AAPC

Medical Coding Training

CPC®

Certified Professional Coder

Certification Preparation

2023

2023

Official Study Guide
CPC® Certification

AAPC

Disclaimer

This course was current when it was published. Every reasonable effort has been made to assure the accuracy of the information within these pages. The ultimate responsibility lies with readers to ensure they are using the codes, and following applicable guidelines, correctly. AAPC employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free, and will bear no responsibility or liability for the results or consequences of the use of this course. This guide is a general summary that explains guidelines and principles in profitable, efficient healthcare organizations.

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Regarding HCPCS Level II

HCPCS Level II codes and guidelines discussed in this book are current as of press time.

Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides, exams, and workbooks are actual, redacted office visits and procedure notes donated by AAPC members. To preserve the real world quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

Reviewers:

Katherine Abel, CPC, CPB, CPMA, CPPM, CDEI, AAPC Approved Instructor, AAPC Fellow

Angela Abu-Khamseen, CPC, AAPC Approved Instructor

Lynn Anderanin, CPC, CPB, CPMA, CPPM, COSC, AAPC Approved Instructor

Lindsay Anne Jenkins, CPC, COC, CANPC, CIRCC, CPMA, AAPC Approved Instructor

Nicole Benjamin, CPC, CEDC, AAPC Approved Instructor

Rhonda Buckholtz, CPC, CPMA, CRC, CDEO, CENTC, CGSC, COBGC, COPC, CPEDC, AAPC Approved Instructor

Angie Clements, CEMC, CGSC, COSC, CPC, CPMA, AAPC Approved Instructor, AAPC Fellow

Julie Davis, CPC, CDEO, COC, CPCO, CPMA, CRC, AAPC Approved Instructor

Renee Dustman, BS, AAPC MACRA Proficient

Kristie Fissler, CPC, COC, CPMA, COSC

Ryan Gosselin, CPC, CPB, CPCO, CPMA, CPPM, CRC, CDEO, AAPC Approved Instructor

Christine Hall, CPC, CPB, CPMA, CRC, AAPC Approved Instructor

Jaci Johnson

Melissa Kirshner, CPC, CRC, CDEO, CFPC, AAPC Approved Instructor, MACRA Proficient, AAPC Fellow

Craig Laursen, CPC, CDEI, AAPC Approved Instructor

Lindaev, CPC, CPCO, CPMA, CCC, CEMC, CGSC, AAPC Approved Instructor

Deborah Marsh, CPC, CHONC

Marissa McClure, CPC, CPB

Kathleen M. Skolnick, COC, CPC, CPCO, CPB, CPMA, CPPM, CEMC, CRC, CDEO, CEDC, CIRCC, COBGC, AAPC Approved Instructor

Kellie Nianajadly, CPC. CANPC, CASCC

John Piaskowski, CCC, CCVTC, CGIC, CGSC, CIRCC, COSC, CPC, CPMA, CRC, CUC, AAPC Approved Instructor

Mia Reddick-Smith, CPC, CPB, CPMA, COC, AAPC Approved Instructor

LisaRae Roper, CPC

Annette Telafor, CPC, CPB, CDEO, CPCO, CPMA, CPPM, CRC, AAPC Approved Instructor

Linda Vargas, CPC, CPCO, CPMA, CCC, CEMC, CGSC, AAPC Approved Instructor

Katie Williams, CPC, CPMA, CRC, COC, CANPC, COSC

Kathryn Williamson, CPC, CIC, CDEI, AAPC Approved Instructor

Dawn Wuerthner, CPC, AAPC Approved Instructor

Charleen Yamasato, CPC, AAPC Approved Instructor

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Answers and Rationales for Test Your Knowledge

Coding as a Profession

Each time an individual receives healthcare, a record is maintained of the resulting observations, medical or surgical interventions, diagnostic test and studies, and treatment outcomes. Coding is the process of translating this written or dictated medical record into a series of numeric and alphanumeric codes. There are separate code sets to describe diagnoses, medical and surgical services/procedures, and supplies. These code sets serve as a common language to ease data collection (for example, to track disease), to evaluate the quality of care, and to determine costs and reimbursements.

