Procedural and Diagnostic Coding Practice Exam (Sample)

Study Guide

BY EXAMZIFY

Everything you need from our exam experts!

Table of Contents

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 coding guideline would you follow for a bilateral procedure?**

   A. Use a unilateral modifier

   B. Do not use any modifier

   C. Use a bilateral modifier

   D. Use a global modifier

2. **Name one of the six sections of the CPT codebook.**

   A. Pathology and Laboratory (P/L)

   B. Evaluation and Management (E/M)

   C. Radiology (R)

   D. Anesthesia (A)

3. **How should codes be sequenced when a patient has multiple illnesses?**

   A. By listing all diagnoses in alphabetical order

   B. The principal diagnosis should be listed first, followed by secondary diagnoses

   C. By grouping similar diagnoses together

   D. By prioritizing based on treatment received

4. **How does the AMA define medical necessity?**

   A. Based on patient preference

   B. According to the latest medical trends

   C. As services or procedures a prudent physician would provide

   D. Determined by insurance company guidelines

5. **Why is "evolving healthcare technology" significant in coding?**

   A. It reduces the workload of medical coders

   B. It allows for more diagnostic coding options

   C. It requires coders to stay updated and adapt codes as new procedures emerge

   D. It eliminates the need for coding completely

6. What must coders continually update to stay compliant?

   A. Personal coding preferences

   B. Knowledge of coding technology

   C. Official coding guidelines and updates

   D. Patient preferences in coding

7. What do the first five digits of a CPT code signify?

   A. The type of healthcare provider

   B. The specific procedure or service performed

   C. The patient's health insurance coverage

   D. The healthcare facility's location

8. Which statement about HCPCS Level II codes is true?

   A. They apply only to hospital inpatient services.

   B. They include codes for durable medical equipment.

   C. They have no modifiers.

   D. All of the above.

9. A problem classified as having a moderate risk of morbidity and mortality is known as what?

   A. High severity

   B. Self-limited

   C. Low severity

   D. Moderate severity

10. Among the components, which one assesses the thoroughness of the patient's history?

   A. Level of medical decision making

   B. Level of history obtained

   C. Nature of the presenting problem

   D. Coordination of care

Answers

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

Explanations

1. What coding guideline would you follow for a bilateral procedure?

A. Use a unilateral modifier

B. Do not use any modifier

C. Use a bilateral modifier

D. Use a global modifier

For a bilateral procedure, the appropriate coding guideline is to use a bilateral modifier. This modifier indicates that a procedure has been performed on both sides of the body, helping to clarify the extent of the service provided. The use of a bilateral modifier is crucial for proper reimbursement and ensures accurate communication about the procedure to insurers. When a procedure is identified as bilateral, it's typically noted in the code description or can be inferred from the nature of the procedure itself. By applying the bilateral modifier, the coder signals that the service was performed on both sides, which often has different coding implications than if only one side was addressed. This practice supports correct billing and avoids complications or denials during claims processing. Modifiers should be used accurately as they can significantly influence payment and ensure appropriate documentation. In this case, opting for a unilateral modifier or not using any modifier at all would misrepresent the procedure performed, and using a global modifier may not apply, as global modifiers relate to services that are considered part of a surgical package rather than denoting sides of a procedure.

2. Name one of the six sections of the CPT codebook.

A. Pathology and Laboratory (P/L)

B. Evaluation and Management (E/M)

C. Radiology (R)

D. Anesthesia (A)

One of the six sections of the CPT codebook is Evaluation and Management (E/M). This section is crucial as it encompasses codes that are used to document patient encounters and care, focusing primarily on the services provided by healthcare practitioners when assessing and managing patient health issues. The E/M codes are integral to coding for office visits, hospital visits, consultations, and other types of patient interactions, emphasizing the complexity of care and the time spent with patients. These codes are designed to capture a wide range of patient scenarios, allowing for accurate billing and reporting of the level of service provided. The E/M section is distinct in that it includes specific criteria for documentation and coding, which are essential for compliance with billing requirements and ensuring that healthcare providers are reimbursed for their services appropriately. This reflects the importance of the evaluation and management aspect of care in the overall healthcare system.

