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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• 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.
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	• 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 4	• 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 5	• 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 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	• 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 8	• 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 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	• 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 11	• 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q137-Q142):

NEW QUESTION # 137
A diagnostic mammogram is performed on the left and right breasts. Computer-aided detection is also used to further analyze the image for possible lesions.
What CPT coding is reported for this radiology service?

- A. 0
- B. 77065-LT, 77065-RT
- C. 77066-50
- D. 77067-50

Answer: A

NEW QUESTION # 138
The documentation states:
He was then sterilely prepped and draped along the flank and abdomen in the usual sterile fashion. I first made a skin incision off the tip of the twelfth rib, extending medially along the banger's lines of the skin. This was approximately 3.5 cm in length. Once this incision was carried sharply, electrocautery was used to gain access through the external oblique, internal oblique, and transverse abdominis musculature and fascia.
What surgical approach was used for this procedure?

- A. Cannot determine based on the documentation
- B. Percutaneous
- C. Laparoscopic
- D. Open

Answer: D

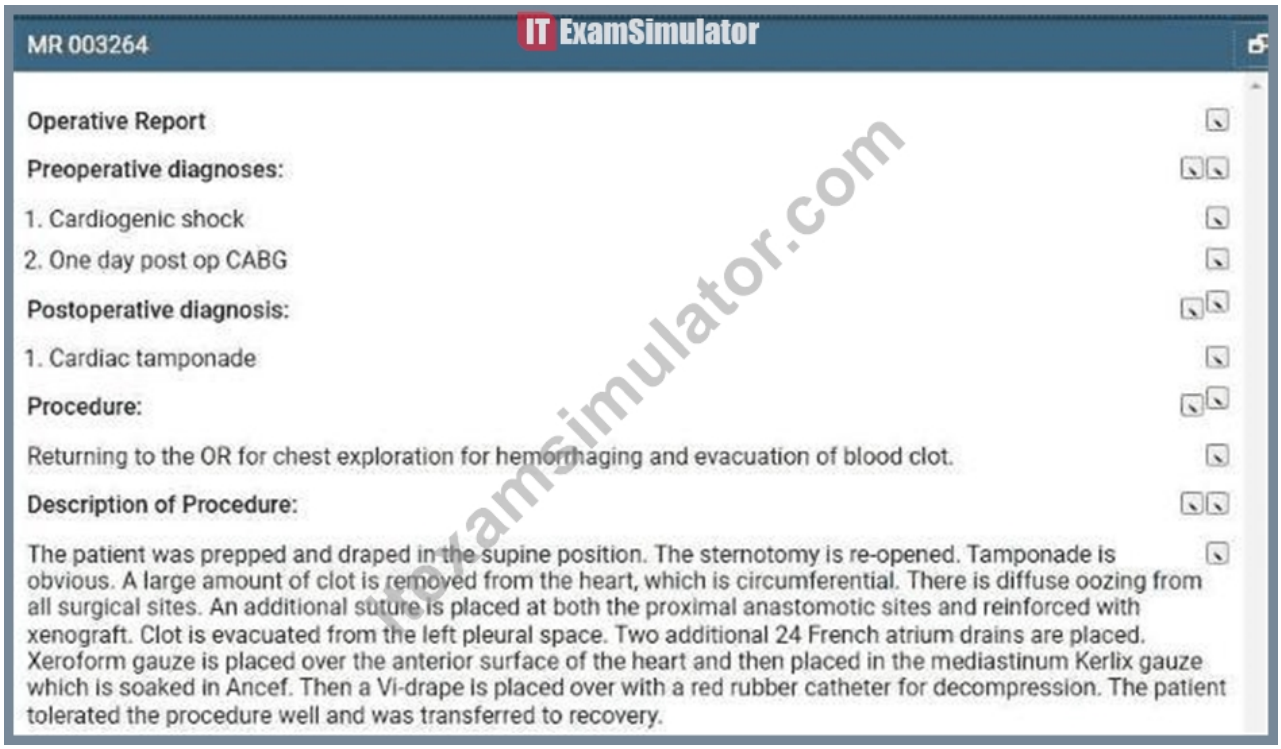
NEW QUESTION # 139
View MR 001394
MR 001394
Operative Report
Procedure: Excision of 11 cm back lesion with rotation flap repair.
Preoperative Diagnosis: Basal cell carcinoma
Postoperative Diagnosis: Same
Anesthesia: 1% Xylocaine solution with epinephrine warmed and buffered and injected slowly through 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 # 140



