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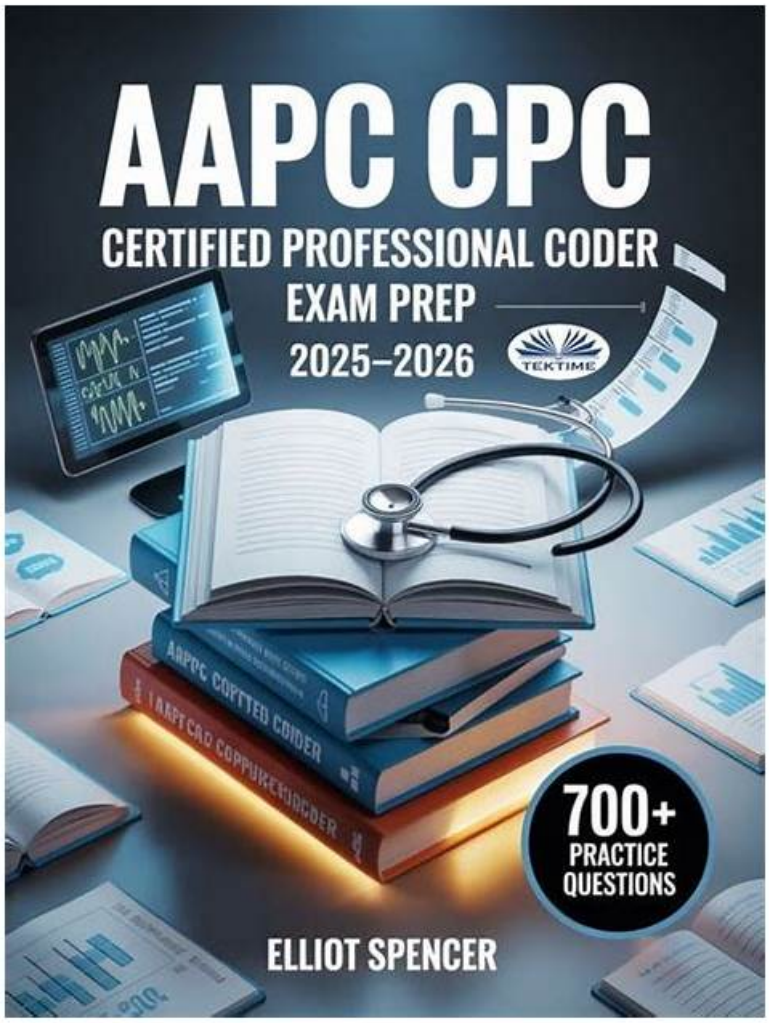

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AAPC CPC Exam Syllabus Topics:

Topic	Details
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	• 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 3	• 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 4	• 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 5	• 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	• 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	• 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 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	• 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	• 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 11	• 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 12	• 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 13	• 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 14	• 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 15	• 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 16	• 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 17	• 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 18	• 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.

>> Original CPC Questions <<

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q327-Q332):

NEW QUESTION # 327
View MR 007400
MR 007400
Radiology Report
Patient: J. Lowe Date of Service: 06/10/XX
Age: 45
MR#: 4589799
Account #: 3216770
Location: ABC Imaging Center
Study: Mammogram bilateral screening, all views, producing direct digital image Reason: Screen Bilateral digital mammography with computer-aided detection (CAD) No previous mammograms are available for comparison.
Clinical history: The patient has a positive family history (mother and sister) of breast cancer.
Mammogram was read with the assistance of GE iCAD (computerized diagnostic) system.
Findings: No dominant speculated mass or suspicious area of clustered pleomorphic microcalcifications is apparent Skin and nipples are seen to be normal. The axilla are unremarkable.
What CPT coding is reported for this case?

- A. 77066, Z80.3, Z12.31
- B. 77067, Z12.31, Z80.3
- C. 77067-50, Z80.3, Z12.31
- D. 77066-50, Z12.31, Z80.3

Answer: B

NEW QUESTION # 328
A patient is diagnosed with compression fractures of the C6, C7 and T1 vertebrae. The patient agrees to have vertebroplasty. Bone cement is injected in the vertebral space until each of the two whole vertebral body is filled. The procedure is performed bilaterally. What CPTcoding is reported?

