

Certified Coding Specialist (CCS) Practice Exam (Sample)

Study Guide



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Questions

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- 1. Which procedure code is suitable for closed treatment of a fracture with manipulation?**
 - A. 24670**
 - B. 24675**
 - C. 24680**
 - D. 24665**
- 2. What code should be used to indicate a procedure performed on the right side?**
 - A. -LT**
 - B. -RT**
 - C. -UT**
 - D. -ST**
- 3. How do diagnosis codes differ from procedure codes?**
 - A. Diagnosis codes describe treatments performed**
 - B. Procedure codes indicate health conditions**
 - C. Diagnosis codes describe health conditions**
 - D. Procedure codes are used for billing purposes**
- 4. When coding benign neoplasms of skin, which of the following is included in the D23 category?**
 - A. Benign lipomatous neoplasm**
 - B. Benign neoplasm of hair follicles**
 - C. Malignant neoplasm of the skin**
 - D. Melanocytic nevi**
- 5. What is the purpose of "diagnostic coding"?**
 - A. For billing purposes only**
 - B. To identify medical conditions through numeric codes**
 - C. To evaluate treatment effectiveness**
 - D. To assess healthcare quality**

- 6. What does the CPT definition of a surgical package include?**
- A. The surgical procedure(s)**
 - B. Follow-up surgery**
 - C. Preoperative tests**
 - D. Yearly follow-up visits**
- 7. What is the primary purpose of clearinghouses in healthcare billing?**
- A. To ensure compliance with medical guidelines**
 - B. To process and transmit claims from providers to payers**
 - C. To handle patient inquiries regarding billing**
 - D. To maintain patient medical records**
- 8. What is one outcome of effective auditing in medical coding?**
- A. A reduction in the number of healthcare providers**
 - B. Enhancement of compliance and improvement in coding practices**
 - C. Higher patient satisfaction scores**
 - D. Decreased administrative costs**
- 9. What type of code is Z79.52?**
- A. Long term (current) use of systemic steroids**
 - B. Adverse effects of glucocorticoids**
 - C. Chronic kidney disease**
 - D. None of the above**
- 10. How is the diagnosis of chronic kidney disease coded?**
- A. With additional procedures noted**
 - B. Only primary conditions are coded**
 - C. Secondary conditions are not necessary**
 - D. With specific chronic stage noted**

Answers

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

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Explanations

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1. Which procedure code is suitable for closed treatment of a fracture with manipulation?

- A. 24670
- B. 24675**
- C. 24680
- D. 24665

In this context, the procedure code that accurately describes the closed treatment of a fracture with manipulation is indeed 24675. This code encompasses the specific requirements for managing a fracture through closed treatment, which involves realignment or repositioning of the fractured bone without the need for surgical intervention. Closed treatment with manipulation indicates that the healthcare provider has applied manual force to correctly align the bones after the fracture, which is essential for proper healing and function. The designation of this code signifies that the provider has performed a more complex manipulation beyond just simple stabilization. It reflects the level of skill and technique required to ensure that the bones are appropriately aligned. In contrast, the other codes refer to different scenarios, such as treatments without manipulation or to fractures of different anatomical locations that do not fit this specific description of treatment. Hence, when selecting a procedure code, understanding the nuances of each option is crucial, as it assures accurate documentation and appropriate reimbursement for the services rendered.

2. What code should be used to indicate a procedure performed on the right side?

- A. -LT
- B. -RT**
- C. -UT
- D. -ST

The correct code to indicate a procedure performed on the right side is the one that specifically designates procedures on the right. In coding terminology, "-RT" is the designation used to indicate that a procedure has been performed on the right side of the body. This coding is crucial for accurately conveying details in patient records and billing, as it ensures that healthcare providers are appropriately reimbursed for the specific procedures carried out. The other options, while potentially relevant in other contexts, do not denote the right side. For instance, "-LT" is used for left side procedures, which would lead to confusion if mistakenly applied in cases concerning the right side. Similarly, "-UT" and "-ST" do not pertain to the lateral orientation of a procedure, making them unsuitable for indicating right-sided interventions. Understanding the specific meaning of these codes is vital for accurate reporting and processing of medical services.

