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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	• 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 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	• 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 5	• 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 6	• 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 7	• 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 8	• 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 9	• 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 10	• 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 11	• 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 12	• 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 13	• 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 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	• 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 16	• 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.

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AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q69-

Q74):

NEW QUESTION # 69
The evisceration of ocular contents was performed using a surgical microscope for enhanced visualization. The procedure was performed on the left eye and an implant was not placed in the ocular cavity.
What CPT coding is reported?

- A. 65093-LT
- B. 65091-LT, 69990-51
- C. 65091-LT
- D. 65093-LT, 69990

Answer: C

Explanation:
1. Procedure and CPT Code Selection:
The procedure performed was an evisceration of ocular contents without the placement of an implant. The surgical microscope was used for enhanced visualization, but this does not require a separate code if the primary procedure code includes it inherently.
CPT Code 65091 is used for an evisceration of the ocular contents without implant placement. This code correctly describes the procedure performed on the left eye.
2. Modifier:
Modifier LT is added to indicate that the procedure was performed on the left eye.
3. Exclusion of Code 69990:
Code 69990 is for the use of an operating microscope, but it should not be billed separately when it is used as part of a procedure where enhanced visualization is typical or expected, such as an evisceration procedure. According to CPT guidelines, 69990 is not separately reported when the microscope is used for visualization in procedures where its use is considered part of the standard of care.
4. Rationale for Excluding Other Options:
Code 65093 is for an evisceration with implant placement, which does not apply since no implant was used.
Options B and C incorrectly include 69990, which is not separately reportable in this scenario.
5. AAPC and CPT Coding Guidelines:
According to AAPC and CPT coding guidelines, 65091 is sufficient to capture the procedure without the need to add code 69990 for the microscope.
Therefore, the correct answer is D. 65091-LT.

NEW QUESTION # 70
A 44-year-old female patient with chest pains had a CT of her chest that identified a mass in her left lower lung. The patient currently has ovarian cancer with metastases to the liver. The radiologist suspects the cancer has spread to her lungs. The physician performed an outpatient bronchoscopic biopsy and the pathology report documents the mass as a tumor of uncertain behavior.
What ICD-10-CM codes are reported for this patient?

- A. D38.1, C56.9, C78.7
- B. R91.8, C56.9, C78.7
- C. C78.02, C22.9, C79.82
- D. C56.9, C78.7, C78.02

Answer: A

Explanation:
For a patient with a mass in the left lower lung suspected to be cancer that is currently documented as a tumor of uncertain behavior, with existing ovarian cancer with metastases to the liver, the ICD-10-CM codes are:
D38.1: Neoplasm of uncertain behavior of bronchus and lung.
C56.9: Malignant neoplasm of unspecified ovary.
C78.7: Secondary malignant neoplasm of liver and intrahepatic bile duct.
D38.1 is used because the behavior of the lung tumor is uncertain, and C56.9 and C78.7 are used to document the known primary and metastatic cancers.
ICD-10-CM guidelines
AMA's CPT Professional Edition (current year)

NEW QUESTION # 71
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 partially removed.
What CPT @ code is reported for this procedure?

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

Answer: A

Explanation:
1. Procedure and CPTCode Selection:
The patient underwent a partial nephrectomy (removal of part of the left kidney) via a laparoscopic approach.
CPTCode 50543 is specifically used for a laparoscopic partial nephrectomy, which is an accurate description of this procedure.
2. Rationale for Excluding Other Options:
Code 50548 is used for a laparoscopic radical nephrectomy, which involves the complete removal of the kidney and surrounding structures; therefore, it does not apply to this partial nephrectomy.
Code 50220 represents an open partial nephrectomy, not a laparoscopic approach, and is therefore incorrect for this procedure.
Code 50546 is for a laparoscopic radical nephrectomy with bilateral removal of kidneys, which is not applicable in this case where only a partial removal of the left kidney was performed.
3. AAPC and CPTCoding Guidelines:
AAPC and CPTguidelines indicate that the use of 50543 is appropriate for any laparoscopic partial nephrectomy, regardless of the laterality, and it specifically identifies laparoscopic technique over open surgery.
Therefore, based on CPTguidelines, the correct answer is C. 50543.

NEW QUESTION # 72
In rhinoplasty:

- A. The lips are reconstructed
- B. The nose is reconstructed
- C. The brow is reconstructed
- D. The chin is reconstructed

Answer: B

Explanation:
Rhinoplasty is a surgical procedure performed to reconstruct or reshape the nose. It can be done for cosmetic reasons or to improve breathing function. The term "rhino" refers to the nose, and "plasty" refers to the surgical molding or forming of a part of the body.
AMA's CPT Professional Edition, medical dictionaries

NEW QUESTION # 73
A 47-year-old male with a history of peripheral artery disease presents with worsening claudication of the left leg. A diagnostic angiography confirms stenosis in the left iliac artery. To restore blood flow to the left leg, the vascular surgeon plans to perform angioplasty, using a balloon to dilate the vessel lumen followed by placement of an expandable stent in the left iliac artery.
What CPT coding is reported for the procedure?

- A. 37267,37263
- B. 37258,37254
- C. 0
- D. 1

Answer: D

Explanation:
The clinical scenario involves a diagnostic angiography (not separately reportable in this case as the therapeutic intervention occurs in the same session and the diagnosis is already known) and a percutaneous transluminal angioplasty (PTA) with stent placement in the

left iliac artery.
To code this correctly:
CPT Code 37267: Transluminal stent placement(s), includes angioplasty within the same vessel, when performed; iliac artery.
This code includes the angioplasty if it is performed in the same vessel as the stent (which is true here - both procedures are done in the left iliac artery).
Since angioplasty is inherent to the stenting (to open the narrowed vessel before stent placement), only the stent code is reported.
No need to report angioplasty separately (e.g., 37263) when performed in the same vessel as the stent.
Other options explained:
A . 37267, 37263 - Incorrect. 37263 (angioplasty in the iliac artery) would only be reported if angioplasty was done in a separate iliac artery segment without stenting. Reporting both codes for the same vessel would be unbundling and against CPT/NCCI guidelines.
B . 37258, 37254 - Incorrect. These codes relate to renal artery procedures, not iliac artery.
C . 37258 - Also incorrect, as this refers to renal stent placement, not iliac.
Official CPT Guideline Reference:
In the CPT manual (Category I codes, 37220-37235), specific instructions state that angioplasty is included when performed in the same vessel as a stent and should not be reported separately.

NEW QUESTION # 74
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