YOUR FREE READER'S COMPANION

The CPC Rapid-Review Pack (2026 Edition)

A companion to The Certified Professional Coder CPC Exam Study Guide · by Patricia Vaughn

Thanks for picking up the study guide and the practice workbook. This companion is the part you carry with you: fold it into your notebook, keep it on your phone, or read it in the parking lot before you walk in to test. It pulls the highest-yield terminology, the anatomy you need to place a procedure, the way the CPT manual is organized and how to fly through it open book, the E/M leveling logic, the big modifier concepts, the ICD-10-CM conventions that trip up beginners, the 17 knowledge areas with their rough emphasis, and fifty rapid-fire questions into a few pages you can drill in an afternoon. Everything here matches the book and the current AAPC CPC content outline, so nothing here contradicts what you studied.

Most people who struggle with the CPC do not fail because coding is impossible. They fail because they tried to memorize a code book instead of learning to navigate one. The exam is open book. You bring your printed CPT, ICD-10-CM, and HCPCS Level II manuals into the room. So the game is not recall, it is knowing how to read a scenario, find the right section, use the index and then verify in the tabular, read the guidelines that live at the front of each section, pick the right modifier, and pace yourself through 100 questions in four hours. Learn the terminology roots so unfamiliar words stop scaring you, learn the section structure and the conventions cold, tab your books so you can flip fast, and practice looking things up under a clock. Do that and you have already beaten most of what sinks people. Carry this, drill it, and walk in calm. - Patricia

High-Yield Medical Terminology

You do not have to memorize ten thousand words. You have to learn the building blocks. Almost every medical term is a root plus a prefix or a suffix, and once you can take a word apart, you can decode one you have never seen. Read the root for the body part or system, the prefix for position or number or direction, and the suffix for the condition or procedure. That skill alone answers a surprising number of anatomy and terminology questions and speeds up every lookup you do in the CPT and ICD-10-CM books.

Common word roots (body parts and systems)

Root	Meaning
cardi/o	heart
angi/o, vas/o	vessel
hem/o, hemat/o	blood
pneum/o, pulmon/o	lung
bronch/o	bronchus (airway)
nephr/o, ren/o	kidney
hepat/o	liver
gastr/o	stomach
enter/o	small intestine
col/o, colon/o	colon
oste/o	bone
arthr/o	joint
my/o	muscle
neur/o	nerve
cerebr/o, encephal/o	brain
derm/o, dermat/o	skin
cyt/o	cell
carcin/o	cancer
aden/o	gland
hyster/o, metr/o	uterus
oophor/o	ovary
cyst/o	bladder or sac

Common prefixes (position, number, direction)

Prefix	Meaning
a-, an-	without, absence of
hyper-	above, excessive
hypo-	below, deficient
tachy-	fast
brady-	slow
dys-	painful, difficult, abnormal
endo-	within
peri-	around
epi-	upon, above
sub-	under, below
intra-	within
inter-	between
pre-	before
post-	after
poly-	many
bi-	two
hemi-	half
neo-	new
anti-	against

Common suffixes (conditions and procedures)

Suffix	Meaning
-itis	inflammation
-oma	tumor, mass
-megaly	enlargement
-algia, -dynia	pain
-ectomy	surgical removal
-otomy	cutting into, incision
-ostomy	creating an opening
-plasty	surgical repair
-pexy	surgical fixation
-rrhaphy	suture, repair

-desis	fusion, binding
-centesis	surgical puncture to withdraw fluid
-scopy	visual examination with a scope
-gram	record or image
-graphy	process of recording
-plegia	paralysis
-sclerosis	hardening
-stenosis	narrowing
-penia	deficiency, too few

Decode it, do not memorize it

- gastritis = gastr/o (stomach) + itis (inflammation) = inflammation of the stomach
- nephrectomy = nephr/o (kidney) + ectomy (removal) = removal of a kidney
- arthroplasty = arthr/o (joint) + plasty (repair) = surgical repair of a joint
- colonoscopy = colon/o (colon) + scopy (viewing with a scope) = scope exam of the colon
- tenorrhaphy = ten/o (tendon) + rrhaphy (suture) = suturing of a tendon

Suffixes matter for procedure coding: -ectomy, -otomy, -ostomy, -plasty, -pexy, -rrhaphy, -desis, and -scopy each point you at a different root operation idea and therefore a different area of the CPT surgery section. Read the suffix first when you are trying to figure out where a procedure lives.

