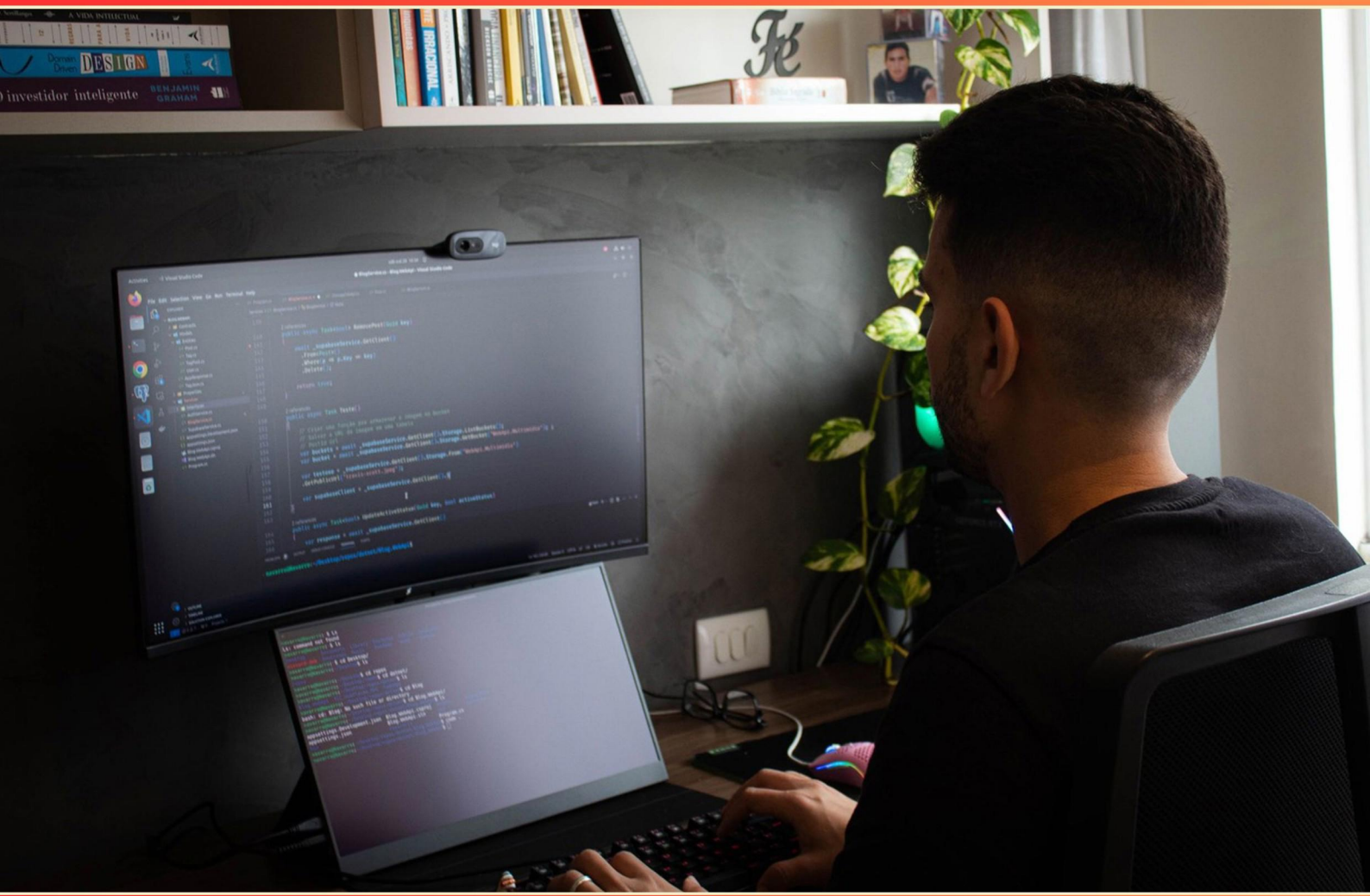
CERTIFIED PROFESSIONAL CODER (CPC) PRACTICE TEST (SAMPLE)

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 CPT and ICD-9-CM codes would be assigned for a patient with dementia requiring a skilled nursing facility admission?

