



# Medical Coding CCS

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## Practice Questions

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### 1. CPT Category I codes consist of how many digits?

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

### 2. ICD-10-CM codes may contain up to how many characters?

- A. 5
- B. 6
- C. 7
- D. 8

### 3. How many characters are in every ICD-10-PCS code?

- A. 5
- B. 7
- C. 8
- D. 10

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### 4. In the MS-DRG system, what is the primary factor that determines the Major Diagnostic Category (MDC) assignment?

- A. The principal diagnosis
- B. The principal procedure
- C. The patient's age
- D. The presence of a complication or comorbidity



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**5. According to UHDDS guidelines, which of the following best defines the principal diagnosis?**

- A. The condition that caused the patient to seek outpatient care
- B. The most resource-intensive condition treated during the stay
- C. The condition established after study to be chiefly responsible for occasioning the admission
- D. The first condition listed on the physician's H&P

**6. Which publication provides the official guidelines for ICD-10-CM coding?**

- A. ICD-10-CM Official Guidelines for Coding and Reporting, published by CMS and NCHS
- B. AHA Coding Clinic for ICD-10-CM/PCS
- C. CPT Assistant published by the AMA
- D. UHDDS Data Dictionary published by AHIMA

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**7. Under HIPAA Privacy Rule, a covered entity must provide patients with a Notice of Privacy Practices (NPP) no later than:**

- A. 30 days after the first service delivery
- B. 60 days after the first service delivery
- C. The date of first service delivery
- D. 90 days after enrollment

**8. In ICD-10-CM, the term 'Excludes1' in a tabular list entry means:**

- A. The excluded code should never be reported with the code at that entry, because the two conditions cannot occur together
- B. The excluded code may be reported together with the code at that entry when both conditions are present
- C. The excluded code has been replaced by the code at that entry
- D. The excluded code represents a complication of the condition at that entry

**9. Under the 2021 E/M guidelines for outpatient visits, the level of service for established patients is based primarily on which two elements?**

- A. History and physical exam
- B. Chief complaint and time
- C. Medical decision making or total time
- D. Number of diagnoses and risk



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**10. In ICD-10-CM, a decimal point is placed after which character position?**

- A. Third
- B. Fourth
- C. Fifth
- D. Sixth

**11. What does the FIRST character of an ICD-10-PCS code represent?**

- A. Section
- B. Body system
- C. Root operation
- D. Approach

**12. In MS-DRG grouping, what does the suffix 'MCC' represent in a three-way DRG split?**

- A. Minor Complication or Comorbidity
- B. Major Coding Criteria
- C. Major Complication or Comorbidity
- D. Multiple Chronic Conditions

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**13. A patient is admitted with chest pain. After workup, the physician documents acute STEMI as the final diagnosis. Which condition should be sequenced as the principal diagnosis?**

- A. Acute STEMI
- B. Chest pain
- C. Coronary artery disease
- D. Hypertension

**14. According to ICD-10-CM conventions, what does the abbreviation 'NEC' mean in the Index?**

- A. Not elsewhere classifiable — the category is for conditions not listed elsewhere
- B. Not enough criteria — additional documentation is needed
- C. Not elsewhere classifiable — used when the condition is not specifically indexed
- D. No established code — a new code request should be submitted



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**15. A hospital wants to use patient health information for a research study. Under HIPAA, which of the following is NOT an acceptable basis for using PHI without individual authorization?**

- A. IRB-approved waiver of authorization
- B. Marketing purposes unrelated to treatment
- C. Preparatory activities to research
- D. Limited data set with data use agreement

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**16. A patient is admitted with acute systolic heart failure and hypertension. The physician's documentation does not specify a causal relationship between the two conditions. Per ICD-10-CM guidelines, the coder should:**

- A. Code only the heart failure; hypertension is assumed to be the cause
- B. Code each condition separately with no combination code
- C. Assume a causal relationship and assign the combination code for hypertensive heart disease
- D. Query the physician before assigning any codes

**17. Which CPT code range covers outpatient office or other outpatient visit services for new patients?**

- A. 99211–99215
- B. 99201–99205
- C. 99241–99245
- D. 99202–99205

**18. When a placeholder character is required in an ICD-10-CM code, which letter is always used?**

- A. A
- B. Z
- C. O
- D. X

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**19. Which character position in ICD-10-PCS represents the Root Operation?**

- A. Character 1
- B. Character 2
- C. Character 3
- D. Character 4

**20. A patient is admitted with COPD exacerbation and also has community-acquired pneumonia documented by the physician. Both conditions received treatment. Which condition should be sequenced as the principal diagnosis?**

- A. Always COPD exacerbation because it was the admitting diagnosis
- B. Always community-acquired pneumonia because it is more acute
- C. Whichever the physician documents first in the discharge summary
- D. Either condition may be sequenced first when both equally meet the definition of principal diagnosis, per UHDDS guidelines

**21. A patient is admitted with fever, productive cough, and elevated WBC. Sputum culture confirms Streptococcal pneumonia. The physician documents both pneumonia and sepsis due to Streptococcus pneumoniae. Which sequencing is correct?**

