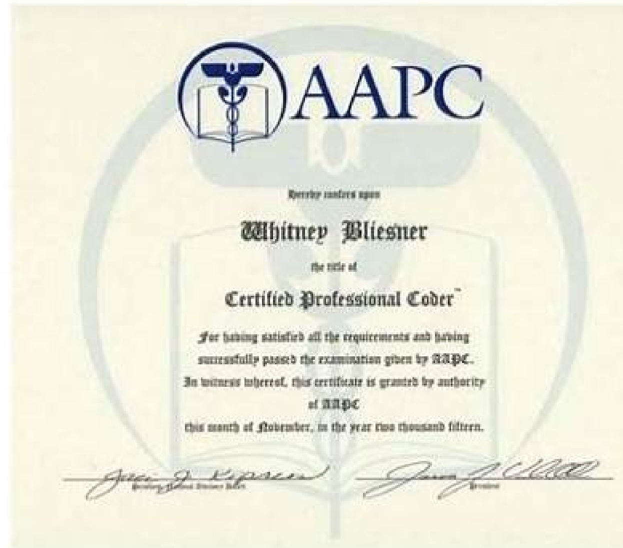
Certification CPC Training & Exam CPC Overview



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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• 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 3	• 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 4	• 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 5	• 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 6	• 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 7	• 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 8	• 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 9	• 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 10	• 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 11	• 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 12	• 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 13	• 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 14	• 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 15	• 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 16	• 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 17	• 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q364-Q369):

NEW QUESTION # 364
A patient arrives with stridor and in respiratory distress. The provider performs a micro laryngoscopy using a Parson's laryngoscope and magnifying telescope. A bronchoscopy was also performed using a 2.5 Stortz bronchoscope. The findings include subglottic web and stenosis with laryngeal edema suggestive of reflux. There was also significant collapse of the trachea at the carina and into the main bronchi bilaterally.
What CPTcoding is reported?

- A. 31629, 31526-51
- B. 31622, 31526-51, 69990
- C. 31622, 69990
- D. 31622, 31526-51

Answer: D

Explanation:
1. Procedure and CPTCode Selection:
The provider performed both a bronchoscopy and a microlaryngoscopy to evaluate the patient's airway due to respiratory distress and stridor.
Code 31622 is used for a diagnostic bronchoscopy, which includes the inspection of the trachea, carina, and bronchial structures. Since the bronchoscopy was diagnostic and no additional therapeutic procedures were performed, this is the appropriate code.
Code 31526 is for direct laryngoscopy with the use of an operating microscope or telescope (microlaryngoscopy). This code is appropriate given the use of a Parson's laryngoscope and magnifying telescope to inspect the larynx.
2. Modifier 51:
Modifier 51 is added to 31526 to indicate that it was performed in conjunction with another procedure (31622, bronchoscopy). Modifier 51 denotes multiple procedures without the necessity of a separate incision.
3. Exclusion of Code 69990:
Code 69990 is used for the use of an operating microscope in microsurgery but is not coded separately when the procedure (such as microlaryngoscopy) already includes visualization with a microscope or telescope as part of the CPTdescriptor. Thus, 69990 is not separately reported in this scenario, per CPTguidelines.
4. AAPC and CPTCoding Guidelines:
The guidelines specify that when visualization or microlaryngoscopy is inherently part of the procedure (as in 31526), 69990 should not be billed separately. Also, the use of Modifier 51 for multiple procedures in the same session is appropriate.
Therefore, the verified answer, following the CPTand AAPC coding rules, is A. 31622, 31526-51.

NEW QUESTION # 365
A surgeon performs midface LeFort I reconstruction on a patient's facial bones to correct a congenital deformity. The reconstruction is performed in two pieces in moving the upper jawbone forward and repositioning the teeth of the maxilla of the mid face.
What CPT code is reported?