A. 99305, 290.0

B. 99255

C. 99396

D. 69436-50

2. Which codes would be used for a consultation for a patient diagnosed with bilateral senile cataracts?

A. 43, V72.81, 366.10, 401.1

B. 692.3, 368.11

C. 686.9, 199.12

D. 99325, 486

3. What was the surgical position of the patient during the cystoscopy?

A. Supine

B. Dorsolithotomy

C. Sitting

D. Prone

4. What is the relevant code for a single energy x-ray absorptiometry bone density study confirming osteopenia?

A. G0130

B. G0131

C. G0132

D. G0133

5. What code is used for manipulating multiple tibial tuberosity fractures in a 13-year-old female?

A. 27538-LT

B. 16030

C. 23030

D. 11752

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6. What code would you use to report the removal of benign polyps found during a sigmoidoscopy?

A. 45338

B. 42825

C. 46250

D. 33536

7. Which CPT code is relevant for the repair and manipulation of multiple fractures sustained during a sports activity?

A. 27538-LT

B. 27252-LT

C. 16030

D. 29425-LT

8. What was the result of the chest x-ray performed on the new patient?

A. Normal findings

B. Patchy bilateral infiltrates

C. Pneumothorax

D. Consolidation in the right lung

9. What was the preoperative diagnosis for the patient undergoing shunt revision?

A. Obstructive symptoms

B. Obstructive hydrocephalus

C. Herniated disc

D. Corneal ulcer

10. What injury did the patient sustain in the car accident?

A. Fractured wrist

B. Right rotator cuff injury

C. Concussion

D. Herniated disc

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Answers

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

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Explanations

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1. What CPT and ICD-9-CM codes would be assigned for a patient with dementia requiring a skilled nursing facility admission?

A. 99305, 290.0

B. 99255

C. 99396

D. 69436-50

The assignment of CPT and ICD-9-CM codes for a patient with dementia requiring admission to a skilled nursing facility is vital for accurately representing the patient's condition and the level of care needed. The correct choice is justified by the specific codes provided. The CPT code 99305 is designated for the initial comprehensive assessment of a patient admitted to a skilled nursing facility, fitting perfectly for a scenario involving a patient with dementia who requires skilled nursing. This code reflects the services medically necessary for evaluating and managing the patient's cognitive impairment and associated healthcare needs. The ICD-9-CM code 290.0 corresponds to "Senile dementia, uncomplicated," which is the appropriate diagnostic code to describe dementia in this context. Accurate coding of the patient's diagnosis is crucial for proper documentation and reimbursement, as it signifies the medical condition being treated. Together, these codes embody both the clinical scenario of skilled nursing facility admission due to dementia and serve to indicate the complexity of care required by the patient. The other options provided do not fit this specific patient scenario regarding either the care level needed (as in the case of the evaluation codes or other unrelated procedures) or the diagnostic context related to dementia.

2. Which codes would be used for a consultation for a patient diagnosed with bilateral senile cataracts?

A. 43, V72.81, 366.10, 401.1

B. 692.3, 368.11

C. 686.9, 199.12

D. 99325, 486

In the context of a patient diagnosed with bilateral senile cataracts, the correct choice focuses on relevant codes that reflect both the consultation and the specific condition. The choice includes codes that represent a comprehensive scenario: the specific diagnosis of bilateral senile cataracts and the appropriate consultation code. Bilateral senile cataracts are indicated by the code 366.10, highlighting the condition of interest. The V72.81 code is pertinent as it is used to identify the status of a patient during an examination. Code 401.1 is relevant for HTN (Hypertension), which might be included in the patient's medical history that could impact treatment decisions during the consultation. This selection effectively captures both the procedure (the consultation) and the diagnosis (the cataracts) in a medically relevant way, enabling proper documentation and billing. In contrast, the other options contain codes that either do not represent a consultation scenario or do not adequately capture a diagnosis relevant to the question regarding cataracts and their implications.