- A. Fever as principal, pneumonia as secondary
- B. Sepsis as principal, pneumonia as secondary — but only if sepsis meets SIRS criteria
- C. Pneumonia as principal, sepsis as secondary
- D. Sepsis as principal, pneumonia coded as the underlying infection

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**22. Under ICD-10-CM coding conventions, when an instructional note states 'Use additional code,' what does this mean?**

- A. A secondary code is required only when the additional condition affects treatment
- B. The code cannot be sequenced as principal diagnosis
- C. The additional code is optional and used at the coder's discretion
- D. An additional code must always be assigned along with the first code when applicable

**23. Under the HIPAA Security Rule, which of the following is classified as an 'addressable' implementation specification rather than 'required'?**

- A. Conducting a risk analysis
- B. Implementing a sanction policy for workforce members
- C. Assigning a security official
- D. Automatic logoff for electronic workstations



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**24. A patient with known type 2 diabetes mellitus is admitted for treatment of a diabetic Charcot's joint (neuropathic arthropathy). Per ICD-10-CM guidelines, the CORRECT code assignment is:**

- A. E11.9 (Type 2 DM without complications) and M14.60 (Charcot's joint, unspecified site)
- B. E11.610 (Type 2 DM with diabetic neuropathic arthropathy)
- C. E11.40 (Type 2 DM with diabetic neuropathy, unspecified) and M14.60
- D. E11.9 and G63 (Polyneuropathy in diseases classified elsewhere)

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**25. A physician spends 45 minutes with an established outpatient patient on the date of service, with more than half that time spent on counseling. Under 2021 E/M guidelines, which code is most appropriate?**

- A. 99214
- B. 99213
- C. 99215
- D. 99212

**26. For a fracture encounter, ICD-10-CM 7th character 'A' indicates which type of encounter?**

- A. Subsequent encounter
- B. Initial encounter
- C. Sequela
- D. Malunion

**27. In the Medical and Surgical section, character 5 represents which axis?**

- A. Body part
- B. Root operation
- C. Qualifier
- D. Approach

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**28. A DRG has a relative weight of 2.5 and the hospital's base rate is \$6,000. What is the approximate MS-DRG payment before adjustments?**

- A. \$6,000
- B. \$15,000
- C. \$10,000
- D. \$12,500

**29. When coding a postoperative complication, what is the first requirement that must be met before assigning a complication code?**

- A. The complication must have extended the LOS by at least 48 hours
- B. There must be a documented relationship between the condition and the procedure in the medical record
- C. The complication must be listed as a POA indicator N
- D. The attending physician must use the exact word 'complication'

**30. When can signs and symptoms be coded as principal diagnoses for inpatient encounters?**

- A. Whenever the coder believes a definitive diagnosis was not reached
- B. When a definitive diagnosis has not been confirmed by the end of the encounter
- C. Always, to ensure the most specific documentation
- D. Never; signs and symptoms are always excluded in inpatient coding



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## Answer Key & Explanations

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### 1. A — 5

All CPT Category I codes are exactly 5 numeric digits. Category II and III codes also use 5-character alphanumeric formats but are distinct from Category I.

### 2. C — 7

ICD-10-CM codes are 3–7 characters long. The maximum length is 7 alphanumeric characters. Codes beyond 3 characters always have a decimal point after the third character.

### 3. B — 7

Every ICD-10-PCS code has exactly 7 alphanumeric characters, each representing a specific value within its axis of classification.

### 4. A — The principal diagnosis

MDC assignment is driven primarily by the principal diagnosis — the condition established after study to be chiefly responsible for the admission. Most MDCs correspond to a body system or disease etiology, and the principal diagnosis ICD-10-CM code maps the case to an MDC.

### 5. C — The condition established after study to be chiefly responsible for occasioning the admission

The UHDDS definition states the principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission to the hospital. It is determined after workup, not necessarily the admitting diagnosis.

### 6. A — ICD-10-CM Official Guidelines for Coding and Reporting, published by CMS and NCHS

The ICD-10-CM Official Guidelines for Coding and Reporting, published jointly by CMS and NCHS, provide the official coding rules and conventions. AHA Coding Clinic provides guidance but is secondary to the official guidelines.

### 7. C — The date of first service delivery

HIPAA requires covered entities to provide the NPP to patients no later than the date of first service delivery (for direct treatment relationships). This ensures patients are informed of their privacy rights from the start of care.

### 8. A — The excluded code should never be reported with the code at that entry, because the two conditions cannot occur together

An Excludes1 note in ICD-10-CM indicates a pure exclusion—the excluded condition and the code at that entry are mutually exclusive and cannot be coded together. This differs from Excludes2, which indicates the excluded condition is not part of the indexed condition but may coexist and be coded together.

### 9. C — Medical decision making or total time

Since 2021, outpatient E/M levels for established patients are determined by either medical decision making (MDM) or total time on the date of the encounter — not the three-component history/exam/MDM framework.



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**10. A — Third**

The decimal point always follows the third character (the category) in every ICD-10-CM code that extends beyond three characters, separating the category from the etiology/anatomical site/severity characters.

