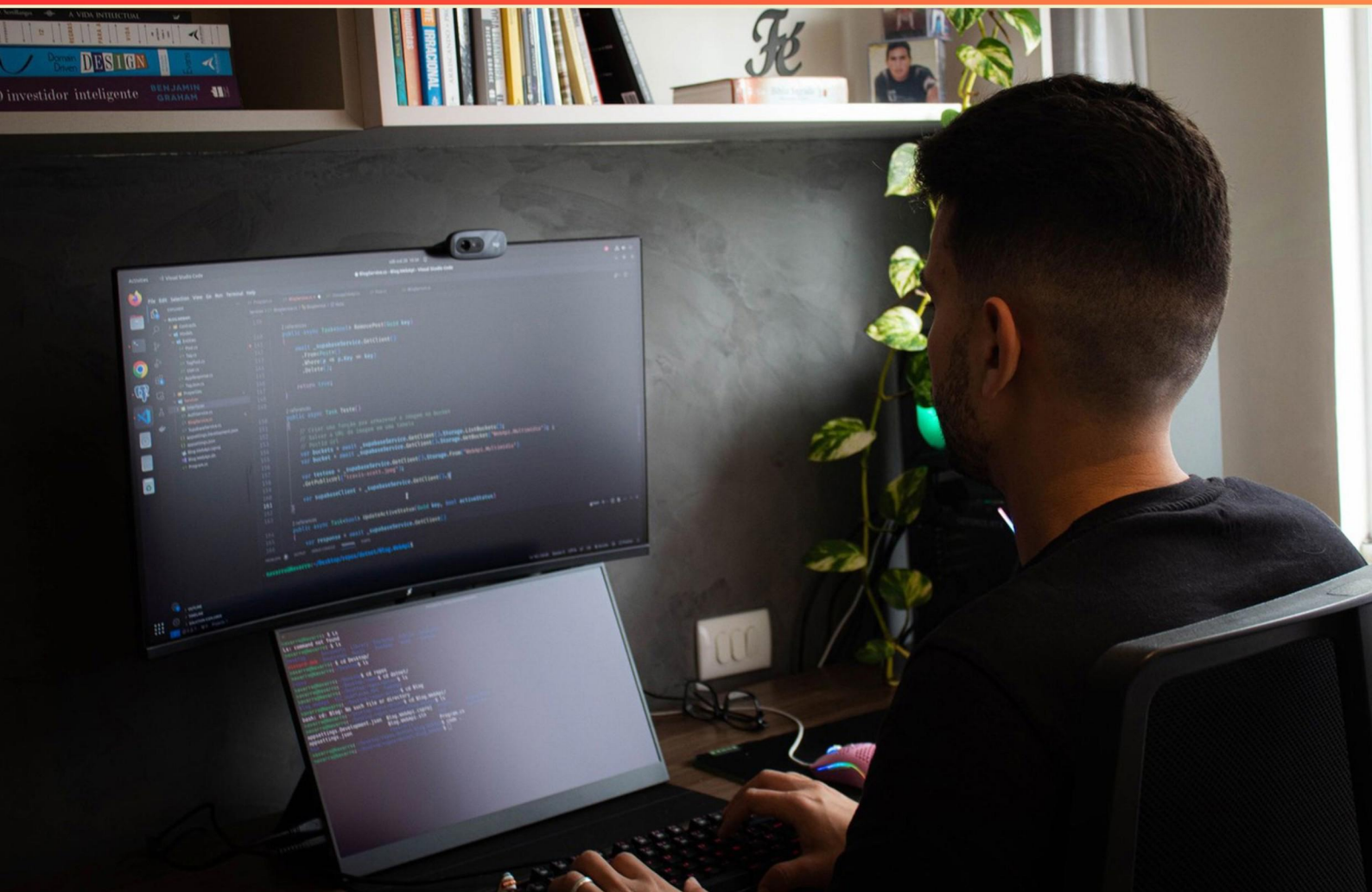


CERTIFIED PROFESSIONAL CODER (CPC) PRACTICE TEST (SAMPLE) STUDY GUIDE



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 is the diagnosis code for acute renal insufficiency?
 - A. 593.9
 - B. 613.0
 - C. 593.1
 - D. 593.9
2. What procedural code indicates a right endoscopic total ethmoidectomy and maxillary antrostomy?
 - A. 31267-51
 - B. 31255-RT
 - C. 36571
 - D. 238.8
3. What procedure code was used for the management of the PICC line in the patient with pancreatic cancer?
 - A. 36571
 - B. 31600
 - C. 31267-51
 - D. 38115
4. In the context of laboratory coding, which procedure would likely be reported with code 88305?
 - A. Biopsy of the colon
 - B. Protime test
 - C. Lipid panel
 - D. TSH test
5. What was the preoperative diagnosis for the patient undergoing shunt revision?
 - A. Obstructive symptoms
 - B. Obstructive hydrocephalus
 - C. Herniated disc
 - D. Corneal ulcer

- 6. What is the term for diverting or creating an artificial passage in the body?**
- A. Bypass
 - B. Shunt
 - C. Fistula
 - D. Ostomy
- 7. What is the primary purpose of the rapid test pack used for the new patient?**
- A. To diagnose bacterial infections
 - B. To diagnose viral infections
 - C. To evaluate respiratory function
 - D. To assess cardiovascular health
- 8. What CPT code would be used to report the removal of a permanent pacemaker generator?**
- A. 33233
 - B. 33536
 - C. 36620
 - D. 45303
- 9. What is the appropriate code when a physician sutures a 1-cm wound on the cheek?**
- A. 12013
 - B. 11752
 - C. 12001-51
 - D. 16030
- 10. For a patient with end-stage renal disease undergoing dialysis three times a week, which code represents a full month of encounters?**
- A. 90960
 - B. 585.6
 - C. V45.11
 - D. V06.6

Answers

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

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Explanations

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1. What is the diagnosis code for acute renal insufficiency?

- A. 593.9
- B. 613.0
- C. 593.1
- D. 593.9**

