

AAPC Certified Professional Coder (CPC) Practice Exam (Sample)

Study Guide



Everything you need from our exam experts!

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Questions

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- 1. How many digits are typically found in a Level I CPT code?**
 - A. Three digits**
 - B. Four digits**
 - C. Five digits**
 - D. Six digits**
- 2. What is a major difference between ICD-10-CM and ICD-10-PCS?**
 - A. ICD-10-CM is for outpatient coding, ICD-10-PCS is for inpatient coding**
 - B. ICD-10-CM includes modifiers while ICD-10-PCS does not**
 - C. ICD-10-CM is used for clinical management whereas ICD-10-PCS focuses on billing**
 - D. ICD-10-CM codes are shorter than ICD-10-PCS codes**
- 3. What is generally required for outpatient coding?**
 - A. Diagnosis codes only**
 - B. Procedure codes only**
 - C. Both diagnosis and procedure codes**
 - D. Only patient insurance information**
- 4. What are "codes" in the context of medical billing?**
 - A. Characters representing patient names**
 - B. Alphanumeric characters that represent medical diagnoses, procedures, or services**
 - C. Random numbers assigned to patient files**
 - D. Symbols representing healthcare providers**
- 5. How does accurate coding impact healthcare providers financially?**
 - A. It reduces the number of patients seen**
 - B. It ensures proper payment and reduces claim denials**
 - C. It increases the length of hospital stays**
 - D. It lowers insurance premiums for providers**

- 6. 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**
- 7. 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**
- 8. What is the correct action if a procedure performed is not listed in the CPT codebook?**
- A. Code the closest related procedure.**
 - B. Use an unlisted procedure code.**
 - C. Ask the patient for an appropriate code.**
 - D. Document the procedure without coding.**
- 9. For a patient with a rotator cuff tear, which procedure is typically aimed at repairing that condition?**
- A. Subacromial decompression**
 - B. Capsulorrhaphy**
 - C. Rotator cuff repair**
 - D. Labral repair**
- 10. The words that follow a code number in the CPT manual are called:**
- A. service descriptor**
 - B. item description**
 - C. coding note**
 - D. procedure/ service descriptor**

Answers

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

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Explanations

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1. 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.

2. What is a major difference between ICD-10-CM and ICD-10-PCS?

- A. ICD-10-CM is for outpatient coding, ICD-10-PCS is for inpatient coding**
- B. ICD-10-CM includes modifiers while ICD-10-PCS does not**
- C. ICD-10-CM is used for clinical management whereas ICD-10-PCS focuses on billing**
- D. ICD-10-CM codes are shorter than ICD-10-PCS codes**

The correct choice highlights a fundamental distinction in the intended uses of ICD-10-CM and ICD-10-PCS coding systems. ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) is designed primarily for diagnosing conditions in outpatient settings, making it vital for medical practices, emergency care, and other non-hospital facilities that treat patients. This coding system focuses on capturing diagnoses, symptoms, and reasons for encounters. In contrast, ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System) is exclusive to inpatient hospital settings, specifically for procedures performed during a patient's stay. This system allows for detailed coding of various medical, surgical, and diagnostic procedures conducted in hospitals, essential for health care facilities to report services rendered to third-party payers. Understanding this distinction is crucial for coders, as it determines which coding system to apply based on the healthcare provider's settings and services rendered. Each system serves a different purpose in the healthcare continuum, aligning with varied documentation and billing requirements. This knowledge directly impacts accurate coding and reimbursement processes, which are essential for efficient healthcare operations.

3. What is generally required for outpatient coding?

- A. Diagnosis codes only
- B. Procedure codes only
- C. Both diagnosis and procedure codes**
- D. Only patient insurance information

For outpatient coding, it is essential to include both diagnosis codes and procedure codes. Diagnosis codes, typically derived from the International Classification of Diseases (ICD), detail the medical conditions or reasons for the patient's visit, which is necessary for justifying the care provided. Procedure codes, generally from the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS), document the specific services or treatments administered during the outpatient visit. The combination of diagnosis and procedure codes ensures comprehensive documentation that supports billing and medical necessity. This dual approach is critical for health insurance reimbursement, as insurers require justification in the form of both the diagnosis and the services performed to approve payment. Hence, understanding the need for both coding types is fundamental for correct outpatient coding practices.

4. What are "codes" in the context of medical billing?

- A. Characters representing patient names
- B. Alphanumeric characters that represent medical diagnoses, procedures, or services**
- C. Random numbers assigned to patient files
- D. Symbols representing healthcare providers

In the context of medical billing, "codes" specifically refer to alphanumeric characters that are used to identify and represent medical diagnoses, procedures, or services. These codes are critical for various functions within the healthcare system including billing, insurance claims processing, and statistical tracking of health outcomes. These codes, such as those defined by the ICD (International Classification of Diseases) for diagnoses and the CPT (Current Procedural Terminology) for procedures, allow for clear communication between healthcare providers and payers. They ensure that services rendered are accurately documented and appropriately reimbursed, as well as facilitate the analysis of healthcare trends and outcomes. Understanding the role and structure of these codes is essential for anyone involved in medical billing, coding, or healthcare administration, as it directly impacts the accuracy of claims processing and the overall financial health of healthcare facilities.

