

ICD-10-CM Coding Practice Exam (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. What do the codes that include a description of "Unspecified" refer to?**
 - A. Codes that cannot be defined properly**
 - B. Cases where further information is needed**
 - C. Codes with no additional details available**
 - D. Instructions on how to code a disease**
- 2. In coding respiratory conditions, what must be verified before assigning a code?**
 - A. Documentation of past respiratory illnesses**
 - B. Presence of specific respiratory symptoms**
 - C. Criteria for coding respiratory failure and sequencing**
 - D. Patient's age and medical history**
- 3. In the context of excisional versus non-excisional debridements, what defines non-excisional debridement?**
 - A. It involves cutting away dead tissue**
 - B. It utilizes tools like ultrasonic devices**
 - C. It requires surgical setting**
 - D. It is primarily for skin rejuvenation**
- 4. When coding for a fracture and a pathological condition, how should they be handled?**
 - A. Both can be coded together**
 - B. Only the fracture should be coded**
 - C. Never code them together**
 - D. Only the pathological condition should be coded**
- 5. What procedure is described as transurethral?**
 - A. Open surgical**
 - B. Endoscopic**
 - C. Laparoscopic**
 - D. Robotic surgery**

6. Which coding guideline would apply if the same procedure is performed on different body parts during the same episode?

- A. Single procedures accomplished**
- B. Multiple procedures during the same operative episode**
- C. Concurrent procedures**
- D. Root operation coding**

7. What does documentation insufficient to determine if a condition was present at admission represent in POA coding?

- A. Y**
- B. N**
- C. U**
- D. W**

8. When coding a procedure that includes gangrene, what should be coded first?

- A. The gangrene diagnosis**
- B. The patient's age**
- C. The procedure performed**
- D. The secondary diagnoses**

9. Which symbol is used in ICD-10-CM to indicate that a code can only be a manifestation?

- A. Colon**
- B. Square brackets**
- C. Parentheses**
- D. Exclamation mark**

10. In coding, what should you do when multiple layers of tissue are excised?

- A. Code all layers separately**
- B. Code only the superficial layer**
- C. Code only the deepest layer**
- D. Do not code excisional debridements**

Answers

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

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Explanations

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1. What do the codes that include a description of "Unspecified" refer to?

- A. Codes that cannot be defined properly**
- B. Cases where further information is needed**
- C. Codes with no additional details available**
- D. Instructions on how to code a disease**

"Unspecified" codes in the ICD-10-CM classification system indicate situations where the condition cannot be classified into a more specific code due to insufficient detail. These codes serve a purpose in capturing data for cases where the exact nature of a condition is not fully known at the time of coding. Choosing codes marked as "unspecified" allows healthcare providers to document a diagnosis even when all information about the patient's condition is not available. This can happen, for instance, during initial assessments or when a more comprehensive evaluation has not yet been completed. While some might think that "unspecified" suggests codes that cannot be defined properly, it primarily acts as an administrative category, allowing for the capture of vital information without having the complete clinical picture. Therefore, in this context, the focus is more on cases lacking additional details rather than a total inability to define a condition.

2. In coding respiratory conditions, what must be verified before assigning a code?

- A. Documentation of past respiratory illnesses**
- B. Presence of specific respiratory symptoms**
- C. Criteria for coding respiratory failure and sequencing**
- D. Patient's age and medical history**

In coding respiratory conditions, specifically for respiratory failure, it is essential to verify the criteria for coding and the correct sequencing of codes. Respiratory failure can be classified as either acute or chronic, and it may present in various ways, which dictates the specific codes to be used. The guidelines for coding respiratory failure are particularly detailed, as accurate coding can impact treatment plans, reimbursement, and the patient's medical record. Moreover, the sequencing of codes is crucial - it often determines which condition is considered the primary diagnosis versus secondary diagnoses. Correctly identifying the primary reason for the healthcare encounter allows for the most accurate and effective coding based on clinical guidelines. Therefore, understanding the established criteria for respiratory failure and ensuring the proper order of codes greatly influences the accuracy of medical coding.

