Medical Coding

Free Practice Test — 30 Real Exam-Style Questions

with full answer key & explanations

Unlock the full bank of 2683 questions + unlimited timed mock exams + mistake book

Practice on the web: https://certs.theorypractice.app/medical-coding

$2.99 / week · $6.99 / month · cancel anytime

What you unlock: all 2683 questions • unlimited timed mock exams • mistake book • instant explanations

Study offline on the free app — search your exam on the App Store or Google Play

Practice Questions

Try all 30 first, then check the answer key at the back.

**1. George, a 32-year-old male hospital to the clinic with weakness, sore arms and legs. He mentions that he has had these symptoms for 6 months. He also mentions the loss of hair texture and bleeding gums on brushing. The physician mentions a lack of Vitamin C in his diet suggesting ascorbic acid deficiency.

What is the correct ICD-10 code for his condition?**

A. E53.9
B. E53.0
C. E53.1
D. E54

**2. The patient has olecranon bursitis in an unspecified elbow.

Which of the following is the proper diagnosis code?**

A. M70.2.
B. M70.21.
C. M70.20.
D. M70.22.

3. When reporting the time involved for an anesthesia procedure when do you start and stop the clock? What is the correct answer?

A. Time starts when the patient is in the operating room before the anesthesiologist is in attendance and ends in the PACU after the anesthesiologist gives report to the post-anesthesia care unit nurses.
B. Time starts when the patient is in the operating room and the anesthesiologist begins to prepare the patient for the induction of the anesthesia and ends in the operating room at the end of the surgery time.
C. Time starts when the patient is in the operating room and the anesthesiologist begins to prepare the patient for the induction of the anesthesia and ends when the anesthesiologist is no longer in attendance after reporting to the nurses in the PACU (post-anesthesia care unit).
D. Time starts when the patient is in the pre-operative waiting area before the anesthesiologist is present and ends at the end of the surgery time.

4. Which anesthesia add-on code is used for anesthesia complicated by utilization of controlled hypotension – 5 extra units?

A. +99100.
B. +99140.
C. +99116.
D. +99135.

5. What is special about services provided in a patient's home?

A. When services are provided in the home by a physician or provider who is not part of an agency, this is considered "non-facility" services
B. None of the above options are correct about patient care within the home
C. When services are provided by a provider or physician who is part of an agency, such as home health, then the service is considered to be provided within a facility
D. Answers A and B are both correct about in home patient care services

**6. A patient is being set up with a continuous positive airway pressure (CPAP) machine upon arriving to the unit from the emergency department.

What is the correct code for CPAP ventilation initiation and management?**

A. 94660
B. 94644
C. 94645
D. 94662

7. Which of these codes is used to indicate adult and child abuse, neglect and other maltreatment, suspected?

A. Z04.71.
B. Z04.72.
C. T76.
D. T74.

**8. A patient has a local infection that is present on admission. The patient goes on to develop sepsis, including kidney failure and heart failure.

What diagnosis is listed first?**

A. Heart failure
B. Sepsis
C. Local infection
D. Kidney failure

9. A 78-year-old woman has to have biopsies done of her right lower lung infiltrate. She is scheduled for a thoracoscopy where a wedge biopsy will be taken of the right lower lobe. Which code should you use for this procedure?

A. 32601
B. 32608
C. 32607
D. 32650

**10. A 2-month-old male with diphtheria presented to the hospital with severe respiratory distress. The emergency department physician performed a pulse oximetry and discovered that the patient's blood oxygen level was in the 60's. The on-call physician ordered an emergency endotracheal intubation to restore oxygen flow to the infant. Once the airflow was established, care was transferred to the on-call pediatrician.

What is the appropriate code for the emergency department procedure(s)?**

A. 31500, 94761
B. 31603, 94760 -51
C. 31603, 94761
D. 31500, 94760-51

11. Which of the following is protected health information (PHI) of a patient?

A. The gender of the patient
B. The name of the patient's physician
C. The name of the patient's health insurance company.
D. The patient's social security number

12. Which of the following Medicare parts covers inpatient hospital care and care provided in skilled nursing facilities, hospital care, and home healthcare?

A. Part A.
B. Part C.
C. Part B.
D. Part D.

13. Which of the following steps is NOT needed before an unlisted services procedure code can be included on a claim?

A. Review Category III codes to make sure an appropriate code does not exist
B. Check to see if a modifier is appropriate to include with your code
C. Review the CPT manual to make sure a more appropriate code does not exist
D. Review Category II codes to make sure an appropriate code does not exist

**14. While working as a coder, you receive a request for information from an insurance company. They are asking to review the chart to validate the coding on a particular date of service that your facility has submitted. The patient's chart includes the labs, surgeries, radiology and patient encounters for the past 5 years.

