

ICD-10-CM CODING PRACTICE EXAM (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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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 should be done if a physician documents an impending condition that has not occurred by the time of discharge?**
 - A. Code the impending condition
 - B. Code the existing underlying conditions
 - C. Wait for further documentation before coding
 - D. Code both conditions regardless of documentation

- 2. Which procedure involves the removal of the whole uterus and cervix?**
 - A. Endometrial ablation
 - B. Partial hysterectomy
 - C. Total hysterectomy
 - D. Myomectomy

- 3. Which of the following medications is used for the treatment of allergies?**
 - A. Ciprofloxacin
 - B. Clarithromycin
 - C. Claritin
 - D. Pantoprazole

- 4. What is urosepsis classified as?**
 - A. A specific infection
 - B. A synonym for sepsis
 - C. A nonspecific term
 - D. An excluded condition

- 5. What does the "A" code signify in fracture coding in ICD-10-CM?**
 - A. Subsequent encounter
 - B. Initial encounter
 - C. Sequela of fracture
 - D. Non-specific encounter

- 6. What term describes fractures that occur in weakened bones due to disease?**
- A. Traumatic fractures
 - B. Pathological fractures
 - C. Spontaneous fractures
 - D. Stress fractures
- 7. When cancer leaves its original site, what is this called?**
- A. Primary growth
 - B. Secondary neoplasm
 - C. Distant spread
 - D. Metastatic site
- 8. When a patient is admitted with a localized infection and later develops sepsis, how should the localized infection be coded?**
- A. As a secondary diagnosis
 - B. As a primary diagnosis
 - C. As an incidental finding
 - D. As a resolved condition
- 9. How is control of post-procedural bleeding coded when unsuccessful?**
- A. It is coded as Control
 - B. A more definitive root operation is coded instead
 - C. No code is required
 - D. Document under evaluation
- 10. A combination code is used to classify which of the following?**
- A. Two separate diagnoses
 - B. A diagnosis with an associated manifestation
 - C. A diagnosis with an associated complication
 - D. All of the above

Answers

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

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Explanations

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1. What should be done if a physician documents an impending condition that has not occurred by the time of discharge?

- A. Code the impending condition
- B. Code the existing underlying conditions**
- C. Wait for further documentation before coding
- D. Code both conditions regardless of documentation

In the context of coding for an impending condition that has not occurred by the time of discharge, the recommended approach is to code the existing underlying conditions. This is based on the principles established in ICD-10-CM guidelines, which specify that conditions must be coded only if they are clinically supported and meet the criteria for specificity. When documenting an impending condition, it is crucial to recognize that coding is generally based on the patient's actual medical status at the time of discharge. If the condition has not manifested, it does not warrant a code. Instead, existing underlying conditions that are relevant to the patient's health and treatment can be appropriately coded. This maintains accuracy in medical records and billing by ensuring that only verified and confirmed diagnoses are used, which adhere to coding standards. In cases where a condition is noted as 'impending' but does not materialize, coding it would not comply with best practices, as there is no supportive evidence of its occurrence. Furthermore, waiting for further documentation before coding is often impractical due to deadlines for claims submission and discharge processing. Coding both conditions without proper documentation could lead to errors or inconsistencies in the medical record, so this is not advised. Thus, focusing on the existing underlying conditions provides a clear and justified approach to coding.

2. Which procedure involves the removal of the whole uterus and cervix?

- A. Endometrial ablation
- B. Partial hysterectomy
- C. Total hysterectomy**
- D. Myomectomy

The procedure that involves the removal of the whole uterus and cervix is a total hysterectomy. In this surgical procedure, both the body of the uterus and the cervix are excised, which may be indicated for various medical reasons, including fibroids, severe endometriosis, or cancer. Understanding the terminology in coding is essential; "total" in the context of hysterectomy clearly defines the extent of tissue removal compared to other procedures. For instance, endometrial ablation is focused solely on the lining of the uterus and does not involve any removal of the uterus itself. A partial hysterectomy, in contrast, only removes part of the uterus, leaving either the cervix intact or a portion of the uterine body. Myomectomy is a specific procedure that removes fibroids from the uterus without removing the entire organ. Knowing these distinctions allows for accurate coding and reporting in medical practice.

