

AAPC CONTINGENCY 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.

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. Which coding system is primarily used for reporting physician services and procedures?**
 - A. International Classification of Diseases (ICD)
 - B. Health Care Common Procedure Coding System (HCPCS)
 - C. Current Procedural Terminology (CPT)
 - D. Current Diagnosis Related Groups (CDRG)
- 2. What purpose do 'evaluation and management' codes serve?**
 - A. They categorize surgical procedures
 - B. They document the level of service provided during a patient encounter
 - C. They indicate the condition being treated
 - D. They establish a diagnosis for laboratory tests
- 3. Local procurement actions should be initiated only when which of the following have been exhausted?**
 - A. Local vendors
 - B. Standard supply lines
 - C. Host nation supply sources
 - D. All of the above
- 4. What is the primary benefit of coding compliance within a healthcare organization?**
 - A. It reduces the risk of audits
 - B. It ensures accurate billing and payment
 - C. It eliminates the need for coding standards
 - D. It decreases employee training time
- 5. What is an "internal audit" in a healthcare setting?**
 - A. A review of patient satisfaction
 - B. A review to assess billing efficiency
 - C. A review to assess compliance with regulations
 - D. A review of physician performance

6. What signifies a "failed claim" in medical billing?

- A. A claim that has been denied due to errors, incomplete information, or lack of coverage.
- B. A claim that is approved but underpaid.
- C. A claim that is submitted with a missing signature.
- D. A claim that is held for further review.

7. What is the purpose of the 'Index' in the ICD coding system?

- A. To provide coding guidelines for technical procedures
- B. To help coders locate appropriate codes based on disease names and conditions
- C. To highlight changes in medical coding policies
- D. To list all available CPT codes

8. What does the term 'diagnosis coding' refer to?

- A. The process of identifying and assigning codes to a patient's diagnosis
- B. A method for organizing patient files
- C. The evaluation of medical services rendered
- D. The analysis of patient treatment outcomes

9. What is the purpose of a "superbill"?

- A. A summary of all patient complaints and follow-up actions
- B. A document that includes details of services provided to a patient for billing purposes
- C. An emergency contact list for healthcare staff
- D. A legal document detailing patient consent

10. Which statement is true regarding diagnosis codes for procedures?

- A. All procedures require a separate diagnosis code
- B. Some procedures may not require an additional diagnosis code if the condition is evident
- C. Diagnosis codes are only necessary for surgical procedures
- D. Diagnosis codes are not required in outpatient settings

Answers

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

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Explanations

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1. Which coding system is primarily used for reporting physician services and procedures?

- A. International Classification of Diseases (ICD)
- B. Health Care Common Procedure Coding System (HCPCS)
- C. Current Procedural Terminology (CPT)**
- D. Current Diagnosis Related Groups (CDRG)

The Current Procedural Terminology (CPT) coding system is extensively utilized in the healthcare industry specifically for reporting physician services and procedures. Developed and maintained by the American Medical Association (AMA), CPT codes provide a standardized language that facilitates clear communication among healthcare providers, insurers, and patients regarding the services rendered. CPT codes cover a wide array of services including evaluations, surgical procedures, and various therapies, making them essential for billing and documentation of the care provided by physicians and other healthcare professionals. By utilizing CPT codes, medical professionals can ensure accurate reporting of their activities and claims, leading to appropriate reimbursement and effective tracking of healthcare services. In contrast, the other coding systems serve different purposes. The International Classification of Diseases (ICD) primarily focuses on diagnosing conditions rather than detailing the procedures performed. Health Care Common Procedure Coding System (HCPCS) includes codes for services not covered under CPT, such as certain medications and durable medical equipment, but doesn't primarily serve the purpose of reporting physician services and procedures. Current Diagnosis Related Groups (CDRG) are used for classifying hospital cases to facilitate billing in inpatient settings, rather than for outpatient physician services. Thus, CPT is the correct choice for reporting physician services and procedures as it is specifically designed for

2. What purpose do 'evaluation and management' codes serve?

- A. They categorize surgical procedures
- B. They document the level of service provided during a patient encounter**
- C. They indicate the condition being treated
- D. They establish a diagnosis for laboratory tests

Evaluation and management (E/M) codes specifically document the level of service provided during a patient encounter. These codes are crucial in the healthcare billing process, as they reflect the complexity and extent of the care that a healthcare provider offers to a patient during an office visit, consultation, or other patient interactions. E/M codes take into account various factors, including the nature of the presenting problem, the level of medical decision-making involved, and the time spent with the patient, thereby allowing for appropriate reimbursement and ensuring that care is accurately represented in medical records. In the context of the other options, surgical procedures and diagnoses are categorized and indicated by different code sets, such as Current Procedural Terminology (CPT) codes for surgery and International Classification of Diseases (ICD) codes for diagnosing conditions. Therefore, E/M codes do not serve to categorize surgical procedures or establish a diagnosis for laboratory tests but rather focus solely on assessing the service delivered during patient encounters.

