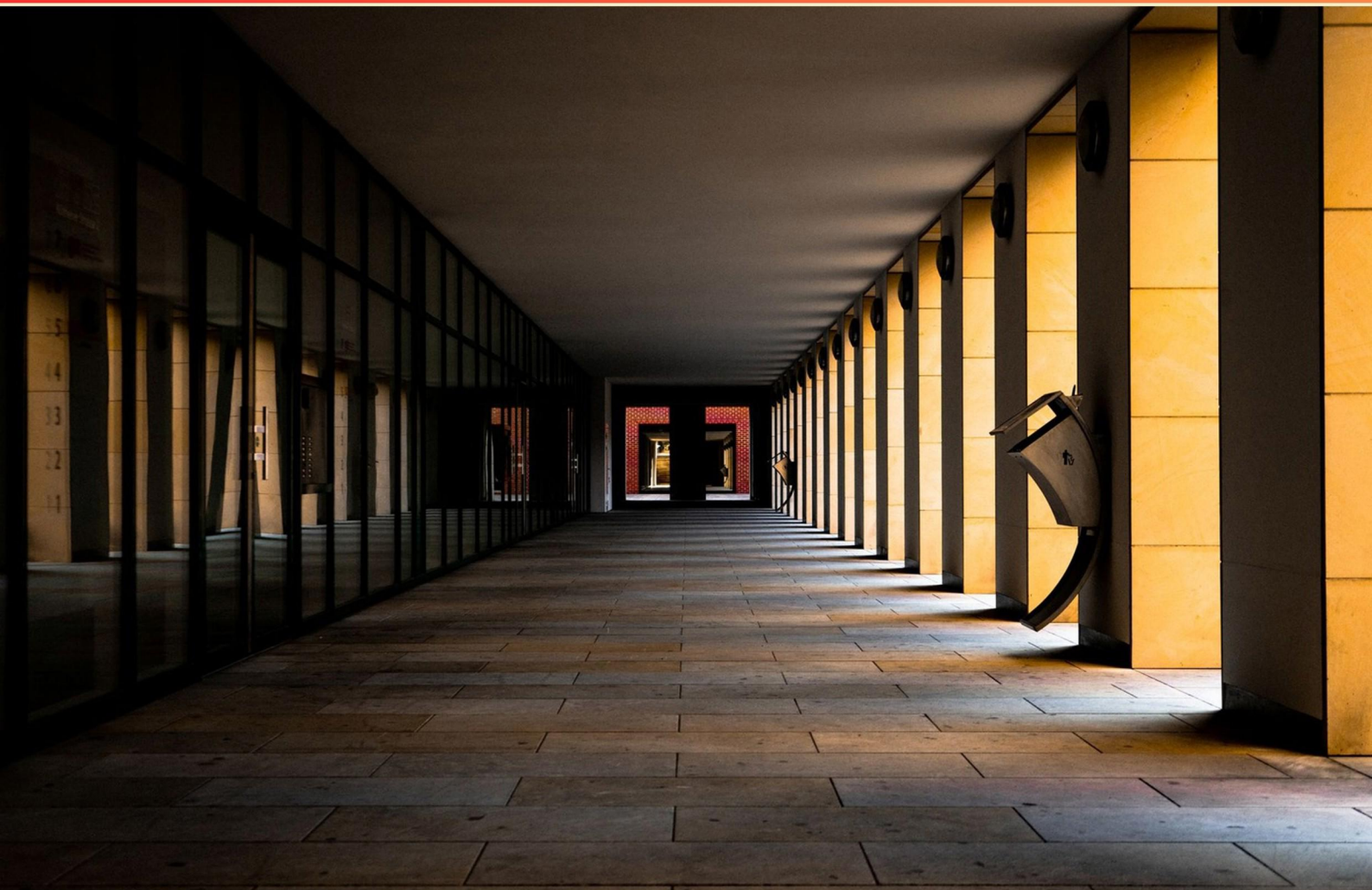


MEDICAL CODING PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

<https://medicalcoding.examzify.com>



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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 does ICD-10-CM primarily focus on when selecting and assigning a diagnostic code?**
 - A. Chronological order of symptoms
 - B. Severity of the condition
 - C. Medication history
 - D. Anatomy, etiology, site, or morphology
- 2. Where do the "notes" appear in ICD-9-CM coding to provide additional instructions?**
 - A. In the supplementary appendix
 - B. In the body of the tabular list
 - C. Only in the alphabetic index
 - D. In both the tabular list and alphabetic index
- 3. 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
- 4. When is "NOS" used in ICD-9-CM coding?**
 - A. For conditions requiring further classification
 - B. When additional codes are available
 - C. When a more detailed code is needed
 - D. When no further information is available to define a condition
- 5. Define the term "active diagnosis" in medical coding.**
 - A. A diagnosis that is resolved from previous episodes
 - B. A condition that is currently untreated
 - C. A diagnosis that is currently being treated or monitored during a patient's visit
 - D. A temporary diagnosis pending further testing

