

Certified Professional Coder (CPC) Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

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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. How was the median lobe treat during the TURP procedure?**
 - A. Resected**
 - B. Emulsified**
 - C. Electrosurgically removed**
 - D. Burned**
- 2. After conducting a radical neck dissection, which CPT code should be reported for the lymphadenectomy?**
 - A. 238.8**
 - B. 38724**
 - C. 27200**
 - D. 30520**
- 3. Which diagnosis code is assigned for acute respiratory failure associated with septicemia?**
 - A. 518.81**
 - B. 518.82**
 - C. 518.83**
 - D. 518.84**
- 4. What code should be assigned for the aftercare of a healed fracture with no further treatment necessary?**
 - A. 27252-LT**
 - B. 20661**
 - C. 16500**
 - D. 16030**
- 5. What diagnosis code is used for a history of myocardial infarction?**
 - A. 412**
 - B. 410.71**
 - C. 410.00**
 - D. 410.11**

6. What diagnosis code corresponds to the viral infection found in the new patient?

- A. **786.09**
- B. **793.19**
- C. **487.1**
- D. **99203**

7. For a patient checking serum digoxin levels after long-term digoxin use, which codes apply?

- A. **80162, V58.83, V58.69, 427.31**
- B. **82040, 84075**
- C. **88305, 88307**
- D. **80050**

8. What were the total ventricular ectopic beats detected during the monitoring period?

- A. **4948**
- B. **1000**
- C. **2500**
- D. **3000**

9. What is the severity of the medical decision making for the patient admitted after the fall from a ladder?

- A. **Low complexity**
- B. **Moderately complex**
- C. **High complexity**
- D. **Simplistic**

10. What injury did the patient sustain in the car accident?

- A. **Fractured wrist**
- B. **Right rotator cuff injury**
- C. **Concussion**
- D. **Herniated disc**

Answers

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

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Explanations

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1. How was the median lobe treat during the TURP procedure?

- A. Resected**
- B. Emulsified**
- C. Electrosurgically removed**
- D. Burned**

During a Transurethral Resection of the Prostate (TURP) procedure, the median lobe is resected as part of the surgical intervention. This approach involves the removal of obstructing prostatic tissue to relieve symptoms associated with benign prostatic hyperplasia. Resection means that the tissue is cut away, allowing for the restoration of urinary flow. The technique used in TURP employs a specialized instrument called a resectoscope, which allows the surgeon to access the prostate through the urethra. The resectoscope has a loop at its end that is heated and shaped to cut away tissue efficiently. Resection is a well-established method for addressing the median lobe's enlargement, as it physically removes the obstructive tissue, unlike other methods that might merely alter or damage the tissue without complete removal. In contrast, the other techniques mentioned—emulsification, electrosurgical removal, and burning—typically refer to different modalities or types of procedures, possibly involving other surgical techniques or devices like laser treatments, which are not preferred for directly addressing the median lobe in a standard TURP procedure. Thus, resection remains the most appropriate and conventional method for treating this specific anatomical structure during a TURP.

2. After conducting a radical neck dissection, which CPT code should be reported for the lymphadenectomy?

- A. 238.8**
- B. 38724**
- C. 27200**
- D. 30520**

The appropriate CPT code for a lymphadenectomy performed during a radical neck dissection is 38724, which specifically describes the excision of lymph nodes in the neck. This code is used to report the removal of deep cervical lymph nodes, which is integral to a radical neck dissection procedure. In a radical neck dissection, not only are the lymph nodes removed, but also various surrounding structures and tissue, due to the nature of cancer treatment aimed at removing all potential paths for the disease to spread. The code 38724 clearly indicates what surgical procedure was performed, focusing on the comprehensive nature of lymphadenectomy within that specific context. The other choices listed do not correctly represent the procedure: - The code 238.8 is a diagnosis code for a specific condition rather than a procedure code. - The code 27200 pertains to a hip-related procedure and is not relevant in this context. - The code 30520 relates to nasal procedures, which is unrelated to neck dissection and lymphadenectomy. Hence, 38724 is the most accurate and relevant code for a lymphadenectomy procedures within the context of radical neck dissection.

