

2026 Realistic CPC Authentic Exam Questions Help You Pass CPC Easily

CPC Exam Outline

Content Domains	Questions
1. 10,000 Series CPT	6
2. 20,000 Series CPT	6
3. 30,000 Series CPT	6
4. 40,000 Series CPT	6
5. 50,000 Series CPT	6
6. 60,000 Series CPT	6
7. Evaluation and Management	6
8. Anesthesia	4
9. Radiology	6
10. Laboratory/Pathology	6
11. Medicine	6
12. Medical Terminology	4
13. Anatomy	4
14. ICD-10-CM/Diagnosis	5
15. HCPCS Level II	3
16. Coding Guidelines	7
17. Compliance and Regulatory	3
18. Cases	10

Time limit: 4 hours

Total questions: 100

Question format: Multiple-choice

Delivery format: Computer-delivered

Mometrix TEST PREPARATION

PracticeMaterial designed this prep material to help you pass the exam on the first try. It may sound complicated, but once you go through regular study and intensive practice, passing the final exam would be a piece of cake. The cost of Certified Professional Coder (CPC) Exam (CPC) certification itself is expensive, ranging from \$100 to \$1000, so you can't risk wasting that amount. PracticeMaterial ensures that this does not happen by providing you with reliable and updated preparation material.

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AAPC CPC Exam Syllabus Topics:

Topic	Details
Topic 1	<ul style="list-style-type: none"> Introduction to CPT®, HCPCS Level II, and Modifiers: This section of the exam measures the skills of coding specialists and introduces candidates to CPT® coding for procedures, HCPCS Level II for supplies and services, and the correct use of modifiers. It helps learners distinguish between different code sets and understand their place in medical billing.
Topic 2	<ul style="list-style-type: none"> The Business of Medicine: This section of the exam measures the skills of medical coders and covers foundational knowledge regarding the healthcare system, reimbursement models, insurance payers, HIPAA compliance, and the ethical responsibilities coders hold within clinical and billing environments. It establishes the context in which coding decisions directly affect healthcare operations and financial outcomes.
Topic 3	<ul style="list-style-type: none"> Hemic & Lymphatic Systems, Mediastinum, Diaphragm: This section of the exam measures the skills of medical coders and includes procedures related to the spleen, lymph nodes, bone marrow, as well as surgical interventions in the mediastinum and diaphragm. Coders must differentiate procedures by region and system accurately.
Topic 4	<ul style="list-style-type: none"> Review of Anatomy: This section of the exam measures the skills of coding specialists and covers a high-level understanding of human anatomy. It includes organs, systems, directional terminology, and anatomical locations, enabling coders to link procedures and diagnoses to the correct bodily structures with accuracy and consistency.
Topic 5	<ul style="list-style-type: none"> Urinary System and Male Genital System: This section of the exam measures the skills of medical coders and assesses understanding of procedures on kidneys, bladder, ureters, prostate, and male reproductive organs. Proper use of CPT codes for surgical and diagnostic interventions is tested.
Topic 6	<ul style="list-style-type: none"> Integumentary System: This section of the exam measures the skills of medical coders and covers procedures related to the skin and related structures. Topics include excisions, biopsies, repairs, and destruction services, focusing on accurate code selection and modifier usage for integumentary interventions.
Topic 7	<ul style="list-style-type: none"> Pathology & Laboratory: This section of the exam measures the skills of medical coders and includes lab tests, specimen analysis, and pathological examination procedures. It ensures that coders understand how to apply codes for chemistry panels, cultures, and histopathological diagnostics.

Topic 8	<ul style="list-style-type: none"> • Radiology: This section of the exam measures the skills of coding specialists and focuses on diagnostic imaging procedures including X-rays, CT scans, MRIs, ultrasounds, and nuclear medicine. It emphasizes proper selection of codes based on anatomical site and modality used.
Topic 9	<ul style="list-style-type: none"> • Musculoskeletal System: This section of the exam measures the skills of coding specialists and focuses on coding procedures involving bones, joints, muscles, and tendons. It covers surgeries, reductions, arthroscopies, and fracture treatments, emphasizing accurate mapping of procedures to anatomical areas.
Topic 10	<ul style="list-style-type: none"> • Cardiovascular System: This section of the exam measures the skills of coding specialists and addresses services related to the heart, arteries, and veins. It involves the coding of diagnostic and therapeutic procedures, including catheterizations, bypasses, and repairs.:
Topic 11	<ul style="list-style-type: none"> • Evaluation & Management Services: This section of the exam measures the skills of coding specialists and covers office visits, hospital care, consultations, and other E • M services. It tests the understanding of time-based coding, medical decision-making, and history • exam components per current CMS guidelines.
Topic 12	<ul style="list-style-type: none"> • Special Senses (Ocular and Auditory): This section of the exam measures the skills of coding specialists and covers the coding of procedures related to the eyes and ears. Topics include surgeries on the cornea, retina, and middle • inner ear, as well as related diagnostic procedures.

AAPC Certified Professional Coder (CPC) Exam Sample Questions (Q109-Q114):

NEW QUESTION # 109

What modifier is appended to indicate when a procedure performed during the postoperative period is unrelated to the original surgery?

