

# CPC GUIDELINES 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 should be assigned when documenting a current MRSA infection that lacks a combination code including the causal organism?**
  - A. Only the code for MRSA
  - B. A code for the condition followed by B95.62
  - C. A general infection code
  - D. A carrier status code
- 2. When treating a metastatic site(s) from a primary malignancy during an encounter, how should coding be handled?**
  - A. The primary malignancy should be the principal diagnosis
  - B. The metastatic site(s) should be coded last
  - C. The metastatic site(s) should be designated as the principal diagnosis
  - D. Only the treatment provided should be recorded
- 3. What is the main purpose of accurately coding for conditions such as hypertension and chronic kidney disease?**
  - A. To expedite patient care
  - B. To ensure correct billing and insurance reimbursements
  - C. To provide an overview of patient demographics
  - D. To create physical records for patients
- 4. What should be assigned as the principal diagnosis if treatment is directed at a malignancy?**
  - A. The patient's symptoms
  - B. The malignancy
  - C. The carrier status
  - D. The secondary diagnosis
- 5. What is the recommended action if a provider documents substance use without signs of abuse or dependence?**
  - A. Assign a code for use
  - B. Assign a code for dependence
  - C. Do not assign any codes
  - D. Assign a code for abuse

- 6. When is it appropriate to use the seventh character "4" for "intermediate stage" in glaucoma coding?**
- A. When the stage is known from imaging results
  - B. When based on clinical documentation stating the intermediate stage
  - C. When the patient reports symptoms of intermediate stage
  - D. When the history suggests a stable condition
- 7. What if the encounter for pain has no established definitive diagnosis?**
- A. Code the site of pain then assign a G89 code
  - B. Only cite the G89 code
  - C. Use codes from a different category altogether
  - D. Only document the patient's pain descriptor
- 8. If both abuse and signs of a behavioral disorder are documented, what is the appropriate coding response?**
- A. Code for abuse only
  - B. Code for behavioral disorder only
  - C. Use codes from the psychoactive substance category
  - D. Do not assign codes
- 9. Should the code for the acute phase of an illness leading to a sequela be included?**
- A. Yes, it is required
  - B. No, it should not be used
  - C. Only if the sequela is severe
  - D. It depends on coding guidelines
- 10. When bilateral glaucoma is documented with different types and no laterality distinction, how is the encounter coded?**
- A. Assign a single code for bilateral glaucoma
  - B. Assign one code for each type of glaucoma
  - C. Use the unspecified code
  - D. Code only for the least severe type

## **Answers**

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

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## **Explanations**

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**1. What should be assigned when documenting a current MRSA infection that lacks a combination code including the causal organism?**

- A. Only the code for MRSA
- B. A code for the condition followed by B95.62**
- C. A general infection code
- D. A carrier status code

*When documenting a current MRSA infection that lacks a combination code that includes the causal organism, it is important to assign a code for the specific condition being treated, in addition to a code that indicates the presence of the MRSA organism. The correct approach involves coding the underlying condition that is being affected by the MRSA infection and then supplementing it with the appropriate code for the MRSA organism itself, which is represented by B95.62. This coding strategy ensures that documentation accurately represents both the condition and the infectious organism. The presence of B95.62 is crucial as it designates the diagnosis as being caused by methicillin-resistant Staphylococcus aureus, which provides clarity in the patient's health record regarding the specific infectious agent involved. This allows for a better understanding for treatment and future management of the infection. In contrast, simply assigning only the MRSA code fails to capture the comprehensive picture of the patient's health status, and using a general infection code would not specify the causal organism involved. Therefore, the combination of codes for both the condition and MRSA (B95.62) reflects accurate clinical information and aligns with coding guidelines.*

**2. When treating a metastatic site(s) from a primary malignancy during an encounter, how should coding be handled?**

- A. The primary malignancy should be the principal diagnosis
- B. The metastatic site(s) should be coded last
- C. The metastatic site(s) should be designated as the principal diagnosis**
- D. Only the treatment provided should be recorded

*In cases where treatment is being administered for metastatic site(s) from a primary malignancy, the metastatic site(s) should be designated as the principal diagnosis. This coding practice reflects the clinical situation accurately, as it emphasizes the active area being treated at that time. In cases of metastatic cancer, the focus is generally on the sites of metastasis because they are often the sites causing current symptoms or necessitating treatment. Coding the metastatic site as the principal diagnosis ensures that the treatment provided is clearly linked to the appropriate clinical reason for the encounter, allowing for better tracking of the patient's medical needs and supporting the rationale for treatment provided. This coding approach aligns with the guidelines that prioritize specific treatment needs, particularly in oncology, where treatment strategies may differ significantly based on whether the disease is at the primary site or at metastatic locations. Proper designation of the principal diagnosis ensures that the coding remains both clinically relevant and compliant with coding standards.*

