SIMULATION EXAM 10

Recommended Time: 4 Hours | 100 Questions | Passing Score: 70%

10,000 Series — Integumentary System (Questions 1–6)

1. A surgeon excises a 2.0 cm malignant basal cell carcinoma from the patient's forehead with 0.4 cm margins. What is the excised diameter for code selection?

A. 2.0 cm

B. 2.4 cm

C. 2.8 cm

D. 3.6 cm

2. A patient has two lacerations: a 6.0 cm laceration on the right forearm repaired with intermediate closure and a 3.5 cm laceration on the right hand repaired with intermediate closure. Both sites are in the same anatomical grouping. How should these be reported?

A. Two separate intermediate repair codes

B. One intermediate repair code for 9.5 cm combining both wounds

C. One complex repair code for 9.5 cm

D. One intermediate repair code for the largest wound only

3. A surgeon performs a free skin graft (split-thickness autograft) to a 30 sq cm wound on the anterior left thigh. The surgeon also excises the 4.0 cm malignant lesion that created the defect. How should the excision be coded?

A. With a separate malignant excision code; the excision is not included in the free skin graft code

B. It is included in the graft code; the excision is bundled

C. With the graft code and modifier 22

D. With the excision code only; the graft is bundled into the excision

4. A dermatologist performs cryodestruction of 10 benign warts on a patient's fingers. Which code(s) should be reported?

A. 17000 × 1, 17003 × 9

B. 17110 × 10

C. 17004

D. 17110 × 1, 17111 × 1

5. A physician performs a full-thickness excision of a 0.5 cm benign lesion from the patient's right eyelid with 0.1 cm margins. The wound is closed with simple sutures. What is the excised diameter?

A. 0.5 cm

B. 0.6 cm

C. 0.7 cm

D. 1.0 cm

6. A surgeon performs an adjacent tissue transfer (advancement flap) to close a 9 sq cm defect on the patient's nose created by excision of a skin cancer. Adjacent tissue transfer codes for the face are based on what measurement?

A. The defect size in square centimeters

B. The flap length in centimeters

C. The donor site area in square centimeters

D. The excised lesion diameter

20,000 Series — Musculoskeletal System (Questions 7–12)

7. A surgeon performs arthroscopic rotator cuff repair of the right shoulder. During the same session, a diagnostic arthroscopy is performed. How should the diagnostic arthroscopy be coded?

A. As a separate code with modifier 59

B. It is not reported separately; it is included in the surgical arthroscopy code

C. As a separate code with modifier 51

D. As a separate code with modifier 76

8. An orthopedic surgeon performs open reduction with internal fixation of a displaced tibial plateau fracture. The surgeon provides all preoperative, surgical, and postoperative care. During the 90-day global period, the patient returns for routine postoperative follow-up visits and cast changes. How should the follow-up visits be coded?

A. With a separate E/M code for each visit

B. With a separate E/M code and modifier 24 for each visit

C. With the fracture treatment code and modifier 76 at each visit

D. They are not coded separately; they are included in the global surgical package

9. A patient undergoes posterior spinal fusion at L2-L3, L3-L4, and L4-L5 with posterior pedicle screw instrumentation. How many total interspaces are being fused?

A. Two

B. Four

C. Three

D. Five

10. A surgeon performs a trigger finger release (tendon sheath incision) on the right ring finger in the office under local anesthesia. Which body system section contains the code for trigger finger release?

A. Musculoskeletal system (20,000 series) — hand/finger tendon subsection

B. Integumentary system

C. Nervous system

D. Medicine section

11. A patient undergoes total knee arthroplasty. During the same session, the surgeon also performs manipulation of the knee under the same anesthetic to verify range of motion after prosthesis placement. Is the manipulation separately coded?

A. Yes, with the manipulation code and modifier 59

B. Yes, with the manipulation code and modifier 51

C. Yes, with the manipulation code and modifier 76

D. No; intraoperative manipulation during the same anesthetic as the arthroplasty is included in the arthroplasty code

12. An orthopedic surgeon removes hardware (plate and screws) from a patient's right femur. The hardware was placed during a previous ORIF procedure that has now fully healed. Which type of procedure is hardware removal?

A. A fracture treatment code with modifier 58

B. A separate hardware removal code

C. The original ORIF code with modifier 76

D. An E/M code only; hardware removal is not a procedure

30,000 Series — Respiratory, Cardiovascular, Hemic, and Lymphatic (Questions 13–18)

13. A patient undergoes a diagnostic bronchoscopy with bronchoalveolar lavage (BAL) and separately with transbronchial lung biopsy during the same session. The BAL and the biopsy are both surgical bronchoscopy procedures with separate CPT codes. How should the diagnostic bronchoscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 25

C. It is not reported separately; it is included in the surgical bronchoscopy codes

D. As a separate code with modifier 51

14. A cardiologist upgrades a patient's existing single-chamber pacemaker to a dual-chamber system. The cardiologist inserts a new atrial lead and replaces the pulse generator with a dual-chamber generator. The existing ventricular lead is tested and left in place. How many component codes should be reported?

A. Two — one for the new atrial lead insertion and one for the generator replacement

B. One — a complete dual-chamber system insertion code

C. Three — one for the atrial lead, one for the ventricular lead testing, and one for the generator

D. One — a generator replacement code only

15. A surgeon performs a right thoracotomy with decortication of the lung for a trapped lung caused by chronic empyema. What does decortication accomplish?

A. Removal of the entire lung

B. Biopsy of the pleural surface

C. Insertion of a chest tube

D. Removal of the thick fibrous peel (cortex) from the surface of the lung to allow it to re-expand

16. A patient undergoes a percutaneous transcatheter closure of an atrial septal defect (ASD) using a closure device. How does this differ from open surgical ASD repair?

A. Percutaneous closure uses a larger incision than open repair

B. Percutaneous closure deploys a device through a catheter without open-heart surgery; open repair requires a sternotomy and cardiopulmonary bypass

C. There is no difference; both require sternotomy

D. Percutaneous closure is only for ventricular defects

17. A patient undergoes selective catheterization of the left renal artery with renal angiography. The catheter is inserted through the right femoral artery. The left renal artery is a first-order branch of the abdominal aorta. How is the catheter placement classified?

A. Non-selective catheterization

B. Third-order selective catheterization

C. First-order selective catheterization

D. Second-order selective catheterization

18. A surgeon performs an open repair of a descending thoracic aortic aneurysm using a tube graft through a left thoracotomy approach. Which vascular subsection contains thoracic aortic aneurysm repair codes?

A. The peripheral vascular subsection

B. The coronary artery subsection

C. The venous system subsection

D. The aorta and great vessel subsection

40,000 Series — Digestive System (Questions 19–24)

19. A patient undergoes a colonoscopy with biopsy of a suspicious mucosal lesion in the cecum and removal of a polyp by snare technique from the sigmoid colon during the same session. How should the diagnostic colonoscopy be coded?

A. It is not reported separately; it is included in the surgical colonoscopy codes

B. As a separate code with modifier 59

C. As a separate code with modifier 25

D. As a separate code with modifier 51

20. A surgeon performs an open Roux-en-Y gastric bypass. During the same operative session, the surgeon also performs a laparoscopic cholecystectomy for symptomatic gallstones. How should the cholecystectomy be coded?

A. It is included in the gastric bypass code

B. With a separate laparoscopic cholecystectomy code and modifier 51

C. With the gastric bypass code and modifier 22

D. With a separate open cholecystectomy code

21. A patient undergoes flexible sigmoidoscopy with removal of a polyp by hot biopsy forceps technique. How should the diagnostic sigmoidoscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. As a separate code with modifier 25

D. It is not reported separately; it is included in the surgical sigmoidoscopy code

22. A surgeon performs an emergent exploratory laparotomy on a patient with a gunshot wound to the abdomen. During the exploration, the surgeon repairs a small bowel laceration and performs a splenectomy for a ruptured spleen. How should the exploratory laparotomy be coded?

A. As a separate code with modifier 51

B. As a separate code with modifier 59

C. It is a "separate procedure" that is bundled when performed with more comprehensive procedures through the same incision

D. As the primary procedure code

23. A patient undergoes an EGD with dilation of the esophagus using a Savary dilator (over-the-wire technique). How should the diagnostic EGD be coded?

A. It is not reported separately; it is included in the surgical EGD dilation code

B. As a separate code with modifier 59

C. As a separate code with modifier 51

D. As a separate code with modifier 25

24. A surgeon performs a laparoscopic repair of a paraesophageal hernia with fundoplication during the same session. The CPT code for laparoscopic paraesophageal hernia repair includes the fundoplication. How should the fundoplication be coded?