What information can be released to the insurance company?**

A. The patient's entire record excluding radiology and labs
B. The patient's entire record for justification
C. The patient's name only
D. The patient's information for the specific date of service

**15. A patient with pancreatic cancer needs to have peripancreatic drains placed for acute pancreatitis.

What CPT code should be used for this procedure?**

A. 48001
B. 48510
C. 48020
D. 48000

16. Of the following, which is defined as the surgical procedure to create an exterior pouch from an internal abscess?

A. Marsupialization.
B. Gastroplasty.
C. Gastrostomy.
D. Hepatography.

17. Which of the following diabetes mellitus categories is defined as Type I diabetes mellitus?

A. E09.
B. E08.
C. E10.
D. E11.

18. Which of the following codes is used to report cysts of right upper eyelid?

A. H02.825.
B. H02.824.
C. H02.822.
D. H02.821.

**19. A patient needs to have a culture done of his stool looking for Salmonella and Shigella. This will be performed as an aerobic stool sample with isolation and preliminary examination.

What is the correct CPT code for this laboratory test?**

A. 87070
B. 87045
C. 87046
D. 87040

20. Can you use signs, symptoms or unspecified codes in the ICD-10-CM instead of an actual diagnosis?

A. Yes, symptom/sign codes can be used, but there are no unspecified codes in the ICD-10-CM
B. No, ICD-10-CM doesn't even have unspecified codes as an option
C. Yes, if a definitive diagnosis hasn't been made by the end of the patient encounter, then unspecified codes or sign/symptom codes may be used to best describe the diagnosis at the end of the encounter
D. No, in ICD-10-CM the purpose of added codes is to prevent the use of signs, symptoms or unspecified codes

**21. Most codes for pregnancy require a final character to indicate the trimester of pregnancy.

Which of the following describes the 1st trimester?**

A. Less than 10 weeks.
B. 28 weeks 0 days until delivery.
C. Less than 14 weeks 0 days.
D. 14 weeks 0 days to less than 28 weeks 0 days.

**22. **

A. The code is a vaccine pending FDA approval.
B. The code is exempt from modifier 51.
C. The code is a duplicate proprietary laboratory analysis.
D. The code is listed out of sequence.

**23. PROCEDURAL NOTEPATIENT: Ray, Alexander

AGE: 59

DATE: 02/15/2015
PREOPERATIVE DIAGNOSIS: Prostate Cancer, Primary
POSTOPERATIVE DIAGNOSIS: Same

PROCEDURE: TURPA patient was placed in supine position on the operating table, draped and anesthetized accordingly. Using a resectoscope with light source, the physician located the prostate and resected the malignant prostatic tissue with electrocautery knife, leaving the appropriate margins. The physician removed the resectoscope and the patient was catheterized for drainage of his bladder contents and resected prostatic tissue. The patient tolerated the procedure well and was transferred to postoperative recovery.

What is the correct code for this surgical procedure?**

A. 52500
B. 52630
C. 52601
D. 52601 -58

24. A 32-year-old married female presents to her OB/GYN office for diaphragm fitting. After performing a pelvic examination and routine physical, the OB measures the cervix and adjusts the diaphragm so that it fits neatly over the cervical opening. The OB then instructs the patient in how to place the diaphragm for most effective birth control, as well as how to remove, clean, and store the diaphragm. Satisfied that the patient understands how to use the device properly, she allows the patient to leave the office with a follow-up appointment scheduled in one month. How should the OB/GYN code for this visit?

A. 57170
B. 99395
C. 99395, 57170
D. 99395, 57170-59

25. The physician performs an arthroplasty of the patella, and also places a prosthesis. This procedure would be coded as:

A. 27438
B. 27437
C. 27424
D. 27422

**26. OPERATIVE NOTE

Organization: Pennhurst Hospital

Patient Name: Mario Hernandez

Preoperative Diagnosis: sarcoma left lower extremity

Postoperative Diagnosis: same

Procedure: excision sarcoma left lower extremity

Surgeon: Mohammed Yashir, MD

ASA Class: 2

Anesthesia: general endotracheal

Indications for Procedure: The patient is a 54-year-old male presenting with a painless mass in the left lateral calf that has been gradually enlarging over the last 5 months.

