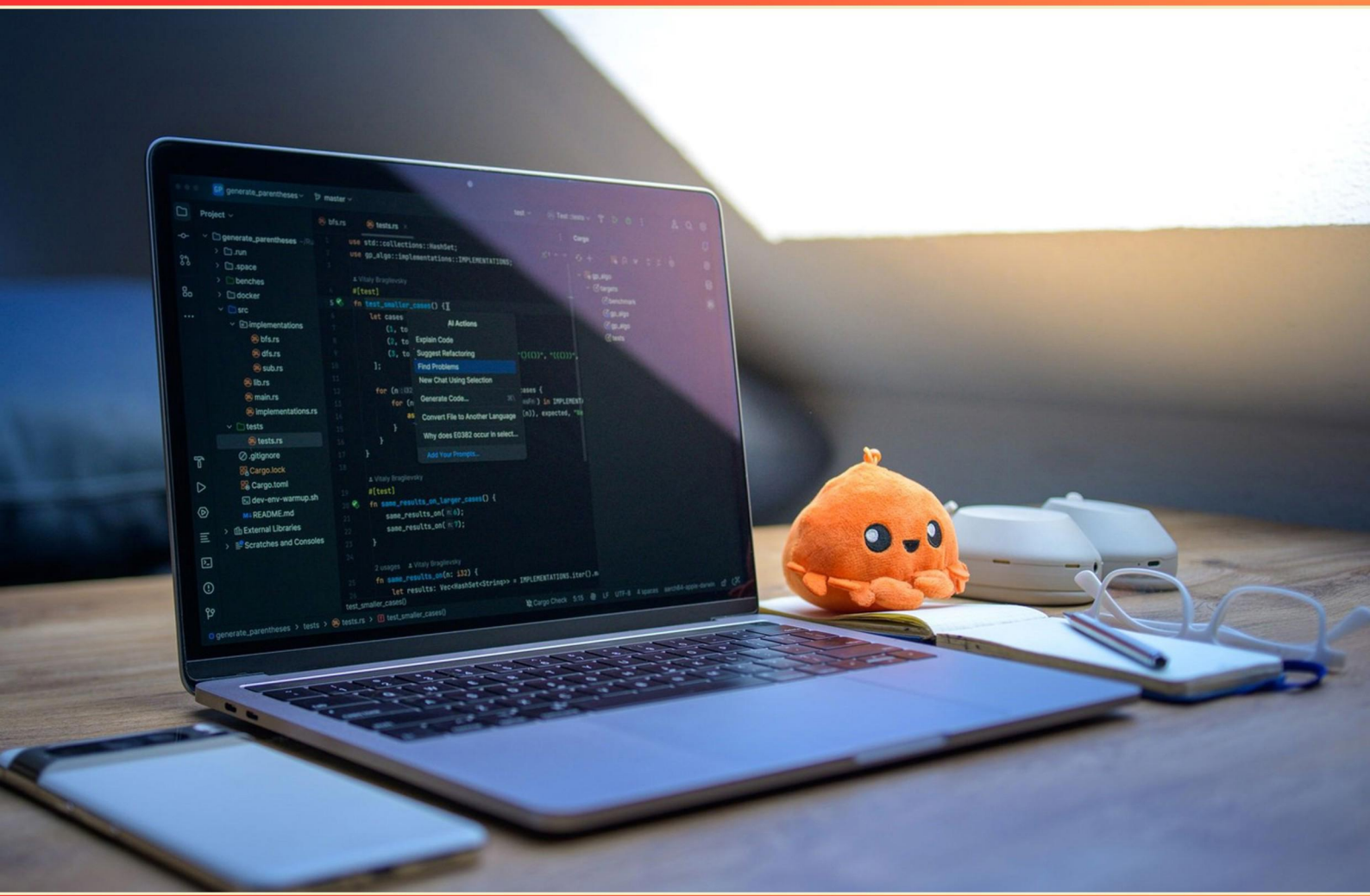
INTEGRATED BILLING AND CODING PRACTICE TEST (SAMPLE)

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

1. Which statement about IPIP usage by the attending physician is supported by the material?

A. The IPIP outline can be used for reports by the attending physician.

B. IPIP is mandatory for all reports.

C. IPIP cannot be used in private practice.

D. IPIP is only used for billing.

2. Which is the outermost layer of the skin?

A. Epidermis

B. Dermis

C. Hypodermis

D. Stratum corneum

3. Which CPT code is used for a cystorrhaphy?

A. 51860

B. 51850

C. 51910

D. 51870

4. A patient is diagnosed with acute erosion of the duodenum. Which ICD-10-CM code best represents this diagnosis?

A. K26.9

B. K27.0

C. K26.0

D. K25.0

5. Diseases of the ear and mastoid process are reported within Chapter 8 of ICD-10-CM and are reported with code range H00-H95.

