

ICD-10-CM Coding Practice Exam (Sample)

Study Guide



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SAMPLE

Questions

SAMPLE

- 1. When experiencing gangrene, which code is always coded first if present?**
 - A. Infection**
 - B. Gangrene**
 - C. Cellulitis**
 - D. Underlying condition**
- 2. What code is assigned to acute myocardial infarctions types 3, 4a, 4b, 4c, and 5?**
 - A. I21.A1**
 - B. I21.A9**
 - C. N18.2**
 - D. I13**
- 3. What should be coded when both sickle cell disease and trait are documented in the patient's record?**
 - A. Only sickle cell trait**
 - B. Only sickle cell disease**
 - C. Both separately as complications**
 - D. Neither, as they are genetic**
- 4. What is removed in a total hysterectomy?**
 - A. Only the cervix**
 - B. Only the uterus**
 - C. The whole uterus and cervix**
 - D. The entire reproductive system**
- 5. What is meant by “complications of other care” in ICD-10-CM?**
 - A. Secondary coding for ruled out conditions**
 - B. Complications that arise from treatments**
 - C. Unascribed complications**
 - D. Previous condition complications**

- 6. How are coronary arteries classified in coding?**
- A. By the type of device used**
 - B. By the number of distinct sites treated**
 - C. By the size of the artery**
 - D. By the patient's age**
- 7. In coding pathology, what must be included when documenting a pathological fracture?**
- A. An examination of the site**
 - B. The type of injury**
 - C. The specific underlying disease causing the fracture**
 - D. Only the treatment received**
- 8. Can Z03 and Z04 be assigned as a secondary diagnosis?**
- A. Yes, they can always be secondary**
 - B. No, they can only be principal**
 - C. Only if accompanied by a primary diagnosis**
 - D. Yes, if it supports the primary diagnosis**
- 9. When coding for excisional debridement, which approach should be documented?**
- A. Incisional biopsy procedures**
 - B. Excision of lesions not requiring incision**
 - C. Direct extraction of tissue through excision**
 - D. Non-invasive irrigation techniques**
- 10. What code is used when a patient tests positive for HIV and is symptomatic?**
- A. M00.9**
 - B. B20**
 - C. R65.2**
 - D. A41.9**

Answers

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

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Explanations

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1. When experiencing gangrene, which code is always coded first if present?

A. Infection

B. Gangrene

C. Cellulitis

D. Underlying condition

In coding for gangrene, the specific disease or condition causing the gangrene is critical. Gangrene indicates tissue death due to a lack of blood supply, which can result from various underlying factors, such as infections or other diseases. However, when gangrene is specifically diagnosed, it is essential to prioritize that diagnosis in the coding process. Gangrene itself needs to be coded first because it represents a distinct clinical entity that dictates the treatment and management approaches. This coding practice is part of the guidelines set by ICD-10-CM to ensure clarity and accuracy in documenting the primary reason for a patient's condition. By establishing gangrene as the primary diagnosis, healthcare providers can appropriately communicate the urgency and severity of the patient's situation, which is vital in ensuring proper treatment and care. While infections, cellulitis, or underlying conditions may contribute to or complicate the gangrene, coding gangrene first emphasizes the importance of recognizing and addressing the immediate threat to the patient's health. The clear clinical picture presented by gangrene aids in resource allocation and treatment planning.

2. What code is assigned to acute myocardial infarctions types 3, 4a, 4b, 4c, and 5?

A. I21.A1

B. I21.A9

C. N18.2

D. I13

The assignment of code I21.A9 is appropriate for acute myocardial infarction types 3, 4a, 4b, 4c, and 5. In the ICD-10-CM coding system, the category I21 refers specifically to types of acute myocardial infarction. The codes following I21 are used to distinguish the various types and circumstances of myocardial infarctions. I21.A9 is designated for unspecified acute myocardial infarction, which encompasses those specific types (3, 4a, 4b, 4c, and 5). This code reflects the importance of specificity in identifying the nature of the myocardial infarction and allows healthcare providers to document these events adequately for treatment and epidemiological tracking. In contrast, the other codes do not pertain directly to the classifications of myocardial infarction. N18.2, for instance, is related to chronic kidney disease, and I13 involves heart diseases secondary to hypertension, both of which fall outside the context of the question regarding myocardial infarctions. Thus, I21.A9 stands out as the correct designation.

