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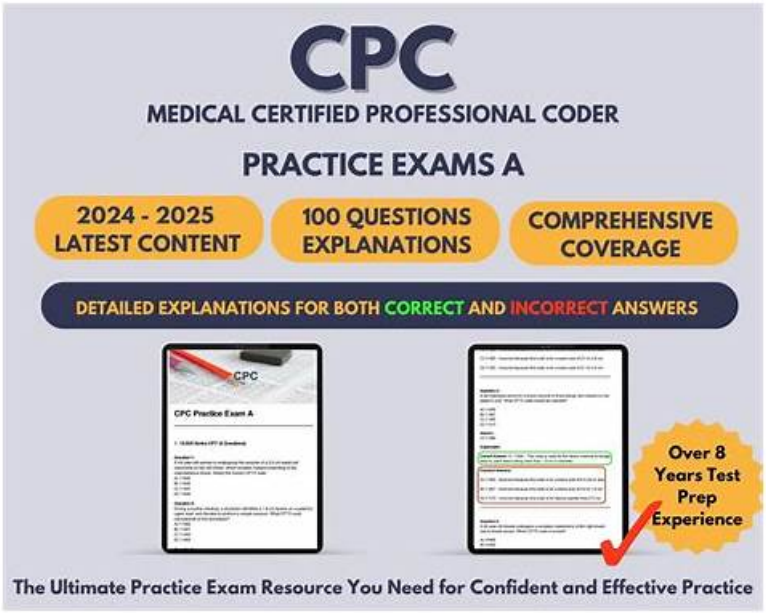

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• 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	• 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 4	• 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	• 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 6	• 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 7	• 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 8	• 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 9	• 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	• 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 11	• 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 12	• 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	• 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 14	• 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 15	• 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 16	• 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 17	• 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 18	• 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.

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

NEW QUESTION # 290
The patient has a ruptured aneurysm in the popliteal artery. The provider makes an incision below the knee and dissects down and around the popliteal artery. After clamping the distal and proximal ends of the artery, the provider cuts out the defect, sutures the remaining ends of the artery together, and places a patch graft to fill the gap. What is the correct CPTcode for the aneurysm repair?

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

Answer: B

Explanation:
1. Procedure and CPTCode Selection:
The patient underwent a repair of a ruptured aneurysm in the popliteal artery, involving incision, dissection, clamping, removal of the aneurysmal section, and patch grafting.
Code 35151 is the correct CPTcode for the repair of an aneurysm in the popliteal artery, as it specifically describes aneurysm repair in this location.
Code 35081 applies to aneurysm repair in the abdominal aorta, which does not pertain to the popliteal artery location.
Code 35152 is for an aneurysm repair involving the popliteal artery with vein graft, but there is no mention of a vein graft in this scenario, only a patch graft.
Code 35045 is used for repair of an aneurysm in the brachial artery and does not apply to the popliteal artery.
2. AAPC and CPTCoding Guidelines:
According to AAPC guidelines, CPTcodes for aneurysm repair should be chosen based on the specific artery involved. Code 35151 is precisely for popliteal artery aneurysm repair without a vein graft, making it the most accurate choice.
Thus, based on CPTguidelines and procedural details, the verified answer is B. 35151.

NEW QUESTION # 291
Which statement regarding lesion excision is TRUE?

- A. Lesion excision codes include removal of a lesion, with margins, and intermediate closure when performed
- B. Lesion excision codes include removal of a lesion, with margins, and simple (nonlayered) closure when performed
- C. Lesion excision codes include removal of a lesion with margins, and complex closure when performed
- D. Lesion excision codes are selected by measuring the greatest clinical diameter of a lesion excluding the margins required to complete the excision

Answer: B

NEW QUESTION # 292
Mr. Roland has difficulty breathing and congestion with a productive cough. The physician takes frontal and lateral view chest X-

rays in the office (the equipment is owned by the physician group). The physician reads the X-rays and determines a diagnosis of walking pneumonia. The physician's interpretation is placed in the patient's chart.
How does the physician bill for the chest X-ray?

