AAPC

CPC®

Certified Professional Coder

STUDY GUIDE

2026

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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.

2233 South Presidents Dr. Suite F, Salt Lake City, UT 84120
800-626-2633, Fax 801-236-2258, www.aapc.com
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Print ISBN: 000-0-000000-000

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Introduction

The Official CPC® Certification Study Guide is organized to help you prepare for the exam, certifying you as a professional medical coder. The Certified Professional Coder (CPC®) credential is awarded by AAPC, the primary organization of more than 220,000 members working in medical coding, billing, auditing, clinical documentation, compliance, and physician practice management worldwide.

This study guide, developed in cooperation with AAPC staff and members, can help you understand and practice the concepts, elements, and rules of medical coding. Throughout the Official CPC® Certification Study Guide are easy-to-understand explanations, examples, coding tips, and exercises meant to help you prepare for your exam.

Medical coding continues to grow and mature as a profession. Medical coders report the diagnoses, procedures, and supplies reported by physicians and other medical professionals to commercial and federal payers, such as Aetna or Medicare. They work closely with medical staff and must master medical terminology, anatomy, and physiology and apply this to healthcare providers' notes or operative reports.

As healthcare evolves so does medical coding. Medical coders perform in a variety of situations for physicians and facilities. They may participate in the actual billing process or audit claims sent to payers. They may code in independent billing companies. Medical coders often become the officers in charge of compliance with federal and state medical billing and coding regulations. They may work for the payers themselves as adjustors or auditors. Experienced coders often become consultants, serving clients who need coding, billing, auditing, or compliance assistance.

Medical coders will prove even more important as elements of healthcare reform and standardized electronic medical records are implemented. Coders will be instrumental as advisers, decision makers, technicians, medical coders, and auditors in the coming years.

CPC® Confirms Credibility

The CPC® credential (and its derivative credentials: COC®, for example) illustrates to employers and colleagues that you understand the many facets of coding. A CPC® possesses the following:

- Knowledge of anatomy, physiology, and medical terminology necessary to correctly code provider diagnoses and services
- Skill in accurate medical coding for diagnoses, procedures, and services in physician-based settings
- Proficiency across a wide range of services, which include evaluation and management, anesthesia, surgical services, radiology, pathology, and medicine
- Sound knowledge of medical coding rules and regulations including compliance and reimbursement
- Understanding of issues such as medical necessity, claims denials, bundling, and charge capture
- Expertise of how to integrate medical coding and reimbursement rule changes into a practice's reimbursement processes

The Study Guide

The Official CPC® Certification Study Guide begins with a view of the business of medicine to help you understand the overall view of the medical office and how the coder fits in. After a review of anatomy, you will learn about ICD-10-CM guidelines with real life examples of how to apply them. Each body system is reviewed in its entirety, includes a review of the anatomy, related ICD-10-CM diagnosis coding, CPT® coding, HCPCS Level II coding, and modifiers. End of chapter reviews provide certification questions similar to those you will find on the exam, along with operative notes for each section for you to code. The study guide concludes with testing techniques and a 50-question review to test your knowledge for the CPC® certification exam.

Unlike most coding certification study guides that focus on each code set, this one more realistically prepares the coder not only for the examination but for the field, where each case more likely will include at least two code sets and require the use of modifiers. Each chapter addresses specifically the particular issues associated with each body area or service offered by the healthcare provider.

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 and exams are actual, redacted office visit 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

- 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 2024 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	1.79	0.83	0.14	3.85	2.89

Table 1.1

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

PE	Physician Expense
PFS	Physician Fee Schedule
PHI	Protected Health Information
PPACA	Patient Protection and Affordable Care Act
PLI	Professional Liability Insurance
RUC	Relative Value Scale (RVS) Update Committee
RVU	Relative Value Unit
RBRVS	Resource Based Relative Value System