3. How should codes be sequenced when a patient has multiple illnesses?

A. By listing all diagnoses in alphabetical order

B. The principal diagnosis should be listed first, followed by secondary diagnoses

C. By grouping similar diagnoses together

D. By prioritizing based on treatment received

The appropriate way to sequence codes when a patient has multiple illnesses is to list the principal diagnosis first, followed by secondary diagnoses. The principal diagnosis is the condition that is primarily responsible for the patient's admission or the reason for the medical encounter. This helps ensure clarity and accuracy in documenting the patient's health status and the rationale for the treatment provided. By listing the principal diagnosis first, healthcare providers can focus on the most significant condition affecting the patient at that time, which streamlines communication among healthcare professionals and improves the overall quality of care. Secondary diagnoses, while also important, provide additional context about the patient's health but are categorized beneath the principal diagnosis for organizational purposes. In contrast, listing codes in alphabetical order does not represent the clinical significance of each condition and could lead to confusion regarding the main issues being addressed. Grouping similar diagnoses together lacks a clear methodology regarding the principal diagnosis, and prioritizing based on treatment received may not accurately reflect the primary reason for the patient's encounter, which is essential for coding accuracy and compliance with regulations.

4. How does the AMA define medical necessity?

A. Based on patient preference

B. According to the latest medical trends

C. As services or procedures a prudent physician would provide

D. Determined by insurance company guidelines

The American Medical Association (AMA) defines medical necessity as services or procedures that are appropriate and necessary to provide a patient with proper healthcare, based on professional judgment. This definition emphasizes the need for a prudent physician—meaning one who is reasonable and exercising good judgment in their practice—to determine what care is essential for a patient's health. This concept ensures that the focus remains on the patient's medical condition and necessary treatments, rather than external influences such as trends, personal patient preferences, or the stipulations set by insurance companies. By framing medical necessity within the context of a physician's judgment and the clinical needs of the patient, it underscores the importance of professional standards in healthcare rather than subjective factors or external dictates.

5. Why is "evolving healthcare technology" significant in coding?

    A. It reduces the workload of medical coders

    B. It allows for more diagnostic coding options

    C. It requires coders to stay updated and adapt codes as new procedures emerge

    D. It eliminates the need for coding completely

The significance of "evolving healthcare technology" in coding is best captured by the idea that it requires coders to stay updated and adapt codes as new procedures emerge. As healthcare technology advances, new diagnostic tools, treatment methods, and procedural approaches are continually developed. This innovation leads to the creation of new coding guidelines and codes that must be understood and correctly applied by medical coders to ensure accurate documentation and billing. Staying current with these changes is crucial for coders, as using outdated codes or failing to incorporate new developments can lead to billing errors, compliance issues, and potential financial loss for healthcare providers. Therefore, being adaptable and continuously learning is an essential part of a medical coder's role, making it imperative to keep pace with the advancements in technology affecting healthcare.

6. What must coders continually update to stay compliant?

    A. Personal coding preferences

    B. Knowledge of coding technology

    C. Official coding guidelines and updates

    D. Patient preferences in coding

The necessity for coders to continually update their knowledge of official coding guidelines and updates is fundamental to maintaining compliance within the field. Official coding guidelines are regularly revised and updated by authoritative organizations such as the American Health Information Management Association (AHIMA) and the Centers for Medicare & Medicaid Services (CMS). These updates include changes in coding practices, new codes being added or existing ones being deleted, and modifications in the rules for coding various diagnoses and procedures. Staying informed about the latest official guidelines ensures that coders accurately represent the services provided and that they adhere to all regulatory requirements. This is critical not only for proper reimbursement but also for avoiding potential issues related to audits or fraudulent claims. In this context, while knowledge of coding technology or personal coding preferences may be beneficial, they do not directly address the requirement for compliance. Similarly, patient preferences are relevant to healthcare delivery but do not influence coding standards and regulations. Thus, the continuous updating of knowledge regarding official coding guidelines is essential for effective and compliant coding practices.

