ICD-10-CM CODING PRACTICE EXAM (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.

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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!

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Questions

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1. **What coding category corresponds to a subsequent encounter for a fracture with routine healing?**

   A. A

   B. D

   C. G

   D. NEC

2. **Which medication is NOT typically used for arthritis treatment?**

   A. Ibuprofen

   B. Deltasone

   C. Lodine

   D. Ativan

3. **What code would be used for a complication that doesn't have a specific designation in ICD-10-CM?**

   A. A

   B. G

   C. NEC

   D. NOS

4. **What does a cystoscopic approach primarily involve?**

   A. Open surgery

   B. Endoscopic procedure

   C. External approach

   D. Injectable procedure

5. **What type of debridement involves the use of a Versajet or ultrasonic technology?**

   A. Excisional debridements

   B. Non-excisional debridements

   C. Mechanical debridements

   D. Surgical debridements

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6. Which term describes the paralysis of both lower limbs?

A. Quadriplegia

B. Paraplegia

C. Hemiplegia

D. Monoplegia

7. What is the primary diagnosis indicated by O80 in ICD-10-CM?

A. Cesarean delivery

B. Vaginal delivery

C. High risk patient prenatal

D. Extraction operation

8. What allows for coding flexibility in procedures involving both repositioning and supplementation of tissue?

A. Exclusive coding for reposition only

B. Requirement for different codes for each operation

C. Only one code is sufficient for billing

D. Combined coding is recommended

9. What is meant by 'unconfirmed conditions' in coding?

A. Conditions that have a clear diagnosis

B. Conditions that are suspected but not verified

C. Diagnoses established as chronic

D. Conditions that have been treated

10. When coding for infectious diseases, what is a crucial step?

A. Always code symptoms first

B. Identify chronic conditions

C. Reference underlying conditions

D. Focus solely on acute diagnoses

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Answers

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

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Explanations

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1. What coding category corresponds to a subsequent encounter for a fracture with routine healing?

A. A

B. D

C. G

D. NEC

The coding category that corresponds to a subsequent encounter for a fracture with routine healing is appropriately designated as the "D" option. In ICD-10-CM coding, when classifying fractures, encounters are broken down into initial and subsequent events to provide clarity on the stage of healing. Following the initial treatment of a fracture, subsequent encounters are coded to indicate how well the fracture is healing. If a fracture is classified as having routine healing, this indicates that there are no complications or non-union at the time of the subsequent visit. Each subsequent encounter can be represented by specific codes, and these are noted as being part of the follow-up process for the healing of the fracture. Additional coding categories exist for more complex situations, such as complications from the fracture or cases of non-union. However, in this scenario, the focus is on the straightforward follow-up of a fracture that is healing without issues, hence the correct categorization of the subsequent encounter for a fracture with routine healing.

2. Which medication is NOT typically used for arthritis treatment?

A. Ibuprofen

B. Deltasone

C. Lodine

D. Ativan

Ativan, which is a brand name for lorazepam, is predominantly an anti-anxiety medication. It belongs to a class of drugs known as benzodiazepines, which are primarily used for the treatment of anxiety disorders, agitation, and sleep disturbances. While it may provide some muscle relaxation or anxiety relief in a patient with arthritis, it does not address the underlying inflammation or pain associated with arthritic conditions. On the other hand, the other medications listed—ibuprofen, Deltasone (prednisone), and Lodine (etodolac)—are specifically used for their anti-inflammatory properties or pain relief, which are key components in the management of arthritis. Ibuprofen is a nonsteroidal anti-inflammatory drug (NSAID) that helps to alleviate pain and inflammation. Deltasone is a corticosteroid that reduces inflammation and suppresses the immune response. Lodine is another NSAID that is effective in treating pain and inflammation in arthritis patients. Therefore, Ativan is not considered a treatment for arthritis due to its lack of relevant therapeutic effects for the condition, making it the correct choice in this context.

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3. What code would be used for a complication that doesn't have a specific designation in ICD-10-CM?

A. A

B. G

C. NEC

D. NOS

The correct choice is "C," which stands for "Not Elsewhere Classified" (NEC). This designation is used in the ICD-10-CM coding system to indicate that a specific complication does not have a dedicated code but still fits within a broader category that captures it. The NEC code is helpful when there is a need to convey that the condition or complication being recorded does not have a unique identifier but still requires documentation. This is particularly common with complications where the clinical specifics might not be accounted for through the existing codes but still pertain to a recognized set of conditions. Using NEC maintains clarity and precision in medical records, allowing healthcare providers to specify that while the complication may not be explicitly defined within the manual, it is still relevant to the patient's care and diagnosis. This ensures accurate tracking for insurance, treatment plans, and overall patient health management.

4. What does a cystoscopic approach primarily involve?

A. Open surgery

B. Endoscopic procedure

C. External approach

D. Injectable procedure

A cystoscopic approach primarily involves an endoscopic procedure. Cystoscopy is a minimally invasive procedure that allows a healthcare provider to visually examine the inside of the bladder and urinary tract using a thin tube called a cystoscope. This device is inserted through the urethra, providing a direct view without requiring open surgery. The endoscopic nature of cystoscopy distinguishes it from other methods, as it allows for both visual inspection and potential treatment of urinary tract conditions without the need for larger incisions or extended recovery times associated with open surgery. This approach is beneficial for both diagnostic purposes and therapeutic interventions, such as removing small tumors or stones from the bladder. Other approaches mentioned, such as an external approach or injectable procedures, do not align with the mechanisms or techniques used in cystoscopy, further emphasizing why an endoscopic procedure is the correct description.