Chapter Review Questions

1. A Medicare patient is receiving chemotherapy at her oncologist's office. While the patient is receiving chemotherapy, the oncologist calls in a prescription for pain medication to a pharmacy in the same building. The pharmacy delivers the medication to the patient in the oncologist's office for the patient to take home. What part of Medicare should be billed for the pain medication by the pharmacy?
   A. Part A
   B. Part B
   C. Part C
   D. Part D

2. What is medical coding?
   A. Reporting services on a CMS-1500
   B. Translating medical documentation into codes
   C. Programming an EHR
   D. Creating a 5010 electronic file for transmission

3. Which one is NOT a covered entity of HIPAA?
   A. Medicare
   B. Workers' compensation
   C. Dentists
   D. Pharmacies

4. Which one falls under a commercial payer?
   A. Medicare
   B. Medicaid
   C. Blue Cross Blue Shield
   D. All the above are commercial payers

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

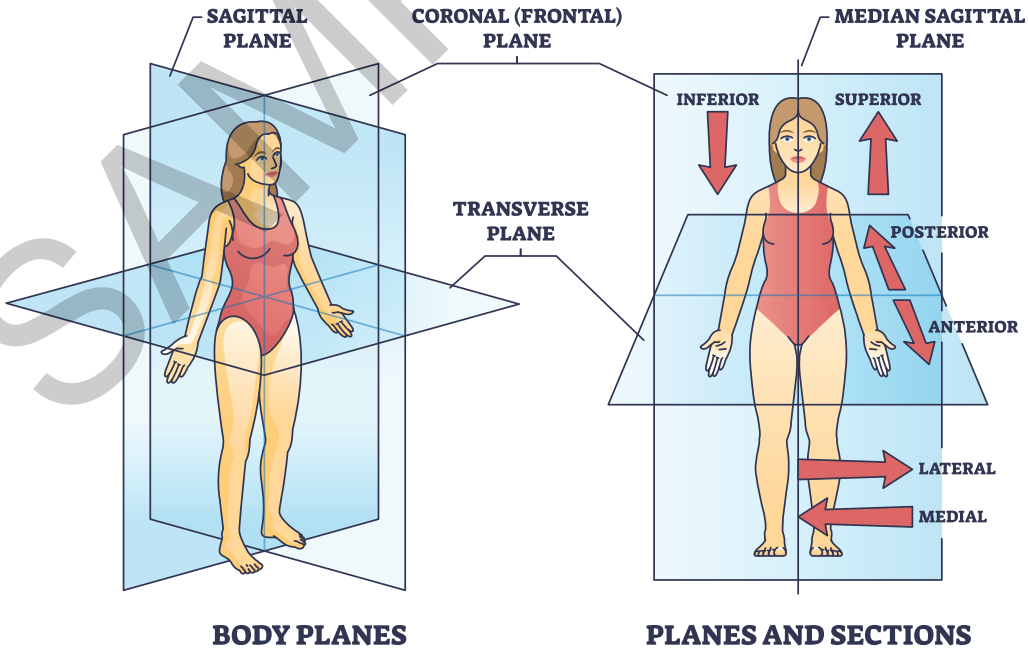
pathy—disease

Cardiomyopathy is a diseased heart muscle.