Procedure:
The skin and subcutaneous tissues were infiltrated with 15 mL 0.25% Marcaine local anesthetic. An elliptical incision was made to ensure that all the skin overlying the palpable lesion was incorporated. This included the previous core needle biopsy site. The ellipse of skin excised with the specimen was 10 x 6 cm. The incision was carried through the skin and superficial subcutaneous tissues. A flap was then raised circumferentially around the incision site to widely include the subcutaneous tissue around the palpable lesion to a margin of 3 cm. We went directly through the deep subcutaneous tissue all the way to the level of the muscle fascia and including as the deep margin. We excised the muscle fascia circumferentially and did not note any obvious involvement of the muscle. At no point during the procedure did we see or directly palpate the lesion. I felt I had what appeared to be a good rim of normal surrounding skin, subcutaneous fat, and muscle fascia. The excised specimen was tagged at the 12:00 axis and sent to surgical pathology. The surgical site was inspected. Hemostasis was achieved using electrocautery. The extent of the excision was marked with 5 clips (superior, inferior, medial, lateral, and mid posterior. I then raised subcutaneous flaps more laterally and medially to facilitate skin closure and allow for a tensionless closure. The subcutaneous tissues were reapproximated with 3-0 Vicryl. The skin was closed with interrupted 3-0 Nylon sutures and reinforced with steri-strips.

Specimen: site of sarcoma, left lower extremity (stitch at 12:00)

Estimated Blood Loss: minimal

Complications: none

According to the OP Note, the patient presented with a painless mass in the left lateral calf that has been gradually enlarging over the last 5 months. An ultrasound and MRI were obtained which demonstrated an approximately 3 x 1 x 2 cm subcutaneous lesion, with no other lesions apparent. Patient's lymph nodes were clear. A core needle biopsy was performed that confirmed a sarcoma. Please assign the correct ICD-10-CM diagnosis code.**

A. C49.9
B. C79.89
C. C49.21
D. C49.22

**27. A 10-year-old girl comes to her pediatrician's office after smashing the nail of her right 2nd digit in the car door the previous night. This morning, the tip of her finger is edematous, there is a large amount of ecchymosis present, and the pain is worse than when the injury initially occurred. The pediatrician uses a disposable Bovie high-temperature cautery pen to cauterize a hole in the nail to allow the subungual hematoma to drain. A small amount of serosanguineous fluid is removed and pain rapidly decreased.

Which of the following codes should you use?**

A. 11740
B. 11730
C. 1175011750
D. 11720

28. Which of these HCPCS Level II Modifiers is used to indicate "medical supervision by a physician: more than four concurrent anesthesia procedures"?

A. AD.
B. QY.
C. QK.
D. AA.

29. Interstitial lung disease is reported with what category?

A. J86.
B. E84.
C. J84.
D. J93.

30. The diaphragm is the major muscle that controls breathing. Is this muscle voluntary or involuntary?

A. Voluntary
B. Neither
C. Both
D. Involuntary

Answer Key & Explanations

1. D — E54
E54 is the correct code for this case because it codes for ascorbic acid deficiency. As there is a lack of vitamin C in his dietary intake therefore the symptoms relate to ascorbic acid deficiency.

Option A is not correct because E53.0 is used to code for riboflavin deficiency.

Option C is not correct because E53.9 is used to code for Vitamin B deficiency, unspecified.

Option D is not correct because E53.1 is used to code for pyridoxine deficiency.

2. C — M70.20.
Because it is the proper code. The other answers cannot be correct because the code does not match with the patient's issue or the diagnosis. Instead, the other codes match with the same issue for a different limb or a different medical problem altogether. M70.21 is code for olecranon bursitis in the right elbow. M70.22 is code for olecranon bursitis in the left elbow. M70.2 is code for the category of olecranon bursitis.

3. C — Time starts when the patient is in the operating room and the anesthesiologist begins to prepare the patient for the induction of the anesthesia and ends when the anesthesiologist is no longer in attendance after reporting to the nurses in the PACU (post-anesthesia care unit).
Time starts when the anesthesiologist is present when he/she begins to prepare the patient for induction of anesthesia in the operating room (or equivalent area) and ends when the anesthesiologist is no longer in personal attendance.

Answer A is incorrect because the anesthesiologist wasn't present when the time first began and ended at the end of surgery, not at the end of the anesthesiologist's attendance.

