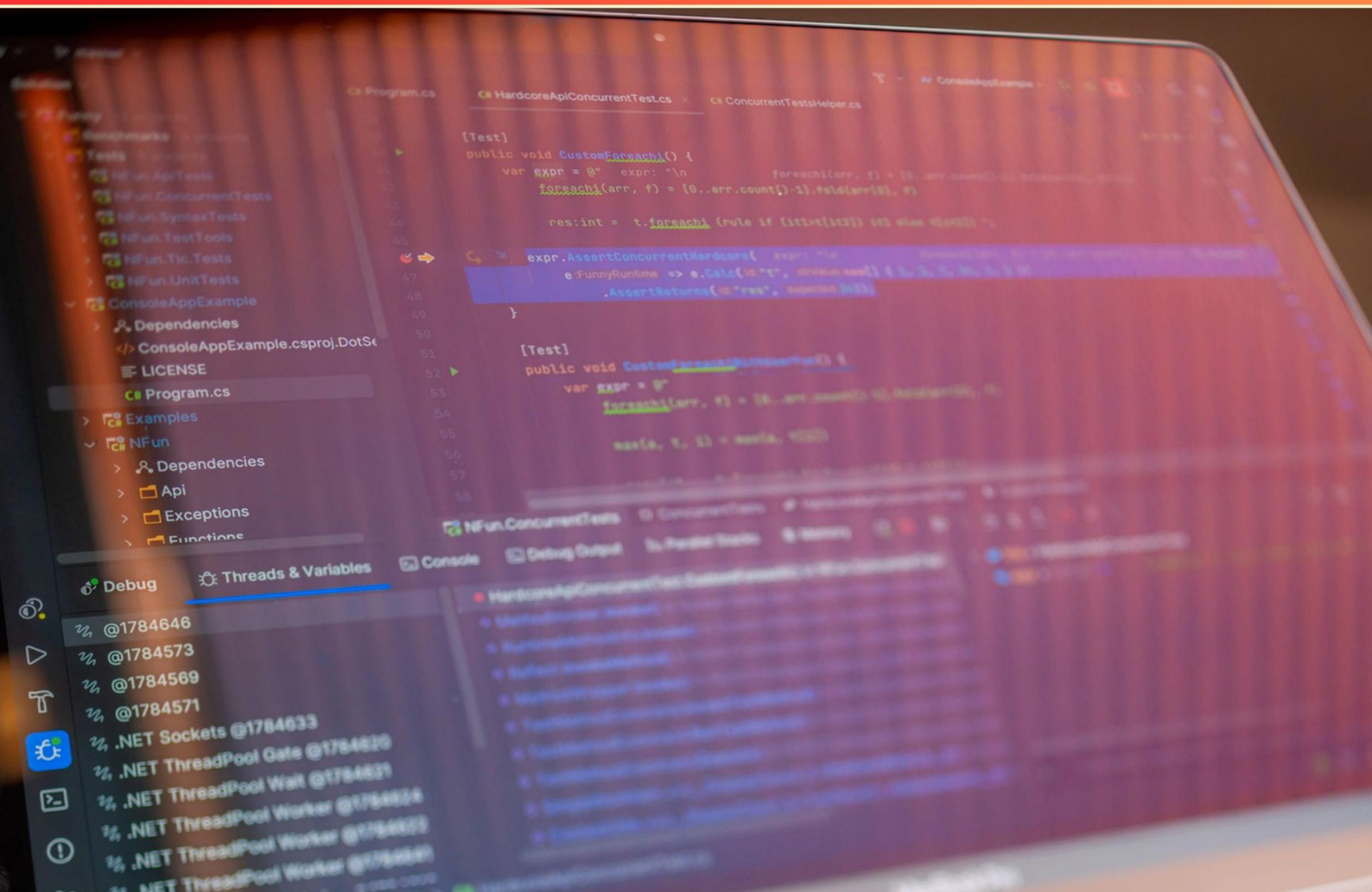


# AAPC CERTIFIED PROFESSIONAL CODER (CPC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



*Prepare with structure. Pass with confidence*



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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.

# 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!

## Questions

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- 1. What is the primary purpose of auditing in medical coding?**
  - A. To reduce coding expenses for healthcare providers
  - B. To ensure accuracy and compliance in coding practices
  - C. To facilitate the billing process for patients
  - D. To streamline healthcare provider operations
- 2. 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
- 3. What anatomical feature separates the two sides of the heart?**
  - A. Chamber wall
  - B. Septum
  - C. Valves
  - D. Aorta
- 4. What is the second division in the CPT coding system?**
  - A. Section
  - B. Subsection
  - C. Subheading
  - D. Category
- 5. When would a coder need to use an "unlisted" CPT code?**
  - A. For commonly performed procedures
  - B. When a procedure does not have a specific code assigned in CPT
  - C. For all surgical procedures
  - D. When billing for preventive services
- 6. How many days does it take for CMS to implement HCPCS Level II Temporary Codes reported as added, changed, or deleted?**
  - A. 30 days
  - B. 60 days
  - C. 90 days
  - D. 120 days

