CPC Exam Cheat Sheet

Final-review quick reference · ICD-10-CM · CPT · HCPCS · E/M · modifiers · exam patterns · 2026 edition

Before you start: You may **not** bring this sheet into the exam. AAPC allows only your approved CPT®, ICD-10-CM and HCPCS Level II code books. Use this to review, then transfer what you need into handwritten annotations and tabs in your own books.

1 ICD-10-CM Quick Rules

Rule	What it means	Common trap
Specificity	Code to the highest level of detail documented.	Stopping at a 3-character category when a 4th–6th character exists.
Placeholder X	Fill empty positions with X before a required 7th character.	Omitting X and placing the 7th character in the wrong slot.
First-listed vs principal	Outpatient uses **first-listed**; inpatient uses **principal**. The CPC tests outpatient.	Applying inpatient rules to an outpatient scenario.
Uncertain diagnoses	Outpatient: code the **signs and symptoms**.	Coding “rule out”, “probable” or “suspected” as confirmed.
Excludes1	Mutually exclusive — never coded together.	Reporting both anyway when a combination code exists.
Excludes2	“Not included here” — both may be coded if documented.	Treating it like Excludes1 and dropping a valid code.
Code first / use additional	Sets the sequencing order.	Reversing etiology and manifestation.
Combination codes	One code captures condition + manifestation or complication.	Assigning two separate codes when a combination exists.

High-yield chapter	Key rule	Watch for
Diabetes E08–E13	Combination code = type + manifestation.	Confusing Type 1 (E10) with Type 2 (E11).
Hypertension I10–I16	Causal link **assumed** with CKD; heart disease must be stated.	Missing hypertensive heart disease as a combination.
Neoplasms C00–D49	Primary site during active treatment; Z85 for history.	Coding a secondary site as primary.
Sepsis A40–A41	Underlying infection first, then R65.2- if severe.	Forgetting the organ-dysfunction code.
Injuries S/T	7th char: A initial, D subsequent, S sequela.	Using S when D is correct.
Z codes	Some may be first-listed; others secondary only.	Assuming Z codes are never primary.

Sequencing shortcut: “A” = **a**ctive treatment, “D” = **d**uring healing, “S” = **s**equela (late effect). The 7th character describes the phase of care, not whether the patient has been seen before.

2 CPT — Sections & Surgery Ranges

CPT section	Range	Surgery subsection	Range
Evaluation & Management	99202–99499	Integumentary	10000–19999
Anesthesia	00100–01999	Musculoskeletal	20000–29999
Surgery	10004–69990	Respiratory	30000–32999
Radiology	70010–79999	Cardiovascular	33000–37799
Pathology & Laboratory	80047–89398	Hemic / Lymphatic	38000–39999
Medicine	90281–99607	Digestive	40000–49999
Category II (F codes)	Performance measures	Urinary	50000–53999
Category III (T codes)	Emerging technology	Male / Female genital	54000–58999
		Maternity & delivery	59000–59899

CPT section	Range	Surgery subsection	Range
		Endocrine	60000–60699
		Nervous system	61000–64999
		Eye & ocular adnexa	65000–68899
		Auditory	69000–69979

Index discipline: Always look up the procedure in the **Index**, then verify in the **Tabular List**. Never code straight from the Index — the Tabular carries the parenthetical notes, inclusion terms and exclusions that change your answer.

3 Modifiers — Most Tested

Mod	Use	Typical exam scenario
22	Increased procedural services	Substantially greater work, documented
24	Unrelated E/M in postoperative period	New problem during a 90-day global
25	Significant, separately identifiable E/M same day as a **minor** procedure	Office visit plus a small excision
26	Professional component only	Radiologist reads a film taken elsewhere
50	Bilateral procedure	Same procedure, both sides
51	Multiple procedures	Several excisions, one session
52	Reduced services	Procedure partially reduced by choice
53	Discontinued procedure	Stopped due to patient risk
57	Decision for **major** surgery (90-day global)	E/M that led to the surgical decision
58	Staged or related procedure in global period	Planned second stage
59	Distinct procedural service	Overrides an NCCI edit when justified
62	Two surgeons	Anterior/posterior spinal fusion
66	Surgical team	Complex multi-specialty procedure
76 / 77	Repeat by same / different physician	Second imaging study same day
78	Unplanned return to OR, related	Postoperative bleed
79	Unrelated procedure in global period	Different site, different problem
80	Assistant surgeon	Assisting through the procedure
TC	Technical component only	Facility owns equipment and staff
LT / RT	Left / right side	Paired organs

25 vs 57 — the classic: 25 goes with a **minor** procedure (0 or 10-day global). **57** goes with a **major** procedure (90-day global). Both attach to the E/M code, never to the procedure.