Proper code assignment is determined both by the content (documentation) in the medical record and by the unique rules that govern each code set in that instance. Coding rules also may vary depending on who pays for the patient care, such as self-pay or health insurance.

Coding is typically performed by either the physician or a coder. When the physician performs the coding, the coder may take on the role of an auditor to verify that the documentation supports the codes the physician selected. In some practices, the coder will receive the medical record and code the services based on what is documented in the notes.

If the medical record is inaccurate or incomplete, it will not translate properly to the language of codes. The coder must evaluate the medical record for completeness and accuracy and communicate regularly with physicians and other healthcare professionals to clarify diagnoses or to obtain additional patient information.

Outpatient coding focuses on physician professional services and outpatient facility coding. Outpatient coders will focus on learning CPT®, HCPCS Level II, and ICD-10-CM codes. They will work in physician offices, outpatient clinics, and facility outpatient departments. Outpatient facility coders will also work with Ambulatory Payment Classifications (APCs).

Hospital inpatient coding focuses on a different subset of skills, where coders will work with ICD-10-CM and ICD-10-PCS. These coders also will assign medical severity diagnosis related groups (MS-DRGs).

Risk adjustment coding focuses on diagnosis coding using the ICD-10-CM code set. Risk adjustment diagnoses are pulled from claims data and medical record documentation in all settings. Risk adjustment coders can work for health plans, providers, or other healthcare entities.

Regardless of the setting, code updates and insurance payment policies may change as often as quarterly. Coders require continuing education to stay abreast of these changes.

The Hierarchy of Providers

A variety of medical providers staff physician offices and hospitals, including physicians and non-physician providers (NPPs) (also known as mid-level providers or physician extenders), such as physician assistants (PA) and nurse practitioners (NP). NPPs are often reimbursed at a lower rate than physicians and require physician oversight. Different providers have different levels of education, and each state has scope of practice guidelines for the various provider levels. Check your state health board's website for scope of practice information.

The Different Types of Payers

Although some patients will pay in full for their own medical expenses, most patients will have some type of insurance coverage. There are two primary types of insurers: commercial and government.

Commercial carriers are private payers that may offer both group and individual plans. The contracts they provide vary, but may include hospitalization, basic, and major medical coverage. For example, Blue Cross Blue Shield organizations are private payers who usually operate in the state in which they are based.

The most significant government insurer is Medicare. Medicare is a federal health insurance program — administered by the Centers for Medicare & Medicaid Services (CMS) — that provides coverage for people over the age of 65, blind or disabled individuals, and people with permanent kidney failure or end-stage renal disease (ESRD). CMS regulations determine the coding requirements for Medicare and non-Medicare payers alike. The Medicare program is made up of several parts:

- Medicare Part A helps cover inpatient hospital care, as well as care provided in skilled nursing facilities, hospice care, and home healthcare.
- Medicare Part B helps cover medically necessary physicians' services, outpatient care, and other medical services (including some preventive services) not covered under Medicare Part A. Medicare Part B is an optional benefit for which the patient must pay a premium, and which generally requires a yearly deductible and co-insurance.

- Medicare Part C, also called Medicare Advantage, combines the benefits of Medicare Part A, Part B, and—sometimes—Part D. The plans are managed by private insurers approved by Medicare. The plans may charge different co-payments, coinsurance, or deductibles for services.
- Medicare Part D is a prescription drug program available to all Medicare beneficiaries. Private companies approved by Medicare provide coverage.

Medicaid is a health insurance assistance program for some low-income people (especially children and pregnant women) sponsored by federal and state governments. It is administered on a state-by-state basis, but state programs must adhere to certain federal guidelines.

State-funded insurance programs providing coverage for children up to 21 years of age may include, Children's Medical Services, Children's Indigent Disability Services, and Children with Special Healthcare Needs, among others.

Understanding RBRVS

Medicare payments for physician services are standardized using a resource-based relative value scale (RBRVS). Resource

costs are divided into three components: physician work, practice expense, and professional liability insurance.

