

Fundamentals of Medical Coding Practice Test (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

- 1. In regards to monitored anesthesia care, what does the abbreviation -QS stand for?**
 - A. Monitored anesthesia care for specific surgical procedures**
 - B. Standard monitored anesthesia care**
 - C. General anesthesia supervision**
 - D. Minimal monitoring anesthesia**
- 2. In order to obtain reimbursement from third-party payers, patient diagnoses must?**
 - A. Align with regulatory laws**
 - B. Justify diagnostic and/or therapeutic procedures or services provided**
 - C. Be validated by a specialist**
 - D. Contain demographic data**
- 3. What term is used to describe a detailed exploration of a patient's history during an E/M service?**
 - A. Comprehensive**
 - B. Problem-focused**
 - C. Expanded problem-focused**
 - D. Detailed**
- 4. Information applicable to a particular CPT section is located in what part of the document?**
 - A. Glossary**
 - B. Index**
 - C. Guidelines**
 - D. Appendix**
- 5. What legislation mandated the payment methodology for durable medical equipment in 1987?**
 - A. HIPAA**
 - B. OBRA**
 - C. CMS**
 - D. COBRA**

- 6. What type of catheter is ideal for long-term medication delivery?**
- A. Swan-Ganz catheter**
 - B. Implanted port**
 - C. Intra-arterial cannula**
 - D. Central venous access device**
- 7. What is the monthly publication by the AMA that serves as an official coding resource?**
- A. HCPCS Update**
 - B. CPT Assistant and HCPCS assistant**
 - C. Coding Insights**
 - D. Medicare Bulletin**
- 8. Which appendix provides coding details for moderate (conscious) sedation?**
- A. Appendix C**
 - B. Appendix D**
 - C. Appendix G**
 - D. Appendix H**
- 9. What component of patient data does the encounter form typically include?**
- A. Insurance claim details**
 - B. Patient demographics**
 - C. Allergy information**
 - D. Procedure codes**
- 10. What type of note summarizes a patient's care and treatment at the conclusion of their stay in a facility?**
- A. Discharge note**
 - B. Progress note**
 - C. Initial assessment note**
 - D. Referral note**

Answers

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

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Explanations

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1. In regards to monitored anesthesia care, what does the abbreviation -QS stand for?
- A. Monitored anesthesia care for specific surgical procedures
 - B. Standard monitored anesthesia care**
 - C. General anesthesia supervision
 - D. Minimal monitoring anesthesia

The abbreviation -QS stands for "standard monitored anesthesia care." Monitored anesthesia care refers to a type of anesthesia service in which a patient is closely monitored by an anesthesiologist during the procedure. The "standard" aspect indicates that the level of monitoring provided adheres to established practices to ensure patient safety and comfort while allowing for a variety of surgical procedures to be performed with varying levels of sedation. This code is often used when billing for anesthesia services, representing that the practitioner provided a level of care that meets the required standards for monitoring during the procedure. It is essential to understand this terminology to accurately document and code for anesthesia services. In contrast, other options describe varying elements of anesthesia care but do not align with the specific meaning of the -QS abbreviation. For instance, the mention of specific surgical procedures or general supervision does not encapsulate the concept of 'standard' which is fundamental to the meaning of -QS. Minimal monitoring suggests a lesser degree of oversight, which also deviates from the standard practices encapsulated by this abbreviation.

2. In order to obtain reimbursement from third-party payers, patient diagnoses must?
- A. Align with regulatory laws
 - B. Justify diagnostic and/or therapeutic procedures or services provided**
 - C. Be validated by a specialist
 - D. Contain demographic data

Patient diagnoses must justify diagnostic and/or therapeutic procedures or services provided to ensure that the claims submitted to insurance companies are valid. This means that the diagnoses should clearly support the need for the medical services rendered to the patient. Third-party payers require this justification to verify that the treatment was necessary and appropriate, based on the patient's health condition. When a healthcare provider submits a claim for reimbursement, the documentation, particularly the diagnosis codes, needs to correlate well with the procedures performed. This correlation establishes the medical necessity, which is a critical criterion in the reimbursement process. Failure to adequately justify the services through proper diagnosis can lead to claims being denied, reduced, or delayed. While aligning with regulatory laws, validation by a specialist, and having demographic data may all play roles in the broader context of healthcare administration and billing, they do not directly address the specific requirement of linking diagnoses to the services provided for reimbursement. Thus, the justification of procedures and services through diagnoses is paramount in obtaining payment from third-party payers.

