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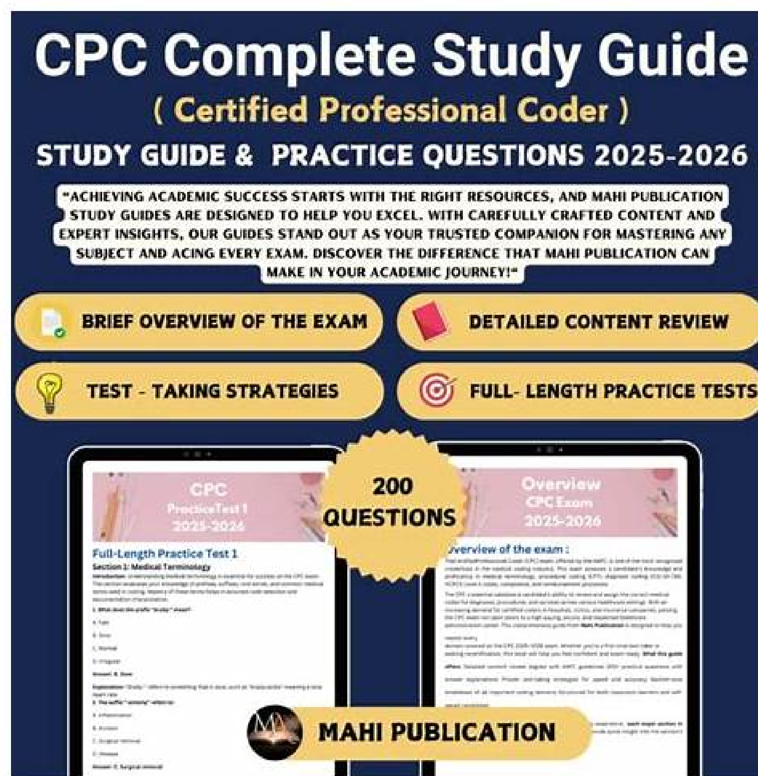

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AAPC CPC Exam Syllabus Topics:

Topic	Details

Topic 1	• 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 2	• 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	• 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	• 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 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	• 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 7	• 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 8	• 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 9	• 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	• 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 11	• 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 12	• 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 13	• 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 14	• 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 15	• 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 16	• 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.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q53-Q58):

NEW QUESTION # 53
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. 63042, 63043, 22808, 22841 x 3
- C. 63017, 63048, 22612, 22808, 22842 x 3
- D. 63047, 63048, 22612, 22614 x 3, 22842

Answer: D

Explanation:
* Laminectomy and Facetectomy (63047 and 63048): The laminectomies at L4 and L5 with facetectomies fall under CPT codes 63047 (for the initial segment) and 63048 (for each additional segment).
* Posterior Arthrodesis (22612 and 22614 x 3): The posterior arthrodesis from L1-L5 is coded with
22612 for the primary segment (L4-L5) and 22614 for each additional segment (L1-L4).
* Placement of Pedicle Screws (22842): The placement of pedicle screws at L2, L3, and L4 is captured under CPT code 22842 for segmental instrumentation.
References:
* AMA's CPT Professional Edition (current year)
* ICD-10-CM (current year)
* HCPCS Level II (current year)

NEW QUESTION # 54
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. 24300, 01710
- B. 24605, 01710
- C. 0
- D. 1

Answer: C

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 # 55
What does the term "manipulation" refer to in the context of fracture or dislocation treatment?

- A. The process of closing a wound associated with a fracture or dislocation.
- B. The process of applying force or traction to align a fracture or dislocation.
- C. The process of stopping bleeding from a fracture or dislocation.
- D. The surgical removal of the fractured or dislocated bone.

Answer: B

Explanation:
In CPT fracture and dislocation care, manipulation refers to the application of force or traction to restore a bone or joint to its normal anatomic position.
This is a key distinction between with manipulation and without manipulation, which directly affects CPT code selection (e.g., 23505 vs. 23500).
Manipulation may be performed closed (no incision) or open (with incision).

NEW QUESTION # 56
A 42-year-old male is diagnosed with a left renal mass. Patient is placed under general anesthesia and in prone position. A periumbilical incision is made and a trocar inserted. A laparoscope is inserted and advanced to the operative site. The left kidney is removed, along with part of the left ureter. What CPT code is reported for this procedure?

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

Answer: A

Explanation:
Laparoscopic nephrectomy: A minimally invasive surgical procedure to remove a kidney.
Part of the ureter: Removal includes part of the ureter.
50220: Nephrectomy (open procedure), which doesn't apply since the procedure was laparoscopic.
50548: Nephrectomy, partial, laparoscopic, which doesn't match the full nephrectomy performed.
50543: Laparoscopy, surgical; nephrectomy with total ureterectomy.
50543 is the correct CPT code for the laparoscopic removal of the kidney along with part of the ureter, fitting the scenario described.
Reference:
AMA's CPT Professional Edition (current year)
ICD-10-CM (current year), HCPCS Level II (current year)

NEW QUESTION # 57
Day 1 - A provider admits the patient to observation care for type 2 diabetes mellitus with hyperglycemia. The provider orders a HbA1c, a urine (microalbumin), and kidney function lab tests.
Blood sugar is high and poorly controlled. The provider discusses the case with the patient's endocrinologist. The provider prescribes an IV insulin drip, along with SQ insulin and keeps the patient in observation overnight.
Day 2 - Patient is in observation care and the provider orders a blood glucose test. The patient's glucose levels have improved. The provider places an order for the dietitian to see the patient.
Provider
documents spending a total time of 25 minutes with the patient.
Day 3 - Patient has a blood glucose test. The patient's glucose level is back to normal. The provider documents spending 15 minutes with the patient. The provider discharges the patient.

What E/M coding is reported by the physician for the patient in observation care?

- A. 99235, 99231, 99238
- B. 99235, 99238
- C. 99221, 99232, 99239
- D. 99222, 99231, 99238

Answer: A

Explanation:
For a patient in observation care, selecting the correct E/M codes requires evaluating each day's service level and the provider's documentation.
Day 1: The patient was admitted for observation, and the physician prescribed IV and SQ insulin, noting diabetes with hyperglycemia requiring complex management. The CPT code 99235 is appropriate here because it represents an initial observation or inpatient care for patients with high-complexity medical decision-making (MDM), which aligns with the patient's unstable glucose and the management requirements.
Day 2: The patient's glucose levels improved, and the provider documented spending 25 minutes with the patient in continued observation care. Since this is an established patient with continued observation, 99231 applies here, indicating subsequent observation care with low MDM complexity.
Day 3: The provider documented spending 15 minutes with the patient, whose glucose levels normalized, and then discharged the patient from observation care. Code 99238 is used for a discharge from observation care and is selected based on discharge times under 30 minutes.
These codes were selected based on CPT guidelines for observation care and the provider's time-based documentation. This matches the medical decision complexity documented per the case and code descriptions available for observation care management.

NEW QUESTION # 58
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