

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. What types of procedures does the 'Surgery' section of CPT include?**
 - A. Surgical procedures on the integumentary, musculoskeletal, respiratory, and other systems
 - B. Only cosmetic surgeries
 - C. Minimal invasive procedures only
 - D. Diagnostic procedures
- 2. A change in the contract can be made within the scope of which of the following?**
 - A. Contractor performance
 - B. Specifications
 - C. Pricing terms
 - D. Government audit procedures
- 3. What type of documentation is crucial for supporting a denial appeal?**
 - A. Basic billing summaries from previous months.
 - B. Thorough medical records that justify the services provided.
 - C. Communication logs between the provider and the insurance.
 - D. Claim denial letters from other insurance companies.
- 4. What does HCPCS Level II stand for?**
 - A. Healthcare Common Patient Coding System Level II
 - B. Healthcare Common Procedure Coding System Level II
 - C. Healthcare Classification Procedure Coding System Level II
 - D. Health Common Procedure Coding System Level Issue
- 5. What type of coding does HCPCS Level II represent?**
 - A. Codes for surgical procedures
 - B. Diagnostic codes for inpatient care
 - C. Codes for non-physician services
 - D. Emergency service coding

6. What is the primary purpose of documentation guidelines in medical coding?

- A. To provide justification for treatments and procedures
- B. To clarify the necessary information needed in the medical record to support the codes billed
- C. To establish the fee schedule for services
- D. To guide patient consent processes

7. Which of the following is NOT required for deployment?

- A. Deployment kit
- B. External hard drive with movies
- C. Military uniforms
- D. Medical supplies

8. Define the term 'secondary diagnosis.'

- A. A diagnosis that is reported in outpatient settings only
- B. The main condition treated in a hospital setting
- C. Any diagnosis that coexists with the principal diagnosis
- D. A diagnosis that does not impact patient care

9. What does a 'coding guideline' refer to?

- A. The latest trends in coding systems
- B. Official instructions on how to interpret and apply coding systems correctly
- C. Guidelines created by each individual coder
- D. Methods for measuring coding efficiency

10. What does 'modality' refer to in terms of diagnostic procedures?

- A. The method or technique used to diagnose a condition
- B. The specific type of medication prescribed
- C. The geographical location where diagnosis is made
- D. The age group of the patient being assessed

Answers

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

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Explanations

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1. What types of procedures does the 'Surgery' section of CPT include?

- A. Surgical procedures on the integumentary, musculoskeletal, respiratory, and other systems**
- B. Only cosmetic surgeries
- C. Minimal invasive procedures only
- D. Diagnostic procedures

The 'Surgery' section of the Current Procedural Terminology (CPT) code set encompasses a wide range of surgical procedures performed on various body systems. Specifically, it includes surgical interventions related to the integumentary system, which covers skin and related structures; the musculoskeletal system, addressing bones and muscles; and the respiratory system, among others. This section is comprehensive and includes both major and minor procedures, ranging from routine operations to complex surgeries across different medical disciplines. By cataloging various types of surgeries in this manner, the CPT allows healthcare professionals to report these services accurately for billing and record-keeping purposes. The other options focus too narrowly on subsets of surgical procedures or specific types, such as cosmetic surgeries or minimally invasive procedures, which are merely parts of the broader spectrum that the surgery section covers. Ultimately, the inclusion of multiple systems and types of surgery demonstrates the section's role in facilitating various surgical practices in healthcare settings.

2. A change in the contract can be made within the scope of which of the following?

- A. Contractor performance
- B. Specifications**
- C. Pricing terms
- D. Government audit procedures

The correct answer is based on the understanding that changes to a contract can occur within the scope of its specifications. Specifications detail the requirements and standards for the deliverables and performance expected under the contract. This means that if adjustments are needed to meet performance goals or compliance standards, those changes can be made as long as they do not fundamentally alter the nature of the contract. Modifications to specifications are often permissible and necessary to adapt to evolving project needs, technical advancements, or unforeseen circumstances. They allow for practical flexibility while maintaining the overall framework of the original agreement. While contractor performance, pricing terms, and government audit procedures have their own specific guidelines and constraints regarding changes, they tend to be less flexible than specifications. Changes to contractor performance could lead to disputes on accountability and quality, pricing terms often require thorough agreement and possibly negotiation which can complicate matters, and audit procedures are dictated by regulatory frameworks that generally do not allow for alterations without significant justification. Therefore, when considering where changes can typically occur within the contractual framework, specifications are the most appropriate focus.