**11. A — Section**

Character 1 identifies the Section (e.g., Medical and Surgical = 0, Obstetrics = 1), which is the broadest classification level in ICD-10-PCS.

**12. C — Major Complication or Comorbidity**

In the three-way MS-DRG split system, DRGs are divided into: with MCC (Major Complication or Comorbidity), with CC (Complication or Comorbidity), and without CC/MCC. MCCs are the most severe secondary diagnoses and yield the highest relative weight and reimbursement.

**13. A — Acute STEMI**

When a definitive diagnosis is established after study, the confirmed condition (acute STEMI) replaces the presenting symptom (chest pain) as the principal diagnosis. Signs and symptoms integral to the confirmed diagnosis are not coded separately.

**14. C — Not elsewhere classifiable — used when the condition is not specifically indexed**

'NEC' (Not Elsewhere Classifiable) in ICD-10-CM means the code is to be used when the information in the medical record provides detail for which a specific code does not exist. The 'other specified' code is often selected.

**15. B — Marketing purposes unrelated to treatment**

HIPAA permits certain research uses of PHI without individual authorization (e.g., IRB waiver, preparatory to research, limited data sets). However, using PHI for marketing purposes unrelated to treatment requires individual authorization and is not a permitted exception.

**16. C — Assume a causal relationship and assign the combination code for hypertensive heart disease**

ICD-10-CM guidelines instruct coders to assume a causal relationship between hypertension and heart failure even when the physician does not explicitly state it, assigning the appropriate combination code from category I11 (Hypertensive heart disease). This is a specific guideline exception to the general rule requiring explicit documentation of causality.

**17. D — 99202–99205**

As of 2021, CPT codes 99202–99205 represent new patient outpatient office visits (99201 was deleted). The established patient codes are 99211–99215.

**18. D — X**

The letter 'X' is the ICD-10-CM placeholder character. It holds a position so that future expansions and 7th-character extensions can be added without redesigning the code set.

**19. C — Character 3**

Character 3 represents the Root Operation, which describes the objective of the procedure (e.g., Excision, Repair, Fusion).

**20. D — Either condition may be sequenced first when both equally meet the definition of principal diagnosis, per UHDDS guidelines**



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Per UHDDS guidelines, when two or more diagnoses equally meet the definition of principal diagnosis (condition chiefly responsible for the admission after study), the coder may sequence either as principal. Both COPD exacerbation and pneumonia represent valid choices in this scenario, and the more resource-intensive condition or the one producing the highest-weighted DRG may be selected.

### **21. D — Sepsis as principal, pneumonia coded as the underlying infection**

Per ICD-10-CM guidelines, when sepsis is present with a localized infection, sepsis is sequenced as the principal diagnosis. The pneumonia causing the sepsis is coded as a secondary diagnosis to identify the underlying infection.

### **22. D — An additional code must always be assigned along with the first code when applicable**

'Use additional code' is a mandatory instruction in ICD-10-CM. When this note appears, an additional code must be assigned to provide more specificity, such as identifying an organism or associated manifestation.

### **23. D — Automatic logoff for electronic workstations**

Automatic logoff is an addressable implementation specification under the Access Control standard of the HIPAA Security Rule. Addressable specifications must be implemented if reasonable and appropriate, or an equivalent alternative must be documented. Risk analysis, sanction policy, and security official designation are required specifications.

### **24. B — E11.610 (Type 2 DM with diabetic neuropathic arthropathy)**

ICD-10-CM provides a specific combination code E11.610 for Type 2 diabetes mellitus with diabetic neuropathic arthropathy (Charcot's joint). ICD-10-CM guidelines instruct coders to use combination codes when available, rather than multiple codes to fully describe a condition.

### **25. C — 99215**

Under 2021 guidelines, CPT 99215 covers 40–54 minutes of total time for established patient office visits. Since 45 minutes falls in the 40–54 minute range, 99215 is appropriate.

### **26. B — Initial encounter**

'A' designates the initial encounter — the period when the patient is receiving active treatment. 'D' is subsequent (routine healing), and 'S' is sequela (late effect).

### **27. D — Approach**

In the Medical and Surgical section, Character 5 represents the Approach—the technique used to reach the operative site (e.g., Open, Percutaneous, Endoscopic).

### **28. B — \$15,000**

MS-DRG payment = Relative Weight x Hospital Base Rate.  $2.5 \times \$6,000 = \$15,000$ . The relative weight reflects the average resources required for cases in the DRG relative to the average case.

### **29. B — There must be a documented relationship between the condition and the procedure in the medical record**

A postoperative complication code requires documentation of a relationship (cause-and-effect) between the procedure and the condition. Coders may query if the relationship is unclear, but documentation of the link is required.



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**30. B — When a definitive diagnosis has not been confirmed by the end of the encounter**

For inpatient coding, signs and symptoms that are not associated with or routinely associated with a definitive diagnosis are coded when the diagnosis has not been confirmed by the end of the encounter. If a definitive diagnosis is established, the symptom is not coded separately if integral to the diagnosis.



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