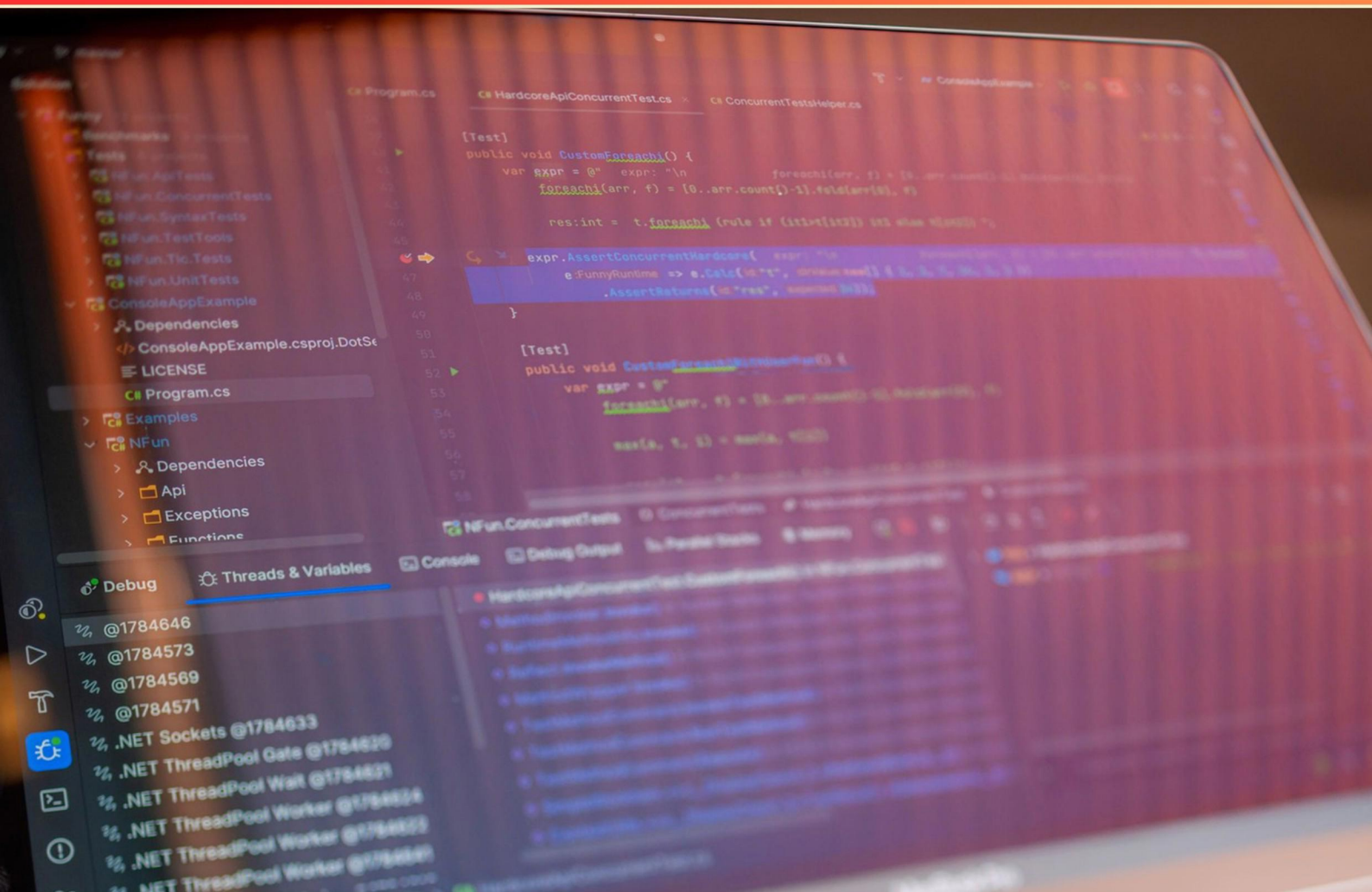


AAPC CERTIFIED PROFESSIONAL CODER (CPC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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Table of Contents

Copyright	1
Table of Contents	2
Introduction	3
How to Use This Guide	4
Questions	5
Answers	8
Explanations	10
Next Steps	16

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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. Where can specific coding information about each section of the CPT manual be found?**
 - A. Appendix
 - B. Guidelines
 - C. Index
 - D. Tables
- 2. What is defined as a request for payment from a payer for healthcare services rendered?**
 - A. A billing statement
 - B. A claim
 - C. An invoice
 - D. A reimbursement request
- 3. Which statement is true regarding codes for hypertension and heart disease in ICD-10-CM?**
 - A. Hypertension and heart disease must always be coded together
 - B. Hypertension and heart disease without a stated causal relationship must be coded separately
 - C. Hypertension is a more severe condition than heart disease
 - D. Heart disease codes take precedence over hypertension codes
- 4. Why is documentation crucial in E/M coding?**
 - A. It enhances patient satisfaction
 - B. It is a requirement for insurance reimbursement
 - C. It allows providers to spend less time with patients
 - D. It primarily serves as a backup for billing statements
- 5. Which statement is TRUE regarding the reporting of burn codes?**
 - A. Burn codes are reported based on the location of the injury
 - B. The lowest degree of burn is reported as primary code
 - C. The highest degree of burn is reported as primary code
 - D. Burns are reported only when they are second degree or higher

