understanding of time-based coding, medical decision-making, and history • exam components per current CMS guidelines.
Topic 7	<ul style="list-style-type: none"> • Hemic & Lymphatic Systems, Mediastinum, Diaphragm: This section of the exam measures the skills of medical coders and includes procedures related to the spleen, lymph nodes, bone marrow, as well as surgical interventions in the mediastinum and diaphragm. Coders must differentiate procedures by region and system accurately.
Topic 8	<ul style="list-style-type: none"> • Radiology: This section of the exam measures the skills of coding specialists and focuses on diagnostic imaging procedures including X-rays, CT scans, MRIs, ultrasounds, and nuclear medicine. It emphasizes proper selection of codes based on anatomical site and modality used.
Topic 9	<ul style="list-style-type: none"> • Female Reproductive System and Maternity Care & Delivery: This section of the exam measures the skills of coding specialists and evaluates coding accuracy for gynecological and obstetric procedures. It includes deliveries, antepartum care, cesarean sections, and surgical procedures involving female reproductive anatomy.
Topic 10	<ul style="list-style-type: none"> • 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.:

Topic 11	<ul style="list-style-type: none"> • 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.
Topic 12	<ul style="list-style-type: none"> • Introduction to CPT®, HCPCS Level II, and Modifiers: This section of the exam measures the skills of coding specialists and introduces candidates to CPT® coding for procedures, HCPCS Level II for supplies and services, and the correct use of modifiers. It helps learners distinguish between different code sets and understand their place in medical billing.
Topic 13	<ul style="list-style-type: none"> • Urinary System and Male Genital System: This section of the exam measures the skills of medical coders and assesses understanding of procedures on kidneys, bladder, ureters, prostate, and male reproductive organs. Proper use of CPT codes for surgical and diagnostic interventions is tested.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q443-Q448):

NEW QUESTION # 443

The patient came in with an inflamed seborrheic keratosis on her nose for a shave removal. After applying local anesthesia, a 0.7 cm dermal lesion was removed using an 11 blade.

What CPT and ICD-10-CM codes are reported?

- A. 11306, L82.1
- B. 11401, L82.1
- **C. 11311, L82.0**
- D. 11421, L82.0

Answer: C

Explanation:

Shave removal → CPT 11300-11313, not excision (11400-11646).

Face (nose) → 11310-11313

0.6-1.0 cm → 11311

Inflamed seborrheic keratosis → L82.0

NEW QUESTION # 444

Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1

Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.

Operation performed: Excision of right thigh benign congenital >1 nevus, excision size with margins 4.5 cm and closure size 5 cm.

Anesthesia: General.0

Intraoperative antibiotics: Ancef.0

Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks involved, which included but were not limited to risks of general anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.

Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient's right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.

This was passed to pathology for review. The wound required # limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.

The patient was then cleaned and turned over to anesthesia for S extubation.

She was extubated successfully in the operating room and taken S to the recovery room in stable condition.

There were no complications.
What E/M coding is reported?

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

Answer: C

Explanation:
Emergency department visit with high severity
99285 = High complexity ED E/M

NEW QUESTION # 445

A 65-year-old man had a right axillary block by the anesthesiologist. When the arm was totally numb, the arm was prepped and draped, and the surgeon performed tendon repairs of the right first, second, and third fingers. The anesthesiologist monitored the patient throughout the case. What anesthesia code is reported?

- A. 01840
- B. 01810
- C. 01830
- D. 01820

Answer: C

Explanation:
* The anesthesia code for an axillary block for procedures on the upper arm and elbow, which includes the monitoring by the anesthesiologist throughout the procedure, is 01830. This code is appropriate for anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of the shoulder and axilla.
References:
* CPT Professional Edition, AMA
* Anesthesia Coding Guidelines

NEW QUESTION # 446

A physician conducts a 15-minute phone call discussing medication management. How is this reported?

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

Answer: D

Explanation:
98012 = Telephone E/M, 11-20 minutes
99447 is for interprofessional consults, not patient calls
HCPCS LEVEL II

NEW QUESTION # 447

A patient underwent a cystourethroscopy with a pyeloscopy using lithotripsy to break up the ureteral calculus. An indwelling stent was also inserted during the same operative session on the same side. This service was performed in the outpatient hospital surgery center. What CPT coding reported?

- A. 52353, 52332-51

- B. 52325, 52332-51
- **C. 0**
- D. 52352, 52332-51

Answer: C

Explanation:

- * Cystourethroscopy: This is a procedure that involves the use of a cystoscope to look inside the urethra and bladder.
- * Pyeloscopy: Involves the examination of the upper urinary tract, typically done through the cystoscope.
- * Lithotripsy: A procedure that uses shock waves or a laser to break up stones in the kidney, bladder, or ureter.
- * Indwelling stent insertion: A procedure to place a stent in the ureter to help urine flow from the kidney to the bladder.
- * 52356: Cystourethroscopy with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization and/or ureteral stent placement).

The code 52356 includes all components mentioned: cystourethroscopy, pyeloscopy, lithotripsy, and stent insertion performed in the same operative session.

References:

- * AMA's CPT Professional Edition (current year)
- * ICD-10-CM (current year), HCPCS Level II (current year)

NEW QUESTION # 448

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