

CERTIFIED CARDIOVASCULAR AND THORACIC SURGERY CODER (CCVTC) PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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. What are the four levels of the 1995 examination?**
 - A. Basic, Intermediate, Detailed, Comprehensive
 - B. Problem focused, Expanded problem focused, Detailed, Comprehensive
 - C. Simple, Moderate, Complex, Comprehensive
 - D. Initial, Follow-up, Detailed, Comprehensive
- 2. Which of the following best describes the quality aspect of HPI?**
 - A. The intensity of the pain experienced
 - B. The duration of symptoms
 - C. The timeline of the condition
 - D. The symptoms associated with the condition
- 3. Which factors must be documented when selecting an Evaluation and Management (E/M) level based on time?**
 - A. Total time spent
 - B. Percentage of time spent with the patient
 - C. What service was provided
 - D. All of the above
- 4. According to the 1995 guidelines, how many body areas and/or organ systems constitute a detailed exam?**
 - A. 1-2
 - B. 3-4
 - C. 2-7
 - D. 5-10
- 5. In a Problem pertinent Review of Systems (ROS), how many systems are involved?**
 - A. 2
 - B. 3
 - C. 1
 - D. 4

- 6. Which review of systems (ROS) includes symptoms such as sensitivity to noise and ear pain?**
- A. Respiratory
 - B. Ears, Nose, Throat (ENT)
 - C. Cardiovascular
 - D. Genitourinary
- 7. Which of the following is NOT a component of the HPI?**
- A. Location
 - B. Severity
 - C. Behavior
 - D. Duration
- 8. Which area would be examined for signs of swelling or abnormal tenderness?**
- A. Cardiovascular
 - B. Neurological
 - C. Endocrine
 - D. Integumentary
- 9. How should ROS and PFSH be updated from an earlier encounter?**
- A. By writing them fresh
 - B. Indicating changes only
 - C. Indicating new states of the Hx with original documents initialized
 - D. By summarizing previous information
- 10. Are initial IP codes submitted solely by the admitting provider?**
- A. Yes
 - B. No, multiple providers submit them
 - C. Only for emergency admissions
 - D. Only if the patient requires surgery

Answers

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

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Explanations

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1. What are the four levels of the 1995 examination?

- A. Basic, Intermediate, Detailed, Comprehensive
- B. Problem focused, Expanded problem focused, Detailed, Comprehensive**
- C. Simple, Moderate, Complex, Comprehensive
- D. Initial, Follow-up, Detailed, Comprehensive

The four levels of the 1995 examination are indeed categorized as Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive. This classification is crucial for properly documenting and coding patient examinations in a way that reflects the complexity of the services provided. The Problem Focused level represents the most basic type of examination, involving a narrowed focus on specific issues related to the patient's current complaint. The Expanded Problem Focused examination builds on that by including additional elements related to the patient's history and other issues, allowing for a more thorough review without delving too deeply into the patient's overall health. The Detailed examination takes this further, requiring a more extensive assessment that includes multiple systems or a thorough review of the patient's past and current medical history. Lastly, the Comprehensive examination is the most in-depth level, requiring an extensive assessment of multiple body systems, providing a complete overview of the patient's health and relevant issues. Each level of examination determines how services will be billed and ensures that healthcare providers are appropriately compensated for the complexity of care they provide to patients, following the guidelines established for medical coding. The other options do not accurately reflect the classification system outlined by the 1995 documentation guidelines.

2. Which of the following best describes the quality aspect of HPI?

- A. The intensity of the pain experienced**
- B. The duration of symptoms
- C. The timeline of the condition
- D. The symptoms associated with the condition

The quality aspect of the history of present illness (HPI) primarily relates to the nature and characteristics of the symptoms experienced by the patient. The intensity of the pain is an essential part of this quality because it provides valuable information about the severity and impact of the condition on the patient's life. For example, a patient might describe their pain as sharp, dull, throbbing, or aching, which helps healthcare providers understand the nature of the symptom and guide diagnostic and therapeutic efforts accordingly. While other aspects such as duration, timeline, and associated symptoms are important in evaluating a patient's overall condition, they do not specifically address the quality of the symptoms themselves. Proficient documentation of the quality of symptoms is crucial in the assessment and management of many cardiovascular and thoracic conditions, allowing for a more targeted approach to treatment. This is why identifying the intensity of the pain directly relates to the quality aspect of HPI.