Anatomic Positions and Planes

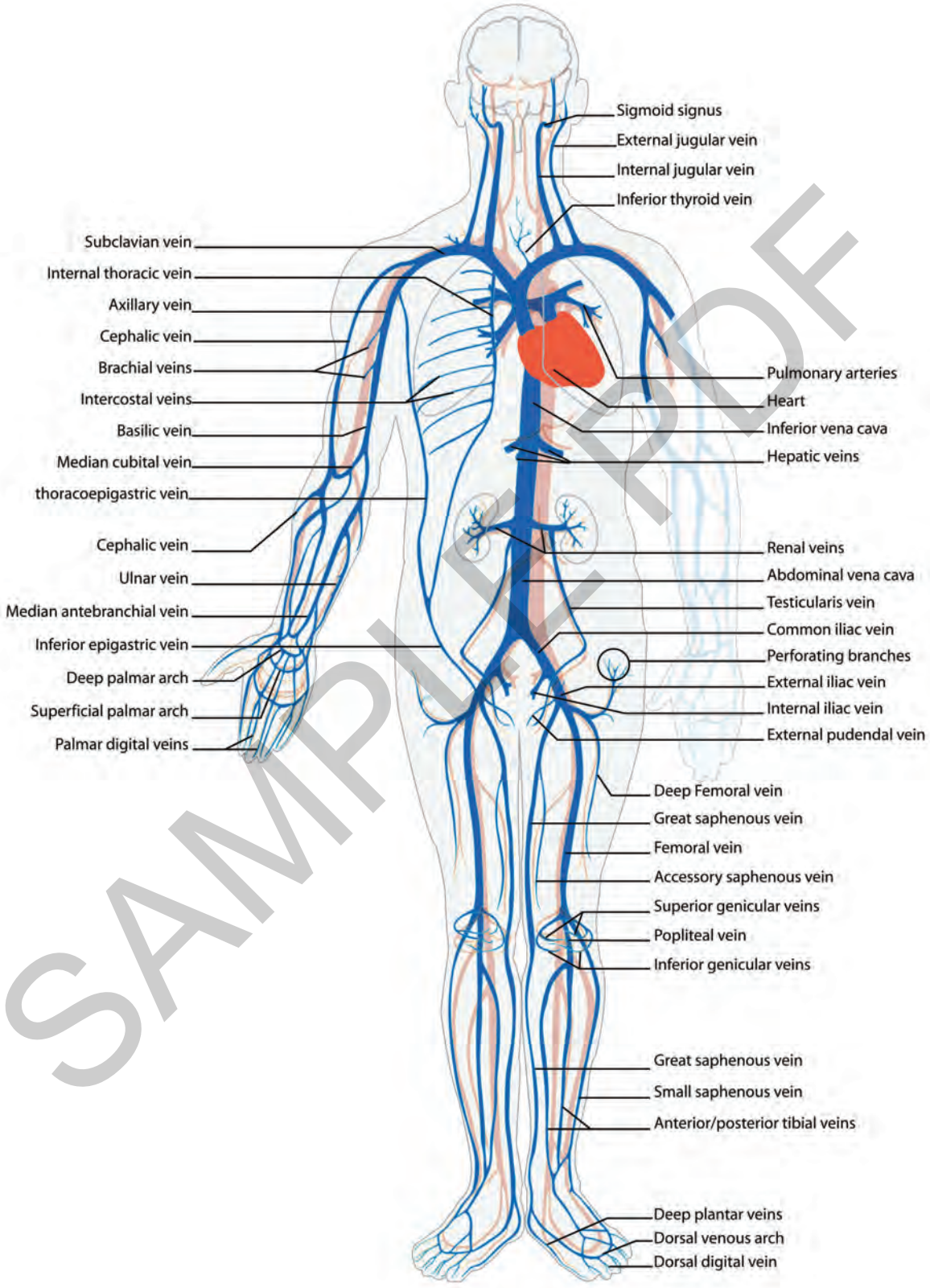
The standard body position is considered the anatomic position. The anatomic position is an upright, face-forward position with the arms by the side and palms facing forward. The feet are parallel and slightly apart. When you view an anatomical picture, it is facing you in this manner.

Anatomical Planes and Directions



Source: stock.adobe.com

Vessels–Venous Circulation



Source: By LadyofHats, Mariana Ruiz Villarreal [Public domain], via Wikimedia Commons

Each character for all categories, subcategories, and codes may be either a letter or a number. Codes can be three to seven characters in length. The 1st character of a category is a letter, followed by 2 additional characters that may be either numbers or alpha characters. Subcategories have an additional four to seven alpha numeric characters and the 7th character is called an extension (discussed later in this chapter). The 4th character in an ICD-10-CM code further defines the site, etiology, and manifestation or state of the disease or condition. To help describe the disease to the highest level of specificity, the subcategory includes the three-character category plus a decimal with an additional character. The 5th or 6th character subclassifications further represent the most accurate level of specificity regarding the patient's condition or diagnosis. Certain ICD-10-CM categories require seven characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. If a code is three, four, or five characters, but requires a 7th character extension, a placeholder X must be used to fill the empty spaces in the code. There are symbols throughout the Tabular List to identify when a code requires an additional character.