A. True

B. Not sure

C. False

D. Both

6. In a tissue mutation identification by sequencing for suspected melanoma, which ICD-10-CM and CPT codes are used?

A. D03.39, 83904

B. D03.39, 83905

C. D03.3, 83904

D. D03.49, 83904

7. DIAGNOSIS codes explain except: What the insurance carrier should pay for it all

A. The insurance carrier payment amount

B. The severity of the illness

C. The prognosis

D. The affected body system

8. In an ophthalmology office, a professional coding specialist is likely to see many different types of health conditions, including which type of health care services?

A. Daily living activities

B. Preventive health care services

C. Emergency care

D. Surgical procedures

9. Which CPT code corresponds to thoracoscopic surgery with biopsy of the lung?

A. 32606

B. 32604

C. 32608

D. 32612

10. Incisional hernia without obstruction or gangrene

A. K43.0

B. K41.9

C. K44.00

D. K43.2

Answers

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

Explanations

1. Which statement about IPIP usage by the attending physician is supported by the material?

A. The IPIP outline can be used for reports by the attending physician.

B. IPIP is mandatory for all reports.

C. IPIP cannot be used in private practice.

D. IPIP is only used for billing.

The main idea is that IPIP provides a structured outline the attending physician can use when preparing reports. The material presents the IPIP outline as a tool to guide documentation, helping to ensure consistency and clarity in the attending's reports. It's not described as something mandatory for every report, nor as something that applies only in private practice or solely for billing. That flexibility is what makes the option stating that the IPIP outline can be used for reports by the attending physician the best fit. The other statements overreach or misstate the scope—implying universal mandatory use, private-practice restrictions, or billing-only use—none of which align with how IPIP is described in the material.

2. Which is the outermost layer of the skin?

A. Epidermis

B. Dermis

C. Hypodermis

D. Stratum corneum

The outermost layer of the skin is the epidermis. It sits above the dermis and forms the protective surface that interfaces with the environment. Within the epidermis, the very outer portion is the stratum corneum, a layer of flattened dead cells that provides a durable, waterproof barrier. The dermis lies beneath the epidermis and contains structures like blood vessels, nerves, and glands. The hypodermis is the deepest layer, mainly fat and connective tissue that anchors the skin to underlying tissues. So while the stratum corneum is part of the epidermis, it's the epidermis as a whole that is the skin's outermost layer.

3. Which CPT code is used for a cystorrhaphy?

A. 51860

B. 51850

C. 51910

D. 51870

The main idea is recognizing that cystorrhaphy means repairing the bladder. In CPT, the repair of the bladder wall is coded with 51860, which is used whenever the procedure involves suturing or reconstructing bladder tissue. The other codes describe different bladder procedures, such as endoscopic evaluation of the bladder (cystourethroscopy) or a drainage procedure for the bladder, and do not represent a repair of the bladder wall. Therefore, the code for a cystorrhaphy is 51860.

4. A patient is diagnosed with acute erosion of the duodenum. Which ICD-10-CM code best represents this diagnosis?

A. K26.9

B. K27.0

C. K26.0

D. K25.0

When coding duodenal conditions, ICD-10-CM uses the K26 block for duodenal ulcers and the K27 block for duodenitis/other duodenal disorders. If the report says an acute erosion of the duodenum, the closest match in coding conventions is an acute duodenal ulcer, because erosion in this region is treated as an ulcerative process in ICD-10-CM. The documentation explicitly specifies acuteness, so the code for an acute duodenal ulcer—K26.0—is the best fit. The other options point to either a non-acute or different duodenal condition (duodenitis) or to a gastric (not duodenal) ulcer, which don't align with the site and description given.

5. Diseases of the ear and mastoid process are reported within Chapter 8 of ICD-10-CM and are reported with code range H00-H95.