A. With a separate fundoplication code and modifier 59

B. It is not coded separately; it is included in the hernia repair code when the code description includes fundoplication

C. With a separate fundoplication code and modifier 51

D. With the hernia repair code and modifier 22

50,000 Series — Urinary, Reproductive, and Endocrine (Questions 25–30)

25. A urologist performs a cystoscopy with bilateral ureteral stent removal and insertion of new bilateral ureteral stents during the same session. The diagnostic cystoscopy is bundled. How should the stent exchange be coded?

A. With removal codes only; the new insertions are bundled

B. With insertion codes only; the removals are bundled

C. With one exchange code if CPT provides a stent exchange code, or with separate removal and insertion codes

D. With separate stent removal and insertion codes, each reported bilaterally with modifier 50

26. A patient undergoes laparoscopic partial nephrectomy for a 2.5 cm renal mass. The surgeon uses intraoperative ultrasound to guide the resection. The intraoperative ultrasound code is NOT included in the partial nephrectomy code. How should the ultrasound be coded?

A. It is included in the partial nephrectomy code

B. With the nephrectomy code and modifier 22

C. With a separate intraoperative ultrasound code

D. With an E/M code for the ultrasound interpretation

27. A physician provides all antepartum care (12 visits), performs a vaginal delivery after previous cesarean (VBAC), and provides all postpartum care. Which code should be reported?

A. The global obstetric code for vaginal delivery after previous cesarean (VBAC)

B. The global code for routine vaginal delivery

C. Individual E/M codes for antepartum care plus the delivery-only code plus the postpartum-only code

D. The global cesarean delivery code with modifier 52

28. A surgeon performs a total abdominal hysterectomy with bilateral salpingo-oophorectomy on a patient with endometrial cancer. The uterine weight is 180 grams. The CPT code description for the hysterectomy includes removal of the tubes and ovaries. How should the BSO be coded?

A. With a separate BSO code and modifier 50

B. It is not coded separately; it is included in the hysterectomy code description

C. With a separate BSO code and modifier 51

D. With a separate oophorectomy code for each side

29. A urologist performs a transurethral vaporization of the prostate (TUVP) for BPH using a bipolar device. How does TUVP differ from TURP?

A. TUVP removes the entire prostate; TURP only removes a portion

B. There is no difference; both are identical procedures

C. TUVP is performed through an open incision; TURP is transurethral

D. TUVP uses thermal energy to vaporize prostate tissue; TURP uses a resectoscope loop to cut and remove tissue

30. A surgeon performs a right thyroid lobectomy with isthmusectomy for a suspicious thyroid nodule. The final pathology reveals papillary thyroid carcinoma. The patient returns two weeks later for a completion thyroidectomy to remove the remaining left lobe. How is the completion thyroidectomy coded?

A. With the total thyroidectomy code

B. With the right lobectomy code and modifier 76

C. With the completion thyroidectomy code (60260)

D. With the left lobectomy code and modifier 58

60,000 Series — Nervous System, Eyes, and Ears (Questions 31–36)

31. A neurosurgeon performs a lumbar laminectomy at L4-L5 with discectomy for a herniated disc causing radiculopathy. No fusion is performed. How should this be coded?

A. With the laminectomy/discectomy code for the lumbar spine

B. With a fusion code; all laminectomies include fusion

C. With the discectomy code and modifier 22

D. With an injection code for the epidural space

32. An ophthalmologist performs a penetrating keratoplasty (corneal transplant) on the left eye. The patient's diseased cornea is removed and replaced with a donor cornea. What does this procedure accomplish?

A. It removes a cataract

B. It treats glaucoma by reducing intraocular pressure

C. It corrects strabismus

D. It replaces the patient's diseased cornea with a healthy donor cornea to restore vision

33. A pain management physician performs a right greater occipital nerve block for treatment of occipital headaches. Which type of nerve procedure is this?

A. Neurolysis (nerve destruction)

B. Nerve block (temporary interruption of nerve signal transmission)

C. Nerve repair

D. Neurostimulator implantation

34. A patient undergoes revision of a spinal cord neurostimulator system — the pulse generator battery is depleted and requires replacement. The electrodes are functioning properly and are left in place. How should this be coded?

A. With a complete system implantation code

B. With separate electrode revision and generator revision codes

C. With the generator revision/replacement code only

D. With the electrode removal code plus a generator insertion code

35. An ophthalmologist performs bilateral intravitreal injections of ranibizumab (anti-VEGF agent) — one injection in each eye. The drug is coded separately with HCPCS J-codes. How should the procedure be coded?

A. With the intravitreal injection code (67028) reported bilaterally using modifier 50 or RT/LT modifiers

B. With a single intravitreal injection code and no modifier

C. With the injection code and modifier 22 for bilateral

D. With two E/M codes, one for each eye

36. An otolaryngologist performs a cochlear implant on the left ear. The procedure includes mastoidectomy approach, placement of the internal receiver-stimulator, and insertion of the electrode array into the cochlea. How many CPT procedure codes are reported for the cochlear implant surgery?

A. Three — one for the mastoidectomy, one for the receiver, and one for the electrode

B. Two — one for the receiver and one for the electrode

C. One for each component separately

D. One — code 69930 covers the cochlear device implantation with or without mastoidectomy

Evaluation and Management (Questions 37–42)

37. An established patient presents to the office with two stable chronic conditions (hypertension and hypothyroidism). The physician reviews lab results, refills medications, and provides standard monitoring. No new problems or diagnostic studies are involved. What level of MDM does this support?

A. Straightforward

B. Low

C. High

D. Moderate

38. A physician provides an initial hospital care service on a newly admitted patient. The physician also provided an office visit earlier the same day that resulted in the decision to admit. Both encounters were by the same physician on the same date. How should these be coded?

A. Both the office visit and the initial hospital care code

B. The office visit code with modifier 57 plus the initial hospital care code

C. Only the initial hospital care code; the office visit is rolled into the admission

D. Only the office visit code; the hospital care is included

39. A patient is placed in observation status after an emergency department evaluation by a different physician. The admitting physician evaluates the patient and provides initial observation care. The next morning, the same physician discharges the patient from observation. Which code set covers the discharge?

A. Observation discharge codes (99217)

B. Hospital discharge codes (99238–99239)

C. Subsequent observation codes (99224–99226)

D. ED visit codes (99281–99285)

40. A physician sees an established patient in the office. The total time on the date of the encounter is 50 minutes. Using the time-based pathway, which code is supported?

A. 99213 (20 minutes)

B. 99214 (30 minutes)

C. 99212 (10 minutes)

D. 99215 (40 minutes)

41. Under the current E/M guidelines, which of the following statements about prolonged services code 99417 is correct?

A. It may be reported with any E/M code level

B. It may only be reported with the highest-level office visit codes (99205 or 99215) and is reported in 15-minute increments

C. It replaces the base E/M code entirely

D. It is reported per hour of additional time

42. A physician provides critical care services to a critically ill patient. The physician also performs a central venous catheter insertion (36556) during the same encounter. Which statement is correct?

A. The central venous catheter insertion is separately reportable; it is NOT bundled into critical care codes

B. The central line insertion is bundled into critical care and cannot be reported separately

C. The central line insertion replaces the critical care code

D. Only the central line code is reported; critical care is bundled

Anesthesia (Questions 43–46)

43. An anesthesiologist provides general anesthesia for a lumbar spinal fusion on a 55-year-old patient with well-controlled asthma (P2). Total anesthesia time is 210 minutes. The payer uses 15-minute time units and assigns no modifying units for P2. Base units are 10. What is the total unit calculation?

A. 23 units

B. 25 units

C. 24 units

D. 22 units

44. A patient is classified as physical status P6. What does this indicate?

A. A moribund patient not expected to survive

B. A patient with severe systemic disease

C. A normal healthy patient

D. A declared brain-dead patient whose organs are being harvested for transplantation

45. An anesthesiologist provides anesthesia for a procedure on a 6-month-old infant and an 80-year-old patient on the same day (separate procedures). Which qualifying circumstances code applies to BOTH patients?

A. 99140 (emergency conditions)

B. 99100 (extreme age — under 1 year or over 70 years)

C. 99116 (total body hypothermia)

D. 99135 (controlled hypotension)

46. An anesthesiologist personally performs the entire anesthesia service for a cardiac surgery case without the involvement of a CRNA. Which modifier should be appended?