Anatomy By Body System (place the procedure)

The CPT surgery section is organized by body system, in roughly head-to-toe order. If you can name the body system from the scenario, you already know which tabbed section to open. Do not chase the exact code from memory; chase the correct section first, then let the index and tabular finish the job.

Body system	What lives there	Landmarks to recognize
Integumentary	skin, subcutaneous tissue, nails, breast	lesions, wounds, repairs, grafts, biopsies
Musculoskeletal	bones, joints, muscles, tendons, ligaments	fractures, casting, arthroscopy, fusions
Respiratory	nose, sinuses, larynx, trachea, lungs, pleura	scopes of the airway, biopsies, thoracentesis
Cardiovascular	heart, arteries, veins, pacemakers	catheterizations, stents, bypass, access
Digestive	mouth to anus, plus liver, pancreas, biliary	scopes, resections, hernia repairs
Urinary	kidney, ureter, bladder, urethra	scopes, stone removal, drainage
Male and female genital	reproductive organs, maternity care	deliveries, biopsies, laparoscopic repairs
Endocrine	thyroid, parathyroid, adrenal	gland excisions
Nervous	skull, brain, spine, peripheral nerves	injections, decompressions, shunts
Eye and ocular adnexa	eyeball, orbit, eyelids	cataract, retinal, corneal work
Auditory	external, middle, inner ear	tube placement, mastoid work

Memory hook: surgery runs top to bottom, skin first, ears last. When you cannot place a procedure, decode the terminology (root gives the organ, suffix gives the action), name the body system, and you are already in the right tab.

How CPT Is Organized and How To Navigate It Open Book

This is the killer skill of the whole exam. The CPT manual is not something you memorize; it is something you drive. Learn the layout and the lookup method and you will out-score people who studied twice as long but never practiced flipping pages under a clock.

The three CPT categories

- Category I codes are the main five-digit procedure and service codes, grouped into six sections: Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine.
- Category II codes are optional four-digit tracking codes ending in the letter F, used for performance measurement. They are never a substitute for a Category I code.
- Category III codes are temporary codes ending in the letter T for emerging technology. If a Category III code exists for the service, you use it instead of an unlisted Category I code.

The index-then-tabular method (never skip a step)

1. Start in the alphabetic index at the back of the CPT book. Look up the main term first. Main terms are usually the procedure, the organ, the condition, or an eponym or abbreviation.
2. The index gives you a single code or a small range of candidate codes. The index never gives you your final answer. Write down the candidates.
3. Turn to those candidates in the tabular (the numeric body of the book) and read every one in context.
4. Read the guidelines at the front of that section and any notes or parenthetical instructions printed near the code. These tell you what is included, what is separate, and which modifier situations apply.
5. Pick the code whose full descriptor matches the documentation, then check whether a modifier is needed. Only then commit.

Read the punctuation and the guidelines

- A semicolon in a code descriptor means the words before the semicolon are the common parent, and the indented codes below share that common part. Read the parent plus the indented add-on together to get the full meaning.
- A code marked as an add-on code (commonly flagged with a plus symbol) is never reported alone; it is always reported in addition to a primary procedure, and it is not subject to the multiple-procedure reduction.
- A symbol meaning "modifier 51 exempt" tells you not to append the multiple-procedure modifier to that code.
- Section guidelines and subsection notes are printed instructions with the force of rules. The single most common reason a well-prepared coder misses a surgery question is skipping the guideline note that sits right above the code range.

The surgical package

Bundled into a surgical code is the typical package: the operation itself, local anesthesia, and normal follow-up care during the global period. Do not code separately for what is already included in the package. When something falls outside the package, that is usually where a modifier earns its keep.

Evaluation and Management (E/M) Leveling Concept

E/M is its own section and a heavily tested one, because almost every specialty uses it. You do not need to recall specific code numbers; you need the leveling logic.

- First identify the category and setting: new versus established patient, office or other outpatient, hospital inpatient or observation, emergency department, consultations, and so on. The setting narrows the code family before you ever think about a level.
- New patient means the patient has not received face-to-face professional services from that provider, or another provider of the same specialty in the same group, within the past three years. Established is anyone who has.
- For office and other outpatient services under current rules, the level is driven by either the medical decision making (MDM) or the total time on the date of the encounter. You pick whichever supports the higher level, as documented.
- Medical decision making has three elements: the number and complexity of problems addressed, the amount and complexity of data reviewed, and the risk of complications or morbidity. The overall MDM level is set by meeting two of these three elements at a given level (straightforward, low, moderate, or high).
- When coding by time, count the provider's total time on that date, both face-to-face and non-face-to-face, spent on that patient's care.
- History and exam are still performed and documented as medically appropriate, but for these office codes they no longer drive the level by themselves.