EXAMPLES

- F01 Vascular Dementia
- H21.4 Pupillary membranes
- I87.00 Postthrombotic syndrome without complications
- O32.0 Maternal care for unstable lie

Index to Diseases and Injuries

Main terms in the Alphabetic Index usually reference the disease, condition, or symptom. Subterms modify the main term to describe differences in site, etiology, or clinical type. Subterms add further modification to the main term.

EXAMPLE

Look in the Alphabetic Index for Pain(s) (see also Painful) R52

abdominal R10.9

colic R10.83

generalized R10.84

with acute abdomen R10.0

lower R10.30

In this example, the subterms further define the location of pain and type of pain.

Conventions

To apply the diagnosis coding system correctly, coders need to understand the various conventions and terms. Section I of the official guidelines includes conventions, general coding guidelines, and chapter specific guidelines.

NEC Not elsewhere classifiable

This abbreviation is used when the ICD-10-CM system does not provide a code specific for the patient's condition. Selecting a code with the NEC classification means the provider documented more specific information regarding the patient's condition, but there is not a code in ICD-10-CM that reports the condition accurately.

NOS Not otherwise specified

This abbreviation is the equivalent of "unspecified" and is used only when the coder lacks the information necessary to report to a more specific code.

[ ] Brackets are used in the Tabular List to enclose synonyms, alternate wording, or explanatory phrases.

EXAMPLE

- B96.2 Escherichia coli [E. coli] as the cause of diseases classified elsewhere

[ ] Brackets are used in the Alphabetic Index to indicate multiple codes are required.

EXAMPLE

Hepatitis

syphilitic (late) A52.74

congenital (early) A50.08 [K77]

late A50.59 [K77]

In this example, two codes are required to accurately report congenital syphilitic hepatitis: A50.08 Early visceral congenital syphilis; and K77 Liver disorders in diseases classified elsewhere.

( ) Parentheses are used to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms in the parentheses are referred to as nonessential modifiers.

EXAMPLE

Cyst (colloid) (mucus) (simple) (retention)