A. Modifier AA

B. Modifier QY

C. Modifier QX

D. Modifier QZ

Radiology (Questions 47–52)

47. A patient undergoes a CT of the brain without contrast followed by a CT of the brain with IV contrast during the same session. How should this be coded?

A. CT brain without contrast only

B. CT brain with contrast only

C. CT brain without contrast followed by with contrast (single combination code)

D. Two separate codes — CT brain without contrast plus CT brain with contrast

48. A hospital performs a two-view chest X-ray on an outpatient. The X-ray is interpreted by a radiologist employed by an independent radiology group that has a contract with the hospital. How should the radiologist bill?

A. With the global X-ray code

B. With modifier TC

C. With no modifier

D. With modifier 26

49. A patient undergoes a nuclear medicine whole-body bone scan to evaluate for metastatic prostate cancer. The patient receives an injection of technetium-99m MDP. What type of imaging is this?

A. MRI

B. Nuclear medicine

C. CT

D. Ultrasound

50. In radiation oncology, a patient completes a course of 35 fractions of radiation therapy. Treatment management (77427) is reported per 5 fractions. How many units of 77427 should be reported?

A. 7 units — 7 full units (35 fractions ÷ 5 = exactly 7 complete units)

B. 6 units

C. 35 units

D. 8 units

51. A patient undergoes fluoroscopic guidance during a lumbar puncture performed by a neurologist. The fluoroscopic guidance code is NOT included in the lumbar puncture code. A separate radiologist provides and interprets the fluoroscopic guidance. How should the radiologist bill?

A. With the lumbar puncture code and modifier 26

B. With the lumbar puncture code and modifier TC

C. With the fluoroscopic guidance code and modifier TC

D. With the fluoroscopic guidance code and modifier 26

52. A physician in a private office performs and interprets a pelvic ultrasound using practice-owned equipment. Which modifier should be appended?

A. Modifier 26

B. Modifier TC

C. No modifier; the global service is reported

D. Modifier 59

Pathology and Laboratory (Questions 53–58)

53. A physician orders a lipid panel and a TSH on the same specimen. TSH is NOT a component of the lipid panel. How should these be reported?

A. Only the lipid panel code; the TSH is bundled

B. The lipid panel code plus the individual TSH code

C. Individual codes for all tests; the lipid panel cannot be used with additional tests

D. The lipid panel code with modifier 22

54. A pathologist examines an appendix specimen removed during an appendectomy for acute appendicitis. At which level of surgical pathology is a non-incidental appendix classified?

A. Level IV (88305)

B. Level III (88304)

C. Level II (88302)

D. Level V (88307)

55. A laboratory performs definitive drug testing for amphetamines (3 analytes), cannabinoids (1 analyte), and cocaine metabolites (1 analyte). How many definitive drug testing codes should be reported?

A. One code per date of service

B. Five codes, one for each individual analyte

C. Two codes — one for amphetamines and one combining cannabinoids and cocaine

D. Three codes — one for each drug class

56. A patient undergoes a fine needle aspiration (FNA) of a thyroid nodule in the physician's office. The physician performs the FNA under ultrasound guidance. The FNA procedure, the ultrasound guidance, and the cytopathology adequacy assessment are three distinct services. How many codes are potentially reportable?

A. One code covering all three services

B. Two codes — the FNA plus the ultrasound guidance; the adequacy assessment is bundled

C. Three codes — one for the FNA procedure, one for the ultrasound guidance, and one for the cytopathology adequacy assessment

D. Two codes — the FNA plus the adequacy assessment; the ultrasound is bundled

57. A laboratory performs a CBC without differential (85027). The physician then orders an automated differential to be performed on the same specimen. How should the differential be coded?

A. With a repeat CBC code (85025) and modifier 91

B. With the automated differential code as a separate test in addition to the CBC without differential

C. It is included in the original CBC code; no additional code is needed

D. With a pathology consultation code

58. Special stains are performed on a breast biopsy specimen. The pathologist orders PAS, trichrome, GMS, and AFB stains — four different stains on the same tissue block. How should these be coded?

A. Four units of the special stain code — one per stain per specimen

B. One special stain code for all four stains combined

C. Two units — one for bacterial stains and one for fungal stains

D. With a pathology consultation code

Medicine (Questions 59–64)

59. A patient receives the following IV services during a single outpatient chemotherapy encounter: 45 minutes of IV hydration, a 2-hour IV infusion of oxaliplatin (chemotherapy agent), and an IV push of ondansetron (antiemetic — non-chemotherapy supportive agent). According to the infusion hierarchy, which service is the initial service?

A. The IV hydration

B. The IV push of ondansetron

C. Each service is reported as a separate initial service

D. The oxaliplatin chemotherapy infusion

60. A patient undergoes a Holter monitor (24-hour ambulatory ECG) recording, scanning analysis, and physician interpretation. Which Medicine subsection contains the Holter monitor codes?

A. Neurology subsection

B. Pulmonary function testing subsection

C. Cardiovascular diagnostic subsection

D. Allergy and immunology subsection

61. An established patient sees a nephrologist for monthly ESRD management. The patient is 60 years old and the physician provides 3 face-to-face visits during the month. Which code should be reported?

A. Three separate E/M office visit codes

B. The ESRD monthly management code for patients 20+ years with 2–3 visits per month (90961)

C. The hemodialysis procedure code × 3

D. The ESRD monthly code for 4+ visits (90960)

62. A 5-year-old patient receives one injection of the Hepatitis A vaccine (single antigen component) during a well-child visit. The physician provides face-to-face counseling about the vaccine. How should the administration be coded?

A. 90460 × 1 (pediatric component-based code for the single antigen component)

B. 90471 × 1 (adult injection-based code)

C. No administration code; it is included in the vaccine product code

D. 90461 × 1 (additional component add-on code)

63. A physical therapist provides 35 minutes of aquatic therapy (97113) to a patient. Aquatic therapy is a timed therapeutic procedure. Using the 8-minute rule, how many units should be reported?

A. 1 unit

B. 3 units

C. 4 units

D. 2 units

64. A psychiatrist provides 45 minutes of psychotherapy and also performs a 20-minute medication management visit (E/M) during the same encounter. How should the psychotherapy be coded?

A. 90834 (standalone 45-minute psychotherapy)

B. 90837 (standalone 60-minute psychotherapy)

C. 90836 (45-minute add-on psychotherapy with E/M)

D. 90838 (60-minute add-on psychotherapy with E/M)

Medical Terminology (Questions 65–68)

65. The suffix "-oma" means which of the following?

A. Tumor or mass

B. Inflammation

C. Surgical removal

D. Blood condition

66. Which combining form refers to the skin?

A. Neur/o

B. Derm/o or dermat/o

C. Oste/o

D. My/o

67. The prefix "tachy-" means which of the following?

A. Slow

B. Painful

C. Below

D. Fast or rapid

68. What does the medical term "osteoporosis" mean?

A. Inflammation of the bone

B. Bone cancer

C. A condition of porous, weakened bones with decreased bone density

D. Surgical removal of bone

Anatomy (Questions 69–72)

69. The aortic valve is located between which two structures?

A. The left ventricle and the aorta

B. The right atrium and the right ventricle

C. The left atrium and the left ventricle

D. The right ventricle and the pulmonary artery

70. Which organ is the largest solid organ in the abdominal cavity?

A. Spleen

B. Pancreas

C. Kidney

D. Liver

71. The sciatic nerve is the largest nerve in the human body. It originates from which region of the spine?

A. Cervical

B. Lumbosacral

C. Thoracic

D. Coccygeal

72. The tympanic membrane (eardrum) separates which two parts of the ear?

A. The middle ear and the inner ear

B. The inner ear and the auditory nerve

C. The external ear and the middle ear

D. The cochlea and the vestibular apparatus

ICD-10-CM / Diagnosis Coding (Questions 73–77)

73. A patient presents with a displaced fracture of the left femoral neck. This is the patient's first visit and active treatment is provided. Which 7th character should be used?

A. A (initial encounter)

B. D (subsequent encounter)

C. S (sequela)

D. G (subsequent encounter for fracture with delayed healing)

74. A patient undergoes a colonoscopy for evaluation of rectal bleeding. A colon polyp is found and removed. The pathology report reveals adenomatous polyp with low-grade dysplasia. Which diagnosis best represents the final confirmed finding?

A. The rectal bleeding code only

B. The screening Z code for colon cancer screening

C. A code for unspecified colon polyp

D. A code for benign neoplasm of the colon (adenomatous polyp)

75. In ICD-10-CM, when a patient has both Type 2 diabetes and hypertension, and the physician does NOT document any causal relationship between the two, how should these be coded?