3. How do diagnosis codes differ from procedure codes?

- A. Diagnosis codes describe treatments performed
- B. Procedure codes indicate health conditions
- C. Diagnosis codes describe health conditions**
- D. Procedure codes are used for billing purposes

Diagnosis codes are specifically used to represent health conditions, illnesses, and diseases that a patient may have during a medical visit. These codes provide a standardized way to document a patient's clinical findings and are critical for establishing a patient's medical history and informing subsequent treatment decisions. They help healthcare providers and insurers to understand the health issues being addressed. In contrast, procedure codes represent the various medical, surgical, or diagnostic procedures that are performed to treat or investigate those health conditions. While procedure codes are essential for billing and reimbursement processes, they do not provide information about the underlying health conditions themselves. Therefore, the information conveyed by diagnosis codes complements the procedural information, enabling comprehensive clinical documentation and coding practices that support healthcare delivery and administrative functions. Understanding this distinction is vital for accurate coding, which ultimately affects patient care, billing, and reimbursement within the healthcare system.

4. When coding benign neoplasms of skin, which of the following is included in the D23 category?

- A. Benign lipomatous neoplasm
- B. Benign neoplasm of hair follicles**
- C. Malignant neoplasm of the skin
- D. Melanocytic nevi

The D23 category in the International Classification of Diseases (ICD) is specifically designated for benign neoplasms of the skin. This category includes various forms of skin neoplasms that do not bear malignant characteristics. Benign neoplasms of hair follicles fall within this category because they are non-cancerous growths originating from hair follicles, reflecting the benign nature designated by D23. This categorization is crucial in medical coding as it helps healthcare professionals communicate effectively about the diagnosis, manage patient care, and ensure proper billing practices. Other options present neoplasms that do not align with the specific classification of benign skin neoplasms. For instance, benign lipomatous neoplasms would be classified under a different category related to fatty tissue. Malignant neoplasm of the skin is clearly outside the scope of benign tumors altogether, while melanocytic nevi, while benign, are coded under a different classification pertaining to pigmented lesions. This means that although melanocytic nevi can be benign, they don't specifically fit into the D23 category according to medical coding guidelines.

5. What is the purpose of "diagnostic coding"?

- A. For billing purposes only
- B. To identify medical conditions through numeric codes**
- C. To evaluate treatment effectiveness
- D. To assess healthcare quality

The purpose of diagnostic coding is to identify medical conditions through numeric codes. This systematic coding approach allows healthcare providers, insurers, and researchers to clearly record and communicate information about patient diagnoses. Each medical condition is assigned a specific numeric or alphanumeric code, typically derived from coding systems like ICD (International Classification of Diseases). This process ensures consistency and accuracy in the documentation of diseases and health conditions, which is crucial for numerous functions, including billing, statistical analyses, treatment planning, and public health reporting. By coding diagnoses accurately, healthcare professionals can effectively track disease prevalence, monitor patient outcomes, and enhance overall patient care through data-driven insights. In contrast to the other options, while diagnostic coding does support billing and may indirectly help evaluate treatment effectiveness or assess healthcare quality, its primary aim is centered on the identification and categorization of medical conditions. This fundamental role is critical for the integrity of medical records and effective healthcare delivery.

6. What does the CPT definition of a surgical package include?

- A. The surgical procedure(s)**
- B. Follow-up surgery
- C. Preoperative tests
- D. Yearly follow-up visits

The definition of a surgical package in the Current Procedural Terminology (CPT) coding system refers to the comprehensive grouping of services associated with a specific surgical procedure. This package typically includes not just the surgical procedure itself but also other related components that ensure coordinated care. Selecting the surgical procedures as part of this package is correct, as it reflects the primary focus of the surgical package. Ideally, the surgical package represents a bundled approach that encompasses various preoperative, intraoperative, and postoperative aspects of care surrounding the surgical intervention. This allows for streamlined billing and simplifies the understanding of what services are interconnected with the surgery. In contrast, follow-up surgery, preoperative tests, and yearly follow-up visits are not considered part of the surgical package as defined by CPT. These services, while potentially necessary for patient care, are typically billed separately or are categorized differently in coding systems. Therefore, they do not fall cleanly under the surgical package's definition, which specifically centers on the direct services provided during the course of the surgical event itself.