3. Local procurement actions should be initiated only when which of the following have been exhausted?

- A. Local vendors
- B. Standard supply lines
- C. Host nation supply sources
- D. All of the above**

The correct answer indicates that local procurement actions should only be initiated after thoroughly evaluating and exhausting all available resources and options. Each of the factors mentioned contributes to ensuring that the procurement process is as effective and efficient as possible. When local vendors have been exhausted, it means that you have explored all options within the community or region before seeking external procurement methods. Engaging with local suppliers can often result in quicker delivery times, lower transportation costs, and a more profound understanding of local needs. The consideration of standard supply lines emphasizes relying on pre-established channels that may offer better pricing and efficiency. These supply lines are typically set up with trusted sources and contracts, providing a structured approach to procurement. Host nation supply sources represent another crucial avenue. Engaging with suppliers within the host nation can foster goodwill and strengthen relationships between the procurement entity and the local economy. It also supports local businesses and may help circumvent complications that arise from international logistics. By ensuring that all these avenues—local vendors, standard supply lines, and host nation sources—have been exhausted, a thorough and responsible approach to procurement is maintained. This not only enhances operational efficiency but also aligns with ethical and strategic goals in sourcing necessary goods and services.

4. What is the primary benefit of coding compliance within a healthcare organization?

- A. It reduces the risk of audits
- B. It ensures accurate billing and payment**
- C. It eliminates the need for coding standards
- D. It decreases employee training time

Ensuring accurate billing and payment is fundamental to coding compliance within a healthcare organization. When coding is accurate, it leads to correct claim submissions to payers, which, in turn, minimizes the chances of claim denials and delays in payment. Accurate coding is critical not only for reimbursement purposes but also for financial planning and resource allocation within the organization. When coding adheres to established guidelines and regulations, it supports ethical billing practices, maintains the integrity of medical records, and fosters trust between the healthcare provider and the patient, as well as with insurers. Other factors, such as reducing the risk of audits or decreasing training time, may be benefits associated with coding compliance, but they stem from the core principle that accurate coding is essential to the financial health and operational efficiency of a healthcare organization. Coding compliance itself encompasses a broader scope than simply avoiding audits or minimizing training efforts; it fundamentally seeks to ensure that the revenue cycle operates efficiently and that the organization remains compliant with regulatory standards.

5. What is an "internal audit" in a healthcare setting?

- A. A review of patient satisfaction
- B. A review to assess billing efficiency
- C. A review to assess compliance with regulations**
- D. A review of physician performance

An internal audit in a healthcare setting is primarily focused on assessing compliance with regulations. This process involves systematic evaluations of the organization's operations to ensure that they are in line with existing laws, rules, and standards applicable to healthcare providers. Compliance audits typically review practices related to patient privacy, billing and coding accuracy, documentation standards, and adherence to healthcare policies. By conducting these audits, healthcare organizations aim to identify any areas of risk or vulnerability in their operations that may lead to regulatory violations. This proactive approach not only helps to mitigate the risk of penalties or legal issues but also enhances the overall quality of care provided to patients by ensuring that healthcare practices are consistent with industry standards. While reviews of patient satisfaction, billing efficiency, and physician performance are valuable components of overall quality improvement and operational efficiency, they do not specifically address the regulatory compliance focus that is central to an internal audit in a healthcare context. This distinction is what makes compliance the correct answer regarding the nature and purpose of internal audits in the healthcare setting.

6. What signifies a "failed claim" in medical billing?

- A. A claim that has been denied due to errors, incomplete information, or lack of coverage.**
- B. A claim that is approved but underpaid.
- C. A claim that is submitted with a missing signature.
- D. A claim that is held for further review.