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

Answer: A

Explanation:
The procedure described involves a LeFort I reconstruction, which is a type of orthognathic surgery performed to correct deformities of the midface. In this scenario, the surgeon performed the reconstruction in two pieces, moving the upper jawbone forward and repositioning the teeth of the maxilla. According to the CPT guidelines, CPT code 21146 describes a LeFort I (maxilla only) osteotomy, two-piece segment, including bone grafts (includes obtaining autografts). This code matches the description provided.
Reference:
AMA's CPT Professional Edition (current year), Code 21146

NEW QUESTION # 366
A 67-year-old patient has osteomyelitis of the shoulder blade and is in surgery to remove the sequestered section of dead infected fragment bone from surrounding bone.
What CPT code is reported?

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

Answer: A

Explanation:
The key phrase is "remove the sequestered section of dead infected fragment bone", which is a sequestrectomy performed for osteomyelitis.
23172 describes sequestrectomy of the scapula (shoulder blade).Therefore, C is correct.

NEW QUESTION # 367
Preoperative diagnosis: Right thigh benign congenital hairy nevus. *1
Postoperative diagnosis: Right thigh benign congenital hairy 0 nevus.
Operation performed: Excision of right thigh benign congenital>1
nevus, excision size with margins 4.5 cm and closure size 5 cm.
Anesthesia: General.0
Intraoperative antibiotics: Ancef.0
Indications: The patient is a 5-year-old girl who presented with her parents for evaluation of her right thigh congenital nevus. It has been followed by pediatrics and thought to have changed over the past year. Family requested excision. They understood the risks involved, which included but were not limited to risks of general anesthesia, infection, bleeding, wound dehiscence, and poor scar formation. They understood the scar would likely widen as the child grows because of the location of it and because of the age of the patient. They consented to proceed.
Description of procedure: The patient was seen preoperatively in > I the holding area, identified, and then brought to the operating room. Once adequate general anesthesia had been induced, the patient's right thigh was prepped and draped in standard surgical fashion. An elliptical excision measuring 6 x 1.8 cm had been marked. This was injected with Lidocaine with epinephrine, total of 6 cc of 1% with 1:100,000. After an adequate amount of time, a #15 blade was used to sharply excise this full thickness.
This was passed to pathology for review. The wound required # limited undermining in the deep subcutaneous plane on both sides for approximately 1.5 cm in order to allow mobilization of the skin for closure. The skin was then closed in a layered fashion using 3-0 Vicryl on the dermis and then 4-0 Monocryl running subcuticular in the skin, the wound was cleaned and dressed with Dermabond and Steri-Strips.
The patient was then cleaned and turned over to anesthesia for S extubation.
She was extubated successfully in the operating room and taken S to the recovery room in stable condition.
There were no complications.
What E/M code is reported for this encounter?

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

Answer: D

Explanation:

Established patient with moderate MDM
99214 aligns with CPC exam standards

NEW QUESTION # 368
(A patient presents with fatigue and unexplained weight gain. To evaluate possible thyroid dysfunction, the provider orders a single laboratory test to measurethyroid-stimulating hormone (TSH). A routine venous blood sample is collected and sent to the laboratory.Which CPT and ICD-10-CM codes are reported?)

- A. 84443, R53.83, R63.5
- B. 84443, E07.9, R53.83, R63.5
- C. 84445, R53.83, R63.5
- D. 84445, E07.9, R53.83, R63.5

Answer: A

Explanation:
TSH testing is reported with CPT84443. The scenario describes a workup for possible thyroid dysfunction, but there isno confirmed thyroid diagnosisprovided-only symptoms (fatigue and weight gain). In outpatient coding, when a definitive diagnosis is not established, you code thesigns/symptomsthat justify the test.
Therefore, the correct ICD-10-CM codes areR53.83(other fatigue) andR63.5(abnormal weight gain), as offered. You shouldnotassign a thyroid disorder code such asE07.9(unspecified disorder of thyroid) unless the provider documents an actual thyroid disorder diagnosis; suspicion alone does not support it in the outpatient setting. Options C and D list84445, which is not the standard CPT code for TSH measurement in CPC exam coding. This question is testing both correct lab code selection and the outpatient guideline principle of codingsymptomswhen the diagnosis is not confirmed. Hence,84443 with R53.83 and R63.5is correct.

NEW QUESTION # 369
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