- The physician work component accounts for just over half (52 percent) of a procedure's/service's total relative value. Physician work is measured by the time it takes to perform the service; the technical skill and physical effort; the required mental effort and judgment; and stress due to the potential risk to the patient.
- Practice expense accounts for 44 percent of the total relative value for each service. Practice expense relative values are resource-based and differ by site of service because, for example, the expense of providing a service in the hospital may be different than the expense of providing the same service in a physician's office.
- The resource-based professional liability insurance (PLI) component accounts for 4 percent of the total relative value for each service.

Below is an excerpt from the 2023 National Medicare Physician Fee schedule, which lists the component values for each CPT® and HCPCS Level II code.

Hcpcs Code	Modifier	Short Description	Proc Stat Code	Not Used For Medicare	Work Rvu	Non-Fac Pe Rvu	Facility Pe Rvu	Mp Rvu	Non-Fac Total	Facility Total
99214		Office /outpatient visit est	A		1.92	1.73	0.82	0.14	3.79	2.88

Table 1.1
Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

CMS annually publishes Physician Fee Schedule (PFS) information on its website (www.cms.hhs.gov/PhysicianFeeSched/) and posts the formula for calculating PFS payment amounts.

Medical Necessity

The term "medical necessity" refers to whether a procedure or service is considered appropriate in a given circumstance. Generally, a medically necessary service or procedure is the least radical service/procedure that allows for effective treatment of the patient's complaint or condition.

CMS has developed policies regarding medical necessity based on regulations found in title XVIII, §1862(a)(1) of the Social Security Act. When a physician provides services to a Medicare beneficiary, he or she should bill only those services that meet

the Medicare standard of "reasonable and necessary" for the diagnosis and treatment of a patient.

National Coverage Determinations (NCDs) explain when Medicare will pay for items or services. Each Medicare Administrative Contractor (MAC) is responsible for interpreting national policies into regional policies, called Local Coverage Determinations (LCDs).

LCDs have jurisdiction only within their regional area. If an NCD doesn't exist for an item, it is up to the MAC to determine coverage.

Commercial (non-Medicare) payers may develop their own medical policies that may not follow Medicare guidelines, and are specified in private contracts between the payer and the practice or provider.

Introduction

This chapter will review medical vocabulary and terminology and introduce the basic elements of human anatomy. You may encounter terms not covered here within subsequent chapters. Objectives for this chapter include:

- Review word elements such as combining forms, prefixes, and suffixes
- Acquire an understanding of procedural and diagnostic terms
- Understand anatomy as it relates to coding

Medical Terminology

The best way to learn medical terminology is by understanding word parts and elements of medical language—root words, prefixes, and suffixes—that serve as the foundation of the medical vocabulary.

The base of the word is considered the root. Root words can stand alone as the main portion of a medical term and the part that holds its fundamental meaning. A word can have more than one root.

Combining vowels are attached to root words to link the root word with the suffix, or one root word to another root word. Combining vowels also make medical terms easier to pronounce. The most common combining vowels are O and I. Occasionally, these vowels are dropped altogether, such as when the suffix begins with a vowel; however, the combining vowel is always placed between two root words, even when the second root word begins with a vowel.

Examples may include:

Root word/Definition

Blephar/o	eyelid
Bucc/o	cheek
Cholecyst/o	gallbladder
Colp/o	vagina
Cyst/o	a fluid sac or pouch, urinary bladder
Derm/o	skin
Encephal/o	brain
Enter/o	intestine
Hem/o, hemat/o	blood

My/o	muscle
Myel/o	spinal cord, bone marrow
Onych/o	nail
Oste/o	bone
Phleb/o	vein
Pulm/o, pulmon/o	lungs
Synov/i	synovial fluid, joint, or membrane

A prefix typically is attached to the beginning of a word to modify or alter its meaning. Prefixes often indicate location, time, or number.

Some common prefixes include:

Prefix/Definition

Ab-	away from
Ad-	toward, near
Ante-	before
Ec-, ecto-	out, outside
End/o-	in, within
Mon/o-	one
Poly-	many, much
Post-	after, behind

A suffix is attached to the end of a word to modify or alter its meaning. In medical terms, suffixes frequently indicate the procedure, condition, disorder, or disease.