Chapter 5

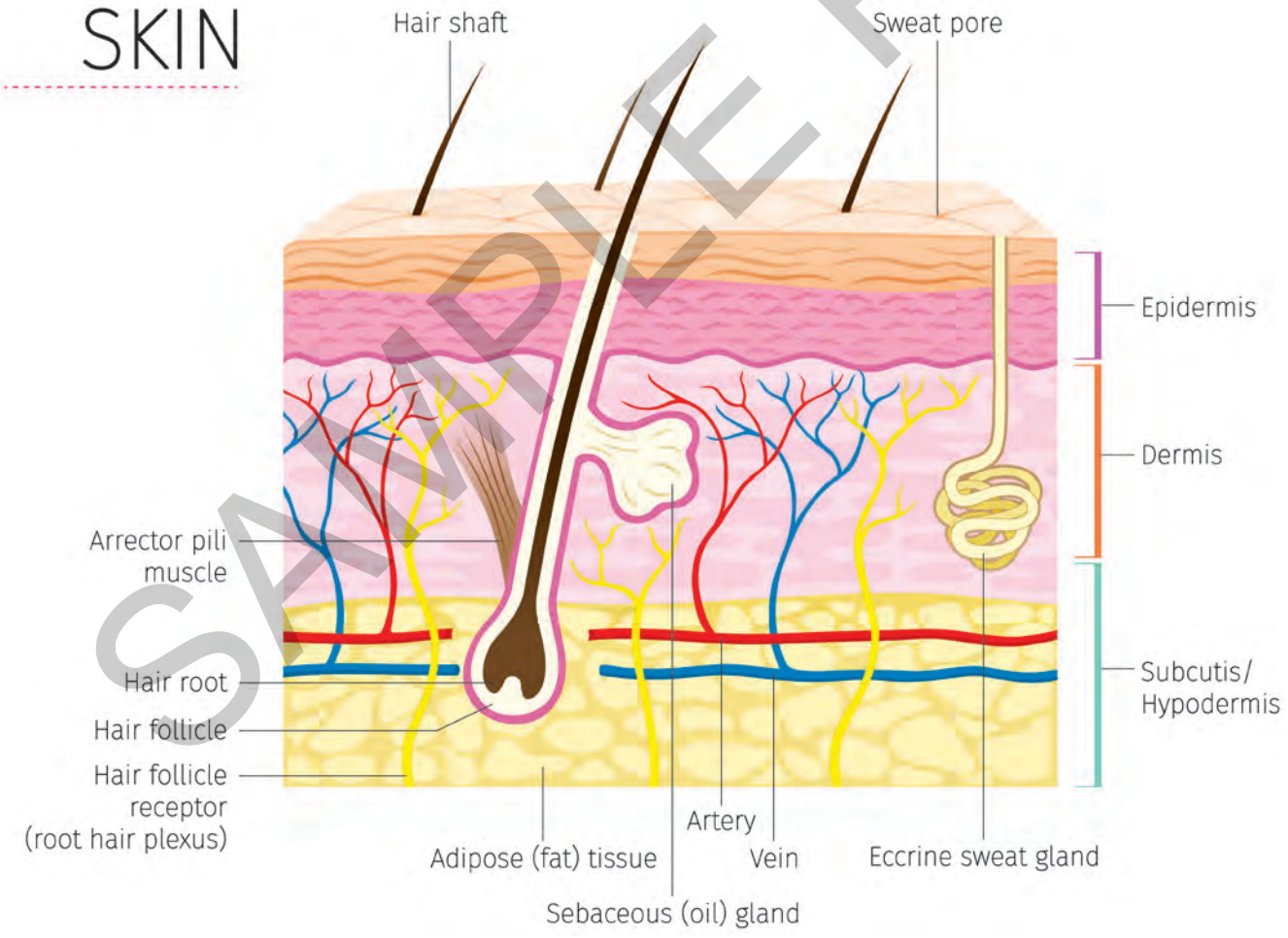
Integumentary System

Introduction

The Integumentary System is made up of the skin, hair, nails, and breasts. Objectives for this chapter include:

- Understand the key components of the skin, hair, nails, and breasts
- Define key terms
- Understand the most common pathologies affecting the skin, hair, nails, and breasts
- Understand procedures and surgeries as they relate to the skin, hair, nails, and breasts
- Recognize common eponyms and acronyms for this section
- Identify when other sections of CPT® or ICD-10-CM should be accessed
- Know when HCPCS Level II codes or modifiers are appropriate

Skin Anatomy



Source: stock.adobe.com

Anatomy and Medical Terminology

The skin is the largest organ system of the body. It is made up of two primary layers. The epidermis is the outermost portion of skin. It contains different types of cells; the most common are squamous cells (flat, scaly cells on the surface of the skin), basal cells (round cells), and melanocytes (which give the skin color). There are four to five layers of the skin: Stratum Corneum, Stratum Lucidum (found in thick skin areas such as palms and soles), Stratum Granulosum, Stratum Spinosum, and Stratum Basale (Germinativum).

The dermis is under the epidermis and is made up of two layers, the upper papillary layer, and the lower reticular layer, and performs most of the skin's functions. The dermis consists of blood vessels, connective tissue, nerves, lymph vessels, glands, receptors, and hair shafts. The subcutaneous tissue is primarily fat cells that smooth the skin and act as a cushion, it is not a layer of the skin, but is just below the dermis.

The protein keratin stiffens epidermal tissue to form fingernails. Nails grow from a thin area called the nail matrix at an average rate of about 1 mm per week.