3. Which diagnosis code is assigned for acute respiratory failure associated with septicemia?

- A. 518.81**
- B. 518.82**
- C. 518.83**
- D. 518.84**

The diagnosis code for acute respiratory failure associated with septicemia is 518.81. This code specifically identifies acute respiratory failure and allows for the association with other underlying conditions such as septicemia. It is important to recognize that coding for respiratory complications must accurately reflect the nature and underlying cause of the condition. The other options represent different types of respiratory failure or are designated for other conditions that do not specifically denote the presence of septicemia as an associated factor. For instance, codes within the 518.x range can represent different manifestations of respiratory failure, but only 518.81 clearly encapsulates the acute nature of respiratory failure in relation to septic conditions. This specificity is essential for proper diagnosis, treatment, and reimbursement procedures within medical coding.

4. What code should be assigned for the aftercare of a healed fracture with no further treatment necessary?

- A. 27252-LT**
- B. 20661**
- C. 16500**
- D. 16030**

The appropriate code to assign for the aftercare of a healed fracture with no further treatment necessary is the one focusing on follow-up care without any additional intervention required. In this context, the code 27252-LT is relevant as it represents the follow-up care for a fracture involving the left side of the body, particularly for a hip or femur, where no additional treatment is needed. This indicates that the initial healing process is complete, and the patient requires monitoring rather than active treatment. The other codes do not align with the scenario of aftercare for a healed fracture. For example, some could relate to more invasive procedures or codes indicating ongoing treatment, such as joint injections or manipulation. Thus, the correct choice is the one that signifies aftercare for a healed condition without further intervention, highlighting the importance of accurate coding in capturing the patient's treatment needs accurately.

5. What diagnosis code is used for a history of myocardial infarction?

- A. 412**
- B. 410.71**
- C. 410.00**
- D. 410.11**

The diagnosis code used for a history of myocardial infarction is indicated by the code for "old myocardial infarction," which is 412. This code denotes that the patient has a prior history of heart attack but is not experiencing one at the time of the visit. The designation helps healthcare providers and insurance companies understand that the patient has a significant past medical history that may require continued monitoring and affects current healthcare decisions. The other codes listed pertain to acute myocardial infarction events. For instance, the codes starting with 410 describe various types of current myocardial infarction, with specific indications of its STEMI or NSTEMI status and localization, which would not be appropriate for indicating merely a history of the condition. Thus, 412 is specifically tailored for documenting a past event rather than an ongoing acute issue, making it the correct choice for the diagnosis of a history of myocardial infarction.

6. What diagnosis code corresponds to the viral infection found in the new patient?

- A. 786.09**
- B. 793.19**
- C. 487.1**
- D. 99203**

The diagnosis code 487.1 corresponds specifically to "Viral infection of the upper respiratory tract, acute." This code is commonly used to document cases where a patient has been diagnosed with a viral infection affecting the upper respiratory system. It provides a clear and concise representation of the patient's condition, which is essential for accurate medical coding, billing, and ensuring appropriate reimbursement for the services provided. Using this particular code also aligns with the coding guidelines for specifying the type of infection and its classification under viral diseases, making it relevant for both clinical and administrative purposes. Understanding the use of this diagnosis code can help coders accurately reflect the patient's medical history and condition on claims and in medical records, facilitating proper management of healthcare resources and patient care.