The diagnosis code for acute renal insufficiency is 593.9. This code falls under the category of disorders of the kidney and urinary tract, specifically addressing situations involving renal dysfunction. Acute renal insufficiency, often characterized by a sudden decrease in kidney function, leads to the build-up of waste products in the blood and can have various underlying causes. The code 593.9 is used when documenting acute renal insufficiency, as it is a nonspecific code for disorders of the kidney where an exact diagnosis has not been established. This aligns with coding standards that require the most precise code available when documenting a patient's condition. Thus, 593.9 effectively captures the clinical picture of acute renal insufficiency. The other codes provided would reference different conditions or specifics that are not relevant to acute renal insufficiency, thus ensuring that 593.9 is the appropriate choice in this context.

2. What procedural code indicates a right endoscopic total ethmoidectomy and maxillary antrostomy?

- A. 31267-51
- B. 31255-RT**
- C. 36571
- D. 238.8

The procedural code that indicates a right endoscopic total ethmoidectomy and maxillary antrostomy is chosen correctly with the code 31255-RT. This code is specifically designed for procedures involving the sinuses and includes both the endoscopic total ethmoidectomy and other sinus surgeries, such as a maxillary antrostomy, clearly denoting the anatomical areas and the approach involved. In this case, the designation "-RT" signifies that the procedure is performed on the right side of the patient, ensuring precise information is captured for the billing and medical records. The specificity of the code allows for proper documentation of the surgical procedure, which is vital for both clinical and billing purposes. The other options do not accurately reflect this specific procedure. While some codes may pertain to ethmoid surgeries or sinus procedures, they do not provide the same detailed indication required for this specific dual procedure on the right side. Thus, selecting 31255-RT effectively conveys the exact procedure being performed.