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3. What was the surgical position of the patient during the cystoscopy?

A. Supine

B. Dorsolithotomy

C. Sitting

D. Prone

The surgical position during a cystoscopy is most commonly the dorsolithotomy position. In this position, the patient lies on their back (supine) with the legs in stirrups, allowing for optimal access to the pelvic organs, including the bladder. This posture provides the necessary exposure and facilitates the insertion of the cystoscope through the urethra into the bladder. While the supine position is also partially correct since patients are initially placed on their backs, it does not provide the specific orientation and access that the dorsolithotomy position achieves in surgical settings. The sitting position is not typically used for cystoscopy because it restricts access to the bladder. Additionally, the prone position is generally contraindicated for this procedure, as it does not allow for the necessary approach to the urinary tract. Thus, the dorsolithotomy position is uniquely suited for cystoscopy, balancing patient comfort and surgical access.

4. What is the relevant code for a single energy x-ray absorptiometry bone density study confirming osteopenia?

A. G0130

B. G0131

C. G0132

D. G0133

The correct code for a single energy x-ray absorptiometry (DEXA) bone density study confirming osteopenia is G0130. This code is specifically used for the reporting of a diagnostic bone density study that utilizes a single-energy x-ray absorptiometry technique, which is appropriate for assessing the bone density of patients at risk for osteoporosis or those already diagnosed with conditions like osteopenia. When using G0130, the procedure being billed is intended for the evaluation of skeletal health through the measurement of bone mineral density, which provides clinicians valuable information about a patient's bone health status. This can guide treatment decisions and risk assessments for fractures or further osteoporosis. The other codes listed pertain to different bone density testing modalities or specify other types of studies. For example, G0131, G0132, and G0133 may relate to different measurement techniques, specific patient populations, or follow-up studies but do not apply to a standard single-energy measurement confirming a diagnosis of osteopenia. Thus, G0130 is the most relevant choice for this context.

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5. What code is used for manipulating multiple tibial tuberosity fractures in a 13-year-old female?

A. 27538-LT

B. 16030

C. 23030

D. 11752

The code for manipulating multiple tibial tuberosity fractures in a patient, specifically a 13-year-old female, is 27538-LT. This code is designated for the treatment of a fracture of the tibial tuberosity, including manipulation and stabilization of the fracture. In this scenario, the '27538' code refers to the manipulation of a fracture of the tibia, while the '-LT' modifier indicates that the procedure is performed on the left side of the body, which is often necessary when documenting procedures for fractures to clarify which limb was affected. When fractures occur in the tibial tuberosity area, especially in younger patients, proper coding is critical to ensure that the procedures are billed accurately for the services performed. The other codes provided do not accurately reflect the procedure or the anatomical site involved. For instance, the codes for other types of procedures or anatomical locations would not encompass the specific treatment outlined in this case scenario focused on the tibial tuberosity. Therefore, 27538-LT is specific and appropriate for the manipulation conducted for multiple fractures in that region, indicating both the complexity and the site of the fractures being treated.

6. What code would you use to report the removal of benign polyps found during a sigmoidoscopy?

A. 45338

B. 42825

C. 46250

D. 33536

The appropriate code for reporting the removal of benign polyps found during a sigmoidoscopy is 45338. This code specifically describes the procedure of performing a sigmoidoscopy with the removal of a polyp(s) using snare technique or forceps. It captures both the diagnostic aspect of sigmoidoscopy and the therapeutic act of polyp removal, which is important for accurately documenting the services provided to the patient. In this scenario, the focus is on coding the procedure associated with the sigmoidoscopy and polyp removal. Other codes listed do not relate to this type of procedure. For instance, codes for procedures involving the trachea or different types of polyps would not apply here. Understanding the specifics of the procedure helps ensure proper coding and billing, maximizing accuracy and compliance with coding guidelines.

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7. Which CPT code is relevant for the repair and manipulation of multiple fractures sustained during a sports activity?

