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## AAPC CPC FINAL PRACTICE TEST

A covered entity does NOT include

- a. Healthcare providers
- b. Health plans
- c. Patients
- d. Clearinghouses - ✓c. Patients

What does MAC stands for?

- a. Medicare Administrative Contractor
- b. Medicare Advisory Contractor
- c. Medicaid Administrative Contractor
- d. Medicaid Alert Contractor - ✓a. Medicare Administrative Contractor

When are providers responsible for obtaining an ABN for a service NOT considered medically necessary?

- a. After providing a service or item to a beneficiary.
- b. Prior to providing a service or item to a beneficiary.
- c. After a denial has been received from Medicare.
- d. During a procedure or service. - ✓b. Prior to providing a service or item to a beneficiary

AAPC credentialed coders have proven mastery of what information?

- a. Code sets
- b. Evaluation and management principles
- c. Documentation guidelines
- d. All of the above - ✓d. All of the above

Local Coverage Determinations are administered by whom?

- a. LMRPs
- b. NCDs
- c. State Law
- d. Each regional MAC - ✓d. Each regional MAC

Rationale: Each Medicare Administrative Contractor (MAC) is then responsible for interpreting national policies into regional policies

Which of the following best describes constituent components of the human lymphatic system?

- a. Lymph nodes, lymphatic vessels, spleen, thoracic duct
- b. Lymph nodes, lymphatic vessels, thymus gland, pancreas
- c. Lymph nodes, lymphatic vessels, tonsils, liver
- d. Lymph nodes, lymphatic vessels, bone marrow, kidneys - ✓a. Lymph nodes, lymphatic vessels, spleen, thoracic duct

The term hemic specifically refers to what bodily fluid?

- a. Bile interstitial fluid
- b. Interstitial fluid

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## AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> <li>• <b>Anesthesia:</b> 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.</li> </ul>
Topic 2	<ul style="list-style-type: none"> <li>• <b>Respiratory System:</b> 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.</li> </ul>
Topic 3	<ul style="list-style-type: none"> <li>• <b>Hemic &amp; Lymphatic Systems, Mediastinum, Diaphragm:</b> 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.</li> </ul>
Topic 4	<ul style="list-style-type: none"> <li>• <b>Digestive System:</b> 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.</li> </ul>
Topic 5	<ul style="list-style-type: none"> <li>• <b>Applying the ICD-10-CM Guidelines:</b> 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.</li> </ul>
Topic 6	<ul style="list-style-type: none"> <li>• <b>Urinary System and Male Genital System:</b> 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.</li> </ul>
Topic 7	<ul style="list-style-type: none"> <li>• <b>Musculoskeletal System:</b> 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.</li> </ul>
Topic 8	<ul style="list-style-type: none"> <li>• <b>Introduction to CPT®, HCPCS Level II, and Modifiers:</b> 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.</li> </ul>
Topic 9	<ul style="list-style-type: none"> <li>• <b>Female Reproductive System and Maternity Care &amp; Delivery:</b> 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.</li> </ul>
Topic 10	<ul style="list-style-type: none"> <li>• <b>Cardiovascular System:</b> 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.:</li> </ul>
Topic 11	<ul style="list-style-type: none"> <li>• <b>The Business of Medicine:</b> 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.</li> </ul>

Topic 12	<ul style="list-style-type: none"> <li>• <b>Review of Anatomy:</b> 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.</li> </ul>
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## AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q49-Q54):

### NEW QUESTION # 49

View MR 002395

MR 002395

Operative Report

Pre-operative Diagnosis: Acute rotator cuff tear

Post-operative Diagnosis: Acute rotator cuff tear, synovitis

Procedures:

- 1) Rotator cuff repair
- 2) Biceps Tenodesis
- 3) Claviculectomy
- 4) Coracoacromial ligament release

Indication: Rotator cuff injury of a 32-year-old male, sustained while playing soccer.

Findings: Complete tear of the right rotator cuff, synovitis, impingement.