5. How does accurate coding impact healthcare providers financially?

- A. It reduces the number of patients seen**
- B. It ensures proper payment and reduces claim denials**
- C. It increases the length of hospital stays**
- D. It lowers insurance premiums for providers**

Accurate coding plays a crucial role in the financial health of healthcare providers by ensuring proper payment and minimizing claim denials. When coding is performed correctly, it accurately reflects the services rendered, which is essential for receiving appropriate reimbursement from insurance carriers and government programs. Proper coding aligns with the documentation in the medical record, thus substantiating the necessity and scope of services provided to patients. Moreover, accurate coding reduces the likelihood of errors that can lead to claim denials. Denied claims can delay payments, require additional administrative work to resolve issues, and potentially lead to lost revenue. By ensuring accuracy in coding, healthcare providers can enhance their cash flow and financial viability, thereby allowing them to focus on providing high-quality patient care. In contrast, the other options do not accurately reflect the financial implications of coding within healthcare. For example, accurate coding does not inherently reduce the number of patients seen nor does it increase hospital lengths of stay. Additionally, it does not directly influence insurance premiums for providers. Thus, the option that emphasizes the connection between accurate coding, proper payments, and reduced claim denials is fundamental to understanding its financial impact.

6. 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.

7. 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.

8. What is the correct action if a procedure performed is not listed in the CPT codebook?

- A. Code the closest related procedure.
- B. Use an unlisted procedure code.**
- C. Ask the patient for an appropriate code.
- D. Document the procedure without coding.

Selecting an unlisted procedure code is the appropriate action when a procedure performed is not specifically listed in the CPT codebook. Unlisted procedure codes are designed for situations where a service or procedure is not available in the standard codes. By using an unlisted code, coders can indicate that a procedure was performed, even though a specific code does not exist for it. This choice allows coders to properly document the service provided and ensures that the payer is aware of the specific treatment rendered. It also enables the healthcare provider to receive reimbursement for the procedure, as the claim will be based on the details provided in the documentation and supported by the use of the unlisted code. Unlisted codes require that additional information is often submitted to justify the use of the code, making documentation and a clear description of the procedure crucial. This is important for claims review and for the payer to understand why the unlisted procedure was necessary. Using a related procedure code or asking the patient for a code would not accurately reflect the services rendered and could lead to denial of a claim or incorrect coding, while simply documenting the procedure without coding leaves the service inadequately represented in billing.

9. For a patient with a rotator cuff tear, which procedure is typically aimed at repairing that condition?

- A. Subacromial decompression**
- B. Capsulorrhaphy**
- C. Rotator cuff repair**
- D. Labral repair**

The procedure specifically aimed at repairing a rotator cuff tear is the rotator cuff repair. This surgical intervention focuses on repairing the torn tendons that make up the rotator cuff, which helps stabilize the shoulder joint and allows for proper function and movement. By addressing the specific tissue damage associated with the tear, the procedure aims to restore the integrity of the rotator cuff, allowing patients to regain strength and range of motion in the affected shoulder. Subacromial decompression, on the other hand, is used to relieve pain by removing bone spurs or inflamed tissue in the subacromial space, but it does not repair the cuff itself. Capsulorrhaphy is related to repairs of the shoulder capsule but does not directly involve repairing the rotator cuff tendons. Lastly, labral repair is focused on repairing the labrum of the shoulder joint, not directly related to any tears in the rotator cuff. Therefore, the specific nature of the rotator cuff repair distinguishes it as the most appropriate procedure for addressing rotator cuff tears.

10. The words that follow a code number in the CPT manual are called:

- A. service descriptor**
- B. item description**
- C. coding note**
- D. procedure/ service descriptor**

The correct answer is that the words that follow a code number in the CPT manual are called a procedure/service descriptor. This terminology is essential because it provides a clear, concise explanation of the procedure or service represented by the code. The descriptor not only defines what the code entails but also specifies the details necessary for appropriate coding and billing practices. Understanding the significance of a procedure/service descriptor is crucial for coders as it ensures accurate documentation and assists in determining the correct reimbursement for healthcare services rendered. The descriptors are integral to interpreting the coding requirements and guidelines, making it easier for practitioners to select the appropriate codes based on the services provided. In contrast, service descriptor, item description, and coding note do not specifically represent the exact terminology used in the CPT manual for this context. While they might relate to different features of coding and documentation, only "procedure/service descriptor" is the term that accurately captures the phrases following a code in the CPT system.