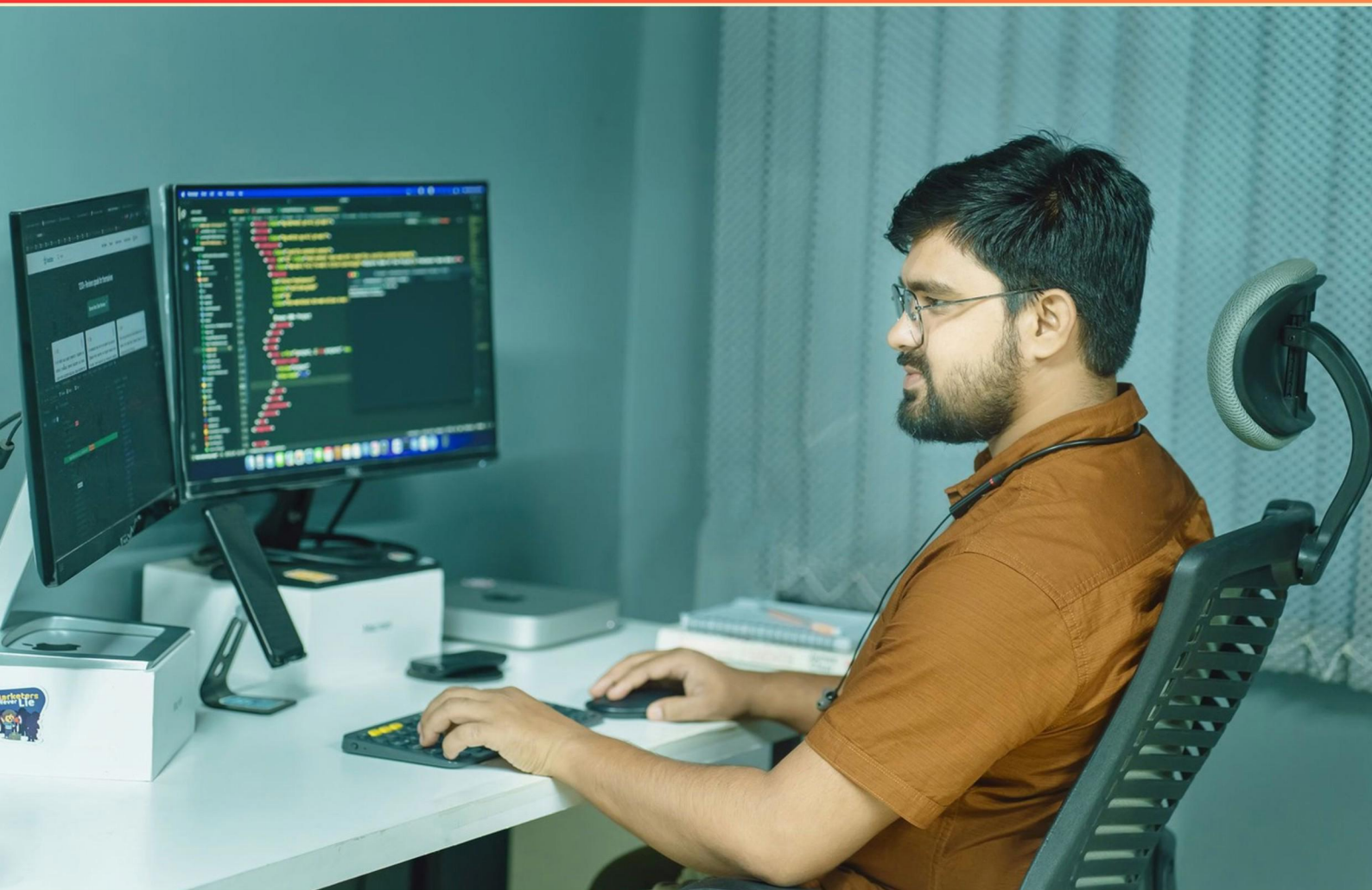


FUNDAMENTALS OF MEDICAL CODING PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://fundamentalsmedcoding.examzify.com>



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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. 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. Which of the following is considered a key component of E/M services?**
 - A. Medical history
 - B. Medical decision making
 - C. Physical examination
 - D. Patient education
- 3. Which government area investigates possible cases of DRG creep?**
 - A. Department of Health and Human Services
 - B. Department of Justice
 - C. Centers for Medicare and Medicaid Services
 - D. Office of Inspector General
- 4. What is the main purpose of the Health Insurance Portability Act of 1966 (HIPAA)?**
 - A. Create treatment guidelines
 - B. Establish protocols for patient check-in
 - C. Create privacy and security standards for health information
 - D. Regulate insurance premium costs
- 5. Which procedure involves the use of chemicals to destroy diseased tissue?**
 - A. Cryosurgery
 - B. Suture
 - C. Chemosurgery
 - D. Graft

