

3-2-1 Code It! Exam 1 Practice (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

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- 1. Who submits the UB-04 claim for reimbursement purposes?**
 - A. Departments of health**
 - B. Hospitals**
 - C. Third-party payers**
 - D. Physician offices**

- 2. What is the main focus of "Section III" in the ICD-10-CM coding guidelines?**
 - A. Outpatient coding and reporting**
 - B. Inpatient coding processes**
 - C. Emergency coding protocols**
 - D. Global surgery definitions**

- 3. What organizes a medical nomenclature by similar conditions, diseases, and procedures, containing codes for each?**
 - A. Classification system**
 - B. Medical nomenclature**
 - C. Data dictionary**
 - D. Hybrid record**

- 4. How does insurance reimbursement depend on accurate coding?**
 - A. Accurate coding allows for faster processing of claims**
 - B. Proper coding ensures claims are processed correctly**
 - C. Reimbursement is guaranteed with correct codes**
 - D. It is based on the frequency of submitted claims**

- 5. What term is used for the general rules included in the ICD-10-CM and ICD-10-PCS classifications?**
 - A. guidelines**
 - B. conventions**
 - C. regulations**
 - D. statutes**

- 6. Why are Z codes important in the health coding system?**
- A. They classify infectious diseases**
 - B. They provide necessary information about factors affecting health status**
 - C. They categorize procedural errors**
 - D. They specify complications during treatment**
- 7. How often is the ICD-10-CM updated according to MMA regulations?**
- A. Monthly.**
 - B. Quarterly.**
 - C. Annually.**
 - D. Biannually.**
- 8. Conditions that are not integral to a disease process should be treated how in coding?**
- A. They are not coded when documented**
 - B. They result in a physician query**
 - C. They should always have modifiers added**
 - D. They should be coded when present**
- 9. Which coding update requires coders to frequently revise their coding practices?**
- A. Annual updates of coding manuals**
 - B. Quarterly revision of clinical guidelines**
 - C. Monthly team meetings**
 - D. Daily case reviews**
- 10. Why must both the ICD-10-CM index and its tabular list be used during code assignment?**
- A. They provide conflicting information**
 - B. Both include level of specificity for accurate coding**
 - C. They always contain complete codes**
 - D. One may leave out critical information**

Answers

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

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Explanations

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1. Who submits the UB-04 claim for reimbursement purposes?

- A. Departments of health**
- B. Hospitals**
- C. Third-party payers**
- D. Physician offices**

The UB-04 claim form is specifically designed for use by institutional providers, primarily hospitals, to request reimbursement for services rendered to patients. Hospitals submit this form to third-party payers, including insurance companies and government entities such as Medicare and Medicaid. This form captures essential information regarding the services provided, including billing codes, patient demographics, and the specific charges associated with each service. While other entities, such as departments of health and physician offices, may handle various aspects of healthcare billing and claims, it is the hospital—the institutional provider—that is responsible for completing and submitting the UB-04 claim. Third-party payers, on the other hand, process these claims but do not submit them. Therefore, the correct answer reflects the direct responsibility of hospitals in the claims submission process.

2. What is the main focus of "Section III" in the ICD-10-CM coding guidelines?

- A. Outpatient coding and reporting**
- B. Inpatient coding processes**
- C. Emergency coding protocols**
- D. Global surgery definitions**

The main focus of "Section III" in the ICD-10-CM coding guidelines is indeed on outpatient coding and reporting. This section is specifically designed to address the guidelines that apply when healthcare services are provided to patients in an outpatient setting. It provides coders with essential instructions on how to accurately assign codes based on the diagnoses and procedures that are documented in outpatient visits, ensuring appropriate reporting for reimbursement and statistical purposes. The emphasis is on clarifying the coding process for situations commonly encountered in outpatient care, such as follow-up visits, routine check-ups, and encounters for preventive services. This understanding is crucial for coders to ensure compliance with regulations and to maintain the integrity of the coding process in outpatient settings. The other options, such as inpatient coding processes, emergency coding protocols, and global surgery definitions, pertain to different sections or aspects of coding guidelines and do not represent the primary focus of Section III.