A. With a combination code from I13

B. With separate codes — E11 for diabetes and I10 for hypertension — reported independently

C. With only the diabetes code; hypertension is included

D. With only the hypertension code; diabetes is assumed

76. A patient is seen for management of chronic pain following a healed right wrist fracture. The fracture healed 6 months ago but the patient has residual chronic pain at the fracture site. Which 7th character should be used on the fracture code?

A. A (initial encounter)

B. D (subsequent encounter)

C. S (sequela)

D. No 7th character is needed

77. A coder is assigning diagnosis codes for a pregnant patient at 28 weeks gestation presenting for a routine prenatal visit. Which ICD-10-CM chapter contains the codes for supervision of pregnancy?

A. Chapter 15 (Pregnancy, childbirth, and the puerperium — O00–O9A)

B. Chapter 21 (Factors influencing health status — Z00–Z99)

C. Chapter 14 (Diseases of the genitourinary system)

D. Chapter 16 (Certain conditions originating in the perinatal period)

HCPCS Level II (Questions 78–80)

78. A patient requires a standard manual wheelchair. Which HCPCS Level II code range covers wheelchairs and wheelchair accessories?

A. J0000–J9999

B. L0000–L9999

C. A4000–A8999

D. E1000–E1399 (within the E-code range for DME)

79. A physician administers 4 mg of ondansetron (Zofran) intravenously. The HCPCS J-code for ondansetron specifies 1 mg per unit. How many units should be reported?

A. 1 unit

B. 4 units

C. 8 units

D. 2 units

80. A Medicare patient receives a covered preventive service — an annual wellness visit. Which modifier may be appended to identify this as a preventive service that should not have cost-sharing?

A. Modifier GA

B. Modifier GZ

C. Modifier 33

D. Modifier QW

Coding Guidelines (Questions 81–87)

81. A surgeon performs a laparoscopic cholecystectomy. During the same session, a diagnostic laparoscopy is performed. How should the diagnostic laparoscopy be coded?

A. It is not reported separately; it is bundled into the surgical laparoscopy code

B. As a separate code with modifier 59

C. As a separate code with modifier 51

D. As a separate code with modifier 25

82. A physician provides an E/M service that results in the decision to perform a major surgical procedure (90-day global period). The surgery is scheduled for the following week. Which modifier should be appended to the E/M code?

A. Modifier 25

B. Modifier 59

C. Modifier 24

D. Modifier 57

83. Under the NCCI, a Column 1/Column 2 edit has a modifier indicator of 0. What does this mean?

A. A modifier may be appended to bypass the edit when clinically justified

B. No modifier is allowed; the edit cannot be overridden under any circumstances

C. The edit applies only to the technical component

D. Modifier 51 automatically bypasses the edit

84. Which of the following services is NOT included in the 90-day global surgical package and MAY be reported separately during the postoperative period?

A. Routine postoperative follow-up visits

B. Cast changes during fracture healing

C. An unrelated E/M service with modifier 24

D. Removal of sutures

85. A CPT code is an add-on code designated with the "+" symbol. Which of the following correctly describes how add-on codes affect reimbursement?

A. Add-on codes are exempt from modifier 51 and are reimbursed at 100% without the multiple procedure payment reduction

B. Add-on codes are subject to the standard 50% multiple procedure reduction

C. Add-on codes are never reimbursed; they are informational only

D. Add-on codes are reimbursed at 150% of their assigned value

86. A surgeon performs a procedure that is documented as involving significantly more work than typically required. The operative report describes extensive adhesiolysis, unusual anatomy, and significantly prolonged operative time. Which modifier should be appended?

A. Modifier 52

B. Modifier 51

C. Modifier 59

D. Modifier 22

87. In CPT, what does the term "unlisted procedure code" mean?

A. A code that has been deleted from the current CPT edition

B. A code that is exempt from all modifiers

C. A code used when no specific CPT code adequately describes the procedure performed

D. A code that requires prior authorization

Compliance and Regulatory (Questions 88–90)

88. Under Medicare's coverage determination system, which type of policy applies uniformly across the entire country?

A. Local Coverage Determinations (LCDs)

B. National Coverage Determinations (NCDs)

C. Medicare Administrative Contractor (MAC) bulletins

D. Provider-specific policies

89. A medical practice discovers through an internal audit that a coder has been consistently reporting incorrect modifiers on spinal injection claims, resulting in overpayments. Under an effective compliance program, what should be done?

A. Investigate the scope of the error, refund the overpayments to affected payers, retrain the coder, and implement corrective action to prevent recurrence

B. Terminate the coder immediately without investigation

C. Ignore the findings if the total amount is under $50,000

D. Continue billing the same way until an external audit identifies the issue

90. The Relative Value Unit (RVU) component that reflects the overhead costs of providing a service — including staff, equipment, supplies, and facility costs — and differs between facility and non-facility settings is which of the following?

A. Work RVU

B. Professional Liability Insurance (PLI) RVU

C. The conversion factor

D. Practice Expense (PE) RVU

Cases — Integrated Coding Scenarios (Questions 91–100)

Case 1 (Questions 91–92):

A 55-year-old patient undergoes a right shoulder arthroscopic rotator cuff repair. During the same session, the surgeon performs a diagnostic arthroscopy and an arthroscopic subacromial decompression. NCCI edits indicate the subacromial decompression is bundled into the rotator cuff repair.

91. How should the diagnostic arthroscopy be coded?

A. As a separate code with modifier 59

B. As a separate code with modifier 51

C. It is not reported separately; it is bundled into the surgical arthroscopy

D. As a separate code with modifier 76

92. The NCCI edits indicate the subacromial decompression is bundled into the rotator cuff repair. How should the decompression be coded?

A. As a separate code with modifier 59

B. It is not reported separately; it is bundled per NCCI edits

C. As a separate code with modifier 51

D. As a separate code with modifier 22

Case 2 (Questions 93–94):

A 68-year-old Medicare patient presents for a screening colonoscopy. During the procedure, the gastroenterologist identifies and removes a 1.5 cm pedunculated polyp from the descending colon using snare technique with electrocautery. A separate 0.4 cm polyp in the sigmoid colon is removed using cold forceps biopsy technique.

93. How should the polyp removals be coded?

A. One snare polypectomy code and one cold forceps biopsy polypectomy code with appropriate modifier

B. One snare polypectomy code only; the biopsy is bundled

C. One diagnostic colonoscopy code plus one polypectomy code

D. Two snare polypectomy codes

94. Which diagnosis should be reported as the first-listed code?

A. K63.5 (Polyp of colon)

B. Z80.0 (Family history of malignant neoplasm of digestive organs)

C. R19.5 (Other fecal abnormalities)

D. Z12.11 (Encounter for screening for malignant neoplasm of colon)

Case 3 (Questions 95–96):

A pain management physician performs bilateral L4, L5, and S1 medial branch nerve radiofrequency ablation under fluoroscopic guidance. The ablation codes include imaging guidance.

95. How should the three levels of ablation be coded?

A. Three primary ablation codes, one for each level

B. One ablation code for all three levels

C. A primary ablation code for the first nerve plus add-on codes for each additional nerve

D. One ablation code with modifier 22

96. The fluoroscopic guidance is included in the ablation codes. How should the fluoroscopy be coded?

A. It is not reported separately; it is included in the ablation codes

B. With a separate fluoroscopy code and modifier 26

C. With a separate fluoroscopy code and modifier 59

D. With a separate fluoroscopy code for each level

Case 4 (Questions 97–98):

A 42-year-old patient undergoes excision of a 1.4 cm benign lipoma from the subcutaneous tissue of the posterior neck. The wound is closed with intermediate layered repair.

97. Which code range should be used for the excision of the subcutaneous lipoma?

A. Skin excision codes (11400–11471)

B. Soft tissue tumor excision codes (subcutaneous) in the musculoskeletal section

C. Shave removal codes (11300–11313)

D. Skin biopsy codes (11102–11107)

98. The wound is closed with intermediate layered repair. Should the intermediate repair be coded separately?

A. No; all closures are included in excision codes

B. No; intermediate repair is included in subcutaneous tumor excision codes

C. Yes, with modifier 22

D. Yes; intermediate and complex closures may be reported separately when not included in the excision code

Case 5 (Questions 99–100):

A patient receives IV services during a single outpatient encounter: a 1.5-hour IV infusion of rituximab (non-antineoplastic biologic agent for rheumatoid arthritis), an IV push of methylprednisolone (non-chemotherapy supportive agent), and 30 minutes of IV hydration with normal saline.