- 6. When unlisted service or procedure codes are reported, what is also required?**
- A. Referral form
 - B. Clinical summary
 - C. Special report
 - D. Patient consent
- 7. What does the term 'brackets' signify in the ICD-10-CM Tabular List?**
- A. Mandatory coding requirements
 - B. Synonyms and alternative terms
 - C. Examples of conditions
 - D. Clarification notes
- 8. What is the primary function of CPT modifiers?**
- A. To indicate the complexity of a code
 - B. To describe alterations in standard procedures
 - C. To classify codes based on service type
 - D. To provide annual coding updates
- 9. Which term describes the attempted reduction or restoration of a fracture or dislocation with manual forces?**
- A. Reduction
 - B. Manipulation
 - C. Realignment
 - D. Rehabilitation
- 10. A fracture site that is surgically opened or exposed is referred to as what?**
- A. Closed fracture treatment
 - B. Open fracture treatment
 - C. Compound fracture
 - D. Simple fracture

Answers

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

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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. Which of the following is considered a key component of E/M services?

- A. Medical history
- B. Medical decision making**
- C. Physical examination
- D. Patient education

Medical decision making is a key component of Evaluation and Management (E/M) services because it involves the process that healthcare providers use to evaluate a patient's condition and determine the appropriate course of treatment. This component reflects the complexity of the patient's situation and the care required, as it includes the assessment of data such as medical history, examination findings, and any applicable diagnostic tests. The intricacy of medical decision making can significantly influence the level of service billed, as higher complexity often corresponds to more time-consuming and labor-intensive evaluations. In E/M coding, medical decision making is categorized based on three elements: the number of possible diagnoses and management options, the amount and complexity of medical information that must be reviewed, and the risk of significant complications, morbidity, or mortality. All of these elements together guide healthcare providers in their clinical reasoning and determine the level of health care provided. Other components, like medical history and physical examination, also play essential roles in E/M services as they contribute to the overall assessment of a patient's health status. However, it is the medical decision-making component that underscores the clinician's reasoning process and directly influences the coding and billing for the encounter, making it fundamentally crucial in the context of E/M services. Patient education, while an important aspect of

3. Which government area investigates possible cases of DRG creep?

- A. Department of Health and Human Services
- B. Department of Justice**
- C. Centers for Medicare and Medicaid Services
- D. Office of Inspector General

The investigation of possible cases of Diagnosis-Related Group (DRG) creep falls primarily under the jurisdiction of the Office of Inspector General (OIG). The OIG is dedicated to protecting the integrity of programs that the Department of Health and Human Services (HHS) administers, particularly Medicare and Medicaid. They conduct investigations and audits to ensure compliance with healthcare regulations and to address fraud and abuse associated with coding and billing practices, including issues related to DRG creep, where hospitals may improperly upgrade the severity of cases to receive higher reimbursement rates. The other choices, while important agencies within the healthcare system, have different primary functions. The Department of Health and Human Services oversees health-related policies but does not specifically focus on investigating DRG creep. The Department of Justice is involved in legal actions and prosecutions related to healthcare fraud but may not conduct the direct investigations into coding practices. The Centers for Medicare and Medicaid Services (CMS) administers the nation's major healthcare programs but is not the primary investigative body for potential abuses associated with DRG assignments. Therefore, the Office of Inspector General is the most appropriate agency for this particular concern.

4. What is the main purpose of the Health Insurance Portability Act of 1966 (HIPAA)?

- A. Create treatment guidelines
- B. Establish protocols for patient check-in
- C. Create privacy and security standards for health information**
- D. Regulate insurance premium costs

The main purpose of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to create privacy and security standards for health information. This landmark legislation was designed to protect patients' personal health information from being disclosed without their consent or knowledge. It established national standards for the protection of electronically protected health information (ePHI), ensuring that patients' sensitive data remains confidential while facilitating the exchange of health information in a secure manner. By focusing on privacy and security, HIPAA sets guidelines that healthcare providers, health plans, and other entities must follow when dealing with patient information. This includes requirements for safeguarding electronic records, establishing patients' rights over their health information, and imposing penalties for violations, all of which fortify the trust between patients and healthcare providers. The other choices do not accurately reflect HIPAA's primary objective. While treatment guidelines and patient check-in protocols relate to healthcare practices, they do not pertain to the confidentiality and integrity of health information as the main focus of HIPAA does. Regulating insurance premium costs is also outside the scope of HIPAA, as it primarily deals with administrative simplification and the protection of health information rather than financial aspects of insurance.

5. Which procedure involves the use of chemicals to destroy diseased tissue?

- A. Cryosurgery
- B. Suture
- C. Chemosurgery**
- D. Graft

The procedure that involves the use of chemicals to destroy diseased tissue is chemosurgery. This technique utilizes chemical substances to selectively eliminate abnormal or diseased cells, making it particularly effective in treating conditions such as skin cancer. The chemicals work by causing necrosis in the targeted tissue, thus helping to ensure that the diseased cells are effectively removed while sparing surrounding healthy tissue. In contrast to chemosurgery, cryosurgery employs extreme cold to freeze and destroy unwanted tissue, and sutures are primarily used for closing wounds or surgical incisions, with no direct destructive action on tissue. Grafting refers to the process of transplanting tissue from one site to another, which does not involve chemical destruction of diseased tissue but rather aims to promote healing and repair. Thus, the correct answer is rooted in the specific mechanism of action of chemosurgery regarding the destruction of abnormal tissues.