ICD-10-CM Coding

Diagnostic codes for the skin are found primarily in three chapters in the ICD-10-CM code book:

- Chapter 2—Neoplasms
- Chapter 12—Diseases of the Skin and Subcutaneous Tissue
- Chapter 19—Injury, Poisoning, and Certain Other Consequences of External Causes

Diagnostic codes for the breast are typically found in Chapter 14, Diseases of the Genitourinary System, categories N60-N65.

Neoplasms

The Table of Neoplasms is broken down into six columns. The first three indicate malignancies, classified as Primary, Secondary, and Ca in situ; after the malignancies are Benign, Uncertain Behavior, and Unspecified Behavior.

- Primary Malignancy—the original location of the cancer (carcinoma) (e.g., skin NOS/eyebrow C44.309).
- Secondary Malignancy—the cancer has spread to a secondary location (metastases) (e.g., skin NOS/eyebrow C79.2).
- Ca *in Situ*—the cancer is encapsulated and has not spread (e.g., skin NOS/eyebrow D04.39).
- Benign—the pathology report indicates no cancer or pre-cancerous cells associated with the lesion (e.g., skin NOS/eyebrow D23.39).
- Uncertain Behavior—A specific pathologic diagnosis. This is a lesion whose behavior cannot be predicted. It's currently benign, but there is a chance that it could undergo malignant transformation over time. There must be a pathology report indicating Uncertain Behavior (e.g., skin NOS/eyebrow D48.5).
- Unspecified Behavior—There is no pathology report indicating the nature of the lesion (e.g., skin NOS/eyebrow D49.2).

	Malignant					
	Primary	**Secondary**	**Ca in situ**	**Benign**	**Uncertain Behavior**	**Unspecified Behavior**
Neoplasm, neoplastic						
Skin NOS	C44.90	C79.2	D04.9	D23.9	D48.5	D49.2
ear (external)	C44.20-	C79.2	D04.2-	D23.2-	D48.5	D49.2
basal cell carcinoma	C44.21-					
specified type NEC	C44.29-					
squamous cell carcinoma	C44.22-					
elbow (*see also* Neoplasm, skin, limb, upper)	C44.60-	C79.2	D04.6-	D23.6-	D48.5	D49.2
eyebrow (*see also* Neoplasm, skin, face)	C44.309	C79.2	D04.39	D23.39	D48.5	D49.2
eyelid	C44.10-	C79.2	D04.1-	D23.1-	D48.5	D49.2
basal cell carcinoma	C44.11-					
sebaceous cell	C44.13-					
specified type NEC	C44.19-					
squamous cell carcinoma	C44.12-					

Source: AAPC ICD-10-CM code book

EXAMPLE

1. Squamous Cell Carcinoma of Right Arm

   To find the appropriate diagnosis code for squamous cell carcinoma of the right arm, using the ICD-10-CM Alphabetic Index Carcinoma/skin appendage directs you to see Neoplasm, skin, malignant. In the Table of Neoplasms look for skin NOS/arm- see also Neoplasm, skin, limb, upper. Look for skin NOS/limb NEC/upper/ squamous cell carcinoma and use the code from the Malignant Primary column - C44.62-. In the Tabular List, C44.622 is reported to indicate squamous cell carcinoma of the right arm.

2. Melanoma of the Lip.

   Your first thought might be to go directly to the Table of Neoplasms. In the case of melanoma, that is not the place to start. Instead, look for Melanoma/skin/lip (lower) (upper) in the ICD-10-CM Alphabetic Index. You are directed to C43.0. Verify the code in the Tabular List.

Diseases of the Skin and Subcutaneous Tissue

Common skin infection and disorder diagnosis codes are found in Chapter 12 of the ICD-10-CM code book under Diseases of the Skin and Subcutaneous Tissue, which includes codes for:

- Skin infections (bacterial and fungal)
- Inflammatory conditions of the skin including dermatitis, erythema, rosacea, and psoriasis
- Other disorders of the skin, including corns and calluses, keloid scars, keratosis, diseases of the hair (e.g., alopecia), sweat glands (e.g., hidradenitis), sebaceous glands (e.g., acne), and ulcers.

