

# Current Procedural Terminology (CPT) HCPCS Level I Coding 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

- 1. What are the risks associated with improper code selection?**
  - A. Increased patient satisfaction rates**
  - B. Claim denials, overbilling, or underbilling, leading to financial losses or legal issues**
  - C. Higher reimbursement rates**
  - D. Enhanced compliance with healthcare regulations**
- 2. Who first developed the CPT coding system?**
  - A. CDC**
  - B. AMA**
  - C. CMS**
  - D. NCHS**
- 3. A code that includes all of the words in the code that follows is classified as what type?**
  - A. Developed**
  - B. Isolated**
  - C. Stand-alone**
  - D. Complete**
- 4. In the context of the CPT manual, what does "synonyms" refer to in the CPT Index?**
  - A. Alternative names for procedures**
  - B. Inaccurate terms**
  - C. Terms used in different languages**
  - D. Historical terms for procedures**
- 5. Which section primarily involves coding for surgical procedures?**
  - A. Evaluation and Management section**
  - B. Surgery section**
  - C. Anesthesia section**
  - D. Pathology and Laboratory section**

- 6. Which of the following modifiers would likely indicate a service was provided by a different provider than usual?**
- A. Modifier 59**
  - B. Modifier 25**
  - C. Modifier 24**
  - D. Modifier 76**
- 7. Where can the lists of unlisted procedures for each section in the CPT manual be found?**
- A. The guidelines of each section**
  - B. Appendix A**
  - C. The introduction section**
  - D. The index**
- 8. What ranges do E0001-E9999 signify in HCPCS Level II?**
- A. Imaging services**
  - B. Durable medical equipment, prosthetics, orthotics, and supplies**
  - C. Laboratory services**
  - D. Preventive care services**
- 9. What kinds of services require the use of HCPCS Level II codes?**
- A. Surgeries performed by surgeons**
  - B. Non-physician services such as ambulance services and prosthetic devices**
  - C. Laboratory tests performed in hospitals**
  - D. Physician consulting services**
- 10. What is the primary purpose of the CPT code set?**
- A. To classify educational programs for healthcare providers**
  - B. To standardize medical billing and reporting for procedures**
  - C. To provide guidance on healthcare legislation**
  - D. To create public health awareness**

## **Answers**

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

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## **Explanations**

**1. What are the risks associated with improper code selection?**

- A. Increased patient satisfaction rates**
- B. Claim denials, overbilling, or underbilling, leading to financial losses or legal issues**
- C. Higher reimbursement rates**
- D. Enhanced compliance with healthcare regulations**

The identified answer emphasizes the potential financial and legal repercussions that can arise from selecting the wrong codes for medical billing and coding. When codes are improperly selected, it can lead to claim denials where insurance payers refuse to process the claims due to inaccuracies, resulting in delays in payment. Additionally, improper coding can result in overbilling, where a provider charges for more services than were actually rendered, or underbilling, where services provided are not accurately reflected, leading to lost revenue. These issues can escalate to involve audits by insurance companies, which may further scrutinize the coding accuracy. In severe cases, persistent inaccuracies can attract legal action or regulatory scrutiny, resulting in penalties or fines for fraudulent coding practices. Thus, the financial implications of incorrect code selection are significant, impacting not just the practice's income but also its reputation and compliance with healthcare regulations. The other answer choices do not accurately capture the direct and detrimental effects of improper coding. Increased patient satisfaction rates, higher reimbursement rates, and enhanced compliance with healthcare regulations generally result from accurate coding practices rather than from the consequences of improper code selection.