7. What do the first five digits of a CPT code signify?

A. The type of healthcare provider

B. The specific procedure or service performed

C. The patient's health insurance coverage

D. The healthcare facility's location

The first five digits of a CPT code signify the specific procedure or service performed. CPT, which stands for Current Procedural Terminology, was developed to provide a uniform language for describing medical, surgical, and diagnostic services. Each five-digit code corresponds to a particular procedure, allowing healthcare providers, insurers, and coders to communicate effectively about the medical services rendered. For example, the number 99213 corresponds to a specific level of established office outpatient visit. This coding system ensures that there is a consistent method for identifying and billing for services, which is crucial for accurate record-keeping, reimbursement, and statistical purposes in healthcare. Other options mentioned do not accurately capture the purpose of the five-digit code; they pertain to different aspects of healthcare operations and provider-patient interactions rather than the coding of specific services.

8. Which statement about HCPCS Level II codes is true?

A. They apply only to hospital inpatient services.

B. They include codes for durable medical equipment.

C. They have no modifiers.

D. All of the above.

The statement that HCPCS Level II codes include codes for durable medical equipment is accurate. HCPCS, which stands for Healthcare Common Procedure Coding System, is designed specifically to accommodate a wide range of services and products not covered by the more specific CPT codes, particularly those related to outpatient services.   Level II codes serve various purposes in the healthcare system, including identifying durable medical equipment (DME) such as wheelchairs, crutches, and oxygen equipment, as well as prosthetics and orthotics. By including these codes, HCPCS Level II ensures that providers can effectively document and bill for essential items that patients may need outside of traditional hospital inpatient services. The other statements lack accuracy or specificity. For instance, HCPCS Level II codes do not apply exclusively to hospital inpatient services; rather, they are used across various healthcare settings, including outpatient and home health care. Additionally, HCPCS Level II codes utilize modifiers to offer further specificity about services and procedures, which enhances the clarity of billing and coding practices.

9. A problem classified as having a moderate risk of morbidity and mortality is known as what?

    A. High severity

    B. Self-limited

    C. Low severity

    D. Moderate severity

The classification of a problem as having "moderate risk of morbidity and mortality" directly aligns with the term "moderate severity." This term is utilized in medical coding and risk assessment to indicate that a condition has a noticeable impact on the patient's health, with potential complications but not to an extreme degree. By categorizing a health concern as moderate severity, it reflects that while there are risks involved, they do not represent the highest level of danger, which would be evident in conditions classified under high severity.   The other terms like "high severity," "self-limited," and "low severity" do not accurately encapsulate the nuances of moderate risk, as they refer to different levels or types of health issues. High severity would indicate significant risk, while self-limited generally describes conditions that resolve on their own without intervention, and low severity would denote minimal risk or impact on the patient's health. Thus, "moderate severity" is the precise classification that best fits the described level of risk.

10. Among the components, which one assesses the thoroughness of the patient's history?

    A. Level of medical decision making

    B. Level of history obtained

    C. Nature of the presenting problem

    D. Coordination of care

The level of history obtained is crucial for evaluating how comprehensive the patient's medical history is during a clinical encounter. This component involves assessing the details gathered about the patient's past and present health statuses, including any relevant medical, surgical, family, and social history. A thorough history is essential for accurate diagnoses, treatment planning, and understanding the patient's overall health context. In coding and documentation, the level of history correlates directly with the complexity of the patient's condition and the necessary level of care. When the history obtained is complete and detailed, it enables healthcare providers to make informed decisions, which aligns with the coding guidelines for determining the appropriate level of service rendered. Therefore, this component specifically targets the thoroughness of history collection, distinguishing it from other aspects like medical decision-making or coordination of care, which focus on different facets of patient management.

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://proceduraldiagnosticcoding.examzify.com

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