3. What term is used to describe a detailed exploration of a patient's history during an E/M service?

- A. Comprehensive**
- B. Problem-focused**
- C. Expanded problem-focused**
- D. Detailed**

The term "comprehensive" is used to describe a detailed exploration of a patient's history during an Evaluation and Management (E/M) service because it encompasses a thorough assessment of multiple aspects of a patient's medical history. In the context of E/M services, a comprehensive history includes a complete review of the patient's present medical condition, relevant past medical history, family history, and social history, giving the healthcare provider a holistic view of the patient's health status. This level of detail supports the healthcare provider in making informed clinical decisions and identifying potential health issues. A comprehensive history typically involves gathering extensive information, which is crucial for accurately coding the service and justifying the level of care provided. In contrast, the other options describe different levels of history: "problem-focused" refers to a limited review that concentrates only on the problem currently being addressed, while "expanded problem-focused" includes a brief history covering the problem plus some additional relevant information. "Detailed" tends to refer to a more thorough examination than "problem-focused," but may not meet the full criteria of a "comprehensive" history in the coding guidelines. Understanding these distinctions is vital for accurate medical coding and reimbursement.

4. Information applicable to a particular CPT section is located in what part of the document?

- A. Glossary**
- B. Index**
- C. Guidelines**
- D. Appendix**

The correct choice is based on the structured organization of the CPT coding manual. In the CPT manual, the guidelines section provides crucial information that is specific to each category of codes within the document. These guidelines include instructions on how to use the codes, the definitions of terms, and any necessary prerequisites or modifiers associated with the codes in that section. This part is essential for medical coders because it ensures accurate coding and billing practices by clarifying the context in which specific codes can be applied. Understanding these guidelines helps coders apply the correct codes according to the nuances of medical procedures, ensuring compliance with regulations and standards. The other sections, while useful, serve different purposes. The glossary offers definitions of terms, the index helps locate codes, and the appendix contains additional resources or supplementary information that is not specific to the coding guidelines themselves. Thus, the guidelines section is the primary source for instructions specific to each CPT section.

5. What legislation mandated the payment methodology for durable medical equipment in 1987?

- A. HIPAA
- B. OBRA**
- C. CMS
- D. COBRA

The correct answer is OBRA, which stands for the Omnibus Budget Reconciliation Act of 1987. This piece of legislation was pivotal in healthcare policy and introduced significant reforms concerning the financing of various healthcare services, including durable medical equipment (DME). Specifically, OBRA established a payment methodology which regulated how Medicare reimbursed providers for durable medical equipment, ensuring that payments were consistent and based on established criteria. This legislation aimed to address concerns regarding the rising costs associated with healthcare, particularly for long-term care and home health services. By defining the payment structure for DME, OBRA sought to make the system more efficient and accountable, ultimately enhancing patient care. In contrast, the other options do not specifically pertain to the legislation related to durable medical equipment payment methodologies in 1987. HIPAA, for example, primarily focuses on the privacy and security of health information, CMS is the Centers for Medicare & Medicaid Services responsible for overseeing federal healthcare programs, and COBRA pertains to health insurance coverage continuation under specific circumstances. Each serves distinct functions within the healthcare system, but none is directly linked to the payment regulations for durable medical equipment established by OBRA.

6. What type of catheter is ideal for long-term medication delivery?

- A. Swan-Ganz catheter
- B. Implanted port**
- C. Intra-arterial cannula
- D. Central venous access device

The implanted port is designed specifically for long-term medication delivery, making it the ideal choice for patients requiring frequent or continuous access to their bloodstream over extended periods. This type of catheter is surgically placed under the skin and provides a reliable and secure way to administer medications, fluids, or blood products without the need for repeated needle sticks. Implanted ports also minimize the risk of infection compared to other types of catheter systems, as they are completely internal and covered by the skin. This makes them particularly suitable for patients undergoing chemotherapy, requiring long-term intravenous therapy, or those needing frequent blood draws. In contrast, options like the Swan-Ganz catheter and intra-arterial cannula serve more specialized or temporary purposes, such as monitoring cardiac function or providing access to arterial blood flow, respectively. Similarly, while a central venous access device can be used for long-term access, it may not offer the same level of comfort and reduced infection risk as an implanted port when treatment duration is expected to be extensive.