**2. Who first developed the CPT coding system?**

- A. CDC**
- B. AMA**
- C. CMS**
- D. NCHS**

The CPT coding system was first developed by the American Medical Association (AMA) in 1966. This system was established to provide a uniform language that accurately describes medical, surgical, and diagnostic services. The primary goal was to ensure that healthcare providers and insurers could communicate effectively regarding the services provided to patients. The AMA's involvement in creating this coding system reflects its commitment to enhancing the practice of medicine through a standardized approach to documenting and billing for healthcare services, which is vital for reimbursement processes. This has allowed for greater transparency and consistency in coding practices across different healthcare settings. The other organizations listed—CDC (Centers for Disease Control and Prevention), CMS (Centers for Medicare & Medicaid Services), and NCHS (National Center for Health Statistics)—play important roles in public health, healthcare policy, and statistics but were not involved in the development of the CPT coding system.

**3. A code that includes all of the words in the code that follows is classified as what type?**

- A. Developed**
- B. Isolated**
- C. Stand-alone**
- D. Complete**

A code that encompasses all the words in the subsequent code is classified as a stand-alone code. Stand-alone codes are complete descriptors that provide all necessary information for the specific procedure, service, or diagnosis they represent. This type of code does not require additional modifiers or codes to convey its full meaning. It is essential for accurate billing, documentation, and understanding of the medical services rendered. Stand-alone codes are designed to be used individually without needing to rely on other codes for context or clarification, ensuring that medical professionals can quickly identify the service provided without ambiguity. In contrast, other classifications may refer to codes that either require additional context to fully explain them or represent a fragment of the information needed to describe a service or diagnosis. This comprehensive nature of stand-alone codes makes them crucial in the coding system, allowing for clear communication in healthcare settings.

**4. In the context of the CPT manual, what does "synonyms" refer to in the CPT Index?**

- A. Alternative names for procedures**
- B. Inaccurate terms**
- C. Terms used in different languages**
- D. Historical terms for procedures**

The term "synonyms" in the CPT Index refers to alternative names for procedures. This allows coders and healthcare professionals to locate codes for specific services or procedures efficiently by using different terms that might be used in clinical settings. For instance, a procedure may have a widely recognized name and one or more alternative names that are used interchangeably in practice. By including synonyms, the CPT manual enhances usability and helps ensure that coders can find the appropriate codes even if they are familiar with a different terminology. This is essential for accurate coding and billing, as using the correct code is crucial for proper reimbursement and documentation in healthcare settings.

**5. Which section primarily involves coding for surgical procedures?**

- A. Evaluation and Management section**
- B. Surgery section**
- C. Anesthesia section**
- D. Pathology and Laboratory section**

The Surgery section is specifically dedicated to coding surgical procedures. This section includes a wide range of codes that cover various types of surgeries performed across different medical specialties. It organizes procedures based on the body system involved and the complexity of the intervention, allowing healthcare providers to accurately report these services. In contrast, the Evaluation and Management section focuses on the assessment and management of patient care, which includes office visits, consultations, and other non-surgical services. The Anesthesia section deals with the provision and management of anesthesia for surgical or other procedures, but it does not cover the surgical procedures themselves. Lastly, the Pathology and Laboratory section encompasses tests and examinations of tissues and body fluids, which are vital for diagnosis but do not involve coding actual surgical interventions. Thus, the focus of the correct answer emphasizes its exclusive categorization of surgical procedures, making it the accurate choice in this context.

**6. Which of the following modifiers would likely indicate a service was provided by a different provider than usual?**

- A. Modifier 59**
- B. Modifier 25**
- C. Modifier 24**
- D. Modifier 76**

The modifier that indicates a service was provided by a different provider than usual is Modifier 24. This modifier is specifically used to signify that a service provided is a significant and separately identifiable evaluation and management service by the same physician or other qualified health care professional during the postoperative period. However, most importantly, it also reflects a scenario where the provider performing the service is different from the one who performed the initial procedure, thus highlighting a nuanced context regarding the provider involved in the care. In contrast, the other modifiers have distinct uses that do not pertain to indicating a different provider. For example, Modifier 59 indicates a distinct procedural service, Modifier 25 is used to denote a significant, separately identifiable E/M service performed on the same day of a procedure, and Modifier 76 signifies a repeat procedure by the same physician on the same day. These modifiers are aimed at clarifying the circumstances of a procedure rather than identifying a different provider, making Modifier 24 the most appropriate choice in this context.