- 6. Which of the following methods can ensure compliance with coding standards?**
- A. Random audits of coding procedures
 - B. Limited training on coding
 - C. Eliminating documentation requirements
 - D. Waiting for insurance company audits
- 7. How are cross-referenced terms denoted in ICD-9-CM coding?**
- A. Italicized in the text
 - B. Highlighted in bold
 - C. Underlined for emphasis
 - D. Marked with "see also" or "see"
- 8. What is "ICD-10-CM" used for?**
- A. For recording medication prescriptions
 - B. For diagnosing and classifying diseases
 - C. For billing insurance claims
 - D. For scheduling patient appointments
- 9. How are procedures classified in subterms procedural coding in ICD-9-CM?**
- A. Based on the patient's characteristics
 - B. By using only alphabetical codes
 - C. According to site and/or surgical technique
 - D. Using a combination of letters and numbers
- 10. Who is responsible for maintaining the ICD coding system?**
- A. Centers for Disease Control and Prevention (CDC)
 - B. World Health Organization (WHO)
 - C. National Institutes of Health (NIH)
 - D. United Nations (UN)

Answers

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

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Explanations

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1. What does ICD-10-CM primarily focus on when selecting and assigning a diagnostic code?

- A. Chronological order of symptoms
- B. Severity of the condition
- C. Medication history
- D. Anatomy, etiology, site, or morphology**

ICD-10-CM primarily focuses on anatomy, etiology, site, and morphology when selecting and assigning a diagnostic code. This means that the code will identify the type of condition, the underlying cause, the specific location of the condition in the body, and any particular characteristics or features of the condition. Choices A and B are not correct because ICD-10-CM does not prioritize the order of symptoms or the severity of the condition when assigning a code. Choice C is also incorrect because medication history is not a factor in determining the diagnostic code. It is important to remember that the primary purpose of ICD-10-CM is to provide a standardized system for classifying and reporting diagnoses, not to simply list symptoms or treatments.

2. Where do the "notes" appear in ICD-9-CM coding to provide additional instructions?

- A. In the supplementary appendix
- B. In the body of the tabular list
- C. Only in the alphabetic index
- D. In both the tabular list and alphabetic index**

In ICD-9-CM coding, the "notes" that provide additional instructions can be found in both the tabular list and the alphabetic index. These notes are crucial for guiding coders on how to properly assign codes and ensure accurate and specific coding. It's important to consult both the tabular list and the alphabetic index to capture all necessary information and follow any coding conventions or rules. The supplementary appendix may contain additional helpful information but specifically, the notes appear in both the tabular list and the alphabetic index for ICD-9-CM coding.

3. 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.

4. When is "NOS" used in ICD-9-CM coding?

- A. For conditions requiring further classification
- B. When additional codes are available
- C. When a more detailed code is needed
- D. When no further information is available to define a condition**

"NOS" stands for "Not Otherwise Specified" in ICD-9-CM coding. It is used when no further information is available to define a condition fully. This indicates that the healthcare provider does not have more specific information about the diagnosis, and therefore, the code is assigned as "NOS". It is important in medical coding to be as specific as possible, but when the specific details are lacking, "NOS" is used to indicate this lack of further information. Regarding the other choices: A. "NOS" is not used for conditions requiring further classification, as in such cases, the goal is to specify the condition more precisely. B. "NOS" is not used when additional codes are available, as other available codes may provide more specific information. C. "NOS" is not used when a more detailed code is needed; instead, a more detailed code should be assigned when possible.

5. Define the term "active diagnosis" in medical coding.

- A. A diagnosis that is resolved from previous episodes
- B. A condition that is currently untreated
- C. A diagnosis that is currently being treated or monitored during a patient's visit**
- D. A temporary diagnosis pending further testing

The term "active diagnosis" refers to a diagnosis that is currently being addressed through treatment or monitoring during a patient's visit. This means that the healthcare provider is actively involved in managing the condition, which could include providing medication, performing procedures, or conducting follow-up assessments to track the progress of the patient's health status. An active diagnosis is significant in medical coding because it directly influences the coding process and reimbursement strategies. Accurate coding is essential for reflecting the current state of the patient's health, ensuring that the healthcare provider is adequately compensated for the services rendered. By coding an active diagnosis, it demonstrates that the condition is ongoing and requires continued medical attention. Other concepts, such as a diagnosis resolved from previous episodes or one that is temporarily pending further testing, would not meet the criteria for being categorized as "active" because they either indicate a resolution or an uncertainty in the diagnosis status, respectively. An untreated condition might also not qualify as active if there's no ongoing management involved. Thus, the definition focused on the treatment or monitoring aspect is key to understanding what constitutes an active diagnosis in medical coding.