7. What is the monthly publication by the AMA that serves as an official coding resource?

A. HCPCS Update

B. CPT Assistant and HCPCS assistant

C. Coding Insights

D. Medicare Bulletin

The correct response highlights the significance of CPT Assistant and HCPCS Assistant as essential resources published monthly by the American Medical Association (AMA). These publications provide critical updates, guidance, and clarification regarding coding practices, particularly in relation to Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS). They are designed to assist medical coders by offering insights into coding changes, coding guidelines, and effective uses of codes, enabling coders to stay informed about the latest coding standards and compliance regulations. While other options like HCPCS Update and Medicare Bulletin also provide information, they do not serve as the official monthly coding resources published by the AMA. CPT Assistant and HCPCS Assistant are specifically tailored to enhance the understanding and application of coding systems essential for billing and reimbursement processes in the healthcare industry.

8. Which appendix provides coding details for moderate (conscious) sedation?

A. Appendix C

B. Appendix D

C. Appendix G

D. Appendix H

The correct choice is associated with Appendix G, which focuses specifically on coding guidelines for moderate (conscious) sedation. This appendix provides essential information and details about how to properly code for procedures that involve this particular type of sedation, including the required elements for documentation and the relevant CPT codes. Understanding the content of Appendix G is crucial for coders because it ensures accurate billing and compliance with regulations regarding sedation practices. This knowledge helps avoid errors in coding that could lead to denials or compliance issues in medical billing. In contrast, other appendices may deal with different aspects of coding or other types of procedures, but they do not specifically address the coding of moderate sedation. Therefore, Appendix G is the dedicated resource for this aspect of coding, making it the correct answer for this question.

9. What component of patient data does the encounter form typically include?

- A. Insurance claim details**
- B. Patient demographics**
- C. Allergy information**
- D. Procedure codes**

The encounter form, often referred to as a charge ticket or superbill, primarily serves as a tool for billing and documentation in a medical practice. It includes procedure codes, which are essential for the billing process. These codes represent the specific services or procedures that a patient received during their visit, facilitating accurate billing and reimbursement. Including procedure codes on the encounter form is crucial because it allows the practice to convey to the insurance payer exactly what medical services were performed. The form aids in ensuring compliance with coding guidelines and reflects the evaluation and management of the patient's condition during the visit. This makes the capture of accurate procedure codes foundational to the revenue cycle management. Other components such as insurance claim details, patient demographics, and allergy information play important roles in patient care and administrative tasks but are not the primary focus of the encounter form. While insurance and demographic data are necessary for the overall processing of patient information and claims, they do not drive the billing process in the same way that procedure codes do. Therefore, the inclusion of procedure codes is what makes the encounter form a central document for coding purposes.

10. What type of note summarizes a patient's care and treatment at the conclusion of their stay in a facility?

- A. Discharge note**
- B. Progress note**
- C. Initial assessment note**
- D. Referral note**

A discharge note serves as a summary of a patient's care and treatment at the conclusion of their stay in a healthcare facility. This document is vital because it provides a comprehensive overview of the patient's condition at discharge, any treatments or interventions that were performed, medication instructions, follow-up appointments, and recommendations for continued care. The discharge note facilitates communication between different care providers, ensuring a smooth transition for the patient from the facility to their next steps, whether that continues at home or involves further care from another provider. In contrast, a progress note documents the ongoing treatment and status updates throughout a patient's stay, while the initial assessment note provides a baseline at the start of care. A referral note is used when a provider directs a patient to another specialist or service, which does not summarize the overall care provided. Each of these alternatives serves a distinct purpose and is used at different points in the patient care process, reinforcing why the discharge note is specifically designed to encapsulate a patient's journey upon leaving a facility.

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://fundamentalsmedcoding.examzify.com>

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