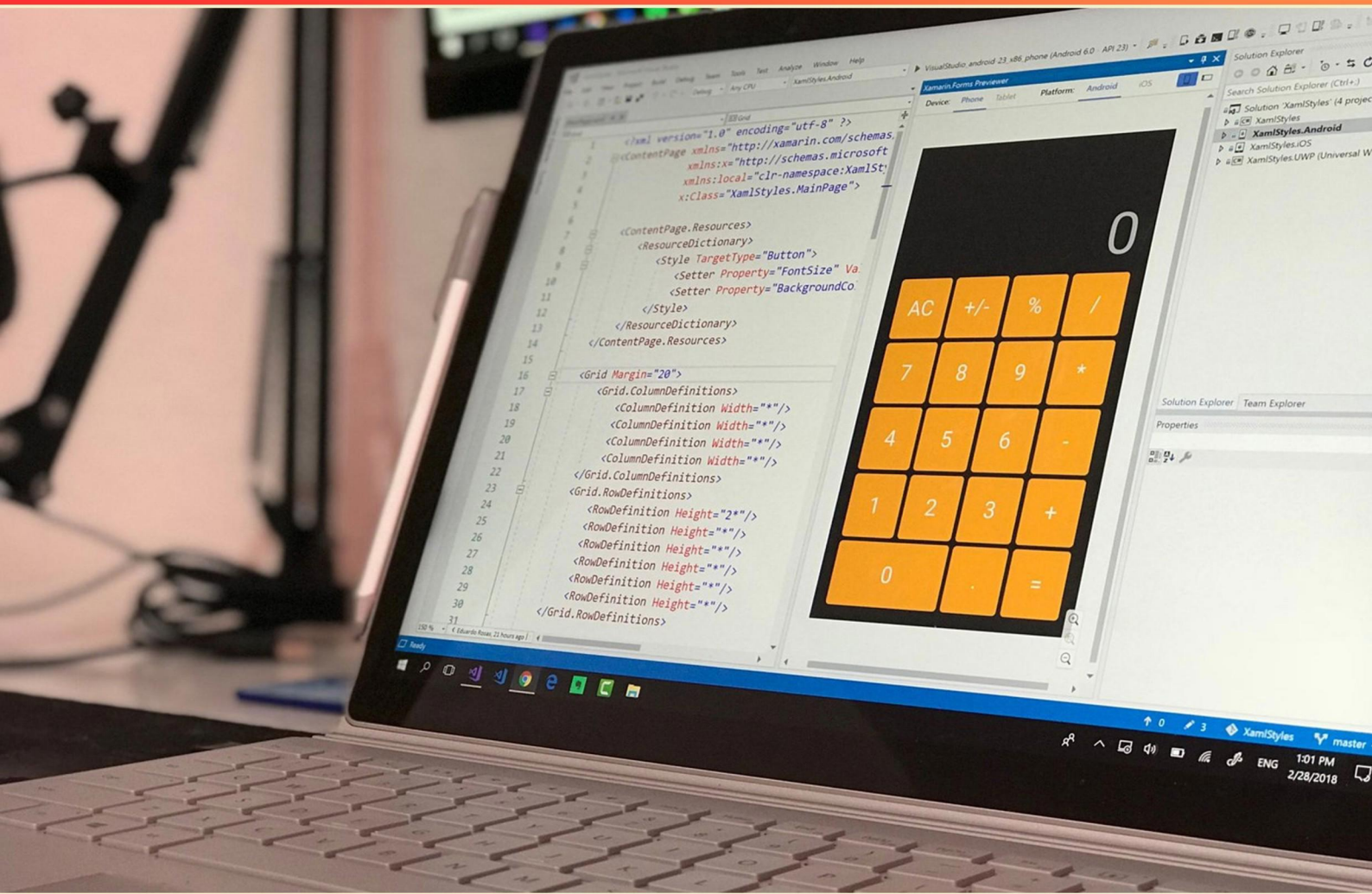


NATIONALLY REGISTERED CERTIFIED CODING SPECIALIST (NRCCS) PRACTICE EXAM (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