**3. What is the main purpose of accurately coding for conditions such as hypertension and chronic kidney disease?**

- A. To expedite patient care
- B. To ensure correct billing and insurance reimbursements**
- C. To provide an overview of patient demographics
- D. To create physical records for patients

*Accurate coding for conditions like hypertension and chronic kidney disease is essential primarily to ensure correct billing and insurance reimbursements. This process involves translating detailed clinical information into standardized codes that payers and insurers recognize. When codes are precise and reflect the patient's conditions accurately, it helps healthcare providers receive the appropriate compensation for their services. Furthermore, correct coding supports the integrity of medical records and contributes to data analytics for provider performance and health outcomes. Inaccurate coding can lead to claim denials and financial losses, as insurers may refuse to reimburse for services rendered if the coding does not align with the documented medical necessity. Therefore, ensuring accurate coding is critical for financial stability within healthcare organizations while also promoting quality care delivery through precise health data representation.*

**4. What should be assigned as the principal diagnosis if treatment is directed at a malignancy?**

- A. The patient's symptoms
- B. The malignancy**
- C. The carrier status
- D. The secondary diagnosis

*The principal diagnosis is determined by the primary condition that is mainly responsible for the patient's treatment plan. When treatment is directed specifically at a malignancy, this indicates that the cancerous condition is the primary focus of care. Therefore, the malignancy itself should be assigned as the principal diagnosis because it drives the clinical decision-making and resource allocation. In contrast, symptoms (the first option) are often manifestations of an underlying condition but do not take precedence over the malignancy when it comes to determining the principal diagnosis. Carrier status, another option, refers to the presence of a genetic trait but does not necessitate treatment and thus is not relevant in this context. The secondary diagnosis refers to additional conditions that may require attention but again, does not supersede the malignancy as the principal diagnosis when that malignancy is the main reason for the patient's treatment.*

**5. What is the recommended action if a provider documents substance use without signs of abuse or dependence?**

- A. Assign a code for use**
- B. Assign a code for dependence
- C. Do not assign any codes
- D. Assign a code for abuse

*Assigning a code for use is the recommended action when a provider documents substance use without evidence indicating abuse or dependence. This approach acknowledges that a patient may be using a substance without it impacting their life negatively. It is important to differentiate between substance use, which may be incidental or managed, and substance abuse or dependence, which implies a more serious level of concern requiring additional intervention and monitoring. By using a code for use, healthcare providers can accurately reflect the patient's current situation, allowing for appropriate care and tracking while avoiding the implications attached to codes for abuse or dependence, which would suggest a more severe issue. It's crucial for documentation and coding purposes to maintain this distinction to ensure that clinical assessments and treatment plans are correctly aligned with the patient's actual condition.*

**6. When is it appropriate to use the seventh character "4" for "intermediate stage" in glaucoma coding?**

- A. When the stage is known from imaging results
- B. When based on clinical documentation stating the intermediate stage**
- C. When the patient reports symptoms of intermediate stage
- D. When the history suggests a stable condition

*Using the seventh character "4" to indicate "intermediate stage" in glaucoma coding is appropriate when clinical documentation explicitly states the intermediate stage. This requirement underscores the importance of accurate and precise medical documentation in coding practices. Clinical documentation acts as a foundation for coding, ensuring that the coded information accurately reflects the patient's condition as assessed by a physician. When a provider notes that a patient is experiencing an intermediate stage of glaucoma, it provides a clear and substantiated basis for using this specific seventh character. This practice aligns with coding guidelines that emphasize the necessity for documentation to guide coding decisions. Other choices focus on less definitive bases for the coding decision. For instance, imaging results may not always yield a clear determination of the intermediate stage without supporting clinical context. Patient-reported symptoms can vary in interpretation and are not sufficient alone for coding purposes. Similarly, a history suggesting a stable condition does not provide evidence of an intermediate stage, which requires explicit documentation from a healthcare provider. Thus, the correct application of coding is fundamentally driven by clinical judgment and detailed documentation.*

