

Medical Coding Practice Test (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

- 1. What might healthcare providers experience if found guilty of coding fraud?**
 - A. Enhanced job stability**
 - B. Public recognition**
 - C. Loss of licensure and legal penalties**
 - D. Increased patient referrals**
- 2. What does "NEC" stand for in ICD-9-CM coding?**
 - A. Not Entitled Condition**
 - B. Not Elsewhere Classified**
 - C. No Excluded Coding**
 - D. Now Enter Code**
- 3. What is the primary aim of medical coding?**
 - A. To ensure accurate billing and reimbursement**
 - B. To provide comprehensive medical histories**
 - C. To enhance patient care standards**
 - D. To document pharmaceutical usage**
- 4. What are the two main types of codes found in ICD-10?**
 - A. Treatment codes and prescription codes**
 - B. Diagnosis codes and procedure codes**
 - C. Service codes and billing codes**
 - D. Assessment codes and referral codes**
- 5. Which of the following is not a part of the coding process?**
 - A. Reviewing clinical documentation**
 - B. Assigning codes based on diagnoses**
 - C. Providing patient treatment**
 - D. Billing for services rendered**
- 6. Who primarily uses M codes in ICD-9-CM?**
 - A. Physicians in clinical settings**
 - B. Health insurance companies**
 - C. Cancer registries**
 - D. Government health agencies**

- 7. What is the purpose of a "coverage determination" in medical coding?**
- A. To finalize a patient's treatment plan**
 - B. To clarify if a procedure or service is covered under a patient's insurance plan**
 - C. To assess the effectiveness of a procedure**
 - D. To document all medical services rendered**
- 8. What is the Coding Clinic for ICD-9-CM, and who publishes it?**
- A. Provides training for coding professionals, published by NCHS**
 - B. A quarterly publication by AHIMA**
 - C. A quarterly publication by AHA**
 - D. Provides certification for coding professionals, published by CMS**
- 9. What is the role of modifiers in medical coding?**
- A. To reduce coding errors**
 - B. To provide additional information about a procedure or service**
 - C. To classify insurance reimbursements**
 - D. To enhance patient records**
- 10. Why are updates made to the ICD system?**
- A. To change the method of reimbursement**
 - B. To reflect new healthcare practices and diagnostic criteria**
 - C. To make coding more complex**
 - D. To limit the number of codes available**

Answers

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

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Explanations

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1. What might healthcare providers experience if found guilty of coding fraud?

- A. Enhanced job stability**
- B. Public recognition**
- C. Loss of licensure and legal penalties**
- D. Increased patient referrals**

Healthcare providers found guilty of coding fraud face serious consequences, including the potential loss of their professional licensure and legal penalties. Coding fraud undermines the integrity of the healthcare system by misrepresenting the services provided, which can lead to overbilling of patients and insurers. The loss of licensure signifies that a provider may no longer legally practice in their field, directly impacting their career and trust within the community. Legal penalties can range from hefty fines to imprisonment, depending on the severity of the fraudulent activities. Such outcomes emphasize the importance of ethical coding practices and adherence to regulations in the healthcare industry.

2. What does "NEC" stand for in ICD-9-CM coding?

- A. Not Entitled Condition**
- B. Not Elsewhere Classified**
- C. No Excluded Coding**
- D. Now Enter Code**

The correct answer is B Not Elsewhere Classified. This refers to a category of codes in the ICD-9-CM coding system that is used for conditions or diseases that do not fit into any other category. Option A, Not Entitled Condition, is incorrect because there is no such category in ICD-9-CM coding. Option C, No Excluded Coding, is also incorrect as it does not accurately explain the use of "NEC" in ICD-9-CM coding. Option D, Now Enter Code, is a made-up phrase and does not accurately represent the purpose of "NEC" in ICD-9-CM coding.

