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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> Applying the ICD-10-CM Guidelines: This section of the exam measures the skills of coding specialists and covers how to apply official ICD-10-CM guidelines to real-world coding scenarios. It emphasizes the hierarchy of instructional notes, general and chapter-specific rules, and how to make judgment calls within compliant coding frameworks.
Topic 2	<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 3	<ul style="list-style-type: none"> • 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.
Topic 4	<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 5	<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 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"> • 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 8	<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 9	<ul style="list-style-type: none"> • 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 10	<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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q290-Q295):

NEW QUESTION # 290

A 42-year-old with chronic left trochanteric bursitis is scheduled to receive an injection at the Pain Clinic. A 22-gauge spinal needle is introduced into the trochanteric bursa under ultrasonic guidance, and a total volume of 8 cc of normal saline and 40 mg of Kenalog was injected.

What CPT code should be reported for the surgical procedure?

- A. 20610-LT, 76942
- B. 20611-LT, 76942

- C. 20611-LT
- D. 20610-LT

Answer: C

Explanation:

The injection into the trochanteric bursa under ultrasonic guidance is coded with CPT 20611, which describes an injection of a major joint or bursa with ultrasound guidance. The modifier -LT indicates the procedure was performed on the left side.

References:

* AMA's CPT Professional Edition (current year), Code 20611

NEW QUESTION # 291

(A 6-month-old child was brought to the hospital with severe breathing difficulties. After testing, the child was diagnosed with tracheal stenosis present from birth. The pediatric surgeon performed a tracheoplasty (surgical widening of the trachea). What CPT and ICD-10-CM codes are reported?)

- A. 00320, 99100, Q32.1
- B. 00326, Q32.1
- C. 00320, J39.8
- D. 00326, 99100, J39.8

Answer: A

Explanation:

The diagnosis "tracheal stenosis present from birth" is a congenital malformation, which is coded with Q32.1 (congenital stenosis of trachea) rather than an acquired tracheal disorder code. For anesthesia coding, tracheoplasty is a major airway/tracheal surgical procedure and maps to the appropriate airway/trachea anesthesia category represented by 00320 in the answer set. Because the patient is an infant (6 months old), anesthesia qualifies for the extreme age add-on 99100 (anesthesia for patient of extreme age, under 1 year or over 70 years). Options including J39.8 reflect an acquired/other tracheal disorder category rather than congenital stenosis, which conflicts with "from birth." Options that omit 99100 miss the age-related qualifying circumstance. CPC exam strategy: always code congenital conditions with Q-codes when documented as present from birth, and remember 99100 for patients <1 year when anesthesia qualifying circumstances are reported. Therefore, 00320, 99100, Q32.1 is correct.

NEW QUESTION # 292

Patient had polyps removed on a previous colonoscopy. The patient returns three months later for a follow-up examination for another colonoscopy. No new polyps are seen.

What diagnosis coding is reported for the second colonoscopy?

- A. Z09, Z86.010
- B. Z09, K63.5
- C. Z86.010, K63.5
- D. K63.5

Answer: A

Explanation:

For a follow-up examination after the removal of polyps with no new polyps found, the appropriate diagnosis codes are:

Z09: Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z86.010: Personal history of colonic polyps.

Using Z09 indicates that the follow-up exam is to check the patient after treatment, and Z86.010 indicates a history of colonic polyps, which is relevant to the patient's medical history.

ICD-10-CM guidelines

AMA's CPT Professional Edition (current year)

NEW QUESTION # 293

A 45-year-old patient comes in with chronic sinusitis that has not responded to medication. The physician decides to use a sinus stent implant to help alleviate the patient's symptoms.

The physician inserts the implant into the ethmoid sinus using a delivery system. This implant is designed to keep the surgical opening

clear, prop open the sinus, and gradually release a corticosteroid with anti-inflammatory properties directly to the sinus lining. The implant is not permanent and will dissolve over time.

What HCPCS Level II code is reported?

- A. C2617
- B. C9600
- C. C1877
- D. S1091

Answer: A

Explanation:

C2617 - Sinus implant, drug-eluting

Described implant:

Ethmoid sinus

Drug-eluting (corticosteroid)

Absorbable

Why others are incorrect:

C1877 - Vascular stent

S1091 - Temporary code

C9600 - Coronary intervention

NEW QUESTION # 294

A 30-year-old patient with a scalp defect is having plastic surgery to insert tissue expanders. The provider inserts the implants, closes the skin, and increases the volume of the expanders by injecting saline solution.

Tissue is expanded until a satisfactory aesthetic outcome is obtained to repair the scalp defect.

What CPT code is reported?

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

Answer: C

Explanation:

The CPT code 11960 is used for the insertion of tissue expanders for other than breast, which includes the scalp in this case. The procedure involves inserting the tissue expanders, closing the skin, and gradually increasing the volume of the expanders until a satisfactory outcome is achieved for repairing the scalp defect.

The other options do not accurately describe the procedure performed on the scalp. References: AMA's CPT Professional Edition (current year)

NEW QUESTION # 295

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