3. What should be coded when both sickle cell disease and trait are documented in the patient's record?

- A. Only sickle cell trait**
- B. Only sickle cell disease**
- C. Both separately as complications**
- D. Neither, as they are genetic**

When both sickle cell disease and sickle cell trait are documented in a patient's record, the coding practice is to focus on sickle cell disease, as this condition represents a more severe manifestation of the genetic disorder. In ICD-10-CM coding, it is essential to prioritize the more serious condition when multiple related diagnoses are present. Sickle cell disease is a significant and chronic condition with implications for health management, treatment, and patient care that extends beyond what is indicated by having sickle cell trait alone. While sickle cell trait may be recorded in the patient's history and has its implications, it does not carry the same clinical significance as sickle cell disease in terms of coding. The ICD-10-CM guidelines instruct coders to assign the code that reflects the more serious condition, which in this case is sickle cell disease. Therefore, while both conditions are genetic, the focus should be on the condition that requires more detailed monitoring and management, hence the coding should reflect sickle cell disease as the priority diagnosis.

4. What is removed in a total hysterectomy?

- A. Only the cervix**
- B. Only the uterus**
- C. The whole uterus and cervix**
- D. The entire reproductive system**

A total hysterectomy involves the surgical removal of both the uterus and the cervix. This procedure generally is performed to treat various medical conditions such as uterine fibroids, endometriosis, or cancer. Removing both the uterus and the cervix is essential for a total hysterectomy and distinguishes this surgery from other types, such as a subtotal or partial hysterectomy, where only the uterus is removed while the cervix remains intact. In contrast, other options do not correctly describe what is removed during a total hysterectomy. Some choices mention only one structure, such as the cervix or just the uterus, which does not encompass the full scope of a total hysterectomy. Furthermore, the choice referring to the removal of the entire reproductive system is inaccurate, as a total hysterectomy does not include the removal of the ovaries or fallopian tubes unless specified as part of a more extensive procedure. Therefore, the correct understanding of this surgical procedure ensures clarity on what is involved in a total hysterectomy.

5. What is meant by “complications of other care” in ICD-10-CM?

- A. Secondary coding for ruled out conditions**
- B. Complications that arise from treatments**
- C. Unascribed complications**
- D. Previous condition complications**

"Complications of other care" in ICD-10-CM refers specifically to complications that arise from treatments or interventions that patients receive. When coding for these complications, it is essential to recognize that they may result from medical procedures, surgeries, or other therapeutic measures that were intended to treat a patient's condition. For instance, a patient who experiences an infection following surgery would have that infection coded as a complication of the surgical procedure. This classification is important in clinical documentation and billing as it helps to convey the severity and complexity of a patient's condition and the care they are receiving. By properly identifying these complications, healthcare providers can ensure accurate coding for reimbursement, as well as provide a clear picture of the patient's treatment journey. The other choices do not accurately capture the essence of the term. Secondary coding for ruled out conditions does not address complications arising from care, while unascribed complications and previous condition complications do not pertain directly to treatment-related adverse outcomes. Understanding the correct meaning helps in accurate diagnosis coding and ensures that medical records reflect the true nature of the care provided.

6. How are coronary arteries classified in coding?

- A. By the type of device used**
- B. By the number of distinct sites treated**
- C. By the size of the artery**
- D. By the patient's age**

The classification of coronary arteries in coding is primarily based on the number of distinct sites treated. This approach is important as it reflects the complexity and extent of the procedure conducted on the coronary arteries. When coding for interventions related to coronary arteries, such as angioplasty or stent placements, the coder must account for each distinct area treated to accurately represent the patient's condition and the services rendered. The focus on distinct sites is pivotal because different sites may require separate coding based on the guidelines set forth in the coding manuals. This attention to detail ensures that the documentation matches the patient's treatment accurately, which is essential for billing purposes and for ensuring the appropriate level of reimbursement. This classification system helps in creating a clear healthcare record and provides necessary information for statistical analysis and outcome measures. In contrast, classifying by the size of the artery or the type of device used does not suffice for coding as it does not capture the full scope of treatment. Additionally, the patient's age does not have a direct impact on how the arteries are categorized in the context of coding for coronary interventions. Thus, the classification by the number of distinct sites treated is the most appropriate and relevant for accurate coding practices.

