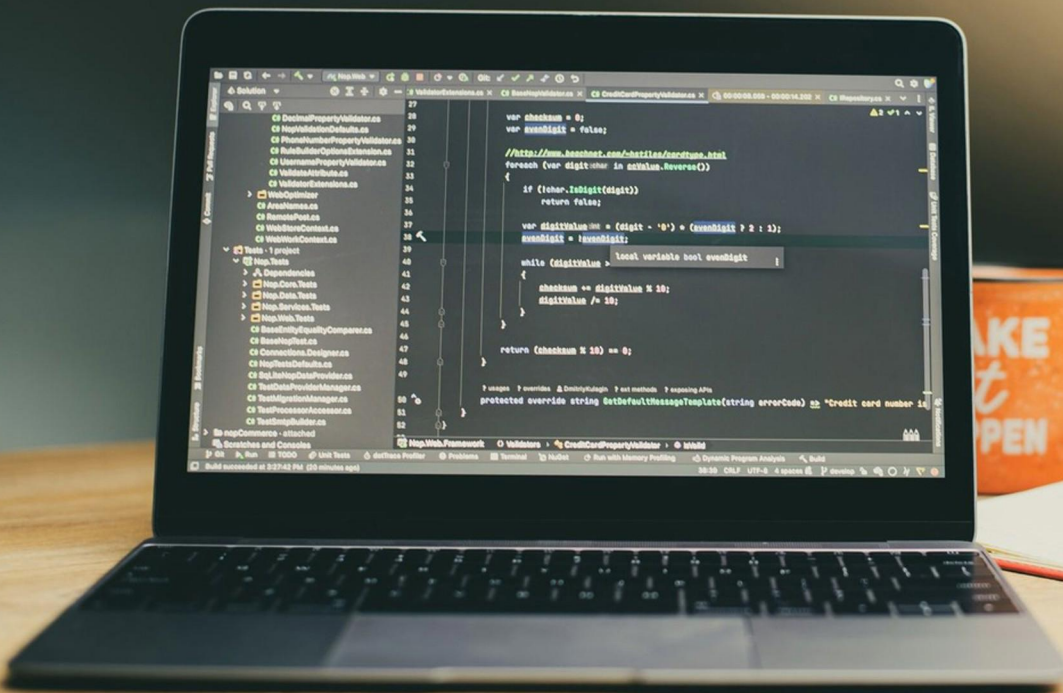


AAPC CERTIFIED PROFESSIONAL CODER (CPC) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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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. A list of the unlisted procedures for use in a specific section of the CPT manual is contained in:**
 - A. Guidelines
 - B. Appendix A
 - C. Appendix B
 - D. Index
- 2. If a Pap smear is reported as "negative for intraepithelial lesion or malignancy," what type of results reporting does this illustrate?**
 - A. World Health Organization
 - B. Bethesda
 - C. ICD Classification
 - D. Diagnostic Criteria
- 3. What does the acronym "DRG" stand for in medical coding?**
 - A. Detailed Review Group
 - B. Diagnostic Reporting Group
 - C. Diagnosis-Related Group
 - D. Data Review Guide
- 4. When should an "add-on code" be used in coding?**
 - A. When the primary service is performed alone
 - B. When it describes a procedure performed in addition to a primary procedure
 - C. When coding for a patient in outpatient services
 - D. For services that require follow-up appointments
- 5. What ICD-10-CM code is reported for a non-union of the scaphoid bone in the wrist?**
 - A. S62.001J
 - B. S62.001K
 - C. S62.010K
 - D. S62.002K

- 6. In which CPT appendix would modifiers be found?**
- A. Appendix A
 - B. Appendix B
 - C. Appendix C
 - D. Appendix D
- 7. What does the term "bundled payment" refer to in healthcare?**
- A. A payment made for services provided outside of hospital facilities
 - B. A single payment for multiple services related to a specific treatment or condition
 - C. A payment structure based on patient outcomes
 - D. A discounted rate for patients with insurance
- 8. How many digits are typically found in a Level I CPT code?**
- A. Three digits
 - B. Four digits
 - C. Five digits
 - D. Six digits
- 9. How should the coding process be influenced by medical necessity?**
- A. Coding should include unnecessary procedures
 - B. Coding must adhere to the principle of appropriate services
 - C. Coding is not related to medical necessity
 - D. Coding should focus solely on patient satisfaction
- 10. What CPT code is reported for a total T-cell count in a patient with AIDS?**
- A. 86356
 - B. 86358
 - C. 86359
 - D. 86360