3. Which of the following medications is used for the treatment of allergies?

- A. Ciprofloxacin
- B. Clarithromycin
- C. Claritin**
- D. Pantoprazole

Claritin is the correct choice because it is an antihistamine specifically designed to relieve allergy symptoms such as sneezing, runny nose, and itchy or watery eyes. Antihistamines work by blocking the action of histamine, a substance in the body that causes allergic symptoms, making Claritin effective for treating conditions like hay fever and other allergies. Ciprofloxacin, although a useful antibiotic, is not indicated for allergies but rather for treating bacterial infections. Clarithromycin is also an antibiotic and is typically used to treat respiratory tract infections and other bacterial conditions, not allergies. Pantoprazole is a proton pump inhibitor used in the treatment of gastrointestinal conditions such as gastroesophageal reflux disease (GERD) and is not related to allergy treatment. Therefore, Claritin stands out as the appropriate medication for managing allergy symptoms.

4. What is urosepsis classified as?

- A. A specific infection
- B. A synonym for sepsis
- C. A nonspecific term**
- D. An excluded condition

Urosepsis is classified as a nonspecific term because it refers to a systemic response to infection that originates from the urinary tract. While it indicates that the infection comes from the urinary system, the term itself does not describe the specific pathogen or the precise nature of the infection. Instead, it highlights the systemic response, which may be due to any number of infectious agents, making it a broader classification. In the context of medical coding and understanding diagnoses, labeling urosepsis as nonspecific is important because it allows healthcare providers and coders to recognize that there can be various underlying causes or pathogens responsible for the condition, which may require further investigation and treatment. This classification communicates to healthcare professionals that, while the urinary tract is a starting point, the implications of urosepsis are extensive and potentially serious, involving widespread effects on the body due to the infection. By understanding urosepsis in this way, coding can be appropriately aligned with the clinical implications of the condition.

5. What does the "A" code signify in fracture coding in ICD-10-CM?

- A. Subsequent encounter
- B. Initial encounter**
- C. Sequela of fracture
- D. Non-specific encounter

The "A" code in fracture coding within the ICD-10-CM framework signifies an initial encounter for the fracture. This means that the patient is being seen for the first time for that specific fracture, which is essential for accurate documentation and coding in the medical record. Initial encounter codes are used during the active treatment phase, where the physician may be performing procedures such as reduction, casting, or surgical intervention to address the fracture. This designation is crucial as it helps healthcare providers and insurers understand the context of the treatment being administered to the patient. The distinction of encounters is important in fracture coding, as it influences not just treatment protocols but also billing practices. In contrast, subsequent encounters would apply to follow-up visits where the patient is being monitored for healing or receiving rehabilitation services, while sequela or late effects of the fracture would address issues arising after the fracture has healed. The non-specific encounter does not adequately convey the treatment circumstance and thus does not have a corresponding code in this scenario.

6. What term describes fractures that occur in weakened bones due to disease?

- A. Traumatic fractures
- B. Pathological fractures**
- C. Spontaneous fractures
- D. Stress fractures

The term that describes fractures occurring in weakened bones due to disease is "pathological fractures." These fractures typically happen in bones that have been compromised by various medical conditions such as osteoporosis, cancer, or infections. Unlike traumatic fractures, which result from a significant force or impact, pathological fractures occur without a strong or excessive force because the bone's structural integrity is already impaired. Pathological fractures highlight the importance of underlying health issues impacting bone strength, recognizing that a fracture can occur even under normal conditions because the bone is not healthy. This understanding is crucial for proper coding and treatment planning in a clinical setting, as it indicates that the primary issue is the underlying disease rather than external trauma.

