SIMULATION EXAM 14

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

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

1. A surgeon excises a 2.4 cm malignant melanoma from the patient's left calf with 1.0 cm margins. What is the excised diameter for code selection?

A. 2.4 cm

B. 3.4 cm

C. 4.4 cm

D. 5.4 cm

2. A patient has a 7.0 cm laceration on the right forearm requiring intermediate repair and a 5.0 cm laceration on the left forearm also requiring intermediate repair. Both forearms are in the same anatomical grouping. A separate 2.0 cm laceration on the chin requires complex repair. How should these be reported?

A. Three separate repair codes

B. One intermediate repair code for 12.0 cm and one complex repair code for 2.0 cm

C. One complex repair code for 14.0 cm combining all wounds

D. One intermediate repair code for the largest wound only

3. A physician performs destruction of 20 actinic keratoses on a patient's face and scalp using liquid nitrogen. Which code should be reported?

A. 17000 × 1, 17003 × 19

B. 17000 × 20

C. 17000 × 1, 17003 × 14

D. 17004

4. A surgeon performs a split-thickness skin graft (autograft) to a 60 sq cm wound on the patient's right anterior thigh following excision of a malignant lesion. The excision that created the defect is NOT included in the skin graft code. How should the excision be coded?

A. With a separate malignant excision code in addition to the graft code

B. It is bundled into the graft code

C. With the graft code and modifier 22

D. With only the graft code; excisions before grafts cannot be separately coded

5. A physician performs a punch biopsy of two separate suspicious skin lesions — one on the right arm and one on the left arm — during the same encounter. How should the biopsies be coded?

A. One biopsy code for both lesions

B. Two separate biopsy codes with modifier 59 on the second

C. The first lesion biopsy code (11102) plus the additional lesion biopsy add-on code (11103)

D. One biopsy code with modifier 50

6. A surgeon performs Mohs micrographic surgery on a lesion of the left cheek. Three stages are performed: stage 1 with 2 blocks, stage 2 with 3 blocks, and stage 3 with 8 blocks. How should the extra blocks in stage 3 be coded?

A. 17315 × 8

B. 17315 × 3 (stage 3 had 8 blocks — 3 blocks beyond the 5-block limit)

C. 17315 is not reported; no stage exceeded the block limit

D. 17315 × 5

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

7. A surgeon performs arthroscopic repair of a torn lateral meniscus and arthroscopic chondroplasty of the lateral tibial plateau of the right knee during the same session. NCCI edits allow both to be reported. How should the diagnostic arthroscopy 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 76

D. It is not reported separately; it is included in the surgical arthroscopy codes

8. An orthopedic surgeon performs open treatment of a displaced olecranon fracture with internal fixation (plate and screws). The surgeon provides all preoperative, surgical, and postoperative care. During the 90-day global period, the patient returns for a routine follow-up visit with X-rays. How should the follow-up visit be coded?

A. It is not coded separately; it is included in the fracture treatment global package

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

C. With a separate E/M code and modifier 25

D. With the fracture treatment code and modifier 76

9. A patient undergoes posterior spinal fusion at L3-L4 and L4-L5 with bilateral posterior pedicle screw instrumentation. The instrumentation spans L3 to L5. How should the spinal instrumentation be coded?

A. It is included in the fusion code

B. With a HCPCS supply code only

C. With a separate posterior segmental spinal instrumentation code

D. With modifier 22 on the fusion code

10. A surgeon performs an aspiration of a Baker's cyst (popliteal cyst) behind the right knee using a needle. No open incision is made. Which type of procedure is this?

A. Excision

B. Aspiration/drainage

C. Arthroscopy

D. Open incision and drainage

11. A patient undergoes a revision total hip arthroplasty. The existing femoral stem and acetabular cup are both removed and replaced with new components. CPT provides codes for revision arthroplasty based on which components are revised. How does this affect code selection?

A. Only one code is reported regardless of how many components are revised

B. The code for the most complex component is reported

C. A primary arthroplasty code is used with modifier 22

D. CPT provides different codes based on whether the acetabular component, the femoral component, or both are revised

12. A surgeon applies a short arm cast to a patient who has a stable, non-displaced scaphoid fracture. The surgeon assumes the global fracture care package. During the global period, the patient returns and the cast is removed. How should the cast removal be coded?

A. It is included in the fracture treatment global package; cast removal is not separately coded

B. With a separate cast removal code

C. With the fracture treatment code and modifier 76

D. With an E/M code only

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

13. A patient undergoes bronchoscopy with transbronchial lung biopsy and separately with bronchial washing during the same session. How should the diagnostic bronchoscopy 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 included in the surgical bronchoscopy codes

D. As a separate code with modifier 25

14. A cardiologist performs a complete pacemaker system removal — the pulse generator and both atrial and ventricular leads are removed. A new dual-chamber pacemaker system is NOT implanted during the same session. How should the removal be coded?

A. With a single system removal code

B. With separate codes for the generator removal and each lead removal

C. With the system insertion code and modifier 52

D. With only the generator removal code; the lead removals are bundled

15. A surgeon performs a right thoracotomy with resection of a mediastinal tumor. The tumor is located in the anterior mediastinum. Which CPT subsection contains codes for mediastinal tumor resection?

A. The cardiovascular subsection

B. The hemic and lymphatic subsection

C. The integumentary subsection

D. The respiratory/mediastinal subsection

16. A patient undergoes endovenous laser ablation of the right great saphenous vein for treatment of varicose veins with venous reflux. The procedure code includes ultrasound guidance. How should the ultrasound guidance be coded?

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

B. With a separate ultrasound guidance code and modifier 26

C. With a separate ultrasound guidance code and modifier 59

D. With a separate ultrasound guidance code without any modifier

17. A surgeon performs a CABG with two saphenous vein grafts and one internal mammary artery graft (used as an in-situ pedicle graft). For an in-situ IMA graft, how is the procurement coded?

A. With a separate procurement code

B. With a separate harvest code and modifier 59

C. The procurement of an in-situ IMA is included in the arterial CABG code; no separate procurement code is reported

D. With an unlisted vascular procedure code

18. A patient undergoes percutaneous placement of an inferior vena cava (IVC) filter for prevention of pulmonary embolism in a patient with DVT who cannot receive anticoagulation. What does the IVC filter accomplish?

A. It dissolves existing blood clots in the vena cava

B. It prevents blood from flowing through the vena cava

C. It repairs a tear in the vena cava wall

D. It traps blood clots traveling from the lower extremities before they reach the lungs

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

19. A patient undergoes a colonoscopy with hot biopsy forceps polypectomy of two polyps from the ascending colon and cold snare polypectomy of one polyp from the sigmoid colon. The two techniques are different. How should the polyp removals be coded?

A. Three separate polypectomy codes, one for each polyp

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

C. One diagnostic colonoscopy code plus one polypectomy code

D. One hot biopsy forceps code with modifier 22

20. A surgeon performs a laparoscopic sleeve gastrectomy (gastric sleeve) for morbid obesity. During the same session, a hiatal hernia is identified and repaired laparoscopically. The hiatal hernia repair is a separate procedure. How should the hernia repair be coded?

A. With a separate hernia repair code and modifier 51 (or appropriate modifier per NCCI guidelines)

B. It is included in the gastric sleeve code

C. With the gastric sleeve code and modifier 22

D. With only the hernia repair code; the gastric sleeve is bundled

21. A patient undergoes an EGD with thermal ablation of Barrett's esophagus using radiofrequency energy. How should the diagnostic EGD 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 included in the surgical EGD ablation code

D. As a separate code with modifier 25

22. A surgeon performs an open repair of a parastomal hernia around an existing colostomy. Which type of hernia repair codes should the coder search for?

A. Inguinal hernia repair codes

B. Femoral hernia repair codes

C. Umbilical hernia repair codes

D. Incisional/ventral hernia repair codes (parastomal hernias are a type of incisional hernia)

23. A patient undergoes a colonoscopy. The gastroenterologist identifies a large, non-pedunculated polyp in the cecum and determines that endoscopic removal is not safe. The physician marks the site with a tattoo injection for future surgical localization. How should the diagnostic colonoscopy and the tattoo injection be coded?

A. Only the diagnostic colonoscopy code; the tattoo injection is bundled

B. The diagnostic colonoscopy code plus the tattoo injection code — both are reported since the tattoo is a separate surgical colonoscopy service

C. Only the tattoo injection code; the diagnostic colonoscopy is bundled

D. The diagnostic colonoscopy code with modifier 22

24. A surgeon performs an open distal pancreatectomy without splenectomy (spleen-preserving technique) for a pancreatic body mass. The spleen is carefully preserved during the procedure. Does the spleen preservation affect code selection?

