Pass Guaranteed Quiz 2026 Fantastic Medical Tests AAPC-CPC: Real American Academy of Professional Coders: Certified Professional Coder Exam Answers

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AAPC CPC FINAL EXAM PREPARATION STUDY GUIDE 2026 – COMPLETE CONCEPT REVIEW & PRACTICE MATERIALS (LATEST EDITION)

100 Essential Q&A with Concept Explanations ✅ ✅

Section 1: ICD-10-CM Coding Guidelines & Conventions

1. Q: What is the primary purpose of the ICD-10-CM codebook?
A: ✅ To provide a standardized system for classifying diagnoses, reasons for encounters, and causes of injury or disease for morbidity coding and statistical reporting.

2. Q: What does the "Excludes1" note indicate?
A: ✅ It means the two conditions cannot be coded together. They are mutually exclusive.

3. Q: What is the difference between "Excludes1" and "Excludes2"?
A: ✅ "Excludes1" means "not coded here," the conditions cannot coexist. "Excludes2" means "not included here," but the conditions *can* be coded together if both are present.

4. Q: When is the 7th character required in ICD-10-CM?
A: ✅ For codes in certain chapters (like Injury, Poisoning, and External Causes - Chapters 19 & 20) to provide information about the encounter (initial, subsequent, sequela).

5. Q: What is a placeholder, and how is it represented?
A: ✅ The letter "X" is used as a placeholder to allow for future expansion and to meet the required character length for a code (e.g., T36.0X1A).

6. Q: What is the rule for coding "uncertain" diagnoses in the outpatient setting?
A: ✅ Do **not** code diagnoses documented as "probable," "suspected," "questionable," or "rule out." Code only the confirmed diagnoses or the signs/symptoms.

7. Q: What is the purpose of the Table of Drugs and Chemicals?
A: ✅ To identify codes for poisoning, adverse effects, and underdosing related to specific drugs, chemicals, and biological substances.

8. Q: How do you code a documented "history of" a condition?
A: ✅ Use a Z code from category Z85-Z87 (Personal history of malignant neoplasm, other diseases) unless the history has a current implication for care.

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Medical Tests American Academy of Professional Coders: Certified Professional Coder Sample Questions (Q47-Q52):

NEW QUESTION # 47
What is the difference between presumptive and definitive testing?

- A. Presumptive testing assumes a diagnosis; definitive testing confirms a diagnosis.
- B. Presumptive testing confirms the presence of a drug class; definitive testing identifies thequantity or presence of a drug.
- C. Presumptive testing is based on exhibited signs and/or symptoms; definitive testing isbased on lab results.
- D. Presumptive testing requires additional observation time; definitive testing requires ablood draw.

Answer: B

Explanation:
A presumptive test reports whether the patient is positive or negative for a specific drug. A definitive test would analyze which specific agent and/or how much of that agent is in the patients' system.

NEW QUESTION # 48
The relative value units of a procedure are based on how much effort is involved, expenses that the practice will incur, and the level of risk associated with it.

- A. True
- B. False

Answer: A

Explanation:
The statement is true. An insurance carrier will use these three measures to determine what the RVU of a procedure should be. Then, based on that, a medical coder can determine what the expected payment should be. Generally, the higher the RVU of a procedure is, the higher the payment will be.

NEW QUESTION # 49
A patient is seen with complaints of recurring infections in the foreskin. The physician recommends circumcision to help improve penile hygiene. The patient agrees, a local anesthetic is injected into the penis, and the procedure is completed by clamping the foreskin and trimming the excess skin. How should the physician report the encounter?

- A. 54150, 64450, Z41.2, Z87.2
- B. 54150-52, 64450, N48.89
- C. 54150-52, Z41.2, Z87.2
- D. 54150, N48.29

Answer: D

Explanation:
A circumcision procedure includes a local anesthetic, also known as a ring block. Therefore, an additional anesthesia code (CPT 64450) should not be reported as a secondary code, nor should modifier 52 be appended on the primary procedure. The code notes for ICD-IO-CM code Z41.2 specifically state that this diagnosis should be used only when the procedure is elective and not related to a specific diagnosis. In this case, because the procedure is related to a recurring condition the patient is experiencing. the

infection should be the primary diagnosis. The diagnosis crosswalk would be "infection" followed by "penis," which directs the coder to N48.29.

NEW QUESTION # 50
If a provider documents in an assessment that a patient is obese, but the BMI extracted from the chart is consistent with morbid obesity, what should be reported on the claim?

- A. Morbid obesity
- B. Obesity and the appropriate BMI
- C. Obesity
- D. Morbid obesity and the appropriate BMI

Answer: B

Explanation:
The diagnosis is always based on the provider's documentation, which in this case would be obesity. Coding guidelines also state that if there is a reportable diagnosis related to weight, "the BMI can be assigned from documentation of someone other than the patient's provider, such as nursing notes."

NEW QUESTION # 51
A young man is triaged in the emergency room after sustaining multiple injuries in a car accident. The physician performs the following limited exams with image documentation: an abdominal and retroperitoneal ultrasound, a transthoracic echocardiography, and a chest ultrasound. He indicates in his report that all findings are normal. What charges should the provider submit to the insurance company?

- A. 93304-TC, 76700-TC, 76770-TC, 76604-TC
- B. 93308-26, 76705-26, 76775-26, 76604-26
- C. 93304-26, 76705-26, 76775-26, 76604-26
- D. 93308, 76705-59, 76770-59, 76604-59

Answer: B

Explanation:
CPT code 93304 describes an echocardiography used to evaluate a congenital defect. In this case, the provider is screening for any trauma-related injuries to the heart. Bearing in mind that the study is limited leads you to CPT 93308. Modifier 26 is used on all CPT codes because the procedures are being performed in a hospital setting. Therefore, only the professional component of the service should be billed. Modifier TC is reported by the entity providing the equipment, which in this case would be the hospital. Modifier 59 is not necessary because the procedures are routinely done in conjunction with each other.

NEW QUESTION # 52
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