

New CPC Test Blueprint & Valid CPC Test Duration

CPC Exam Outline

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18. Cases	10

Time limit: 4 hours

Total questions: 100

Question format: Multiple-choice

Delivery format: Computer-delivered

Mometrix TEST PREPARATION

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The AAPC CPC PDF is the most convenient format to go through all exam questions easily. It is a compilation of actual AAPC

CPC exam questions and answers. The PDF is also printable so you can conveniently have a hard copy of AAPC CPC Dumps with you on occasions when you have spare time for quick revision. The PDF is easily downloadable from our website and also has a free demo version available.

AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<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 ear, as well as related diagnostic procedures.
Topic 2	<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 3	<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 4	<ul style="list-style-type: none"> 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 5	<ul style="list-style-type: none"> 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 6	<ul style="list-style-type: none"> 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 7	<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 8	<ul style="list-style-type: none"> 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	<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 10	<ul style="list-style-type: none"> 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 11	<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 12	<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 13	<ul style="list-style-type: none"> 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 14	<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 15	<ul style="list-style-type: none"> 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 16	<ul style="list-style-type: none"> 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.

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Valid CPC Test Duration & CPC Reliable Learning Materials

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q19-Q24):

NEW QUESTION # 19

The documentation states:

He was then steriley prepped and draped along the flank and abdomen in the usual sterile fashion. I first made a skin incision off the tip of the twelfth rib, extending medially along the banger's lines of the skin. This was approximately 3.5 cm in length. Once this incision was carried sharply, electrocautery was used to gain access through the external oblique, internal oblique, and transverse abdominis musculature and fascia.

What surgical approach was used for this procedure?

- A. Cannot determine based on the documentation
- B. Open**
- C. Percutaneous
- D. Laparoscopic

Answer: B

NEW QUESTION # 20

Refer to the supplemental information when answering this question:

View MR 000281

What anesthesia and diagnosis codes are reported for this case?

- A. 00811, D62, N18.6, Z99.2**

- B. 00812, D62, N18.6, Z99.2
- C. 00811, D64.9, K62.5, N18.6, Z99.2
- D. 00812, D64.9, K62.5, N18.6, Z99.2

Answer: A

Explanation:

CPT Code 00811: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to the splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing This code is reported for anesthesia services provided during a colonoscopy that is diagnostic in nature.

ICD-10-CM Code D62: Acute posthemorrhagic anemia

This is the most accurate postoperative diagnosis. The operative report states "Anemia due to acute blood loss." ICD-10-CM Code N18.6: End stage renal disease This code captures the patient's documented history of ESRD.

ICD-10-CM Code Z99.2: Dependence on renal dialysis

This code is necessary to report the patient's dialysis status, as it affects the overall risk of the procedure.

Why other options are incorrect:

00812: This code is for therapeutic colonoscopies, not diagnostic.

D64.9: This code is for anemia, unspecified. D62 is more specific to the patient's condition.

K62.5: This code is for lower gastrointestinal bleeding, but the anemia is the primary diagnosis in this case.

Reference:

CPT Code 00811: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to the splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing ICD-10-CM Code D62: Acute posthemorrhagic anemia

ICD-10-CM Code N18.6: End stage renal disease ICD-10-CM Code Z99.2: Dependence on renal dialysis AAPC

Coder's Desk Reference: This resource provides detailed information on coding guidelines and procedures.

NEW QUESTION # 21

An 8-year-old patient is placed under general anesthesia for treatment of a right orbital fracture due to a traumatic fall to the nose and face from a swing set. An on-call otolaryngologist is asked to perform a general otolaryngologic examination to evaluate the patient. A mild nasal fracture is the diagnosis given by the otolaryngologist.

What is the CPT and ICD-10-CM coding for the otolaryngologist's services?

- A. 0
- B. 21310, 92502-51
- C. 1
- D. 2

Answer: C

Explanation:

1. Procedure and CPT Code Selection:

The otolaryngologist was asked to perform a general otolaryngologic examination of the patient under general anesthesia to evaluate for injuries sustained from a traumatic fall.

CPT Code 92502 is appropriate for a general otolaryngologic examination under general anesthesia. This code is used specifically when an ENT examination is performed under anesthesia, as was the case here.

2. Rationale for Excluding Other Options:

Code 92512 is for nasal function studies, such as rhinomanometry, which does not apply to a general otolaryngologic examination. Code 21310 is for the treatment of a nasal fracture (closed treatment), which would only be appropriate if the otolaryngologist had performed a fracture reduction or repair. Since only an examination was performed, 21310 is not appropriate.

Code 92502-51 (option B) is incorrect because the -51 modifier (multiple procedures) is unnecessary; only a single examination was performed.

3. ICD-10-CM Code:

Since only the examination was performed and not treatment, the ICD-10-CM code for nasal fracture (likely S02.2XXA for unspecified fracture of the nasal bones, initial encounter) would be reported separately by the facility or based on final documentation.

4. AAPC and CPT Coding Guidelines:

AAPC guidelines support the use of 92502 for general ENT examinations performed under anesthesia, especially in cases of trauma evaluation without surgical intervention.

Therefore, the correct answer is D. 92502.

NEW QUESTION # 22

A provider performs a mastoidectomy and complete labyrinthectomy for right-sided peripheral vertigo. What CPT and ICD-10-CM codes are reported?

- A. 69905, 69990, H81.391
- B. 69910, 69990, H81.391
- C. 69905, 69990-51, R42
- D. 69910, 69990-51, R42

Answer: A

Explanation:

69905 = Transmastoid labyrinthectomy

69990 = Operating microscope (separately reportable)

H81.391 = Peripheral vertigo, right ear

R42 (dizziness) is not reported when a definitive diagnosis exists

RADIOLOGY & IMAGING QUESTIONS

NEW QUESTION # 23

A patient complains of tarry, black stool, and epigastric tightness. An esophagogastroduodenoscopy is recommended to evaluate the source of the bleeding. The endoscope is inserted orally. The esophagus appears normal on scope insertion. No evidence of bleeding in the stomach. The scope is then passed into the duodenum, where a polyp is found and removed with hot biopsy forceps. No evidence of bleeding post procedure.

What CPT code is reported?

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

Answer: D

NEW QUESTION # 24

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