A. Yes; CPT provides specific codes that differentiate distal pancreatectomy with and without splenectomy

B. No; all distal pancreatectomy codes include splenectomy

C. No; the code is the same regardless of whether the spleen is removed

D. Yes; modifier 52 must be appended when the spleen is preserved

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

25. A urologist performs a cystoscopy with transurethral resection of a bladder neck contracture and separately performs a biopsy of a suspicious bladder wall lesion during the same session. The diagnostic cystoscopy is bundled. How should the two surgical procedures be coded?

A. Only the resection code; the biopsy is bundled

B. Only the biopsy code; the resection is bundled

C. One code for both procedures combined

D. Both the resection code and the biopsy code with appropriate modifier

26. A patient undergoes a laparoscopic nephroureterectomy (removal of the kidney and entire ureter) for a urothelial carcinoma of the renal pelvis. What distinguishes a nephroureterectomy from a simple nephrectomy?

A. A nephroureterectomy removes only the ureter

B. A nephroureterectomy is always performed through an open approach

C. A nephroureterectomy removes the kidney, the entire ureter, and a cuff of bladder at the ureteral orifice; a simple nephrectomy removes only the kidney

D. There is no difference; both terms describe the same procedure

27. A physician provides only antepartum care for a high-risk pregnancy. The patient is transferred to a maternal-fetal medicine specialist at 32 weeks for the remainder of care and delivery. How should the first physician's antepartum care be reported?

A. With the global delivery code and modifier 52

B. With the antepartum care-only code (if the required number of visits is met) or individual E/M codes for each visit if the threshold is not met

C. With the delivery-only code

D. With an E/M code for the last visit only

28. A surgeon performs a radical hysterectomy with bilateral pelvic lymph node dissection for cervical cancer. How does a radical hysterectomy differ from a total hysterectomy?

A. A radical hysterectomy removes the uterus, cervix, upper vagina, and parametrial tissue with wider margins; a total hysterectomy removes only the uterus and cervix

B. A radical hysterectomy preserves the cervix; a total hysterectomy removes it

C. There is no difference; both are identical procedures

D. A radical hysterectomy is always laparoscopic; a total hysterectomy is always open

29. A patient undergoes cystoscopy with injection of bulking agent into the subureteral tissue for treatment of vesicoureteral reflux. The diagnostic cystoscopy is bundled. What does the bulking agent accomplish?

A. It dissolves kidney stones

B. It treats bladder cancer

C. It removes a ureteral obstruction

D. It creates a tissue mound beneath the ureteral orifice to prevent urine from refluxing from the bladder back up the ureter

30. A surgeon performs a left adrenalectomy using a posterior retroperitoneal approach. CPT provides codes based on the surgical approach. Which of the following correctly describes the posterior retroperitoneal approach?

A. An incision through the anterior abdominal wall

B. A laparoscopic approach through abdominal ports

C. An incision through the back, accessing the adrenal gland through the retroperitoneum without entering the peritoneal cavity

D. A thoracic approach through the chest

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

31. A neurosurgeon performs a craniotomy for clipping of an intracranial aneurysm located in the internal carotid artery distribution. The bone flap is replaced. Craniotomy codes for aneurysm repair are organized by which factor?

A. The vascular territory — carotid circulation vs. vertebrobasilar circulation

B. The patient's age

C. The type of anesthesia used

D. The size of the aneurysm in centimeters

32. An ophthalmologist performs a pneumatic retinopexy for repair of a rhegmatogenous retinal detachment of the left eye. The procedure involves injecting a gas bubble into the vitreous cavity to push the detached retina back into position, followed by cryopexy to seal the retinal tear. What does pneumatic retinopexy accomplish?

A. It removes the vitreous humor

B. It uses a gas bubble and cryotherapy to reattach the retina without a scleral buckle or vitrectomy

C. It implants an intraocular lens

D. It creates a drainage pathway for glaucoma

33. A pain management physician performs a lumbar sympathetic block at L2 under fluoroscopic guidance for treatment of complex regional pain syndrome of the left lower extremity. How is a sympathetic block classified differently from a somatic peripheral nerve block?

A. A sympathetic block targets motor nerves; a somatic block targets sensory nerves

B. Both are classified identically

C. A sympathetic block is always performed without imaging guidance

D. A sympathetic block targets the autonomic sympathetic nervous system; a somatic block targets peripheral sensory or motor nerves

34. A neurosurgeon performs a posterior fossa craniectomy for decompression of a Chiari malformation with duraplasty. The bone is removed and NOT replaced. What additional procedure is described by "duraplasty"?

A. Removal of the dura mater

B. Implantation of a neurostimulator electrode

C. Expansion of the dura by opening it and suturing in a patch graft to enlarge the intradural space

D. Closure of the skin incision

35. An otolaryngologist performs a stapedotomy (partial stapedectomy) with insertion of a piston prosthesis for treatment of otosclerosis. How does a stapedotomy differ from a stapedectomy?

A. A stapedotomy creates a small hole in the stapes footplate and inserts a piston prosthesis; a stapedectomy removes the entire stapes and replaces it with a prosthesis

B. A stapedotomy removes the entire stapes; a stapedectomy creates a small opening

C. There is no difference; both terms describe the same procedure

D. A stapedotomy is performed on children; a stapedectomy is on adults

36. An ophthalmologist performs a lateral canthotomy and cantholysis on the right eye for treatment of orbital compartment syndrome caused by a retrobulbar hemorrhage. What does this emergency procedure accomplish?

A. It removes the crystalline lens

B. It releases pressure within the orbit by incising the lateral canthus and the lateral canthal tendon to decompress the orbit

C. It repairs a retinal detachment

D. It corrects strabismus

Evaluation and Management (Questions 37–42)

37. An established patient presents to the office with multiple new complaints including chest pain, shortness of breath, and leg swelling. The physician performs an extensive evaluation, orders a chest CT, echocardiogram, D-dimer, troponin, and BNP. The management involves urgent hospitalization with anticoagulation therapy. What level of MDM does this support?

A. Low

B. Moderate

C. Straightforward

D. High

38. A physician provides care to a patient in a domiciliary care facility (assisted living). This is the physician's first visit to this patient. Which E/M code set should be used?

A. Office visit codes (99202–99215)

B. Initial hospital care codes (99221–99223)

C. Domiciliary care codes for new patients (99324–99328 or current equivalent)

D. Nursing facility codes (99304–99306)

39. A patient is admitted to the hospital on Friday evening. The admitting physician sees the patient on Friday for the admission. On Saturday, the same physician sees the patient for a follow-up visit. On Sunday, the patient is discharged. How many E/M codes are reported for these three days?

A. Three codes — initial hospital care (Friday), subsequent hospital care (Saturday), and discharge day management (Sunday)

B. One code covering the entire admission

C. Two codes — initial care and discharge only

D. Four codes — two subsequent care codes for Saturday and Sunday plus the admission and discharge

40. A physician performs an E/M service on an established patient and determines during the visit that the patient needs a minor surgical procedure (10-day global period) to be performed the same day. The E/M is significant and separately identifiable. Which modifier should be appended to the E/M code?

A. Modifier 57

B. Modifier 25

C. Modifier 59

D. Modifier 58

41. Under the current E/M guidelines, a physician sees a new patient in the office. The visit involves 75 minutes of total time. Using the time-based pathway, which code(s) should be reported?

A. 99205 only; the additional time is not reportable

B. 99204 plus 99417 × 1

C. 99203 plus 99417 × 3

D. 99205 plus 99417 × 1

42. A physician provides telephone evaluation and management to an established patient. The call lasts 30 minutes and involves complex medical decision-making regarding medication adjustments for multiple chronic conditions. Which code category covers this service?

A. Office visit codes (99211–99215)

B. Critical care codes (99291–99292)

C. Telephone E/M service codes (99441–99443)

D. Chronic care management codes (99490)

Anesthesia (Questions 43–46)

43. An anesthesiologist provides general anesthesia for a laparoscopic appendectomy on a 30-year-old healthy patient (P1). Total anesthesia time is 60 minutes. The payer uses 15-minute time units. No modifying units for P1. Base units are 6. What is the total unit calculation?

A. 10 units

B. 9 units

C. 11 units

D. 8 units

44. A patient undergoes a surgical procedure under spinal anesthesia (subarachnoid block) provided by an anesthesiologist. The anesthesiologist also provides sedation during the procedure. How is the spinal anesthesia coded?

A. With a spinal injection code from the pain management section

B. With the standard anesthesia code for the surgical procedure — the type of anesthetic does not change the CPT code

C. With moderate sedation codes

D. With a neuraxial injection code plus the anesthesia code

45. An anesthesiologist provides anesthesia for an emergency craniotomy on a 2-year-old child with a traumatic brain injury (P4). Which qualifying circumstances codes apply?