Memory hook for MDM: problems, data, risk - pick the level that two of the three reach. When a question hands you a moderate risk plus a moderate problem set, moderate is your floor even if the data is light.

The Big Modifier Concepts

Modifiers are two-character add-ons that change the meaning of a code without changing the code itself. The exam loves modifier logic because it tests whether you understand the coding rather than just the lookup. Learn the concepts below; the exact selection follows from the concept.

- A distinct procedural service concept: when a procedure that would normally be bundled is truly separate (different session, different site, different lesion, or otherwise independent), a modifier signals it is distinct so it is not denied as a bundling error.
- A significant, separately identifiable E/M concept: when a provider performs a significant E/M service on the same day as a procedure, a modifier tells the payer the visit stood on its own beyond the usual pre-procedure evaluation.
- Bilateral concept: when the same procedure is performed on both sides of a paired body part, a modifier communicates the bilateral nature rather than reporting the code twice without explanation.
- Multiple procedures concept: when several procedures are performed in the same session, a modifier flags the secondary ones so the payer applies the expected reduction. Add-on codes and "modifier 51 exempt" codes are excluded from this.
- Reduced or discontinued service concepts: separate modifiers exist for a service that was partially reduced by choice versus one that was started and then stopped, and for whether the stop happened before or after anesthesia. Read the scenario for how far the procedure got.
- Professional versus technical component: for services that have both a physician (interpretation) part and an equipment (technical) part, one modifier reports only the professional work and another reports only the technical portion.
- Staged or related procedure during the global period, unrelated procedure during the global period, and return to the operating room: distinct modifiers separate planned staged care, unrelated same-period care, and complications requiring a return trip.
- Anatomic site modifiers (such as right, left, and the specific finger, toe, eyelid, or coronary artery indicators) pin down exactly where the service happened, which prevents duplicate-denial and supports medical necessity.

Rule of thumb: decide first whether the base code already tells the whole story. If documentation shows something outside the normal package - a separate service, a second side, a stopped procedure, only the interpretation - that is your cue that a modifier concept applies.

ICD-10-CM Conventions Quick Reference

Diagnosis coding is fully testable and, unlike CPT descriptors, the ICD-10-CM conventions are public and fair game. Know these cold and read every note in the tabular before you assign a diagnosis code. All of these come straight from the ICD-10-CM Official Guidelines for Coding and Reporting.

Excludes1 versus Excludes2 (the classic trap)

- Excludes1 means NOT CODED HERE. The two codes can never be reported together because the conditions cannot occur at the same time (for example a congenital form versus an acquired form of the same condition).
- Excludes2 means NOT INCLUDED HERE. The excluded condition is not part of this code, but a patient can have both at the same time, so you may report both codes together when documented.
- Memory hook: Excludes ONE means only ONE of the two. Excludes TWO means you can code TWO.

NEC versus NOS

- NEC = Not Elsewhere Classifiable. It means "other specified." The record names a condition, but the code book has no more specific code, so you use the "other specified" code.
- NOS = Not Otherwise Specified. It is the equivalent of "unspecified." The documentation does not give you enough detail to pick a more specific code.

Placeholder X and the 7th character

- Some codes reserve empty character positions for future expansion. When a code needs a 7th character but is shorter than six characters, you fill the empty positions with the placeholder X so the 7th character lands in the 7th position.
- Certain categories require a 7th character that adds meaning, most famously the injury and fracture chapters (A = initial encounter, D = subsequent encounter, S = sequela).

The word "with", and sequencing notes

- The word "with" (or "in") in the alphabetic index or a code title means the two conditions are assumed to be related, read as "associated with" or "due to," even when the provider did not explicitly connect them.
- "Code first" appears at a manifestation and tells you to sequence the underlying cause first. "Use additional code" appears at the etiology and tells you to add the manifestation code second. Etiology first, manifestation second. A "code first" code can never be the principal or first-listed diagnosis.
- "See" in the index is a mandatory instruction to go to another main term. "See also" is a suggestion when the first entry does not fit.
- A combination code is a single code that captures two diagnoses, or a diagnosis with an associated complication. Assign it when it fully describes the condition.
- Laterality (right, left, bilateral) is built into many codes. Read for it, and always confirm the code in the

tabular. Never assign straight from the index.