7. When cancer leaves its original site, what is this called?

- A. Primary growth
- B. Secondary neoplasm**
- C. Distant spread
- D. Metastatic site

The term that describes when cancer leaves its original site and spreads to other parts of the body is classified as a secondary neoplasm. In cancer terminology, a secondary neoplasm refers to a new and distinct tumor that arises from the spread of the cancerous cells, as opposed to the primary tumor, which is the original site of the cancer. When cancer cells detach from the primary tumor and migrate through the bloodstream or lymphatic system to establish a new tumor in a different organ or tissue, they are considered secondary neoplasms. This process illustrates the aggressive nature of cancer and its ability to invade other areas, making treatment more complex. In contrast, primary growth refers specifically to the original tumor where the cancer began. Distant spread generally indicates the same concept of reaching far-off parts of the body but does not specifically refer to the tumor itself. A metastatic site, while related, emphasizes the location of the secondary neoplasm rather than naming the phenomenon of spreading itself. Hence, secondary neoplasm accurately encapsulates the process of cancer spreading to new sites in the body.

8. When a patient is admitted with a localized infection and later develops sepsis, how should the localized infection be coded?

- A. As a secondary diagnosis
- B. As a primary diagnosis**
- C. As an incidental finding
- D. As a resolved condition

When coding for a patient admitted with a localized infection who later develops sepsis, coding the localized infection as a primary diagnosis is appropriate in this scenario. This is because the localized infection is the condition that led to the subsequent development of sepsis. In ICD-10-CM guidelines, the principal diagnosis is defined as the condition established after study that was the reason for the admission of the patient to the hospital. Since the patient was initially admitted due to the localized infection, this condition should be coded as the primary diagnosis. The other options do not align with the coding standards because coding the localized infection as a secondary diagnosis would diminish its role in the patient's clinical scenario, as it directly contributed to the development of the more severe condition, sepsis. Labeling it an incidental finding would imply it was not a significant factor in the patient's admission, which is not the case here. Also, coding it as a resolved condition would misrepresent the clinical status of the infection at the time of admission, as it was actively contributing to the patient's health issues.

9. How is control of post-procedural bleeding coded when unsuccessful?

- A. It is coded as Control
- B. A more definitive root operation is coded instead**
- C. No code is required
- D. Document under evaluation

When coding for control of post-procedural bleeding that is unsuccessful, it is important to reflect the complexity and the nature of the procedure. In this case, selecting a more definitive root operation rather than simply coding it as "Control" is appropriate because the attempt to manage the bleeding can involve additional surgical interventions. This approach aligns with the principles of surgical coding, which dictate that when a procedure intended to control a complication (like post-procedural bleeding) is unsuccessful, the coder must acknowledge the overall procedural context. By coding a more definitive root operation, the coding accurately represents the additional surgical efforts undertaken to address a serious complication rather than simply capturing an unsuccessful attempt to control the bleeding. This ensures that healthcare records accurately reflect the complexity of the patient's situation and the care provided, which is essential for quality reporting and reimbursement.

10. A combination code is used to classify which of the following?

- A. Two separate diagnoses
- B. A diagnosis with an associated manifestation
- C. A diagnosis with an associated complication
- D. All of the above**

A combination code is used in medical coding to represent a single code that captures multiple elements of a patient's condition, which can include various scenarios such as a diagnosis with an associated manifestation or a diagnosis complicated by another condition. The first scenario involves using a combination code for two different aspects of a medical condition that are intricately linked, such as a primary diagnosis combined with its manifestation. This helps streamline documentation and billing by ensuring that the relationship between the diagnosis and its expected manifestation is clearly understood. The second scenario addresses how a combination code can also identify a diagnosis alongside a complication. This is crucial in situations where the primary diagnosis leads to or is complicated by another condition, as correct coding must reflect these relationships to maintain accuracy in medical records and ensure appropriate reimbursement. Therefore, any instance where a single code can effectively summarize and encompass the complexity of relationships between a primary diagnosis, a manifestation, and potential complications can effectively utilize a combination code. This holistic approach to coding minimizes the risk of miscommunication and ensures that patients' conditions are well-represented.

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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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