3. What type of documentation is crucial for supporting a denial appeal?

- A. Basic billing summaries from previous months.
- B. Thorough medical records that justify the services provided.**
- C. Communication logs between the provider and the insurance.
- D. Claim denial letters from other insurance companies.

Thorough medical records that justify the services provided are essential for supporting a denial appeal because they offer detailed evidence of the medical necessity and appropriateness of the care that was delivered. These records provide context and substantiate the claims made in the appeal, enabling the reviewer to understand the reasoning behind the services rendered. Medical records typically include patient history, examination findings, treatment plans, and any relevant diagnostic information, which together create a comprehensive picture of the patient's health and the rationale for the specific services billed. This documentation acts as a primary source of factual evidence that can counter the reasons outlined in the denial, thereby strengthening the case for overturning the denial. The other options may contain valuable information, but they lack the comprehensive detail and specificity found in thorough medical records. Basic billing summaries may not provide the necessary clinical justification, communication logs can be helpful but do not contain medical details, and claim denial letters from other insurance companies are not directly relevant to the appeal being made for the current claim.

4. What does HCPCS Level II stand for?

- A. Healthcare Common Patient Coding System Level II
- B. Healthcare Common Procedure Coding System Level II**
- C. Healthcare Classification Procedure Coding System Level II
- D. Health Common Procedure Coding System Level Issue

HCPCS Level II stands for the Healthcare Common Procedure Coding System, specifically the Level II portion of this system. This coding system is used primarily for billing and reporting healthcare services, supplies, and equipment that are not covered by the CPT (Current Procedural Terminology) codes. HCPCS Level II codes are essential for items such as durable medical equipment (DME), prosthetics, and non-physician services, allowing for a comprehensive categorization of healthcare-related products and services. Understanding the correct full name is important as it highlights the system's purpose: to provide a common language for billing across various healthcare contexts. This coding system aids in ensuring that healthcare providers receive proper reimbursement and that services delivered are accurately represented in claims to insurance providers. The use of "Procedure" in this context emphasizes the focus on services and items rather than patient-based categorization, which distinguishes it from other coding systems that may focus specifically on diagnoses or patient records.

5. What type of coding does HCPCS Level II represent?

- A. Codes for surgical procedures
- B. Diagnostic codes for inpatient care
- C. Codes for non-physician services**
- D. Emergency service coding

The correct answer is C, as HCPCS Level II codes are specifically designed to represent non-physician services. This includes a wide range of items and services such as ambulance services, durable medical equipment, prosthetics, and certain medications administered by healthcare providers. The HCPCS (Healthcare Common Procedure Coding System) is utilized primarily for billing purposes in Medicare and Medicaid programs, along with some private insurers. To contextualize further, HCPCS Level II does not cover surgical procedures or diagnostic codes which are generally classified under other coding systems like CPT (Current Procedural Terminology) for surgical and procedural services, or ICD (International Classification of Diseases) codes, which focus on diagnoses rather than specific services or items. Emergency service coding typically falls under specific guidelines and may also use CPT codes, but this does not encompass the broader range of non-physician services that HCPCS Level II represents.

6. What is the primary purpose of documentation guidelines in medical coding?

- A. To provide justification for treatments and procedures
- B. To clarify the necessary information needed in the medical record to support the codes billed**
- C. To establish the fee schedule for services
- D. To guide patient consent processes

The primary purpose of documentation guidelines in medical coding is to clarify the necessary information needed in the medical record to support the codes billed. These guidelines ensure that the documentation in the patient's medical record contains sufficient detail to justify the coding selections made by medical coders. Accurate coding is essential for proper billing and reimbursement, and the guidelines serve as a framework to ensure that all necessary elements are captured in the documentation. This clarity helps prevent coding errors, supports compliance with regulations, and promotes effective communication among healthcare providers, coders, and insurance companies. While providing justification for treatments and procedures is important, it focuses more on the rationale behind decisions rather than the specifics of documentation required for coding. Establishing a fee schedule and guiding patient consent processes are separate aspects of healthcare operations that do not pertain to the primary role of coding documentation.