HCPCS Level II Overview

HCPCS Level II is public domain and testable. It fills the gaps CPT does not cover.

- These are alphanumeric codes, one letter followed by four digits, grouped by the leading letter into ranges for things like durable medical equipment, drugs administered other than by mouth, supplies, ambulance and transport, orthotics and prosthetics, and certain services.
- Use HCPCS Level II for supplies, injectable and infused drugs, durable medical equipment, prosthetics, orthotics, and similar items that CPT does not describe.
- HCPCS Level II has its own set of modifiers, many of them anatomic (for example indicators for specific fingers, toes, eyelids, or coronary arteries) and many payer or benefit specific. When a question involves a supply, a drug, or equipment, reach for the HCPCS Level II book, not CPT.
- Look it up the same way: index by the item or drug name, then verify the descriptor and any use notes in the tabular listing.

The 17 Knowledge Areas and Where To Spend Your Time

The CPC exam is 100 multiple-choice questions in 4 hours, open book, and you pass at 70 percent. Questions are spread across 17 knowledge areas, but they are not equal in weight. Surgery, split across the body systems, is by far the largest block, and E/M is the next heaviest single service area. Spend your study time in proportion.

Knowledge area	Emphasis
Surgery (all body systems combined)	Largest block by far
Evaluation and Management (E/M)	Heavy, used by every specialty
Anatomy and Medical Terminology	High yield, speeds every lookup
ICD-10-CM	Heavy, conventions fully testable
Medicine section	Moderate
Radiology	Moderate, watch professional vs technical
Pathology and Laboratory	Moderate, watch panels and units
Anesthesia	Lighter, know the base and time concept
HCPCS Level II	Lighter but easy points
Modifiers (applied across sections)	Woven through many questions
Compliance and Regulatory	Lighter, memorize the rules
Practice Management	Lighter, memorize the terms

Rough plan: put the bulk of your hours into surgery navigation and E/M leveling, keep ICD-10-CM conventions and anatomy sharp because they feed everything else, and do quick memorization passes on anesthesia, HCPCS, compliance, and practice management for the easy points. Note that a CPC-A apprentice designation applies until you document two years of experience, and AAPC membership is required to hold the credential.

Compliance Basics

Compliance and regulatory questions are gift points if you memorize a handful of rules. Code what is documented, no more and no less.

- Medical necessity is the foundation. A service is billable only when the diagnosis supports the reason it was done. The ICD-10-CM code has to justify the CPT or HCPCS code.
- The National Correct Coding Initiative (NCCI) edits define which code pairs should not be reported together and prevent improper unbundling. A modifier may override an edit only when the documentation genuinely supports a distinct service.
- Upcoding (billing a higher-level code than the documentation supports) and unbundling (billing separately for parts that should be one code) are classic violations.
- The False Claims Act makes it illegal to knowingly submit false claims to a federal program, with treble (triple) damages plus per-claim penalties. The Anti-Kickback Statute bars paying or receiving anything of value to induce federally funded referrals.
- HIPAA protects patient information: the Privacy Rule covers protected health information (PHI), the Security Rule covers electronic PHI, and the minimum necessary standard says use or disclose only the least PHI needed for the task.
- If it is not documented, it cannot be coded. When documentation is unclear or contradictory, the coder queries the provider rather than assuming.

Fifty Rapid-Fire Practice Questions

Cover the answers, say each one out loud, then check the key. Do the whole set the night before and again the morning of. If you miss one, flag the area and reread that section. These are method and concept drills, not the graded exam, and none of them ask you to recall a CPT code number or descriptor - the real exam is open book for exactly that reason. Use these to find your soft spots.