- A. 22513, 22515

- B. 22513-50, 22513-50
- C. 22510-50, 22512-50 x 2
- D. 22510, 22512 x 2

Answer: C

Explanation:
1. Procedure Type and CPTCode Selection:
The physician performed an injection into the wrist joint for degenerative osteoarthritis management using Synvisc (a viscosupplementation product).
Code 20606 is the correct CPTcode for an arthrocentesis, aspiration, and/or injection procedure in an intermediate joint, such as the wrist. This code specifically includes the use of ultrasound guidance, which is often standard in such injections.
Code 20551 (injection of a single tendon origin) and 20526 (injection into a carpal tunnel) are incorrect here as they do not apply to intra-articular injections for joint osteoarthritis management.
2. Diagnosis Code Selection (ICD-10-CM):
The diagnosis is degenerative osteoarthritis in the right wrist.
ICD-10-CM Code M19.231 is used for primary osteoarthritis of the right wrist. This code directly reflects the diagnosis of primary osteoarthritis affecting this specific joint.
M19.031 would represent primary osteoarthritis in the wrist but does not specify laterality; therefore, it is less accurate than M19.231, which denotes the right wrist.
3. Summary of Code Application:
The correct CPTand ICD-10-CM codes are 20606 for the injection procedure and M19.231 for primary osteoarthritis of the right wrist.
4. AAPC and CPTCoding Guidelines:
According to AAPC CPC guidelines, proper joint injection codes require specific identification of the joint location and guidance if used. Additionally, selecting the most specific ICD-10-CM code for laterality is essential for accuracy in musculoskeletal diagnoses.
Thus, based on CPTand ICD-10-CM coding guidelines, the verified answer is B. 20606, M19.231.

NEW QUESTION # 329
A patient who was training for a marathon collapsed due to heat exhaustion on a very hot day. The patient is driven by his wife to a non-facility urgent care center for him to be treated. On examination, the physician diagnoses heat exhaustion and dehydration. The physician began IV therapy of normal saline that consists of pre-packaged fluid and electrolytes. The hydration lasts for 1 and 30 minutes.
What CPT coding is reported?

- A. 96365, 96366
- B. 0
- C. 1
- D. 96360, 96361

Answer: D

Explanation:
1. Procedure and CPT Code Selection:
The patient received IV hydration therapy with normal saline, which lasted for 1 hour and 30 minutes.
CPT Code 96360 is used for initial IV hydration for the first hour. This code applies to the first 31-60 minutes of hydration therapy.
CPT Code 96361 is used for each additional hour of IV hydration. Since the hydration lasted 1 hour and 30 minutes, 96361 should be reported once to cover the additional 30 minutes after the initial hour.
2. Rationale for Excluding Other Options:
Code 96365 is for initial IV infusion for therapeutic, prophylactic, or diagnostic purposes, rather than hydration, and is not applicable in this case.
Code 96366 is used for additional therapeutic, prophylactic, or diagnostic infusions and does not apply to hydration services.
Option A (96360) would only cover the initial hour of hydration, missing the additional 30 minutes, which is appropriately coded with 96361.
3. AAPC and CPT Coding Guidelines:
According to AAPC and CPT guidelines, 96360 should be used for the first hour of IV hydration, and 96361 should be used for each additional hour or portion of an hour beyond the initial 60 minutes.
Therefore, the correct answer is D. 96360, 96361.