3. Which factors must be documented when selecting an Evaluation and Management (E/M) level based on time?

- A. Total time spent
- B. Percentage of time spent with the patient
- C. What service was provided
- D. All of the above**

When selecting an Evaluation and Management (E/M) level based on time, it is essential to document several specific factors to ensure compliance with coding guidelines and accuracy in billing. The total time spent is critical because it reflects the overall amount of time dedicated to the patient's care, which is a key determinant in coding the E/M level. Additionally, documenting the percentage of time spent with the patient provides clarity on how much of that total time was directly related to patient interaction, which is crucial for justifying the chosen level of service. Moreover, recording what service was provided during that time is necessary to outline the nature of the services rendered and how they relate to the patient's condition and treatment plan. Documenting all these factors together allows for a comprehensive picture of the visit, ensuring that the chosen E/M level accurately reflects the complexity and time involved in the patient's care. This thorough documentation helps protect against audits and supports the medical necessity of the services billed. Thus, including all of these elements strengthens the case for the selected E/M code, making it essential to document total time, percentage of time with the patient, and specifics of the services provided.

4. According to the 1995 guidelines, how many body areas and/or organ systems constitute a detailed exam?

- A. 1-2
- B. 3-4
- C. 2-7**
- D. 5-10

A detailed exam, as per the 1995 guidelines for evaluation and management services, is defined by the examination of specific body areas or organ systems. According to these guidelines, a detailed exam includes the assessment of at least two to seven body areas and/or organ systems. This range requires the physician to conduct a comprehensive examination, ensuring a thorough evaluation of the patient's condition. The rationale behind this definition is to provide a structured approach to patient examinations, allowing for appropriate assessment and documentation. By encompassing two to seven areas or systems, the exam strikes a balance between the extremes of a focused and a comprehensive exam. This standard helps coders accurately categorize the level of service provided and ensures appropriate reimbursement based on the complexity of the services rendered. Other options do not align with this established range, reinforcing that two to seven is the correct context for a detailed exam according to the guidelines.

5. In a Problem pertinent Review of Systems (ROS), how many systems are involved?

- A. 2
- B. 3
- C. 1**
- D. 4

In the context of a Problem Pertinent Review of Systems (ROS), only one system is typically involved. This type of review focuses specifically on the systems relevant to the patient's current medical issue or complaint. The Problem Pertinent ROS is designed to capture only the information necessary for the immediate assessment and is not intended to encompass a comprehensive analysis of multiple systems, which is characteristic of a more detailed review. In clinical practice, this means that during a focused visit where a specific problem is being addressed—such as chest pain or shortness of breath—the physician would inquire about symptoms only related to that particular system, which could be the cardiovascular system in this case. Therefore, recognizing that the Problem Pertinent ROS deals with just one system is essential for accurately coding and documenting a patient's evaluation.

6. Which review of systems (ROS) includes symptoms such as sensitivity to noise and ear pain?

- A. Respiratory
- B. Ears, Nose, Throat (ENT)**
- C. Cardiovascular
- D. Genitourinary

The review of systems (ROS) that includes sensitivity to noise and ear pain pertains specifically to the Ears, Nose, Throat (ENT) category. This section of the ROS addresses various conditions and symptoms related to the auditory and vestibular systems, as well as related structures such as the sinuses and throat. Sensitivity to noise, known as hyperacusis, and ear pain, or otalgia, are both common complaints evaluated within this system; they help healthcare providers assess potential issues that may involve the ear, inner ear structures, or related environmental factors. In contrast, the other categories cover different systems of the body that do not focus on ear-related symptoms. The Respiratory system would encompass respiratory symptoms such as coughing or breathlessness, the Cardiovascular system would address heart-related concerns and symptoms like chest pain or palpitations, and the Genitourinary system includes symptoms related to the urinary tract and reproductive organs. Thus, those options do not correlate with symptoms typically associated with ENT conditions.