Infections of the Skin and Subcutaneous Tissue

Skin infections can be bacterial or fungal. Carbuncles and furuncles (boils) typically are caused by a staphylococcal infection. Several furuncles together make up a carbuncle and often involve a group of hair follicles.

Notice that in the bulleted list that some of the items include "not separately reported." If the provider performs a service that is separately reported with another CPT® or HCPCS Level II code, the time spent on that service is not included in the time used to determine the level of E/M service. Reporting a separate service and including the time spent on that separate service in the level of the E/M service is considered double billing as you are billing for the same time twice.

DOCUMENTATION DISSECTION

Emergency Department Visit

PROBLEM: Foreign body in nose.

HISTORY OF PRESENT ILLNESS: The patient is a 3-year-4-month-old child who comes in today after having put a raisin in her left nostril. Grandmother was unable to remove this.

HISTORY WAS PROVIDED BY: Grandmother

PAST MEDICAL HISTORY: She has a past medical history of otherwise good health.

MEDICATIONS: She is on no current prescription medications.

ALLERGIES: Has no known drug allergies.

REVIEW OF SYSTEMS: The patient has had some recent URI symptoms.

SOCIAL HISTORY: There are no cigarette smokers at home.

PHYSICAL EXAMINATION:

GENERAL: Alert, smiling child.

HEENT: There is clear rhinorrhea. There is a raisin noted in the mid left nostril. Pharynx is without inflammation.

NECK: Supple.

CHEST: Lungs are clear without wheeze or rhonchi.

ABDOMEN: Soft, nontender.

EMERGENCY DEPARTMENT COURSE: The raisin was grasped with bayonet forceps and removed atraumatically. Examination of the nostril fails to reveal any further foreign body or problems.

DIAGNOSIS: Foreign body removal, left nostril.

Note: Use the following four tables to determine the level of MDM.

Rationale: This patient is being seen in the emergency department. The level is selected based on the AMA CPT® E/M services guidelines.

The number and complexity of problems addressed – low (acute problem).

The amount and complexity of data to be reviewed and analyzed – History obtained from grandmother.

The risk of complications and morbidity or mortality of patient management – low (minor procedure).

The low complexity condition with low complexity data and low risk make 99283 the correct code.

A compression stocking was applied, which will need to remain in place for the next 72 hours. The patient was monitored until complete consciousness returned. Total intra-services sedation time: 28 min. The patient was then taken to the recovery room in stable condition. No specimens were sent to lab.

[1] The postoperative diagnoses are used for reporting.

[2] This is documentation of the sclerotherapy being performed.

47. **Answer:**

Version A:

There is one CPT® code reported for this case. What CPT® coding is reported?

47. A. 36471

There are two ICD-10-CM codes reported for this case. What ICD-10-CM coding is reported?

47. AA. I83.811

47. BB. Z86.718

Version B:

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

B. 36471, I83.811, Z86.718

RATIONALE: In the CPT® Index, look for Sclerotherapy/Venous referring you to 36468–36471. Multiple veins in the same leg were injected. Verification of this code range directs the coder to 36471. In the ICD-10-CM Alphabetic Index, look for Varicose/vein – see Varix. Look for Varix/leg/right/with/pain referring you to code I83.811. The postoperative diagnosis also indicates a history of deep vein thrombosis (DVT). In the Alphabetic Index, look for History/personal (of)/thrombosis referring you to Z86.718. Verify codes in the Tabular List.

