

AHIMA CERTIFIED CODING SPECIALIST – PHYSICIAN-BASED (CCS-P) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://ahimaccsp.examzify.com>



Copyright © 2026 by Examzify - A Kaluba Technologies Inc. product.

ALL RIGHTS RESERVED.

No part of this book may be reproduced or transferred in any form or by any means, graphic, electronic, or mechanical, including photocopying, recording, web distribution, taping, or by any information storage retrieval system, without the written permission of the author.

Notice: Examzify makes every reasonable effort to obtain accurate, complete, and timely information about this product from reliable sources.

SAMPLE

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

SAMPLE

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

SAMPLE

- 1. What do ICD-10 codes primarily describe?**
 - A. Medical treatments and procedures
 - B. Medical diagnoses and conditions
 - C. Patient demographics and health history
 - D. Prescription medication and dosages
- 2. Which organism is commonly known for causing tuberculosis?**
 - A. Chlamydia trachomatis
 - B. Mycobacterium tuberculosis
 - C. Bacillus cereus
 - D. Clostridium perfringens
- 3. What does the term “unbundling” refer to in coding?**
 - A. The practice of bundling several services into one code.
 - B. The practice of separating components of a service that should be billed together.
 - C. The procedure of coding without modifiers.
 - D. Grouping procedures for cost-effectiveness in billing.
- 4. In the claims appeal process, what is the significance of making a request within 120 days?**
 - A. It determines the claim amount
 - B. It establishes the time frame for necessary documentation
 - C. It is required to preserve the right to appeal
 - D. It allows for expedited claim processing
- 5. What is the function of the HCPCS Level II codes?**
 - A. To code laboratory tests
 - B. To code physician services only
 - C. To code non-physician services, including supplies and equipment
 - D. To categorize prescription drugs

6. What is the purpose of an ABN?

- A. To estimate patient expenses
- B. To inform patients of potential payment issues with Medicare
- C. To document services provided
- D. To create a refund record

7. What does a disease index do?

- A. Lists patients in order of treatment
- B. Lists diagnostic codes in order
- C. Organizes billing information
- D. Details patient histories

8. Which document summarizes the episode of care and current status of a patient?

- A. Transfer Note
- B. Discharge Note
- C. Progress Note
- D. Initial Plan

9. What do parenthetical notes in CPT coding provide?

- A. Examples of code usage
- B. Definitions of medical terms
- C. Additional information or instruction related to the codes
- D. Summary of coding guidelines

10. What is a primary use of spreadsheet software in medical office management?

- A. To maintain patient records
- B. To create detailed medical histories
- C. To facilitate data collection and analysis
- D. To generate appointment schedules

Answers

SAMPLE

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

SAMPLE

Explanations

SAMPLE

1. What do ICD-10 codes primarily describe?

- A. Medical treatments and procedures
- B. Medical diagnoses and conditions**
- C. Patient demographics and health history
- D. Prescription medication and dosages

ICD-10 codes are specifically designed to describe medical diagnoses and conditions. The system categorizes a wide range of health-related issues, allowing healthcare providers to accurately document a patient's health status and the reasons for their encounters within the healthcare system. This coding helps in standardizing the classification of diseases, which is critical for clinical, billing, and epidemiological purposes. These codes facilitate effective communication among healthcare professionals and institutions, ensuring clear understanding of the diagnosis conveyed. By using ICD-10 codes, coders can depict complex medical conditions with greater specificity, which enhances the quality of patient care and data analysis. Other choices represent different aspects of healthcare documentation. Medical treatments and procedures fall under the Current Procedural Terminology (CPT) coding system, while patient demographics and health history are typically recorded in electronic health records but not classified under ICD-10 codes. Prescription medications and dosages pertain to pharmaceutical coding and billing, which is separate from what ICD-10 codes are meant to address.

2. Which organism is commonly known for causing tuberculosis?

- A. Chlamydia trachomatis
- B. Mycobacterium tuberculosis**
- C. Bacillus cereus
- D. Clostridium perfringens

The organism commonly known for causing tuberculosis is *Mycobacterium tuberculosis*. This bacterium is specifically adapted to infect humans and is primarily transmitted through airborne particles when an infected individual coughs or sneezes. Tuberculosis primarily affects the lungs, but it can also impact other parts of the body, including the kidneys, brain, and spine. Understanding the nature of *Mycobacterium tuberculosis* is crucial for recognizing the disease it causes, its transmission patterns, and the necessary treatment protocols. This organism's slow-growing and waxy cell wall contributes to its resistance to typical disinfectants, making it particularly resilient in various environments. Other organisms mentioned may be pathogenic as well, but they are associated with different diseases and do not cause tuberculosis. For instance, *Chlamydia trachomatis* is linked to sexually transmitted infections, *Bacillus cereus* is known for food poisoning, and *Clostridium perfringens* is often associated with gas gangrene or foodborne illness. Identifying *Mycobacterium tuberculosis* is essential for the effective control and management of tuberculosis on a public health scale.

