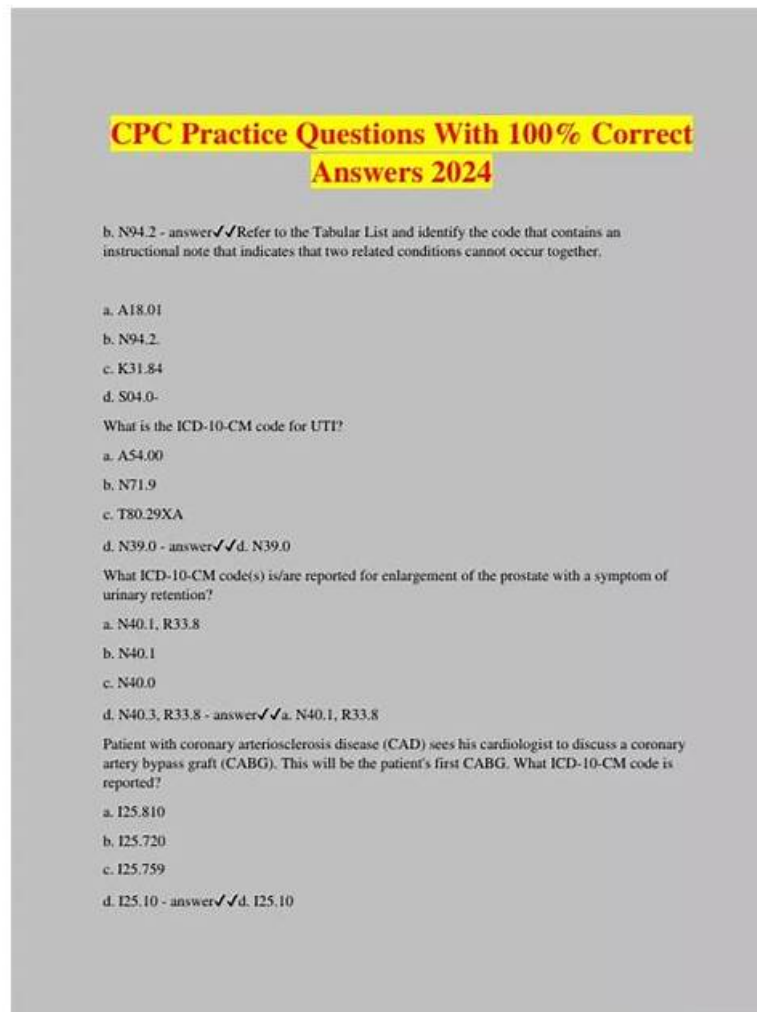


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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<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 2	<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 3	<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 4	<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 5	<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 6	<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.
Topic 7	<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 8	<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 9	<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 10	<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 11	<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 12	<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.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q409-Q414):

NEW QUESTION # 409

A 44-year-old female patient with chest pains had a CT of her chest that identified a mass in her left lower lung. The patient currently has ovarian cancer with metastases to the liver. The radiologist suspects the cancer has spread to her lungs. The physician performed an outpatient bronchoscopic biopsy and the pathology report documents the mass as a tumor of uncertain behavior.

What ICD-10-CM codes are reported for this patient?

- A. C56.9, C78.7, C78.02
- B. C78.02, C22.9, C79.82
- C. D38.1, C56.9, C78.7
- D. R91.8, C56.9, C78.7

Answer: C

Explanation:

For a patient with a mass in the left lower lung suspected to be cancer that is currently documented as a tumor of uncertain behavior, with existing ovarian cancer with metastases to the liver, the ICD-10-CM codes are:

- * D38.1: Neoplasm of uncertain behavior of bronchus and lung.
- * C56.9: Malignant neoplasm of unspecified ovary.
- * C78.7: Secondary malignant neoplasm of liver and intrahepatic bile duct.

D38.1 is used because the behavior of the lung tumor is uncertain, and C56.9 and C78.7 are used to document the known primary and metastatic cancers.

References:

- * ICD-10-CM guidelines
- * AMA's CPT Professional Edition (current year)

NEW QUESTION # 410

View MR 099405

MR 099405

CC: Shortness of breath

HPI: 16-year-old female comes into the ED for shortness of breath for the last two days. She is an asthmatic.

Current medications being used to treat symptoms is Advair, which is not working and breathing is getting worse. Does not feel that Advair has been helping. Patient tried Albuterol for persistent coughing, is not helping. Coughing 10-15 minutes at a time. Patient has used the Albuterol 3x in the last 16 hrs. ED physician admits her to observation status.

ROS: No fever, no headache. No purulent discharge from the eyes. No earache. No nasal discharge or sore throat. No swollen glands in the neck. No palpitations. Dyspnea and cough. Some chest pain. No nausea or vomiting. No abdominal pain, diarrhea, or constipation.

PMH: Asthma

SH: Lives with both parents.

FH: Family hx of asthma, paternal side

ALLERGIES: PCN-200 CAPS. Allergies have been reviewed with child's family and no changes reported.