Answers

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

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Explanations

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1. A list of the unlisted procedures for use in a specific section of the CPT manual is contained in:

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

The correct answer is that the list of unlisted procedures for specific sections of the CPT manual is found in the Guidelines. Each section of the CPT codebook includes a set of guidelines that provide essential information on the usage, coding conventions, and specific requirements pertinent to that section. Among the information provided, these guidelines detail codes that are considered unlisted, which are necessary for reporting services not specifically described by other codes. In contrast, Appendix A provides a list of modifiers, which are used to indicate that a service has been altered in some way but not changed in its definition or code. Appendix B includes a summary of changes made in the current edition of the CPT manual, highlighting what has been added, revised, or deleted. The Index is a tool for finding codes and descriptions based on keywords or phrases rather than providing guidance on unlisted procedures.

2. If a Pap smear is reported as "negative for intraepithelial lesion or malignancy," what type of results reporting does this illustrate?

- A. World Health Organization
- B. Bethesda**
- C. ICD Classification
- D. Diagnostic Criteria

The statement "negative for intraepithelial lesion or malignancy" reflects a reporting standard defined by the Bethesda System. This system is specifically designed for reporting cervical cytology (Pap smear) results and provides a clear and standardized way for conveying the findings of the screening. The Bethesda System categorizes Pap test results into various classifications, enabling healthcare providers to easily interpret and communicate patient results. The phrase indicates that no abnormal cells were found that would suggest the presence of precancerous changes or cervical cancer, which is a key objective of the Bethesda classification. Other reporting systems, such as those set by the World Health Organization, primarily focus on disease classification rather than cytology reporting. The ICD (International Classification of Diseases) is a system used for coding diagnoses and procedures for billing purposes, and it does not specifically pertain to cytology results. Diagnostic criteria usually refer to the clinical criteria used to establish a diagnosis rather than systems used for reporting laboratory test results. Thus, the Bethesda System is the most appropriate answer, as it directly addresses the context of Pap smear reporting.

3. What does the acronym "DRG" stand for in medical coding?

- A. Detailed Review Group
- B. Diagnostic Reporting Group
- C. Diagnosis-Related Group**
- D. Data Review Guide

The acronym "DRG" stands for Diagnosis-Related Group. This classification system is used mainly in inpatient hospital settings to categorize hospitalization cases into groups that are expected to have similar hospital resource use. The DRG system is essential for determining reimbursement rates for hospitals under Medicare and many private insurance plans. It helps ensure that hospitals are compensated in a standardized manner for the services they provide, facilitating a more uniform approach to hospital billing. Each DRG represents a bundle of services related to particular medical conditions, allowing for more efficient management of healthcare costs. This coding system is crucial for medical coders, as they need to accurately assign DRGs based on the diagnoses and procedures documented in the patient's medical record, influencing the hospital's revenue cycle.

4. When should an "add-on code" be used in coding?

- A. When the primary service is performed alone
- B. When it describes a procedure performed in addition to a primary procedure**
- C. When coding for a patient in outpatient services
- D. For services that require follow-up appointments

An add-on code is specifically designated for use when a procedure is performed in addition to a primary procedure. This means that it enhances or adds extra detail to the primary service being billed. The purpose of add-on codes is to acknowledge the additional work done by the provider and to ensure that it is appropriately compensated in the billing process. For instance, if a surgeon performs a primary surgical procedure and then carries out a secondary procedure that is directly related to the primary one, the add-on code corresponding to that secondary procedure should be used. Add-on codes cannot be reported independently; they must be linked to a primary procedure code. This structure helps to provide clarity in the billing process and ensures that additional services are recognized and reimbursed. The other options do not accurately reflect the correct application of add-on codes. For instance, an add-on code does not apply to a primary service performed in isolation or for services requiring follow-up appointments, as these situations do not inherently involve additional procedures being performed concurrently or subsequently to the primary procedure.