6. Which of the following methods can ensure compliance with coding standards?

- A. Random audits of coding procedures**
- B. Limited training on coding
- C. Eliminating documentation requirements
- D. Waiting for insurance company audits

The method of conducting random audits of coding procedures is a proactive approach that helps ensure compliance with coding standards. Audits serve as a systematic examination of the coding practices used within a healthcare facility. By routinely checking coding accuracy and adherence to established guidelines, organizations can identify areas that need improvement, rectify discrepancies, and reinforce proper coding practices among staff. Random audits provide an opportunity to assess the effectiveness of current training programs and identify recurrent issues, which can be addressed through further education or revisions to procedures. This method encourages accountability among coding staff and fosters a culture of compliance and quality assurance essential in the healthcare industry. In contrast, limited training on coding may lead to a lack of understanding of the coding system, resulting in non-compliance. Eliminating documentation requirements compromises the integrity of the coding process, leading to inaccuracies and potential legal issues. Waiting for insurance company audits places the responsibility of ensuring compliance on external parties rather than proactively managing coding standards internally. This reactive approach can lead to compliance failures and financial penalties.

7. How are cross-referenced terms denoted in ICD-9-CM coding?

- A. Italicized in the text
- B. Highlighted in bold
- C. Underlined for emphasis
- D. Marked with "see also" or "see"**

In ICD-9-CM coding, cross-referenced terms are denoted by being marked with "see also" or "see." This is done to guide coders to related terms or conditions that may need to be considered when assigning codes. This format helps coders navigate the classification system efficiently and accurately link the diagnosis codes to the appropriate conditions or terms. The other options (italicized in the text, highlighted in bold, underlined for emphasis) are not how cross-referenced terms are typically denoted in ICD-9-CM coding. The correct method is explicitly marking them with "see also" or "see" to direct coders to related terms within the coding system.

8. What is "ICD-10-CM" used for?

- A. For recording medication prescriptions
- B. For diagnosing and classifying diseases**
- C. For billing insurance claims
- D. For scheduling patient appointments

ICD-10-CM, which stands for the International Classification of Diseases, 10th Revision, Clinical Modification, is specifically designed for diagnosing and classifying diseases. It is a coding system used by healthcare providers to represent various health conditions and diseases in a standardized format. This facilitates accurate documentation and communication regarding patient diagnoses, ultimately improving health data analysis, research, and epidemiological studies. While the other options pertain to important functions within healthcare, they do not align with the primary purpose of ICD-10-CM. For instance, recording medication prescriptions involves different coding systems, billing insurance claims often utilizes both ICD and other codes like CPT (Current Procedural Terminology), and scheduling appointments does not require disease classification or diagnostic coding at all. Thus, the focus of ICD-10-CM on understanding and categorizing medical diagnoses is what makes it an essential tool in the healthcare system.

9. How are procedures classified in subterms procedural coding in ICD-9-CM?

- A. Based on the patient's characteristics
- B. By using only alphabetical codes
- C. According to site and/or surgical technique**
- D. Using a combination of letters and numbers

Procedures in subterms procedural coding in ICD-9-CM are classified according to site and/or surgical technique. This means that the procedures are grouped based on where they are performed on the body and the specific surgical techniques used. This classification system helps in accurately coding procedures for medical billing and statistical purposes. Options A, B, and D are incorrect: - Option A, based on the patient's characteristics, is not the primary basis for classifying procedures in subterms procedural coding. - Option B, by using only alphabetical codes, is not the way procedures are classified in ICD-9-CM, as alphanumeric codes (combination of letters and numbers) are used. - Option D, using a combination of letters and numbers, is partially correct but does not specifically address the criteria of classifying procedures according to site and/or surgical technique.

10. Who is responsible for maintaining the ICD coding system?

- A. Centers for Disease Control and Prevention (CDC)
- B. World Health Organization (WHO)**
- C. National Institutes of Health (NIH)
- D. United Nations (UN)

The World Health Organization (WHO) is responsible for maintaining the ICD (International Classification of Diseases) coding system. This organization oversees the development and updates of the ICD, which is crucial for health management, statistics, and research on diseases and health conditions globally. The ICD serves as a universally accepted framework for the classification of diseases, injuries, and causes of death, facilitating the communication of health information across different countries and health systems. While other entities, such as the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH), play significant roles in public health and medical research in the United States, they do not manage the ICD directly. The United Nations (UN) does not have a direct role in maintaining the ICD coding system, as its focus is broader, encompassing a wide range of international issues beyond health classification systems.

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!

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