A. 99100 only (extreme age)

B. 99140 only (emergency conditions)

C. Neither applies to this scenario

D. Both 99100 (extreme age — under 1 year) does NOT apply since the child is 2 years old; only 99140 (emergency conditions) applies

46. In the anesthesia payment formula, which component varies based on the patient's overall health status?

A. Base units

B. Time units

C. Modifying units (including physical status)

D. Conversion factor

Radiology (Questions 47–52)

47. A patient undergoes an MRI of the right knee with IV gadolinium contrast. A prior MRI without contrast was performed at a different facility on a different date. Today's study is only with contrast. How should today's study be coded?

A. MRI knee without contrast followed by with contrast

B. MRI knee with contrast

C. MRI knee without contrast

D. Two separate MRI codes

48. A radiologist at a hospital performs and interprets a pelvic ultrasound on a patient in the emergency department. The hospital owns the ultrasound equipment and employs the radiologist. How should this be billed?

A. The hospital bills the global code since both components are provided by hospital employees

B. The hospital bills modifier TC and the radiologist bills modifier 26

C. The radiologist bills the global code

D. Two separate global codes

49. A patient undergoes a nuclear medicine renal scan (renogram) with Lasix (furosemide) washout to evaluate for urinary obstruction. What does this study evaluate?

A. The blood supply to the kidneys

B. The size of kidney stones

C. The glomerular filtration rate only

D. Kidney function and drainage — the radiotracer uptake evaluates kidney function, and the Lasix washout assesses whether delayed drainage is due to obstruction or a dilated non-obstructed system

50. In radiation oncology, treatment simulation code 77280 covers which type of simulation?

A. CT simulation with 3D reconstruction

B. Complex simulation with three or more treatment areas

C. Simple simulation (single treatment area, single port)

D. No simulation is needed for this code

51. A patient undergoes a screening low-dose CT of the chest for lung cancer. The patient is a 58-year-old with a 30 pack-year smoking history. Which CPT code covers this specific screening study?

A. 71271 (low-dose CT for lung cancer screening) — a specific code distinct from diagnostic chest CT

B. 71250 (CT chest without contrast — the standard diagnostic code)

C. 71260 (CT chest with contrast)

D. 71275 (CT angiography of the chest)

52. A patient undergoes arthrography of the left knee — the radiologist injects contrast into the knee joint under fluoroscopic guidance, followed by X-ray imaging of the joint. How should the injection component be coded?

A. It is included in the X-ray code

B. With a separate joint injection code for the contrast administration

C. With the X-ray code and modifier 22

D. With a fluoroscopic guidance code only

Pathology and Laboratory (Questions 53–58)

53. A physician orders a comprehensive metabolic panel (CMP), a CBC with automated differential (85025), and a urinalysis with microscopy (81001) on the same patient. Do any of these three tests share overlapping components?

A. Yes; the CMP and the CBC both include glucose

B. Yes; the CMP and the urinalysis share overlapping components

C. Yes; the CBC and the urinalysis both include white blood cell counts

D. No; none of these three tests share overlapping components

54. A pathologist examines a total colectomy specimen from a patient with ulcerative colitis. At which level of surgical pathology is a total colectomy classified?

A. Level IV (88305)

B. Level V (88307)

C. Level VI (88309)

D. Level III (88304)

55. A laboratory performs a quantitative serum ferritin level to evaluate for iron deficiency anemia. Which type of laboratory test is a serum ferritin?

A. A quantitative clinical chemistry test

B. A qualitative screening test

C. A presumptive drug test

D. A cytopathology test

56. A patient undergoes both a presumptive drug screen (80307) and a confirmatory definitive drug test for opiates (4 analytes) on the same specimen. How should these be coded?

A. Only the definitive code; the presumptive is bundled

B. Both codes — the presumptive code (one unit) and the definitive opiate code (for 3–4 analytes)

C. Only the presumptive code; the definitive is bundled

D. One combined code for both presumptive and definitive

57. A pathologist performs a frozen section on a breast lumpectomy specimen during surgery. The surgeon awaits the frozen section results before deciding whether to perform additional resection. How is the frozen section coded?

A. It is included in the surgical pathology level code

B. With a separate special stain code

C. With an immunohistochemistry code

D. With the intraoperative frozen section code (88331 for the first specimen, 88332 for each additional specimen)

58. A laboratory performs a nucleic acid amplification test (NAAT) for Chlamydia trachomatis and a separate NAAT for Neisseria gonorrhoeae on the same specimen. How should these be coded?

A. One NAAT code for both organisms combined

B. With a single culture code covering both organisms

C. Two separate NAAT codes — one for Chlamydia and one for Gonorrhea — since each organism has its own detection code

D. With a presumptive drug testing code

Medicine (Questions 59–64)

59. A patient receives a 1-hour IV infusion of iron sucrose (non-chemotherapy therapeutic agent) followed by 30 minutes of IV hydration during the same outpatient encounter. According to the infusion hierarchy, which service is the initial service?

A. The IV hydration

B. The iron sucrose therapeutic infusion

C. Both are reported as initial services

D. Neither; both are add-on codes

60. An adult patient receives a single influenza vaccine injection during a pharmacy visit. No physician counseling is provided. How should the vaccine administration be coded?

A. 90471 × 1 (adult injection-based code, first vaccine)

B. 90460 × 1 (pediatric component-based code)

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

D. 90472 × 1 (additional vaccine injection code)

61. A patient undergoes a complete pulmonary function test including spirometry (94010), lung volumes (94726), and diffusing capacity (94729). Each test has its own CPT code. How should these be coded?

A. With a single comprehensive PFT code covering all three tests

B. With only the spirometry code; the other tests are bundled

C. With the spirometry code and modifier 22

D. Each test is reported with its own CPT code — spirometry, lung volumes, and diffusing capacity are separate services

62. A therapist provides 20 minutes of therapeutic exercise (97110), 15 minutes of manual therapy (97140), and 12 minutes of gait training (97116) during the same session. Using the 8-minute rule, how many total timed units are reported?

A. 2 units

B. 4 units

C. 3 units — total treatment time of 47 minutes supports 3 timed units allocated based on actual minutes

D. 1 unit of 97110 only

63. A psychiatrist provides 40 minutes of psychotherapy and a 25-minute medication management visit (E/M) during the same encounter. How should the psychotherapy be coded?

A. With the add-on psychotherapy code 90836 (45 minutes, 38–52 minute range) plus the E/M code

B. With standalone psychotherapy code 90834 (45 minutes)

C. With add-on psychotherapy code 90833 (30 minutes) plus the E/M code

D. With standalone psychotherapy code 90837 (60 minutes)

64. An ophthalmologist performs optical coherence tomography (OCT) of the optic nerve and an OCT of the retina on the same patient during the same visit. Each has its own CPT code. How should these be coded?

A. With only one OCT code; the second is bundled

B. With separate OCT codes — one for the optic nerve (92133) and one for the retina (92134)

C. With one OCT code and modifier 22

D. With the comprehensive eye exam code only; the OCTs are included

Medical Terminology (Questions 65–68)

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

A. Surgical repair

B. Inflammation

C. Enlargement

D. Destruction, breakdown, or separation

66. Which combining form refers to the vein?

A. Arter/o

B. Angi/o

C. Phleb/o or ven/o

D. Lymph/o

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

A. Half or one side

B. All or complete

C. Double

D. Around

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

A. Rapid breathing

B. Slow breathing

C. Painful breathing

D. Absence of breathing

Anatomy (Questions 69–72)

69. The internal mammary artery (also called the internal thoracic artery) is commonly used as a bypass graft in CABG surgery. Where does this artery originate?

A. From the aortic arch

B. From the femoral artery

C. From the carotid artery

D. From the subclavian artery

70. Which structure in the urinary system stores urine before elimination?

A. The kidney

B. The ureter

C. The urinary bladder

D. The urethra

71. The menisci of the knee are crescent-shaped cartilage structures that serve what primary function?

A. They act as shock absorbers and distribute weight-bearing forces across the joint surface

B. They connect the femur to the tibia

C. They produce synovial fluid

D. They stabilize the patella

72. The thyroid gland produces which hormones?

A. Insulin and glucagon

B. Thyroxine (T4) and triiodothyronine (T3)

C. Cortisol and aldosterone

D. Epinephrine and norepinephrine

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

73. A patient presents with a closed displaced fracture of the left ankle (bimalleolar). This is the initial encounter with active treatment. Which 7th character should be used?