Case 3

Operative Report

Preoperative Diagnosis: History of carcinoma of the colon, colonic polyps

Postoperative Diagnosis: History of carcinoma of the colon, colonic polyps

Operative Procedure: Colonoscopy

Indications: The patient is a 75-year-old white male patient of Dr. Smith whom I have followed for a number of years for colon polyps. About three years ago, he underwent a radical right hemicolectomy for carcinoma of the hepatic flexure of the colon. His postoperative course has been uneventful to date. He returns now for his routine follow-up recommended screening colonoscopy. [1] He appears to understand the risks, rationale, expected outcome, and typical postoperative course and is willing to proceed.

Procedure:

The patient was placed on the table in the left lateral decubitus position, given intravenous Demerol and propofol for sedation. Following this, a digital rectal exam was performed, which was essentially unremarkable. This was followed by introduction of the Olympus video colonoscope, which was advanced through a relatively normal appearing rectum, sigmoid colon, descending colon, and transverse to the level of the ileocolic anastomosis. This was unremarkable in its appearance and widely patent. The scope was then withdrawn. There were no polyps, [2] telangiectasias, angiodysplasias, or other endoluminal abnormalities encountered. The scope was removed. The patient tolerated the procedure well and was transferred to the recovery area in stable condition.

[1] Routine follow-up exam after completed treatment for a malignant neoplasm.

[2] There were no polyps so the colonic polyps is a history code.

48. **Answer:**

Version A:

There is one CPT® code reported for this case. What CPT® coding is reported?

48. A. G0105

There are three ICD-10-CM codes reported for this case. What ICD-10-CM coding is reported?

48. AA. Z08

48. BB. Z85.038

48. CC. Z86.0100

Version B:

What are the diagnosis and procedure codes for this Medicare patient?

C. G0105, Z08, Z85.038, Z86.0100

RATIONALE: When coding for a screening colonoscopy for a Medicare patient, a HCPCS Level II code is required. It is extremely important when coding from operative reports that you do not code from the preoperative and postoperative diagnosis headings and the procedure heading. From the indication, we know the patient has a history of colon cancer that has been treated. In the description of the procedure, we see that the there are no polyps or other abnormalities. In this case, the indication and description of the procedure provide information that is lacking in the procedure and diagnosis headings of the report. The patient has a history of colon cancer, which qualifies as a high-risk screening. The procedure is reported with code G0105. In the HCPCS Level II Index, look for Colonoscopy, cancer screening/patient at high risk referring you to code G0105. The patient has a history of colon cancer. In ICD-10-CM Alphabetic Index, look for Examination/follow-up (routine) (following)/malignant neoplasm referring you to Z08. There is an instructional note in the Tabular List for Z08 to use additional code to identify the personal history of malignant neoplasm (Z85.-). Look in the Alphabetic Index for History/personal (of)/malignant neoplasm (of)/colon NEC referring you to Z85.038. The patient also has a history of polyps. Look the Alphabetic Index for History/personal (of)/disease or disorder (of)/digestive system/colonic polyp referring you to see History personal, neoplasm, benign, colon polyp. This refers you to code Z86.0100. Verify both codes in the Tabular List.

Case 4

Surgical Pathology Report

Preoperative Diagnosis: Abdominal pain

Tissues Submitted: Gallbladder, NOS

Gross Description: The specimen is received in formalin in a container labeled "gallbladder." [1] The specimen consists of an unopened gallbladder measuring 6.0 cm in length by up to 2.5 cm in diameter at the tip. The light purple-tan serosal surface is glistening and the duct at the margin measures 0.2 cm. The gallbladder contains a small amount of thick, dark green-brown fluid. The dark pink-tan mucosa is velvety and free of ulceration, erosion, and cholesterolosis. The wall appears slightly thickened. No stones are noted within the gallbladder or loose within the container. Representative sections from the tip, mid portion, and neck region are submitted along with a section demonstrating the duct adjacent to the margin.

Microscopic Description: A microscopic examination has been performed.

Clinical Diagnosis: Gallbladder: mild chronic cholecystitis [2]

[1] The specimen examined is the gallbladder.

[2] The clinical diagnosis is used for reporting.

Index

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2026 CPC® Study Guide
9 798892 581066
Print ISBN: 979-8-892581-066