99. Which code range should be used for the rituximab infusion?

A. Chemotherapy administration codes (96413–96417)

B. Hydration codes (96360–96361)

C. Therapeutic drug infusion codes (96365–96368)

D. Moderate sedation codes (99151–99157)

100. According to the infusion hierarchy, which service is reported as the initial service?

A. The rituximab therapeutic infusion, because therapeutic infusion outranks hydration and IV push in the hierarchy

B. The IV hydration, because it may have been administered first

C. The IV push of methylprednisolone

D. Each service is reported as a separate initial service

SIMULATION EXAM 10 — ANSWER KEY WITH EXPLANATIONS

10,000 Series — Integumentary System

1. **C. 2.8 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 2.0 cm + (0.4 cm × 2) = 2.8 cm. The margin is doubled because normal tissue is removed circumferentially around the entire lesion. This 2.8 cm excised diameter determines the correct code within the malignant excision range for the face/forehead anatomical grouping.
2. **B. One intermediate repair code for 9.5 cm combining both wounds** When multiple wounds are repaired using the same classification (both intermediate) and are in the same anatomical grouping (forearm and hand are in the same extremity grouping), their lengths are added together and reported as a single code. The two wounds total 6.0 + 3.5 = 9.5 cm. Only wounds of different classifications or different anatomical groupings are reported separately.
3. **A. With a separate malignant excision code; the excision is not included in the free skin graft code** For free skin grafts, the excision that created the defect may be reported separately from the graft code. This is a key distinction from adjacent tissue transfer, where the excision is bundled into the flap code. The malignant excision code and the graft code are both reported because they represent different surgical services — removal of the lesion and reconstruction of the defect.
4. **D. 17110 × 1, 17111 × 1** For destruction of benign lesions (warts), code 17110 covers the first lesion and code 17111 covers the second through fourteenth additional lesions as a flat code. For 10 warts: 17110 × 1 (first lesion) plus 17111 × 1 (lesions 2 through 10 — the code covers all additional lesions in this range in a single unit). Premalignant codes (17000–17004) are for actinic keratoses, not benign warts.
5. **C. 0.7 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 0.5 cm + (0.1 cm × 2) = 0.7 cm. Even very small margins are doubled because tissue is removed circumferentially. This 0.7 cm excised diameter determines the correct code within the benign excision range for the eyelid anatomical grouping.
6. **A. The defect size in square centimeters** Adjacent tissue transfer codes are based on the size of the defect being repaired, measured in square centimeters. The codes are organized by defect size ranges and anatomical location (trunk, scalp/extremities, face/eyelids/nose/ears/lips). The excision that created the defect is included in the adjacent tissue transfer code.

20,000 Series — Musculoskeletal System

7. **B. It is not reported separately; it is included in the surgical arthroscopy code** Diagnostic arthroscopy is always bundled into surgical arthroscopy when both are performed on the same joint during the same session. The rotator cuff repair is a surgical arthroscopic procedure — the diagnostic examination is included and is not separately reportable. Reporting both codes constitutes unbundling.
8. **D. They are not coded separately; they are included in the global surgical package** When the surgeon assumes the global fracture care package, all routine postoperative follow-up visits, cast application, cast changes, and cast removal during the healing period are bundled into the fracture treatment code. None of these routine services are reported separately during the global period.
9. **C. Three** Three interspaces are being fused: L2-L3, L3-L4, and L4-L5. Each interspace is the disc space between two adjacent vertebrae. The primary fusion code covers the first interspace, and add-on codes are reported for each additional interspace (two add-on codes for the two additional interspaces).
10. **A. Musculoskeletal system (20,000 series) — hand/finger tendon subsection** Trigger finger release involves incising the tendon sheath (A1 pulley) to allow the flexor tendon to glide freely. The codes are located in the musculoskeletal system section under the hand/finger tendon procedures subsection. Trigger finger is a tendon condition, not a nerve, skin, or medicine service.
11. **D. No; intraoperative manipulation during the same anesthetic as the arthroplasty is included in the arthroplasty code** Manipulation of the knee performed during the same anesthetic as a total knee arthroplasty to verify range of motion is considered part of the arthroplasty procedure and is not separately coded. The manipulation under anesthesia code is only separately reportable when performed as a standalone procedure — typically weeks after the arthroplasty when adhesions have developed.
12. **B. A separate hardware removal code** CPT provides specific codes for hardware removal (20680 for deep hardware, 20670 for superficial hardware). When hardware is removed after fracture healing as a separate surgical procedure, the hardware removal code is reported. This is not a repeat of the original ORIF and does not use the original fracture treatment code.

30,000 Series — Respiratory, Cardiovascular, Hemic, and Lymphatic

13. **C. It is not reported separately; it is included in the surgical bronchoscopy codes** Diagnostic bronchoscopy is always bundled into surgical bronchoscopy when both are performed during the same session. The BAL and the transbronchial biopsy are separate surgical bronchoscopic procedures, each reported with their own code. The diagnostic examination is included in the surgical codes.
14. **A. Two — one for the new atrial lead insertion and one for the generator replacement** Pacemaker coding is component-based. Upgrading from a single-chamber to a dual-chamber

system requires two component codes: one for inserting the new atrial lead and one for replacing the generator with a dual-chamber model. The existing ventricular lead is tested and left in place — no lead code is needed for a lead that was not inserted, repositioned, or removed.

15. **D. Removal of the thick fibrous peel (cortex) from the surface of the lung to allow it to re-expand** Decortication involves surgically stripping the thick fibrous membrane (peel or cortex) that forms on the visceral pleural surface of the lung in chronic empyema. This peel restricts lung expansion — removing it allows the lung to re-expand and function normally. Decortication is a distinct procedure from lobectomy, pleurodesis, or chest tube insertion.

16. **B. Percutaneous closure deploys a device through a catheter without open-heart surgery; open repair requires a sternotomy and cardiopulmonary bypass** Percutaneous transcatheter ASD closure involves inserting a catheter through a peripheral vein, advancing it to the heart, and deploying a closure device across the defect — all without opening the chest. Open surgical repair requires a sternotomy, cardiopulmonary bypass, and direct surgical closure or patch placement. These are fundamentally different approaches with different CPT codes.

17. **C. First-order selective catheterization** The left renal artery is a direct branch of the abdominal aorta — a first-order vessel. Selective catheterization into the renal artery from a femoral access is classified as first-order selective catheterization. Second-order would be a branch of the renal artery. Non-selective catheterization would be placement in the aorta without entering a branch vessel.

18. **D. The aorta and great vessel subsection** Thoracic aortic aneurysm repair codes — both open and endovascular — are located in the aorta and great vessel subsection of the cardiovascular surgery section. This subsection covers procedures on the thoracic and abdominal aorta, the great vessels, and related structures.

40,000 Series — Digestive System

19. **A. It is not reported separately; it is included in the surgical colonoscopy codes** When surgical procedures (biopsy and snare polypectomy) are performed during a colonoscopy, the diagnostic examination is bundled into the surgical codes. Each surgical technique is reported with its own code, but the diagnostic colonoscopy is not reported as an additional code.

20. **B. With a separate laparoscopic cholecystectomy code and modifier 51** The laparoscopic cholecystectomy for symptomatic gallstones is a separate surgical procedure from the gastric bypass — it addresses a different organ and a different diagnosis. It is reported with its own code and modifier 51 (multiple procedures). The cholecystectomy is not bundled into the gastric bypass code because they are distinct surgical services.

21. **D. It is not reported separately; it is included in the surgical sigmoidoscopy code** When a surgical procedure (hot biopsy forceps polypectomy) is performed during a sigmoidoscopy, the

diagnostic examination is bundled into the surgical code. Only the surgical sigmoidoscopy code is reported. The endoscopic hierarchy applies consistently across all GI endoscopy.

22. **C. It is a "separate procedure" that is bundled when performed with more comprehensive procedures through the same incision** Exploratory laparotomy is designated as a "separate procedure" in CPT. When performed with more comprehensive procedures (small bowel repair, splenectomy) through the same incision, the exploratory laparotomy is bundled. It may only be coded independently when it is the sole procedure or serves a distinct purpose at a different site.
23. **A. It is not reported separately; it is included in the surgical EGD dilation code** When a surgical procedure (esophageal dilation) is performed during an EGD, the diagnostic examination is bundled into the surgical code. Only the surgical EGD dilation code is reported. The endoscopic hierarchy applies — the diagnostic component is always included in the surgical code.
24. **B. It is not coded separately; it is included in the hernia repair code when the code description includes fundoplication** When the CPT code for laparoscopic paraesophageal hernia repair specifically includes fundoplication in its code description, the fundoplication is bundled. The coder must read the complete code description to verify. Reporting a separate fundoplication code when it is already included constitutes unbundling.