3. What organizes a medical nomenclature by similar conditions, diseases, and procedures, containing codes for each?

- A. Classification system**
- B. Medical nomenclature**
- C. Data dictionary**
- D. Hybrid record**

The classification system is designed to organize a medical nomenclature by grouping similar conditions, diseases, and procedures. This system provides a structured framework that assigns specific codes to each entity within healthcare, enabling consistent documentation and communication among healthcare providers. By categorizing these elements, the classification system helps facilitate data analysis, reimbursement processes, and health statistics, allowing for better public health surveillance and research. While medical nomenclature refers to the naming of medical conditions and procedures, it does not inherently organize them into a system with codes. A data dictionary, on the other hand, is a repository that defines data elements and their attributes but does not function as a classification tool. Lastly, a hybrid record refers to a combination of paper and electronic records, which is unrelated to the organization of medical nomenclature. Thus, the classification system is the most accurate answer as it encompasses both the organization and coding of medical data.

4. How does insurance reimbursement depend on accurate coding?

- A. Accurate coding allows for faster processing of claims**
- B. Proper coding ensures claims are processed correctly**
- C. Reimbursement is guaranteed with correct codes**
- D. It is based on the frequency of submitted claims**

Accurate coding is essential for ensuring that insurance claims are processed correctly. When healthcare providers submit claims for reimbursement, they must use specific codes that reflect the services provided, diagnoses, and procedures performed. If the codes are accurate and specific, insurance companies are more likely to approve the claims without delays or requests for additional information. Proper coding minimizes the risk of denials or rejections, which can occur if the codes do not match the services rendered or are not documented adequately. By ensuring that the coding accurately reflects the patient's condition and the care provided, healthcare providers can facilitate a smoother claims process, leading to appropriate reimbursement for the services rendered. While faster processing of claims can be a benefit of accurate coding, it is the correctness of the coding itself that primarily determines whether the claims will be accepted and paid. Other factors, such as frequency or guaranteed reimbursement, do not capture the direct role of coding accuracy in the claims process.

5. What term is used for the general rules included in the ICD-10-CM and ICD-10-PCS classifications?

- A. guidelines**
- B. conventions**
- C. regulations**
- D. statutes**

The correct term for the general rules included in the ICD-10-CM and ICD-10-PCS classifications is "conventions." These conventions provide important instructions that help in the correct coding of diagnoses and procedures. They are essential for ensuring uniformity and consistency in how codes are applied, making it easier for healthcare professionals, billers, and coders to accurately document patient care. Conventions include definitions, instructional notes, official guidelines, and categories that guide users in selecting the appropriate codes for various conditions and services. Other terms, while they may seem related, do not correctly capture the specific nature of these rules. For example, "guidelines" often refer to broader recommendations or a set of instructions that may or may not be exclusive to coding, while "regulations" and "statutes" imply legal requirements rather than coding standards in healthcare settings. Therefore, "conventions" distinctly describes the set of rules specifically designed for accurate coding within the ICD-10 framework.

6. Why are Z codes important in the health coding system?

- A. They classify infectious diseases**
- B. They provide necessary information about factors affecting health status**
- C. They categorize procedural errors**
- D. They specify complications during treatment**

Z codes are an essential part of the health coding system because they provide necessary information about factors affecting health status that are not classified as diseases or injuries. They are used to identify reasons for encounters that are not primarily related to a specific illness or injury, such as social determinants of health, personal history, family history, and issues related to circumstances that may influence patient care, such as lifestyle factors or social environment. These codes help healthcare providers and insurers to understand the broader context of a patient's health and their healthcare needs. By capturing these non-clinical factors, Z codes improve the accuracy of health records and enable better resource allocation, patient management, and public health tracking. Thus, their role in the coding system underscores the importance of comprehensive patient information in delivering quality care and managing health conditions effectively.

