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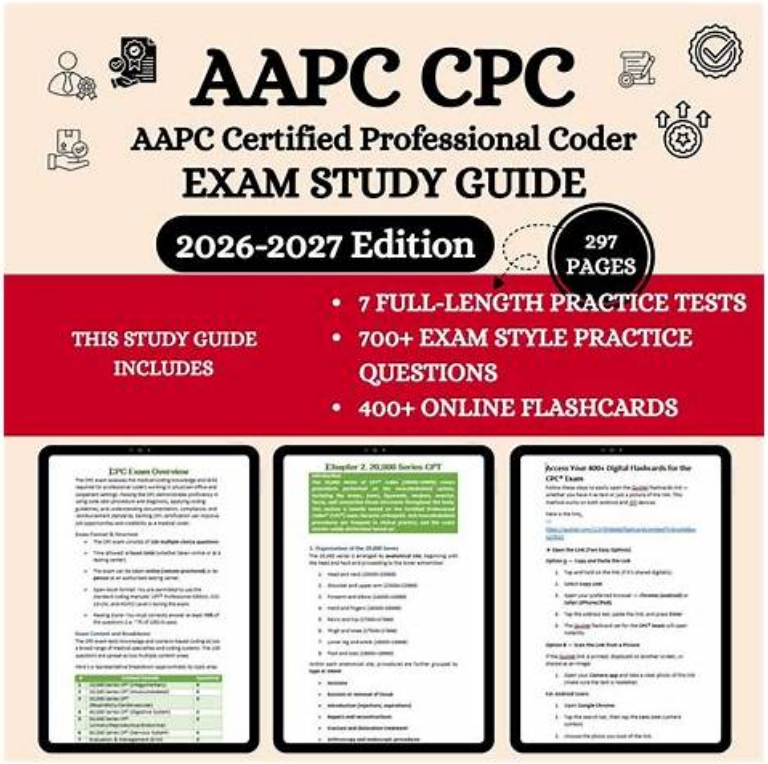


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## AAPC CPC Exam Syllabus Topics:

| Topic | Details |
|---|---|
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|---|---|
| Topic 1 | • 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 2 | • 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 3 | • 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 4 | • 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 5 | • 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 6 | • 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 7 | • 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 | • 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 9 | • 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 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. |

## AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q274-Q279):

**NEW QUESTION # 274**
A 65-year-old gentleman presents for refill of medications and follow-up for his chronic conditions. The patient indicates good medicine compliance. No new symptoms or complaints.
Appropriate history and exam are obtained. Labs that were ordered from previous visit were reviewed and discussed with patient. The following are the diagnoses and treatment:

Hypokalemia - stable. Refill Potassium 20 MEQ
Hypertension - blood pressure remaining stable. Patient states home readings have been in line with goals. Refill prescription Lisinopril.
Esophageal Reflux - Patient denies any new symptoms. Stable condition. Continue taking over the counter Prevacid oral capsules, 1 every day.
Patient is instructed to follow up in 3 months. Labs will be obtained prior to visit.
What CPT code is reported?

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

**Answer: C**

**NEW QUESTION # 275**
The surgeon performs Roux-en-Y anastomosis of the extrahepatic biliary duct to the gastrointestinal tract on a 45-year-old patient.
What CPT code is reported?

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

**Answer: C**

Explanation:
The Roux-en-Y anastomosis of the extrahepatic biliary duct to the gastrointestinal tract is a specific surgical procedure that involves connecting the biliary duct to the gastrointestinal tract.
Procedure Description: Roux-en-Y anastomosis of the extrahepatic biliary duct involves creating a direct connection between the biliary duct and the gastrointestinal tract.
Procedure Specificity: The procedure is complex and involves extensive surgical technique and anastomosis.
Coding Decision:
CPT 47780 specifically describes the Roux-en-Y anastomosis of the extrahepatic biliary duct to the gastrointestinal tract.
AMA's CPT Professional Edition (current year).
CPT Assistant for detailed coding guidelines on biliary and gastrointestinal procedures.

**NEW QUESTION # 276**
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: C**

Explanation:
The procedure involves a right nephrectomy with partial ureterectomy for a nonfunctioning right kidney with ureteral stricture.
* Procedure Description:
* Right nephrectomy (removal of the kidney).
* Partial ureterectomy (removal of part of the ureter).
* CPT Coding:
* 50220: Nephrectomy, including partial ureterectomy, any open approach.
References:
* AMA's CPT Professional Edition (current year).
* CPT Assistant for detailed coding guidelines on nephrectomy procedures.