6. When unlisted service or procedure codes are reported, what is also required?

- A. Referral form
- B. Clinical summary
- C. Special report**
- D. Patient consent

When reporting unlisted service or procedure codes, a special report is required to provide the necessary information supporting the use of the unlisted code. This report should include detailed documentation about the procedure or service performed, including specifics about why the unlisted code was used instead of an existing code. The rationale is that unlisted codes are utilized when no specific code accurately describes the service rendered, and the special report helps the payer understand the context and necessity of the service. In general, unlisted codes are used in circumstances where standard codes do not adequately capture the service provided, thus making this additional documentation crucial for claim approval. It enables payers to evaluate the medical necessity and appropriateness of the charge based on the unique circumstances surrounding the treatment. A well-crafted special report can help ensure that the service is reimbursed appropriately.

7. What does the term 'brackets' signify in the ICD-10-CM Tabular List?

- A. Mandatory coding requirements
- B. Synonyms and alternative terms**
- C. Examples of conditions
- D. Clarification notes

The term 'brackets' in the ICD-10-CM Tabular List signifies synonyms and alternative terms for codes. When you see brackets around a term, it indicates that the term listed is not part of the formal code description but serves to provide additional context or clarification. This helps coders understand that there may be various terms or phrases that describe the same condition, allowing for more precise coding based on patient documentation. This feature is particularly useful when navigating through complex medical terminology, ensuring that coders are aware of different ways a diagnosis might be expressed. In contrast, other elements within the Tabular List serve different functions, such as mandatory coding requirements or examples of conditions, which are indicated through different symbols or conventions. Thus, recognizing what brackets represent aids in accurate coding and enhances the coders' ability to maintain compliance with coding standards.

8. What is the primary function of CPT modifiers?

- A. To indicate the complexity of a code
- B. To describe alterations in standard procedures**
- C. To classify codes based on service type
- D. To provide annual coding updates

The primary function of CPT modifiers is to describe alterations in standard procedures. Modifiers are two-digit codes appended to a primary CPT code to provide additional information about the service or procedure performed. They can indicate various factors, such as whether a procedure was altered in some way, whether multiple procedures were performed, or whether a procedure was performed on a specific site. This added information allows for a more precise billing and coding process, reflecting the nuances of the services provided to patients. The other choices focus on aspects that are not the primary purpose of modifiers. For example, indicating the complexity of a code or classifying codes based on service type are not functions served by modifiers. Additionally, while there are annual updates to the coding guidelines and codes themselves, modifiers do not provide these updates but rather remain as tools to refine and clarify the billing of current codes.

9. Which term describes the attempted reduction or restoration of a fracture or dislocation with manual forces?

- A. Reduction
- B. Manipulation**
- C. Realignment
- D. Rehabilitation

The term that describes the attempted reduction or restoration of a fracture or dislocation using manual forces is "manipulation." This procedure involves a trained healthcare provider using their hands to apply force to the affected area in order to realign bones and joints to their normal positions. Manipulation is essential in treating fractures and dislocations as it helps restore function and alleviate pain. The other terms provided have distinct meanings in the context of orthopedic care. For instance, "reduction" specifically refers to the process of bringing the fractured fragments of bone or dislocated joint into proper alignment, while "realignment" generally describes the outcome of such a procedure rather than the method used. "Rehabilitation" focuses on the recovery process that follows treatment, which may include physical therapy and exercises to restore strength and range of motion after manipulation has taken place. Understanding these differences is crucial for both coding and clinical practice.

10. A fracture site that is surgically opened or exposed is referred to as what?

- A. Closed fracture treatment
- B. Open fracture treatment**
- C. Compound fracture
- D. Simple fracture

The correct response describes a situation where a fracture site is surgically opened or exposed, which is commonly understood in medical terminology as open fracture treatment. This method is necessary for certain types of fractures that cannot be adequately managed through non-surgical means. When a fracture is treated openly, any foreign objects, debris, or damaged tissue can be directly addressed, and proper alignment of the bone can be achieved through surgical intervention. This approach is typically reserved for more severe fractures or fractures where healing is unlikely to occur properly without surgical assistance. Open treatments allow for better access and visualization of the injury, which facilitates appropriate stabilization and reduces the risk of complications such as improper healing or infection. In contrast, the other options mention fracture treatments without the element of surgical exposure. Closed fracture treatment refers to managing fractures without making an incision, while a compound fracture refers specifically to a fracture where there is an open wound and the bone is exposed, which is a specific type of open fracture. A simple fracture, on the other hand, indicates a straightforward break that doesn't involve the skin or surrounding tissues being compromised, thus does not necessitate surgical intervention.

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:

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

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