3. In the context of excisional versus non-excisional debridements, what defines non-excisional debridement?

- A. It involves cutting away dead tissue**
- B. It utilizes tools like ultrasonic devices**
- C. It requires surgical setting**
- D. It is primarily for skin rejuvenation**

Non-excisional debridement is defined by its method of tissue removal, which emphasizes the use of non-invasive or minimally invasive techniques rather than cutting away tissue. The correct choice recognizes that non-excisional debridement often utilizes tools like ultrasonic devices, which can effectively remove dead or damaged tissue without the need for surgical intervention. This approach minimizes trauma to healthy tissue and is typically performed in non-surgical settings, making it less invasive than excisional debridement. By using instruments such as ultrasonic devices, healthcare providers can disrupt and remove necrotic tissue while preserving the underlying healthy tissue. This method is beneficial for patient recovery and comfort, aligning with modern practices aimed at promoting healing and tissue regeneration. In contrast, other options do not accurately define non-excisional debridement. The notion of cutting away dead tissue directly relates to excisional methods rather than non-excisional ones. Requiring a surgical setting is also a characteristic of excisional procedures, as they necessitate a controlled environment for surgical operations. The mention of skin rejuvenation is not a primary goal of non-excisional debridement, which focuses more on the removal of non-viable tissue to assist in wound healing.

4. When coding for a fracture and a pathological condition, how should they be handled?

- A. Both can be coded together**
- B. Only the fracture should be coded**
- C. Never code them together**
- D. Only the pathological condition should be coded**

When coding for a fracture and a pathological condition, it is essential to understand the guidelines set forth in the ICD-10-CM coding system. The correct approach is to ensure that only one of these conditions is coded, depending on their clinical significance and the specific scenario presented in the medical documentation. The rationale for coding them separately focuses on the guidelines of clinical significance. In cases where a pathological condition contributes to the development of a fracture, the focus should typically be placed on the underlying pathological condition rather than the fracture itself. This is because the fracture is a manifestation of the underlying disease process rather than an independent injury. Therefore, the guidelines direct coders to highlight the cause (i.e., the pathological condition) over the effect (the fracture), when the fracture is due to the underlying disease. By coding only the pathological condition, coders ensure that the medical records accurately reflect the patient's situation, which is crucial for treatment, research, and insurance purposes. It also helps avoid redundancy in coding and potential over-reporting of conditions that arise from the same underlying cause. Hence, understanding the relationship between a fracture and a pathological condition is vital for accurate coding practices.

5. What procedure is described as transurethral?

- A. Open surgical
- B. Endoscopic**
- C. Laparoscopic
- D. Robotic surgery

Transurethral procedures involve accessing the urinary tract through the urethra, which is typically done using an endoscopic approach. This technique allows for visualization and intervention within the urinary bladder or prostate without the need for external incisions, making it minimally invasive. Instruments are inserted through the urethra, allowing for direct access to the target area to perform various therapeutic or diagnostic procedures. Endoscopy is characterized by its use of flexible or rigid scopes that provide visualization and can facilitate interventions. In the case of transurethral procedures, such as transurethral resection of the prostate (TURP) or bladder tumor resection, the endoscopic method is crucial because it minimizes discomfort and recovery time for the patient compared to more invasive surgical techniques. Other options delineate distinct types of surgical methods: open surgical procedures involve larger incisions and more extensive surgical intervention; laparoscopic procedures utilize small incisions and specialized instruments but are not typically accessed through the urethra; while robotic surgery employs robotic assistance for precision in various surgical fields, it also doesn't inherently refer to the access point through the urethra. Therefore, the identification of transurethral procedures as endoscopic accurately captures the essence of the technique.

6. Which coding guideline would apply if the same procedure is performed on different body parts during the same episode?

- A. Single procedures accomplished
- B. Multiple procedures during the same operative episode**
- C. Concurrent procedures
- D. Root operation coding

When the same procedure is performed on different body parts during the same episode, the relevant coding guideline relates to multiple procedures during the same operative episode. This guideline is critical because it addresses how to appropriately code and report multiple instances of the same procedure within a single surgical or treatment session. In this situation, coding practices often specify how to combine or modify codes to ensure that they accurately reflect the services rendered without over-coding. For example, if a surgeon performs an appendectomy on both sides of the body during one operation, the coding would need to reflect that multiple procedures were executed. Coding scenarios can be complex, especially regarding how to report services for procedures that affect multiple anatomical sites. Therefore, familiarity with the guidelines surrounding multiple procedures ensures accurate reporting and billing practices. This option emphasizes the consideration of both medical necessity and clinical details essential for coding practices, ensuring providers are adequately compensated for the services they deliver.