A. D (subsequent encounter)

B. S (sequela)

C. G (subsequent encounter with delayed healing)

D. A (initial encounter)

74. A patient has a confirmed diagnosis of breast cancer — invasive ductal carcinoma of the right breast, upper outer quadrant. Which ICD-10-CM code would most specifically capture this diagnosis?

A. C50.9 (Malignant neoplasm of breast, unspecified)

B. D05.90 (Carcinoma in situ of breast, unspecified)

C. C50.411 (Malignant neoplasm of upper-outer quadrant of right female breast) or the appropriate laterality and quadrant-specific code

D. Z85.3 (Personal history of malignant neoplasm of breast)

75. In ICD-10-CM, when a patient presents for chemotherapy administration and also has the underlying malignancy being treated, which code is sequenced first?

A. The malignancy code

B. Z51.11 (Encounter for antineoplastic chemotherapy) as the first-listed diagnosis, followed by the malignancy code

C. Only the malignancy code; the encounter code is not needed

D. Only the chemotherapy encounter code; the malignancy is assumed

76. A patient has documented hypertensive heart disease with heart failure. Under ICD-10-CM, how should this be coded?

A. A code from I11 (Hypertensive heart disease) plus an additional code from I50 to specify the type of heart failure

B. Only I10 (Essential hypertension)

C. Only I50.9 (Heart failure, unspecified)

D. Separate codes for hypertension and heart failure without linkage

77. A coder is assigning a diagnosis for a patient with a history of organ transplant who presents with transplant rejection. Which ICD-10-CM code category covers complications of transplanted organs?

A. Z94 (Transplanted organ and tissue status)

B. Z87 (Personal history of other diseases)

C. Z48 (Encounter for surgical aftercare)

D. T86 (Complications of transplanted organs and tissue)

HCPCS Level II (Questions 78–80)

78. A patient receives an infusion of paclitaxel (Taxol) 175 mg IV for ovarian cancer treatment. The HCPCS J-code for paclitaxel specifies 1 mg per unit. How many units of the J-code should be reported?

A. 1 unit

B. 17 units

C. 175 units

D. 18 units

79. A provider administers a subcutaneous injection of epoetin alfa (Epogen) 10,000 units to a dialysis patient. The HCPCS J-code specifies 1,000 units per billing unit. How many units should be reported?

A. 1 unit

B. 10 units

C. 100 units

D. 10,000 units

80. A Medicare patient receives a service. The provider did not obtain an ABN and appended modifier GZ. Medicare denies the claim. What is the financial consequence?

A. The provider cannot bill the patient and must absorb the denied amount

B. The provider may bill the patient the full charge

C. The provider must appeal the denial before taking any action

D. Medicare automatically reconsiders the claim

Coding Guidelines (Questions 81–87)

81. A surgeon performs a laparoscopic appendectomy. During the same session, a diagnostic laparoscopy is performed to evaluate the pelvis for possible endometriosis. No endometriosis is found, and no pelvic procedures are performed. The diagnostic laparoscopy served as the approach for the appendectomy. How should the diagnostic laparoscopy 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 when it served only as the approach for the surgical laparoscopy

82. A patient develops a wound dehiscence during the 90-day global period of an abdominal surgery. The surgeon returns the patient to the operating room for repair of the dehiscence. Which modifier should be appended?

A. Modifier 58

B. Modifier 79

C. Modifier 78

D. Modifier 24

83. Under the NCCI, which X modifier indicates that the procedure was performed by a different practitioner?

A. Modifier XE (Separate Encounter)

B. Modifier XP (Separate Practitioner)

C. Modifier XS (Separate Structure)

D. Modifier XU (Unusual Non-Overlapping Service)

84. A CPT code has a global period of "010." What does this indicate?

A. A 10-day global period — routine postoperative care for 10 days following the procedure is included

B. A 0-day global period

C. A 90-day global period

D. The global period does not apply

85. Which of the following correctly describes when modifier 22 (increased procedural services) should be used?

A. Modifier 22 is appropriate only when the operative report documents that the work substantially exceeded what is typically required and no more specific code or modifier captures the additional work

B. Modifier 22 should be appended to every complex case

C. Modifier 22 replaces modifier 51 for multiple procedures

D. Modifier 22 is used when the procedure was reduced in scope

86. In CPT, when a code description includes the term "each" or "per," what does this indicate?

A. The code is always reported once regardless of quantity

B. The code is an add-on code

C. The code is reported based on the number of units performed — each unit represents one occurrence of the described service

D. The code requires modifier 59

87. A surgeon performs a procedure that involves both an open component and an endoscopic component. The open component requires conversion from the endoscopic approach. How should this be coded?

A. Only the open procedure code; the endoscopic approach is not separately coded when conversion occurs

B. Both the endoscopic and open procedure codes

C. The endoscopic code with modifier 22

D. The endoscopic code with modifier 53 plus the open code

Compliance and Regulatory (Questions 88–90)

88. Under the False Claims Act, which of the following mental states satisfies the "knowingly" standard?

A. Only intentional fraud with specific criminal intent

B. Actual knowledge, deliberate ignorance, or reckless disregard of the truth or falsity of the claim

C. Only gross negligence

D. Only actual knowledge with documented intent to defraud

89. A healthcare organization receives notification of an OIG audit. The compliance officer reviews the organization's internal audit records and discovers previously undetected coding errors. What is the appropriate action?

A. Destroy the internal audit records before the OIG reviews them

B. Report the errors only if the OIG specifically asks about them

C. Wait for the OIG to discover the errors independently

D. Proactively disclose the errors to the OIG, investigate the scope, refund overpayments, and implement corrective action

90. Under the Medicare Physician Fee Schedule, the Geographic Practice Cost Index (GPCI) adjusts payment for which factor?

A. The physician's years of experience

B. The patient's insurance type

C. Geographic variations in the cost of practicing medicine

D. The complexity of the procedure

Cases — Integrated Coding Scenarios (Questions 91–100)

Case 1 (Questions 91–92):

A 60-year-old patient undergoes excision of a 2.0 cm malignant basal cell carcinoma from the tip of the nose with 0.4 cm margins. The wound requires a full-thickness skin graft from the postauricular area to reconstruct the nasal defect.

91. What is the excised diameter for code selection?

A. 2.8 cm

B. 2.4 cm

C. 2.0 cm

D. 3.6 cm

92. The excision creates a defect that is repaired with a free full-thickness skin graft. Should the excision be coded separately from the graft?

A. No; the excision is bundled into the free skin graft code

B. Yes; for free skin grafts, the excision may be coded separately from the graft

C. No; only the graft code is reported

D. Yes, but only with modifier 22

Case 2 (Questions 93–94):

A 72-year-old patient undergoes a left total knee arthroplasty for severe osteoarthritis. The anesthesiologist provides general anesthesia. Total anesthesia time is 150 minutes. The patient is classified as P3 (severe COPD on home oxygen and poorly controlled diabetes). The payer uses 15-minute time units and assigns 1 modifying unit for P3. Base units for the procedure are 7.

93. What is the total anesthesia unit calculation?

A. 17 units

B. 19 units

C. 16 units

D. 18 units

94. The patient is 72 years old. Does qualifying circumstances code 99100 (extreme age) apply?

A. No; the patient must be under 1 year or over 80 to qualify

B. No; 99100 does not apply to any patient over age 70

C. Yes; extreme age is defined as under 1 year or over 70 years

D. Yes; extreme age is defined as over 65 years

Case 3 (Questions 95–96):

A patient receives IV services during a single outpatient encounter: a 90-minute IV infusion of rituximab (antineoplastic agent for lymphoma — chemotherapy), an IV push of dexamethasone (non-chemotherapy supportive agent), and 45 minutes of IV hydration with normal saline.

95. According to the infusion hierarchy, which service is the initial service?

A. The rituximab chemotherapy infusion

B. The IV hydration

C. The dexamethasone IV push

D. Each service is a separate initial service

96. The rituximab is administered as an antineoplastic agent for lymphoma. Which code range should be used for the administration?

A. Therapeutic drug infusion codes (96365–96368)

B. Chemotherapy administration codes (96413–96417)

C. Hydration codes (96360–96361)

D. Moderate sedation codes (99151–99157)

Case 4 (Questions 97–98):

A 55-year-old patient presents for a diagnostic colonoscopy due to rectal bleeding. The gastroenterologist identifies a 1.0 cm pedunculated polyp in the sigmoid colon and removes it by snare technique. A separate biopsy is taken from the terminal ileum.

97. Should the diagnostic colonoscopy (45378) be reported in addition to the surgical codes?

A. Yes, with modifier 59

B. Yes, with modifier 25

C. Yes, with modifier 33

D. No; the diagnostic colonoscopy is bundled into the surgical colonoscopy codes

98. The patient presented with rectal bleeding — not for a screening. Which diagnosis should be reported as the first-listed code?