Some common suffixes include:

Suffix/Definition

-centesis	puncture, tap
-desis	binding, fusion
-ectomy	excision, surgical removal
-graphy	act of recording data
-pexy	surgical fixation
-plasty	plastic repair, plastic surgery, reconstruction
-tripsy	crushing

Due to Greek and Latin origins of medical terms, the conventions for changing from singular to plural endings are dictated by a specific set of guidelines, as demonstrated in the table below.

Plural Endings:

Word Ending	Plural Ending	Singular Example	Plural Example
a	ae	vertebra	vertebrae
en	ina	lumen	lumina
ex (ix, yx)	ices	index	indices
is	es	prognosis	prognoses
ma	mata	stigma	stigmata
nx (anx, inx, ynx)	nges	phalanx	phalanges
on	a	phenomenon	phenomena
um	a	serum	sera
us	i	thrombus	thrombi

Using the word parts for translation, you will find the approximate meaning of the complete medical term.

EXAMPLE

The word "cardiomyopathy" can be broken down to find its meaning:

cardi/o—heart

my/o—muscle

pathy—disease

Cardiomyopathy is a diseased heart muscle.
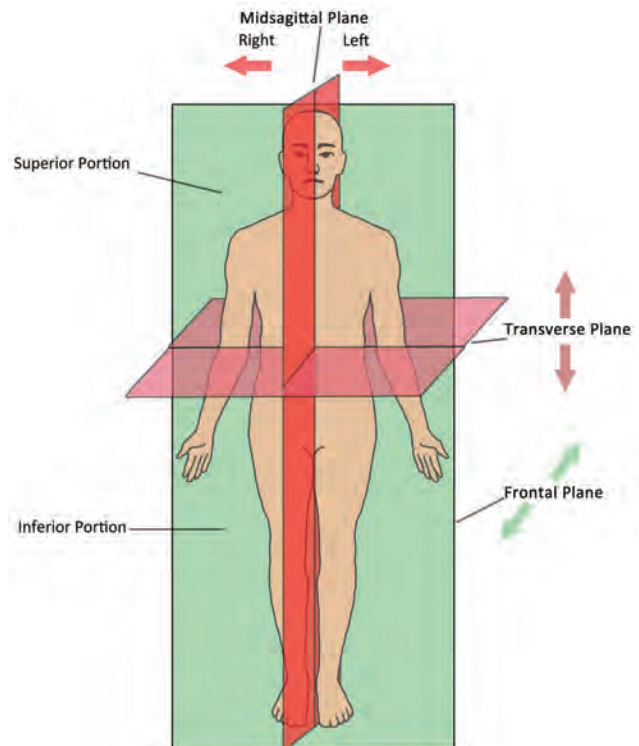
Anatomic Positions and Planes

The standard body position is considered the anatomic position. The anatomic position is an upright, face-forward position with the arms by the side and palms facing forward. The feet are parallel and slightly apart. When you view an anatomical picture, it is facing you in this manner.

Anatomical Planes and Directions

Source: AAPC

Introduction to CPT®

The Current Procedural Terminology (CPT®) code book is a compilation of guidelines, codes, and descriptions used to report healthcare services. The CPT® code set, or the Healthcare Common Procedure Coding System (HCPCS) Level I, is copyrighted and maintained by the American Medical Association (AMA). In 1983, the Healthcare Financing Administration (now the Centers for Medicare & Medicaid Services [CMS]) adopted CPT®, and its own HCPCS Level II, mandating these code sets be used for billing Medicare. In August 2000, the Transactions and Code Sets Final Rule (45 CFR 160.103) named CPT®, HCPCS Level II, and their respective modifiers as standard code sets for national use.

The CPT® code set includes three categories of medical nomenclature and descriptors:

- Category I CPT® codes utilize a five-digit numerical code (for example, 12345). The codes are reviewed and updated annually by an AMA panel. It is mandatory to use Category I CPT® codes for reporting and reimbursement. For Medicare, a HCPCS Level II code may be used instead of HCPCS Level I CPT® code if available.

- Category II CPT® codes are optional "performance measurement" tracking codes. They are used for the Quality Payment Program, an incentive-based program developed by CMS to record evidence-based measures, discussed later in this chapter. The format for Category II codes is alphanumeric, with the letter F in the last position (e.g., 0001F).

- Category II codes may be reported in addition to evaluation and management (E/M) services or clinical services CPT® Category I codes.