7. Which of the following is NOT required for deployment?

- A. Deployment kit
- B. External hard drive with movies**
- C. Military uniforms
- D. Medical supplies

The choice indicating the external hard drive with movies is not required for deployment is correct because this item does not have any functional role in the military operational readiness or mission capability. Deployment kits typically include essential gear and supplies necessary for a combat or operational environment, such as military uniforms for identification and discipline, and medical supplies for health and safety. The deployment kit is crucial for providing soldiers with what they need for immediate use, and medical supplies are vital for addressing injuries or health conditions that may arise during deployment. Military uniforms are necessary for maintaining a standard appearance and ensuring the soldier's identification and compliance with regulations. In contrast, an external hard drive filled with entertainment content like movies does not serve any operational purpose and is therefore not a requirement for deployment.

8. Define the term 'secondary diagnosis.'

- A. A diagnosis that is reported in outpatient settings only
- B. The main condition treated in a hospital setting
- C. Any diagnosis that coexists with the principal diagnosis**
- D. A diagnosis that does not impact patient care

The term 'secondary diagnosis' refers to any diagnosis that coexists alongside the principal diagnosis. In medical coding and billing, a secondary diagnosis is essential because it provides additional context about a patient's health conditions that may not be the primary reason for their visit or treatment but still influences their overall care and management. This can include chronic diseases, comorbidities, or other health issues that could affect the patient's treatment plan and outcomes. Understanding the role of secondary diagnoses is crucial as they can impact resource allocation, treatment strategies, and reimbursement processes. Secondary diagnoses help healthcare providers deliver comprehensive care by recognizing all relevant patient health conditions, ensuring that the full spectrum of care coordination is achieved. In contrast, the other options imply limitations or mischaracterizations of the role and scope of secondary diagnoses in clinical practice.

9. What does a 'coding guideline' refer to?

- A. The latest trends in coding systems
- B. Official instructions on how to interpret and apply coding systems correctly**
- C. Guidelines created by each individual coder
- D. Methods for measuring coding efficiency

A 'coding guideline' refers to official instructions that provide directions on how to interpret and apply coding systems correctly. These guidelines are crucial for ensuring accuracy and consistency in coding practices. They help coders understand how to correctly assign codes based on clinical documentation and coding rules. This ensures compliance with regulatory requirements and helps minimize billing errors. Official coding guidelines are often established by recognized organizations, such as the American Medical Association (AMA) or the Centers for Medicare and Medicaid Services (CMS), and include detailed information on issues like how to handle specific diagnoses, coding conventions, and usage of modifiers. By following these guidelines, coders can ensure that their coding is aligned with national standards and that they are adhering to best practices within the profession.

10. What does 'modality' refer to in terms of diagnostic procedures?

- A. The method or technique used to diagnose a condition**
- B. The specific type of medication prescribed
- C. The geographical location where diagnosis is made
- D. The age group of the patient being assessed

In the context of diagnostic procedures, 'modality' refers to the method or technique used to diagnose a condition. This term encompasses a variety of imaging techniques and diagnostic tests, such as X-rays, MRI scans, CT scans, ultrasound, and other procedures that provide critical information about a patient's health status. Choosing the appropriate modality is essential for accurately diagnosing medical conditions, as different modalities have unique strengths in terms of detail, type of information gleaned, and suitability for specific patient scenarios. Considering the other options, the specific type of medication prescribed relates to treatment rather than diagnosis; the geographical location where diagnosis is made does not pertain to the method itself; and the age group of the patient being assessed pertains to demographic factors affecting care but does not define the procedures used for diagnosis. Thus, the answer highlighting modality as the method or technique used aligns perfectly with the established definitions in medical terminology.

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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://aapccontingency.examzify.com>

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

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