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5. What type of debridement involves the use of a Versajet or ultrasonic technology?

A. Excisional debridements

B. Non-excisional debridements

C. Mechanical debridements

D. Surgical debridements

The correct answer is non-excisional debridements. This type of debridement utilizes advanced technologies such as the Versajet system or ultrasonic devices to remove necrotic tissue and foreign materials from wounds without the need for surgical excision of viable tissue. Non-excisional debridement methods are less invasive compared to excisional techniques, as they primarily focus on cleansing the wound and promoting healing by removing only the dead or devitalized tissue. The use of high-pressure water jets or ultrasonic vibrations allows for precision and minimizes trauma to the surrounding healthy tissue, facilitating a more effective healing process. In contrast, other types of debridement, such as excisional debridements, involve the surgical removal of both necrotic and healthy tissue based on clinical judgement, which is not the approach taken in non-excisional methods. Mechanical debridements typically involve the use of physical force, such as wet-to-dry dressings or scrubbing, rather than the precision technology offered by ultrasonic or Versajet systems. Surgical debridements, similarly, rely on surgical instruments to remove tissue, which is again distinct from the non-invasive methods associated with the correct answer.

6. Which term describes the paralysis of both lower limbs?

A. Quadriplegia

B. Paraplegia

C. Hemiplegia

D. Monoplegia

The term that describes the paralysis of both lower limbs is paraplegia. This condition specifically refers to the loss of motor and/or sensory function in the lower half of the body, typically caused by spinal cord injury, diseases, or conditions affecting the spinal column. In contrast, quadriplegia refers to paralysis affecting all four limbs, hemiplegia refers to paralysis on one side of the body (usually an arm and a leg), and monoplegia indicates paralysis affecting only one limb. Understanding these terms is crucial in accurately describing and documenting the nature and extent of paralysis.

7. What is the primary diagnosis indicated by O80 in ICD-10-CM?

A. Cesarean delivery

B. Vaginal delivery

C. High risk patient prenatal

D. Extraction operation

The primary diagnosis indicated by O80 in ICD-10-CM corresponds to a vaginal delivery. Specifically, O80 is used to code for a single live birth during a vaginal delivery, which is an uncomplicated delivery scenario. This code is part of the O80-O84 range in ICD-10-CM, which encompasses various aspects of maternal and newborn health related specifically to deliveries. In the context of this coding system, a vaginal delivery is considered less complex compared to procedures like a cesarean delivery, which is covered under a different code (O82 for cesarean delivery). The other choices, such as high risk pregnancy or extraction operations, pertain to different circumstances which are not represented by the O80 code. Thus, the specificity of O80 in indicating a straightforward vaginal delivery is what makes this answer correct.

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8. What allows for coding flexibility in procedures involving both repositioning and supplementation of tissue?

A. Exclusive coding for reposition only

B. Requirement for different codes for each operation

C. Only one code is sufficient for billing

D. Combined coding is recommended

The correct answer highlights the requirement for different codes for each operation, which is essential for capturing the complexity and details of surgical procedures that involve both repositioning and supplementation of tissue. In the context of ICD-10-CM coding, it is crucial to provide a comprehensive account of all performed procedures to ensure accurate billing and documentation. When a procedure involves multiple actions, such as repositioning and adding tissue, using separate codes allows for a clearer representation of the services rendered. This approach not only promotes clarity and accuracy in coding but also aids in the analysis of surgical outcomes and healthcare utilization. Utilizing distinct codes for each operation supports the need for specificity in the coding process, reflecting the nuances of the procedures and ensuring that healthcare providers are properly reimbursed for the full scope of care provided to patients. This level of detail is particularly important in situations involving complex surgical interventions where multiple techniques are employed. Combined coding may seem efficient; however, it could lead to an oversimplification of the services provided, potentially impacting billing accuracy. Requiring different codes for each part of the procedure maintains the integrity of the medical record and payment systems.

9. What is meant by 'unconfirmed conditions' in coding?

A. Conditions that have a clear diagnosis

B. Conditions that are suspected but not verified

C. Diagnoses established as chronic

D. Conditions that have been treated

'Unconfirmed conditions' in coding refer to those situations where a healthcare provider suspects a particular condition but has not yet established a definitive diagnosis through necessary tests or clinical evaluation. These conditions are often documented in the patient's record to indicate that further investigation is required to confirm or rule out the suspected diagnosis. This understanding is essential, especially in coding scenarios, as the documentation needs to reflect the uncertainty surrounding the diagnosis. In coding systems like ICD-10-CM, codes may differ based on the level of certainty about a diagnosis. This means that if a condition is suspected but not confirmed, it will be coded differently compared to a condition that has a clear diagnosis or is established as chronic. The focus on the unverified status highlights the importance of a thorough clinical evaluation before assigning a definitive code, ensuring that the data reflects accurate disease management and resource allocation.

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10. When coding for infectious diseases, what is a crucial step?

A. Always code symptoms first

B. Identify chronic conditions

C. Reference underlying conditions

D. Focus solely on acute diagnoses

In coding for infectious diseases, referencing underlying conditions is a crucial step because it ensures a comprehensive understanding of the patient's health status. Infectious diseases can often be complicated by pre-existing conditions, which may affect treatment and management. By identifying and coding these underlying conditions, the coder can provide a more complete picture of the patient's health. This captures the complexity of the case, which is essential for accurate coding and billing, as well as for ensuring appropriate care. Additionally, recognizing the interaction between chronic conditions and infections can influence decisions on therapies and interventions. Understanding the context in which an infectious disease occurs enhances data quality and supports better health outcomes, as healthcare professionals rely on this information for clinical decisions.

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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:

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

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