VISIT US ONLINE FOR
THE FULL VERSION STUDY GUIDE

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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. Who developed the ICD-10 to track morbidity and mortality statistics?**
 - A. The Centers for Disease Control and Prevention (CDC)
 - B. The World Health Organization (WHO)
 - C. The American Medical Association (AMA)
 - D. The National Institutes of Health (NIH)
- 2. What is the ICD-10 code for hypertension, unspecified?**
 - A. I10
 - B. I11
 - C. I12
 - D. I13
- 3. What does OSHA recommend for treating an eye injury such as a burn or chemical splash?**
 - A. Apply a cooling compress
 - B. Flush the eye for 15 minutes with a constant water flow
 - C. Use saline solution only
 - D. Seek immediate medical attention without any first aid
- 4. What is the first step to select an ICD-10 code that corresponds to a diagnosis in a medical record?**
 - A. Locate the term in the Codebook
 - B. Locate the term in the Alphabetic Index
 - C. Locate the term in the Tabular List
 - D. Locate the term in the Diagnostic Criteria
- 5. Which of the following is part of the Hippocratic Oath?**
 - A. To maximize patient communication
 - B. To use the best treatment for the patient
 - C. To ensure patient satisfaction
 - D. To maintain hospital accreditation

- 6. How many digits are used in basic CPT codes?**
- A. 4 digits
 - B. 5 digits
 - C. 6 digits
 - D. 7 digits
- 7. What is a requirement for home health care under Medicare?**
- A. The patient must be in need of physical therapy
 - B. The patient must have a chronic illness
 - C. The patient must be over the age of 75
 - D. The patient must be familiar with their diagnosis
- 8. What does 'UA' stand for in medical terms?**
- A. Urinalysis
 - B. Ultrasound Analysis
 - C. Urinary Assessment
 - D. Urethra Analysis
- 9. Which organ is responsible for the production of bile?**
- A. Gallbladder
 - B. Pancreas
 - C. Liver
 - D. Kidney
- 10. Which of the following is NOT a type of injection?**
- A. IM
 - B. SQ
 - C. PO
 - D. IV

Answers

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

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Explanations

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1. Who developed the ICD-10 to track morbidity and mortality statistics?

- A. The Centers for Disease Control and Prevention (CDC)
- B. The World Health Organization (WHO)**
- C. The American Medical Association (AMA)
- D. The National Institutes of Health (NIH)

The World Health Organization (WHO) developed the ICD-10 as part of its ongoing efforts to standardize the classification of diseases and health-related conditions globally. The ICD (International Classification of Diseases) system provides a comprehensive framework for documenting diseases, injuries, and other health problems, facilitating consistent morbidity and mortality statistics across different regions and health systems. The ICD-10 is essential for public health reporting, health insurance coding, and maintaining health care databases, thereby improving the quality of health outcomes and research. By creating a standardized coding system, WHO enables health organizations worldwide to share comparable health data, leading to better understanding and management of health trends. In contrast, while the Centers for Disease Control and Prevention (CDC) utilizes ICD coding for morbidity and mortality statistics in the United States, they did not develop the coding system itself. The American Medical Association (AMA) focuses on physicians' rights and medical statistics, and the National Institutes of Health (NIH) engages in medical research, but neither organization was responsible for the creation of the ICD-10. Thus, the clear association of the ICD-10's development with the WHO makes it the correct choice.

2. What is the ICD-10 code for hypertension, unspecified?

- A. I10**
- B. I11
- C. I12
- D. I13

The ICD-10 code for hypertension, unspecified, is I10. This code is specifically designated for essential (primary) hypertension that isn't further specified or classified. It is commonly used in clinical documentation when a healthcare provider diagnoses a patient with high blood pressure but does not identify any specific type or underlying conditions that might be associated with it. The other codes represent different aspects of hypertension. For example, I11 is used for hypertensive heart disease, which indicates that hypertension is causing damage to the heart. I12 pertains to hypertension with chronic kidney disease, while I13 denotes hypertension that is accompanied by both heart and chronic kidney conditions. Therefore, when the documentation lacks specific details about the type of hypertension, the appropriate and correct choice is I10.