**7. What if the encounter for pain has no established definitive diagnosis?**

- A. Code the site of pain then assign a G89 code**
- B. Only cite the G89 code
- C. Use codes from a different category altogether
- D. Only document the patient's pain descriptor

*In situations where a patient presents with pain but lacks a definitive diagnosis, the most appropriate coding approach is to code for the specific site of pain alongside a G89 code. The G89 codes are used for pain management and are specifically designated to indicate that the pain is either acute or chronic. By coding the site of the pain, you provide a more detailed and accurate representation of the patient's condition, which is essential for both clinical documentation and billing purposes. The G89 code further specifies the nature of the pain without indicating an underlying condition. This combination ensures that the pain is appropriately documented and accounted for in medical records, facilitating better care management and helping to track the patient's treatment journey. This method aligns with the coding guidelines that encourage specificity and clarity in documentation. Choosing only the G89 code would not provide the necessary detail about the location of the pain, which can be crucial for treatment planning. Opting for codes from a different category without specifying the site would not accurately represent the patient's presenting problem. Finally, documenting only the patient's pain descriptor lacks the required coding specificity and would not fulfill the necessary coding requirements for reimbursement or care quality metrics.*

**8. If both abuse and signs of a behavioral disorder are documented, what is the appropriate coding response?**

- A. Code for abuse only
- B. Code for behavioral disorder only
- C. Use codes from the psychoactive substance category**
- D. Do not assign codes

*When both abuse and signs of a behavioral disorder are documented, the appropriate response is to use codes from the psychoactive substance category. This approach is necessary because the presence of both conditions indicates a significant interplay between substance abuse and behavioral health issues. Using codes from the psychoactive substance category allows for a comprehensive understanding of the patient's situation and ensures that all relevant diagnoses are captured appropriately. This coding helps in accurate treatment planning, billing, and resource allocation, as it provides a clearer picture of the individual's needs. Additionally, recognizing both the abuse and any associated behavioral disorders is crucial for effective clinical management, as these conditions often influence each other and require coordinated care. By coding both aspects thoroughly, healthcare providers can tailor interventions that address both the substance use and any underlying or secondary behavioral health issues.*

**9. Should the code for the acute phase of an illness leading to a sequela be included?**

- A. Yes, it is required
- B. No, it should not be used**
- C. Only if the sequela is severe
- D. It depends on coding guidelines

*In coding practices, particularly when adhering to the guidelines set forth by organizations like the ICD, it is essential to accurately reflect the clinical scenario depicted in the medical record. When a patient is treated for an acute phase of an illness that has led to a sequela, the guideline generally specifies that only the sequela code should be reported for the current visit, rather than including the code for the acute phase of the illness. This is because the acute phase of the illness is typically considered resolved when the focus shifts to treating the effects or residuals of that illness, which are classified as sequelae. The intention of coding guidelines is to ensure that the coding accurately represents the patient's current condition and avoids duplication of codes that may misrepresent the current state of health. Therefore, including the code for the acute phase when only the sequela is being treated is not required and may lead to inaccuracies in documentation and data reporting. The guideline's focus is on the sequela, which is what primarily impacts the current health status of the patient. This approach helps maintain clarity and accuracy in medical coding, billing, and reporting.*

**10. When bilateral glaucoma is documented with different types and no laterality distinction, how is the encounter coded?**

- A. Assign a single code for bilateral glaucoma
- B. Assign one code for each type of glaucoma**
- C. Use the unspecified code
- D. Code only for the least severe type

*When bilateral glaucoma is documented with different types, it is crucial to assign one code for each type of glaucoma to accurately reflect the patient's clinical condition. This coding approach helps to ensure that the different types of glaucoma are specifically captured in the patient's medical records, which is vital for treatment planning and ongoing care. Using separate codes allows healthcare providers to understand the varying severity and characteristics of each type, which is essential for appropriate management. For instance, one type of glaucoma may require a different therapeutic approach compared to another. Proper documentation with specific codes ensures that all aspects of the patient's glaucoma are appropriately tracked and treated. In contrast, a single code for bilateral glaucoma would not provide the granularity needed to convey the complexities of having multiple types. Similarly, using an unspecified code could lead to a loss of important clinical detail, potentially impacting treatment decisions and care continuity. Coding only for the least severe type would fail to provide a complete picture of the patient's condition. Therefore, assigning one code for each type of glaucoma is the most accurate and comprehensive way to document the encounter.*

## 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](mailto:hello@examzify.com).

Or visit your dedicated course page for more study tools and resources:

<https://cpcguidelines.examzify.com>

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

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