7. What is the primary purpose of clearinghouses in healthcare billing?

- A. To ensure compliance with medical guidelines**
- B. To process and transmit claims from providers to payers**
- C. To handle patient inquiries regarding billing**
- D. To maintain patient medical records**

The primary purpose of clearinghouses in healthcare billing is to process and transmit claims from providers to payers. Clearinghouses serve as intermediaries between healthcare providers, such as hospitals and clinics, and insurance companies. They facilitate the electronic submission of claims, ensuring the required formats and codes are used according to payer specifications. This streamlining helps prevent errors in claims that could lead to delays in payment, making the billing process more efficient. By converting claims from various providers into a standardized format suitable for payers, clearinghouses enhance the accuracy and efficiency of claims processing. This reduces the administrative burden on healthcare providers and minimizes the likelihood of rejected claims, which can be costly in terms of time and resources. Other options describe important functions within healthcare but do not align with the primary role of clearinghouses. Compliance with medical guidelines and maintaining patient records are crucial aspects of healthcare operations but are not directly related to the billing process. Handling patient inquiries concerns customer service, which is also vital but distinct from the claim processing function of clearinghouses.

8. What is one outcome of effective auditing in medical coding?

- A. A reduction in the number of healthcare providers**
- B. Enhancement of compliance and improvement in coding practices**
- C. Higher patient satisfaction scores**
- D. Decreased administrative costs**

Effective auditing in medical coding is essential for ensuring that coding practices align with coding guidelines and regulations. One key outcome of this process is the enhancement of compliance and the improvement in coding practices. When audits are conducted thoroughly, they can identify areas where coding may be inaccurate or inconsistent with established standards. This leads to better adherence to compliance requirements, reducing the risk of penalties, and ensuring that healthcare providers are reimbursed appropriately for their services. Furthermore, improved coding practices can result in more accurate data reporting, which is critical for both clinical and administrative decision-making. While the other options might relate to outcomes of a strong overall healthcare system or suggest benefits arising from various practices, they are more indirect and not guaranteed outcomes of auditing specifically. For example, a reduction in providers or decreased administrative costs could stem from multiple factors other than auditing. Higher patient satisfaction scores may result from improved care, but they don't directly connect to the auditing process in the same way that compliance enhancement does. Hence, the clear and direct outcome of effective auditing is indeed the improvement and compliance in coding practices.

9. What type of code is Z79.52?

- A. Long term (current) use of systemic steroids**
- B. Adverse effects of glucocorticoids**
- C. Chronic kidney disease**
- D. None of the above**

Z79.52 is a code used in the ICD-10-CM classification system that indicates a long-term (current) use of systemic steroids. This type of code is part of the Z code category, which identifies the status of a patient's health that is significant to the current treatment and care. When a patient is under long-term treatment with systemic steroids, it is important to document this condition accurately. This information is crucial for healthcare providers to understand the patient's medication history and potential side effects. Long-term steroid use can lead to various health issues, so appropriate monitoring and adjustments in treatment may be required. The other options listed refer to different conditions or complications. Adverse effects of glucocorticoids relate to the negative outcomes that can arise from steroid use, while chronic kidney disease is a separate, specific condition that has its own coding. However, Z79.52 does not pertain to these conditions, reinforcing that the code specifically indicates a patient is currently using systemic steroids for an extended period. This specificity is important for ensuring proper coding, compliance, and the associated reimbursement processes in medical billing.

10. How is the diagnosis of chronic kidney disease coded?

- A. With additional procedures noted**
- B. Only primary conditions are coded**
- C. Secondary conditions are not necessary**
- D. With specific chronic stage noted**

The diagnosis of chronic kidney disease (CKD) is coded with a specific focus on identifying the stage of the disease. This is important because staging provides critical information regarding the severity of the condition, informs treatment options, and impacts management strategies. Each stage of chronic kidney disease is classified based on the level of kidney function, usually measured by the estimated glomerular filtration rate (eGFR), and carries significant clinical implications. By coding with the specific chronic stage noted, healthcare providers ensure that the patient's medical records accurately reflect the severity of the condition. This approach is essential for tracking progression, allocating resources, and determining eligibility for treatments, including dialysis or transplantation. Additionally, coding to the specific stage allows for appropriate reimbursement and reflects compliance with coding guidelines and regulations. The other choices do not capture the comprehensive detail necessary for coding CKD accurately. While procedures and primary/secondary conditions are also important in coding practices, they do not specifically address the requirement of detailing the chronic stage of kidney disease in this context.