

Latest Updated AAPC Simulated CPC Test - CPC Certified Professional Coder (CPC) Exam



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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<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 2	<ul style="list-style-type: none">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 3	<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 4	<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 5	<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.
Topic 6	<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 7	<ul style="list-style-type: none"> • Pathology & 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.
Topic 8	<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 9	<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 10	<ul style="list-style-type: none"> • Respiratory System: This section of the exam measures the skills of medical coders and evaluates the ability to code procedures involving the nose, sinuses, larynx, trachea, bronchi, and lungs. Attention is given to services like endoscopies, excisions, and resections within the respiratory tract.
Topic 11	<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 12	<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 13	<ul style="list-style-type: none"> • Musculoskeletal System: This section of the exam measures the skills of coding specialists and focuses on coding procedures involving bones, joints, muscles, and tendons. It covers surgeries, reductions, arthroscopies, and fracture treatments, emphasizing accurate mapping of procedures to anatomical areas.
Topic 14	<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 15	<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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q138-Q143):

NEW QUESTION # 138

A patient with three thyroid nodules is seen for an FNA biopsy. Using ultrasonic guidance, the provider inserts a 25-gauge needle into each nodule. Nodular tissue is aspirated and sent to pathology.

What CPT coding reported?

- A. 10005, 10006 x 2
- B. 10021, 10004 x 2, 76942
- C. 10006 x 3
- D. 10005, 10006 x 2, 76942

Answer: A

Explanation:

The CPT code 10005 is for fine needle aspiration biopsy, including ultrasound guidance, for the first lesion. CPT code 10006 is for each additional lesion with ultrasound guidance. Since the provider aspirated tissue from three nodules, the coding should be 10005 for the first nodule and 10006 x 2 for the additional two nodules.

AMA's CPT Professional Edition (current year)

NEW QUESTION # 139

A patient who has colon adenocarcinoma undergoes a laparoscopic partial colectomy. The surgeon removes the proximal colon and terminal ileum and reconnects the cut ends of the distal ileum and remaining colon.

What procedure and diagnosis codes are reported?

- A. 44160, C18.2
- B. 44204, C18.2
- C. 44205, C18.9
- D. 44140, C18.9

Answer: C

NEW QUESTION # 140

According to the Application of Cast and Strapping CPT guidelines, what is reported when an orthopedic provider performs initial fracture care treatment for a closed scaphoid fracture of the wrist, applies a short arm cast, and the patient will be returning for subsequent fracture care?

- A. 25622, 29075
- B. 29075-22
- C. 0
- D. 1

Answer: D

Explanation:

For initial fracture care of a closed scaphoid fracture, code 25622 is used, which includes treatment and initial casting. The application of the cast is part of the fracture care and is not reported separately. CPT guidelines specify that casting or strapping performed as part of the fracture care is included in the fracture care code.

References: AMA's CPT Professional Edition (current year), Surgery section, Musculoskeletal System

NEW QUESTION # 141

A 25-year-old woman underwent percutaneous breast biopsy on the right breast with placement of a Gelmark clip. The procedure was performed using stereotactic imaging. What CPT codes will be reported?

- A. 19081, 19283
- B. 19100, 76098
- **C. 0**
- D. 19101, 19283

Answer: C

Explanation:

CPT code 19081 is used for percutaneous biopsy of breast(s) using stereotactic guidance, which includes the placement of a localization device and imaging of the biopsy specimen when performed. This accurately describes the procedure performed on the right breast with the placement of a Gelmark clip using stereotactic imaging. The other codes either describe open biopsies or separate procedures that are not applicable here.

AMA's CPT Professional Edition (current year)

NEW QUESTION # 142

A patient presents with fever, cough, SOB, and a recent history of COVID-19. A PCR test was positive for COVID-19. The provider documents a final diagnosis of "pneumonia with history of COVID-19." What ICD-10-CM coding is reported?

- A. J18.9, U09.9
- **B. J18.9, Z86.16**
- C. U07.1, J22
- D. U07.1, J20.9

Answer: B

Explanation:

The provider documents history of COVID-19, not active COVID-19.

Z86.16 = Personal history of COVID-19

J18.9 = Pneumonia, unspecified organism

Codes U07.1 and U09.9 are for current or post-COVID conditions, which are not documented here. Therefore, A is correct.

NEW QUESTION # 143

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