7. What does documentation insufficient to determine if a condition was present at admission represent in POA coding?

- A. Y**
- B. N**
- C. U**
- D. W**

In the context of Present on Admission (POA) coding, the code representing documentation that is insufficient to determine if a condition was present at admission is "U." This coding designation is specifically used when there is a lack of clear documentation to ascertain whether a diagnosis existed at the time of a patient's admission to a healthcare facility. The designation "U" is particularly crucial for healthcare providers as it acknowledges the ambiguity related to the admission status of certain conditions and ensures that this uncertainty is accurately reflected in the coded data. It plays an essential role in hospital reimbursement and quality reporting, as proper identification of conditions that were present at admission impacts various clinical and financial metrics. The other options correspond either to conditions that are clearly marked as present (Y) or not present (N) at admission or to specific conditions that are not applicable or documented differently (W). Therefore, "U" is the appropriate classification for instances where there is insufficient documentation to confirm the presence of a condition at the time of admission.

8. When coding a procedure that includes gangrene, what should be coded first?

- A. The gangrene diagnosis**
- B. The patient's age**
- C. The procedure performed**
- D. The secondary diagnoses**

When coding a procedure involving gangrene, initiating the coding with the gangrene diagnosis is essential. This is because the underlying condition, in this case, gangrene, provides crucial context for the procedure itself. It signifies the reason for the surgical intervention, indicating the seriousness of the condition that necessitates treatment. In ICD-10-CM coding practice, the main focus is often on accurately representing the primary diagnosis that led to the procedural need. By addressing the gangrene first, the coder ensures that the primary indication for the procedure is documented, aligning with coding guidelines that prioritize establishing the principal diagnosis before detailing the procedure performed or any secondary diagnoses. Other factors, such as the patient's age or secondary diagnoses, while relevant for the overall understanding of the patient's status, are not central to coding the procedure itself and should follow after establishing the primary diagnosis. Thus, prioritizing the coding of gangrene accurately reflects the clinical situation and meets the guidelines for proper coding practice.

9. Which symbol is used in ICD-10-CM to indicate that a code can only be a manifestation?

- A. Colon**
- B. Square brackets**
- C. Parentheses**
- D. Exclamation mark**

In ICD-10-CM coding, parentheses are used to enclose supplementary words that may clarify the code but are not essential to its definition. This includes additional information that helps in understanding the context or specificity of the diagnosis but does not change the code assignment. In particular, when a code is classified as a manifestation, it indicates that the code is to be used in conjunction with another code that represents the underlying condition. Therefore, when you see a code enclosed in parentheses, it signifies that it is a manifestation and cannot stand alone. For example, a manifestation code might describe the symptoms or complications arising from a primary condition. The use of parentheses in coding highlights that the manifestation itself isn't the primary diagnosis; rather, it relies on the primary condition to provide a complete clinical picture. Understanding this relationship is crucial in proper coding practices, as it ensures that care providers understand the need to always reference and apply the underlying condition when documenting patient encounters.

10. In coding, what should you do when multiple layers of tissue are excised?

- A. Code all layers separately**
- B. Code only the superficial layer**
- C. Code only the deepest layer**
- D. Do not code excisional debridements**

When coding for excision of multiple layers of tissue, the correct practice is to focus on coding only the deepest layer excised. This is because the coding guidelines are structured to capture the most significant and comprehensive level of the surgical procedure performed. In many instances, when multiple layers are removed, coding for just the deepest layer reflects the complexity of the procedure and provides an accurate representation of the surgical service. In this context, coding aims to ensure that the report of the procedure matches the extent of tissue removed and the surgical effort required. The rationale is that the deeper layers often encompass the more serious conditions or the more complex nature of the operation, thereby justifying the procedure's coding based on the most extensive surgical work performed. Although coding all layers separately may seem logical at first, it is generally not the standardized approach for layered excisions under current guidelines. Similarly, coding only the superficial layer would undervalue the procedure, and not coding excisional debridements at all would omit critical information that could affect patient care and billing. These reasons substantiate why the correct answer is to code only the deepest layer excised.

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://icd10cmcoding.examzify.com>

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

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