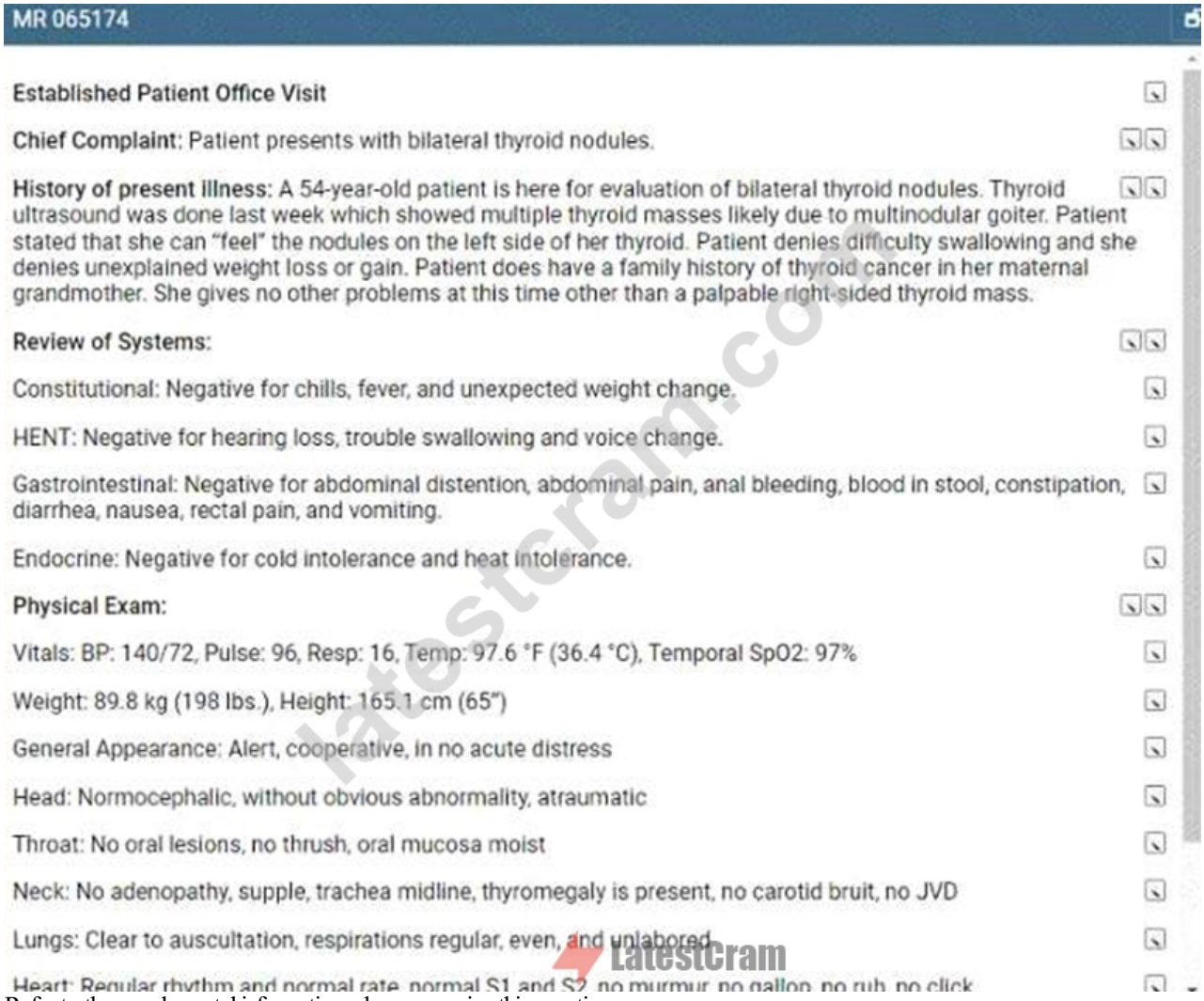
**NEW QUESTION # 277**
A patient with severe diverticulitis in the sigmoid colon presents to surgery for a partial colectomy. The physician performs an exploratory laparoscopic laparotomy to verify the location of the diverticulitis. Once identified, it was noted that there was bleeding from the diverticulitis. The physician transects the descending colon and then transects at the line of the rectum.
The physician mobilizes the splenic flexure in order to create a colostomy with the proximal portion of the remaining colon. The distal portion of the colon is closed. The physician washes the patient's abdomen with saline, removes all trocars and instruments, and then closes the abdomen with sutures.
What CPT and ICD-10-CM codes are reported?