50,000 Series — Urinary, Reproductive, and Endocrine

25. **D. With separate stent removal and insertion codes, each reported bilaterally with modifier 50** When bilateral ureteral stents are removed and new stents are inserted during the same session, both the removal and insertion codes are reported. Each code is reported bilaterally with modifier 50 or RT/LT modifiers. The diagnostic cystoscopy is bundled into the surgical codes. The coder should verify NCCI edits to confirm both removal and insertion are separately reportable.
26. **C. With a separate intraoperative ultrasound code** When the partial nephrectomy code does NOT include intraoperative ultrasound and ultrasound guidance is used during the procedure, a separate ultrasound code is reported. The coder must always verify whether the procedure code includes imaging guidance before reporting a separate code.
27. **A. The global obstetric code for vaginal delivery after previous cesarean (VBAC)** CPT provides a specific global code for vaginal delivery after previous cesarean section (VBAC). When the physician provides all three components — antepartum care, VBAC delivery, and postpartum care — the global VBAC code captures the entire package. The standard vaginal delivery code would not reflect the higher complexity and risk of a VBAC.
28. **B. It is not coded separately; it is included in the hysterectomy code description** When the hysterectomy CPT code description specifically includes removal of the tubes and ovaries, the bilateral salpingo-oophorectomy is bundled. The coder must read the complete code description to verify what is included. Reporting a separate BSO code when it is already included in the hysterectomy code constitutes unbundling.

29. **D. TUVP uses thermal energy to vaporize prostate tissue; TURP uses a resectoscope loop to cut and remove tissue** Transurethral vaporization of the prostate (TUVP) uses thermal energy (electrical or laser) to vaporize obstructing prostate tissue — the tissue is destroyed and absorbed rather than physically removed. TURP uses a resectoscope with an electrosurgical loop to cut and remove tissue chips that are irrigated out. Both are transurethral approaches but use different techniques with different CPT codes.

30. **C. With the completion thyroidectomy code (60260)** A completion thyroidectomy — removing the remaining thyroid lobe after a previous lobectomy — has its own specific CPT code (60260). This code is distinct from the initial total thyroidectomy code (60240) because the surgical complexity differs due to scar tissue, altered anatomy, and the previous surgical field. The coder should not use the total thyroidectomy or lobectomy codes for this procedure.

60,000 Series — Nervous System, Eyes, and Ears

31. **A. With the laminectomy/discectomy code for the lumbar spine** A lumbar laminectomy with discectomy for herniated disc is coded using the appropriate laminectomy/discectomy code for the lumbar spine. Since no fusion is performed, only the decompression code is reported. If fusion were also performed, separate codes for both the decompression and the fusion would be needed.

32. **D. It replaces the patient's diseased cornea with a healthy donor cornea to restore vision** Penetrating keratoplasty (corneal transplant) involves removing the full thickness of the patient's diseased or damaged cornea and replacing it with a full-thickness healthy donor cornea. This restores corneal clarity and improves vision in conditions such as keratoconus, corneal scarring, and corneal dystrophies. It is not a cataract, glaucoma, or strabismus procedure.

33. **B. Nerve block (temporary interruption of nerve signal transmission)** A greater occipital nerve block involves injecting a local anesthetic (with or without corticosteroid) around the greater occipital nerve to temporarily interrupt pain signal transmission. This is a diagnostic and therapeutic nerve block — not a permanent nerve destruction (neurolysis), nerve repair, or neurostimulator implantation. The effect is temporary.

34. **C. With the generator revision/replacement code only** When the neurostimulator pulse generator is depleted and requires replacement but the electrodes are functioning properly and are left in place, only the generator revision/replacement code is reported. No electrode codes are needed because the electrodes were not manipulated. Component-based coding means each component is coded only when directly involved in the procedure.

35. **A. With the intravitreal injection code (67028) reported bilaterally using modifier 50 or RT/LT modifiers** Intravitreal injection codes are unilateral. When performed bilaterally, the procedure is reported for each eye using laterality modifiers — either modifier 50 or on separate lines with RT and LT. The drug product is coded separately with the appropriate HCPCS J-code for each eye.

36. **D. One — code 69930 covers the cochlear device implantation with or without mastoidectomy** CPT code 69930 covers the complete cochlear device implantation including the mastoidectomy approach, placement of the internal receiver-stimulator, and insertion of the electrode array into the cochlea — all in a single code. The components are not coded separately. The external processor fitting is a separate service coded later using audiology codes.

Evaluation and Management

37. **B. Low** Two stable chronic conditions constitute low-level problem complexity. Reviewing lab results constitutes limited/low-level data. Refilling medications with standard monitoring constitutes low-level risk. The elements support low MDM, coding at 99213 for an established patient. Moderate MDM would require more complex problems, additional data, or higher-risk management.
38. **C. Only the initial hospital care code; the office visit is rolled into the admission** When the same physician provides an office visit and subsequently admits the patient to the hospital on the same date, only the initial hospital care code is reported. The office evaluation is rolled into the admission service. This prevents double billing for the same physician's cognitive services on the same date.
39. **A. Observation discharge codes (99217)** When a patient is discharged from observation status on a different date than the admission, the observation discharge code (99217) is reported. Hospital discharge codes (99238–99239) are for inpatient discharge, not observation discharge. If the patient had been admitted and discharged on the same date, the same-day codes (99234–99236) would be used.
40. **D. 99215 (40 minutes)** Under the time-based pathway, 99215 requires a minimum of 40 minutes of total time for an established patient. The physician spent 50 minutes, which meets and exceeds the 40-minute threshold. The additional 10 minutes beyond 40 does not meet the threshold for prolonged services (99417 requires 15 additional minutes). The base code is 99215.
41. **B. It may only be reported with the highest-level office visit codes (99205 or 99215) and is reported in 15-minute increments** Prolonged services add-on code 99417 may only be reported with 99205 (new patient) or 99215 (established patient) — the highest-level office visit codes. Each unit represents 15 minutes of additional time beyond the base code threshold. It cannot be used with lower-level codes.
42. **A. The central venous catheter insertion is separately reportable; it is NOT bundled into critical care codes** Central venous catheter insertion (36555–36558) is one of the procedures that is separately reportable during a critical care encounter. Many procedures are bundled into critical care (chest X-ray interpretation, pulse oximetry, ventilator management), but central line insertion is specifically excluded from the bundle and may be reported separately.

Anesthesia

43. **C. 24 units** Base units (10) + Time units (210 minutes ÷ 15 minutes/unit = 14.0) + Modifying units (P2 = 0) = 24.0 total units. Physical status P2 (well-controlled asthma) typically does not add modifying units. The calculation: 10 + 14 + 0 = 24.

44. **D. A declared brain-dead patient whose organs are being harvested for transplantation** Physical status P6 indicates a declared brain-dead patient whose organs are being removed for donor purposes. This is the only physical status classification applied to deceased patients. P1 through P5 describe living patients with increasing severity of disease. P6 carries no anesthesia charge in some systems.

45. **B. 99100 (extreme age — under 1 year or over 70 years)** Qualifying circumstances code 99100 covers extreme age, defined as under 1 year or over 70 years. Both a 6-month-old infant (under 1 year) and an 80-year-old patient (over 70 years) qualify for 99100. This is the only qualifying circumstances code that applies to both patients based on the information given.

46. **A. Modifier AA** Modifier AA indicates that the anesthesiologist personally performed the entire anesthesia service without the involvement of a CRNA or anesthesia assistant. For cardiac surgery cases where the anesthesiologist provides the entire service personally, modifier AA is the correct modifier. Modifier QY would indicate medical direction of a CRNA.

Radiology

47. **C. CT brain without contrast followed by with contrast (single combination code)** When a CT is performed first without contrast and then repeated with contrast during the same session, a single combination code is reported — "without contrast followed by with contrast." This captures the complete dual-phase study. Two separate codes are not reported.

48. **D. With modifier 26** When a radiologist from an independent group provides only the interpretation and report (professional component) for imaging performed at a hospital, modifier 26 is appended. The hospital bills the technical component with modifier TC. Each entity bills only for the component it provided.

49. **B. Nuclear medicine** A whole-body bone scan is a nuclear medicine procedure that uses a radioactive tracer (technetium-99m MDP) to detect areas of increased bone metabolism indicating metastatic disease, fractures, or infection. The tracer is injected intravenously and accumulates in areas of active bone turnover. A gamma camera detects the emitted radiation.