3. What does OSHA recommend for treating an eye injury such as a burn or chemical splash?

- A. Apply a cooling compress
- B. Flush the eye for 15 minutes with a constant water flow**
- C. Use saline solution only
- D. Seek immediate medical attention without any first aid

Flushing the eye for 15 minutes with a constant water flow is a critical step recommended by OSHA for treating eye injuries caused by burns or chemical splashes. This immediate action helps to dilute and remove the harmful substance from the eye, thereby minimizing potential damage to the delicate tissues of the eye. The flush should be steady and thorough to ensure that any irritants are washed away effectively, which is especially crucial for chemical exposure where the substance can continue to cause harm if not promptly removed. In cases of eye injuries, time is of the essence, and starting the flushing process as soon as possible is imperative. This recommendation is based on ensuring that the eye is kept clear of irritants and reducing the risk of long-term damage or complications, which could occur if the chemical or burn is not dealt with quickly. While cooling compresses or saline solutions may have their contexts in other treatments, they do not replace the immediate flushing action that is so vital in these scenarios. Seeking immediate medical attention without administering any first aid overlooks the necessity of initiating a first response to mitigate injury at the moment it occurs.

4. What is the first step to select an ICD-10 code that corresponds to a diagnosis in a medical record?

- A. Locate the term in the Codebook
- B. Locate the term in the Alphabetic Index**
- C. Locate the term in the Tabular List
- D. Locate the term in the Diagnostic Criteria

Selecting an ICD-10 code corresponding to a diagnosis in a medical record begins with locating the term in the Alphabetic Index. This index serves as a primary tool for finding the correct code related to a specific diagnosis, allowing coders to search for terms alphabetically. By doing so, coders can identify potential codes or headings associated with a particular condition quickly. Once the relevant term is found in the Alphabetic Index, it typically provides a code or a range of codes leading to a more detailed examination in the Tabular List, where the exact code can be confirmed and any additional coding guidelines or rules can be applied. This structured approach ensures that coders follow a systematic process, minimizing errors and ensuring accurate coding practices in line with ICD-10 standards.

5. Which of the following is part of the Hippocratic Oath?

- A. To maximize patient communication
- B. To use the best treatment for the patient**
- C. To ensure patient satisfaction
- D. To maintain hospital accreditation

The Hippocratic Oath is a foundational document in the medical profession, historically taken by physicians to uphold specific ethical standards and responsibilities towards patients. One of the central themes of the Oath is the commitment to providing the best possible care and treatment for patients—this underscores the principle of beneficence, which involves acting in the best interest of the patient. The emphasis on using the best treatment for patients aligns perfectly with the core values of medical ethics, advocating for a dedication to patient welfare. This commitment has been central to medical practice since the time of Hippocrates, making it a relevant and essential element of the Oath, thereby solidifying why this answer is indeed correct. In contrast, while ideas like maximizing patient communication and ensuring patient satisfaction are important in modern healthcare, they do not encapsulate the fundamental commitments laid out in the Hippocratic Oath. Similarly, maintaining hospital accreditation relates more to institutional standards and governance rather than a physician's direct ethical obligations toward individuals under their care.

6. How many digits are used in basic CPT codes?

- A. 4 digits
- B. 5 digits**
- C. 6 digits
- D. 7 digits

Basic CPT codes consist of 5 digits, which has been the standard format since the American Medical Association first published the Current Procedural Terminology (CPT) codes. Each code is numeric and specifically designed to identify medical, surgical, and diagnostic services, allowing for standardized reporting and billing processes in the healthcare system. While there are additional and more complex codes that may extend beyond 5 digits in specific categories, the foundational CPT codes that anatomy and procedural descriptions rely on are always expressed in this 5-digit format, ensuring clarity and uniformity in medical documentation and insurance claims.