- 7. Why is the correct use of codes vital for healthcare providers?**
- A. It allows the use of any coding system
  - B. It enhances the reputation of coders
  - C. It ensures offers the best patient care
  - D. It impacts reimbursement and financial stability for services provided
- 8. What is the default type of diabetes mellitus when the type is not documented in the medical notes?**
- A. Type 1
  - B. Type 2
  - C. Gestational Diabetes
  - D. Insulin-dependent Diabetes
- 9. What is a "diagnosis code"?**
- A. A code that describes a patient's diagnosis or reason for a healthcare encounter
  - B. A code that indicates the level of care provided
  - C. A code used for billing medical devices
  - D. A code that tracks patient insurance information
- 10. In which circumstance would you report an external cause code?**
- A. For health conditions without physical injury
  - B. Only for work-related injuries
  - C. For causes of injury or health condition
  - D. Adverse effects of medication only

## **Answers**

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

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## **Explanations**

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## 1. What is the primary purpose of auditing in medical coding?

- A. To reduce coding expenses for healthcare providers
- B. To ensure accuracy and compliance in coding practices**
- C. To facilitate the billing process for patients
- D. To streamline healthcare provider operations

*The primary purpose of auditing in medical coding is to ensure accuracy and compliance in coding practices. This process involves reviewing coded data against medical documentation to verify that the codes assigned are correct and reflective of the services provided. Auditing helps maintain high standards of coding accuracy, which is crucial for appropriate reimbursement, minimizing claim denials, and avoiding potential legal issues associated with coding fraud or errors. By focusing on compliance, audits help healthcare organizations adhere to regulations and guidelines set by various entities, such as the Centers for Medicare & Medicaid Services (CMS) and the American Academy of Professional Coders (AAPC). Regular audits also identify areas for improvement in coding practices and education, thereby enhancing the overall quality of coding within a healthcare facility.*

## 2. 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.*

## 3. What anatomical feature separates the two sides of the heart?

- A. Chamber wall
- B. Septum**
- C. Valves
- D. Aorta

*The anatomical feature that separates the two sides of the heart is known as the septum. The septum is a thick wall of muscle that divides the heart into the left and right sides, preventing the mixing of oxygenated and deoxygenated blood. This separation is crucial for maintaining the efficiency of the circulatory system, allowing the left side of the heart to pump oxygen-rich blood to the body while the right side pumps oxygen-poor blood to the lungs for oxygenation. In addition to the septum, different components of the heart serve distinct roles. The chamber wall refers to the walls of the heart chambers but does not specifically denote the separation. Valves control blood flow within the chambers but do not separate the sides of the heart. The aorta is the large artery that carries blood from the heart to the body but is not involved in the separation of the heart's sides. Understanding these distinctions is essential for recognizing the function of the septum in heart anatomy.*

#### 4. What is the second division in the CPT coding system?

- A. Section
- B. Subsection**
- C. Subheading
- D. Category

*In the CPT coding system, the correct answer is that the second division is known as a subsection. The CPT (Current Procedural Terminology) coding system is organized hierarchically, which allows coders to easily locate and apply codes. To clarify the structure, the first division is the section, which groups codes based on the type of service provided—such as Evaluation and Management, Surgery, or Radiology. Within these sections, the subsections further categorize codes into more specific areas, allowing for precise coding of procedures and services. For example, within the Surgery section, there may be subsections for different body systems or types of surgical procedures. Understanding this hierarchy is essential for effective coding, as it ensures that the correct codes are utilized for billing and reimbursement purposes. Each subsection can contain codes that share similar characteristics, thereby making it easier for healthcare providers to document and code services accurately.*

#### 5. When would a coder need to use an "unlisted" CPT code?

- A. For commonly performed procedures
- B. When a procedure does not have a specific code assigned in CPT**
- C. For all surgical procedures
- D. When billing for preventive services

*The appropriate scenario for using an "unlisted" CPT code is when a procedure does not have a specific code assigned in the CPT (Current Procedural Terminology) system. Unlisted codes serve as a placeholder for unique or less common procedures that may not yet have a dedicated code. This allows coders to report services that are performed but not explicitly classified under the existing codes. Using unlisted codes can also facilitate accurate billing and reimbursement when a provider performs a procedure that falls outside the standard codes. It's important for the coder to provide detailed documentation along with the unlisted code to justify the service provided and allow the payer to understand the necessity and context of the procedure. In contrast, commonly performed procedures will typically have specific codes assigned, surgical procedures do not universally require unlisted codes (as many have specific codes), and preventive services are generally covered under established codes as well. Thus, unlisted codes are specifically designated for those instances where no other codes apply.*

**6. How many days does it take for CMS to implement HCPCS Level II Temporary Codes reported as added, changed, or deleted?**