- 6. What ICD-10-CM code should be reported for elevated blood sugar?**
- A. R73.09
 - B. R71.1
 - C. R73.8
 - D. R74.8
- 7. When a patient undergoes tests and the results return normal, what type of service is provided?**
- A. Diagnostic services
 - B. Screening services
 - C. Therapeutic services
 - D. Consultative services
- 8. Bile empties into the duodenum through what structure?**
- A. Bile duct
 - B. Common bile duct
 - C. Pancreatic duct
 - D. Hepatic duct
- 9. What does the root word cool/o stand for?**
- A. Uterus
 - B. Vagina
 - C. Ovary
 - D. Fallopian Tube
- 10. In which section of the CPT manual would you find codes for surgical procedures?**
- A. The Anesthesia section
 - B. The Surgery section
 - C. The Radiology section
 - D. The Pathology and Laboratory section

Answers

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

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Explanations

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1. Where can specific coding information about each section of the CPT manual be found?

- A. Appendix
- B. Guidelines**
- C. Index
- D. Tables

The correct choice is guidelines. In the CPT manual, the guidelines provide crucial coding information for each section, which helps coders understand the rules and recommendations for accurately coding a variety of procedures and services. These guidelines may include definitions, instructions for reporting specific codes, and clarification of coding practices that should be followed within the associated section. While the index serves as a tool to locate codes by terms and the appendix contains additional information that may also aid coders, these sections do not specifically delve into the detailed coding instructions for each section in the same way that guidelines do. The tables can provide valuable information such as conversion factors or code descriptions but are not the primary resource for comprehensive coding guidance. Thus, the guidelines are essential for ensuring accurate and compliant coding practices in accordance with the standards outlined in the CPT manual.

2. What is defined as a request for payment from a payer for healthcare services rendered?

- A. A billing statement
- B. A claim**
- C. An invoice
- D. A reimbursement request

The term that accurately describes a request for payment from a payer for healthcare services rendered is "a claim." In the realm of medical billing and coding, a claim is a formal request submitted to an insurance company or payer for compensation for healthcare services provided to a patient. This claim includes detailed information about the services rendered, the diagnoses, and any other relevant documentation needed for the payer to process the payment. A claim is essential in the healthcare billing process as it serves as the primary means of communicating the need for payment based on the services performed. Once the claim is submitted, the payer reviews it to determine whether the claim is valid and how much they are willing to reimburse based on the terms of the patient's insurance policy. While the other options like a billing statement, an invoice, and a reimbursement request may involve aspects of financial transactions in healthcare, they do not accurately encapsulate the formal process of seeking payment from a payer for services rendered. A billing statement typically provides a summary of charges or amounts owed to the provider, an invoice is often associated with the billing process but may not follow the formal claim submission process, and a reimbursement request might imply an action taken after services are provided, rather than the initial claim process itself.

3. Which statement is true regarding codes for hypertension and heart disease in ICD-10-CM?

- A. Hypertension and heart disease must always be coded together
- B. Hypertension and heart disease without a stated causal relationship must be coded separately**
- C. Hypertension is a more severe condition than heart disease
- D. Heart disease codes take precedence over hypertension codes

The statement regarding hypertension and heart disease codes in ICD-10-CM is accurate in that hypertension and heart disease without a stated causal relationship must be coded separately. In coding practices, it is important to understand the relationship between different medical conditions. When hypertension is present but does not directly cause heart disease, each condition should be assigned its own code rather than linking them through a single code. This allows for accurate representation of the patient's health conditions and ensures that each diagnosis can be independently assessed for treatment and management. In situations where there is a causal relationship, there may be different coding instructions. However, when such a relationship is not indicated or explicitly stated, maintaining separate codes provides clarity and specificity in the patient's record, which is an essential aspect of clinical documentation and coding standards in ICD-10-CM.

4. Why is documentation crucial in E/M coding?

- A. It enhances patient satisfaction
- B. It is a requirement for insurance reimbursement**
- C. It allows providers to spend less time with patients
- D. It primarily serves as a backup for billing statements

Documentation is crucial in Evaluation and Management (E/M) coding primarily because it is a requirement for insurance reimbursement. Proper documentation substantiates the details of patient encounters, justifying the level of service billed to payers. Insurers require thorough records to ensure that the services rendered align with the codes submitted for reimbursement. This includes clinical findings, medical decision-making, and the complexity of care provided. Without adequate documentation, claims can be denied, delayed, or subjected to audits. While enhancing patient satisfaction, allowing providers to spend less time with patients, and serving as backup for billing statements can all have some relevance to documentation practices, they do not address the fundamental necessity of supporting claims for reimbursement from insurance companies, which is a critical aspect of E/M coding. Insurers rely on the documentation to verify that the services billed were necessary and appropriately rendered, making it the most significant reason for its importance in this context.