3. What procedure code was used for the management of the PICC line in the patient with pancreatic cancer?

- A. 36571**
- B. 31600
- C. 31267-51
- D. 38115

The procedure code selected represents the management of a peripherally inserted central catheter (PICC) line. In the context of patients with pancreatic cancer, managing the PICC line is significant because patients may require long-term intravenous access for therapeutic medications, nutritional support, or chemotherapy. The specific code 36571 corresponds to the insertion of a PICC line, which is a common procedure for patients needing extended intravenous therapy. This code relates directly to catheter management and is appropriate for documenting service related to vascular access, making it crucial for coding and billing practices in healthcare settings. While other codes relate to different procedures or aspects of care—such as respiratory interventions or other surgical services—they do not apply to the management of the PICC line. The focus here should be on recognizing the unique characteristics and usage of the correct code relevant to catheter care in a patient dealing with a serious condition like pancreatic cancer.

4. In the context of laboratory coding, which procedure would likely be reported with code 88305?

- A. Biopsy of the colon**
- B. Protime test
- C. Lipid panel
- D. TSH test

The procedure that would likely be reported with code 88305 is a biopsy of the colon. This code is specifically designated for the professional interpretation of a tissue sample, which is typically obtained through a biopsy for pathological examination. The purpose of using this code is to document the microscopic examination of excised tissue specimens, including biopsies, where the physician evaluates the structure and abnormalities present in the cells. The other choices refer to laboratory tests or panels that involve analyzing bodily fluids or blood but do not pertain to the examination of tissue samples. For instance, a protime test measures the time it takes for blood to clot, while a lipid panel assesses lipid levels in the blood, and a TSH test evaluates thyroid-stimulating hormone levels. None of these procedures involve the pathological examination of a tissue sample, which is why they would not be associated with the code 88305.

5. What was the preoperative diagnosis for the patient undergoing shunt revision?

- A. Obstructive symptoms
- B. Obstructive hydrocephalus**
- C. Herniated disc
- D. Corneal ulcer

The preoperative diagnosis of obstructive hydrocephalus is specifically linked to conditions where there is an accumulation of cerebrospinal fluid (CSF) within the brain's ventricles due to a blockage in its normal flow. In this context, a shunt revision would typically be performed to address complications related to hydrocephalus, which might include symptoms like increased intracranial pressure or neurological deficits resulting from the excess fluid. Obstructive hydrocephalus is a more precise diagnosis than obstructive symptoms because it describes the underlying pathological condition responsible for the need for intervention. While obstructive symptoms could suggest various issues related to fluid build-up, it does not specifically indicate the presence of hydrocephalus, which is critical in justifying a shunt revision procedure. Other diagnoses such as herniated disc and corneal ulcer are not related to cerebrospinal fluid management or the need for shunt-related surgeries, thus ruling them out as appropriate preoperative diagnoses for this scenario.

6. What is the term for diverting or creating an artificial passage in the body?

- A. Bypass
- B. Shunt**
- C. Fistula
- D. Ostomy

The correct term for diverting or creating an artificial passage in the body is "shunt." A shunt typically refers to a surgical procedure or device used to redirect the flow of bodily fluids from one area to another. This can occur, for example, when a doctor needs to alleviate pressure in a part of the body by creating an alternative pathway for fluid—often in the context of blood flow or cerebral spinal fluid. While both "fistula" and "ostomy" involve the creation of artificial passages, they have different specific contexts. A fistula generally refers to an abnormal connection between two organs or vessels that normally wouldn't connect, which can occur spontaneously or be surgically created. An ostomy is a surgical procedure that creates an opening in the body for the purpose of expelling waste, typically when normal elimination routes are not possible. A bypass usually refers specifically to a procedure designed to bypass a blockage in the blood vessels or another structure, rather than creating an artificial passage. Therefore, "shunt" is the most accurate term based on the definition provided in the question, as it implies a redirection of flow through an artificial passage.