EXAMPLE

A physician examines a patient currently taking Statin therapy for coronary artery disease during an E/M visit. Report 4013F *Statin therapy, prescribed or currently being taken (CAD)* and the appropriate office visit code (99202–99215).

- Category III CPT® codes are temporary codes assigned by the AMA for emerging technology, services, and procedures. Category III codes are alphanumeric, with the letter T in the last position, e.g., 0075T. Unlike the Category II CPT® codes, Category III codes can be reported alone without an additional Category I code.

The AMA updates the CPT® code book annually.

The Organization of the CPT® Code book

The CPT® code book is organized by:

- CPT® sections-Category I has six sections that include services and surgical procedures separated into subsections.
- Section Guidelines
- Section Table of Contents
- Notes
- Category II Codes
- Category III Codes
- Appendices A–P
- Alphabetized Index

The CPT® subsections also include:

- Indicator icons
- Boldfaced type
- Italicized type
- Cross-referenced terms
- Anatomy illustrations
- Procedural reviews that aid with medical terminology and anatomy
- Introduction Guidelines

CPT® guidelines introduce each section/subsection of the CPT® code book. Guidelines apply only for the section/subsection in which they appear.

TESTING TECHNIQUE

Review every guideline in your code book. Underline or highlight specific coding information within the guidelines.

CPT® Conventions and Iconography

An established set of conventions and symbols is used throughout the CPT® code book, as follows:

- ;   Semicolon and Indented Procedure-A CPT® procedure or service code that contains a semicolon is divided

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into two parts; the description before and after the semicolon.

a) The words before the semi-colon are considered the common procedure in the code descriptor.

b) The indented descriptor is dependent on the preceding common procedure code descriptor.

c) It is **not** necessary to report the main code (e.g., 00160) when reporting the indented codes (e.g., 00162 or 00164).

EXAMPLE

00160   Anesthesia for procedures on nose and accessory sinuses; *not otherwise specified*

00162   *radical surgery*

00164   *biopsy, soft tissue*

The full descriptor for 00162 and 00164 includes the text before the semicolon in 00160. For instance, the full descriptor for 00162 is *Anesthesia for procedures on nose and accessory sinuses; radical surgery.*

+   Add-on Codes (see CPT® Appendix D)-Some procedures, identified with a "**+**" symbol, are commonly carried out in addition to a primary procedure. Add-on codes must be used with their specified primary procedure (see parenthetical notes listed below the code descriptor). The last chapter in ICD-10-CM is for the provisional assignment of new diseases of uncertain etiology or emergency use.

EXAMPLE

11200   Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

+ 11201   each additional ten lesions, or part thereof. (List separately in addition to code for primary procedure)
(Use 11201 in conjunction with 11200)

In this example, 11201 Is reported with 11200 when more than 15 lesions are removed.

●   A bullet placed before the code number indicates new procedures and services added to the CPT® code book.

EXAMPLE

● 33900 Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral

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▲ A triangle indicates that a code descriptor has been revised.

EXAMPLE

CPT® Numerical Section:
▲ 35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium)

Appendix B:
▲ 35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, ~~Dacron~~polyester, ePTFE, bovine pericardium)

▶◀ Opposing horizontal triangles (bowties) indicate new or revised guidelines or instructions.

EXAMPLE

99223 Initial hospital Inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

▶ (For services of 90 minutes or longer, use prolonged services code 99418) ◀

⊘ The "forbidden" symbol identifies codes that are modifier 51 exempt (See Appendix E).

EXAMPLE

⊘ 20974 Electrical stimulation to aid bone healing; noninvasive (nonoperative)

⚡ A lightning bolt identifies vaccines pending Food and Drug Administration (FDA) approval. If a vaccine is approved by the FDA a revision notation is provided on the AMA CPT® "Category I Vaccine Codes" website: https://www.ama-assn.org/practice-management/cpt/category-i-vaccine-codes (see Appendix K for Products Pending FDA Approval).

EXAMPLE

⚡ 90667 Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use

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Cardiovascular System

Introduction

This chapter will review the cardiovascular system. Codes relevant to this system are found in several sections of the CPT® code book (specifically surgery, radiology, and medicine) throughout the ICD-10-CM (primarily Chapter 9), and HCPCS Level II code books.