3. What is the primary aim of medical coding?

- A. To ensure accurate billing and reimbursement**
- B. To provide comprehensive medical histories**
- C. To enhance patient care standards**
- D. To document pharmaceutical usage**

The primary aim of medical coding is to ensure accurate billing and reimbursement. Medical coding involves the translation of complex medical diagnoses, procedures, and services into universally recognized alphanumeric codes. This process is crucial for healthcare providers, as it enables them to receive proper reimbursement from insurance companies for the services rendered. Accurate coding minimizes the risk of billing errors, which can lead to claim denials, delayed payments, and financial loss for healthcare facilities. While providing comprehensive medical histories, enhancing patient care standards, and documenting pharmaceutical usage are all important aspects of healthcare, they do not directly reflect the primary purpose of medical coding. The focus of coding is on accurately categorizing and billing medical services to ensure that providers are compensated for their work, thus reinforcing its central role in the healthcare reimbursement process.

4. What are the two main types of codes found in ICD-10?

- A. Treatment codes and prescription codes
- B. Diagnosis codes and procedure codes**
- C. Service codes and billing codes
- D. Assessment codes and referral codes

The correct answer highlights the primary types of codes used in the International Classification of Diseases, 10th Revision (ICD-10). This coding system is primarily designed to classify diseases and health-related conditions for statistical purposes, billing, and insurance. The two main types of codes in ICD-10 are diagnosis codes and procedure codes. Diagnosis codes serve to identify the medical conditions or diseases that a patient may have during a visit to a healthcare provider. These codes are essential for documenting the patient's health status and are used to communicate the nature of the patient's complaints or illnesses to insurance companies and other health organizations. Procedure codes, while more commonly associated with the Current Procedural Terminology (CPT), also exist in various coding systems to describe the medical, surgical, or diagnostic services provided to the patient. Although ICD-10 does not focus specifically on procedures as much as CPT, the integration of coding systems allows certain procedural codes to be linked with corresponding diagnosis codes to ensure accurate billing and healthcare management. The other options mistakenly suggest the existence of types of codes that do not align with the primary functions of the ICD-10 coding system. For instance, treatment, prescription, service, billing, assessment, and referral codes are not classifications under ICD-10 but rather

5. Which of the following is not a part of the coding process?

- A. Reviewing clinical documentation
- B. Assigning codes based on diagnoses
- C. Providing patient treatment**
- D. Billing for services rendered

In the coding process, the primary focus is on accurately translating clinical documentation and diagnoses into standardized codes. This ensures that healthcare services are appropriately documented and can be used for billing, data collection, and reimbursement purposes. The act of providing patient treatment is not part of the coding process itself; it is a distinct role performed by healthcare providers who deliver care to the patient. While coding professionals rely on the information provided in clinical documentation from healthcare providers to assign codes, they do not engage in the direct treatment of patients. Reviewing clinical documentation and assigning codes based on diagnoses are both integral to the coding process, ensuring that the correct information is captured and used for billing. Moreover, billing for services rendered is a natural outcome of the coding process, as the assigned codes are essential for creating accurate billing statements. Therefore, the option related to providing patient treatment stands apart from the essential tasks involved in medical coding.

6. Who primarily uses M codes in ICD-9-CM?

- A. Physicians in clinical settings
- B. Health insurance companies
- C. Cancer registries**
- D. Government health agencies

Cancer registries primarily use M codes in ICD-9-CM. M codes in ICD-9-CM are specifically designed to classify neoplasms (tumors) and are crucial for cancer registries to track and analyze cancer data. Physicians in clinical settings may use M codes as well, but the primary users for M codes are cancer registries for their focus on cancer-related conditions. Health insurance companies and government health agencies typically use different types of codes for various purposes, not specifically M codes related to neoplasms.

