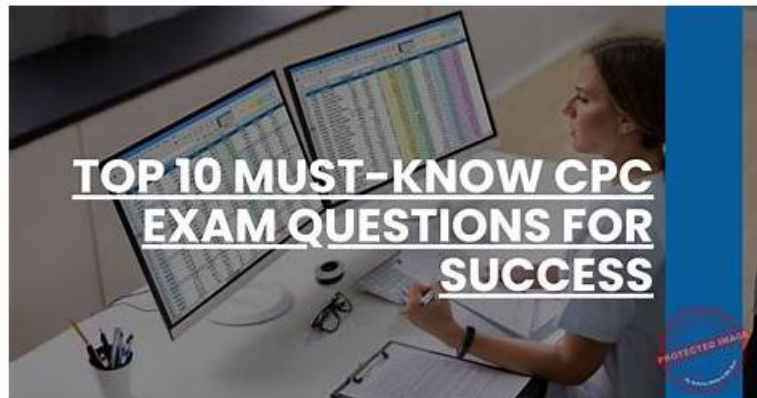


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>> CPC Valid Test Syllabus <<

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### AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"><li>• Pathology &amp; 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.</li></ul>
Topic 2	<ul style="list-style-type: none"><li>• 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.</li></ul>
Topic 3	<ul style="list-style-type: none"><li>• 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.</li></ul>

Topic 4	<ul style="list-style-type: none"> <li>• <b>Special Senses (Ocular and Auditory):</b> 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</li> <li>• inner ear, as well as related diagnostic procedures.</li> </ul>
Topic 5	<ul style="list-style-type: none"> <li>• <b>Female Reproductive System and Maternity Care &amp; Delivery:</b> 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.</li> </ul>
Topic 6	<ul style="list-style-type: none"> <li>• <b>Musculoskeletal System:</b> 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.</li> </ul>
Topic 7	<ul style="list-style-type: none"> <li>• <b>Integumentary System:</b> 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.</li> </ul>
Topic 8	<ul style="list-style-type: none"> <li>• <b>Evaluation &amp; Management Services:</b> This section of the exam measures the skills of coding specialists and covers office visits, hospital care, consultations, and other E</li> <li>• M services. It tests the understanding of time-based coding, medical decision-making, and history</li> <li>• exam components per current CMS guidelines.</li> </ul>
Topic 9	<ul style="list-style-type: none"> <li>• <b>Digestive System:</b> 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.</li> </ul>
Topic 10	<ul style="list-style-type: none"> <li>• <b>Endocrine System and Nervous System:</b> 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.</li> </ul>
Topic 11	<ul style="list-style-type: none"> <li>• <b>Overview of ICD-10-CM:</b> 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.</li> </ul>
Topic 12	<ul style="list-style-type: none"> <li>• <b>Accurate ICD-10-CM Coding:</b> 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.</li> </ul>
Topic 13	<ul style="list-style-type: none"> <li>• <b>Introduction to CPT®, HCPCS Level II, and Modifiers:</b> 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.</li> </ul>
Topic 14	<ul style="list-style-type: none"> <li>• <b>Radiology:</b> 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.</li> </ul>
Topic 15	<ul style="list-style-type: none"> <li>• <b>Applying the ICD-10-CM Guidelines:</b> 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.</li> </ul>

## AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q255-

## Q260):

### NEW QUESTION # 255

A 40-year-old woman with progressive sensory neural hearing loss in the right ear since the age of 13 has not gained benefit from her hearing aid. She has normal hearing in the left ear. A cochlear implant is placed for the right ear. Anesthesia is provided by a CRNA with medical direction by an anesthesiologist who is concurrently directing 5 CRNAs. PS is 3.

What anesthesia CPT and ICD-10-CM codes are reported by the Anesthesiologist?

- A. 00300-QX-P3, H90.5
- B. 00120-AA-P3, H90.41
- C. 00120-AD-P3, H90.41
- D. 00300-QY-P3, H90.5

**Answer: C**

Explanation:

Anesthesia CPT:

00120 - Anesthesia for ear procedures

AD modifier:

Anesthesiologist medically directing >4 CRNAs

P3 - Severe systemic disease

Diagnosis Code:

H90.41 - Sensorineural hearing loss, unilateral, right ear

Why others are incorrect:

AA - Personally performed

QX / QY - Incorrect direction model

H90.5 - Unspecified hearing loss

### NEW QUESTION # 256

(A driver crashes into a guardrail and sustains a fracture of the anterior fossa cranial base with involvement of the sphenoid sinus, without CSF leak. The patient undergoes surgical nasal sinus endoscopy with sphenoidotomy to evaluate and treat the sinus injury. No CSF leak repair is performed. What is the correct procedure and diagnosis coding combination to report this service?)

