AAPC CERTIFIED PROFESSIONAL CODER (CPC) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

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How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

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Questions

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1. What does "NCCI" stand for in coding?

A. National Coding Certification Institute
B. National Correct Coding Initiative
C. National Clinical Coding Index
D. National Committee for Coding Integrity

2. What is the medical term for the condition of an enlarged heart?

A. Cardiomyopathy
B. Cardiopathy
C. Cardiomegaly
D. Carditis

3. What is the significance of appendix B in the CPT manual?

A. It contains modifiers
B. It lists coding guidelines
C. It details additions, deletions, and revisions
D. It offers unlisted procedures

4. What does the root word cool/o stand for?

A. Uterus
B. Vagina
C. Ovary
D. Fallopian Tube

5. When is coding for an external cause essential?

A. When the patient is admitted for a scheduled procedure
B. When it is related to an underlying chronic condition
C. Only when the injury is severe
D. When it relates to the cause of an injury or health condition

6. Where is the hypertension table located in ICD-10-CM?

A. In the introduction
B. There is no hypertension table
C. In the cardiology section
D. At the end of the chapter

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7. How many digits are typically found in a Level I CPT code?

A. Three digits

B. Four digits

C. Five digits

D. Six digits

8. Which punctuation mark between codes in the index of the CPT manual indicates two codes are available?

A. comma

B. hyphen

C. semicolon

D. colon

9. What is the code for a secondary neoplasm of the descending colon?

A. C78.3

B. C78.5

C. C78.9

D. C78.0

10. What does the use of "bundled payments" aim to improve?

A. Patient choice of services

B. Overall healthcare cost efficiency for treatments

C. Individual service pricing

D. Patient referrals to specialists

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Answers

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1. B
2. C
3. C
4. B
5. D
6. B
7. C
8. A
9. B
10. B

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Explanations

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1. What does "NCCI" stand for in coding?

A. National Coding Certification Institute

B. National Correct Coding Initiative

C. National Clinical Coding Index

D. National Committee for Coding Integrity

"NCCI" stands for "National Correct Coding Initiative." This initiative was created by the Centers for Medicare & Medicaid Services (CMS) to promote correct coding methodologies and assist with the prevention of improper payment for services. The NCCI includes a set of coding guidelines and edits that help ensure that billed services are medically necessary and coding is done accurately, reflecting the services that were actually performed. The purpose of the NCCI is to eliminate the occurrence of inappropriate coding, which can lead to erroneous claims and ultimately result in denial of payment. It provides coders with a framework to identify services that should not be reported together based on established policy. Understanding NCCI guidelines is crucial for coding professionals to ensure compliance and to help healthcare providers receive appropriate reimbursement. The other options represent concepts or acronyms that do not align with the widely recognized definition of NCCI within the coding profession, which reinforces that B is the most accurate and relevant answer in this context.

2. What is the medical term for the condition of an enlarged heart?

A. Cardiomyopathy

B. Cardiopathy

C. Cardiomegaly

D. Carditis

The medical term for the condition of an enlarged heart is cardiomegaly. This term specifically refers to the enlargement of the heart muscle, which can occur for various reasons, including hypertension, heart valve disease, or cardiomyopathy. Understanding this condition is important in the field of medicine, as it can be indicative of underlying health issues that necessitate further evaluation and management. Cardiomyopathy refers to diseases of the heart muscle that can lead to cardiomegaly, but it does not specifically denote enlargement. Cardiopathy is a general term that can refer to any heart disease but lacks the specificity of describing an enlarged heart. Carditis refers to inflammation of the heart or its surrounding structures, which is also distinct from the concept of enlargement. Thus, cardiomegaly is the precise term used to denote an enlarged heart.

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3. What is the significance of appendix B in the CPT manual?

A. It contains modifiers

B. It lists coding guidelines

C. It details additions, deletions, and revisions

D. It offers unlisted procedures

Appendix B in the CPT manual plays a crucial role in keeping coders informed about the changes made to the coding system. It details additions, deletions, and revisions that have occurred in the current version of the CPT codes, allowing coders to stay up-to-date with the latest codes and their appropriate use. This information is vital as it assists coders in understanding which codes are new, which ones have been removed, and any modifications that have been made to existing codes. Being aware of these changes is essential for accurate coding and billing practices, as it ensures compliance with current standards and avoids potential claims denials. While modifiers, coding guidelines, and unlisted procedures are important components of the CPT manual, they are addressed in other sections rather than in Appendix B. Modifiers are typically listed in a dedicated section and provide additional information about a procedure. Coding guidelines explain how to apply codes correctly and often accompany specific code descriptions. Unlisted procedures are found in different sections designated for those particular coding scenarios. Thus, the primary focus of Appendix B is on modifications to the code set itself, making it an essential resource for any coding professional.

4. What does the root word cool/o stand for?

A. Uterus

B. Vagina

C. Ovary

D. Fallopian Tube

The root word "cool/o" is a combining form used in medical terminology that specifically refers to the vagina. It originates from the Greek word "kolpos," which translates to "a womb" or "vagina." Understanding root words is essential for decoding medical terminology, as they often indicate the anatomical structures or conditions being referenced. In this case, while other terms related to the female reproductive system are important, they do not share the root "cool/o." For instance, "uterus" is associated with the root "hyster/o," "ovary" corresponds to "oophor/o," and "fallopian tube" relates to "salping/o." This knowledge aids in connecting medical vocabulary with proper anatomical references, making it easier to understand descriptions and procedures linked to specific body parts.