1. What organization awards the CPC credential?
2. How many questions are on the CPC exam?
3. How much time do you get?
4. Is the CPC exam open book or closed book?
5. Which three manuals do you bring to the exam?
6. What is the passing percentage?
7. Which CPT section is the largest block of the exam?
8. What designation applies until you have two years of experience?
9. Which six sections make up CPT Category I codes?
10. What are Category II codes used for, and how do they end?
11. What do Category III codes represent, and how do they end?
12. What is the first step of the correct CPT lookup method?
13. Does the CPT index ever give you your final code?
14. Which part of the CPT book do you verify the code in?
15. What does a semicolon in a CPT descriptor separate?
16. Is an add-on code ever reported by itself?
17. Is an add-on code subject to the multiple-procedure reduction?
18. What is included in the standard surgical package?
19. For office E/M, which two factors can drive the level?
20. Within how many years of prior face-to-face service is a patient still "established"?
21. Name the three elements of medical decision making.
22. How many of the three MDM elements must be met to reach a level?
23. When coding E/M by time, whose time and which date do you count?
24. What does a modifier change?
25. Which modifier concept signals a truly separate, distinct procedure?
26. Which modifier concept reports a significant, separately identifiable E/M on a procedure day?
27. Which modifier concept reports the same procedure on both sides of a paired body part?
28. Which two components can a professional-versus-technical split report separately?
29. What does Excludes1 mean?
30. What does Excludes2 mean?
31. Can two codes with an Excludes1 note be reported together?
32. What does NEC stand for and mean?

33. What does NOS stand for and mean?
34. What is the placeholder character in ICD-10-CM?
35. In what position must the 7th character always appear?
36. What does a 7th character of "A" usually indicate?
37. What does a 7th character of "S" indicate?
38. When the word "with" links two conditions, what relationship is assumed?
39. Where do you sequence a "code first" condition?
40. Can a "code first" code be the principal diagnosis?
41. Which list must you always confirm a diagnosis code in?
42. What format is a HCPCS Level II code?
43. Name two things you code with HCPCS Level II rather than CPT.
44. What do NCCI edits prevent?
45. What is upcoding?
46. What is unbundling?
47. What does the False Claims Act prohibit, and what damages can it impose?
48. State the minimum necessary standard.
49. What does the root nephr/o refer to, and the suffix -ectomy?
50. When documentation is unclear, what should the coder do?

Answer key

Q	Answer
1	AAPC
2	100 multiple-choice questions
3	4 hours
4	Open book
5	CPT, ICD-10-CM, and HCPCS Level II
6	70 percent
7	Surgery (combined across body systems)
8	CPC-A (apprentice)
9	E/M, Anesthesia, Surgery, Radiology, Pathology and Laboratory, Medicine
10	Performance tracking; they end in the letter F
11	Emerging technology, temporary; they end in the letter T
12	Look up the main term in the alphabetic index
13	No; it gives candidate codes only
14	The tabular (numeric body of the book)
15	The common parent descriptor from the indented codes that share it

16	No; always with a primary procedure
17	No; add-on codes are exempt from the reduction
18	The operation, local anesthesia, and normal follow-up care in the global period
19	Medical decision making or total time on the date
20	Three years
21	Problems addressed, data reviewed, risk
22	Two of the three
23	The provider's total time on the date of the encounter
24	The meaning of a code without changing the code itself
25	A distinct procedural service
26	A significant, separately identifiable E/M service
27	A bilateral procedure
28	The professional (interpretation) and technical (equipment) components
29	NOT CODED HERE; the two codes are never used together
30	NOT INCLUDED HERE; both codes may be used together
31	No
32	Not Elsewhere Classifiable; other specified
33	Not Otherwise Specified; unspecified
34	X
35	The 7th (seventh) position
36	Initial encounter
37	Sequela
38	A causal relationship, read as associated with or due to
39	First (sequence it first, before the manifestation)
40	No
41	The tabular list
42	One letter followed by four digits (alphanumeric)
43	Any two of: supplies, injectable or infused drugs, durable medical equipment, prosthetics, orthotics
44	Improper unbundling and incorrect code pairs
45	Billing a higher-level code than the documentation supports
46	Billing separately for parts that should be reported as one code
47	Knowingly submitting false claims; treble (triple) damages plus per-claim penalties
48	Use or disclose only the minimum PHI needed for the purpose

49	Kidney; surgical removal
50	Query the provider; never assume or code from an unclear record

That is the whole pack. Learn the terminology roots so no word scares you, drill the ICD-10-CM conventions and the modifier concepts until they are automatic, and practice the index-then-tabular lookup under a clock, because the exam is open book, timed, and it just wants to see that you can navigate your manuals and keep your rules straight. You have done the work. Walk in, work steadily, and pass. - Patricia