- A. 0
- B. 1
- C. 2
- D. 3

Answer: A

Explanation:

Modifier -79 is used to indicate an unrelated procedure or service performed by the same physician during the postoperative (global) period.

-57 = decision for surgery

-25 = significant, separately identifiable E/M

-55 = postoperative management only

Modifier usage is a high-yield CPC exam topic.

NEW QUESTION # 110

The documentation states:

He was then sterilely prepped and draped along the flank and abdomen in the usual sterile fashion. I first made a skin incision off the tip of the twelfth rib, extending medially along the banger's lines of the skin. This was approximately 3.5 cm in length. Once this incision was carried sharply, electrocautery was used to gain access through the external oblique, internal oblique, and transverse abdominis musculature and fascia.

What surgical approach was used for this procedure?

- A. Laparoscopic
- B. Cannot determine based on the documentation
- C. Percutaneous
- D. Open

Answer: D

Explanation:

The documentation describes making a skin incision off the tip of the twelfth rib and extending medially along the banger's lines of the skin. The use of electrocautery to gain access through multiple layers of musculature and fascia indicates an open surgical approach. Open surgery involves making a large incision to expose and directly view the surgical site. This is distinct from percutaneous (which involves needles or catheters), laparoscopic (which uses small incisions and a camera), and other minimally invasive techniques.

References:

AMA's CPT Professional Edition, ICD-10-CM, and HCPCS Level II (current year)

NEW QUESTION # 111

A patient has chronic cholesteatoma in the right middle ear. The otolaryngologist performed a tympanoplasty with a radical mastoidectomy, removing the middle ear cholesteatoma. Grafting technique was used to repair the eardrum without ossicular chain reconstruction.

What CPT code is reported for this surgery?

- A. 0
- B. 1
- **C. 2**
- D. 3

Answer: C

Explanation:

The procedure involves a tympanoplasty with a radical mastoidectomy and removal of a cholesteatoma from the middle ear, including grafting of the eardrum without ossicular chain reconstruction.

* Procedure Description:

* Tympanoplasty.

* Radical mastoidectomy.

* Removal of cholesteatoma from the middle ear.

* Grafting technique used to repair the eardrum without ossicular chain reconstruction.

* CPT Coding:

* 69645: Tympanoplasty with mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), radical or complete, with removal of cholesteatoma; with mastoid obliteration.

References:

* AMA's CPT Professional Edition (current year).

* CPT Assistant for detailed coding guidelines on otolaryngology procedures.

NEW QUESTION # 112

A 44-year-old female patient with chest pains had a CT of her chest that identified a mass in her left lower lung. The patient currently has ovarian cancer with metastases to the liver. The radiologist suspects the cancer has spread to her lungs. The physician performed an outpatient bronchoscopic biopsy and the pathology report documents the mass as a tumor of uncertain behavior.

What ICD-10-CM codes are reported for this patient?

- A. R91.8, C56.9, C78.7
- B. C78.02, C22.9, C79.82
- C. C56.9, C78.7, C78.02
- **D. D38.1, C56.9, C78.7**

Answer: D

Explanation:

For a patient with a mass in the left lower lung suspected to be cancer that is currently documented as a tumor of uncertain behavior, with existing ovarian cancer with metastases to the liver, the ICD-10-CM codes are:

* D38.1: Neoplasm of uncertain behavior of bronchus and lung.

* C56.9: Malignant neoplasm of unspecified ovary.

* C78.7: Secondary malignant neoplasm of liver and intrahepatic bile duct.

D38.1 is used because the behavior of the lung tumor is uncertain, and C56.9 and C78.7 are used to document the known primary and metastatic cancers.

References:

- * ICD-10-CM guidelines
- * AMA's CPT Professional Edition (current year)

NEW QUESTION # 113

A patient is seen at the doctor's office for nausea, vomiting, and sharp right lower abdominal pain. CT scan of the abdomen is ordered. Labs come back indicating an increased WBC count with review of the abdominal CT scan. The physician determines the patient has a ruptured appendicitis. The physician schedules an appendectomy and takes the patient to the operating room. The appendix is severed from the intestines and removed via scope inserted through an umbilical incision. What CPT and diagnosis codes are reported?

- A. 44960. K35.80. R11.2.R10.31
- B. 44950. K35.890
- C. 44970, K35.32
- D. 44970, K35.32.R11.2.R10.31

Answer: C

Explanation:

Procedure Coding:

44970 - Laparoscopic appendectomy

Appendix removed via scope through umbilical incision, confirming laparoscopic approach Diagnosis Coding:

K35.32 - Acute appendicitis with perforation and localized peritonitis, without abscess Documentation supports ruptured (perforated) appendicitis No abscess documented Why Other Options Are Incorrect:

B - Signs/symptoms (R11.2, R10.31) not coded once definitive diagnosis is established C - 44960 = open appendectomy (not performed) D - 44950 = open appendectomy, diagnosis code incorrect ICD-10-CM Guideline Reference:

Do not code symptoms when a definitive diagnosis is confirmed.

NEW QUESTION # 114

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