- A. 44206, 44213-51, K57.41
- B. 44206, 44213, K57.33
- C. 44212, 44213, K57.33
- D. 44212, 44213-51, K57.41

**Answer: C**

Explanation:
Procedure Coding (CPT):
44212 - Laparoscopic partial colectomy with end colostomy and closure of distal segment (Hartmann-type procedure) Correct because:
Sigmoid/descending colon resection
Proximal colostomy created
Distal rectal stump closed
44213 - Laparoscopic mobilization of splenic flexure
Separately reportable because:
Mobilization was necessary to exteriorize colon for colostomy
Not bundled into 44212
Modifier not required (no multiple-procedure discount with add-on logic) Diagnosis Coding (ICD-10-CM):
K57.33 - Diverticulitis of large intestine with perforation and bleeding, without abscess Documentation supports:
Diverticulitis
Active bleeding
No abscess reported
Why Other Options Are Incorrect:
A / B - 44206 = colectomy with anastomosis (not performed)
A / B - K57.41 includes abscess (not documented)
C - Missing splenic flexure add-on explanation
CPT & ICD-10-CM Guideline Alignment:
Hartmann procedure # anastomosis
Bleeding elevates diagnosis specificity
Splenic flexure mobilization is separately reportable when clinically required

**NEW QUESTION # 278**


MR 065174

Established Patient Office Visit

**Chief Complaint:** Patient presents with bilateral thyroid nodules.

**History of present illness:** A 54-year-old patient is here for evaluation of bilateral thyroid nodules. Thyroid ultrasound was done last week which showed multiple thyroid masses likely due to multinodular goiter. Patient stated that she can "feel" the nodules on the left side of her thyroid. Patient denies difficulty swallowing and she denies unexplained weight loss or gain. Patient does have a family history of thyroid cancer in her maternal grandmother. She gives no other problems at this time other than a palpable right-sided thyroid mass.

**Review of Systems:**

Constitutional: Negative for chills, fever, and unexpected weight change.

HENT: Negative for hearing loss, trouble swallowing and voice change.

Gastrointestinal: Negative for abdominal distention, abdominal pain, anal bleeding, blood in stool, constipation, diarrhea, nausea, rectal pain, and vomiting.

Endocrine: Negative for cold intolerance and heat intolerance.

**Physical Exam:**

Vitals: BP: 140/72, Pulse: 96, Resp: 16, Temp: 97.6 °F (36.4 °C), Temporal SpO2: 97%

Weight: 89.8 kg (198 lbs.), Height: 165.1 cm (65")

General Appearance: Alert, cooperative, in no acute distress

Head: Normocephalic, without obvious abnormality, atraumatic

Throat: No oral lesions, no thrush, oral mucosa moist

Neck: No adenopathy, supple, trachea midline, thyromegaly is present, no carotid bruit, no JVD

Lungs: Clear to auscultation, respirations regular, even, and unlabored

Heart: Regular rhythm and normal rate, normal S1 and S2, no murmur, no gallop, no rub, no click



Refer to the supplemental information when answering this question:
View MR 065174
What E/M code is reported for this encounter?

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

**Answer: A**

Explanation:
To determine the correct E/M code, we need to consider the three key components: history, examination, and medical decision making (MDM).
* History:
* The documentation indicates an expanded problem-focused history. This is supported by the detailed history of present illness, including the patient's description of symptoms, family history, and review of systems with pertinent positives and negatives.
* Examination:
* The examination is also expanded problem-focused. The physician focused on the relevant systems (head, neck, throat) and documented specific findings related to the chief complaint (thyromegaly).
* Medical Decision Making:
* The MDM is straightforward. The physician is evaluating a new problem (bilateral thyroid nodules) with a low level of risk. Although further workup is planned, this alone doesn't automatically increase the MDM complexity.
Based on these components, 99213 is the most appropriate code.
Why other options are incorrect:
* 99212: Requires a problem-focused history and examination, which is less comprehensive than what was documented.
* 99214 and 99215: Require a higher level of MDM (low or moderate complexity) and/or a more detailed examination. The documentation doesn't support this level of service.

References:
* CPT Codes 99211-99215: Office or other outpatient visit for the evaluation and management of an established patient
* 1995 and 1997 Documentation Guidelines for Evaluation and Management Services: These guidelines provide detailed criteria for selecting the appropriate E/M code based on history, examination, and MDM.
* AAPC Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.

**NEW QUESTION # 279**
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