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

B. K63.5 (Polyp of colon)

C. The rectal bleeding code (K62.5) as the first-listed diagnosis, since the bleeding prompted the diagnostic colonoscopy

D. Z87.19 (Personal history of diseases of the digestive system)

Case 5 (Questions 99–100):

A surgeon performs a right carotid endarterectomy for symptomatic high-grade carotid stenosis. The surgeon provides all preoperative, surgical, and postoperative care. During the 90-day global period, the patient develops a completely unrelated urinary tract infection and is evaluated by the same surgeon.

99. How should the UTI evaluation during the global period be coded?

A. With an E/M code and modifier 24 (unrelated E/M during the postoperative period)

B. It is included in the global package and cannot be separately coded

C. With the endarterectomy code and modifier 76

D. With a UTI treatment code and modifier 79

100. The surgeon provides all components of care for the endarterectomy. Which global package arrangement applies?

A. Modifier 54 (surgical care only)

B. No modifier; the complete global package is reported

C. Modifier 55 (postoperative management only)

D. Modifier 56 (preoperative management only)

SIMULATION EXAM 14 — ANSWER KEY WITH EXPLANATIONS

10,000 Series — Integumentary System

1. **C. 4.4 cm** The excised diameter is calculated as lesion diameter plus margins on both sides: 2.4 cm + (1.0 cm × 2) = 4.4 cm. Wide margins are standard for malignant melanoma. This 4.4 cm excised diameter determines the correct code within the malignant excision range for the leg anatomical grouping.

2. **B. One intermediate repair code for 12.0 cm and one complex repair code for 2.0 cm** Wounds of the same classification in the same anatomical grouping are combined. The two intermediate repairs on the forearms (7.0 + 5.0 = 12.0 cm) are in the same grouping and classification. The complex repair on the chin (2.0 cm) is a different classification and is reported separately. Different classifications are always reported separately.

3. **D. 17004** When 15 or more actinic keratoses are destroyed, only the flat code 17004 is reported. At 20 lesions, the threshold of 15 or more is met. Codes 17000 and 17003 are not reported in addition to 17004. This single flat code replaces all other codes in the premalignant destruction series.

4. **A. With a separate malignant excision code in addition to the graft code** For free skin grafts, the excision that created the defect may be coded separately from the graft code. This is a key distinction from adjacent tissue transfer, where the excision is bundled. The malignant excision and the skin graft represent different surgical services — tumor removal and wound reconstruction.

5. **C. The first lesion biopsy code (11102) plus the additional lesion biopsy add-on code (11103)** CPT provides a primary biopsy code for the first lesion (11102) and an add-on code for each additional lesion biopsied during the same encounter (11103). Two separate lesions biopsied at different sites require 11102 × 1 plus 11103 × 1. The add-on code structure captures the additional work without requiring modifier 59.

6. **B. 17315 × 3 (stage 3 had 8 blocks — 3 blocks beyond the 5-block limit)** Code 17315 is reported for each tissue block beyond 5 in any single stage. Stage 3 had 8 blocks, exceeding the 5-block limit by 3 blocks, so 17315 × 3. Stages 1 and 2 had 2 and 3 blocks respectively, both within the 5-block limit. The complete coding would be 17311 × 1 (first stage), 17312 × 2 (stages 2 and 3), and 17315 × 3 (extra blocks in stage 3).

20,000 Series — Musculoskeletal System

7. **D. It is not reported separately; it is included in the surgical arthroscopy codes** Diagnostic arthroscopy is always bundled into surgical arthroscopy when both are performed on the same joint during the same session. The meniscus repair and chondroplasty are both surgical procedures — the diagnostic examination is included. Both surgical codes may be reported with appropriate modifiers per NCCI guidelines.

8. **A. It is not coded separately; it is included in the fracture treatment global package** Routine follow-up visits including X-rays during the fracture treatment global period are bundled into the fracture treatment code. The global package includes all routine postoperative care, imaging for healing assessment, and cast/splint management. Only unrelated E/M services (modifier 24) or unrelated procedures (modifier 79) may be separately reported.

9. **C. With a separate posterior segmental spinal instrumentation code** Posterior pedicle screw instrumentation is coded separately from the fusion using the appropriate posterior segmental instrumentation code. The instrumentation stabilizes the fusion construct. Instrumentation and fusion codes represent distinct surgical components — the fusion addresses the biological bone healing, and the instrumentation addresses the mechanical stabilization.

10. **B. Aspiration/drainage** Aspiration of a Baker's cyst using a needle is a drainage procedure — fluid is withdrawn from the cyst through percutaneous needle aspiration without an open incision. This is different from excision (surgical removal of the cyst), arthroscopy (camera-guided surgery), and open incision and drainage (which requires a surgical incision).

11. **D. CPT provides different codes based on whether the acetabular component, the femoral component, or both are revised** Revision total hip arthroplasty codes are differentiated by which components are revised. CPT provides separate codes for revision of the acetabular component only, the femoral component only, or both components. When both the femoral stem and acetabular cup are revised, the code for revision of both components is selected.

12. **A. It is included in the fracture treatment global package; cast removal is not separately coded** When the surgeon assumes the global fracture care package, cast application, cast changes, and cast removal are all bundled. The cast removal is a routine part of fracture management during the healing period and is not separately coded. Only casting performed by a different provider or for non-fracture conditions is separately reportable.

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 bundled into surgical bronchoscopy when both are performed during the same session. The transbronchial biopsy and bronchial washing are separate surgical procedures, each with their own code. The diagnostic examination is included in the surgical codes.

14. **B. With separate codes for the generator removal and each lead removal** Pacemaker component removal uses a component-based approach. When the generator and both leads are removed, separate codes are reported for the generator removal and for each lead removal. Each component has its own removal code reflecting the distinct surgical work involved.

15. **D. The respiratory/mediastinal subsection** Mediastinal tumor resection codes are located in the respiratory system/mediastinal subsection of CPT. The mediastinum — the space between the lungs containing the heart, great vessels, trachea, esophagus, and lymph nodes — has its own code range within the respiratory subsection for procedures on mediastinal structures.

16. **A. It is not reported separately; it is included in the ablation code** Endovenous ablation codes include the ultrasound guidance used during the procedure. When imaging guidance is bundled into the procedure code, a separate guidance code should not be reported. Reporting both constitutes double billing.

17. **C. The procurement of an in-situ IMA is included in the arterial CABG code; no separate procurement code is reported** When the internal mammary artery is used as an in-situ pedicle graft (left attached to its origin and redirected to the coronary artery), the procurement is included in the arterial CABG code. A separate procurement code is only reported when the IMA is harvested as a free graft — detached from its origin and requiring separate anastomosis.

18. **D. It traps blood clots traveling from the lower extremities before they reach the lungs** An IVC filter is a small, cage-like device placed in the inferior vena cava that traps blood clots traveling from the lower extremities toward the lungs. It prevents pulmonary embolism by catching the clots before they can pass through the right heart and into the pulmonary arteries. The filter does not dissolve existing clots.

40,000 Series — Digestive System

19. **B. One hot biopsy forceps polypectomy code and one cold snare 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 hot biopsy forceps and cold snare techniques have different CPT codes. Modifier 59 or XS is appended to the lesser procedure. The diagnostic colonoscopy is bundled into the surgical codes.

20. **A. With a separate hernia repair code and modifier 51 (or appropriate modifier per NCCI guidelines)** The hiatal hernia repair is a separate surgical procedure from the gastric sleeve, addressing a different anatomical problem. It is reported with its own code and modifier 51 for multiple procedures. The hernia repair is not bundled into the gastric sleeve code because they address different conditions.

21. **C. It is not reported separately; it is included in the surgical EGD ablation code** When a surgical procedure (thermal ablation of Barrett's esophagus) is performed during an EGD, the

diagnostic examination is bundled into the surgical code. Only the surgical EGD ablation code is reported. The endoscopic hierarchy applies consistently.

22. **D. Incisional/ventral hernia repair codes (parastomal hernias are a type of incisional hernia)** A parastomal hernia occurs at the site of a stoma (colostomy, ileostomy) — essentially a hernia through the abdominal wall defect created for the stoma. Parastomal hernias are classified as a type of incisional/ventral hernia in CPT. The coder should search the incisional/ventral hernia repair code range.

23. **B. The diagnostic colonoscopy code plus the tattoo injection code — both are reported since the tattoo is a separate surgical colonoscopy service** The colonoscopy identified an unresectable polyp (no surgical removal was performed) and the physician performed a tattoo injection as a separate surgical service. The diagnostic colonoscopy is reported because no polypectomy or other "higher" surgical procedure was performed that would bundle it. The tattoo injection is a separate surgical colonoscopy code reported in addition.