- A. 71046-26
- B. 71046-TC
- C. 71046-26-TC
- D. 0

Answer: D

Explanation:
For a physician who owns the equipment and interprets the chest X-rays (both frontal and lateral views), code 71046 is used. This code includes both the technical and professional components, as the equipment is owned by the physician group and the physician also provides the interpretation.
References:
* AMA's CPT Professional Edition (current year)
* ICD-10-CM (current year)

NEW QUESTION # 293
View MR 005398
MR 005398
Operative Report
Preoperative Diagnosis: Nonfunctioning right kidney with ureteral stricture.
Postoperative Diagnosis: Nonfunctioning right kidney with ureteral stricture.
Procedure: Right nephrectomy with partial ureterectomy.
Findings and Procedure: Under satisfactory general anesthesia, the patient was placed in the right flank position. Right flank and abdomen were prepared and draped out of the sterile field. Skin incision was made between the 11th and 12th ribs laterally. The incision was carried down through the underlying subcutaneous tissues, muscles, and fascia. The right retroperitoneal space was entered. Using blunt and sharp dissection, the right kidney was freed circumferentially. The right artery, vein, and ureter were identified. The ureter was dissected downward where it is completely obstructed in its distal extent. The ureter was clipped and divided distally. The right renal artery was then isolated and divided between 0 silk suture ligatures. The right renal vein was also ligated with suture ligatures and 0 silk ties. The right kidney and ureter were then submitted for pathologic evaluation. The operative field was inspected, and there was no residual bleeding noted, and then it was carefully irrigated with sterile water. Wound closure was then undertaken using 0 Vicryl for the fascial layers, 0 Vicryl for the muscular layers, 2-0 chromic for subcutaneous tissue, and clips for the skin. A Penrose drain was brought out through the dependent aspect of the incision. The patient lost minimal blood and tolerated the procedure well.
What CPT coding is reported for this case?

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

Answer: D

NEW QUESTION # 294
Patient has a 5 cm tumor in the left lower quadrant abdominal wall. A horizontal skin incision is made directly over the tumor in the patient's left lower quadrant and dissection was carried down through the dermis and subcutaneous tissue. The tumor is located and completely excised using electrocautery. The specimen is sent immediately to pathology to rule out cancer. What CPT and ICD-10-CM codes are reported?

- A. 22901, D49.2
- B. 22901, C76.2
- C. 22903, D49.2
- D. 22903, R19.04

Answer: C

Explanation:
1. Procedure and CPT Code Selection:
The scenario describes the excision of a 5 cm tumor located in the left lower quadrant of the abdominal wall. The tumor was excised down to the dermis and subcutaneous layers and removed using electrocautery.
Code 22903 is appropriate for the excision of a soft tissue tumor in the abdominal wall greater than 5 cm, making it the correct CPT code.
Code 22901 applies to the excision of a soft tissue tumor in the abdominal wall but only for tumors 5 cm or less. Given that the tumor in this case is exactly 5 cm, it meets the threshold for 22903, which is more appropriate here.
2. Diagnosis and ICD-10-CM Code Selection:
ICD-10-CM Code D49.2 is used for a neoplasm of unspecified behavior in the abdominal area, reflecting the fact that the pathology report is pending to determine if the tumor is malignant.
Code C76.2 would be incorrect because it is for malignant neoplasms of unspecified abdominal areas, which we cannot confirm based on the initial excision. Similarly, R19.04 (indicating a mass in the abdominal region) is a symptom code and is not appropriate for a definitive diagnosis when a neoplasm code (D49.2) exists.
3. AAPC and CPT Coding Guidelines:
Per AAPC coding guidelines, the size of the tumor is critical in selecting the correct excision code for abdominal wall neoplasms. Additionally, if the tumor's pathology is not confirmed as malignant, it is coded as a neoplasm of unspecified behavior until further details are known.
Therefore, based on CPT and ICD-10-CM coding guidelines, the verified answer is B. 22903, D49.2.

NEW QUESTION # 295
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