Procedure: The patient was prepared for surgery and placed in left lateral decubitus position. Standard posterior arthroscopy portals were made followed by an anterior-superior portal. Diagnostic arthroscopy was performed. Significant synovitis was carefully debrided. There was a full-thickness upper 3rd subscapularis tear, which was repaired. The lesser tuberosity was debrided back to bleeding healthy bone and a Mitek 4.5 mm helix anchor was placed in the lesser tuberosity. Sutures were passed through the subscapularis in a combination of horizontal mattress and simple interrupted fashion and then tied. There was a partial-thickness tearing of the long head of the biceps. The biceps were released and then anchored in the intertubercular groove with a screw. There was a large anterior acromial spur with subacromial impingement. A CA ligament was released and acromioplasty was performed. Attention was then directed to the supraspinatus tendon tear. The tear was V-shaped and measured approximately 2.5 cm from anterior to posterior. Two Smith & Nephew PEEK anchors were used for the medial row utilizing Healicoil anchors. Side-to-side stitches were placed. One set of suture tape from each of the medial anchors was then placed through a laterally placed Mitek helix PEEK knotless anchor which was fully inserted after tensioning the tapes. A solid repair was obtained. Next there were severe degenerative changes at the AC joint of approximately 8 to 10 mm. The distal clavicle was resected taking care to preserve the superior AC joint capsule. The shoulder was thoroughly lavaged. The instruments were removed and the incisions were closed in routine fashion. Sterile dressing was applied. The patient was transferred to recovery in stable condition.

What CPT coding is reported for this case?

- A. 29827, 29824-51, 29826-51
- **B. 29827, 29828-51, 29824-51, 29826**
- C. 29827, 29828-51, 29824-51, 29826, 29805-59
- D. 29827, 29824-51, 29826-51, 29805-59

**Answer: B**

### NEW QUESTION # 50

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, moderate 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: B**

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.

References:

\* CPT Professional Edition, AMA

### NEW QUESTION # 51

An 87-year-old male with a history of atrioventricular block and prior dual-chamber pacemaker implantation presents to the cardiology clinic for an in-person device evaluation. The physician performs a full electronic analysis of the pacemaker system, assessing atrial and ventricular lead function, battery status, sensing thresholds, and pacing thresholds. After the assessment, the pacemaker settings are adjusted to optimize heart rate response. The patient tolerates the procedure well and is advised to return for routine follow-up.

What CPT code is reported?

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

**Answer: A**

Explanation:

80324 - Drug test(s), definitive, qualitative or quantitative, LC/MS; acetaminophen LC-MS = definitive testing Acetaminophen is specifically identified by 80324 Why others are incorrect:

60143 / 80299 - Therapeutic drug assays (obsolete or nonspecific)

B0329 - HCPCS code (not appropriate here)

### NEW QUESTION # 52

Which CPT code can append modifier 50?

- **A. 0**

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

**Answer: D**

Explanation:

Modifier 50 (Bilateral Procedure) is appended when a procedure is performed on both sides during the same session and the CPT code is not inherently bilateral.

77066 is already defined as bilateral mammography

77065 is unilateral

75572 (CT heart) is not a bilateral procedure

73115 (MRI upper extremity joint) may be performed bilaterally and allows modifier 50

### NEW QUESTION # 53

This 27-year-old male has morbid obesity with a BMI of 45 due to a high calorie diet. He has decided to have an open Roux-en-Y gastric bypass. The patient is brought to the operating room and placed in supine position. A midline abdominal incision is made. The stomach is mobilized, and the proximal stomach is divided and stapled creating a small proximal pouch in continuity with the esophagus. A short limb of the proximal bowel of 155 cm is divided. It is brought up and anastomosed to the gastric pouch. The other end of the divided bowel is connected back into the distal small bowel to the short limb's gastric anastomosis to restore intestinal continuity. The abdominal incision is closed.

What are the procedure and diagnosis codes for this encounter?

- A. 43847, E66.9, Z68.42
- B. 43645, E66.8, Z68.42
- C. 43644, E66.01, Z68.43
- D. 43847, E66.01, Z68.42

**Answer: D**

Explanation:

Open Roux-en-Y Gastric Bypass: The procedure involves creating a small gastric pouch and anastomosing it to the jejunum

CPT Code 43847: This code describes a surgical gastric restrictive procedure with gastric bypass for morbid obesity, open.

ICD-10-CM Code E66.01: This code represents morbid (severe) obesity due to excess calories.

ICD-10-CM Code Z68.42: This code indicates a BMI of 45.

Reference:

AMA's CPT Professional Edition (current year)

ICD-10-CM (current year)

### NEW QUESTION # 54

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