24. **A. Yes; CPT provides specific codes that differentiate distal pancreatectomy with and without splenectomy** CPT provides different codes for distal pancreatectomy with splenectomy and distal pancreatectomy without splenectomy. The spleen-preserving technique is more complex surgically but avoids the immunological consequences of splenectomy. The code selection must match whether the spleen was removed or preserved.

50,000 Series — Urinary, Reproductive, and Endocrine

25. **D. Both the resection code and the biopsy code with appropriate modifier** The bladder neck contracture resection and the bladder wall biopsy are two distinct surgical procedures performed at different sites within the bladder during the same cystoscopic session. Both may be reported with appropriate modifiers (59 or XS) to indicate distinct services. The diagnostic cystoscopy is bundled into the surgical codes.

26. **C. A nephroureterectomy removes the kidney, the entire ureter, and a cuff of bladder at the ureteral orifice; a simple nephrectomy removes only the kidney** Nephroureterectomy is more extensive than simple nephrectomy — it removes the kidney, the entire length of the ureter, and a small cuff of bladder tissue surrounding the ureteral orifice. This is the standard treatment for upper tract urothelial carcinoma to prevent tumor recurrence in the remaining ureteral stump.

27. **B. With the antepartum care-only code (if the required number of visits is met) or individual E/M codes for each visit if the threshold is not met** When a physician provides only antepartum care and transfers the patient before delivery, the antepartum-only code is reported if the minimum number of visits is met. If fewer visits were provided, individual E/M codes are reported for each visit. The delivery and postpartum codes are reported by the physician who provides those services.

28. **A. A radical hysterectomy removes the uterus, cervix, upper vagina, and parametrial tissue with wider margins; a total hysterectomy removes only the uterus and cervix** A radical

hysterectomy is a more extensive procedure than a total hysterectomy. It removes the uterus, cervix, upper portion of the vagina, parametrial tissue (tissue alongside the uterus), and uterosacral ligaments — all with wider surgical margins. This is performed for cervical cancer to ensure complete tumor removal with adequate margins.

29. **D. It creates a tissue mound beneath the ureteral orifice to prevent urine from refluxing from the bladder back up the ureter** The bulking agent (such as dextranomer/hyaluronic acid) is injected beneath the ureteral orifice to create a tissue mound that acts as a one-way valve, preventing urine from refluxing from the bladder back up the ureter toward the kidney. This is a minimally invasive treatment for vesicoureteral reflux, particularly in pediatric patients.

30. **C. An incision through the back, accessing the adrenal gland through the retroperitoneum without entering the peritoneal cavity** The posterior retroperitoneal approach accesses the adrenal gland through an incision in the back (flank or posterior approach), entering the retroperitoneum directly without traversing the peritoneal cavity. This approach avoids disturbing the abdominal organs and may offer advantages for smaller adrenal tumors. CPT provides different codes based on the surgical approach.

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

31. **A. The vascular territory — carotid circulation vs. vertebrobasilar circulation** Craniotomy codes for intracranial aneurysm repair (61697–61710) are organized by the vascular territory of the aneurysm. The internal carotid artery is in the carotid circulation, which has different codes from the vertebrobasilar circulation. This organization reflects the different surgical approaches and complexity associated with each vascular territory.

32. **B. It uses a gas bubble and cryotherapy to reattach the retina without a scleral buckle or vitrectomy** Pneumatic retinopexy involves injecting an expandable gas bubble into the vitreous cavity, which rises and presses against the detached retina, pushing it back into position. Cryotherapy or laser is applied to seal the retinal tear. This is a less invasive alternative to scleral buckling or vitrectomy for selected retinal detachments.

33. **D. A sympathetic block targets the autonomic sympathetic nervous system; a somatic block targets peripheral sensory or motor nerves** Sympathetic nerve blocks target the sympathetic chain ganglia of the autonomic nervous system. A lumbar sympathetic block at L2 interrupts sympathetic innervation to the lower extremity for conditions mediated by sympathetic dysfunction such as CRPS. Somatic nerve blocks target peripheral sensory or motor nerves for direct pain signal interruption.

34. **C. Expansion of the dura by opening it and suturing in a patch graft to enlarge the intradural space** Duraplasty involves opening the dura mater and suturing in a patch graft (autologous tissue, allograft, or synthetic material) to expand the intradural space. In Chiari decompression, duraplasty creates additional room for the cerebellar tonsils and CSF flow at the craniocervical junction. The duraplasty component may affect the CPT code selection.

35. **A. A stapedotomy creates a small hole in the stapes footplate and inserts a piston prosthesis; a stapedectomy removes the entire stapes and replaces it with a prosthesis** Stapedotomy is a more conservative approach — a small hole (fenestra) is created in the stapes footplate, and a piston prosthesis is inserted through the opening. Stapedectomy removes the entire stapes structure before placing the prosthesis. Both procedures restore sound conduction in otosclerosis, but stapedotomy preserves more native anatomy.

36. **B. It releases pressure within the orbit by incising the lateral canthus and the lateral canthal tendon to decompress the orbit** Lateral canthotomy and cantholysis is an emergency procedure for orbital compartment syndrome — a condition where elevated pressure within the orbit compresses the optic nerve and retinal blood supply, threatening permanent vision loss. Incising the lateral canthus and canthal tendon allows the orbital contents to expand, relieving the pressure.

Evaluation and Management

37. **D. High** Multiple new complaints with potentially life-threatening etiology (chest pain, shortness of breath, leg swelling suggesting PE or heart failure) constitute high-level problem complexity. Ordering multiple urgent diagnostic tests constitutes extensive data. Urgent hospitalization with anticoagulation constitutes the highest risk. All three MDM elements meet the high threshold.

38. **C. Domiciliary care codes for new patients (99324–99328 or current equivalent)** When a physician provides care to a patient in a domiciliary (assisted living) facility for the first time, domiciliary care codes for new patients are used. These codes are specific to the setting — they are distinct from office visit codes, hospital care codes, and nursing facility codes. The setting determines the code set.

39. **A. Three codes — initial hospital care (Friday), subsequent hospital care (Saturday), and discharge day management (Sunday)** Three distinct E/M services are reported — one for each day. Friday: initial hospital care (99221–99223). Saturday: subsequent hospital care (99231–99233). Sunday: discharge day management (99238–99239). Each day of the hospitalization is coded with the appropriate code for that type of service.

40. **B. Modifier 25** Modifier 25 is appended to the E/M code when a significant, separately identifiable E/M service is performed on the same day as a minor procedure (10-day global period). Modifier 57 would be appropriate only for major procedures with 90-day global periods. The global period of the procedure determines whether modifier 25 or 57 is used.

41. **D. 99205 plus 99417 × 1** Under the time-based pathway, 99205 requires 60 minutes for a new patient. The physician spent 75 minutes — 15 minutes beyond the 60-minute threshold. Each unit of 99417 covers 15 minutes. The 15 additional minutes support 1 unit of 99417. Total: 99205 + 99417 × 1.

42. **C. Telephone E/M service codes (99441–99443)** Telephone E/M codes cover medical management provided via telephone to an established patient. A 30-minute call falls in the 21–30

minute range (99443). These are time-based codes specifically for telephone encounters. Standard office visit codes require face-to-face encounters and do not apply to telephone-only services.

Anesthesia

43. **A. 10 units** Base units (6) + Time units (60 minutes ÷ 15 minutes/unit = 4.0) + Modifying units (P1 = 0) = 10.0 total units. Physical status P1 (healthy patient) does not add modifying units. The calculation: 6 + 4 + 0 = 10.

44. **B. With the standard anesthesia code for the surgical procedure — the type of anesthetic does not change the CPT code** The anesthesia CPT code is based on the surgical procedure, not the type of anesthetic. Spinal anesthesia, general anesthesia, or MAC for the same procedure all use the same anesthesia code. The sedation provided during the spinal block is part of the anesthetic management and is not separately coded.

45. **D. Both 99100 (extreme age — under 1 year) does NOT apply since the child is 2 years old; only 99140 (emergency conditions) applies** The child is 2 years old — extreme age (99100) applies to patients under 1 year or over 70 years, so it does NOT apply to a 2-year-old. The emergency craniotomy qualifies for 99140 (emergency conditions). Only 99140 is reported. The P4 physical status adds modifying units separately from the qualifying circumstances codes.