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5. When is coding for an external cause essential?

A. When the patient is admitted for a scheduled procedure

B. When it is related to an underlying chronic condition

C. Only when the injury is severe

D. When it relates to the cause of an injury or health condition

Coding for an external cause is essential when it pertains to the reason behind an injury or health condition. This is crucial for several reasons. First, external cause codes provide valuable context to the circumstances surrounding an injury or health issue, such as whether it resulted from an accident, fall, or other incident. This data can be vital for both public health statistics and for healthcare providers to understand the implications of injuries and assess prevention strategies. Second, these codes help to clarify the type of event or exposure leading to the injury, which can influence treatment decisions and risk assessment. For instance, knowing that an injury resulted from a specific external factor can guide the medical team in preventing future occurrences or in managing similar incidents with other patients. In contrast, coding for a scheduled procedure or a chronic condition does not warrant external cause coding since these scenarios do not pertain to the occurrence of an injury. Similarly, the severity of an injury alone does not dictate the need for external cause coding, as the focus should always remain on accurately capturing the nature of incidents contributing to health outcomes. Therefore, external cause coding is an integral part of capturing the complete clinical picture, facilitating effective treatment, and improving public health tracking and response.

6. Where is the hypertension table located in ICD-10-CM?

A. In the introduction

B. There is no hypertension table

C. In the cardiology section

D. At the end of the chapter

The hypertension table does not exist as a separate entity in ICD-10-CM. Instead, hypertension codes are integrated within the appropriate sections of the classification, particularly among the diseases of the circulatory system. ICD-10-CM includes various coding guidelines and instructional notes related to hypertension, but they are not organized into a specific table. Understanding this structure is important as it affects how coders locate and assign codes for hypertension in clinical documentation. Codes can be found under categories like I10–I15 which encompass essential hypertension and other related conditions. Therefore, the assertion that there is no hypertension table aligns with the classification's organizational approach. This knowledge can be useful when navigating the ICD-10-CM manual and ensuring accurate coding practices.

7. How many digits are typically found in a Level I CPT code?

A. Three digits

B. Four digits

C. Five digits

D. Six digits

Level I CPT codes are typically composed of five digits. The American Medical Association (AMA) develops and maintains the Current Procedural Terminology (CPT) coding system, which includes a comprehensive list of medical services and procedures. Each of these five-digit codes corresponds to a specific medical service or procedure, allowing for clear communication regarding healthcare procedures among providers, payers, and patients. Understanding the structure of CPT codes is crucial for accurate coding practices, as it impacts billing, reimbursement, and healthcare data management. The five-digit code format is designed to allow for a broad range of procedures, ensuring that the coding system can accommodate the evolving nature of medical practices and procedures.

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8. Which punctuation mark between codes in the index of the CPT manual indicates two codes are available?

A. comma

B. hyphen

C. semicolon

D. colon

The correct answer is the comma, which is used in the index of the CPT manual to indicate that two codes are available for selection. When you see a comma between two codes, it signifies that both codes are appropriate options for a given procedure or service. This is particularly helpful when there are multiple codes that may apply, allowing the coder to choose the most accurate code based on the specific clinical scenario. The other punctuation marks serve different purposes in the coding system. A hyphen is used to denote a range of codes, indicating that the codes listed before and after the hyphen represent a continuum of related codes. The semicolon often separates instructional notes or modifies a code description without indicating additional options. A colon is typically used to introduce a list of codes or to specify further explanations regarding the code. Understanding the function of each punctuation mark is essential for accurate coding and selection of the proper procedures in billing and documentation.

9. What is the code for a secondary neoplasm of the descending colon?

A. C78.3

B. C78.5

C. C78.9

D. C78.0

The correct code for a secondary neoplasm of the descending colon is C78.5. This code specifically identifies secondary malignant neoplasms that are located in the gastrointestinal tract, including the colon. C78.5 is used to denote secondary malignant neoplasms in the colon, while other codes, like C78.0, refer to the specific site of secondary cancers in the lungs, and C78.3 and C78.9 are used for other anatomical sites or unspecified areas related to the presence of secondary neoplasms. Each code is part of the broader ICD-10-CM coding system, which categorizes diseases and health conditions based on their nature and location to facilitate accurate communication and billing in healthcare settings.

10. What does the use of "bundled payments" aim to improve?

A. Patient choice of services

B. Overall healthcare cost efficiency for treatments

C. Individual service pricing

D. Patient referrals to specialists

The concept of bundled payments is designed to enhance overall healthcare cost efficiency for treatments. This model consolidates payments for multiple services that are provided during a specific episode of care into a single, comprehensive payment. By doing so, it encourages healthcare providers to streamline processes and coordinate more effectively, ultimately reducing unnecessary services and ensuring that patients receive high-quality care. With bundled payments, providers are incentivized to focus on the overall outcome for the patient rather than the individual components of care. This approach can lead to more efficient use of resources and a reduction in healthcare expenditures, as it aligns the financial interests of providers with the goal of delivering better patient outcomes. The other options, while they touch on important aspects of healthcare delivery, do not directly align with the primary goal of the bundled payment model. The focus is indeed on cost efficiency and quality of care rather than just patient choice, individual service pricing, or patient referrals to specialists.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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