7. What is the purpose of a "coverage determination" in medical coding?

- A. To finalize a patient's treatment plan
- B. To clarify if a procedure or service is covered under a patient's insurance plan**
- C. To assess the effectiveness of a procedure
- D. To document all medical services rendered

A coverage determination is essential in medical coding as it serves to clarify whether a specific procedure or service is covered under a patient's insurance plan. This process involves reviewing the terms of the insurance policy to ensure that the healthcare provider can bill the insurance for the services rendered without the risk of denial due to lack of coverage. By determining coverage beforehand, providers and patients can avoid unexpected out-of-pocket expenses, as they will know in advance which treatments or services are paid for by the insurance plan. This step is critical in ensuring appropriate billing practices and enhances communication between healthcare providers, patients, and insurance payers. Other options do not accurately represent the function of a coverage determination. For instance, finalizing a treatment plan is more focused on the clinical decision-making process, while assessing the effectiveness of a procedure pertains to clinical outcomes rather than coverage. Documenting all medical services rendered is also important but is related to record-keeping rather than determining insurance coverage. Thus, understanding the role of coverage determination is crucial for both compliance and efficient healthcare delivery.

8. What is the Coding Clinic for ICD-9-CM, and who publishes it?

- A. Provides training for coding professionals, published by NCHS**
- B. A quarterly publication by AHIMA**
- C. A quarterly publication by AHA**
- D. Provides certification for coding professionals, published by CMS**

The publication mentioned in choice C is a quarterly publication by AHA, specifically the American Hospital Association. This publication provides official coding guidelines for ICD-9-CM, which stands for International Classification of Diseases, 9th Revision, Clinical Modification. This coding system is used to classify and report medical diagnoses and procedures in the United States. The other options are incorrect as they mention different organizations and purposes that do not align with the Coding Clinic for ICD-9-CM. For example, choice A mentions NCHS, which stands for National Center for Health Statistics, but this organization does not publish the Coding Clinic for ICD-9-CM. Choice B mentions AHIMA, which stands for American Health Information Management Association, but this organization publishes a different quarterly publication, not the Coding Clinic for ICD-9-CM. And choice D mentions CMS, which stands for Centers for Medicare and Medicaid Services, which does not publish the Coding Clinic for ICD-9-CM, but rather they are responsible for creating and maintaining the official coding guidelines for ICD-9-CM. Overall, choice C is the only correct answer as it provides the correct publisher and purpose for the Coding Clinic for ICD-9-CM.

9. What is the role of modifiers in medical coding?

- A. To reduce coding errors**
- B. To provide additional information about a procedure or service**
- C. To classify insurance reimbursements**
- D. To enhance patient records**

Modifiers play a crucial role in medical coding by providing additional information about a procedure or service. They are two-digit codes used to give clarity on how a service or procedure was altered by specific circumstances, without changing the basic definition or code description of the procedure. This additional information can indicate various factors such as whether a service was performed bilaterally, whether multiple procedures were performed, or if a procedure was altered due to a specific reason. By using modifiers, coders can communicate essential details to payers about the nature of the services rendered. This ensures that the claim accurately reflects the complexity or nuances of the situation, which can influence reimbursement and avoid misunderstandings that might lead to claim denials. Thus, understanding and appropriately applying modifiers are key to ensuring that healthcare providers are reimbursed accurately for their services.

10. Why are updates made to the ICD system?

- A. To change the method of reimbursement
- B. To reflect new healthcare practices and diagnostic criteria**
- C. To make coding more complex
- D. To limit the number of codes available

Updates to the ICD (International Classification of Diseases) system are made primarily to reflect new healthcare practices and diagnostic criteria. As medical knowledge advances, new diseases are discovered, existing diseases may be reclassified, and diagnostic criteria may be refined. This ensures that the coding system remains relevant and accurately represents the current understanding of health and diseases. Furthermore, updating the ICD system allows for more precise coding, which can improve health data collection, facilitate better patient care management, enhance disease tracking, and support research initiatives. It ensures that healthcare providers, insurers, and researchers have access to standardized codes that can effectively communicate patient conditions and treatment outcomes. Other choices do not capture the primary purpose of these updates. For instance, changing the method of reimbursement is related to payment systems and not the core function of ICD updates. Making coding more complex or limiting the number of codes does not align with the objective of enhancing clarity and specificity in healthcare documentation.

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://medicalcoding.examzify.com>

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