46. **C. Modifying units (including physical status)** Modifying units vary based on the patient's health status (physical status classification) and qualifying circumstances. Physical status P3 and P4 typically add modifying units, while P1 and P2 do not. Qualifying circumstances codes (99100, 99116, 99135, 99140) also contribute modifying units. Base units are fixed per code, time units vary by duration, and the conversion factor is a dollar amount.

Radiology

47. **B. MRI knee with contrast** Today's study is performed only with IV gadolinium contrast. Since no "without contrast" phase is performed during today's session, the code is MRI knee with contrast. The combination code (without followed by with) would only be used if both phases were performed during the same session. A prior study at a different facility on a different date does not affect today's coding.

48. **A. The hospital bills the global code since both components are provided by hospital employees** When the hospital employs both the technologist and the radiologist, both the technical and professional components are provided by the same entity. The hospital bills the global code without any modifier. The components are not split because the same employer provides both.

49. **D. Kidney function and drainage — the radiotracer uptake evaluates kidney function, and the Lasix washout assesses whether delayed drainage is due to obstruction or a dilated non-obstructed system** A renal scan with Lasix washout uses a radiotracer to evaluate kidney function (how well each kidney takes up the tracer) and drainage (how quickly the tracer washes out after

Lasix administration). Delayed washout after Lasix suggests true obstruction; prompt washout suggests a dilated but non-obstructed system.

50. **C. Simple simulation (single treatment area, single port)** Simulation code 77280 covers simple simulation involving a single treatment area with a single port or parallel opposing ports. Code 77285 covers intermediate simulation. Code 77290 covers complex simulation. The complexity level reflects the treatment setup.

51. **A. 71271 (low-dose CT for lung cancer screening) — a specific code distinct from diagnostic chest CT** Low-dose CT for lung cancer screening has a specific CPT code (71271) that is distinct from standard diagnostic chest CT codes. LDCT uses lower radiation doses and is performed on high-risk patients as a screening tool. The screening code and diagnostic CT codes are not interchangeable.

52. **B. With a separate joint injection code for the contrast administration** Arthrography involves two components: the injection of contrast into the joint and the subsequent imaging. The injection is coded with the appropriate joint injection code (with fluoroscopic guidance), and the imaging is coded with the X-ray code. These are separate services reported with separate codes.

Pathology and Laboratory

53. **D. No; none of these three tests share overlapping components** The CMP measures metabolic and liver chemistry markers. The CBC measures blood cell components. The urinalysis evaluates urine. These three tests analyze completely different specimens and analytes with no overlap. All three codes are reported in full.

54. **C. Level VI (88309)** A total colectomy specimen is classified at Level VI surgical pathology (88309) — the highest complexity level. Level VI specimens require the most extensive examination including evaluation of the entire colon for disease extent, dysplasia, margins, and lymph node involvement. Total colectomy for ulcerative colitis requires thorough examination of the entire mucosal surface.

55. **A. A quantitative clinical chemistry test** A serum ferritin is a quantitative clinical chemistry test that measures the exact concentration of ferritin in the blood, reported as a numerical value in ng/mL. Ferritin reflects body iron stores. Low ferritin indicates iron deficiency. It is not a screening test, drug test, or cytopathology test.

56. **B. Both codes — the presumptive code (one unit) and the definitive opiate code (for 3–4 analytes)** Presumptive and definitive drug testing are distinct services that may both be reported when performed on the same specimen. The presumptive code (80307) is reported once per date of service. The definitive opiate code is selected based on the 4-analyte count. Both codes are appropriate when both levels of testing are performed.

57. **D. With the intraoperative frozen section code (88331 for the first specimen, 88332 for each additional specimen)** Intraoperative frozen section has its own specific CPT codes — 88331 for

the first tissue block and 88332 for each additional tissue block examined during the same operative session. Frozen section is a separate service from the final surgical pathology examination and is not bundled into the surgical pathology level code.

58. **C. Two separate NAAT codes — one for Chlamydia and one for Gonorrhea — since each organism has its own detection code** Infectious agent detection codes are specific to the organism being detected. Chlamydia NAAT (87491) and Gonorrhea NAAT (87591) are separate tests with separate CPT codes, even when performed on the same specimen. Each organism requires its own detection code.

Medicine

59. **B. The iron sucrose therapeutic infusion** The infusion hierarchy places therapeutic drug infusion above hydration. The iron sucrose infusion is the initial service because it ranks higher than the hydration. The hydration is reported as a secondary service using the appropriate add-on code. Only one initial infusion per encounter.

60. **A. 90471 × 1 (adult injection-based code, first vaccine)** For an adult patient without physician counseling, the adult injection-based administration code is used. A single vaccine injection = 90471 × 1. The pediatric component-based codes are not used because no physician counseling was provided and the setting is a pharmacy. The vaccine product is coded separately.

61. **D. Each test is reported with its own CPT code — spirometry, lung volumes, and diffusing capacity are separate services** Spirometry (94010), lung volumes (94726), and diffusing capacity (94729) are each separate pulmonary function tests with their own CPT codes. When all three are performed, each is reported individually. There is no single comprehensive PFT code that bundles all three tests.

62. **C. 3 units — total treatment time of 47 minutes supports 3 timed units allocated based on actual minutes** The 8-minute rule considers total treatment time across all timed services. Total time is 47 minutes (20 + 15 + 12). At 15 minutes per unit, 47 minutes supports 3 units (45 minutes) with 2 remaining minutes that do not meet the 8-minute minimum for a fourth unit. Units are allocated: 1 unit to 97110, 1 unit to 97140, and 1 unit to 97116.

63. **A. With the add-on psychotherapy code 90836 (45 minutes, 38–52 minute range) plus the E/M code** When a psychiatrist provides both an E/M service and psychotherapy during the same encounter, the add-on psychotherapy codes are used. Forty 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.

64. **B. With separate OCT codes — one for the optic nerve (92133) and one for the retina (92134)** OCT of the optic nerve (92133) and OCT of the retina (92134) are distinct diagnostic tests with separate CPT codes evaluating different structures. When both are performed during the same

encounter, both codes are reported. They are not bundled into each other or into the comprehensive eye examination code.

Medical Terminology

65. **D. Destruction, breakdown, or separation** The suffix "-lysis" means destruction, breakdown, separation, or loosening. Common examples include hemolysis (destruction of red blood cells), neurolysis (destruction of nerve tissue), and adhesiolysis (separation of adhesions). "-Plasty" means repair, "-itis" means inflammation, and "-megaly" means enlargement.

66. **C. Phleb/o or ven/o** The combining forms "phleb/o" and "ven/o" both refer to veins. Common terms include phlebotomy (puncture of a vein for blood draw), phlebitis (inflammation of a vein), venous (relating to veins), and intravenous (within a vein). "Arter/o" refers to arteries, "angi/o" refers to blood vessels generally, and "lymph/o" refers to lymph.

67. **A. Half or one side** The prefix "hemi-" means half or one side. Common terms include hemiplegia (paralysis of one side of the body), hemicolectomy (removal of half the colon), and hemisphere (half of the brain). "Pan-" means all, "bi-" means two, and "peri-" means around.

68. **B. Slow breathing** Bradypnea means slow breathing, from the prefix "brady-" (slow) and the root "pnea" (breathing). Normal adult respiratory rate is 12–20 breaths per minute; bradypnea is below this range. Tachypnea means rapid breathing. Dyspnea means difficult or painful breathing. Apnea means absence of breathing.

Anatomy

69. **D. From the subclavian artery** The internal mammary artery (internal thoracic artery) originates from the subclavian artery and descends along the inner surface of the anterior chest wall. It is commonly used as a bypass graft in CABG surgery — typically the left IMA (LIMA) is anastomosed to the left anterior descending (LAD) coronary artery due to excellent long-term patency rates.

70. **C. The urinary bladder** The urinary bladder is a hollow, muscular organ that stores urine produced by the kidneys until it is eliminated through the urethra during urination. The ureters transport urine from the kidneys to the bladder. The urethra transports urine from the bladder to outside the body.

71. **A. They act as shock absorbers and distribute weight-bearing forces across the joint surface** The medial and lateral menisci are C-shaped (crescent-shaped) fibrocartilage structures that sit between the femoral condyles and the tibial plateau. They absorb shock, distribute weight-bearing forces evenly, improve joint congruency, and enhance joint stability. Meniscal tears are among the most common knee injuries treated with arthroscopic surgery.

72. **B. Thyroxine (T4) and triiodothyronine (T3)** The thyroid gland produces two primary hormones: thyroxine (T4) and triiodothyronine (T3). These hormones regulate metabolism, body

temperature, heart rate, and energy production. The thyroid also produces calcitonin, which helps regulate calcium levels. Insulin is from the pancreas. Cortisol is from the adrenal cortex. Epinephrine is from the adrenal medulla.