50. **A. 7 units — 7 full units (35 fractions ÷ 5 = exactly 7 complete units)** Treatment management (77427) is reported per 5 fractions. For 35 fractions: 35 ÷ 5 = exactly 7 complete units. Since the division is exact with no remainder, all 7 units are reported without modifier 52. Modifier 52 would only be needed for an incomplete final unit (fewer than 5 fractions remaining).

51. **D. With the fluoroscopic guidance code and modifier 26** The radiologist provides only the professional component (fluoroscopic guidance and interpretation) while the neurologist performs the lumbar puncture. Since the fluoroscopy code is not included in the lumbar puncture code, the radiologist reports the fluoroscopic guidance code with modifier 26 for the professional component.

52. **C. No modifier; the global service is reported** When a physician performs and interprets an ultrasound in their own office using practice-owned equipment, both the technical and professional components are provided by the same entity. The global code is reported without any modifier.

Pathology and Laboratory

53. **B. The lipid panel code plus the individual TSH code** TSH is not a component of the lipid panel. When all panel components are performed plus an additional test not included in the panel, the panel code is reported plus the individual code for the additional test. The lipid panel captures the bundled lipid components, and the TSH code captures the additional analyte.

54. **A. Level IV (88305)** A non-incidental appendix specimen (removed for appendicitis) is classified at Level IV surgical pathology (88305). This differs from an incidental appendix, which is Level II (88302). The clinical reason for the appendectomy determines the level — an appendix removed for disease requires more thorough pathological examination than one removed incidentally.

55. **D. Three codes — one for each drug class** Definitive drug testing codes are reported per drug class, with the specific code selected based on the number of analytes within each class. Three drug classes (amphetamines, cannabinoids, cocaine) require three separate codes. Each code is selected based on the analyte count within its respective class.

56. **C. Three codes — one for the FNA procedure, one for the ultrasound guidance, and one for the cytopathology adequacy assessment** The FNA procedure, the ultrasound guidance, and the cytopathology adequacy assessment (88172) are three distinct services, each with their own CPT code. The FNA code covers the needle aspiration. The ultrasound guidance code covers the imaging. The cytopathology code covers the pathologist's immediate evaluation of specimen adequacy.

57. **B. With the automated differential code as a separate test in addition to the CBC without differential** The original CBC was ordered without differential (85027). When the physician subsequently orders an automated differential on the same specimen, it is a separate test reported with its own code. The differential was not included in the original CBC order. This is different from a CBC with differential (85025), which bundles both into a single code.

58. **A. Four units of the special stain code — one per stain per specimen** Special stain codes are reported per stain per specimen. Four different stains (PAS, trichrome, GMS, AFB) performed on the same tissue block require four units of the special stain code. Each stain identifies different tissue components or organisms and represents a separate laboratory service.

Medicine

59. **D. The oxaliplatin chemotherapy infusion** The infusion hierarchy places chemotherapy infusion at the highest level. The oxaliplatin chemotherapy infusion is always the initial service when provided on the same date as other IV services. The hydration is reported as a secondary service. The IV push of the antiemetic is reported as a push add-on. Only one initial service per encounter.

60. **C. Cardiovascular diagnostic subsection** Holter monitor (ambulatory ECG) codes are located in the Medicine section under the cardiovascular diagnostic subsection. These codes cover the recording, scanning analysis, physician review, and interpretation of ambulatory ECG recordings. Despite involving cardiac rhythm, these are diagnostic Medicine codes — not Surgery or Radiology codes.

61. **B. The ESRD monthly management code for patients 20+ years with 2–3 visits per month (90961)** ESRD monthly management codes bundle all dialysis-related physician services for the calendar month. Code 90961 covers patients 20 years and older with 2–3 face-to-face visits per month. The patient had 3 visits, which falls in the 2–3 range. Code 90960 requires 4 or more visits.

62. **A. 90460 × 1 (pediatric component-based code for the single antigen component)** For a patient through 18 years of age with physician counseling, the pediatric component-based administration codes are used. Hepatitis A vaccine has one antigen component, so only 90460 × 1 is reported. Code 90461 is for each additional component within a multi-component vaccine — since Hepatitis A has only one component, 90461 is not needed.

63. **D. 2 units** Aquatic therapy (97113) is a timed therapeutic procedure reported per 15-minute unit. Thirty-five minutes of aquatic therapy: the first 15 minutes qualifies for unit 1, the next 15 minutes qualifies for unit 2, and the remaining 5 minutes does not meet the 8-minute minimum for a third unit. Total: 2 units.

64. **C. 90836 (45-minute add-on psychotherapy with E/M)** When a psychiatrist provides both an E/M service (medication management) and psychotherapy during the same encounter, the add-on psychotherapy codes are used. The 45 minutes of psychotherapy falls in the 38–52 minute range, corresponding to add-on code 90836. The E/M code is reported first, and the add-on code is reported second. Standalone codes are not used with E/M.

Medical Terminology

65. **A. Tumor or mass** The suffix "-oma" means tumor or mass. Common examples include carcinoma (malignant epithelial tumor), melanoma (tumor of melanocytes), lipoma (fatty tumor), and fibroma (fibrous tumor). "-Itis" means inflammation, "-ectomy" means surgical removal, and "-emia" means blood condition.

66. **B. Derm/o or dermat/o** The combining forms "derm/o" and "dermat/o" both refer to the skin. Common terms include dermatology (study of the skin), dermatitis (inflammation of the skin), and

dermabrasion (abrasion of the skin surface). "Neur/o" refers to nerve, "oste/o" refers to bone, and "my/o" refers to muscle.

67. **D. Fast or rapid** The prefix "tachy-" means fast or rapid. Common terms include tachycardia (rapid heart rate), tachypnea (rapid breathing), and tachyarrhythmia (rapid abnormal heart rhythm). The opposite prefix "brady-" means slow. "Dys-" means painful or difficult, and "sub-" means below.

68. **C. A condition of porous, weakened bones with decreased bone density** Osteoporosis means a condition of porous bones, from "osteo" (bone) and "porosis" (porous condition). It is characterized by decreased bone mineral density and deterioration of bone microarchitecture, leading to increased fracture risk. Osteitis means inflammation of bone. Osteosarcoma is bone cancer. Osteotomy is incision into bone.

Anatomy

69. **A. The left ventricle and the aorta** The aortic valve is located between the left ventricle and the ascending aorta. It opens during ventricular systole to allow oxygenated blood to flow from the left ventricle into the aorta for distribution to the body. The tricuspid valve is between the right atrium and right ventricle. The mitral valve is between the left atrium and left ventricle. The pulmonary valve is between the right ventricle and pulmonary artery.

70. **D. Liver** The liver is the largest solid organ in the abdominal cavity, weighing approximately 1,500 grams (about 3.3 pounds) in adults. It is located in the right upper quadrant of the abdomen. The liver performs over 500 functions including bile production, detoxification, protein synthesis, and glucose metabolism. The spleen, pancreas, and kidneys are smaller abdominal organs.

71. **B. Lumbosacral** The sciatic nerve is the largest and longest nerve in the human body. It originates from the lumbosacral plexus (nerve roots L4, L5, S1, S2, S3), exits the pelvis through the greater sciatic foramen, and runs down the posterior thigh. It divides into the tibial and common peroneal nerves above the knee. Sciatic nerve blocks and sciatica are common clinical topics.

72. **C. The external ear and the middle ear** The tympanic membrane (eardrum) separates the external auditory canal (external ear) from the tympanic cavity (middle ear). Sound waves traveling through the external ear cause the tympanic membrane to vibrate, transmitting sound energy to the ossicles in the middle ear. Myringotomy (incision of the tympanic membrane) creates an opening between these two spaces.

ICD-10-CM / Diagnosis Coding

73. **A. A (initial encounter)** The 7th character "A" indicates the initial encounter — the period during which the patient is receiving active treatment for the injury. This is the patient's first visit and active fracture treatment is provided. "D" would be for subsequent encounters during routine healing. "S" would be for sequela. "G" would indicate delayed healing.

74. **D. A code for benign neoplasm of the colon (adenomatous polyp)** The pathology confirms an adenomatous polyp with low-grade dysplasia. The definitive diagnosis — based on pathology results — is a benign neoplasm of the colon. This is the most specific code available based on the confirmed findings. The rectal bleeding was the presenting symptom but is superseded by the confirmed pathological diagnosis.