NEW QUESTION # 330
A three-year-old patient is in the operative suite for stage 2 of treatment for double right outlet syndrome. The patient previously had the pulmonary artery banded and is returning for removal of the pulmonary band and transposition repair of the great vessels via aortic pulmonary reconstruction.
The surgeon performs a time-out and pre-incision review of respiration and BP then the previous sternal incision site is inspected and lightly painted with povidone. Next, reopens the sternal cavity and inserts central cannulae in the IVC, SVC and ascending aorta for extra corporeal membrane oxygenation (ECMO) bypass, chemical cardioplegia is initiated, stopping the heart and ECMO is initiated. A physician assistant monitors vitals and oxygenation until heart function resumes. The surgeon carefully incised and removes the Dacron band encircling the pulmonary artery, with nominal need for dilation. A section of coronary ostia is removed and sutured to the root of the pulmonary trunk. The pulmonary trunk and aortic root are then transected and transposed to allow for ideal cardiac circulation. Once structural integrity is visually confirmed, the physician assistant is permitted to administer the cardioplegia reversal solution and the surgeon removes the central cannulae after heart function safely resumes. The sternotomy is closed and the patient is transported to the NICU.
What CPTcodes are reported for the surgery today?

- A. 33779-58, 33955-58, 33985-58
- B. 33778-58, 33955-58, 33985-58
- C. 33779-78, 33953-78, 33985-78
- D. 33778-78, 33953-78, 33985-78

Answer: C

Explanation:
1. Procedure Details and CPTCode Selection:
The patient is undergoing stage 2 treatment for double outlet right ventricle (DORV) with a removal of the pulmonary artery band and transposition repair of the great vessels.
Code 33779 is specific for correction of a double outlet right ventricle, with transposition of the great arteries.
This code accurately reflects the procedure performed, including the complex repair involving the transposition of the pulmonary trunk and aortic root.
Code 33953 is used to report the initiation of extracorporeal membrane oxygenation (ECMO), which was used to maintain oxygenation during the procedure.
Code 33985 is for the termination of ECMO following the surgical repair once heart function has resumed.
Both 33953 and 33985 accurately document the initiation and termination of ECMO during this complex heart repair.
2. Modifier Selection:
Modifier 78 (unplanned return to the operating room for a related procedure during the postoperative period) is appropriate here.
This is a subsequent stage in the treatment plan, but due to the complexity and specific surgical intervention required, it is treated as a return to the OR for related procedure coding.
Modifier 58 (staged or related procedure during the postoperative period) would not be as suitable here because the procedure involves a new return to the OR.
3. AAPC and CPTCoding Guidelines:
AAPC guidelines support the use of specific modifiers (78 for unplanned return) and appropriate ECMO codes (33953 and 33985) in complex cardiac cases requiring bypass and staged treatment.
Thus, the correct CPTcodes based on CPTand AAPC coding standards are C. 33779-78, 33953-78,
33985-78.

NEW QUESTION # 331
The evisceration of ocular contents was performed using a surgical microscope for enhanced visualization.
The procedure was performed on the left eye and an implant was not placed in the ocular cavity.
What CPTcoding is reported?

- A. 65091-LT
- B. 65093-LT
- C. 65093-LT, 69990
- D. 65091-LT, 69990-51

Answer: A

Explanation:
1. Procedure and CPTCode Selection:
The procedure performed was an evisceration of ocular contents without the placement of an implant. The surgical microscope was

used for enhanced visualization, but this does not require a separate code if the primary procedure code includes it inherently.
CPTCode 65091 is used for an evisceration of the ocular contents without implant placement. This code correctly describes the procedure performed on the left eye.
2. Modifier:
Modifier LT is added to indicate that the procedure was performed on the left eye.
3. Exclusion of Code 69990:
Code 69990 is for the use of an operating microscope, but it should not be billed separately when it is used as part of a procedure where enhanced visualization is typical or expected, such as an evisceration procedure.
According to CPTguidelines, 69990 is not separately reported when the microscope is used for visualization in procedures where its use is considered part of the standard of care.
4. Rationale for Excluding Other Options:
Code 65093 is for an evisceration with implant placement, which does not apply since no implant was used.
Options B and C incorrectly include 69990, which is not separately reportable in this scenario.
5. AAPC and CPTCoding Guidelines:
According to AAPC and CPTcoding guidelines, 65091 is sufficient to capture the procedure without the need to add code 69990 for the microscope.
Therefore, the correct answer is D. 65091-LT.

NEW QUESTION # 332
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