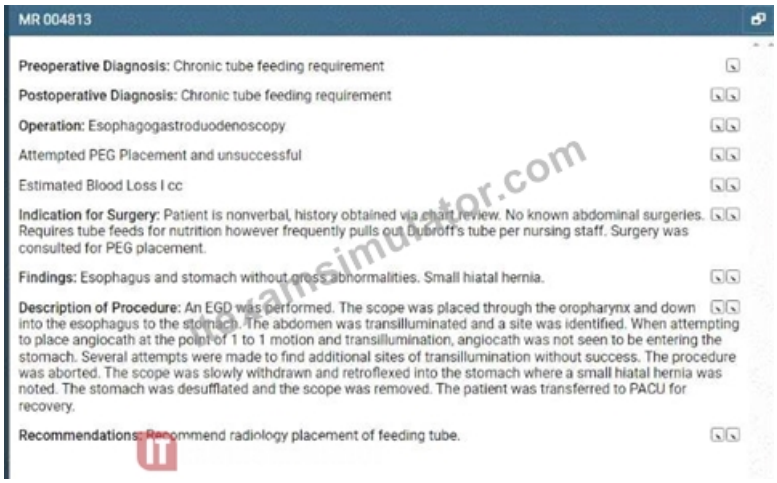
Refer to the supplemental information when answering this question:
View MR 003264
What is the procedural coding?

- A. 32120-58
- B. 35820-78
- C. 32658-78
- D. 33020-58

Answer: C

Explanation:
The patient had a post-operative complication (cardiac tamponade) following a previous CABG surgery, requiring a return to the operating room for exploration and evacuation of a blood clot. This is coded using CPT code 32658 (Exploration, mediastinum, with or without drainage; for postoperative hemorrhage, drainage of abscess, or to locate foreign body). Modifier 78 is appended to indicate an unplanned return to the operating room by the same physician following the initial procedure for a related procedure during the postoperative period.
References:
CPT Code 32658: Exploration, mediastinum, with or without drainage; for postoperative hemorrhage, drainage of abscess, or to locate foreign body Modifier 78: Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period AAPC Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.

NEW QUESTION # 141


MR 004813

Preoperative Diagnosis: Chronic tube feeding requirement

Postoperative Diagnosis: Chronic tube feeding requirement

Operation: Esophagogastroduodenoscopy

Attempted PEG Placement and unsuccessful

Estimated Blood Loss I cc

Indication for Surgery: Patient is nonverbal, history obtained via chart review. No known abdominal surgeries. Requires tube feeds for nutrition however frequently pulls out Dubroff's tube per nursing staff. Surgery was consulted for PEG placement.

Findings: Esophagus and stomach without gross abnormalities. Small hiatal hernia.

Description of Procedure: An EGD was performed. The scope was placed through the oropharynx and down into the esophagus to the stomach. The abdomen was transilluminated and a site was identified. When attempting to place angiocath at the point of 1 to 1 motion and transillumination, angiocath was not seen to be entering the stomach. Several attempts were made to find additional sites of transillumination without success. The procedure was aborted. The scope was slowly withdrawn and retroflexed into the stomach where a small hiatal hernia was noted. The stomach was desufflated and the scope was removed. The patient was transferred to PACU for recovery.

Recommendations: Recommend radiology placement of feeding tube.

Refer to the supplemental information when answering this question:
View MR 004813
What CPTand ICD-10-CM codes are reported?

- A. 43752-52, K94.29, K44.9
- B. 43246, K94.29, Z93.1
- C. 43246-52, K94.29, K44.9
- D. 43752, K94.29, Z93.1

Answer: C

Explanation:
* CPT Code 43246: Esophagogastroduodenoscopy, with transoral insertion of intra-abdominal tube (e.g., gastrostomy or jejunostomy)
* This code describes the attempted PEG tube placement.
* Modifier -52: Reduced services. This modifier is appended because the procedure was aborted and the PEG tube was not successfully placed.
* ICD-10-CM Code K94.29: Other specified disorders of digestive system
* This code captures the patient's chronic feeding requirement, which is the reason for the attempted PEG tube placement.
* ICD-10-CM Code K44.9: Diaphragmatic hernia without obstruction or gangrene
* This code reports the small hiatal hernia that was found during the procedure.
References:
* CPT Code 43246: Esophagogastroduodenoscopy, with transoral insertion of intra-abdominal tube (e.g., gastrostomy or jejunostomy)
* Modifier 52: Reduced services
* ICD-10-CM Code K94.29: Other specified disorders of digestive system
* ICD-10-CM Code K44.9: Diaphragmatic hernia without obstruction or gangrene
* AAPC Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.

NEW QUESTION # 142
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