- A. 31291, 31231-59, S02.19XA
- B. 31291, S02.109A
- C. 31287, S02.19XA
- D. 31287, 31231-59, S02.109A

**Answer: C**

Explanation:

Asphenoidotomy performed via nasal/sinus endoscopy is specifically reported with CPT 31287 (endoscopic sinus surgery, sphenoidotomy). A diagnostic nasal endoscopy code (such as 31231) is generally not separately reported when it is integral to performing the surgical endoscopic sinus procedure, so options including 31231-

59 are incorrect in typical CPT exam logic unless a distinct, separately identifiable diagnostic endoscopy is clearly documented and medically necessary beyond the surgical approach. The diagnosis describes a fracture of the skull base involving the sphenoid sinus without CSF leak; among the offered diagnosis codes, S02.

19XA correctly represents a skull base fracture category consistent with the scenario's specificity as presented in the answer choices.

Code 31291 represents a different sinus procedure (not sphenoidotomy). CPC key point:

choose the code matching the specific sinus and surgical action (sphenoidotomy # 31287) and avoid unbundling the diagnostic endoscopy that is part of the operative endoscopic approach.

### NEW QUESTION # 257

A 26-year-old male presents with a deep laceration from a kitchen knife to his right hand. The surgeon washes the open wound with sterile saline. Clamps are applied. The provider cleans the vessel and prepares the edges of the wound. She then repairs the bleeding vessel with sutures. The clamps are removed and the provider uses a Doppler probe to check the blood flow pattern through the repaired vessel.

What CPT code is reported?

- A. 35702-RT
- **B. 35207-RT**
- C. 35236-RT
- D. 35206-RT

**Answer: B**

Explanation:

1. Procedure and CPTCode Selection:

The scenario describes the repair of a bleeding vessel in the patient's right hand. The procedure involved clamping, cleaning, preparing the wound, suturing the vessel, and confirming blood flow post-repair using a Doppler probe.

Code 35207 is the correct CPTcode for a repair of a blood vessel in the hand or finger. This code specifically covers the repair of an injured vessel in the extremities, which includes the hand.

Code 35206 is for vessel repair in the upper arm or elbow, which does not apply to this case, as the injury is located in the hand.

Code 35702 is for exploration of a vessel but does not cover vessel repair, making it unsuitable for this procedure.

Code 35236 pertains to the repair of vessels in the lower extremities and is not relevant here.

2. Modifier:

Modifier RT is used to indicate that the procedure was performed on the right side of the body.

3. AAPC and CPTCoding Guidelines:

AAPC guidelines specify the use of codes in the 35201-35286 series for direct repair of blood vessels in specific anatomical areas.

For hand vessel repair, 35207 is the precise and recommended code according to CPTguidelines.

Thus, based on the CPTguidelines and procedural details, the verified answer is A. 35207-RT.

### NEW QUESTION # 258

A 65-year-old gentleman presents for refill of medications and follow-up for his chronic conditions. The patient indicates good medicine compliance. No new symptoms or complaints.

Appropriate history and exam are obtained. Labs that were ordered from previous visit were reviewed and discussed with patient.

The following are the diagnoses and treatment:

Hypokalemia - stable. Refill Potassium 20 MEQ

Hypertension - blood pressure remaining stable. Patient states home readings have been in line with goals. Refill prescription Lisinopril.

Esophageal Reflux - Patient denies any new symptoms. Stable condition. Continue taking over the counter Prevacid oral capsules, 1 every day.

Patient is instructed to follow up in 3 months. Labs will be obtained prior to visit.

What CPT code is reported?

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

**Answer: C**

Explanation:

The patient presented for a follow-up visit for chronic conditions, including hypokalemia, hypertension, and esophageal reflux. During this visit, the physician reviewed and discussed lab results, managed prescriptions, and noted that there were no new symptoms or complaints.

The level of service provided included an appropriate history and exam, as well as the management of multiple chronic conditions, which aligns with the criteria for CPT code 99214. This code is used for an established patient office or other outpatient visit that requires at least 2 of the following 3 key components: a detailed history, a detailed examination, and medical decision-making of moderate complexity.

CPT Professional Edition, AMA

Evaluation and Management Coding Guidelines

### NEW QUESTION # 259

Which place of service code is submitted on the claim for a service that is performed in an outpatient surgical floor?

- A. 0
- **B. 1**

- C. 2
- D. 3

**Answer: B**

## NEW QUESTION # 260

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