A. True

B. Not sure

C. False

D. Both

The main concept here is matching the correct ICD-10-CM code range to the chapter for ear and mastoid diseases. In ICD-10-CM, diseases of the ear and mastoid process are in Chapter 8 and use the range H60-H95. The range H00-H95 would span both eye diseases (H00-H59) and ear diseases (H60-H95), which is not how the ear/mastoid disorders are coded. So the statement is false because the correct range for ear and mastoid conditions is H60-H95, not H00-H95.

6. In a tissue mutation identification by sequencing for suspected melanoma, which ICD-10-CM and CPT codes are used?

A. D03.39, 83904

B. D03.39, 83905

C. D03.3, 83904

D. D03.49, 83904

When coding this scenario, you bill the diagnosis prompting the test with an ICD-10-CM code and the laboratory test itself with a CPT code. For a tissue mutation identification by sequencing performed to evaluate a suspicious melanoma where the site isn't specified, the diagnosis fits melanoma in situ, unspecified site, coded as D03.39. The lab test described—mutation analysis by sequencing to identify a tissue mutation—maps to a single-gene sequencing mutation analysis, billed as CPT 83904. The alternative CPT 83905 would be used only if sequencing for multiple genes or a broader panel were performed, which isn't indicated here. If a specific site were documented, a different D03.x code might be used; if the melanoma were invasive, a different cancer code would apply.

7. DIAGNOSIS codes explain except: What the insurance carrier should pay for it all

A. The insurance carrier payment amount

B. The severity of the illness

C. The prognosis

D. The affected body system

Diagnosis codes describe the patient's condition and where it affects the body, and they can convey information about how severe the illness is. They also help form the clinical picture that informs prognosis, and they support medical necessity for the services billed. What the insurer will pay for a service, however, is not determined by the diagnosis code itself. Payment amount is mainly driven by the CPT/HCPCS procedure codes, modifiers, and the payer's reimbursement rules and contracts. That's why the statement about what the insurance carrier should pay for it all is the one that diagnosis codes do not explain.

8. In an ophthalmology office, a professional coding specialist is likely to see many different types of health conditions, including which type of health care services?

A. Daily living activities

B. Preventive health care services

C. Emergency care

D. Surgical procedures

In ophthalmology, the focus often includes routine eye health maintenance and early detection of problems. Preventive health care services cover these routine eye exams, vision screenings, and monitoring for conditions that can affect the eyes, such as diabetes or hypertension, before symptoms appear. Because these preventive visits are a common and ongoing part of eye care, they're a frequent type of service you'll code in this setting. Daily living activities describe functional status rather than medical services coded for, emergency care represents urgent, episodic care, and surgical procedures refer to operative interventions. While those do occur in or around ophthalmology, they're not the typical, broad category of visits you'd most often encounter for everyday practice coding. The preventive care category best aligns with the routine, ongoing eye health services provided in a typical ophthalmology office.

9. Which CPT code corresponds to thoracoscopic surgery with biopsy of the lung?

A. 32606

B. 32604

C. 32608

D. 32612

The key idea is choosing the CPT descriptor that exactly matches the tissue and approach used. When a biopsy is taken from the lung through a thoracoscopy, the code must reflect a thoracoscopic procedure with a biopsy of lung tissue. That descriptor aligns precisely with performing a biopsy of the lung via a thoracoscopic (minimally invasive) approach. The other codes in this thoracoscopy range describe biopsies of other thoracic structures or different thoracoscopic procedures, not the lung itself. So they wouldn't accurately represent a lung biopsy performed through thoracoscopy. By matching the procedure to the descriptor that specifies a thoracoscopic lung biopsy, you ensure the coding reflects the actual operation performed.

10. Incisional hernia without obstruction or gangrene

A. K43.0

B. K41.9

C. K44.00

D. K43.2

The key idea is selecting the ICD-10-CM code for an incisional (ventral) hernia without any complication like obstruction or gangrene. An incisional hernia is a hernia that occurs at the site of a prior surgical incision, and when there are no obstructive or gangrenous changes, the specific code for that uncomplicated condition is K43.2. The other codes point to different scenarios (hernias at other sites or with complications such as obstruction or gangrene, or to diaphragmatic hernia). Since the situation describes an incisional hernia with no obstruction or gangrene, K43.2 best matches the diagnosis.

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://integratedbillingcoding.examzify.com

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