**7. Where can the lists of unlisted procedures for each section in the CPT manual be found?**

**A. The guidelines of each section**

**B. Appendix A**

**C. The introduction section**

**D. The index**

The lists of unlisted procedures for each section in the CPT manual can indeed be found in the guidelines of each section. These guidelines are specifically designed to provide additional context and detail regarding the procedures and services coded within that section. Unlisted procedure codes are essential for reporting services that do not have a specific CPT code and are outlined in the guidelines to ensure proper coding practices. By referring to the section guidelines, coders can identify and understand when to use these unlisted codes appropriately based on the nature of the service provided. While other parts of the CPT manual, such as the appendix or the index, serve important roles for various other references, they do not contain the specific lists of unlisted procedures designated for each section. The introduction section generally covers foundational information about the CPT manual itself and does not delve into specific coding details. Thus, the guidelines are the most appropriate location for coders to locate unlisted procedures pertinent to their coding work.

**8. What ranges do E0001-E9999 signify in HCPCS Level II?**

**A. Imaging services**

**B. Durable medical equipment, prosthetics, orthotics, and supplies**

**C. Laboratory services**

**D. Preventive care services**

The correct choice reflects that the range E0001-E9999 in the HCPCS Level II coding system is designated for durable medical equipment (DME), prosthetics, orthotics, and supplies. This classification specifically includes items that are designed for extended use, typically aiding patients in their recovery or enhancing their quality of life. Durable medical equipment encompasses devices such as wheelchairs, oxygen tanks, and hospital beds, which are essential for home care or outpatient treatment. Prosthetics refers to artificial devices that replace missing limbs or body parts, while orthotics involves support devices that assist with functional mobility and alignment. Additionally, supplies related to these areas, such as diabetic testing strips or bandages, also fall under this range. The other answer choices do not correctly categorize this range. Imaging services, laboratory services, and preventive care services are classified under different codes in the HCPCS system and do not include the specific range E0001-E9999, which focuses on equipment and supplies that are necessary for the management of a patient's health condition outside of surgical or acute care settings.

**9. What kinds of services require the use of HCPCS Level II codes?**

- A. Surgeries performed by surgeons**
- B. Non-physician services such as ambulance services and prosthetic devices**
- C. Laboratory tests performed in hospitals**
- D. Physician consulting services**

The use of HCPCS Level II codes is specifically designed to classify non-physician services and supplies, which encompasses a broad range of items not captured by the CPT system. This includes services such as ambulance transportation, durable medical equipment, prosthetic devices, orthopedic braces, and certain medications administered outside of physician offices. Each of these services represents complexities and needs unique identifiers for billing and insurance purposes. In contrast, surgeries performed by surgeons, laboratory tests conducted in hospitals, and physician consulting services fall under the categories typically represented by CPT codes. These focus more on physician-provided services and procedures. Therefore, recognizing that HCPCS Level II is centered on non-physician services helps clarify why option B is the most appropriate choice in this context.

**10. What is the primary purpose of the CPT code set?**

- A. To classify educational programs for healthcare providers**
- B. To standardize medical billing and reporting for procedures**
- C. To provide guidance on healthcare legislation**
- D. To create public health awareness**

The primary purpose of the CPT code set is to standardize medical billing and reporting for procedures. This coding system, maintained by the American Medical Association (AMA), provides a uniform language for describing medical, surgical, and diagnostic services. By using CPT codes, healthcare providers can accurately document and bill for procedures performed, ensuring consistency and clarity in communication among healthcare professionals, payers, and patients. Standardization through CPT coding allows for efficient processing of claims and aids in clinical data collection and research. It supports the healthcare system in tracking outcomes, managing healthcare costs, and improving the quality of care. Thus, the CPT code set plays an essential role in the healthcare industry by facilitating accurate billing practices and ensuring that procedures are recognized uniformly across different settings and specialties.

## 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://cpthcpcslvl1coding.examzify.com>**

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