Objectives for this chapter are:

- Provide an overview of cardiovascular system anatomical concepts
- Define key terms recognizing common eponyms and acronyms

- Explain the most common pathologies that affect this system
- Highlight relevant procedures and how to apply CPT® codes that represent them
- Introduce ICD-10-CM and HCPCS Level II codes and guidelines as they apply to this system

Anatomy and Medical Terminology

The cardiovascular system is comprised of the heart, arteries, and veins.

The Heart
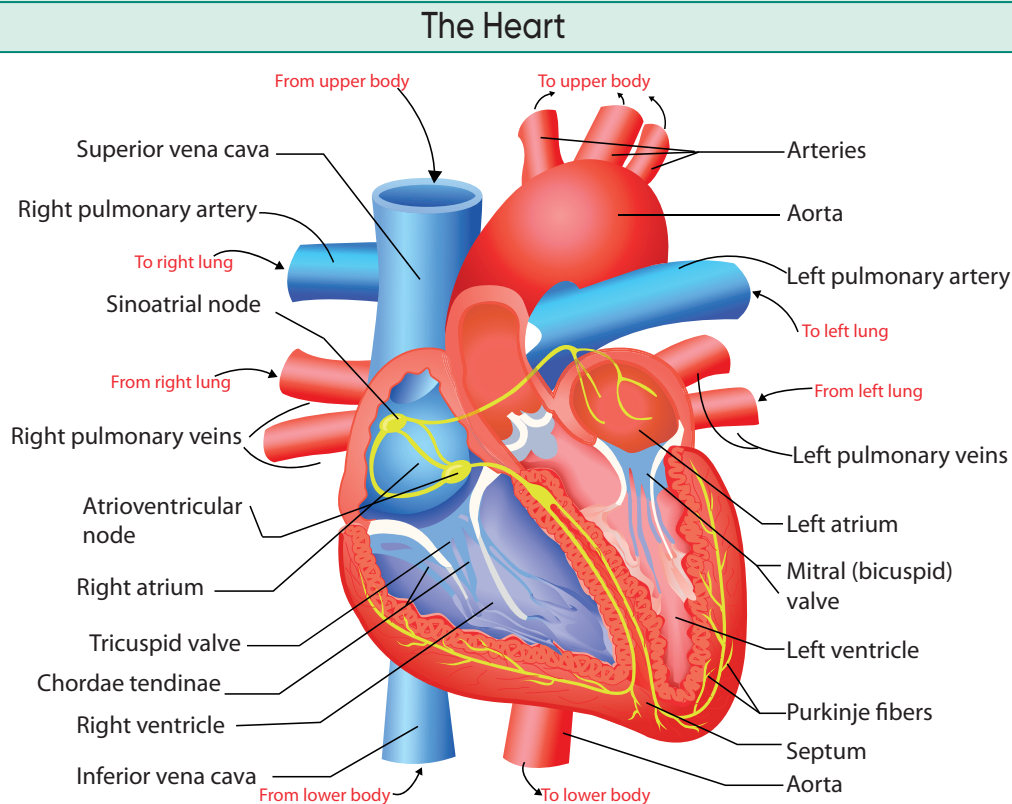
The Heart

Source: ShutterStock.com

Chapter Review Questions

1. Which vessel does the tip of a central venous catheter terminate in?

    A. Basilic vein

    B. Subclavian vein

    C. Aorta

    D. Pulmonary artery

2. Which chamber of the heart is the most muscular?

    A. Right atria

    B. Left atria

    C. Right ventricle

    D. Left ventricle

3. A patient with hypertension and chronic kidney disease, stage 5, is admitted by his primary care physician. What ICD-10-CM code(s) is/are reported?

    A. I10

    B. I12

    C. I10, N18.5

    D. I12.0, N18.5

4. The patient is a 69-year-old white female with 10-year status post dual chamber pacemaker where the generator is at its end of life. The pacemaker generator is explanted, and the leads are then attached to the new generator. What is/are the CPT® code(s) for this encounter?