Answer B is incorrect because the time ended at the surgery end time and not at the end of the anesthesiologist's attendance.

Answer D is incorrect because the time started before the anesthesiologist was in attendance.

4. D — +99135.
+99100: Anesthesia for patient of extreme age (younger than 1 year and older than 70) – 1 extra unit.

+99116: Anesthesia complicated by utilization of total body hypothermia – 5 extra units.

+99135: Anesthesia complicated by utilization of controlled hypotension – 5 extra units.

+99140: Anesthesia complicated by emergency conditions (specify) – 2 extra units.

5. D — Answers A and B are both correct about in home patient care services
Both A and B are correct. Services provided within the home by someone part of an agency are considered facility services. Services provided by a physician or provider who is not part of an agency are not facility services, they are termed "non-facility" services.

6. A — 94660
94660 is the correct code for initiation and management of CPAP ventilation.

Codes 94644 and 94645 are incorrect because these codes refer to continuous inhalation treatment with aerosol medication.

Code 94662 is incorrect because this code is for continuous negative pressure ventilation initiation and management.

7. C — T76.
T74 - adult and child abuse, neglect and other maltreatment, confirmed

T76 – adult and child abuse, neglect and other maltreatment, suspected

Z04.71 – encounter for examination and observation following alleged physical adult abuse

Z04.72 – encounter for examination and observation following alleged physical child abuse.

8. C — Local infection
According to ICD-10-CM official coding guideline 1. C.1.d.1 the local infection is sequenced first, followed by sepsis codes and organ dysfunction.

9. C — 32607
32607 is the correct code for a unilateral infiltrate and requires a thoracoscopy with wedge biopsy.

Code 32601 is incorrect because this is for a thoracoscopy without biopsies.

Code 32608 is incorrect because this includes a biopsy of masses or nodules.

Code 32650 is incorrect because this code is for a surgical thoracoscopy with pleurodesis.

10. D — 31500, 94760-51
The appropriate code for the emergency department procedures are 31500 for (Intubation, Endotracheal, Emergency Procedure) and 94760, for the pulse oximetry. The pulse ox was a multiple procedure, so it should be appended with modifier -51.

Code 31603 is not the appropriate code because it refers to a tracheostomy. These two procedures are often confused in coding but the code for an endotracheal intubation is within the larynx section and the code for the tracheostomy is within the trachea section.

11. D — The patient's social security number
PHI is written, verbal or electronic information that can be used to identify an individual, including the patient's social security number.

12. A — Part A.
Medicare Part A covers inpatient hospital care and care provided in skilled nursing facilities, hospital care, and home healthcare.

Medicare Part B helps cover medically necessary physicians’ services, outpatient care, and other medical services not covered under Part A.

Medicare Part C combines the benefits of Parts A, B, and sometimes D. It is also known as Medicare Advantage.

Medicare Part D is prescription drug coverage.

13. D — Review Category II codes to make sure an appropriate code does not exist
Before you include an unlisted services procedure code on a claim, you do NOT have to review Category II codes to make sure an appropriate code does not exist. In order to assign an unlisted procedures code, you first must review all of the CPT codes in that section to make sure a more appropriate code does not exist. You must also check to see a modifier is available to include on the claim. Lastly, before assigning an unlisted procedure code, you must check if a Category III code is more appropriate.

14. D — The patient's information for the specific date of service
Only the patient's information for that specific date of service should be released. Additionally, the request for information should only include the specific items stated. If the service under question was a radiology claim, only radiology should be released, no other information.

15. D — 48000
48000 is the correct code for peripancreatic drain placement for pancreatitis.

Code 48001 is

incorrect because there was no mention of cholecystostomy, gastrostomy or jejunostomy.

Code 48020 is incorrect because there was no removal of pancreatic calculus.

Code 48510 is incorrect because there was external drainage of pancreatic pseudocyst.

16. A — Marsupialization.
Gastroplasty – stomach operation for repair or reconfiguration

Gastrostomy – artificial opening between the stomach and the abdominal wall

Hepatography – radiographic recording of the liver

Marsupialization – surgical procedure to create an exterior pouch from an internal absces.

17. C — E10.
There are five diabetes mellitus categories in ICD-10-CM. They are:

E08 - Diabetes mellitus categories is defined as diabetes mellitus due to an underlying condition

E09 – Drug or chemical induced diabetes mellitus

E10 – Type I diabetes mellitus

E11 – Type II diabetes mellitus

E13 – Other specified diabetes mellitus.