5. Which statement is TRUE regarding the reporting of burn codes?

- A. Burn codes are reported based on the location of the injury
- B. The lowest degree of burn is reported as primary code
- C. The highest degree of burn is reported as primary code**
- D. Burns are reported only when they are second degree or higher

The correct approach for reporting burn codes is to report the highest degree of burn as the primary code. This practice aligns with coding guidelines that prioritize capturing the most severe aspect of the patient's condition in order to ensure accurate representation of the injury's impact on treatment and prognosis. When documenting burn injuries, the intent is to provide a comprehensive overview of the extent and severity of damage. By reporting the highest degree of burn, coders ensure that they communicate the seriousness of the patient's condition to insurers and healthcare providers. This is crucial for determining appropriate treatment protocols and understanding patient needs. The other statements do not align with the coding guidelines. For example, while the location of the injury is relevant for comprehensive coding, it is the severity that dictates the primary code designation. Additionally, burn codes can include first-degree burns, but in the context of coding for treatment, they often focus on more severe second and third-degree burns to reflect significant medical interventions.

6. What ICD-10-CM code should be reported for elevated blood sugar?

- A. R73.09**
- B. R71.1
- C. R73.8
- D. R74.8

The correct code for reporting elevated blood sugar is R73.09. This specific code is utilized to identify abnormal glucose levels in the blood that do not meet the criteria for diabetes mellitus or other specific conditions. R73.09 refers to "Other abnormal glucose," indicating that the elevated blood sugar is present but not classified under a definitive diagnosis, allowing for the documentation of an abnormal finding that might need further investigation or monitoring. The other options represent different conditions or abnormal findings related to glucose and blood sugar levels. For example, R71.1 pertains to abnormal findings in the blood but does not specifically address glucose levels. R73.8 is used for other specified abnormal glucose levels but is broader and less specific than R73.09. R74.8 relates to other specified abnormal tests, which is not directly applicable to elevated blood sugar alone. Thus, R73.09 is the most accurate choice for capturing the specific diagnosis of elevated blood sugar without further categorization.

7. When a patient undergoes tests and the results return normal, what type of service is provided?

- A. Diagnostic services
- B. Screening services**
- C. Therapeutic services
- D. Consultative services

In the context of medical coding and billing, when a patient undergoes tests and the results return normal, the service provided is classified as screening services. Screening services are specific tests performed on asymptomatic individuals to detect potential health issues early, even before symptoms are present. These services aim to identify conditions like high blood pressure, diabetes, or cancer at a stage where they are more manageable or treatable. Unlike diagnostic services, which are aimed at identifying a condition when a patient is showing symptoms or has already been diagnosed, screening services focus on prevention and early detection. Therefore, when testing results return normal, it generally indicates that the screening was successful in determining that the patient does not currently exhibit the condition under examination, aligning perfectly with the goal of screening. Therapeutic services, in contrast, involve treatment interventions to alleviate or cure an existing health problem, while consultative services refer to an expert opinion on a case. Since normal results from tests do not indicate either treatment or consultation is necessary, those options do not apply in this scenario.

8. Bile empties into the duodenum through what structure?

- A. Bile duct
- B. Common bile duct**
- C. Pancreatic duct
- D. Hepatic duct

Bile empties into the duodenum through the common bile duct. This duct is a crucial part of the biliary system, which plays an essential role in the digestion of fats. The common bile duct carries bile produced by the liver and stored in the gallbladder, delivering it directly to the duodenum. This process is vital for the emulsification of fats, which aids in their digestion and absorption. The other structures, while related to bile and its movement, do not directly empty bile into the duodenum. The bile duct can refer generally to pathways carrying bile, but the specific term for the duct that delivers bile to the duodenum is the common bile duct. The pancreatic duct is separate and carries digestive enzymes from the pancreas to the duodenum, and the hepatic duct is involved in transporting bile from the liver but does not directly connect to the duodenum. Therefore, the common bile duct is the most precise answer for this question regarding the structure through which bile enters the duodenum.

9. 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.

10. In which section of the CPT manual would you find codes for surgical procedures?

- A. The Anesthesia section
- B. The Surgery section**
- C. The Radiology section
- D. The Pathology and Laboratory section

The Surgery section of the CPT manual contains codes for surgical procedures. This section is specifically designed to outline various types of surgical interventions, including the description of the procedures and the guidelines for their coding. By categorizing procedures related to different body systems, the Surgery section facilitates accurate coding for a wide range of surgical activities, from general surgery to specialized techniques. In contrast, the Anesthesia section focuses solely on anesthesia services and their respective coding, while the Radiology section includes codes for imaging studies and diagnostic tests. The Pathology and Laboratory section deals with laboratory tests, specimen analyses, and pathology services. Each of these sections has a distinct purpose, but it is the Surgery section that is dedicated to surgical procedures, making it the correct choice for this question.

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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://aapccpc.examzify.com>

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

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