    A. 33213

    B. 33208

    C. 33213, 33233

    D. 33228

5. A 38-year-old's blood pressure was progressively trending downward, and it was determined that an emergent central venous access was needed for fluid resuscitation. A non-tunneled catheter was used to access the subclavian vein and secured into place to infuse medication. Due to the patient's low blood pressure and anticipated need for vasopressor agents, a radial arterial line was also desired. The left radial artery pulse was easily palpable, and the skin was punctured by a needle, and the angiocatheter was placed in the left wrist. What are the CPT® codes for this encounter?

    A. 36555, 36625-51

    B. 36556, 36620-51

    C. 36558, 36640-51

    D. 36569, 36620-51

6. Mrs. Doelle goes to the procedure room to have a permanent pacemaker implanted. She is given a mild sedative, and the area just under the right clavicle is prepped and draped in a sterile manor. An incision is made to create a pocket for the pulse generator. A venogram is shot through an indwelling antecubital IV, and a catheter is threaded from the pocket into the right subclavian vein. The catheter is then advanced into the right atrium under fluoroscopic guidance. Using the Seldinger technique the catheter is withdrawn over a guide wire, and a 32 FR Medtronic pacing wire is threaded back over the guide wire and into the right atrium under fluoroscopy. The guide wire is removed, and the pacing tip is screwed into the myocardium. Thresholds are tested for sensing and capture. The lead is then attached to the pulse generator and placed into the pocket. The pocket is closed with interrupted 4-0 Prolene. What is/are the CPT® code(s) for this encounter?

   A. 93288-26, 33249

   B. 33206, 36140-51, 93288-26, 75820-26

   C. 33206

   D. 33206, 33212-51

7. Using Xylocaine local anesthesia, aseptic technique, and ultrasound guidance for vascular access, a 21-gauge needle was used to aspirate the right cephalic vein of a 72-year-old patient. When blood was obtained, a 0.018 inch platinum tip guidewire was advanced to the central venous circulation. A 6 French dual lumen PICC was introduced through a 6 French peel-away sheath to the superior vena cava and right atrium junction, and after removal of the sheath, the catheter was attached to the skin with a STAT-LOCK device and flushed with 500 units of Heparin in each lumen. A sterile dressing was applied, and the patient was discharged in improved condition. Permanent ultrasound recordings were placed in the record. What is/are the CPT® code(s) for this encounter?

   A. 36573, 76942-26

   B. 36556, 76942-26

   C. 36561

   D. 36573

8. After obtaining an aortogram and CT scan, a 45-year-old woman was found to have an infrarenal abdominal aortic aneurysm measuring at least 4.5 cm in size that has not ruptured. It was felt that with the rapid recent expansion, she should have this aneurysm repaired. The infrarenal artery aneurysm was repaired at the level of the renal arteries to the aortic bifurcation. What is the CPT® code for this procedure?

   A. 34702

   B. 34701

   C. 34706

   D. 34707

9. **Operative Report #1**

   Preoperative Diagnosis: Sick sinus syndrome with bradycardia/tachycardia

   Postoperative Diagnosis: Permanent DDDR pacemaker insertion

   Operation Performed: Pacemaker insertion

   Anesthesia: Local with conscious sedation

   Complications: None

   Estimated Blood Loss: Minimal

   Adjunctive Procedures: Fluoroscopy

   Description of Procedure: Following informed consent, the left subclavian artery was prepped and draped in the usual sterile manner. Following local, administration of 1% Xylocaine anesthesia, the left subclavian vein was entered with an 18-gauge, thin-wall needle. J-wire was placed. Transverse incision was created and dissected at the pectoral fascia. A

CPC® Exam

The CPC® exam tests coding skills for professional services. The categories include:

- Integumentary Surgical Coding
- Respiratory Surgical Coding
- Nervous System Surgical Coding
- Endocrine System Surgical Coding
- Digestive System Surgical Coding
- Urinary System Surgical Coding
- Musculoskeletal System Surgical Coding
- Mediastinum & Diaphragm Surgical Coding
- Male/Female Genital Surgical Coding
- Hemic & Lymphatic Surgical Coding
- Maternity & Delivery
- Eye & Ocular Adnexa Surgical Coding
- ICD-10-CM
- HCPCS Level II
- Radiology
- Pathology
- Laboratory
- Medicine
- Anesthesia
- Evaluation and Management
- Anatomy and Physiology
- Medical Terminology
- Coding Guidelines
- Practice Management

Preparing for Your Exam

The CPC® exam is open book. The code books allowed during the exam include AMA CPT® Professional, HCPCS Level II, and ICD-10-CM code books. You must use the current year version of all code books. Please visit AAPC's website for the list of approved code books.