7. In coding pathology, what must be included when documenting a pathological fracture?
- A. An examination of the site
 - B. The type of injury
 - C. The specific underlying disease causing the fracture**
 - D. Only the treatment received

When documenting a pathological fracture, it is essential to include the specific underlying disease that caused the fracture. This is foundational to understanding the context of the fracture, as pathological fractures occur in bones weakened by an underlying condition, such as osteoporosis, cancer, or metabolic disorders. Accurately coding the underlying disease provides insight into the patient's overall health status and aids in effective treatment planning. Pathological fractures are distinct from traumatic fractures in that they typically result from minimal or no trauma due to pre-existing pathological conditions. Therefore, knowing the underlying disease is vital for proper documentation and coding, as it guides clinical management and can have significant implications for prognosis and treatment options. Proper coding in these circumstances ensures that healthcare providers understand the multifactorial nature of the patient's condition.

8. Can Z03 and Z04 be assigned as a secondary diagnosis?
- A. Yes, they can always be secondary
 - B. No, they can only be principal**
 - C. Only if accompanied by a primary diagnosis
 - D. Yes, if it supports the primary diagnosis

The assertion that Z03 and Z04 codes can only be assigned as principal diagnoses is based on their definitions and guidelines provided within the ICD-10-CM coding system. Z03 refers to "Encounter for observation for suspected conditions not found," while Z04 pertains to "Encounter for observation for other specified reasons." Both of these codes are used when a patient is observed but does not have a definitive diagnosis that warrants treatment. In many coding scenarios, Z03 and Z04 are designated as principal diagnoses to capture the reason for the encounter. They indicate that the primary purpose of the visit was to rule out a condition and no other definitive diagnosis was established. Assigning them as secondary diagnoses does not align with their intended use. Thus, they are not appropriate for coding as secondary diagnoses, as their primary role is to outline the reason for the observation, rather than any additional health conditions that may need to be recorded. To summarize, understanding the context of Z03 and Z04 is key in recognizing why they should only be assigned as principal diagnoses. The design of the codes is specifically meant to provide clarity about the reason for patient encounters where no definitive diagnosis has been found.

9. When coding for excisional debridement, which approach should be documented?

- A. Incisional biopsy procedures**
- B. Excision of lesions not requiring incision**
- C. Direct extraction of tissue through excision**
- D. Non-invasive irrigation techniques**

In the context of coding for excisional debridement, documenting the approach of directly extracting tissue through excision is essential. This method specifically highlights the surgical technique used during the procedure. Excising tissue means that a portion of the affected area, including necrotic or infected tissue, is surgically removed, which is the core aspect of excisional debridement. Capturing this detail accurately is important for billing and medical records, as it reflects the nature and extent of the procedure performed, which can affect reimbursement and clinical documentation. The use of the term "excision" clearly denotes invasive action taken to remove tissue, distinguishing it from other methods that may not involve cutting or removing tissue. Using specific terminologies like "direct extraction" conveys to coders and healthcare providers that a significant level of intervention occurred, which is crucial in maintaining clarity and precision in coding practices. This level of accuracy in documentation also supports the justification for the surgical intervention when reviewing medical records and submitting claims to insurance providers.

10. What code is used when a patient tests positive for HIV and is symptomatic?

- A. M00.9**
- B. B20**
- C. R65.2**
- D. A41.9**

The correct choice, B20, is the appropriate code for a patient who tests positive for HIV and exhibits symptoms. This code specifically designates "Human immunodeficiency virus [HIV] disease," which encompasses symptomatic HIV infection, including any AIDS-related conditions. In the context of ICD-10-CM, this coding reflects the clinical significance of the diagnosis, indicating that the patient is not merely a carrier of the virus but is experiencing adverse health effects due to it. The other codes listed relate to different medical situations, thereby making them unsuitable for this scenario. M00.9 refers to unspecified infectious arthropathy, which does not connect to HIV. R65.2 is related to severe sepsis with septic shock but is not specific to HIV. A41.9 addresses unspecified sepsis, which again, does not capture the nuances of an HIV positive status with symptomatic disease. Therefore, B20 distinctly identifies the patient's HIV-related health status, which is pivotal in ensuring accurate diagnosis and treatment planning.