ICD-10-CM / Diagnosis Coding

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

74. **C. C50.411 (Malignant neoplasm of upper-outer quadrant of right female breast) or the appropriate laterality and quadrant-specific code** ICD-10-CM provides highly specific breast cancer codes that capture the quadrant location and laterality. C50.411 specifies the upper-outer quadrant of the right breast. Using an unspecified code (C50.9) when more specific information is documented would be undercoding. D05 codes are for carcinoma in situ, not invasive carcinoma.

75. **B. Z51.11 (Encounter for antineoplastic chemotherapy) as the first-listed diagnosis, followed by the malignancy code** When a patient presents specifically for chemotherapy administration, the encounter code Z51.11 is sequenced as the first-listed diagnosis to identify the reason for the visit. The malignancy code is reported as a secondary diagnosis to identify the condition being treated. This sequencing reflects that the purpose of the encounter is the chemotherapy service.

76. **A. A code from I11 (Hypertensive heart disease) plus an additional code from I50 to specify the type of heart failure** ICD-10-CM presumes a causal relationship between hypertension and heart disease when both are documented. Category I11 captures hypertensive heart disease. An additional code from I50 specifies the type of heart failure (systolic, diastolic, combined; acute, chronic, acute on chronic). Both codes are needed for complete coding.

77. **D. T86 (Complications of transplanted organs and tissue)** Complications of transplanted organs — including rejection, failure, and infection — are coded using category T86. Specific subcategory codes identify the transplanted organ and the type of complication. Z94 codes identify transplant status without complication. The T86 code is the appropriate choice when an active complication is present.

HCPCS Level II

78. **C. 175 units** The HCPCS J-code for paclitaxel specifies 1 mg per unit. The physician administered 175 mg: 175 mg ÷ 1 mg/unit = 175 units. HCPCS drug codes specify a defined quantity per unit, and the total units must reflect the total amount administered.

79. **B. 10 units** The HCPCS J-code for epoetin alfa specifies 1,000 units per billing unit. The physician administered 10,000 units: 10,000 ÷ 1,000 = 10 billing units. The coder must carefully distinguish between the drug's dosage units and the HCPCS billing units.

80. **A. The provider cannot bill the patient and must absorb the denied amount** When modifier GZ is appended (no ABN obtained) and Medicare denies the claim, the provider cannot transfer the cost to the patient. The patient was not informed of potential noncoverage and did not agree to financial responsibility. The provider must absorb the denied amount as a write-off.

Coding Guidelines

81. **D. It is not reported separately when it served only as the approach for the surgical laparoscopy** When the diagnostic laparoscopy served solely as the approach for the laparoscopic appendectomy and no independent diagnostic evaluation was performed for a separate clinical purpose, the diagnostic component is bundled into the surgical laparoscopy. The diagnostic examination is integral to the surgical approach and is not separately reportable.

82. **C. Modifier 78** Modifier 78 (unplanned return to the OR for a related procedure during the postoperative period) is appended when a complication (wound dehiscence) requires an unplanned return to the operating room during the global period. Modifier 58 is for planned staged procedures. Modifier 79 is for unrelated procedures.

83. **B. Modifier XP (Separate Practitioner)** Modifier XP specifically indicates that the procedure was performed by a different practitioner. This is one of four X modifiers (XE, XS, XP, XU) that CMS encourages as more specific alternatives to modifier 59. XE indicates separate encounter, XS indicates separate structure, XU indicates unusual non-overlapping service.

84. **A. A 10-day global period — routine postoperative care for 10 days following the procedure is included** A global period of "010" indicates a 10-day global period. Routine postoperative care for 10 days following the procedure is included in the surgical code. An E/M service on the same day requires modifier 25 if significant and separately identifiable. After 10 days, follow-up visits are separately reportable without modifiers.

85. **D. Modifier 22 is appropriate only when the operative report documents that the work substantially exceeded what is typically required and no more specific code or modifier captures the additional work** Modifier 22 is reserved for cases where the documentation supports substantially increased work — unusual anatomy, extensive adhesiolysis, morbid obesity causing significant surgical difficulty, or other documented complicating factors. It should not be appended routinely and requires supporting documentation in the operative report.

86. **C. The code is reported based on the number of units performed — each unit represents one occurrence of the described service** When a code description includes "each" or "per," it indicates the code is reported per unit of service. For example, "per lesion" means one code per lesion treated, "each additional hour" means one code per additional hour, and "per allergen" means one code per allergen tested.

87. **A. Only the open procedure code; the endoscopic approach is not separately coded when conversion occurs** When a procedure begins endoscopically (arthroscopically) but is converted to

an open approach, only the open code is reported. The abandoned endoscopic approach is not coded separately. This rule applies consistently throughout CPT for all endoscopic-to-open conversions.

Compliance and Regulatory

88. **B. Actual knowledge, deliberate ignorance, or reckless disregard of the truth or falsity of the claim** The False Claims Act's "knowingly" standard encompasses actual knowledge, deliberate ignorance, and reckless disregard. Specific criminal intent is not required. A provider who submits false claims while deliberately avoiding learning the truth or while acting with reckless disregard for accuracy satisfies the knowledge standard.

89. **D. Proactively disclose the errors to the OIG, investigate the scope, refund overpayments, and implement corrective action** When previously undetected errors are discovered during preparation for an external audit, the appropriate action is proactive disclosure. The organization should investigate the scope of the errors, quantify overpayments, initiate refunds, and implement corrective action. Destroying records or concealing errors constitutes obstruction.

90. **C. Geographic variations in the cost of practicing medicine** The GPCI adjusts each RVU component (Work, Practice Expense, PLI) for geographic variations in the cost of practicing medicine. Areas with higher costs of living have higher GPCIs, resulting in higher payments. GPCIs ensure that physician payment reflects actual regional cost differences.

Cases — Integrated Coding Scenarios

91. **A. 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. This 2.8 cm excised diameter determines the correct code within the malignant excision range for the nose/face anatomical grouping.

92. **B. Yes; for free skin grafts, the excision may be coded separately from the graft** For free skin grafts, the excision that created the defect is not included in the graft code and may be reported separately. The malignant excision code and the full-thickness skin graft code are both reported. This differs from adjacent tissue transfer, where the excision is bundled.

93. **D. 18 units** Base units (7) + Time units (150 minutes ÷ 15 minutes/unit = 10.0) + Modifying units (P3 = 1) = 18.0 total units. The calculation: 7 + 10 + 1 = 18.

94. **C. Yes; extreme age is defined as under 1 year or over 70 years** The patient is 72 years old, which exceeds the 70-year threshold for extreme age. Qualifying circumstances code 99100 applies to patients under 1 year or over 70 years. This add-on code recognizes the increased anesthetic complexity and risk in elderly patients. When reported with P3, the total modifying units would include both the P3 unit and the 99100 unit.

95. **A. The rituximab chemotherapy infusion** When rituximab is used as an antineoplastic agent for lymphoma, it is coded using chemotherapy administration codes. The infusion hierarchy places

chemotherapy at the highest level — it is always the initial service. The hydration is the lowest-priority service. The IV push is reported as an add-on.

96. **B. Chemotherapy administration codes (96413–96417)** Rituximab administered for lymphoma treatment (antineoplastic indication) uses the chemotherapy administration codes. This differs from rituximab for rheumatoid arthritis (non-antineoplastic), which uses therapeutic drug infusion codes. The drug's clinical indication — cancer treatment vs. non-cancer treatment — determines the code range.

97. **D. No; the diagnostic colonoscopy is bundled into the surgical colonoscopy codes** The diagnostic colonoscopy is always bundled into the surgical colonoscopy when surgical procedures (snare polypectomy and biopsy) are performed during the same session. Only the surgical codes are reported.

98. **C. The rectal bleeding code (K62.5) as the first-listed diagnosis, since the bleeding prompted the diagnostic colonoscopy** The patient presented for a diagnostic colonoscopy prompted by rectal bleeding — not for a routine screening. The symptom that prompted the evaluation (rectal bleeding) is the first-listed diagnosis. The polyp code is reported as a secondary diagnosis. The screening Z code would only be primary if the colonoscopy were for routine screening.

99. **A. With an E/M code and modifier 24 (unrelated E/M during the postoperative period)** The UTI is completely unrelated to the carotid endarterectomy. During the 90-day global period, an E/M service for an unrelated condition may be reported separately with modifier 24. This modifier tells the payer the evaluation is for a different condition — not a routine postoperative visit.

100. **B. No modifier; the complete global package is reported** When the surgeon provides all components — preoperative evaluation, the surgical procedure, and all postoperative care — the complete global package is reported without splitting modifiers. No modifier 54, 55, or 56 is needed.