5. What ICD-10-CM code is reported for a non-union of the scaphoid bone in the wrist?

- A. S62.001J
- B. S62.001K**
- C. S62.010K
- D. S62.002K

The correct code for a non-union of the scaphoid bone in the wrist is S62.001K. This code specifically indicates a non-union of the scaphoid bone in the right wrist. In ICD-10-CM coding, the letters and numbers within the code provide significant details regarding the specific condition, affected body part, and any relevant descriptors. The "S62" section pertains to injuries of the wrist and hand, while the subsequent numbers indicate the specific bone involved. The final letter "K" denotes a non-union status. The various choices presented refer to different specifics, such as side (right vs left) and the nature of the injury (for instance, whether it's fractured or not), and in this case, the code with "K" is essential as it captures the non-union status, differentiating it from other codes that may indicate a simple fracture or a different condition entirely.

6. In which CPT appendix would modifiers be found?

- A. Appendix A**
- B. Appendix B
- C. Appendix C
- D. Appendix D

Modifiers are found in Appendix A of the CPT (Current Procedural Terminology) manual. This appendix provides a comprehensive list of modifiers, which are two-digit codes that are added to CPT codes to indicate that a service or procedure has been modified in some way. Modifiers can provide essential information about a procedure, such as whether it was performed bilaterally, whether it was a repeat procedure, or if special circumstances existed during the service. Understanding how to apply modifiers correctly is critical for accurate coding and billing, as they can affect reimbursement and compliance. The other appendices in the CPT manual serve different purposes. For example, Appendix B lists codes that are considered "revised" and new codes that have been added, while Appendix C contains the index of surgical procedures. Appendix D focuses on the modifiers used in a different context, often specific to surgical services. Knowing where to locate modifiers is crucial for any coder, as it aids in proper coding practices and enhances the understanding of procedural nuances.

7. What does the term "bundled payment" refer to in healthcare?

- A. A payment made for services provided outside of hospital facilities
- B. A single payment for multiple services related to a specific treatment or condition**
- C. A payment structure based on patient outcomes
- D. A discounted rate for patients with insurance

The term "bundled payment" in healthcare refers to a single payment that covers multiple services related to a specific treatment or condition. This payment model is designed to streamline costs and improve efficiency in healthcare delivery. Rather than billing separately for each service provided during a patient's treatment—which could include consultations, tests, procedures, and follow-up visits—healthcare providers receive one comprehensive payment that encompasses all of these services. This approach encourages coordinated care and can lead to more effective management of patient outcomes while potentially reducing overall healthcare costs. This payment model contrasts with other structures that may emphasize individual service billing or discount arrangements, which do not capture the holistic nature of treatment for specific medical conditions. Instead of dealing with a fragmented payment system, bundled payments promote collaboration among healthcare providers, fostering a greater focus on patient care as a whole.

8. 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.

9. How should the coding process be influenced by medical necessity?

- A. Coding should include unnecessary procedures
- B. Coding must adhere to the principle of appropriate services**
- C. Coding is not related to medical necessity
- D. Coding should focus solely on patient satisfaction

The correct choice emphasizes that coding must adhere to the principle of appropriate services, which is fundamentally linked to medical necessity. Medical necessity ensures that the services provided are essential for the diagnosis or treatment of a patient's condition. When coding, it is crucial to reflect the medical services that were deemed necessary by healthcare providers based on clinical guidelines and patient needs. This alignment is vital as it not only supports accurate billing and reimbursement but also helps to maintain compliance with regulations governing healthcare services. In addition, appropriate coding captures the medical rationale behind performed services, thereby ensuring that documentation accurately represents patient care. Failing to document and code for medically necessary services can lead to denied claims or legal repercussions for providing inappropriate care. Thus, coding closely tied to medical necessity underscores the importance of delivering appropriate patient-focused care instead of unnecessary tests or procedures that do not contribute meaningfully to a patient's well-being.

10. What CPT code is reported for a total T-cell count in a patient with AIDS?

- A. 86356
- B. 86358
- C. 86359**
- D. 86360

The correct code for reporting a total T-cell count in a patient with AIDS is accurately reflected by the selected answer. This specific CPT code is designated for services related to T-cell testing, which is essential in the management and monitoring of patients with HIV/AIDS. Total T-cell counts are critical in assessing the immune system's status in HIV/AIDS patients. This helps guide treatment decisions and monitor responses to therapy. The distinction between the various codes lies in their specific definitions and the type of tests they cover. The selected code encompasses the total count of T-lymphocytes and is consistent with the coding guidelines for tests that directly address monitoring T-cell levels in immunocompromised patients, such as those with AIDS. Understanding the application of these codes ensures accurate billing and effective communication between healthcare providers and payers while reflecting the complexities involved in managing patients with HIV/AIDS.

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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