18. D — H02.821.
H02.821: cysts of right upper eyelid

H02.822: cysts of right lower eyelid

H02.824: cysts of left upper eyelid

H02.825: cysts of left lower eyelid.

19. B — 87045
87045 is the correct code for aerobic stool culture with isolation and preliminary examination for Salmonella and Shigella species.

Code 87040 is incorrect because this code is for blood bacterial culture.

Code 87046 is incorrect because, even though this is an aerobic stool culture, it is for additional pathogens with identification of isolates.

Code 87070 is incorrect because this code is for culture of any other source except for urine, blood or stool.

20. C — Yes, if a definitive diagnosis hasn't been made by the end of the patient encounter, then unspecified codes or sign/symptom codes may be used to best describe the diagnosis at the end of the encounter
Both sign/symptom and unspecified codes are appropriate to use when the actual diagnosis is unable to be made. In some cases, the infecting organism needs to be identified for a specific code to be used, so in these cases when the infecting organism isn't known at the time of the patient's encounter an "unspecified" code is appropriate to be used.

ICD-10-CM does have codes for signs and symptoms or "unspecified" codes. Although they are not listed for every possible diagnosis, if they are an option they are allowed to be used based on the information available at the time of the patient's visit/encounter.

21. C — Less than 14 weeks 0 days.
1st trimester - Less than 14 weeks 0 days.

2nd trimester - 14 weeks 0 days to less than 28 weeks 0 days.

3rd trimester - 28 weeks 0 days until delivery.

22. B — The code is exempt from modifier 51.
This code is exempt from modifier 51 (multiple procedures), so it cannot be performed multiple times.

23. C — 52601
The correct code for this surgical procedure is 52601 (Transurethral Electrosurgical Resection of the Prostate Including Control of Postoperative Bleeding, Complete). The procedure TURP stands for transurethral resection of the prostate, which is the procedure described in the procedural note.

Code 52500 is only used for the resection of a bladder neck not the prostate.

Code 52630 is used for the regrowth

of prostatic tissue and modifier-58 is inappropriate because it is used for the primary procedure.

24. D — 99395, 57170-59
The OB/GYN should code for this visit with 99395 (Routine Physical and Pelvic Examination). OB/GYNs are considered primary care physicians who can perform routine physical examinations.

Code 57170 (Diaphragm or Cervical Cap Fitting with Instructions) also needs to be included on the claim because the OB performed an additional service. Furthermore, it is necessary to combine the modifier -59 with code 57170 to indicate that there was a distinct procedural service provided to the patient on the same day as an E/M service, which in this case, is a routine physical and pelvic exam.

25. A — 27438
27438: Using the CPT alphabetic index: Patella, Repair, Arthroplasty or Patella, Repair, with Prosthesis. An alternative indexing option would also be: Arthroplasty, knee. This would provide the code range: 27437-27447. There is often more than one way to index a procedure within the CPT codebook.

26. D — C49.22
According to the ICD-10-CM Neoplasm table, sarcoma is a malignancy of the connective tissue. The patient's sarcoma is located on the left calf, which is the lower limb. The neoplasm table identifies ICD-10-CM diagnosis code C49.22. The Tabular List indicates that C49.2 is a malignant neoplasm of connective and soft tissue of lower limb, including hip. A 5th digit is needed for specificity, referencing the lower left limb, C49.22.

27. A — 11740
11740 is correct because the subungual hematoma was able to be evacuated by using a disposable Bovie cautery pen in the office.

Code 11720 is incorrect because there was no debridement done of the nail.

Code 11730 is incorrect because there was no avulsion and 11750 is incorrect because there was no excision of the nail for permanent removal.

28. A — AD.
AA - anesthesia services performed personally by anesthesiologist

AD - medical supervision by a physician: more than four concurrent anesthesia procedures

QK - medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

QY - medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.

29. C — J84.
Interstitial lung disease – J84

Pyothorax (empyema) – J86

Pneumothorax – J93

Cystic fibrosis – E84.

30. C — Both
The diaphragm is voluntary and involuntary. It is involuntary because you do not have to consciously think about taking a breath every time you inhale or exhale. This is illustrated when you hiccup involuntarily. It is also voluntary because you can change the way you breathe, for instance when you hold your breath.

Ready to pass?

Unlock the full Medical Coding bank, every explanation, and unlimited timed mock exams.

Scan to start practising
https://certs.theorypractice.app/medical-coding

Also on iOS & Android — search your exam name on the App Store or Google Play