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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	• 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 2	• 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 3	• 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	• 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 5	• 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 6	• 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 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	• 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 9	• 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 10	• 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 11	• 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 12	• 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 13	• 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 14	• 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 15	• 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 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	• 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q226-Q231):

NEW QUESTION # 226
A patient is diagnosed with sepsis and associated acute respiratory failure.
What ICD-10-CM code selection is reported?

- A. A41.9, R65.20, J96.00
- B. A41.9, R65.21, J96.00
- C. A41.9
- D. A41.9, J96.00

Answer: B

Explanation:
For a patient diagnosed with sepsis and associated acute respiratory failure, the ICD-10-CM codes are:
A41.9: Sepsis, unspecified organism.
R65.21: Severe sepsis with septic shock.
J96.00: Acute respiratory failure, unspecified whether with hypoxia or hypercapnia.
These codes appropriately capture the severity of the sepsis and the presence of acute respiratory failure.
ICD-10-CM guidelines
AMA's CPT Professional Edition (current year)

NEW QUESTION # 227
(Full Case:Preoperative diagnosis:Low back pain; possible spinal stenosis L3-4.Postoperative diagnosis:No evidence of discogenic pathology or spinal stenosis at L3-4; normal discography L3-4.Procedure:Awake discography and injection, L3-4.Anesthesia:IV narcotic with reversal and local; propofol given transiently, then patient alert/responsive for pain response during injection.Technique:Patient to OR; right decubitus; sterile prep/drape; C-arm used to mark entry; local ethyl chloride + 1% Xylocaine; docking needle placed posterolateral at L3-4 under AP/lateral; inner needle advanced to disc nucleus center; contrast injected while monitoring patient response; normal bilocular pattern; 1.5 cc volume; no pain with pressurization.
Documentation:No videotape; plain films available; post-discography CT planned/reviewed for other causes.
Question:What CPT and ICD-10-CM coding is reported?)

- A. 62292, M54.50
- B. 62290, M48.061, M54.50
- C. 62290, M54.50
- D. 62292, M48.07, M54.50

Answer: C

Explanation:
This service is alumbar discographyat a single level (L3-L4) withinjection of contrastinto the intervertebral disc underfluoroscopic (C-arm) guidancewhile the patient is awake/able to report symptoms, which is exactly what CPT62290describes for diagnostic discography at a lumbar level. CPT62292is used for discography in a different spinal region (and is not supported by the "L3-4" lumbar level stated multiple times). The post- discography CT scan is referenced as planned/reviewed but is not clearly documented as performed
/interpreted as part of this same physician service in the stem, and it is not part of the answer choices. For ICD-10-CM, the confirmed postoperative finding is "normal discography," but the reason for the study remains the patient'slow back painand suspected stenosis; in outpatient/procedural settings you code thereason for the testwhen the definitive suspected condition is not confirmed. Here, the stenosis was ruled out ("no evidence"), so donotcode spinal stenosis; reportM54.50for low back pain. Therefore,62290 with M54.50is correct.

NEW QUESTION # 228
A 47-year-old female presents to the operating room for a partial corpectomy on one upper thoracic vertebral body, T3. Two

surgeons are performing the surgery. One surgeon performs the transthoracic approach and excises the damaged portion of the vertebral body. The second surgeon inserts a bone graft into the vertebral gap, closing the gap, and inserts a metal plate. Both surgeons work together, each as a primary surgeon.
How does each surgeon report their portion of the surgery?

- A. 63090-66, 63091-66
- B. 63085-62, 63086-62
- C. 63090-80, 63091-80
- D. 63087-62, 63088-62

Answer: D

Explanation:
For this scenario, two surgeons are working together, each as a primary surgeon. Therefore, the correct coding requires the use of the modifier -62, which indicates co-surgeons.
The transthoracic approach to excise the damaged portion of the vertebral body is coded with 63087.
The insertion of the bone graft and metal plate is coded with 63088.
Both codes are appended with modifier -62 to indicate that two surgeons worked together as primary surgeons on this case.
Reference:
AMA's CPT Professional Edition (current year)
ICD-10-CM (current year)
HCPCS Level II (current year)

NEW QUESTION # 229
A patient has nausea with several episodes of emesis along with severe stomach pain due to dehydration.
Normal saline is infused in the same bag with 2 mg ondansetron to help with the nausea. Then a dose of 15 mg ketorolac tromethamine was given for the stomach pain.
What J codes are reported for these services?

- A. J2405 x 2, J1835 x 15
- B. J2405 x 2, J1885
- C. J2405, J1885
- D. J2405, J1885 x 15

Answer: C

Explanation:
The correct J codes are selected based on the specific medications administered and their quantities:
J2405 represents "ondansetron, 1 mg," and since the patient received a 2 mg dose, J2405 is reported once with a quantity of 2 mg.
J1885 represents "ketorolac tromethamine, 15 mg," which matches the single 15 mg dose administered to the patient, so J1885 is reported once.
Each J code is billed according to the precise dosage given, as no multipliers are required beyond the single- unit codes provided in choice A, making it the correct answer.

NEW QUESTION # 230
(A female patient underwent a mastectomy on herleft breastlast year due to breast cancer. The surgery was successful in eliminating the cancer and no further treatment was required. However, a recent diagnosis now includes cancer thatmetastasized to her liver.
What ICD-10-CM coding is reported?)

- A. C78.7, C79.81
- B. C22.9, C50.912
- C. C78.7, Z85.3
- D. C78.7, C50.912

Answer: C

Explanation:
When a prior malignancy has been eradicated and the patient is no longer receiving treatment for the primary site, ICD-10-CM directs you to use apersonal history of malignant neoplasmcode rather than an active primary cancer code. Here, the breast cancer

was treated successfully last year and no further therapy was required, so the breast cancer ishistory, not active. The new current condition ismetastatic cancer to the liver, which is coded as asecondary malignant neoplasm of liver and intrahepatic bile duct (C78.7). Because the primary breast cancer is not documented as active or under current treatment, you donotcode an active breast malignancy (C50.-). Instead, you addZ85.3 (personal history of malignant neoplasm of breast)to show the prior cancer history relevant to the current metastatic disease. Option A incorrectly codes a primary liver cancer. Option C incorrectly codes active breast cancer. Option D codes metastasis to the adrenal gland, not the liver.

NEW QUESTION # 231

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