7. For a patient checking serum digoxin levels after long-term digoxin use, which codes apply?

- A. 80162, V58.83, V58.69, 427.31**
- B. 82040, 84075**
- C. 88305, 88307**
- D. 80050**

In the scenario of checking serum digoxin levels after long-term digoxin use, the appropriate coding involves both the laboratory test for digoxin and relevant diagnoses that reflect the patient's ongoing management. The code 80162 specifically pertains to the quantitative measurement of digoxin levels, which is the necessary laboratory test being performed. Additionally, V58.83 indicates the patient is under long-term (chronic) use of digoxin, which is critical for capturing the context of the patient's ongoing treatment. V58.69 reflects the management of a long-term drug therapy, which further emphasizes the patient's clinical scenario and medical history concerning digoxin use. The code 427.31 is applicable as it refers to atrial fibrillation, which is a common condition that digoxin is often used to treat, thereby establishing a direct link to the reason for monitoring digoxin levels. This selection of codes provides a comprehensive representation of both the lab service being utilized and the clinical context of the patient's health status, ensuring accurate and complete coding for the services rendered.

8. What were the total ventricular ectopic beats detected during the monitoring period?

- A. 4948**
- B. 1000**
- C. 2500**
- D. 3000**

The total ventricular ectopic beats detected during the monitoring period is 4948. This figure typically represents the sum of irregular heartbeats originating from the ventricles that are recorded over a defined time frame, such as in the context of a Holter monitor study or cardiac monitoring. Ventricular ectopic beats, also known as PVCs (premature ventricular contractions), can be measured and reported by diagnostic devices, and their frequency can vary significantly based on the individual's cardiac condition and activity level during the monitoring. The high total detected in this scenario indicates a significant level of ectopic activity, which could warrant further evaluation by a healthcare provider to understand the underlying cause and potential implications for the individual's cardiac health. The other options reflect lower counts of ectopic beats that might not align with potential clinical scenarios seen in patients with higher incidences of ectopy. Thus, the selection of 4948 aligns with the expected data that would be significant enough to capture attention in a clinical context.

9. What is the severity of the medical decision making for the patient admitted after the fall from a ladder?

- A. Low complexity**
- B. Moderately complex**
- C. High complexity**
- D. Simplistic**

The severity of medical decision making for a patient admitted after a significant incident, such as a fall from a ladder, is typically assessed based on various factors including the patient's medical history, the nature of the injuries sustained, and the complexity of the treatment required. In this case, the admission due to a fall suggests that there may be significant trauma involved, which could involve an array of assessments like imaging studies, consultations from specialists, and potential interventions to address any serious injuries such as fractures or head trauma.

Moderately complex medical decision making indicates that there are multiple medical problems to assess, and there might be a need for more extensive evaluation and management plans. This situation reflects a higher level of complexity due to the number of potential issues that need to be addressed, the level of risk involved, and the necessity of careful patient management. While lower complexities might indicate straightforward cases without many factors to consider, a fall from a ladder typically involves many variables, hence justifying the rationale for classifying the medical decision making as moderately complex. This complexity ensures that all aspects of the patient's condition are carefully evaluated to provide effective and appropriate care.

10. What injury did the patient sustain in the car accident?

- A. Fractured wrist**
- B. Right rotator cuff injury**
- C. Concussion**
- D. Herniated disc**

The correct answer indicates that the patient sustained a right rotator cuff injury during the car accident. This type of injury commonly occurs due to sudden impact or the force of the body being thrown against the seatbelt or steering wheel in an accident, leading to strains or tears in the rotator cuff muscles and tendons. The rotator cuff is crucial for maintaining shoulder stability and mobility, and injuries to this area can significantly affect a person's range of motion and arm function. Other injuries, while possible in car accidents, were not specified in the scenario. For instance, a fractured wrist may occur if the patient braced themselves with their arms during impact, and a concussion can happen if there is a sudden stop causing the head to move. A herniated disc could result from the spinal stress during a collision but was less likely to be the primary injury referenced here. Each option represents a distinct type of injury, but the context or mechanisms of the car accident particularly relate to the potential of a rotator cuff injury being the most relevant and likely outcome in this case.

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://certifiedprofessionalcoder.examzify.com>

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

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