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CPC Exam Outline

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Time limit: 4 hours
Total questions: 100
Question format: Multiple-choice
Delivery format: Computer-delivered

Mometrix TEST PREPARATION

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Taking CPC practice exams is also important because it helps you overcome your mistakes before the final attempt. When we talk about the Certified Professional Coder (CPC) Exam (CPC) certification exam, the AAPC CPC practice test holds more scoring power because it is all about how you can improve your CPC Exam Preparation. UpdateDumps offers desktop practice exam software and web-based CPC practice tests. These CPC practice exams help you know and remove mistakes.

AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<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 2	<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 3	<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 4	<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 5	<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 6	<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 7	<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 8	<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 9	<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 10	<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 and exam components per current CMS guidelines.
Topic 11	<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 12	<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 and inner ear, as well as related diagnostic procedures.
Topic 13	<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 14	<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.
Topic 15	<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 16	<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 17	<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 18	<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 19	<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.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q316-Q321):

NEW QUESTION # 316

A 5-year-old is brought to the QuickCare in the ED to repair two lacerations: a 3 cm laceration on her right arm and 2 cm laceration

on her nose. Her arm is repaired with a simple one-layer closure with sutures. Her nose is repaired with a simple repair using tissue adhesive, 2-cyanoacrylate.

How are the repairs reported?

- A. 0
- B. 12032, 12041-59
- **C. 1**
- D. 12002, 12011-59

Answer: C

Explanation:

The CPT code 12002 is used for simple repair of superficial wounds of 2.5 cm or less. This code includes the repair of both the 3 cm laceration on the right arm and the 2 cm laceration on the nose as both are simple repairs. The other options suggest more complex repairs or multiple separate procedures, which are not necessary in this scenario. References: AMA's CPT Professional Edition (current year)

NEW QUESTION # 317

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 CPT codes are reported?

- A. 35876-RT, 75710-26
- B. 35875-RT, 75716-26
- C. 37184-RT, 75716-26
- **D. 35875-RT, 75710-26**

Answer: D

Explanation:

35875 = Thrombectomy, femoral-popliteal artery

RT = Right side

75710-26 = Angiography, extremity, unilateral, professional component

NEW QUESTION # 318

A patient presents to the labor and delivery department for a planned cesarean section for triplets. She is at 37 weeks gestation. She is given a continuous epidural for the delivery.

What anesthesia coding is reported?

- A. 01958
- B. 01967
- C. 01967, 01968
- D. 01961

Answer: C

Explanation:

The patient presents for a planned cesarean section for triplets and receives continuous epidural anesthesia. CPT code 01967 is used for neuraxial labor analgesia/anesthesia for planned vaginal delivery, and code 01968 is an add-on code for cesarean delivery following neuraxial labor analgesia/anesthesia. Since this is a planned cesarean section with triplets, both codes 01967 and 01968 are applicable.

NEW QUESTION # 319

A patient has a 5 cm tumor in the left lower quadrant abdominal wall, excised through dermis and subcutaneous tissue. Pathology is pending to rule out cancer.

What CPT and ICD-10-CM codes are reported?

- A. 22903, D49.2
- B. 22901, D49.2
- C. 22903, R19.04

Answer: A

Explanation:

22903 = Excision of soft tissue tumor, abdominal wall, subcutaneous, 3 cm or greater D49.2 = Neoplasm of unspecified behavior of soft tissue R codes are not used when a neoplasm is documented

NEW QUESTION # 320

An abdominal X-ray includes decubitus, supine, and erect views.

What CPT code is reported?

- A. 74018-26
- B. 74021-26
- C. 74022-26
- D. 74019-26

Answer: B

Explanation:

74021 = Abdomen, complete, including decubitus and erect views

-26 = Professional component

NEW QUESTION # 321

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