7. Which of the following is NOT a component of the HPI?

- A. Location
- B. Severity
- C. Behavior**
- D. Duration

The Health History Information (HPI) is a crucial component of patient assessment and documentation, particularly in the context of cardiovascular and thoracic surgery. It provides a detailed account of the patient's presenting complaint, including various elements that contribute to understanding the condition. The components of HPI generally include factors such as location, severity, and duration of symptoms. - Location refers to where the symptoms are felt, which is essential in diagnosing conditions. - Severity describes the intensity or seriousness of the symptoms, helping to gauge the urgency or seriousness of the issue. - Duration indicates how long the symptoms have been present, which is vital for determining the chronicity of a condition and its potential implications. Behavior, while it may describe how a symptom manifests or affects the patient, does not directly fit into the standard components outlined in HPI. The focus of HPI is more on the physical characteristics of the symptoms rather than the behavioral responses to them. Thus, behavior is not considered a fundamental component of the HPI in the same way as the other listed elements. This is why it is identified as the correct answer as the component that does not belong within the HPI.

8. Which area would be examined for signs of swelling or abnormal tenderness?

- A. Cardiovascular**
- B. Neurological
- C. Endocrine
- D. Integumentary

The correct choice relates to the cardiovascular system, where signs of swelling or abnormal tenderness, often in the extremities, can indicate issues such as heart failure or venous insufficiency. In the cardiovascular examination, clinicians specifically look for conditions like edema, which can manifest in the ankles or legs and is a crucial aspect of assessing the patient's overall vascular health. While neurological assessments might involve physical examinations of muscle tone or sensory response, swelling or tenderness isn't a primary focus. Similarly, the endocrine system typically examines hormonal levels and metabolic functions rather than direct physical signs of swelling. The integumentary system, which includes the skin, hair, and nails, might also show swelling or tenderness, particularly in instances of skin infections or allergic reactions, but when specifically discussing signs of swelling related to cardiovascular concerns, the most direct and relevant examinations will focus on the cardiovascular area.

9. How should ROS and PFSH be updated from an earlier encounter?

- A. By writing them fresh
- B. Indicating changes only
- C. Indicating new states of the Hx with original documents initialized**
- D. By summarizing previous information

In the context of updating the Review of Systems (ROS) and Past Family and Social History (PFSH) from an earlier encounter, the approach of indicating new states of the history with original documents initialized is the most accurate. This method ensures that the updated information reflects any changes while retaining the integrity of the original records. When clinicians document changes in ROS and PFSH, it is essential to clearly delineate between what remains consistent and what has evolved. By marking new conditions or changes in the patient's history, it provides a clear and concise view of the patient's health status over time, which is crucial for ongoing care and treatment planning. This method also aligns with best practices in medical documentation, where clear records are vital for continuity of care. It allows healthcare providers to track how a patient's condition may have worsened or improved, ensuring more informed decision-making during subsequent visits. The practice of initializing original documents also emphasizes accuracy and clarity, which are paramount in maintaining high-quality medical records. Other methods, such as merely summarizing prior information or writing everything fresh, may lead to loss of valuable detail or create unnecessary redundancy, which could detract from the clarity and effectiveness of the medical record.

10. Are initial IP codes submitted solely by the admitting provider?

- A. Yes**
- B. No, multiple providers submit them
- C. Only for emergency admissions
- D. Only if the patient requires surgery

The correct response is that initial inpatient (IP) codes are typically submitted solely by the admitting provider. In the context of inpatient admissions, the admitting provider is responsible for documenting the patient's condition at the time of admission and assigning the appropriate diagnosis codes for the patient's stay. This process is crucial for accurate billing and proper medical record keeping. The admitting provider has the most direct knowledge of the patient's medical situation upon admission, which is why they handle the coding of the initial diagnosis. Other providers, such as consultants or specialists, may contribute to the patient's overall care and document their findings, but they do not submit the initial codes. This delineation ensures that there is a clear point of accountability and maintains the integrity of the patient's admission record. In circumstances like emergency admissions or surgical requirements, while these may influence the nature of the admission or subsequent treatment plans, they do not alter the responsibility of the admitting provider in terms of coding the initial inpatient diagnosis.

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://ccvtc.examzify.com>

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

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