A. 27538-LT

B. 27252-LT

C. 16030

D. 29425-LT

The appropriate selection for the repair and manipulation of multiple fractures, particularly in the context of sports injuries, centers around the specific services provided and their classification within the Current Procedural Terminology (CPT) coding system. The chosen code, 27538-LT, corresponds to the complex repair of multiple fractures in the femur or associated structures, taking into account the nature of the reconstructive work needed following such injuries. This code reflects procedures that encompass the manipulation and stabilization of fractures effectively, which aligns perfectly with the scenario where an athlete sustains multiple fractures during a sports activity. The other codes, although they pertain to different types of fractures or treatments, do not cover the comprehensive service described in the question. For instance, 27252-LT relates to a specific type of femur fracture but may not account for multiple fractures or may cover less complex procedures. The code 16030 relates to advanced wound care rather than fracture repair. Finally, 29425-LT pertains to the treatment of certain types of ankle fractures or other lower limb structures but is not suitable for the repair of multiple fractures, particularly from the context of complex manipulation. Overall, 27538-LT is the most fitting code as it captures both the severity

8. What was the result of the chest x-ray performed on the new patient?

A. Normal findings

B. Patchy bilateral infiltrates

C. Pneumothorax

D. Consolidation in the right lung

The choice of patchy bilateral infiltrates as the result from the chest x-ray indicates the presence of irregularly distributed opacities in both lungs. This finding can suggest a range of conditions, such as an infectious process, inflammatory diseases, or even pulmonary edema. It reflects a more complex pattern of lung involvement rather than isolated findings, which could point to conditions such as pneumonia or interstitial lung disease. In contrast, other findings like normal results would indicate no abnormalities, while pneumothorax denotes air in the pleural space, leading to lung collapse, which would typically present differently on an x-ray. Consolidation in the right lung suggests a solidification of lung tissue due to fluid, solid, or other materials, indicating a localized area of infection or inflammation rather than the bilateral nature of the infiltrates observed. Thus, patchy bilateral infiltrates adequately demonstrate a significant alteration in lung function or pathology, making it the most fitting result in this context.

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9. What was the preoperative diagnosis for the patient undergoing shunt revision?

A. Obstructive symptoms

B. Obstructive hydrocephalus

C. Herniated disc

D. Corneal ulcer

The preoperative diagnosis of obstructive hydrocephalus is specifically linked to conditions where there is an accumulation of cerebrospinal fluid (CSF) within the brain's ventricles due to a blockage in its normal flow. In this context, a shunt revision would typically be performed to address complications related to hydrocephalus, which might include symptoms like increased intracranial pressure or neurological deficits resulting from the excess fluid. Obstructive hydrocephalus is a more precise diagnosis than obstructive symptoms because it describes the underlying pathological condition responsible for the need for intervention. While obstructive symptoms could suggest various issues related to fluid build-up, it does not specifically indicate the presence of hydrocephalus, which is critical in justifying a shunt revision procedure. Other diagnoses such as herniated disc and corneal ulcer are not related to cerebrospinal fluid management or the need for shunt-related surgeries, thus ruling them out as appropriate preoperative diagnoses for this scenario.

10. What injury did the patient sustain in the car accident?

A. Fractured wrist

B. Right rotator cuff injury

C. Concussion

D. Herniated disc

The correct answer indicates that the patient sustained a right rotator cuff injury during the car accident. This type of injury commonly occurs due to sudden impact or the force of the body being thrown against the seatbelt or steering wheel in an accident, leading to strains or tears in the rotator cuff muscles and tendons. The rotator cuff is crucial for maintaining shoulder stability and mobility, and injuries to this area can significantly affect a person's range of motion and arm function. Other injuries, while possible in car accidents, were not specified in the scenario. For instance, a fractured wrist may occur if the patient braced themselves with their arms during impact, and a concussion can happen if there is a sudden stop causing the head to move. A herniated disc could result from the spinal stress during a collision but was less likely to be the primary injury referenced here. Each option represents a distinct type of injury, but the context or mechanisms of the car accident particularly relate to the potential of a rotator cuff injury being the most relevant and likely outcome in this case.

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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:

https://certifiedprofessionalcoder.examzify.com

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

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