7. How often is the ICD-10-CM updated according to MMA regulations?

- A. Monthly.**
- B. Quarterly.**
- C. Annually.**
- D. Biannually.**

The correct answer is based on the regulations set forth by the Centers for Medicare & Medicaid Services (CMS) in relation to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). The ICD-10-CM is updated on a regular basis to reflect changes in medical knowledge and practice, make improvements to the classification system, and adjust for emerging issues. According to the regulations, the updates to ICD-10-CM occur on a scheduled basis, which is typically biannually. This allows for the incorporation of new codes, revisions to existing codes, and any necessary deletions. The updates help ensure that healthcare providers are using the most current and accurate coding for diagnoses, which is essential for proper billing, reimbursement, and data collection. The other intervals mentioned, such as monthly, quarterly, and annually, do not align with the established update frequency as prescribed. While there may be interim guidance or changes that providers need to be aware of more frequently, the formal updates to the coding system itself take place biannually. This structured approach helps maintain consistency and keeps healthcare professionals informed about the latest coding standards.

8. Conditions that are not integral to a disease process should be treated how in coding?

- A. They are not coded when documented**
- B. They result in a physician query**
- C. They should always have modifiers added**
- D. They should be coded when present**

When coding for conditions that are not integral to a disease process, it is important to recognize that these conditions can still impact a patient's care and treatment. Therefore, they should be coded when present. This ensures that the medical record accurately reflects all aspects of a patient's health status and provides a complete picture for anyone reviewing the record, including other healthcare providers and insurance companies. Coding these additional conditions is crucial as they often affect the complexity of the treatment provided or influence the overall management of the patient's condition. Proper coding of these non-primary conditions allows for more accurate reporting, which can help in understanding the full scope of a patient's medical issues and potentially inform future treatment options. In contexts where the other choices were offered, they refer to scenarios that do not align with the recommended practices for coding additional conditions that might not directly lead to the disease process but are relevant enough to encompass the patient's overall health assessment.

9. Which coding update requires coders to frequently revise their coding practices?

- A. Annual updates of coding manuals**
- B. Quarterly revision of clinical guidelines**
- C. Monthly team meetings**
- D. Daily case reviews**

The answer is based on the nature of coding updates and the frequency with which these updates can affect coding practices. Annual updates of coding manuals represent a systematic and comprehensive revision of coding standards and guidelines that coders must follow. Since coding manuals are typically updated only once per year, these changes can lead to significant alterations in coding practices that necessitate a thorough review and adaptation from coders to ensure compliance with the most current standards. While other options mention revisions or meetings that could influence knowledge and understanding of coding, they are generally not formal updates to coding practices. Quarterly revisions of clinical guidelines may provide updated information, but they do not directly change coding standards like an annual update. Monthly team meetings and daily case reviews offer opportunities for ongoing education and discussion but lack the binding authority of formal coding updates that require coders to implement changes in their practice. Therefore, the annual updates of coding manuals is the most critical factor in the need for coders to frequently revise their coding practices.

10. Why must both the ICD-10-CM index and its tabular list be used during code assignment?

- A. They provide conflicting information**
- B. Both include level of specificity for accurate coding**
- C. They always contain complete codes**
- D. One may leave out critical information**

Using both the ICD-10-CM index and its tabular list is essential because each serves a unique purpose that ensures accurate and complete code assignment. The index provides an alphabetical list of terms that help identify the right codes based on the medical language of diagnoses. However, it may not contain comprehensive details necessary for making a final coding decision. The tabular list, on the other hand, offers a structured presentation of codes along with additional information, including guidelines, notes for coding, and the importance of specificity. This section helps coders verify the accuracy and relevance of the code selected from the index. Relying on only one of these resources may potentially result in missing critical information that could affect the overall coding accuracy. By utilizing both, coders can ensure that they are capturing all relevant details and adhering to coding standards, ultimately leading to more precise coding and improved patient documentation. This practice emphasizes the importance of a comprehensive approach to medical coding where both resources complement each other in verifying information needed to accomplish accurate coding.

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.

Or visit your dedicated course page for more study tools and resources:

<https://321codeit1.examzify.com>

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

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