- A. 30 days
- B. 60 days
- C. 90 days**
- D. 120 days

*The implementation timeline for HCPCS Level II Temporary Codes reported as added, changed, or deleted is indeed 90 days. This period is established to provide adequate time for the Centers for Medicare & Medicaid Services (CMS) to ensure that all necessary changes are accurately integrated into their systems and communicated to all relevant stakeholders, including providers, suppliers, and coding professionals. The 90-day window allows for adjustments in policy, conferring with stakeholders on updates, and ensuring that the information is correctly disseminated and understood throughout the healthcare community. The other timeframes do not align with the established regulations for implementing these temporary codes. A shorter period like 30 or 60 days would likely not provide sufficient time for the level of communication and updates needed, while a longer timeframe, such as 120 days, exceeds the standard for such code changes. Therefore, 90 days is the correct answer, as it reflects the operational needs and regulatory requirements for effective code implementation by CMS.*

**7. Why is the correct use of codes vital for healthcare providers?**

- A. It allows the use of any coding system
- B. It enhances the reputation of coders
- C. It ensures offers the best patient care
- D. It impacts reimbursement and financial stability for services provided**

*The correct use of codes is vital for healthcare providers primarily because it directly affects reimbursement and financial stability for the services they provide. Proper coding ensures that healthcare providers receive appropriate payment for their services from insurance companies and other payers. Accurate coding translates the medical services and diagnoses into universally recognized codes that payers use to process claims. When coding is done correctly, providers are more likely to get reimbursed promptly and at the accurate levels, which is essential for maintaining the financial health of their practices. Furthermore, precise coding can also help prevent claim denials and delays, which can disrupt cash flow and lead to financial difficulties. Additionally, effective coding practices can ensure compliance with healthcare regulations, mitigate the risk of audits, and reduce potential legal issues related to billing practices. Overall, the financial impact of coding accuracy is crucial for the sustainability and operational success of healthcare organizations.*

**8. What is the default type of diabetes mellitus when the type is not documented in the medical notes?**

- A. Type 1
- B. Type 2**
- C. Gestational Diabetes
- D. Insulin-dependent Diabetes

*When the type of diabetes mellitus is not specified in medical documentation, the default classification is Type 2 diabetes. This classification is based on statistical prevalence, as Type 2 diabetes is far more common than Type 1. Consequently, in coding practices, if the specific type is not clear, Type 2 is assumed unless there are clear indicators suggesting otherwise. Understanding the prevalence of diabetes types is crucial for accurate coding and billing processes. Type 1 diabetes, which is often diagnosed in childhood or early adulthood, represents a smaller percentage of the population compared to Type 2, typically associated with lifestyle factors and often diagnosed in adults. Gestational diabetes pertains specifically to glucose intolerance that occurs during pregnancy and would not be considered a default type in general coding situations. Insulin-dependent diabetes is generally used interchangeably with Type 1 but is not the standard classification for unspecified cases. Thus, when documenting diabetes without clear specification, defaulting to Type 2 is the accepted practice in the medical coding community.*

**9. What is a "diagnosis code"?**

- A. A code that describes a patient's diagnosis or reason for a healthcare encounter**
- B. A code that indicates the level of care provided
- C. A code used for billing medical devices
- D. A code that tracks patient insurance information

*A diagnosis code is a unique alphanumeric code used to identify a patient's medical condition or the reason for a healthcare encounter accurately. These codes are critical in the healthcare system as they provide a standardized method for documenting the diagnosis, which facilitates communication among healthcare providers, insurers, and patients. By using these codes, healthcare providers can ensure that they receive appropriate reimbursement for their services, as these codes are often part of the claims submitted for payment. The specific format and structure of diagnosis codes can vary depending on the coding system being used, such as ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) in the United States, which is widely adopted for this purpose. This coding system illustrates the various medical conditions and factors affecting health, allowing for detailed and specific coding that reflects the patient's situation. The other options refer to different types of codes used in healthcare. The level of care code pertains to resource utilization and complexity of services rather than diagnosis. Codes for billing medical devices are specific to the devices utilized rather than the patient's medical condition. Finally, codes tracking patient insurance information would relate to administrative processes rather than directly to the diagnosis itself. Thus, the diagnosis code stands out as the correct answer, as it specifically pertains to encapsulating*

**10. In which circumstance would you report an external cause code?**

- A. For health conditions without physical injury
- B. Only for work-related injuries
- C. For causes of injury or health condition**
- D. Adverse effects of medication only

*The correct response indicates that external cause codes are reported specifically to capture the circumstances surrounding an injury or health condition. These codes provide critical information regarding the events or factors that led to an injury or health issue, including details such as the location, activity, and cause. For example, if a patient sustains an injury while playing a sport, the external cause code would help to describe not only the injury but also the activity and the context in which it occurred. This coding is vital for analyzing injury patterns, understanding public health implications, and ensuring better healthcare planning and resource allocation. Accurately documenting external causes allows for a more comprehensive view of health issues and aids in reporting for statistical purposes. In contrast, health conditions without physical injury might not require such detail, as they do not involve external causes of injury. Reporting only for work-related injuries limits the scope of the data captured, while focusing solely on adverse effects of medication does not encompass the broad range of circumstances that external cause codes are designed to identify. Thus, the choice that encompasses all instances of injuries and health conditions, including how they occurred, is the most comprehensive and accurate understanding of when to report external cause codes.*

## 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](mailto:hello@examzify.com).

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

<https://aapccpc.examzify.com>

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

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