PE: General appearance: normal, alert. Talks in sentences. Pink lips and cheeks. Oriented. Well developed.

Well nourished. Well hydrated.

Eyes: normal. External eye: no hyperemia of the conjunctiva. No discharge from the conjunctiva Ears: general/bilateral. TM: normal.

Nose: rhinorrhea. Pharynx/Oropharynx: normal. Neck: normal.

Lymph nodes: normal.

Lungs: before Albuterol neb, mode air entry b/l. No rales, rhonchi or wheezes. After Albuterol neb.

improvement of air entry b/l. Respiratory movements were normal. No intercostals inspiratory retraction was observed.

Cardiovascular system: normal. Heart rate and rhythm normal. Heart sounds normal. No murmurs were heard.

GI: abdomen normal with no tenderness or masses. Normal bowel sounds. No hepatosplenomegaly Skin: normal warm and dry.

Pink well perfused Musculoskeletal system patient indicates lower to mid back pain when she lies down on her back and when she rolls over. No CVA tenderness.

Assessment: Asthma, acute exacerbation

Plan: Will keep her in observation overnight. Will administer oral steroids and breathing treatment. CXR ordered and to be taken in the morning.

What E/M code is reported?

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

Answer: C

Explanation:

99222: This code is used for initial hospital care, per day, for the evaluation and management of a patient, which requires a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making of moderate complexity.

The documentation shows a detailed history (including HPI, ROS, PMH, SH, and FH) and a detailed examination (covering multiple organ systems). The medical decision making involves the management of an acute asthma exacerbation, which includes admitting the patient to observation status, administering oral steroids, and planning for further diagnostic testing.

CPT Professional Edition, AMA

NEW QUESTION # 411

Patient has esotropia of the right eye and presents to operating suite for strabismus surgery. The physician resects the medial rectus horizontal and lateral rectus muscles of the eye and secures them with adjustable sutures. Extensive scar tissue is noted, due to a previous surgery involving an extraocular muscle. Extraocular muscle is isolated, and the muscle is freed from surrounding scar tissues.

What CPT codes are reported for this surgery?

- A. 67314, 67334
- B. 67311, 67334
- C. 67316, 67335
- D. 67312, 67335

Answer: A

Explanation:

Esotropia of the right eye: Indicates strabismus surgery is required.

Resection of medial rectus horizontal and lateral rectus muscles: Specific muscles addressed during the surgery.

Adjustable sutures: Used in securing the muscles, indicating specific techniques.

Extensive scar tissue from previous surgery: Requires additional work and isolation.

CPT codes 67314 and 67334 are used to report the resection of two muscles with adjustable sutures (67314) and surgery on an extraocular muscle involving extensive scar tissue (67334).

NEW QUESTION # 412

A 67-year-old male presents with DJD and spondylolisthesis at L4-L5. The patient is placed prone on the operating table and, after induction of general anesthesia, the lower back is sterilely prepped and draped. One incision was made over L1-L5. This was confirmed with a probe under fluoroscopy. Laminectomies are done at vertebral segments L4 and L5 with facetectomies to relieve pressure to the nerve roots. Allograft was packed in the gutters from L1-L5 for a posterior arthrodesis. Pedicle screws were placed at L2, L3, and L4. The construct was copiously irrigated and muscle, fascia and skin were closed in layers.

Select the procedure codes for this scenario.

- A. 63005 x 2, 22612, 22614 x 3, 22842
- B. 63017, 63048, 22612, 22808, 22842 x 3
- C. 63047, 63048, 22612, 22614 x 3, 22842
- D. 63042, 63043, 22808, 22841 x 3

Answer: C

NEW QUESTION # 413

Refer to the supplemental information when answering this question:

View MR 903096

What CPT and ICD-10-CM coding is reported?

- A. 62290, M54.50
- B. 62290, M48.061, M54.50
- C. 62292, M54.50
- D. 62292, M48.07, M54.50

Answer: A

Explanation:

- * CPT Code 62290: Discography, lumbar, single or multiple levels, radiological supervision and interpretation
- * This code accurately describes the procedure performed. The documentation indicates a lumbar discography was performed at a single level (L3-4) with radiological supervision (C-arm visualization).
- * ICD-10-CM Code M54.50: Low back pain, unspecified
- * This code is the most appropriate diagnosis based on the documentation. The preoperative diagnosis states "Low back pain possible spinal stenosis L3-4." While spinal stenosis was considered, it was not confirmed. The postoperative diagnosis indicates no evidence of spinal stenosis or discogenic pathology. Therefore, the definitive diagnosis is low back pain.

Why other options are incorrect:

- * 62292: This code is for a discography with injection of contrast and/or medication for therapeutic purposes. The documentation doesn't indicate any therapeutic injection was performed.
- * M48.061 and M48.07: These codes represent spinal stenosis, which was not confirmed in the postoperative diagnosis.

References:

- * CPT Code 62290: Discography, lumbar, single or multiple levels, radiological supervision and interpretation
- * ICD-10-CM Code M54.50: Low back pain, unspecified
- * AAPC Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.

NEW QUESTION # 414

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