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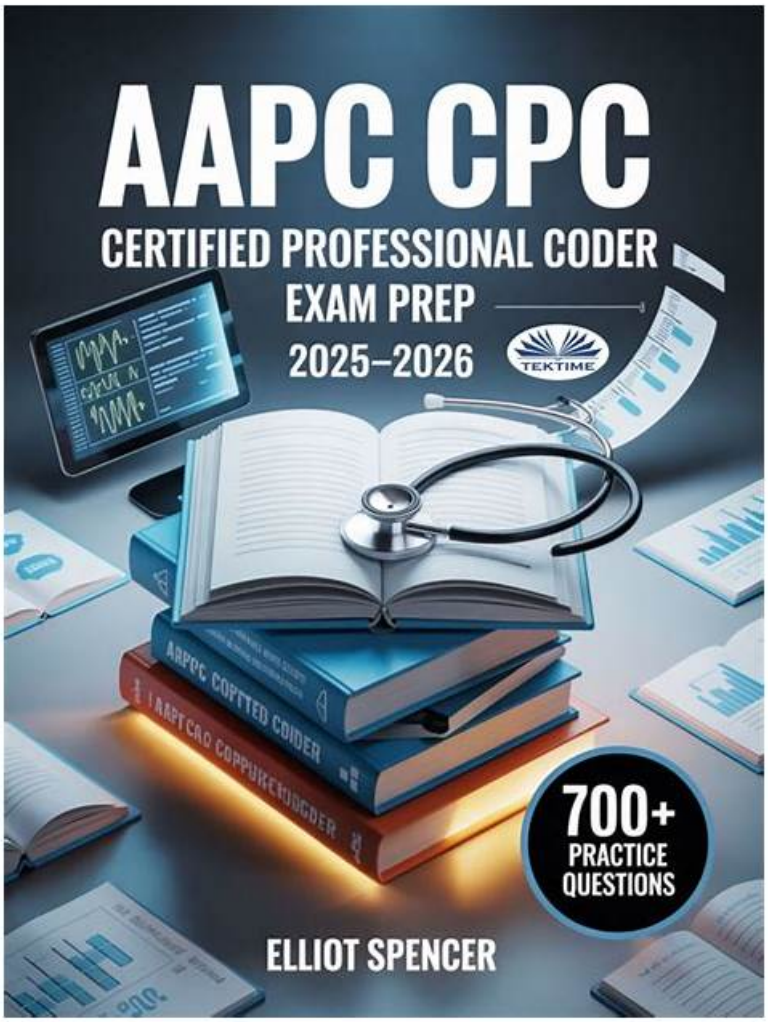

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• 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.
Topic 2	• 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 3	• 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 4	• 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 5	• 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 6	• 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 7	• 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.
Topic 8	• 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 9	• 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 10	• 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 11	• 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q374-Q379):

NEW QUESTION # 374
A catheter was placed into the abdominal aorta via the right common femoral artery access. An abdominal aortography was performed. The right and left renal artery were adequately visualized. The catheter was used to selectively catheterize the right and left renal artery. Selective right and left renal angiography were then performed, demonstrating a widely patent right and left renal artery.
What CPT coding is reported?

- A. 36252, 75625-26
- B. 0
- C. 1
- D. 36253, 75625-26

Answer: A

Explanation:
CPT code 36252 describes selective catheter placement of the main renal artery with angiography of both kidneys, which matches the procedure of selectively catheterizing the right and left renal arteries and performing angiography. Additionally, CPT code 75625-26 is for an abdominal aortography with interpretation and report. The -26 modifier indicates that the professional component of the service was performed.
Reference:
AMA's CPT Professional Edition (current year), Codes 36252, 75625-26

NEW QUESTION # 375
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. 47100, 77012-26
- B. 47000, 10005
- C. 47000, 77002-26
- 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 # 376
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. 52352, 52332-51
- C. 0
- D. 52325, 52332-51

Answer: C

NEW QUESTION # 377
View MR 001394
MR 001394
Operative Report
Procedure: Excision of 11 cm back lesion with rotation flap repair.
Preoperative Diagnosis: Basal cell carcinoma
Postoperative Diagnosis: Same
Anesthesia: 1% Xylocaine solution with epinephrine warmed and buffered and injected slowly through a 30-gauge needle for the patient's comfort.
Location: Back
Size of Excision: 11 cm
Estimated Blood Loss: Minimal
Complications: None
Specimen: Sent to the lab in saline for frozen section margin control.
Procedure: The patient was taken to our surgical suite, placed in a comfortable position, prepped and draped, and locally anesthetized in the usual sterile fashion. A #15 scalpel blade was used to excise the basal cell carcinoma plus a margin of normal skin in a circular fashion in the natural relaxed skin tension lines as much as possible The lesion was removed full thickness including epidermis, dermis, and partial thickness subcutaneous tissues. The wound was then spot electro desiccated for hemorrhage control. The specimen was sent to the lab on saline for frozen section.
Rotation flap repair of defect created by foil thickness frozen section excision of basal cell carcinoma of the back. We were able to devise a 12 sq cm flap and advance it using rotation flap closure technique. This will prevent infection, dehiscence, and help reconstruct the area to approximate the situation as it was prior to surgical excision diminishing the risk of significant pain and distortion of the anatomy in the area. This was advanced medially to close the defect with 5 0 Vicryl and 6-0 Prolene stitches.
What CPT coding is reported for this case?

- A. 0
- B. 14001, 11606-51, 12034-51
- C. 1
- D. 14001, 11606-51

Answer: D

Explanation:
For the excision of an 11 cm lesion with a rotation flap repair, the appropriate CPT codes are 14001 for the adjacent tissue transfer or rearrangement (12 sq cm flap) and 11606-51 for the excision of a malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter over 4.0 cm. Modifier 51 indicates multiple procedures. The detailed operative report specifies the lesion size and the technique used, justifying these codes.

NEW QUESTION # 378
When a provider's documentation refers to use, abuse, and dependence of the same substance (e.g. alcohol), which statement is correct?

- A. If both use and abuse are documented, assign abuse as the first code and use as the additional code.
- B. If both abuse and dependence are documented, assign only the code for abuse.
- C. If both use and dependence are documented, assign only the code for dependence.
- D. If use, abuse, and dependence are documented, report all three codes separately.

Answer: C

Explanation:
According to ICD-10-CM coding guidelines for substance use, abuse, and dependence, when multiple levels (use, abuse, and dependence) of the same substance are documented, only the highest level of severity is coded. The hierarchy is as follows: dependence > abuse > use.
D: If both use and dependence are documented, assign only the code for dependence is correct, as dependence represents the highest severity level and supersedes both use and abuse.
A: is incorrect because if both use and abuse are documented without dependence, only abuse would be coded as it is of a higher severity than use.
B: is incorrect because all three codes (use, abuse, dependence) should not be reported together; only the highest level should be coded.

C: is incorrect because if both abuse and dependence are documented, only dependence (the higher severity level) should be coded, not abuse.
Therefore, the correct answer is D. If both use and dependence are documented, assign only the code for dependence.

NEW QUESTION # 379
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