The best strategy to prepare for the exam is reading your code books cover to cover. Examinees should review all coding guidelines found within each section and subsection of the CPT® code book, the Official Coding Guidelines in the ICD-10-CM code book, and all coding guidelines in the HCPCS Level II code book. This study guide should be used along with your

code books as you prepare for the exam. Your ICD-10-CM code book may contain the 2022 ICD-10-CM guidelines (common for publishers as the guidelines are released after the print date of the code books). So that you have the most up-to-date guidelines, you may want to print the 2023 ICD-10-CM guidelines from https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf and take them into the certification examination. The updates are indicated by bold font.

Successful examinees have well-thumbed code books. Become familiar with all parts of your CPT®, ICD-10-CM, and HCPCS Level II code books, and know how to locate the codes, guidelines, tables, and instructions within them quickly. This may be the most important tip we can give you: We recommend going through your books to mark them, tab and label them, and make notes in them for easy reference.

Anything with which you feel you might need some extra help is something we would suggest tabbing or marking. For the exam, you can write helpful notes in your books and tab them for easy reference, but you may not glue, tape, staple, or add anything to the books. You also may wish to highlight certain guidelines in your code books. Handwritten notes are acceptable in the coding books only if they pertain to daily coding activities. Long passages of information are not permitted on the blank pages. Questions from the Study Guides, Practice Exams, or the Exam itself are prohibited. Altering, whiting out, painting, or printing over any pages within the code books (e.g., marketing pages, table of contents, reference pages, etc.) to supplement information is prohibited. Keep in mind, all notes in your code books should be relevant to work performed daily by a coder.

Examples of items to highlight or add:

ICD-10-CM code book in the Tabular List:

- Code first notes
- Use additional code notes
- Codes that are excluded from a category

CPT® code book:

- Key words in the subsection guidelines (e.g., new and established patient definition in the E/M section)
- Draw an E/M table in your CPT® if you think it will better assist you in determining E/M services.
- Key words in the Repair (Closure) guideline section defining simple, intermediate, or complex repairs.

Answers and Rationales for Chapter Review Questions

Chapter 1

1. D. Part D

   RATIONALE: Medicare Part D is for prescription drug coverage. The patient's prescription for the pain medication would be billed to Medicare Part D.

2. B. Translating medical documentation into codes

   RATIONALE: Coding is the process of translating written or dictated medical records into numeric or alpha-numeric codes.

3. B. Workers' compensation

   RATIONALE: A covered entity of HIPPA

   - A healthcare provider, such as:
     - Doctors
     - Clinics
     - Psychologists
     - Nursing Homes
     - Pharmacies

   - A health plan, to include:
     - Health Insurance Companies
     - HMOs
     - Company Health Plans
     - Government programs that pay for healthcare, such as Medicare, Medicaid, and the military and veterans' healthcare programs
     - A healthcare clearinghouse

4. C. Blue Cross Blue Shield

   RATIONALE: There are two primary types of insurers: commercial and government. Commercial payers are private payers that offer both group and individual plans. For example, Blue Cross Blue Shield organizations are private payers who usually operate in the state in which they are based.

5. B. When a service is not expected to be covered by Medicare

   RATIONALE: The Advance Beneficiary Notice (ABN) is a standardized form that explains to the patient why Medicare may deny the service or procedure. The ABN form should be completed for services potentially non-covered by Medicare to advise the patient of potential financial responsibility.

6. B. $100 or 25% of cost

   RATIONALE: CMS instructions stipulate, "Notifiers must make a good faith effort to insert a reasonable estimate…the estimate should be within $100 or 25 percent of the actual costs, whichever is greater."

7. C. Clearinghouse

   RATIONALE: A Healthcare Clearinghouse is an entity that processes nonstandard health information they receive from another entity into a standard (such as standard electronic format, or data content), or vice versa.

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