7. What is a requirement for home health care under Medicare?

- A. The patient must be in need of physical therapy**
- B. The patient must have a chronic illness
- C. The patient must be over the age of 75
- D. The patient must be familiar with their diagnosis

Home health care under Medicare has specific criteria to ensure that patients receive the necessary support for their health conditions. One primary requirement is that the patient must be under the care of a physician and referred for home health services. While the need for various types of care (such as skilled nursing care, physical therapy, or occupational therapy) is crucial, the specific requirement here emphasizes that the patient should need skilled services. Thus, the option stating that the patient must be in need of physical therapy aligns well with the inherent standards set by Medicare for home health care. Physical therapy is one of the skilled services that can qualify a patient for these benefits, ensuring they receive proper rehabilitation and support for recovery in a home setting. This focus on skilled care is critical, as it distinguishes home health from other less intensive support services that may not qualify under Medicare. Other answers, such as having a chronic illness, being over a certain age, or familiarizing oneself with their diagnosis do not align with the fundamental requirements for Medicare coverage of home health care and do not necessarily ensure that skilled care will be provided.

8. What does 'UA' stand for in medical terms?

- A. Urinalysis
- B. Ultrasound Analysis
- C. Urinary Assessment
- D. Urethra Analysis

In medical terms, 'UA' commonly stands for Urinalysis. This is a laboratory test that evaluates the composition and characteristics of urine, which can provide valuable information regarding a patient's health status. Urinalysis is used to screen for various conditions, including kidney disease, diabetes, infections, and other systemic illnesses. By analyzing the constituents of urine, such as cells, proteins, glucose, and other substances, healthcare providers can draw important conclusions about a patient's metabolic and physiologic state. The other options, while they may sound plausible, do not have the same established meaning in medical terminology. Ultrasound analysis typically refers to imaging studies rather than urinalysis. Urinary assessment may refer to a broader evaluation of urinary function but is not a standard abbreviation like 'UA.' Similarly, urethra analysis is not a recognized term in clinical practice and does not reflect the standardized laboratory test indicated by 'UA.' Thus, Urinalysis is the accurate and widely accepted meaning of 'UA' in the medical field.

9. Which organ is responsible for the production of bile?

- A. Gallbladder
- B. Pancreas
- C. Liver
- D. Kidney

The liver plays a crucial role in the digestive system by producing bile, a substance that helps emulsify fats in the small intestine, aiding in their digestion and absorption. Bile is essential for the breakdown of lipids and also assists in the elimination of certain waste products from the body, such as bilirubin, which is a byproduct of the breakdown of red blood cells. In contrast, the gallbladder stores and concentrates bile produced by the liver until it is needed in the digestive process. The pancreas produces digestive enzymes and hormones but does not create bile. The kidneys are primarily involved in filtering blood and removing waste through urine production, rather than in the production of bile. Understanding the distinct functions of these organs highlights the liver's unique role in bile production and its importance in digestion.

10. Which of the following is NOT a type of injection?

- A. IM
- B. SQ
- C. PO
- D. IV

The correct answer is C, as "PO" stands for "per os," which is a Latin term meaning "by mouth." This refers to the oral administration of medication, which is fundamentally different from injections. Injections involve administering substances directly into the body using a syringe or needle, which can occur through different routes such as intramuscular (IM), subcutaneous (SQ), or intravenous (IV). Each of these methods involves piercing the skin and introducing a substance into specific tissues or directly into the bloodstream. In contrast, medications taken via the oral route are absorbed through the gastrointestinal tract and are not delivered through an injection method, making "PO" the only option that does not fit the category of injection types. Understanding this distinction is crucial for proper medication administration and coding in medical 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://nrccs.examzify.com>

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

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