7. What is the primary purpose of the rapid test pack used for the new patient?

- A. To diagnose bacterial infections
- B. To diagnose viral infections**
- C. To evaluate respiratory function
- D. To assess cardiovascular health

The primary purpose of the rapid test pack used for a new patient can be attributed to its ability to quickly diagnose viral infections. Rapid test packs are specifically designed to detect viral pathogens efficiently and provide timely results that can significantly influence the management of a patient's condition. This is particularly important in clinical settings where identifying a viral infection promptly can lead to appropriate treatment decisions, isolation measures, and prevent further transmission, especially in contagious diseases like influenza or COVID-19. In contrast, diagnosing bacterial infections typically requires different types of tests, which may include cultures or specific bacterial identification methods rather than rapid tests often used for viral infections. Evaluating respiratory function and assessing cardiovascular health involve separate diagnostic tools, such as spirometry for respiratory evaluation and various imaging or monitoring techniques for cardiovascular assessment. Therefore, the focus on diagnosing viral infections accurately positions the rapid test pack as a crucial tool in modern patient care.

8. What CPT code would be used to report the removal of a permanent pacemaker generator?

- A. 33233**
- B. 33536
- C. 36620
- D. 45303

The correct CPT code for the removal of a permanent pacemaker generator is 33233. This code specifically represents the procedure involving the removal of a permanent pacemaker or a pulse generator for a previously implanted device. The coding guidelines for this procedure indicate that it is critical to differentiate between the removal of just the generator (the pacemaker itself) and other related procedures, such as the removal of leads or replacing the device. The other codes listed correspond to different medical procedures: - The code associated with cardiac surgery, particularly for myocardial revascularization, is not aligned with pacemaker procedures. - One code pertains to arterial puncture and catheterization, which relates to vascular access rather than device removal. - Another code corresponds to the removal of a polyp or other structures in the gastrointestinal tract, which is unrelated to the context of cardiovascular devices. These distinctions are vital for accurately coding procedures and ensuring correct billing and documentation in clinical practice. Thus, 33233 is the only appropriate choice for reporting the removal of a permanent pacemaker generator.

9. What is the appropriate code when a physician sutures a 1-cm wound on the cheek?

- A. 12013
- B. 11752
- C. 12001-51**
- D. 16030

The appropriate coding for suturing a 1-cm wound on the cheek is based on the guidelines for wound repair. In this scenario, the correct choice involves the code for simple repairs of wounds. When coding for wound repair, specific codes are assigned based on the type of repair and the length of the wound. For a simple repair like a 1-cm cheek wound, the relevant code is 12001, which is designated for a simple repair of a wound of the face, ears, eyelids, scalp, neck, hands, feet, and genitalia, with a length of 2.5 cm or less. The addition of the modifier 51 indicates that this procedure is being billed along with other procedures and is secondary in terms of payment hierarchy. This is often applicable in cases where multiple procedures are performed during the same session, making it necessary to denote that this particular repair is not the primary procedure. Thus, the combination of the base code 12001 and the modifier 51 accurately reflects the procedure as it accounts for the size and location of the wound, along with the context in which it is performed.

10. For a patient with end-stage renal disease undergoing dialysis three times a week, which code represents a full month of encounters?

- A. 90960**
- B. 585.6
- C. V45.11
- D. V06.6

The code representing a full month of encounters for a patient with end-stage renal disease undergoing dialysis three times a week is 90960. This specific code is defined in the ICD-10-CM coding system and is utilized to denote ongoing management of patients with end-stage renal disease (ESRD) who are receiving dialysis treatments. It captures the nature and frequency of the dialysis as well as the necessity for chronic management of their condition. When coding for ESRD, it's critical to indicate the frequency of dialysis to provide an accurate account of the patient's treatment, which is why 90960 is an essential code in documenting the patient's encounters within a month.

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:

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

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