4 Global Surgical Package

Included in the surgical code	Not included — report separately
Pre-op visit the day before or day of surgery	Return to OR for a complication — modifier **78**
The procedure itself	Unrelated condition in the global period — **24** or **79**
Immediate post-op care in recovery	Staged or planned second procedure — **58**
Routine follow-up during the global period	The E/M that decided the surgery — **57**
Post-op pain management	Significant comorbidity needing separate management
Suture removal and wound checks	

- **Major surgery** = 90-day global period. **Minor surgery** = 0 or 10-day global period.
- **Add-on codes** (+ symbol, CPT Appendix D) are never reported alone and are **exempt from modifier 51**.
- **Separate procedure** in parentheses = bundled when done in the same session and area; report alone only if independent.
- **Unlisted codes** end in -99 or -9. Attach the operative report and a cover letter.

5 E/M Quick Reference (2021 rules, still current)

	New patient	Established	Basis for level selection
Office / outpatient	99202–99205	99211–99215	MDM **or** total time on the date of service
Hospital inpatient / observation	99221–99223 initial	99231–99233 subsequent	Merged code set since 2023
Same-day admit & discharge	99234–99236	—	Admitted and discharged, same date
Discharge	99238 (≤30 min) / 99239 (>30 min)	—	Time-based
Emergency department	99281–99285	No distinction	ED has no new vs established
Critical care	99291 first 30–74 min	+99292 each addl 30	Continuous attention, one patient

- **MDM has three elements** — problems addressed, data reviewed, risk. **Two of the three** must meet or exceed the level. Do not average them.
- **New patient** = no professional service from this physician, or same specialty in the same group, within **3 years**.
- **99211** is the only code in the family with no MDM or time requirement and no physician presence needed.
- **+99417** attaches only to 99205 and 99215. Medicare uses **G2212** instead.

6 HCPCS Level II

Letter	Covers	Exam note
A	Medical and surgical supplies, transport	Ambulance and dressings appear often
E	Durable medical equipment (DME)	Wheelchairs, hospital beds, walkers
J	Drugs administered other than orally	Watch the **units** — dosage per code descriptor
L	Orthotics and prosthetics	Braces, artificial limbs
G	Temporary Medicare procedures	G2211 visit complexity, G2212 prolonged
Q / V	Temporary codes / vision and hearing	Less frequent but tested

7 Exam Question Patterns

Pattern	How to beat it
The distractor — four near-identical codes differing by one detail.	Re-read for laterality, approach and extent before choosing.
The modifier trap — two services, some answers carry a modifier.	Ask: bundled? same day? minor or major global?
The sequencing question — same codes, different order.	Find the reason for the encounter; obey code-first notes.
The included service — an extra service that is already bundled.	The correct answer usually codes *less*, not more.
The global period question — a follow-up visit after surgery.	Same condition inside the global = included. Unrelated = modifier 24.

8 Most Common Mistakes

- Coding from the Index without verifying in the Tabular List.
- Missing indented code descriptions — read the parent code's wording too.
- Miscounting MDM elements and landing on the wrong E/M level.
- Confusing new vs established patient (the 3-year, same-specialty, same-group rule).

- Ignoring parenthetical notes — they carry bundling and modifier instructions.
- Misapplying the injury 7th character (A / D / S).
- Coding “rule out” or “suspected” diagnoses in an outpatient scenario.

9 Test Day

- **100 questions · 4 hours · 70% to pass.** That is roughly 2.4 minutes per question.
- First pass: no more than one minute per question. Flag and return — do not stall.
- Your code books are allowed. Tabs and handwritten annotations are allowed; loose notes are not.
- **Tab at minimum:** E/M guidelines, CPT Appendix A (modifiers), each surgery subsection, ICD-10-CM conventions, Table of Neoplasms, Table of Drugs and Chemicals, external cause codes.
- Read the whole stem. One detail mid-sentence usually decides the answer.
- For operative reports: identify **approach**, **extent** and **anatomic site** before you open the book.

Keep going: Full guides for every rule on this sheet are at **clearcpc.com/blog** — free, no sign-up. Working through a 90-day plan? See **clearcpc.com/cpc-study-plan**. Spot an error? support@clearcpc.com