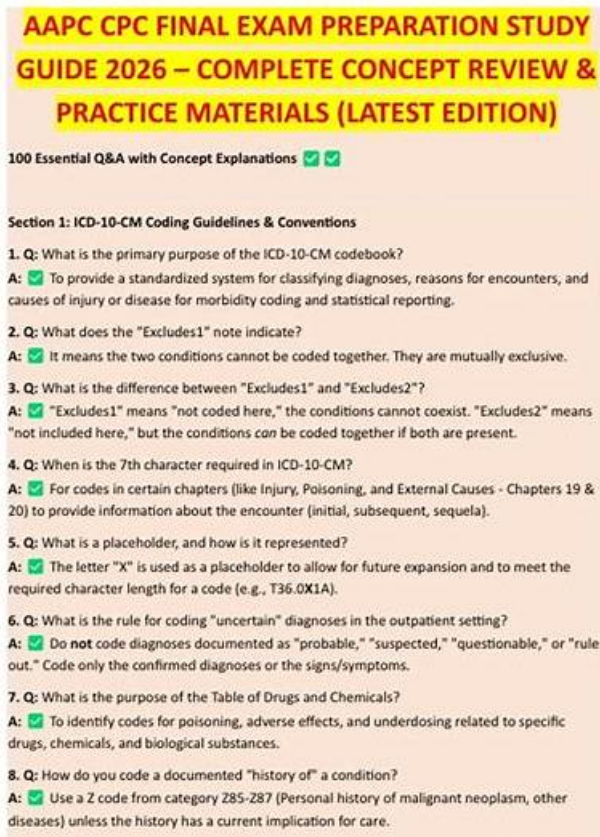


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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> 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 2	<ul style="list-style-type: none"> 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 3	<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 4	<ul style="list-style-type: none"> • 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 5	<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 6	<ul style="list-style-type: none"> • Radiology: This section of the exam measures the skills of coding specialists and focuses on diagnostic imaging procedures including X-rays, CT scans, MRIs, ultrasounds, and nuclear medicine. It emphasizes proper selection of codes based on anatomical site and modality used.
Topic 7	<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 8	<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 9	<ul style="list-style-type: none"> • 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	<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 11	<ul style="list-style-type: none"> • 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q278-Q283):

NEW QUESTION # 278

A patient has suspicious lesions on his feet. Biopsies confirm squamous cell carcinoma. The patient elects to destroy a 0.6 cm lesion on the right dorsal foot and a 2.0 cm lesion on the left dorsal foot using cryosurgery.

What CPT coding is reported?

- A. 17272, 17271
- B. 17000, 17003
- C. 17262, 17261
- D. 0

Answer: C

Explanation:

Malignant lesion destruction # CPT 17260-17286

Trunk/extremities

0.6-1.0 cm # 17261

1.1-2.0 cm # 17262

Both lesions are reported separately.

NEW QUESTION # 279

A patient with lateral epicondylitis of the left elbow is taken to the operating room for manipulation under general anesthesia. The physician performs stretching and rotation to restore motion.

What CPT coding is reported for the physician?

- A. 0
- B. 1
- C. 24605, 01710
- D. 24300, 01710

Answer: A

Explanation:

24300 = Manipulation of elbow under anesthesia

Anesthesia codes (01710) are not reported by the surgeon, only by the anesthesiologist

24605 is for closed treatment of elbow dislocation, which is not documented

NEW QUESTION # 280

MR 004813

Preoperative Diagnosis: Chronic tube feeding requirement

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Postoperative Diagnosis: Chronic tube feeding requirement

Operation: Esophagogastroduodenoscopy

Attempted PEG Placement and unsuccessful

Estimated Blood Loss 1 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 Dobhoff'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 CPT and ICD-10-CM codes are reported?

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

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 # 281

(A 78-year-old patient with intermittent asthma with exacerbations in her pulmonologist's office for pulmonary function testing. The pulmonologist performs spirometry with flow volume loops, measuring before and after administering a bronchodilator. What CPT and ICD-10-CM codes are reported?)

- A. 94070, 94010, J45.901
- B. 94070, 94010, J45.21
- C. 94060, 94010, J45.21
- D. 94060, 94010, J45.901

Answer: C

Explanation:

Spirometry performed before and after bronchodilator is coded with 94060. That code includes the pre- and post-bronchodilator spirometry components as a single bundled service, so it already captures the "before and after" testing. The scenario also lists measurements like vital capacity/breathing capacity and flow volume, but the defining element for coding is the bronchodilator responsiveness testing captured by 94060. For diagnosis, "intermittent asthma with exacerbation" maps to J45.21 (mild intermittent asthma with (acute) exacerbation). Code J45.901 represents "unspecified asthma with (acute) exacerbation" and is not as specific as the documented intermittent asthma. Options using 94070 do not represent spirometry pre/post bronchodilator testing; they are different pulmonary testing codes. CPC exam focus: choose the most specific asthma diagnosis available and recognize that 94060 already includes the pre/post testing, so adding a separate basic spirometry code in the same session is typically not correct, but the test's options explicitly pair 94060 and 94010—within those choices, option B correctly matches the diagnosis specificity.

NEW QUESTION # 282

A 55-year-old patient was recently diagnosed with an enlarged goiter. It has been two years since her last visit to the endocrinologist. A new doctor in the exact same specialty group will be examining her. The physician performs a medically appropriate history and exam. The provider reviewed the TSH results and ultrasound. The provider orders a fine needle aspiration biopsy which is a minor procedure. What E/M code is reported?

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

Answer: B

Explanation:

The patient is seeing a new doctor in the same specialty group for an enlarged goiter and is undergoing a medically appropriate history and exam, along with a fine needle aspiration biopsy.

Procedure Description:

Medically appropriate history and exam.

Review of TSH results and ultrasound.

Ordering of fine needle aspiration biopsy.

CPT Coding:

99202: Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

Since it has been two years since the last visit and the patient is being seen by a new doctor in the same specialty group, the encounter is considered a new patient visit.

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NEW QUESTION # 283

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