3. What does the term “unbundling” refer to in coding?

- A. The practice of bundling several services into one code.
- B. The practice of separating components of a service that should be billed together.**
- C. The procedure of coding without modifiers.
- D. Grouping procedures for cost-effectiveness in billing.

The term “unbundling” refers specifically to the practice of separating components of a service that should actually be billed together under a bundled payment. In the context of coding and billing, certain procedures or services are meant to be billed as a single unit due to their close relationship and the fact that they are often performed concurrently. Unbundling occurs when a provider intentionally submits separate claims for these services or components, which can lead to higher reimbursements, hence potentially violating coding guidelines and payer policies. In the medical coding context, this practice is scrutinized because it can result in improper billing. Coders are trained to recognize those instances where unbundling takes place, to ensure they follow correct coding guidelines, and to uphold ethical billing standards. Understanding unbundling helps coders not just in compliance but also in ensuring that claims are submitted accurately and fairly for the services rendered.

4. In the claims appeal process, what is the significance of making a request within 120 days?

- A. It determines the claim amount
- B. It establishes the time frame for necessary documentation
- C. It is required to preserve the right to appeal**
- D. It allows for expedited claim processing

Making a request within 120 days in the claims appeal process is crucial because it serves to preserve the right to appeal a denied claim. Many insurance companies and federal programs have specific guidelines regarding the time frame in which an appeal must be filed. If a provider or patient fails to submit the appeal within this designated time, they may lose the opportunity to challenge the decision made on the claim. This timeline is often set to ensure a streamlined process and to encourage timely resolution of claims, which ultimately benefits both the provider and the insurer. It creates a sense of urgency that helps prevent delays in the resolution process and ensures that cases are reviewed when the details are still fresh. The other choices do not accurately represent the primary significance of the 120-day request time frame. While establishing a time frame for documentation and possibly influencing claim processing speed are relevant considerations in the claims process, the main reason for adhering to the 120-day guideline directly relates to the ability to effectively contest a claim decision.

5. What is the function of the HCPCS Level II codes?

- A. To code laboratory tests
- B. To code physician services only
- C. To code non-physician services, including supplies and equipment**
- D. To categorize prescription drugs

HCPCS Level II codes serve a vital role in the healthcare coding system, specifically focusing on non-physician services, which encompass a wide range of items. These codes are used to represent various services and supplies that are not typically included in the CPT (Current Procedural Terminology) coding system. This includes durable medical equipment (DME), prosthetics, orthotics, ambulance services, and certain other non-physician services. By using HCPCS Level II codes, healthcare providers can accurately bill for these supplies and services to Medicare and other insurers. This is essential for proper reimbursement and helps ensure that patients receive the necessary equipment and services. Additionally, the coding system enhances communication between providers, insurers, and patients regarding what services have been provided. You can see that while coding laboratory tests or prescription drugs might involve specialized sections within the coding systems (such as CPT for labs and National Drug Codes for pharmaceuticals), HCPCS Level II is specifically designed to address the broader category of non-physician-related services and products.

6. What is the purpose of an ABN?

- A. To estimate patient expenses
- B. To inform patients of potential payment issues with Medicare**
- C. To document services provided
- D. To create a refund record

The correct answer relates to the purpose of the Advance Beneficiary Notice of Noncoverage (ABN). An ABN is a critical tool used in healthcare settings, specifically to inform patients when a healthcare provider believes that Medicare may not cover a specific service or item. It serves to indicate to patients that they may be financially responsible for the costs associated with that service, ensuring patients are aware of potential payment issues before they receive the service. This notification allows patients to make informed decisions about their care, including whether they wish to proceed with the service despite the potential costs. Additionally, the ABN must be signed by the patient as acknowledgment that they understand their financial responsibility, which protects both the patient and the provider from misunderstandings regarding coverage. In contrast, estimating patient expenses, documenting services provided, and creating a refund record do not capture the primary role of the ABN in the context of Medicare coverage and patient notifications. The focus of an ABN is specifically on clarifying coverage issues, which is crucial for maintaining honest communication between providers and patients.