A "failed claim" in medical billing refers to a claim that has been denied because it contains errors, incomplete information, or lacks the necessary coverage. This definition encompasses a broad range of issues that can lead to a claim being rejected by an insurance payer. When a claim is denied, it means that the billing process has not met the required standards, whether due to inaccuracies in the documentation or a patient not being eligible for the services billed. Identifying and correcting these issues is crucial as it allows the provider to resubmit the claim successfully after addressing the reasons for the denial. The other situations describe circumstances that may not lead to a failure to bill effectively. For instance, an approved claim that is underpaid does not equate to a failed claim; rather, it represents a discrepancy that may be disputed later. A claim submitted with a missing signature might qualify as incomplete but does not specifically denote denial due to broader issues. Finally, a claim held for further review is not necessarily a failure; it indicates that the payer needs more information before making a determination. Thus, the clearest indicator of a "failed claim" aligns with the first option, describing a denial based on specific issues.

7. What is the purpose of the 'Index' in the ICD coding system?

- A. To provide coding guidelines for technical procedures
- B. To help coders locate appropriate codes based on disease names and conditions**
- C. To highlight changes in medical coding policies
- D. To list all available CPT codes

The purpose of the 'Index' in the ICD coding system is indeed to help coders locate appropriate codes based on disease names and conditions. The ICD index is structured to provide a user-friendly way to find the relevant codes that correspond to specific terms, such as symptoms, diagnoses, and medical conditions. This is critical for accurate coding and ensures that coders can quickly and efficiently identify codes that reflect the patient's diagnoses, which in turn supports precise billing and quality patient care. The index acts as a reference tool, guiding coders through an extensive list of codes by allowing them to search for specific terms, thus facilitating the coding process. This function is essential, as it streamlines the coding process and reduces the likelihood of errors, making it a foundational element of the ICD coding system.

8. What does the term 'diagnosis coding' refer to?

- A. The process of identifying and assigning codes to a patient's diagnosis**
- B. A method for organizing patient files
- C. The evaluation of medical services rendered
- D. The analysis of patient treatment outcomes

The term 'diagnosis coding' specifically refers to the process of identifying and assigning codes to a patient's diagnosis. This involves translating the clinician's written diagnoses into a standardized code system, such as ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification). This coding is crucial for various reasons, including billing and reimbursement, data collection for healthcare analysis, and ensuring accurate patient records. Assigning the correct diagnosis codes is a foundational aspect of medical coding and ensures that healthcare providers receive appropriate compensation for services rendered. It also plays a vital role in public health, allowing for the aggregation of data that can inform healthcare trends and policies.

9. What is the purpose of a "superbill"?

- A. A summary of all patient complaints and follow-up actions
- B. A document that includes details of services provided to a patient for billing purposes**
- C. An emergency contact list for healthcare staff
- D. A legal document detailing patient consent

The purpose of a "superbill" is to serve as a detailed document that encompasses the services provided to a patient during a healthcare encounter, which is essential for billing purposes. This document typically contains key information such as the patient's demographics, the diagnosis codes (ICD codes), procedure codes (CPT or HCPCS codes), and other relevant details regarding the encounter. Superbills are crucial for healthcare providers as they streamline the billing process, ensuring that the claims submitted to insurance companies accurately reflect the services rendered. They help facilitate faster reimbursement and reduce the likelihood of billing errors, which can result in delays or denials of payments. By providing a comprehensive summary of patient interactions and the associated charges, superbills play an integral role in the financial and administrative aspects of healthcare practices.

10. Which statement is true regarding diagnosis codes for procedures?

- A. All procedures require a separate diagnosis code
- B. Some procedures may not require an additional diagnosis code if the condition is evident**
- C. Diagnosis codes are only necessary for surgical procedures
- D. Diagnosis codes are not required in outpatient settings

The statement that some procedures may not require an additional diagnosis code if the condition is evident is accurate because it reflects the practical realities of medical coding. In situations where the procedure being performed is clearly justified by the patient's condition—such as a routine follow-up for a well-documented ongoing issue—coders may rely on the established medical records that demonstrate the necessity of the procedure without needing to assign an additional diagnosis code. This practice aligns with coding guidelines that allow for flexibility based on the clarity of the patient's medical situation. Therefore, when the diagnosis is apparent from the medical documentation related to the procedure, it is permissible to proceed without a separate diagnosis code, as the reason for the procedure can be inferred directly from the clinical information present in the records. This understanding helps streamline the coding process and supports efficient communication between healthcare providers and payers, ensuring that procedures are appropriately documented and billed.

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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://aapcccontingency.examzify.com>

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

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