75. **B. With separate codes — E11 for diabetes and I10 for hypertension — reported independently** ICD-10-CM does not presume a causal relationship between diabetes and hypertension (unlike the presumed relationship between hypertension and CKD). When no causal relationship is documented, both conditions are coded independently — E11 for Type 2 diabetes and I10 for essential hypertension. Category I13 would require both heart disease and CKD with hypertension.

76. **C. S (sequela)** The chronic pain is a residual condition (sequela) that persists after the fracture has healed. The 7th character "S" indicates the encounter is for treatment of a sequela — a late effect resulting from a previous injury. The fracture itself has healed, but the patient has residual chronic pain at the fracture site. "D" would indicate the fracture is still in the healing phase.

77. **A. Chapter 15 (Pregnancy, childbirth, and the puerperium — O00–O9A)** Codes for supervision of pregnancy, including routine prenatal visits, are found in ICD-10-CM Chapter 15 (O00–O9A). This chapter covers all conditions related to pregnancy, childbirth, and the postpartum period. The trimester is captured in the code for conditions that vary by gestational age. Chapter 21 (Z codes) may provide supplementary information but is not the primary chapter.

HCPCS Level II

78. **D. E1000–E1399 (within the E-code range for DME)** Wheelchairs and wheelchair accessories are covered within the E-code range for durable medical equipment. Standard manual wheelchairs have specific E-codes within the E1000–E1399 range. Power wheelchairs have their own specific codes within the broader E-code range. J-codes cover drugs, L-codes cover orthotics/prosthetics.

79. **B. 4 units** The HCPCS J-code for ondansetron specifies 1 mg per unit. The physician administered 4 mg: 4 mg ÷ 1 mg/unit = 4 units. HCPCS drug codes specify a defined quantity per unit, and the total units must reflect the total amount administered. Always verify the per-unit dosage in the code description.

80. **C. Modifier 33** Modifier 33 (preventive services) identifies services that are mandated preventive services under applicable law. An annual wellness visit is a covered preventive service under Medicare. Modifier 33 signals the payer to waive cost-sharing (copay, coinsurance, deductible). Modifier GA relates to ABN compliance, modifier GZ to expected denials without ABN.

Coding Guidelines

81. **A. It is not reported separately; it is bundled into the surgical laparoscopy code** Diagnostic laparoscopy is bundled into surgical laparoscopy when both are performed during the same

session. This follows the same endoscopic hierarchy that applies to all endoscopic procedures. Only the surgical laparoscopy code (cholecystectomy) is reported.

82. **D. Modifier 57** Modifier 57 (decision for surgery) is appended to the E/M code when the visit results in the initial decision to perform a major surgical procedure with a 90-day global period. The decision was made during this visit, making modifier 57 the correct choice. Modifier 25 would be appropriate only for minor procedures with 0-day or 10-day global periods.
83. **B. No modifier is allowed; the edit cannot be overridden under any circumstances** NCCI modifier indicator 0 means that no modifier is permitted to bypass the edit. The Column 2 code cannot be reported with the Column 1 code regardless of the clinical circumstances. Indicator 1 means a modifier may be appended when clinically justified. Understanding modifier indicators is essential for correct NCCI edit application.
84. **C. An unrelated E/M service with modifier 24** An E/M service for a condition unrelated to the surgery may be reported separately during the 90-day global period with modifier 24. Routine follow-up visits, cast changes, and suture removal are all included in the global package and are not separately reportable.
85. **A. Add-on codes are exempt from modifier 51 and are reimbursed at 100% without the multiple procedure payment reduction** Add-on codes are never subject to the multiple procedure payment reduction. They are reimbursed at 100% of their allowed amount. They do not require modifier 51 and must always be reported with a designated primary procedure code. This reimbursement structure recognizes that add-on codes represent additional work already factored into the code valuation.
86. **D. Modifier 22** Modifier 22 (increased procedural services) is appended when the work required to perform a procedure is substantially greater than typically required. The documentation describes extensive adhesiolysis, unusual anatomy, and prolonged operative time — all supporting increased work. The operative report must document the specific reasons for the increased work.
87. **C. A code used when no specific CPT code adequately describes the procedure performed** Unlisted procedure codes are used when no existing CPT code accurately describes the procedure performed. These codes require submission of a detailed operative report or description of the procedure to support the claim. Each CPT subsection has its own unlisted procedure code. Claims with unlisted codes typically require manual review by the payer.

Compliance and Regulatory

88. **B. National Coverage Determinations (NCDs)** NCDs are coverage policies issued by CMS that apply uniformly across the entire country. All MACs must follow NCDs regardless of their regional policies. NCDs take precedence over LCDs when there is a conflict. LCDs vary by MAC jurisdiction and address services not covered by NCDs.

89. **A. Investigate the scope of the error, refund the overpayments to affected payers, retrain the coder, and implement corrective action to prevent recurrence** Under an effective compliance program, discovered coding errors must be investigated, overpayments quantified and refunded, the responsible individual retrained, and corrective action implemented. Immediate termination without investigation, ignoring findings, or continuing incorrect billing would all be inappropriate responses that could compound the compliance violation.

90. **D. Practice Expense (PE) RVU** The Practice Expense RVU reflects overhead costs — staff, equipment, supplies, rent, and utilities — associated with providing the service. PE RVUs differ between facility and non-facility settings. In non-facility settings (physician's office), PE RVUs are higher because the physician bears all overhead. In facility settings, PE RVUs are lower because the facility provides and bills for overhead separately.

Cases — Integrated Coding Scenarios

91. **C. It is not reported separately; it is bundled into the surgical arthroscopy** Diagnostic arthroscopy is always bundled into surgical arthroscopy when both are performed on the same joint during the same session. The rotator cuff repair is the surgical procedure — the diagnostic examination is included and is not separately reportable.

92. **B. It is not reported separately; it is bundled per NCCI edits** When NCCI edits indicate that subacromial decompression is bundled into the rotator cuff repair, the decompression cannot be reported separately. Appending modifier 59 to bypass the edit without clinical justification for a truly distinct service would constitute a compliance violation. The coder must follow the current NCCI edits.

93. **A. One snare polypectomy code and one cold forceps biopsy polypectomy code with appropriate modifier** When polyps are removed using different techniques during the same colonoscopy, each technique is reported with its own code. The snare polypectomy and the cold forceps biopsy polypectomy have different CPT codes. Modifier 59 or XS is appended to the lesser procedure. The diagnostic colonoscopy is bundled into the surgical codes.

94. **D. Z12.11 (Encounter for screening for malignant neoplasm of colon)** The patient presented for a screening colonoscopy, making Z12.11 the first-listed diagnosis. The polyp codes are reported as secondary diagnoses. Medicare guidelines support reporting the screening Z code as primary even when findings are identified and removed during the screening.

95. **C. A primary ablation code for the first nerve plus add-on codes for each additional nerve** Radiofrequency ablation of medial branch nerves uses a primary code for the first nerve destroyed and add-on codes for each additional nerve in the same spinal region. Three levels require one primary code plus two add-on codes. Since the codes include imaging guidance, no separate fluoroscopy code is reported.

96. **A. It is not reported separately; it is included in the ablation codes** The radiofrequency ablation codes include fluoroscopic guidance in their code descriptions. When imaging guidance is bundled into the procedure code, a separate fluoroscopy code should not be reported. This applies to both the primary code and the add-on codes.

97. **B. Soft tissue tumor excision codes (subcutaneous) in the musculoskeletal section** A subcutaneous lipoma is a soft tissue tumor located beneath the skin. The excision is coded using the soft tissue tumor excision codes in the musculoskeletal section — not the skin excision codes. The distinction between a skin lesion and a subcutaneous tumor determines which code range is used.

98. **D. Yes; intermediate and complex closures may be reported separately when not included in the excision code** For soft tissue tumor excisions in the musculoskeletal section, intermediate and complex wound closures may be reported separately because the closure is not inherently included in the subcutaneous tumor excision code. Simple closure would be included. The coder should verify whether the specific excision code includes the closure before reporting it separately.

99. **C. Therapeutic drug infusion codes (96365–96368)** Rituximab for rheumatoid arthritis is a non-antineoplastic biologic agent. Non-antineoplastic drugs are coded using the therapeutic drug infusion codes, not the chemotherapy codes. The drug classification — not the administration technique — determines the code range.

100. **A. The rituximab therapeutic infusion, because therapeutic infusion outranks hydration and IV push in the hierarchy** The infusion hierarchy places therapeutic drug infusion above hydration and IV push. The rituximab therapeutic infusion is the initial service because it ranks highest among the services provided (no chemotherapy was given). The hydration is reported as a secondary service. The IV push is reported as a push add-on. Only one initial service per encounter.