7. What does a disease index do?

- A. Lists patients in order of treatment
- B. Lists diagnostic codes in order**
- C. Organizes billing information
- D. Details patient histories

A disease index serves as a vital tool in healthcare management, specifically designed to catalog the various diagnostic codes associated with patient conditions. By organizing these codes in a systematic manner, typically according to established classification systems like the ICD (International Classification of Diseases), it allows healthcare professionals to quickly access specific diagnoses. This facilitates accurate coding for billing, statistical analysis, and tracking health outcomes over time. The ability to reference diagnostic codes directly contributes to the overall efficiency of healthcare operations, including research and data collection, and helps ensure compliance with reporting requirements. Therefore, the primary function of a disease index is to list diagnostic codes in an orderly fashion, which supports various aspects of healthcare administration and facilitates better clinical decision-making.

8. Which document summarizes the episode of care and current status of a patient?

- A. Transfer Note
- B. Discharge Note**
- C. Progress Note
- D. Initial Plan

The document that summarizes the episode of care and current status of a patient is the discharge note. This document is typically created when a patient is ready to leave a healthcare facility, whether it's the hospital or another type of healthcare setting. The discharge note provides a comprehensive overview of the patient's treatment, including the diagnoses, treatment administered during the stay, any complications or changes in the patient's condition, and recommendations for follow-up care. It serves an important role in ensuring continuity of care as it communicates vital information to both the patient and other healthcare providers involved in the patient's ongoing care. Other documents, such as the transfer note, progress note, and initial plan, fulfill different purposes. The transfer note is used when a patient is moved from one department or facility to another, and it focuses on the details relevant to that transition rather than summarizing the entire episode of care. Progress notes document the ongoing care and treatment of a patient, providing updates on the patient's condition and response to treatment but do not encapsulate the entirety of the care provided. The initial plan outlines the treatment and procedures intended at the beginning of care and does not provide a summary or status at the conclusion of treatment.

9. What do parenthetical notes in CPT coding provide?

- A. Examples of code usage
- B. Definitions of medical terms
- C. Additional information or instruction related to the codes**
- D. Summary of coding guidelines

Parenthetical notes in CPT coding serve primarily to provide additional information or instructions related to the codes. These notes can clarify the use of a specific code, highlight any special circumstances, or denote recommended procedures that may be performed in conjunction with the procedure being coded. This contextual information is crucial for ensuring that the codes are applied correctly and that the rationale for their use is understood. For instance, a parenthetical note may specify that a certain code should only be used in particular situations or when specific conditions are met, which aids coders in making accurate coding decisions. By offering this supplementary guidance, parenthetical notes help coders interpret the rules and nuances of the coding system, thereby promoting precise documentation and billing practices. In contrast, examples of code usage, definitions of medical terms, and summaries of coding guidelines serve different purposes and are not the primary function of parenthetical notes. Examples of code usage are typically found in coding references or training materials but are not part of CPT's parenthetical notes. Definitions of medical terms may appear in dictionaries or medical vocabularies rather than in the coding system itself. Summaries of coding guidelines provide broader context but are not delivered in the same manner as the concise notes presented in parentheses within the code descriptions.

10. What is a primary use of spreadsheet software in medical office management?

- A. To maintain patient records
- B. To create detailed medical histories
- C. To facilitate data collection and analysis**
- D. To generate appointment schedules

Spreadsheet software is primarily utilized in medical office management for facilitating data collection and analysis due to its versatile functionalities. This allows healthcare professionals to organize large amounts of data, perform calculations, and generate various reports, enabling them to analyze trends related to patient care, billing, and operational efficiency. By using spreadsheet software, medical office staff can easily manipulate data, create graphs and charts for better visualization, and analyze patient demographics or treatment outcomes over time. This analytical capability is crucial for making informed decisions regarding patient management, resource allocation, and overall office productivity. While maintaining patient records, creating detailed medical histories, and generating appointment schedules are essential tasks in a medical office, these functions are typically better suited to electronic health record (EHR) systems or practice management software. In contrast, spreadsheets focus more on managing quantitative data and deriving insights from it, which is why their role in data collection and analysis stands out in this context.

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://ahimaccsp.examzify.com>

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

SAMPLE